PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: September 29, 2016

To: Gus Bustamante, Permanent Supportive Housing Services Program Manager

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ADHS Fidelity Reviewers

Method

On August 29 – 31, 2016, T.J. Eggsware and Jeni Serrano completed a review of the PSA Behavioral Heath Agency's 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. In order to effectively review PSH services within the current behavioral health system, the review process includes evaluating the working collaboration between each PSH provider and referring clinics with whom they work to provide services.

People Service Action (PSA) offers a variety of services, including: supportive living, counseling, recovery support, Art Awakenings, peer support training, and supportive living. The spectrum of housing supports, as listed on the agency website, includes: Supportive Living (SL), Supportive Living Assertive (SLA), Morten Project, and PSH. Only the PSH program and tenants served were included in this review. Members are referred to the PSH program through two main routes: (1) clinic staff completes an application for scattered site housing through the Regional Behavioral Health Authority (RBHA), and if members are eligible, they are added to a voucher waitlist and (2) directly through clinic based treatment teams. For members streamed through the RBHA scattered site housing process, once the member receives a voucher/subsidy a service provider is selected; if PSA is selected, PSA staff attends the housing briefing with the member. For some tenants, PSA partners with Chicanos Por La Causa (CPLC) to house members using a subsidy in five apartment complexes, with PSA as the service provider. Members directly referred by clinic staff may already be housed when the referral for supported housing services is made. Due to services originating at external clinics, information gathered at the Lifewell Behavioral Wellness' Oak clinic and the Southwest Network's Highland clinic were included in the review as example referral sources, with a focus on co-served members.

The individuals served through the agency are referred to as *participants, clients, or tenants*; 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 Clinical Director and Permanent Supportive Housing Services (PSHS) Program Manager;
- Individual interview with the PSHS Program Manager;

- Group interview with two Case Managers (CM) at SWN Highland clinic and two CMs at Lifewell Behavioral Wellness Oak clinic;
- Group interview with nine direct PSA PSHS staff;
- Interviews with 12 tenants who are participating in the PSH program;
- Interview with a RBHA Housing Liaison;
- Review of agency documents including: intake documents, the agency *Program Description Supported Living – Permanent Supported Housing Services*, job descriptions, the agency PSHS informational flyer, agency policies and procedures, and;
- Review of ten randomly selected agency tenant records, including clinic records for a sample of co-served tenants.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing (PSH) model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the PSH model along 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:

- For the majority of tenants, functional separation exists between housing management and PSH services; when service staff interacts with housing management (i.e., landlords) it is to advocate with or on behalf of tenants, or to facilitate tenant communication with housing management at the request of the tenant.
- The PSH housing program allows for tenant choice and tenant privacy; staff and tenants confirm scattered site units are integrated in the community. Tenants select units of their choice in the communities where they want to live; tenants can live with whom they choose, and service staff does not have keys for entry.
- Tenants do not have to accept program services or treatment through PSA in order to remain housed. Tenants decide on the types of assistance and services they receive through PSA. One member reported he was using alcohol, was not evicted, and has since maintained sobriety and his housing.
- PSA has marketed its PSH program to clinical teams, and some clinic staff reported referrals were made to the program following a presentation by PSA at the clinic. The agency provided PSH materials and resources for review. The agency website outlines Permanent Supportive Housing Services (PSHS) and other housing supports offered through PSA.
- If a tenant faces eviction, PSA staff report that they work with the tenant and landlord to facilitate a mutual rescission, so tenants can avoid having an eviction on their rental history.

