PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: November 21, 2018

To: Gus Bustamante, Permanent Supportive Housing Services Program Manager
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AHCCCS Fidelity Reviewers

Method

On October 22-24, 2018, TJ Eggsware and Annette Robertson 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 the Central Region of Arizona.

The PSA website lists Permanent Supportive Housing Services (PSHS) as one type of housing support out of several available. Members are referred to the PSH program (i.e., PSHS) through two primary routes: (1) direct referrals by clinic teams, and, (2) voucher programs, including through the Regional Behavioral Health Authority (RBHA); members who receive vouchers are offered to choose a service provider to assist them in their housing search. Due to system structure with separate treatment providers, information gathered at the Lifewell Behavioral Wellness Lifewellness Center Oak and the Terros Health 51st Avenue Recovery Center & LADDER location were included in the review as sample referral sources. 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 Housing Director, Permanent Supportive Housing Services Program Manager, and Quality Management Director;
- Interviews with four Co-occurring Specialists II (i.e., direct service staff)at PSA;
- Individual interview with one member and group interview with ten members who participate in the PSH program;
- Group interview with three Case Managers (CMs) and one Housing Specialist (HS) at Lifewellness Center Oak, and interview with one HS at the Terros 51st Avenue Recovery Center & LADDER location;
- Review of ten randomly selected agency tenant records, including a sub-group of clinic records for co-served tenants; and,

- Review of PSA documents including: job descriptions for Co-Occurring Specialist II, Intake Specialist Housing and Permanent Supportive Housing Services Peer Support Specialist positions; *Workshop/Forum Feedback Form*; *PSA Behavioral Health Agency Policies and Procedures Referral, Screening and Enrollment, 3.1;* and *Transition Planning and Discharge, 3.26*; *Program Description Supported Living-Permanent Supported Housing Services*; and, sign-in sheets from two collaborative meetings between PSA staff and clinic HSs during October 2018.

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:

- Members interviewed reported their satisfaction with services through PSA.
- Functional separation exists between housing management and services for the majority of members in the PSA PSH program.
- The majority of PSA PSH members reside in integrated settings where they control access their residences.
- Clinic Housing Specialists reported two recent meetings hosted by PSA staff were helpful in providing information. PSA staff reported their collaborative relationship with the RBHA also allows them to relay information to clinic staff.

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

- PSH is intended for members with the most significant housing challenges. Clinic staff should ensure members who voice an independent living goal are supported to pursue that option. The focus of assessment should be on supporting tenancy.
- Staff at clinics, PSA, as well as, system stakeholders should continue their efforts to increase independent housing options, promoting the benefits of PSH services by developing relationships with landlords and housing providers.
- Support members who are not affiliated with voucher programs to live in safe, affordable housing where they have rights of tenancy. Many members are in settings where it is unclear if they have rights of tenancy (i.e., no formal lease) or are safe (i.e., no HQS).
- PSH services should be adaptable to meet tenants' changing needs and preferences. The intake date for just over 71% of members occurred the 12 months prior to the review. An example was found of PSA administrative staff directing PSH staff to engage a member in discharge discussions soon after intake. Monitor staff contacts with members to ensure outreach and engagement occurs and is documented by PSH staff. Frequent varied outreach that occurred regularly was not located in all applicable records reviewed.

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 2.5	Choice in housing types is restricted. When determining if someone was ready for PSH, clinic Housing Specialists meet with them for an assessment. The HS discusses the assessment with the clinic team. If a member is assessed by clinic staff to not be ready for independent living, multiple staff may meet with the member to recommend a treatment setting versus independent housing. Clinic staff reported the member ultimately determines the option pursued and members cannot be forced to accept the clinic team's recommendation. However, an example was found in records of a member being referred to a treatment setting around the same time as PSH. Affordability and access also contribute to constrained choice. Members have fewer avenues to access an integrated, affordable residence due to limited subsidy opportunities. If a member is not homeless, they are ineligible for rental assistance (i.e., scattered site housing) through the RBHA or certain programs. Staff reported waitlists from local municipalities rarely open and accept applications for voucher programs (e.g., Section 8). Multiple factors limiting housing options and access were reported. Staff reported fewer landlords are open to rental agreements with members with vouchers. Rental increases at	• To support member choice, clinic staff assessment should focus on identifying what services may be beneficial in supporting members' independent living goals. • Staff at clinics and PSA should continue efforts to collaborate. Educate the community about the benefits of PSH; develop relationships with landlords and housing providers, to increase access to housing. For example, explore whether time can be afforded in HS schedules at clinics to interact with landlords, to explain PSH, voucher programs, etc. Those efforts may be beneficial later when those same staff interact with the landlord and the member as a potential tenant. • System partners should continue to work with affordable housing stakeholders to establish or improve relationships with landlords. Collaborate to advocate in removing barriers to housing people with criminal or poor rental histories.

