PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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Method

On March 18-20, 2019 T.J. Eggsware and Annette Robertson completed a review of the Southwest Behavioral & Health Services 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.

A range of services are available through Southwest Behavioral & Health Services, including treatment for substance use conditions, residential treatment and Community Living. The agency PSH program, The Link, is the focus of this review. Information on the program was not available on the agency website, which according to agency staff, was in the process of being updated. The program documents provided for the review highlight that The Link staff can help members with symptom management, life management, transportation, activities, community integration, and to identify and access resources. Due to the nature of the referrals, which usually originate at external provider clinics, information gathered at La Frontera-EMPACT Comunidad and Lifewell Behavioral Wellness Oak was included in the review, with a focus on co-served members.

The individuals served through the agency are referred to as *clients*, but for the purpose of this report, the term "tenant" or "member" will be used.

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

- Interview with seven program administrative staff, including the PSH Program Director, the BHP Team Lead and Senior Team Leads;
- Interview with four PSH direct service staff;
- Interviews with four tenants who participate in the PSH program;
- Interviews with two Housing Specialists and four Case Managers from the two partnering clinics;
- Review of ten randomly selected member records, including co-served PSH members of La Frontera-EMPACT Comunidad and Lifewell Behavioral Wellness Oak;

- Review of agency documents such as The Link organizational chart, group descriptions, meeting minutes, brochure, flyer and program description, sample member record documents related to housing status, budgets and member safety planning.

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:

- The majority of The Link PSH tenants had a choice of unit based on data provided and interviewee reports.
- Most of The Link members live in settings where there is no overlap in housing management responsibilities and PSH services.
- About 88% of all tenants live in integrated settings in the community.
- The Link member service plans appeared to reflect member goals. Identified needs and objectives seemed individualized, with language that varied member-to-member. Additionally, the services provided by PSH staff varied by member and seemed to be flexible based on members' changing needs and/or preferences.
- PSH program administrators provided documentation of regular trainings of The Link staff in the PSH model. They also provided tracking of their more than two dozen presentations at clinic staff meetings or to answer questions about The Link since the last fidelity review.

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

- Ensure members who voice an independent living goal are supported to pursue that option. Any assessment should focus on supporting tenancy. Regularly train clinic staff on PSH, with a focus on members having a choice of housing. This is an area that referral sources directly influence. Avoid intermingling training on PSH with other treatment programs unless highlighting the benefits of PSH in comparison. Frequently orienting clinic staff on members having choice in housing may empower them to more faithfully align their services to the PSH model. Steering members from independent living should be discouraged, whether it occurs at referring clinics, PSH agencies, or by system partners. PSH is intended for members with the most significant housing challenges.
- System partners should empower tenants to have full control over the composition of their households. PSH, clinic and voucher administrative staff can partner to talk with tenants about the pros and cons of having someone join their living situation. This type of interaction can support member choice if no outside approval is required. 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 if members receive a subsidy. Members should not need to obtain clinic or PSH staff approval.

- Staff at clinics, The Link, 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. Those efforts may be beneficial later when those same staff interact with the landlord and the member as a potential tenant.
- 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 evidence units meet Housing Quality Standards). The Link program serves members who live in various types of housing. The Link staff should explore strategies to ensure all PSH members' housing meets Housing Quality Standards (HQS). PSH staff with knowledge of HQS can advocate with members if repairs or other intervention is needed. Ideally, all units where PSH members reside should meet HQS.
- PSH services should be adaptable to meet tenants' changing needs and preferences. Some members experience a delay between referral and PSH program intake, in addition to any potential delay that occurred at the clinic or prior to PSH referral. Evaluate the reasons for delays to determine what adjustments the PSH program can make to ensure speedier access to PSH services. Also, monitor to ensure members are not discharged from PSH prematurely. Only about 39% of members retained PSH services for more than a year.
- Southwest Behavioral & Health Services and the RBHA should evaluate if their respective agency websites accurately explain PSH services. Updating the PSH agency webpage with information about The Link and member outcomes may factor in educating stakeholders about the program. On one page of the RBHA website it is noted that homeless adults determined to have a serious mental illness are eligible for PSH. On another page it explains that subsidies are available to homeless adults.

