PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Gus Bustamante, Permanent Supportive Housing Services Program Manager
Sara Marriott, President & Chief Executive Officer

From: TJ Eggsware, BSW, MA, LAC
Karen Voyer-Caravona, MA, LMSW
AHCCCS Fidelity Reviewers

Method

On October 17-19, 2017, TJ Eggsware and Karen Voyer-Caravona completed a review of the People/Service/Action (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.

PSA offers a variety of services, including: outpatient supports to assist members to enhance independent living skills, peer and family recovery supports, and Art Awakenings. The agency website lists a spectrum of housing supports available through PSA, such as Supportive Living, Supportive Living Assertive, and Permanent Supportive Housing Services (PSHS). Members are referred to the PSH program through two primary routes: (1) Direct referrals by clinic treatment teams, usually for members who are housed or have an income, need assistance to obtain or maintain housing, who may not qualify for vouchers or may face extended waits for rental assistance; and (2) An application is submitted to access voucher programs through the Regional Behavioral Health Authority (RBHA), and if eligible, members join the voucher waitlist. Members streamed through the RBHA process are offered to choose from PSA and similar providers for PSH services once they receive a voucher. A Coordinated Entry process is in place in order to streamline services so that homeless individuals can be connected to available resources and housing. Due to system structure with separate providers involved in member treatment, information gathered at the Lifewell Behavioral Wellness' Oak and Windsor clinics were included in the review as sample referral sources, with a focus on co-served members. However, records reviewed and members interviewed during the review at PSA were not exclusively served at those clinics.

The individuals served through the agency are referred to as *participants, clients, or tenants*; for the purpose of this report, the terms *tenant* or *member* will be used.

During the site visit, reviewers participated in the following activities

- Overview of the PSH program and group interview with the PSHS Program Manager and Quality Management Director;
- Interviews with direct service staff including: five staff titled Co-occurring Specialists and one Senior Housing Specialist;

- Interviews with 12 members who are participating in the PSH program;
- Group interview with three Case Managers (CMs) at Lifewell Oak, and group interview with seven CMs and one Housing Specialist at Lifewell Windsor;
- Review of ten randomly selected agency tenant records, including a sub-group of clinic records for co-served tenants; and,
- Review of documents including: *PSA Behavioral Health Agency Policies and Procedures Referral, Screening and Enrollment, 3.1; and Transition Planning and Discharge, 3.26*; clinical oversight/staff supervision documents, job descriptions for Co-Occurring Specialist II and Permanent Supportive Housing Services Peer Support Specialist positions, PSA's member satisfaction survey, the agency *Permanent Supportive Housing Program Description*, and the PSHS informational flyer.

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

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

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- Members stated their appreciation of the services delivered by PSA once they were connected with the agency. Members interviewed confirmed they decide on the types of assistance and services they receive through PSA.
- Most clinic staff reported members have the option to pursue independent living without readiness requirements or screening.
- For the majority of tenants, functional separation exists between housing management and PSH services.
- Most tenants appear to reside in integrated settings, and control who accesses their residence.
- Staff confirmed that tenants do not have to accept program services or treatment through PSA to maintain tenancy or rental assistance, if applicable.

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

- At the clinic, orient members to the process of obtaining vouchers and available PSH supports as soon as members express a living situation goal, and/or when housing applications are submitted. It appears that sometimes there are delays in referrals by clinic staff, leaving just a few weeks or less to locate a unit before the member's voucher expires. As early as possible, work with members who do not qualify for vouchers or who will likely face extended wait-time to explore alternative living arrangements or other resources to obtain and maintain safe, stable, and affordable housing. Also, consider assigning the member's primary PSA staff contact as soon as

possible after intake to start the housing search.

- At clinics, ongoing training should occur regarding how to work with members to develop personalized needs and objectives. All service plans should be individualized and directly reflect the expressed goals, needs, and action steps for achieving those goals. Ensure service plans are modified to reflect the member's current status, goals, needs, and services. PSH and clinic staff should obtain input from each other when modifying plans if an integrated single plan is not an option.
- Since PSH is intended for members with the most significant housing challenges, consider further training and education with staff on strategies to engage members and market PSH services. Coordinate efforts by clinic and PSA staff to proactively engage members in PSH services with the goal of supporting ongoing tenancy. It appears member graduation from PSH is a focus at PSA, with members quickly cycling through the PSH program. Monitor staff contacts with members to ensure outreach and engagement occurs and is documented by PSH staff.
- Review whether a waitlist should be implemented at the PSH program to give members an option of seeking services through another program that may not be at capacity. PSA caseloads are above optimal staff-to- member ratios for PSH services, and it is not clear to what effect this had in staff ability to outreach and maintain contact with members or to actively assist members in their housing searches. Some notes indicated that staff worked in the office to identify housing options for members to research on their own, or relied primarily on the member to identify options.