			renovated complexes and residences where rental costs are outside of the voucher allowance were identified as barriers. Members with prior criminal convictions or evictions face an added burden. One clinic staff said they requested time in their schedule to meet with landlords to develop rapport with hopes of increasing options.	
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	Certain market factors, some outside of direct PSA control, can limit members' options. Not all PSH members receive a voucher or housing subsidy, but those that do seem to have a choice of unit. Most members interviewed reported they felt they could obtain a unit of their choice without pressure to accept a unit. About half of those interviewed confirmed they had a subsidy. Members with no voucher can explore options within their budget. Some members are supported by their natural supports for some or all housing costs. Examples were found in records of PSA staff going with members to visit multiple properties. One record included documentation of clinic staff assisting a member with their independent housing search prior to referral to PSA.	
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 4	There is no waitlist for PSH services through PSA unless a member applies for vouchers. Members with no voucher, or prospect for a voucher, can be referred directly to PSA by clinic staff. These members are usually housed, but could benefit from support to improve their current living situation or maintain a residence. Wait time for a voucher usually occurs before members are referred to PSH. Members may be placed on multiple distinct wait lists. Members who apply to programs not connected with the RBHA are subject to waitlists or application processes associated with those programs. If	

			eligible, members are added to voucher waitlists. Members may access a waitlist through a Coordinated Entry process. It does not fall under the direct control of the RBHA. The RBHA manages the waitlist for scattered site housing, Community Living, as well as treatment settings not associated with PSH. Staff at clinics and PSA reported members with a voucher are allowed 30 days to secure housing. The timeline can be extended in unique situations, when additional justification is provided to the voucher administrator. Extensions are granted, usually allowing up to 120 days.	
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 2.5	Tenants who do not receive a voucher control the composition of their household, but those with certain RBHA affiliated voucher administrators need clinic team input or approval. Some staff reported clinic teams provide a letter to the housing agency to approve or deny requests from tenants to add people to their leases. Some staff were uncertain if approval was needed, if verbal approval was sufficient, or if a letter was required. PSA staff reported examples of successes in roommate matching. PSA staff collaborates to introduce members to potential roommates. The members decide whether a roommate situation would be mutually beneficial. Examples of successes were reported linking older adults as potential roommates to lower housing costs and offer opportunities for mutual support.	• Work with voucher administrators (i.e., 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. Empower tenants to have full control over the composition of their household by discussing pros and cons of having someone join their living situation. This type of interaction can support member choice if no outside approval is required. • At PSA, consider developing guidelines for the roommate matching approach. System partners may explore whether this approach can be expanded 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. Landlords may inform PSA or housing staff of issues in the residence (e.g., frequent visitors). Based on interviews and data provided it appears roughly less than 5%, reside in settings where there is overlap with housing management and services associated with the residence including: halfway house, congregate settings and treatment settings. PSA owns and manages two small properties with PSH tenants. PSA staff asserted there is separation of housing management and services at the PSA properties.	• Educate members in residences where there may be overlap with services and management of other housing arrangements. Explore eligibility for subsidy programs if that is the member's preference.
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	PSA staff reported they have no role in housing management, including at the property owned and operated by PSA where a small number of PSH tenants reside. Staff reported that their interactions with 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, it is estimated that less than 5% of members are in settings where housing management and services overlap.	• Educate members in residences where there may be overlap with services and management of other housing arrangements. Explore eligibility for subsidy programs if that is the member's preference.
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	The majority of tenants reside in independent housing or residences not affiliated with any system of care. PSA's PSH staff does not maintain offices at housing sites or dwellings. No office space is maintained at the units managed by PSA. Roughly less than 5% of members are in locations where social service staff are based in the setting, in an office on-site, or frequently visit the residence.	• Educate members in residences where social service staff are on-site or frequently visit (without member control) of other housing arrangements. Explore eligibility for subsidy programs if that is the member's preference.
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 housing. Those who have no income pay nothing. About half of the tenants interviewed confirmed they receive a voucher or subsidy. Members without vouchers may pay in excess of 50% of their income toward housing costs. To address this issue, PSA program administrators reported that about two months prior to review, they secured access to an online resource to aid staff in identifying alternative options for housing with tiered housing costs of 30, 40, or 50% based on member income. Staff cited they learned about ten to 12 new housing options in a specific area of the community where there was a limited known housing pool. Due to incomplete data, it was not clear if all tenants pay a reasonable amount of income toward housing. Complete housing cost data, including tenant payment and income, was provided for 151 of the 181 housed members. About 44% of housed tenants pay 30% or less toward housing costs, some pay nothing. At least 27% of tenants pay 50% or more of their income toward housing costs. Multiple records included PSA staff documented notes explaining the lack of housing cost data. A small number of housed members live separately from family, but rely in part or fully on them for housing costs. A small number of members are in treatment settings per treatment agreements provided in lieu of a lease.	• Regularly engage with tenants to confirm housing cost information. Discuss the benefits to them of PSH staff being aware of that information in order to support tenancy and affordable 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. A distinct cost burden exists when 50% or more of tenant income is used for housing costs, potentially leading to housing instability. A reduction in housing costs can be viewed as a positive step for those members. Some tenants may still choose to pay more than 50% of income toward housing costs. • For those without vouchers, formalizing strategies to match roommates, utilization of the online affordable housing locator service, or information gathered by the Housing Resources staff, may all offer solutions to aid members in securing more affordable housing.
3.2 Safety and Quality				
3.2.a	Whether housing meets	1, 2.5, or 4	HQS inspections were provided and confirmed by reviewers for approximately 27% of housed	• Develop procedures to confirm if units meet HQS for those who are in residences