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

- With the current system structure, PSA 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. Agency staff should also focus efforts on exploring other independent housing options, promoting the benefits of PSH services and developing relationships with landlords and housing providers.
- Collaborate to address the challenges of housing tenants with criminal histories. PSA staff reported members are not always forthright with them regarding information about past felony convictions. Barriers or delays to accessing housing can arise when landlords do background checks on potential tenants and identify those issues. Determine if the agency can complete background checks for referred members prior to the housing search if it is a recurring issue.
- The program should obtain rental payment information, leases or residency agreements, HQS reports and other housing related documents for all tenants who receive PSH services through the program, without constraining member choice for those who elect to not provide the information. For RBHA affiliated housing, seek to create collaborative agreements between landlords (may be referred to as housing providers) and PSH agencies, allowing for sharing of rental documents, including leases and inspections.
- PSA should expand opportunities to increase tenant voice into the design and provision of services, at the agency level not only in regards to their individualized services.
- Ensure agency PSH program description and documents align with the SAMHSA EBP of PSH. Specifically, agency documents referencing discharge and level-of-care criteria.
- The program should consider tracking staff success by tenant outcome measures (e.g., number of members assisted with obtaining housing, length of time supported to maintain the residence), not just focused on billing. PSA staff is acutely aware of encounter expectations, including reimbursement rates for certain service codes. Encounter information is tracked as stats on the electronic health record (EHR). Staff discussed billing expectations, and billing limitations. Staff reported that assisting members to look for residences with a voucher can be time consuming, including non-billable elements (e.g., cannot bill for travel), and fewer options available which extend the housing search. This can be disruptive to providing services to other members.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 (1)	An integrated, affordable apartment may not be an available option for all members. If a member is not homeless, they are no longer eligible for scattered site housing through the RBHA. RBHA staff reported that as of September 1, 2016, members are required to be homeless with a VI-SPDAT score of eight or higher to qualify for the scattered housing waitlist. Homelessness is defined as those members living in residential or transitional settings, members residing places not intended to be habituated by humans, shelters, transitional living, hotels, and members who are homeless and enter into a treatment facility and are ready for discharge. Other housing options include community living, but clinic staff report members who want to reside in a specific part of town may be difficult to place through the community living program. The extent to which clinic staff assists members to locate other housing in the community was difficult to ascertain. Limited transitional living options exist. It is not clear to what extent clinic staff is capable of actively assisting a member to locate housing in the community if they do not meet eligibility requirements for RBHA affiliated scattered site housing, community living or transitional living. One tenant interviewed who does not receive a subsidy or voucher reported he wanted to pursue that option, but he may not qualify since he is	• Stakeholders should collaborate to engage community partners in educating landlords about PSH so more housing options are available to members. For example, develop landlord outreach and marketing brochures and create a database of landlords willing to work with PSH providers. • Clinic and PSA staff should orient members to the requirements of voucher or subsidy programs. Work with members who do not qualify to explore alternative living arrangements or other resources to obtain and maintain safe, stable, and affordable housing. • Provide training to differentiate PSH from other supports available in the system; PSH should include services to help members with the most significant challenges to obtain and maintain independent housing. Some clinic staff equates PSH primarily with in-home independent living skills (ILS) support.

			housed. PSA staff report that if a tenant with no income loses a voucher, the only other option may be a treatment facility.	
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)	It appears the majority of members served have a choice of unit. Some members are housed prior to referral, but most are referred through the RBHA scattered site housing list. Members referred for PSA services through the CPLC subsidy must select from one of five apartment complexes; for those tenants the subsidy is affiliated with the residence not the member, so choice of unit is limited. PSA staff and clinic staff reported there are fewer options for members who have felony convictions or eviction histories, because many landlords will not rent to them, and an increasing number of landlords are not accepting tenants with vouchers. These market factors contribute to limiting choice, but it appears the program has attempted to cultivate some resources by building relationships with landlords. PSA staff reported it can be easier to locate housing for members with no voucher if they have enough income (e.g., two and a half times the monthly rental rate). When the program began, the PSHS Program Manager primarily assisted members with vouchers to locate housing, but as the number of members served grew, direct care staff recently assumed the responsibility. Staff reports no specific training on how to interact with landlords, or how to go into the community to develop resources.	• Train PSA direct service staff on how to interact and develop relationships with landlords. Though market factors may pose barriers to assisting members with locating housing, training and consultation on how to cultivate community resources may be beneficial.
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on	1 – 4 (4)	There is no waitlist for PSH home retention services through PSA, though some clinic staff reported significant delays in members accessing the service after referral. PSA does not maintain a waitlist for members	• Determine if the PSH program can directly request extensions through the voucher program since they are primarily responsible for assisting the members to locate housing.

