PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: December 9, 2016

To: Carole Schmidt, Program Director of Permanent Supportive Housing

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ADHS Fidelity Reviewers

Method

On November 7-9, 2016, Jeni Serrano and T.J. Eggsware completed a review of the AHCCMS' 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.

AHCCMS is contracted with the Regional Behavioral Health Authority (RBHA) to provide Permanent Supportive Housing supports. Members are introduced to AHCCMS services through three primary streams: (1) members apply for a scattered site housing voucher through the RBHA, are put on a waitlist, and when issued a voucher are offered AHCCMS services from a list of other similar providers; (2) members who have an income and need assistance with the housing search and in-home supports may be directly referred by clinic staff to AHCCMS; (3) members who are already housed can be referred for in-home services directly rather than going through any other application or waitlist procedures. AHCCMS currently provides PSH support services to 44 members, some of whom may already be housed, were referred with a voucher, or are in need of a voucher. The agency classifies direct service staff as Clinical Coordinators (CCs), tasked with coordinating with the clinical teams and keeping paperwork updated, and Community Support Workers (CSWs), who provide most direct services. The agency staff utilize a recovery curriculum, referred to as CORE, with members who elect to participate in the service.

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 the Permanent Supportive Housing Program Director, and Chief of Behavioral Health Services of AHCCMS;
- Interview with one AHCCMS PSH Clinical Coordinator and two AHCCMS PSH Community Support Workers;
- Group Interview with seven tenants who are participating in the PSH program;
- Interview with three clinic Case Managers from East Valley clinic and two Case Managers from Enclave clinic;
- Review of ten randomly selected agency tenant records, including clinic records for a sample of co-served tenants;

- Review of agency documents, including: AHCCMS' *Permanent Supportive Housing Procedural and Guideline Manual*, mission statement, organizational chart, PSH informational flyer/brochure; and,
- Review of program position descriptions: Permanent Supportive Housing Program Director, Community Resource Coordinator, Community Support Worker, and Clinical Coordinator.

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:

- All staff has optimal caseload sizes for effective service provision.
- Program does not have a waitlist; all members referred by clinical teams are eligible for services.
- Functional separation exists between housing management and PSH services; when service staff interacts with housing management (i.e., landlords) it is to advocate with or on behalf of tenants, or to facilitate tenant communication with housing management at the request of the tenant.
- The PSH housing program allows for tenant choice in composition of their household, and tenant privacy; tenants can live with whom they choose, and service staff does not have keys for entry.
- Staff and tenants confirm units are integrated in the community.
- Tenants do not have to accept program services or treatment through AHCCMS in order to remain housed.

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

- With the current system structure, AHCCMS has limited capacity to fully align housing priority with the EBP criteria. However, PSH services are not just limited to members who qualify for RBHA affiliated housing vouchers. Agency staff should also focus efforts on exploring other independent housing options, promoting the benefits of PSH services, and developing relationships with landlords and housing providers.
- The program should obtain leases or residency agreements, HQS reports and other housing related documents for all tenants who receive PSH services through the program, without constraining member choice for those who elect to not provide the information. Seek to create collaborative relationships or agreements with landlords (may be referred to as housing providers) to share rental documents, including leases and inspections.

- AHCCMS should explore all housing options with members, focusing on those who pay more than 50% of income toward housing costs, and who do not qualify for scattered site housing through the RBHA, or may experience long wait times for other subsidies. Some members appear to wait for weeks or more for a voucher. Some members reported they believe they are on voucher waitlists, however, it is unclear if they qualify since they are housed.
- Provide training to differentiate PSH from other supports available in the system; PSH should include services to help members with the most significant challenges to obtain and maintain independent housing. Some clinic staff equates AHCCMS' services primarily with in-home independent living skills (ILS) support, and report AHCCMS' PSH program has nothing to do with housing so they wouldn't refer someone who is homeless, since it is not a voucher program. There appears to be confusion among clinic staff regarding the intent of PSH services.
- AHCCMS should expand opportunities to increase tenant's voices into the design and provision of services at the agency, in addition to their individualized services.