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	For some members, choice of housing may be constricted. Clinic staff interviewed at one location affirmed that independent housing or treatment is sought based on members' goals. Other staff there described a good candidate for PSH services as someone who is emotionally stable, communicates with the clinic staff, attends appointments, with identified goals, and has moderate to high commitment. At another location, staff discussed matching members to the most appropriate setting when staff determines they need to develop independent living skills. Some rely on a treatment placement application form to help in determining the setting. Though it appears clinic staff approach the assessment in an effort to be supportive to members, it does not appear all clinic staff has a shared understanding or application of members' choice of housing. Affordability and access constrain choice. Staff reported fewer landlords are open to rental agreements with members with vouchers and rising rental costs are an issue. It was reported that certain landlords no longer accept vouchers administered by a specific housing provider due to a history of late rental payments. In addition, members have fewer options if they are unable to demonstrate income of two and half times the monthly rent, a frequent requirement. Some landlords modified what they accept as evidence	• To support member choice, clinic staff assessment should focus on identifying what services may be beneficial in supporting members' independent living goals. • It is perceived by the referral sources that members with financial constraints are ineligible for services with The Link program. If this is inaccurate, the program should seek to educate referral sources on requirements for program enrollment. • System partners should collaborate to establish, preserve and improve relationships with property managers over issues such as late rental payments, income requirements, and background issues.

			of income. For example, some no longer take into account whether a member receives funds for nutrition assistance. If a member is not homeless, they are ineligible for rental assistance (i.e., scattered site housing) through the RBHA or certain programs. Most clinical staff reported that members need an income or voucher/subsidy to be referred to The Link.	
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	All interviewees confirmed that PSH staff assists members to locate housing based on member preference. However, market factors can limit options, and choice was limited for tenants in agency Community Living/Community Housing. Some members are in transitional settings, awaiting housing subsidy. Not all PSH members receive a voucher or subsidy, but most of those who do, seem to have a choice of unit. Members with no voucher can explore options within their budget. The majority of tenants, about 87%, had a choice of unit based on data provided. Many are tenants in apartments, homes, or condos and some live with family or friends. PSH staff assisted 27 unhoused members to obtain housing and 28 members to move locations since October 2018.	
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 formal waitlist for PSH services through The Link unless a member applies for vouchers. Wait time for a voucher usually occurs prior to a member's PSH program intake. Members may be placed on multiple distinct housing subsidy 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. The RBHA manages the waitlist for scattered site housing and Community Living,	• The RBHA should educate staff and make it clear on applications, and informative materials, if members can decline Community Living without losing their place on eligibility lists.

			as well as treatment settings not associated with PSH. Members cannot be simultaneously on lists for a treatment setting and scattered site voucher for RBHA affiliated programs. Members with no voucher, or prospect for a voucher, can be referred directly to The Link by clinic staff for assistance to obtain and/or maintain housing. Clinic staff reported members experience a delay of many weeks before PSH staff makes contact. Additionally, an interviewee said that members on the wait-list for Community Living may move to the bottom of the waitlist after they decline three placements. Few members in The Link program are in those settings. After intake, members of The Link can search or wait for their unit of choice without restriction or risk of program discharge.	
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	Based on residence information provided, in many situations PSH tenants choose the composition of their household. Clinic staff said at least one of the housing voucher administrators request clinic team approval before members can add someone to their living situation.	• Ultimately, tenants should control the composition of their households. Aside from standard leasing and background check requirements applied to any tenant, members should not need to obtain clinic or PSH staff approval to live with someone.
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	Based on member housing information provided by The Link staff, the majority of tenants (slightly less than 96%) reside in properties where housing management has no role in service provision. Just over 4% of housed members live in transitional settings where there may be overlap between housing services and management.	