	eligibility lists.		referred through the voucher or subsidy programs; waitlists are managed through the RBHA. Clinic staff report they are not given a timeframe for how long members will be on the waitlist before receiving a voucher. If members meet eligibility requirements, it appears they can wait for the unit of their choice without risking discharge from the program or losing priority for services or units, which was confirmed by one member interviewed. When members receive a scattered-site housing voucher they generally have 30 days to find a housing unit, but can request extensions for up to 120 days without losing their place on the eligibility list and having to resubmit a new housing application. Applications for extensions are submitted by clinical team CMs.	• The RHBA and agency should continue efforts to educate referral sources on how waitlists are prioritized so they can orient members who seek housing support services.
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 (4)	Tenants decide the composition of their households. Many tenants live alone, but there were examples of members who live with others (e.g., family, caregiver) which was substantiated in leases provided for review.	
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)	For the majority of tenants, property managers (i.e., landlords) have no role in providing social services, though they may inform PSA staff if there are issues in the residence (e.g., excessive traffic). They do not attend service meetings.	• See recommendation for 2.1.b, Extent to which service providers do not have any responsibility for housing management functions.
2.1.b	Extent to which service	1, 2.5, or 4	For most tenants, PSA has no role in housing management, but the agency manages one small	• Limit the number of units owned, and operated by PSA in order to maintain a

	providers do not have any responsibility for housing management functions	(4)	ten-unit non-integrated property where five PSH members reside. In that residence, with housing management and services through the same entity, functional separation does not exist. For example, the PSHS Program Manager's name was listed on one lease. PSA staff are not required to report lease infractions in any property where tenants reside.	clear functional separation of management and social service functions. If the number of tenants living in these types of residences were to increase, the program will not align as closely with the PSH model.
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	PSA's PSH staff do not maintain offices at housing sites or dwellings. No office space is maintained at the units owned and operated by PSA.	
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 (3)	Per PSA staff and tenant report, tenants using scattered site vouchers pay no more than 30% of their income toward rent. Tenants who do not have an income do not pay rent, though it was not clear if all members were oriented to rental cost obligations; one member reported she had not paid rent, and thought it was an oversight. The majority of tenants interviewed confirm they receive a voucher or subsidy for all or part of their rental costs. However, some reported they are not satisfied with their neighborhood or rental costs. Incomplete tenant housing cost data was provided, so it was not clear if all members in the program pay a reasonable amount for housing. Per PSA staff report, certain tenants declined to provide rental cost information. Based on data provided for 79% of housed members, the average payment was less than 30%. However, of the	• Work with tenants to confirm housing cost information. Work with tenants who pay more than 50% to determine their interest in pursuing more affordable housing. A cost burden exists when 50% or more of tenant income is used for housing costs, potentially leading to housing instability. However, tenants may choose to continue to pay more than 50% of income toward housing costs.

			subgroup with data available, there are tenants who pay more than 30% of income toward housing costs, with at least 13% of tenants who 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)	HQS inspections were provided and confirmed by reviewers for approximately 28% of the 83 housed tenants participating in PSA's PSH program. PSA staff report they attempt to obtain copies of HQS, but certain housing management agencies contracted through the RBHA, identified as housing providers, do not provide copies without a release from the tenant. Additionally, there are tenants with no voucher who live in residences that may not go through the inspection process. For this subset of tenants there is no formal mechanism to ensure tenants reside in settings that meet HQS; staff use observation, or reports from clinic teams. Staff report they are not formally trained on HQS, but some reported they reviewed resources online.	• Develop mechanisms to obtain copies of the HQS inspection reports as soon as possible upon the tenant obtaining housing and/or upon enrollment in the PSH program. • Develop procedures to confirm if tenant units meet HQS for those who enter the program already housed or are in residences not associated to the RBHA voucher/subsidy programs. • PSH staff are not expected to directly conduct inspections, but it would be beneficial for them to be familiar with those standards so they can work with tenants of substandard residences to explore other housing options, or to resolve quality standard concerns.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 (4)	Most tenants served through PSA reside in integrated setting; those who receive a voucher through the scattered site program are able to choose a unit in their community within Maricopa County that accepts the housing voucher. Some tenants live in housing with support through the Bridge to Permanency program, or were housed in integrated settings prior to referral for PSH services. Examples of tenants in non-integrated settings	