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 (1)	An integrated, affordable apartment may not be an available option for all members. Clinic staff reported the clinical teams screen members for psychiatric stability, financial stability, whether members have legal issues, and if they are able to have a house. If their history shows evidence that they are unable to live independently, members are less likely to be referred to PSH, and the teams may refer to residential treatment. If a member is not homeless, they are no longer eligible for scattered site housing through the RBHA. Per the RBHA website, housing subsidies are available to homeless adults enrolled with Mercy Maricopa Integrated Care (MMIC) who have been determined to have a serious mental illness, with a qualifying VI-SPDAT score. During interviews with AHCCMS staff, it did not appear they were fully informed of RBHA affiliated scattered site housing eligibility requirements. For example, some noted a change requiring that members be homeless for a year or more, while others cited examples of members residing with family who were believed to be on housing waitlists. One member interviewed reported that he was on the RBHA scattered housing list for about a year and a half. The member reported that he was referred by his clinical team to AHCCMS and he	• Stakeholders should collaborate to engage community partners in educating landlords about PSH so more housing options are available to members. For example, develop landlord outreach and marketing brochures and create a database of landlords willing to work with PSH providers. • Clinic and AHCCMS staff should orient members to the requirements of voucher or subsidy programs. Work with members who do not qualify to explore alternative living arrangements or other resources to obtain and maintain safe, stable, and affordable housing.

			has been engaged in the program for the past three months, with the goal to obtain permanent housing. The member reported he meets with AHCCMS staff weekly to work on recovery curriculum, but it is not clear if the focus of services is on assisting the member to obtain housing. The member reported he resided at a shelter pending a RHBA voucher for housing, then moved into a recovery home after he received a flyer while at the shelter. The member recently found out that since he now resides in this recovery home, paying rent, he no longer meets the criteria for homelessness and therefore is not qualified for the RHBA voucher or other community vouchers, even though he is not in permanent housing.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 (1)	If members receive a RHBA voucher or can pay the rent on their own income then it appears they have choice of unit, with some restrictions of landlords not accepting the tenants' vouchers or exclusions due to past eviction histories or felony convictions. These factors contribute to limiting choice, but there is also little evidence that the AHCCMS program staff builds relationships with landlords, or cultivates resources for members with these barriers, other than consulting with an outside agency (i.e., apartment finders) for resources. Members who enter the program without a voucher have few options, and may reside in a congregate residence or with family while they wait for a voucher. It does not appear the program has cultivated, or is fully aware, of housing options in the community. For one member who had a voucher and wanted to rent a house, AHCCMS staff took the member to drive around and look for a residence that would accept the voucher. But it did not appear that staff	• Agency should train staff to search for affordable housing, build relationships with landlords, and not rely on resources such as apartment finders. Though market factors or individual landlord exclusions may pose barriers to assisting members with locating housing, training and consultation on how to cultivate community resources may be beneficial.

			identified options in advance. The member voiced frustration and declined to go and search again unless staff had researched ahead of time. The member subsequently needed to request an extension to the voucher, and began missing or cancelling appointments to search for a residence.	
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)	AHCCMS does not maintain a waitlist for members referred, but reports they will likely use the VI-SPDAT if the program reaches capacity. Clinic staff reported AHCCMS is always open for new referrals and once referred for services, intake is scheduled in a timely manner. Clinic staff reported that if a member is housed and needs in-home support, services start in a timely manner; however, if a member is referred with no voucher then AHCCMS requests that clinical staff apply for RHBA voucher. While a member is on the RHBA voucher waitlist, AHCCMS staff will meet with the member, usually weekly, to work on the agency recovery curriculum. Once a member receives a RBHA scattered site housing voucher, then the member can file extensions, if needed. Other than this search time, there was no report of limits to which members can wait for a unit of their choice.	• Formalize the plan to manage a waitlist if the program reaches capacity.
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 (4)	Tenants who receive the RHBA scattered site voucher, or are responsible for their entire rent, decide the composition of their households. It appears the majority of tenants were able to select the composition of their household, with less than 10% of members in congregate settings (e.g., boarding home, transitional living) by choice or while they wait for a voucher. Two members interviewed have been living together for the past few years and when the male received the	