	HUD's Housing Quality Standards	1	members. A small number of members own their home. Per data provided, about 52% of the housed members have no voucher. For this group, it appears there is no formal mechanism to ensure tenants reside in settings that meet HQS.	not associated with the RBHA or other voucher/subsidy programs. It may be beneficial to contract with an outside agency to perform HQS inspections for tenants in those types of locations. • Obtain HQS reports as they are completed.
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 the PSA PSH program reside in integrated settings. Many members live alone and some live with their natural/informal supports. A small number of members live in non-integrated settings. Examples of tenants in non-integrated settings include boarding homes, halfway houses, treatment settings, and PSA owned properties. Two or more PSA PSH tenants reside in the same apartment complexes, but it is unclear if other units were occupied by individuals with disabilities.	• 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 for approximately 63% of the housed tenants. Leases were provided for some members but data provided listed them as homeless. A small number of members own their home so a formal lease is not applicable. Subgroups of members are in settings where formal agreements may not exist. PSA staff provided a *statement* for some members. The statements were point-in-time progress notes summarizing the member' housing status. Some statements clarified the member's situation. Some	• 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, regardless if the housing is through the RBHA. Obtaining a copy of rental agreements enables the agency to confirm members have legal rights to their housing units. Educate tenants how having a lease protects their rights. 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.

			live with family or friends permanently or temporarily, some reside in other congregate settings and a small number appear to be in treatment settings. Other statements did not align with the data reported by the agency. For example, a statement provided listing a member as homeless, but for who an address was also listed on a data collection document. Vice versa, for some members data provided listed the member as homeless, but statements indicated a different status. Other examples of statements noting members lived with family, but reported as homeless in data. In those cases it was not clear if members were asked to leave the family residence between the time the statement and when data was provided for the review. Some statements noted that members resided with family, had no lease, and paid no rent. PSA reports some members declined to provide copies of leases or how much they paid toward housing. Some leases specified conversion to month-to-month terms after a specific date. Of those, some noted the terms when the tenant or landlord could end the agreement, with 30 or 60 days' notice. Not all expired leases included a caveat related to conversion to a month-to-month agreement.	• Statements provided offered clarifying information for some members. However, the statements do not replace formal agreements to confirm PSH members have rights of tenancy. Additionally, payment toward housing costs is separate from members having rights of tenancy. Paying nothing toward housing does not eliminate the requirement for rights of tenancy. If members live with family and pay nothing, they may be tenuously housed. Family may ask them to leave with little or no notice.
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 boarding residences, treatment settings, or halfway houses, tenancy may be linked to compliance with rules of the program or treatment participation.	• Support members to explore other options if they are in locations where remaining may be linked to program compliance or treatment participation.
Dimension 6 Access to Housing				