			include one member who resides in a sober living residence, and five tenants who reside in a ten-unit non-integrated property managed by PSA. PSA also partners with CPLC to house members using a subsidy in one of five apartment complexes, with PSA as the service provider. For tenants in those residences, no evidence was found during the review that more than 25% of units have disability related entry requirements; active PSA service members residing in those complexes ranged from 1-5%.	
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)	PSA staff reported they are familiar with the *Arizona Residential Landlord and Tenant Act*, and review the tenant's lease if issues arise, but legal rights of tenancy could not be verified for more than half of PSH members. Leases were provided and confirmed by reviewers for approximately 48% of the 83 housed tenants participating in PSA's PSH program. Some members are housed prior to referral to the PSH program, reside with family, or are in other settings not affiliated with the RBHA. It is not clear if the program has formal mechanisms to request copies of rental agreements for members with no voucher/subsidy at time of referral. Some tenants interviewed confirmed they have a lease, but others reported they have no lease. Agency documents indicated that tenants of the PSA owned and operated residence are considered month-to-month, but no original lease was located for one of those tenants. It is unclear how the service staff confirm tenants have rights to those units. Though the agency does not appear inclined to evict members with undue cause, rights of tenancy cannot be confirmed	• Develop mechanisms to obtain copies of the leases/rental agreements as soon as possible upon the tenant obtaining housing and/or upon enrollment in the PSH program. Attend lease signings, and discuss with tenants the benefits of allowing staff to review their leases with them, and to keep copies on file. Obtaining a copy of rental agreements enables the agency to confirm members have legal rights to their housing units. • The program and RBHA should consider seeking consultation regarding how the agency can confirm whether tenants have legal rights to housing units for tenants in in non-subsidized settings, or housing not affiliated with the RBHA (e.g., living with family).

			without rental agreements.	
5.1.b	Extent to which tenancy is contingent on compliance with program provisions.	1, 2.5, or 4 (4)	Tenancy is not contingent on compliance with program provisions or participation in treatment. Most tenants interviewed reported staff visits occur weekly, but indicated services through PSA were optional, with no additional program provisions to maintain tenancy. PSA agency documents indicated members are expected to participate in the development of their service plan in order to receive services, but does not specify that participation is required to maintain tenancy.	
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)	Clinic staff seem willing to refer members to various housing subsidy/voucher waitlists, but not all members are eligible for the RBHA affiliated scatterd site vouchers. Clinic staff did not appear to require members to demonstrate a positive clinical presentation, sobriety, adherence to medications, or successful completion of a treatment program in order to access housing supports. Clinic staff were familiar with a *housing first* approach, noting it may be easier for other issues to be addressed once tenants are in stable housing. Staff reported some members have limited options, and staff educate them about lengthy timeframes they may spend on waitlists, but report they will support the member's stated preference. It was not clear if all PSA staff interviewed were familiar with a *housing first* approach, but agreed the agency uses the approach after it was defined by one of the staff. PSA staff support tenants with	• Review agency documentation to ensure agency PSH program descriptions fully align with the SAMHSA EBP of PSH and do not contain language referencing level-of-care exclusions or discharge criteria.