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 2.5	Most clinic staff reported if members state their preference is independent living they can pursue it, free from assessment and assignment (e.g., to residential type treatment). Although the clinical team may recommend treatment versus independent housing, they report the member ultimately determines the option pursued, and tenants interviewed confirmed their preferences were honored. Nonetheless, some members may have fewer avenues to access an integrated, affordable residence due to constricted subsidy opportunities. Waitlists from local municipalities occasionally open and accept applications for housing voucher programs (e.g., Section 8). Additionally if a member is not homeless, they are not eligible for tenant based rental assistance (i.e., scattered site housing) through the RBHA. For members without vouchers, reviewers found limited evidence that clinic staff actively assisted members to explore housing options or offered PSH. Some PSA referrals occurred after weeks or months of unsuccessful searches by members on their own.	• As early as possible, work with members who do not qualify for vouchers or who will likely face extended wait-time to explore alternative living arrangements or other resources to obtain and maintain safe, stable, and affordable housing.
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within	1 or 4 4	The majority of members served through PSA had a choice of unit. Some members were housed prior to referral or receive no rental assistance. Approximately 49% of members have a subsidy obtained through the RBHA system. One type of voucher is available only for locations on the outskirts of Maricopa County. Most members who	• Provide training and guidance to clinic staff across the system regarding building trust and rapport with members. Some members reported they were not supported by their clinic staff. • System partners should continue to work with affordable housing stakeholders

	apartment programs, tenants are offered a choice of units		receive a voucher can choose from units where they are accepted. Nonetheless, constraint exists due to market factors such as locations restricting criminal histories (e.g., assault or substance offenses), and rents priced just above or well-above the voucher limit. Though the circumstances varied and appeared to be influenced by factors mostly outside of PSA staff control, some tenants interviewed reported they accepted the first unit offered. One tenant reported a constrained timeline to locate housing and a criminal history. One tenant reported accepting the first option due to fear (of not having other options). One reported fear that clinic staff would interfere to withdraw the option.	toward advocacy efforts with the goal of removing barriers to housing people with criminal histories.
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	If members meet eligibility requirements for voucher programs, it appears they can wait for the unit of their choice without risking discharge or losing priority. There is no waitlist for PSH services through PSA unless a member applies for vouchers. Members who apply for Section 8 or other programs not connected with the RBHA are subject to waitlists or application processes associated with those agencies. The RBHA maintains the waitlist for scattered site housing, and other programs (e.g., Community Living). Staff at clinics and PSA reported members who secure a housing voucher are allowed 30 days for a housing search, but can request extensions, and some reported voucher administrators now allow 60 days to search due to market issues such as rising rent, not accepting vouchers, and restrictions against people with assaultive histories.	
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control	1, 2.5, or 4	Tenants generally decide the composition of their households, with some exceptions. Tenants who	• Empower tenants to have full control over the composition of their household by

	the composition of their household	2.5	do not receive a voucher can elect their housemates, but those with RBHA affiliated vouchers need clinic team approval. Clinic teams provide a letter to the housing administrative agency to approve or deny requests from tenants to add people to their leases. Based on PSA data provided, leases list only the member served, with few examples cited during interviews of members with vouchers residing with others of their choosing. Documentation in one record reviewed demonstrated that staff attempted to connect two members with no vouchers so they could meet and have the option to search for a residence together in order to share housing costs.	discussing pros, cons, etc. of having someone join their living situation. • Work with housing providers to educate members on the process of adding others to leases, while supporting member choice in controlling the composition of their households, rather than seeking clinical team approval. • Consider developing guidelines for the roommate matching approach, and explore strategies to expand this option to members across the system.
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 and do not attend service meetings, though they may inform PSA or housing staff of issues in the residence (e.g., excessive traffic). A small number of PSA PSH members (about 6%) reside in settings where there may be overlap with housing management and services associated with the residence (e.g., half-way-house, transitional settings, congregate settings). Additionally, PSA owns and operates properties where about 4% of tenants reside. However, staff asserted there is separation of housing management and services within PSA, with no role by housing management in providing services.	• Educate members in residences where there may be overlap with services and management of other housing arrangements, and explore eligibility for subsidy programs if that is the member's preference.
2.1.b	Extent to which service providers do not have any	1, 2.5, or 4 4	Other than at properties that PSA manages, which represent about 4% of housed tenants, PSA has no role in housing management. Staff asserted there is separation of housing management and services	• Limit the number of PSH members housed in units owned, and operated by PSA in order to maintain a clear functional separation of management and social