6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	Staff at one of the two clinics was familiar with a *housing first* approach. Staff reported some members have limited housing options due to their financial resources, past evictions, criminal history, etc. Clinic staff reported when determining if someone was ready for PSH, the clinic Housing Specialist staff meet with them for an assessment. The assessment appears to emphasize whether members are ready for independent living. Assessment of what services may be beneficial to support the members' independent living goals may be secondary. The assessment is discussed with the clinic team. The clinic staff may recommend treatment versus independent housing. It was reported that the member ultimately selects the option pursued. Some staff reported that income or a voucher is required for a member to be referred to PSA PSH services. An example was found in a member's records of PSA staff reporting PSH services would cease due to the member no longer having AHCCCS benefits (i.e., Non-Title 19). Another member was informed they were not eligible for services due to Non-Title 19 status. It appeared PSH services were delayed for a month or more. The member informed clinic staff of meeting with PSA staff and being told they were ineligible for services due to Non-Title 19 status. Clinic staff contacted PSA staff to resolve the issue and a referral was resubmitted. PSA's policy *Referral, Screening and Enrollment, 3.1,* indicates Non-Title 19 status as exclusionary criteria for counseling services only.	• Ensure clinic staff assessment is targeted at identifying what services may be beneficial in supporting members' living goal. • On a regular basis, provide refresher education to clinic staff on a *housing first* approach. Not all clinic staff interviewed were familiar with the approach. • If no income or voucher is required to refer members to PSH services with PSA, continue efforts to educate clinic staff on current program requirements. • Ensure PSA staff who interact with clinic staff provide the same information whether members can receive PSH services regardless if they are eligible for AHCCCS benefits.
6.1.b	Extent to which tenants with	1, 2.5, or 4	Staff at clinic and PSA, did not consistently confirm those members who have a history of difficulty	• With the current system structure, the agency has limited capacity to fully align

	obstacles to housing stability have priority	2.5	maintaining housing are prioritized. PSA direct service staff reported they prioritize their caseloads based on who is homeless or when a voucher may be expiring. Members may be prioritized differently depending on what programs they seek voucher/subsidy assistance from; some members do not have or do not seek financial assistance. Per the RBHA website, PSH is available to homeless adults determined to have a serious mental illness (SMI). Members must have a Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) score in the range for PSH. All clinic staff interviewed seemed aware that members who were homeless were prioritized. It was reported those members who were inpatient or incarcerated are a priority, as well. One clinic staff reported the RBHA developed an online portal where clinic staff submit referrals for certain treatment settings or supportive housing (i.e., scattered-site). The staff reported the portal has streamlined the referral process. Staff reported members can be directly referred to PSA for PSH and it did not appear those members must meet the homeless requirement indicated on the RBHA website. Staff reported there is no waitlist, or eligibility requirement, for members referred directly to PSA PSH by clinic staff. If housed, they may or may not have a voucher, and can benefit from support to maintain tenancy. Some may have no voucher and need assistance to look for housing.	housing priority with the EBP criteria. Any type of prioritization usually occurs before members are admitted to the PSH program. 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. • At PSA, consider formalizing procedures to prioritize support to those members with the most significant housing challenges. This may help to guide staff efforts when the program experiences staff turnover or is at a capacity.
6.2 Privacy				
6.2.a	Extent to which tenants control	1 – 4	PSA staff and tenants reported staff do not hold copies of tenant keys, nor do they enter units	• Work with members in settings where they do not have full control over entry to their

	staff entry into the unit	4	without permission. A small number of members are in settings where social service staff are in the residence or can access it freely, such as halfway houses, boarding homes or treatment settings.	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 4	Goals noted on the clinic plans appeared to be specific to the most of the members reviewed. Members interviewed reported their clinic service plans generally reflected their goals. Members can select a PSH service provider of their choice to assist them to obtain or maintain a residence. However, clinic staff reported they encourage members to select PSA due to positive prior experiences.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	Clinic staff reported plans are updated at least annually or when members experience a change in status. However, in clinic records reviewed, some were nearly a year old. It appears updates may be driven by the need to include references to new services rather than based on goal changes or other changes in a member's status. On some plans, the same symptom management focused need was repeated linked with a general description of services by staff position. Member specific goals were not always directly addressed.	• 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. Share updated plans when completed. 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 3	Members develop an initial service plan at intake with PSA. It was reported the first goal usually focused on obtaining housing. Goals at PSA appeared to be written using members' words. Needs/objectives seemed individualized, but contained similar elements member-to-member. For example, for members to develop one to four of a type of skill; the skill/s identified appeared	• System partners should continue to evaluate requirements for members to maintain vouchers/subsidies if they elect to end services. PSH and clinic services are not integrated, so scenarios where members close from one or both providers impact whether members are able to choose the services they receive. These scenarios can