			varied challenges, including those with co-occurring diagnosis, felony convictions, and poor rental histories. PSA staff offer assistance to any tenant referred for services, but some PSA staff report members may have symptoms that can make it difficult for them to interact with landlords. PSA staff reports they do not apply readiness requirements for program admission, but agency documents noted exclusionary and discharge criteria. On the agency documents outlining PSH services, under discharge criteria it lists: "eviction from the housing placement by the landlord and inability to find housing; needs exceed services available within the program; and illegal activity on the premises or in housing." Exclusionary criteria includes: "the individual requires a higher level of care and/or is unable to remain safe without increased services indicative of need for a placement, danger to others (DTO) and or danger to self (DTS) which places the individual and others in immediate risk or the visible future;" and "the individual presents behaviors which are unresponsive to intervention during the initial clinical contact and/or needs immediate crisis intervention."	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (2.5)	Clinic staff interviewed stated they must complete the VI-SPDAT for all members referred for RBHA affiliated scattered site housing services. Staff stated they believe members are prioritized if they are homeless for at least a year, but if they decide to accept another option, such as community living, they are no longer considered homeless. RBHA staff interviewed reported that starting in July 2016 clinic staff was notified of changes to how the scattered site housing waitlist was managed. Members who were not homeless, who did not have a VI-SPDAT submitted with the	• With the current system structure, PSA 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. Agency staff should also focus efforts on exploring other independent housing options, promoting the benefits of PSH services and developing relationships with landlords and housing providers.

			application for scattered site housing, or whose VI-SPDAT score fell below eight were removed from the list as of September 2016. Clinic staff was notified of members who did not meet the new RBHA threshold, and given the opportunity to submit updated documents if the member's situation changed. There is no eligibility requirement for tenants referred for services only (i.e., no voucher/subsidy).	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 (4)	PSA staff and tenants reported staff do not hold copies of tenant keys, and do not enter units without permission from tenants, including the units owned and managed by PSA. Leases reviewed outlined the circumstances when landlords could enter the units; a subset had addenda signed by the tenant to authorize entry in other circumstances, but PSA does not have a process in place to enter tenant units.	
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)	It is not clear if all tenants have a choice of service providers. Clinic staff interviewed reported they may select service providers on behalf of members who receive a voucher, or after agencies conduct trainings with clinic staff to explain their services. PSA staff reported some members do not initially select a provider, and they are referred after a delay, sometimes with limited time to locate a residence using their voucher. Goals noted on the clinic plans appeared to be specific to the members reviewed, but it was not clear if goals were always in the member's voice. There were	• Clinical staff should provide tenants with a list of PSH providers to choose from. PSA can include their fidelity review results, as well as other agency PSH documents on their website so clinic staff or members can access the information in order to make a more informed decision when selecting a provider. • Ongoing training should occur regarding how to work with members to develop personalized goals and objectives.

			goals and objectives written using clinical jargon which appeared to focus on requesting a specific service, not necessarily individualized member goals.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (4)	Tenants are engaged to develop an initial service plan upon enrolling in housing support services, which sometimes contains different information than what was listed on the plan from the referring clinic. Per PSA staff report, plans are reviewed every six months, but can be modified earlier if tenants want to work on something else, or achieve a goal. In PSA documentation there were examples of plans modified within six months from the prior plan, with adjusted goals and/or objectives.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	PSA staff work with members to create a service plan at intake, when tenants select the services they will receive from PSA. PSA service plans reviewed included individualized goals and objectives and appeared to reflect the voice of the member. However, services tended to contain similar types of information (e.g., ILS skills training (H2014) for maintaining healthy living environment), but allowed for adjustments to the frequency of the service. Tenants referred for services only can stop services through PSA if they choose. For tenants referred through the RBHA scattered site housing list, tenants can choose to accept PSA services after they receive a voucher, and are free to stop and start services through PSA without risking tenancy; some members elected to withdraw after PSA assisted them with finding housing. PSA staff may engage clients to end services due to lack of medical necessity, but there were no examples of	• 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).