	responsibility for housing management functions		within PSA, with no role by service staff in housing management functions. Staff reported that their interactions with the housing management branch of PSA were the same as they might have with any other landlord. PSA staff are not required to report lease infractions at any property. As mentioned above, about 6% of members are in settings where housing management and services may overlap.	service functions.
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 does not maintain offices at housing sites or dwellings. No office space is maintained at the units managed by PSA. In about 4% of settings where members reside, social service staff may be based in the residence, in an office on-site or frequently visit the residence.	
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	Per PSA staff and tenant report, tenants housed through voucher programs pay no more than 30% of their income toward rent, and those who have no income pay nothing. Half of the tenants interviewed confirm they receive a voucher or subsidy. One record included a signed statement from a member who paid a nominal fee to live with family. Complete housing cost data, including tenant payment and monthly income, was provided for 140 of the 227 housed members. Of the 140 tenants, about 66% pay 30% or less; 5% of members pay 31-40%; about 4% pay 41-50%; and about 25% pay more than 50%. Due to incomplete data, it was not clear if all tenants pay a reasonable amount of income toward housing.	• Work with tenants to confirm housing cost information. • 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. A distinct 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. • For those without vouchers, formalizing strategies to match roommates may aid members in sharing housing costs.
3.2 Safety and Quality				
3.2.a	Whether	1, 2.5,	HQS inspections were provided and confirmed by	• Refine mechanisms to obtain copies of the

	housing meets HUD's Housing Quality Standards	or 4 1	reviewers for approximately 19% of housed members. PSA staff report they attempt to obtain copies of HQS, but some housing management agencies contracted through the RBHA (i.e., housing providers) are not responsive in providing copies. Per data provided, about 45% of the 254 members have no voucher and/or live in residences that may not go through the inspection process, including 4% who own their home. For this group, it appears there is no formal mechanism to ensure tenants reside in settings that meet HQS. PSH staff reported they received HQS training and rely on their observations.	HQS inspection reports. Consider tracking inspection due dates and obtain updated inspections as they are completed. • Develop procedures to confirm if units meet HQS for those who are in residences not associated to the RBHA or other voucher/subsidy programs. It may be beneficial to contract with an outside agency to perform HQS inspections for tenants in residences not affiliated with RBHA or other voucher administrators.
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 settings. Examples of tenants in non-integrated settings include: transitional settings, PSA owned properties (i.e., small sized non-integrated apartment complexes), half-way-house, and other congregate settings. In complexes where more than one PSA PSH tenant resides, it appeared at most about 8% are served by PSA, based on program tenant data in comparison to the total number of units at the applicable complexes. Though it is unclear if other units were occupied by individuals with disabilities, it does not appear PSA PSH tenants are clustered.	• Inform tenants living in settings that are not fully integrated of alternative housing options. Continue to build relationships with landlords in the community to expand the potential pool of integrated housing options that can be explored with PSH members.
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	Leases were provided and confirmed by reviewers for approximately 37% of the housed tenants participating in PSA's PSH program. Some members are housed prior to referral to the PSH	• Develop mechanisms to obtain copies of all leases/rental agreements as soon as possible upon the tenant obtaining housing and/or enrollment in the PSH program,