2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Interviewees confirmed that The Link program staff has no role in housing management functions. They do not collect rent, enforce lease requirements or perform any other property management functions. Interviewees stated that communication with landlords and property management is limited to providing support to members during their interactions with landlord(s). In records, an example was documented of PSH and clinic staff collaborating to address tenancy issues with a member who allowed regular guests. There was no evidence that staff reported the issue to the landlord. Clinic staff documented arranging a meeting with staff from the housing subsidy administrator agency to discuss excessive traffic in the member's residence. It was noted the purpose was to prevent eviction. About 9% of housed members are in settings where other Southwest Behavioral & Health Services staff may provide services. The Link program administrators reported they have established relationships with those staff and educated them about PSH. Staff said the other agency staff may inform PSH staff if there are issues that might impact tenancy. PSH staff takes the information for follow-up but does not overlap housing service and management functions.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	The Link program does not maintain offices at any apartment complexes or any housing sites. About 13% of housed members are in settings where social service staff may have office space or visit frequently to provide services. The settings include transitional settings and Community Living.	• 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 3	Based on data provided, 55% of housed members pay no more than 30% of income toward housing costs. Most of those members receive a subsidy and some live with family. However, at least 22% of housed members pay more than 50% of income toward housing costs. It appears a mix of rising housing costs, less availability of affordable options and tenants electing housing that aligns with their preference are factors in the range of housing costs.	• For members who pay more than 50% of income toward housing costs, explore alternate more affordable options based on their preferences. Any reduction in housing costs for members paying more than 50% of their income toward housing is positive. Housing where tenants pay 50% or more of their income is generally considered a severe cost burden. Some may elect to pay more than 50% of their income toward housing for a setting of their preference.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Complete and current HQS inspections were provided for approximately 28% of the housed tenants. The Link staff said they are trained in HQS standards but they do not perform inspections for members' units. PSH administrators reported PSH staff are trained on HQS by staff from another branch at the agency who are qualified to conduct inspections.	• Staff should ensure all PSH members are in housing that meet HQS, not just those members who receive a subsidy. Develop procedures to confirm if units meet HQS for those who are in residences not associated with the RBHA or other voucher/subsidy programs. Explore options for HQS evaluations for tenants' units, such as directly, or in partnership with other PSH agencies, contracting with an agency to perform HQS inspections in residences not affiliated with subsidy programs.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Based on interviewee reports and housing data provided, the majority of The Link tenants, about 88%, live in integrated settings in the community.	• For those members in non-integrated housing, assist them to research integrated housing options of their choice.
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	It appears the program tracks lease end dates. Organized binders with housing documents such as monthly budget forms and leases were provided for evaluation. Most leases had a handwritten note of the lease term on the document. An example was found in a record reviewed of a PSH staff working with a member in advance of their lease end date to plan for renewal. Reviewers were provided with leases for about 52% of all housed members. The percent of members with a lease was lower than the prior year review. It is not clear if changes in the housing market or other variables contributed to the decrease. Approximately 20% of members are in settings where they may not have legal rights to the housing unit, such as living with family or friends, transitional housing, or a half-way house.	• Ensure all PSH members have rights of tenancy. For members without legal rights to the housing where they reside, explore alternative options based on their preference. Explore options of formal agreements so members who live with family or friends have that option available. Additionally, rights of tenancy should be seen as distinct from housing costs in that, regardless if a member has a subsidy, prioritization of the rights of tenancy should be ensured.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Most members are in settings where tenancy is not contingent on them adhering to program rules or treatment. Members interviewed said they only need to follow their leases and there were no other program rules or service requirements. About 13% of members are in settings where there are likely rules 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	1 – 4 3	Clinic and PSH staff interviewees stated they feel staff at their respective agencies practice a housing-first approach. However, based on interviews and records, some clinic staff seems to approach housing from a continuum of care perspective where members progress from higher	• System partners should ensure clinic staff assessment is targeted at identifying what services may be beneficial in supporting members' living goals. Orient members to available options, including independent living avenues, with or without supportive

	gain access to housing units		to lower treatment before independent living. At one clinic, staff discussed matching members to an appropriate setting and some rely on a treatment placement application form to help in determining the setting they refer the member. Based on PSH, clinic records and interviews, there were examples of members who transitioned from treatment to independent living. For example, a member's current service plan, and prior plans, indicated an independent living goal. The member was in a treatment setting until their name was selected from a waitlist at an affordable complex. In another situation a member was placed in a treatment setting without being fully informed of the program beforehand. It is not clear if affordable housing market constraints, or changes to subsidy programs, are factors in clinic staff assessing members for level of care in place of steps and supports toward independent living.	services.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Prioritization is dependent on what programs members seek voucher/subsidy assistance from, if they pursue those options. Per the RBHA website, PSH is available to homeless adults determined to have a serious mental illness (SMI). Clinic staff was uncertain how the RBHA prioritizes members for RBHA affiliated subsidies. One said selection seemed to be by lottery. Staff reported members can be directly referred to The Link 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 The Link PSH by clinic staff. If housed, they may or may not have a voucher, and can benefit from support to maintain tenancy. Link staff can assist members with their	• The RBHA should consider revising the agency website for consistency. On one page it is noted that homeless adults determined to have a serious mental illness are eligible for PSH. On another page it explains that subsidies are available to homeless adults. PSH services may be separate from subsidies. Not all PSH members receive subsidies. • It is perceived by the referral sources that members with no income or voucher are ineligible for services with The Link. If this is inaccurate, The Link staff should educate referral sources on program requirements. • At The Link, consider formalizing procedures to prioritize support to those members with the most significant housing