			instances when members wanted to continue services and were closed. Staff interviewed reported members cannot close from services through the RBHA or clinics completely and maintain the voucher or subsidy for RBHA affiliated housing.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (4)	An initial plan is developed at program entry and reviewed at least every six months, but if a member wants to work on a new goal, or achieved a goal, PSA staff report they work with the tenant to revise the service plan. Evidence of service plan revision earlier than six months after the last plan was located in PSA documentation for some members, but for other members it was not clear if the plan was updated every six months.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 (2)	Some staff are persons with a lived experience, but it was difficult to determine what extent they are involved in service design decisions. The agency conducts general surveys focusing on customer satisfaction, clinical services, ability of the clinician, cultural diversity, and transportation, but staff did not identify how the information is used to drive PSH services. When asked for examples of trends in the data collection, or how the data was used, none were identified by staff. Member forums are held, which seem to focus primarily on educating tenants, with a question and answer portion. During the member interview, some had questions about their housing, supports, and how to access services. There was tenant-to-tenant feedback and mutual support. It was not clear to the reviewers if tenants asked their primary PSA staff the specific questions that arose during the group interview.	• Expand the tenant's role in designing, assessing, and determining services. Tenant satisfaction can be measured in many ways (e.g., interviews by peers, group opportunities, and written opportunities). • Develop or enhance opportunities for tenants to drive services. For example, involve individuals with a lived experience in quality assurance activities. Educate members about the EBP of PSH and then obtain tenant input on the agency documents that describe PSH services. • Develop committees, PSH tenant forums, or boards where the information gathered is used to inform service design decisions. Support true member control (e.g., the board could be chaired by a non-member but should include significant numbers of members).
7.4 Quality and Adequacy of Services				

7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	PSA's PSH program is expanding from 100 members to up to 250. The member to staff caseload average is about 11:1, with ten direct service staff assigned a caseload. The program lead carries a small caseload, and other direct staff caseloads usually range from 15-16 members, with some as high as 18 per staff report. Some newer staff work with a higher ratio of members with a voucher whom they assist to look for apartments, which can take more time from their schedule than serving those members already housed. As a result, the time per week that staff can dedicate to any one member may be limited.	
7.4.b	Behavioral health services are team based	1 – 4 (2)	Members receive services through the referring clinic, PSA, and in some cases, other providers (e.g., for counseling) simultaneously. PSA and clinic service providers maintain separate files with some similar documents that contain the same information. Clinic staff and PSH staff report barriers to coordinated services, noting that the quality, frequency, and timeliness of coordination varies by staff assigned. CM turnover was cited by PSA staff as a barrier to coordination. PSA staff reported they make phone calls to CM staff in the morning, but staff are usually in meetings and may not have a staff available to receive calls, or calls are not returned. Email, phone, and face-to-face coordination reportedly occurs, but evidence of regular contacts was not consistently located in member files at the clinics or PSH agency. CM staff reported some delays in PSA follow up after referral. In PSH and clinic documentation there were noted delays in making contact with members after referral or intake. PSA staff reported delays are occasionally due to waiting for paperwork from the clinics, but that agency staff	• Ongoing collaboration efforts between PSA and the clinic CMs should occur. Soliciting input into the service planning process and sharing written documentation is encouraged if an integrated health record cannot be implemented. • Determine if PSH agency intake forms are redundant to documents provided by the clinic. Shortening the amount of time it takes to conduct the intake process, having the primary PSH staff that works with the member complete the intake, and engaging the clinic CM to attend the intake may help to build a stronger working alliance. • The RBHA should determine if there are ways to administratively monitor members with multiple providers (e.g., through claim submission) to determine if providers are coordinating services. Work with providers to address barriers to collaboration. It may be beneficial for the RBHA, the clinics, and PSA direct care staff to brainstorm solutions.

			works to make contact with members within seven days for intake. The staff member who does the intake with the member for PSH services is not the same person who later provides services, and CMs are no longer required to attend the intake. Staff report the intake can take from one to three hours.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (2)	PSH service staff primarily work from 8 a.m. – 5 p.m., Monday through Friday. Staff can make some adjustments to their schedules (e.g., 9 a.m. - 6 p.m.) if a tenant cannot meet during regular hours. A new staff joined the team, working Tuesday through Saturday, offering some coverage on the weekend. Staff rotate an on-call phone weekly, acting in a consultative role, but no staff reported having received an after hours call that required them to go into the field to support a member. Some calls are elevated to the crisis line, directed to the warm line, or information is relayed to the CM.	• Optimally, PSH services should be available 24 hours a day, seven days a week.

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	1
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	4
Average Score for Dimension		3.25
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.17
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
7.1.b: Extent to which tenants have the opportunity to modify services selection.	1,4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences.	1-4	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	2
Average Score for Dimension		2.75
Total Score		21.67
Highest Possible Score		28