			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. However, documentation in one record included a signed statement from a tenant that indicated they owned their home with a mortgage that they elected not to share with the agency.	regardless if the housing is thru the RBHA. Obtaining a copy of rental agreements enables the agency to confirm members have legal rights to their housing units. • 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 the majority of PSA's PSH members, tenancy is not contingent on compliance with program provisions or participation in treatment. However, for the small number of members in congregate, transitional, or settings with treatment components, tenancy may be linked to compliance with rules of the program. PSA staff report there are no rules or addenda to leases through the PSH program linking continued tenancy to treatment.	• Educate members in residences where tenancy may be linked to program compliance or treatment participation of other housing arrangements. If the member has no subsidy, explore eligibility for subsidy programs if that is the member's preference.
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	Based on interviews with clinic staff, the majority do not appear to require members to demonstrate a positive clinical presentation in order to access housing supports. Staff at one of the two clinics were familiar with a *housing first* approach. Though one clinic staff alluded to team assessment of member readiness to live independently during an interview, other staff clarified that the member's preference drives the options pursued. Overall it appears most clinic staff are supportive of referring members to various housing voucher waitlists if the member prefers independent living. Staff reported some members have limited housing options due to past evictions, criminal history, etc. Once referred, PSA contact occurs within a week based on data reviewed, and there	• On a regular basis, provide refresher education to clinic staff on a *housing first* approach.

			was no evidence of PSA staff screening members. Although one PSA staff cited challenges of adherence to a *housing first* model when serving homeless members who become housed and want to allow others to live with them, and also noted some members may not be ready for independent living. It appears some agency documents have been adjusted to accommodate PSH services. For example, the *Referral, Screening and Enrollment* policy has a section referencing exclusionary criteria, but indicates it does not apply to PSH.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	PSA staff reported there is no waitlist, or eligibility requirement, for members referred directly by clinic staff (usually individuals with no vouchers) but this may also include tenants already housed with a voucher. When referred, those members are served and none are excluded from PSH services. About 36% of all 254 PSA PSH members have no voucher, roughly 6% own their own home, have a mortgage, or apartment with no voucher, and about 49% have a RBHA affiliated voucher. To access RBHA affiliated vouchers, members must be homeless, with a VI-SPDAT score in the range for PSH. Some clinic staff seemed unsure how or if members are prioritized, and did not consistently confirm those members who have a history of difficulty maintaining housing are prioritized. PSA direct service staff reported they prioritize their caseloads based on who is homeless. There appeared to be confusion related to applications for RBHA affiliated scattered site housing and the system's Coordinated Entry process among clinic and PSA staff. PSA staff reported that some clinic staff complete scattered site housing applications. However, they were also informed that certain clinic staff no longer complete scattered site	• Stakeholders should continue efforts to educate providers on the Coordinated Entry process and how members are prioritized for PSH services. For example, try to identify at which clinics staff have reported inaccurate information about application processes in order to provide targeted training. • With the current system structure, the agency 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 staff at clinics and PSA should continue their efforts to explore other independent housing options, promoting the benefits of PSH services and developing relationships with landlords and housing providers.

			applications and that PSA staff needed to take members to a shelter to begin the application process. Members also seemed confused about applications and prioritization. One member interviewed reported hospitals are used just to have a place to stay when people do not have housing, and another indicated he thought about returning to jail in order to ensure access to a bed and steady meals.	
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. However, based on staff descriptions of certain living situations, about 4% of members are in settings where social service staff are in the residence or can access it freely.	• Work with members in settings where they do not have full control over entry to their unit to explore alternative options, and/or to affirm that their current situation aligns with their housing goal.
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	Goals noted on the clinic plans appeared to be specific to the members reviewed. However, the first need noted on the plans, sometimes repeated on the same plan, tended to relate to symptom management (e.g., needs to actively participate in mental health treatment to address the symptoms of…) regardless of the identified goal. Objectives linked to the identified needs tended to list interventions by staff position, but specific goals (often related to securing or exploring other housing) were not always directly addressed.	• Ongoing staff training should occur regarding how to work with members to develop personalized needs and objectives. All service plans should be individualized and directly reflect the expressed goals, needs, and action steps for achieving those goals.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	Clinic staff reported plans are revised at least annually, or when members experience a change in status. However, in clinic records reviewed it did not appear plans were revised when the member's living situation changed (securing or losing	• Ensure service plans are modified to reflect the member's current status, goals, needs, and services. PSH and clinic staff should obtain input from each other when modifying plans if an integrated single plan