			individualized. Services appeared to be written with a broader perspective, for example listing contact to occur one to four times per month. Clinic staff reported PSA staff usually makes contact with members soon after referral. Members meet with separate staff for intake before PSH services begin. Based on records reviewed, one member experienced a delay of more than a month after requesting assistance with housing and intake at PSA. There was variation in the first PSH staff documented outreach after intake, usually a phone call to set a meeting, some more than a week after intake. It was unclear if tenants with RBHA affiliated housing subsidies can stop services through PSA or through their respective clinics if they choose. Some staff reported member eligibility for services was the reason they received a voucher. Members with no RBHA affiliated voucher can close from clinic services and maintain tenancy, but they are not be able to receive PSA services.	affect members with or without RBHA affiliated or other vouchers/subsidies. • Consider assigning the member's primary PSH staff contact as soon as possible after referral to start the housing search or to provide more immediate tenancy support.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	Members reported goals at PSA are in their words and they select the services they receive. PSH staff reported they revise the PSA plan once a member's status changes but at least every six months. Reviewers were unable to verify if plans were revised at least every six months based on records reviewed. The majority of reviewed records of members were admitted to the PSH program in the six months prior to review. It is not clear if the program adapts services to meet the needs of all members. Staff turnover at PSA appears to result in lapses in service provision. Additionally, PSH staff may inconsistently outreach support members who do not keep in contact with	• Ensure outreach and engagement occurs and is documented when members are not in contact with PSH staff. If members are not in contact with the program, seek to establish contact and offer services based on the person's preference. • Provide PSH services at the member's preference and desired speed. Empower members to select supports of their choice and desired level of engagement. • Review program practices or influences that may prematurely introduce member discharge. PSH services include those that assist members to obtain and also to retain housing. Introducing the potential for

			staff. For example, in one record, there was no documented outreach for over a month. There were efforts to inform clinic staff that PSH staff was not in contact with the member, but limited evidence of outreach to the member prior to closure. There was an example in a member record of PSA staff that provides clinical oversight asking PSH staff what services the member received. PSH staff explained that the member wanted assistance to locate housing and nothing else. Documentation indicated the clinical oversight staff directed PSH staff to continue assisting the member with their housing search and to start discussing discharge. The conversation occurred just over two months after the member started services.	discharge too early may limit staff's ability to offer services to support members to retain housing. Tracking member successes year-to-year, such as members retaining housing or other goal attainment milestones, may be inhibited by premature discharges. Maintaining housing through the lease period improves tenant's ability to seek more desirable housing by improving their credit score and having a positive rental history. Additionally, the evidence is strong that alcohol use declines with time in housing. • Consider revising the agency policy with a caveat to guide outreach, transition planning and discharges for the PSH program.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	Per report, some PSH staff and a member of the agency executive team are persons with a lived experience. A Peer Specialist position is assigned to the PSH program but was vacant at the time of review. The agency conducts general member surveys annually. A weekly agency-wide meeting is facilitated by a Peer Support Specialist. A forum feedback document was provided, but appears to be a general document for attendees to reflect on events or activities.	• 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 board membership where the information gathered is used to inform service design decisions.
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 members. Caseload ratios seem to fluctuate based on staff attrition, new member referrals and discharges. The intake date for just over 71% of members occurred the 12 months prior to the review. In preparation for the review, the member roster listed 276 members. Data was subsequently	• Hire and explore strategies to retain qualified staff. Optimum caseloads are no more than 15 members per direct care staff.

			provided for 257 members and later revised to ultimately show 239 members served by 13 staff who carry caseloads. The Team Lead and a Housing Resource staff carry caseloads of about 15 members. Staff interviewed reported caseloads range from 20 to the mid-20s or more. Based on data provided, seven staff carried caseloads of 20 or more, three carried caseloads of 23 or more.	
7.4.b	Behavioral health services are team based	1 – 4 2	All members receive services through the referring clinic and PSA for PSH, as well as other providers simultaneously, in some cases. Providers maintain separate files. Similar documents are completed at PSA intake that members take part in at their referring clinics. Providers do not consistently solicit and include input from the other agency's staff when service plans are updated. Members have two or more service plans. Plans can have similar or different information across providers. In records there was evidence of coordination between PSA and clinic staff at the time of referral, to request documents, if the member was not in contact with PSA staff, or to schedule meetings. Clinic Housing Specialists are the primary liaison between PSA staff and clinic staff. Staff gave examples of positive collaborative efforts.	• 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 and integrated team cannot be implemented.
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. Staff rotate an on-call phone every two weeks for after-hours issues. If the issue cannot be resolved over the phone, members may be referred to other resources such as the local crisis response team, warm line, or the clinic team. PSA staff do not go into the field to assist members experiencing a crisis after hours.	• 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. PSA staff reported they have frequent contact with members oftentimes updating the clinical team on member's status. Due to that familiarity, PSH may be better positioned to respond to and support members in the community outside of regular 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 housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.17
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	1
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	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		2.38
Total Score		20.8
Highest Possible Score		28