			housing search. Link staff said if a member has a voucher with an imminent expiration, they are prioritized.	challenges. With the current system structure, the agency has limited capacity to fully align housing priority with the EBP criteria. Any type of prioritization usually occurs before PSH program intake. However, at intake the PSH program may be able to prioritize members for speedier admission if they have soon to expire vouchers, are homeless or precariously housed.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Data provided by the agency showed that most tenants live in units where they control entry to their units. The Link staff and members interviewed confirmed that the PSH staff does not enter tenant units without permission, nor do they hold keys to tenant units. About 13% of housed members reside in settings where they may not have full control over entry to their unit, including transitional living, half-way house or settings where members have roommates.	• For members that reside in settings where they do not have full control over entry to their unit, assist to explore other housing options and/or confirm 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	Behavioral Health clinic plans completed at least once in the prior year were located in most clinic files reviewed. Goals noted on the clinic plans appeared to be specific to the members reviewed. Need and objective information varied somewhat from member-to-member. Members interviewed reported their current clinic service plans reflect their goals. Due to prior positive experiences, some clinic staff may recommend specific PSH providers, but staff at another clinic said members choose the provider.	• Ensure clinic staff approach service planning with a consistent approach of identifying individualized member goals, needs and objectives.
7.1.b	Extent to which	1 or 4	Most interviewees confirmed member clinic	• Ongoing clinical staff training should occur

	tenants have the opportunity to modify service selection	1	service plans are updated annually, and in some clinic records more than one plan was completed over a year period. However, an example was found in a record of a plan not being revised after a significant event. It appears updates may be driven by the need to include references/referrals to new services, rather than basing updates on goal changes or other changes in a member's status. Some plans contained language that seemed to be written from the clinic team perspective. At both provider clinics, the phrase "maintain my mental health" was represented on a plan.	regarding how to work with members to develop personalized needs and/or objectives. • When applicable, clinic staff should work with members to update service plans to reflect current status, goals, needs, and services.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Both the staff and tenant groups interviewed reported that tenants are able to choose the services they desire from The Link. Service plans in records at the PSH agency seemed to reflect member goals. Needs and objectives appeared individualized, with language that varied member-to-member. Elements of needs, objectives and even certain service items reflected individualized interests. Under objective areas, members were able to identify their personalized plan name. Staff confirmed members can close from The Link and maintain their subsidy. Interviewees provided varied responses whether members can end clinic services and maintain RBHA affiliated subsidies. However, it does not appear members can choose to not have clinic services. Members must be affiliated with a clinic to maintain PSH services with The Link. Staff interviewed said members can transition to Navigator status at the clinic, but cannot fully terminate services.	• Educate staff and members on how choices of the services members select do or do not impact other services. For example, if terminating clinic services is allowed. If allowed, what is the impact on applicable subsidies and/or PSH services. Consider developing a simple decision flow chart that tracks how modifying services from one provider can impact other supports. • System partners should continue to evaluate requirements for members to maintain vouchers/subsidies and or services across providers if they elect to end services at any of the providers. 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 affect members with or without RBHA affiliated or other vouchers/subsidies.
7.2.b	Extent to which	1 – 4	After PSH intake, based on records reviewed,	• Attempt to evaluate why some members