			housing), and plans did not consistently reference PSH services through PSA. In the sample records reviewed, when plans were modified, there were minimal changes to content. Additionally, there were delays in offering PSH support or referral to housing programs after members expressed a goal to seek housing or change their living situation.	is not an option. This collaboration may prompt staff to revise plans for their prospective agency when members have a change in status necessitating a service plan review.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 4	It appears members have a choice of service providers, but clinic staff may encourage them to work with PSA due to positive prior experiences. Tenants with no RBHA affiliated housing subsidies can stop services through PSA if they choose. Additionally, staff at clinics and PSA reported members with RBHA affiliated housing subsidies can end all services and maintain tenancy. Per PSA staff report, some members elected to withdraw after PSA assisted them with finding housing. Members who elect to end clinic services are transitioned to a *Navigator* status, which does not require active service provision.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	Tenants are engaged to develop an initial service plan upon enrolling in PSA, but similar information was stated on the intake documents in member records reviewed (such as noting the person was willing to a commitment of contact with PSA staff one to four times per month). PSA staff reported the initial plan usually includes a goal related to finding safe, stable housing. PSA staff also reported the plan is reviewed at least every six months, and can be revised earlier if a member wants to work on a new goal, or achieved a goal. Evidence of service plan revision due to changes in member status was not located in the ten member records reviewed at PSA. The majority of PSH members have been with the program for less than six months, so reviewers were unable to	• Ongoing training should occur regarding how to engage members to develop personalized goals and needs/objectives. Monitor member changes (e.g., obtaining or losing housing) and offer treatment plan revisions as they occur. • Ensure outreach and engagement occurs and is documented when members are not in contact with PSH staff.

			verify if plans were revised at least every six months. It appears the PSH program staff struggle in supporting members who do not keep in contact with staff. PSA staff and documents refer to an expectation that members participate in the program, and there were notable gaps in active outreach and engagement if member contact with PSA staff lapsed. One member entered PSA services housed, with a desire to move residences, three months prior to when his lease was set to expire. After intake, PSH staff had contact with the member twice during the first month of service, no contact during the second month, and made outreach calls to the member and the CM the third month when the lease was to expire. The member experienced a hospitalization, unstable housing (i.e., paying for motel, considering half-way-house), and subsequently, homelessness.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	Based on interviews with PSA staff, it was difficult to determine to what extent persons with a lived experience are involved in PSH service design decisions. Per report, some PSH staff and the PSA Ombudsperson are persons with a lived experience. Staff were unable to confirm if any persons with a lived experience were on the PSH agency board of directors, and no advisory council exists. However, the agency website indicates that a quarter of the over 200 PSA staff have lived experience, and also includes information about the agency Chief Recovery Officer (CRO) and her lived experience. The agency conducts general surveys, but other mechanisms to obtain member input on service design or provision were not identified during interviews. During the member	• Develop or enhance opportunities for members/tenants to drive services. Member input can be obtained in many ways such as interviews by peers, written opportunities, council meetings, PSH tenant forums and involvement in quality assurance activities, committees, 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).

			interview, some had questions about housing and how to access supports (e.g. vouchers), and there was member-to-member sharing of experiences.	
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 3	PSA's PSH program is targeted to serve 250, but at the time of review data was provided for 254 members. Staff reported caseloads range from 15-20, but some exceed 20 members. Clinic staff reported PSA staff usually makes contact with members soon after referral. However, records reviewed showed that members may have contact with multiple PSA staff before their primary specialist, and frequent staff changes may occur.	• Hire qualified staff to ensure caseloads of no more than 15 members per direct care staff.
7.4.b	Behavioral health services are team based	1 – 4 2	Members receive services through the referring clinic, PSA PSH, and in some cases, other providers (e.g., for employment support) simultaneously. Providers maintain separate files with some similar documents containing redundant information. Some members in other PSA service tracks are served by separate PSA staff, and it is not clear if those staff coordinate treatment. In some records there was evidence of coordination between PSA and clinic staff, usually at referral, to request documents, if the member was not in contact with PSA staff, or occasionally, for staffings.	• Optimally, 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, hold regular planning sessions to coordinate care. Soliciting input, and sharing of service plans and other documentation is encouraged if an integrated health record is not possible.
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, but can flex their schedules if a tenant cannot meet during regular hours. Some staff worked weekend hours. For after-hours issues, staff act in a consultative role and rotate an on-call phone weekly, but staff reported rarely receiving calls. Additionally, staff reported they do not go into the field to provide support after hours. Some calls are elevated to the crisis line, or directed to the clinic team.	• Optimally, PSH services should be available 24 hours a day, seven days a week including the ability to respond to members in the community after normal 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	2.5
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		3.25
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	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	1,4	1

housing unit		
5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	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	4
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	2
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	3
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		2.13
Total Score		20.88
Highest Possible Score		28