	services can be changed to meet tenants' changing needs and preferences	3	services provided by The Link staff are highly flexible, and appear to be based on tenants' changing needs and/or preferences. The focus of services is to promote member independence. Tenants affirmed that that The Link staff are supportive and provide services based on their preferences. There was evidence of The Link staff working with members to revisit and update their service plans. Staff at one clinic commended The Link staff's ability to locate and obtain furniture and other similar resources for newly housed tenants. Some members experience delayed access to PSH services. Based on data provided, the average time between referral and PSH intake was over 29 days. The reasons for delayed intake was not requested from The Link staff for each of the applicable members during the course of the review. Link staff attributed the delays to various factors. Some members do not respond to outreach or may not have a location where they can be contacted. Delays in paperwork transmission from the referring agency can also cause interruptions. PSH staff said that at a minimum to begin PSH, The Link needs a document with the member's diagnosis. The program's referral form lists a range of documents required for referral. It notes that in order for the referral to occur, a complete referral packet is required within five business days. There is a space to note the due date for documents after which the referral is considered non-viable.	experience a delay between the date of referral and PSH intake date. As noted, during the course of the review the reasons for delayed intake was not requested from The Link staff for each of the applicable members. Evaluation of that information by the program may be useful. • If possible, identify trends or at what point/s there are delays between referral and intake. If there is a trend in certain providers or clinics, then collaborate with staff from those providers to streamline the process. • If paperwork processing or transmittal between agencies results in a delay, the PSH program should assess what minimally is necessary to start PSH services. Consider revising the referral packet form to indicate the minimum required for intake and subsequent forms requested as soon as possible after referral. • Some PSH staff encouraged members to abstain from substances. PSH staff would benefit from training in co-occurring treatment, harm reduction strategies, and expanding use of recovery language.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 3	The program conducts general agency member surveys every six months. Per report, some PSH staff are persons with lived experience. Since the last review, the PSH program has implemented a	• Continue exploring opportunities that allow tenants to provide input on service design. Member input can be obtained in many ways such as interviews by peers and

			more formal weekly peer roundtable, facilitated by two staff who are persons with lived experience. In that forum, PSH members can provide feedback on services. PSH staff gave examples of member suggestions for groups and outings that were later implemented.	involvement in quality assurance activities, where the information gathered is used to inform service design decisions. • Consider revising the agency survey to include specific housing items. Consider consulting with staff from other PSH agencies on survey formats utilized.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	Staff reported PSH caseloads usually range from 14-15 and rarely above a peak of 15. At the time of review, 13 direct service staff served approximately 96 PSH members diagnosed with a SMI. The Link program administrator reported that the majority of the 13 staff work with only The Link members. The remainder of their caseloads are comprised of other agency programs.	
7.4.b	Behavioral health services are team based	1 – 4 3	Members are served by staff from different agencies with separate records. Tenants receive their psychiatric care from the RBHA provider clinics, where some also receive integrated health services. The Link program primarily assists with the housing search and independent living skills needed to obtain and/or maintain housing. PSH staff provided examples of their efforts to educate and inform other agencies about The Link PSH services. In PSH records, and most clinic records reviewed, there were examples of PSH staff coordinating with clinic staff. It was often noted on The Link member service plans if the document was sent to the clinic staff and/or if clinic staff were invited to the service planning meeting. Certain PSH records included multiple documented requests of paperwork from clinic staff. It does not appear all clinic staff collaborate with PSH staff when members' clinic service plans	• System partners should seek to identify positive examples of collaborative efforts between providers. Attempt to replicate those successes with other providers and clinics. Communicate with clinic leadership to resolve barriers to integrated services and to address service delays. • Optimally, all behavioral health services should be provided through an integrated team. With separate providers, there are inherent barriers to this, including providers maintaining separate intake processes, records with possibly redundant information, etc. 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

			are updated. However, The Link staff affirmed some clinic staff are receptive and reciprocal collaborators. One PSH staff gave an example of coordinated efforts that resulted in a member receiving life-saving care. In service plans at The Link, member medical conditions and status were referenced for follow up actions. A Link program administrator confirmed that 19% of PSH members receive in-home counseling through the agency. Members can receive other services, such as support for employment searches, through the PSH agency.	necessitating a service plan review.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	PSH program staff is available on-call 24 hours a day, seven days a week per staff report and a program flyer. PSH staff report they can elect to perform on-call duties. On-call coverage rotates between those staff weekly. Staff said when members call most topics are addressed over the phone and staff rarely need to go into the field. Staff encourages members to utilize other supports, including family and friends, but also the local crisis line, before contacting PSH staff. PSH staff said this is due to the PSH staff not permanently involved in members' lives. Not all members interviewed were aware of PSH staff after hour or weekend availability.	• Ensure all members are informed of PSH staff on-call availability. While members are with the PSH program, they should be able to contact the program's on-call as a primary resource in the event of a crisis. Some staff said PSH staff likely has more contact with members than clinic staff. Due to that familiarity, PSH staff 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	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	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	3
7.3.a: Extent to which services are consumer driven	1-4	3
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	3
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		3.13
Total Score		22.05
Highest Possible Score		28