			voucher, he was then able to have his girlfriend added, so both individuals are listed on the lease and have control of their composition of their household.	
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)	AHCCMS reports that for the majority of tenants, property managers (i.e., landlords) have no role in providing social services. Housing management does not attend service meetings.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 (4)	AHCCMS staff reports that they have no role in housing management. AHCCMS staff is not required to report lease infractions or collect rent. When AHCCMS staff interact with landlords it is with, or, on behalf of tenants.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	AHCCMS staff do not maintain offices at housing sites or dwellings.	
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)	About 49% of tenants who receive a voucher (e.g., scattered site housing) pay 30% or less of their income toward housing costs, and those with no income have no payment. Conversely, those tenants without a voucher pay more than 30%, with about 39% paying more than 50% of income toward housing costs.	• Explore housing options with members who pay more than 50% of income toward housing costs, who do not qualify for scattered site housing through the RBHA, or may be experiencing long wait times for other subsidies.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 (1)	AHCCMS staff reported continued efforts to obtain copies of HQS inspections, however only three were provided for this review. Lack of data is reflected in the score.	• Develop mechanisms to obtain copies of the HQS inspection reports as soon as possible upon the tenant obtaining housing/or upon enrollment in the PSH program. • Develop relationship with housing management in order to obtain copies of HQS inspections for all members of the program.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 (4)	Tenants served through AHCCMS reside in integrated settings. Tenants who receive the RBHA scattered site voucher reported that they are able to choose a unit in their community within Maricopa County at properties that accept the housing voucher. Most other tenants reside with family, or other settings integrated in the community. About 95% of tenants reside in integrated settings.	
Dimension 5 Rights of Tenancy				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing	1 or 4 (1)	AHCCMS staff reports that they continue to struggle with obtaining leases from tenants to verify rights of tenancy. AHCCMS provided 30% of leases for this review. Lack of data is reflected in	• Develop mechanisms to obtain copies of the leases/rental agreements as soon as possible upon the tenant obtaining housing and/or upon enrollment in the PSH

	unit.		the score.	program. Attend lease signings, and discuss with tenants the benefits of allowing staff to review their leases with them, and to keep copies on file. Obtaining a copy of rental agreements enables the agency to confirm members have legal rights to their housing units. • The program and RBHA should consider seeking consultation regarding how the agency can confirm whether tenants have legal rights to housing units for tenants in non-subsidized settings, or housing not affiliated with the RBHA (e.g., living with family).
5.1.b	Extent to which tenancy is contingent on compliance with program provisions.	1, 2.5, or 4 (4)	Tenancy is not contingent on compliance with program provisions or participation in treatment. Tenants are not required to accept PSH services in order to maintain tenancy. PSH services through AHCCMS are not tied directly to any housing subsidy or site-based housing locations. Tenants can start, stop, and restart services at any time they choose.	
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 (2)	Clinic staff reported the clinical teams screen members for psychiatric stability, financial stability, legal issues, etc. One staff indicated the assessment includes whether members are "able to have a house and keep a house." Based on this information, if a member has had difficulty living independently, it appears they are less likely to referred to PSH, and the teams may refer to residential treatment. Most clinic staff interviewed were unfamiliar with	• Provide training to differentiate PSH from other supports available in the system; PSH should include services to help members with the most significant challenges to obtain and maintain independent housing. Some clinic staff equates AHCCMS services primarily with in-home independent living skills (ILS) support. Staff at agencies that use a housing first approach should not screen members for readiness to live independently, or determine the options

			a *housing first* approach, but one noted it may be easier for other issues to be addressed once tenants are in stable housing. Staff reported some members have limited options. Staff educate them about lengthy timeframes they may spend on waitlists, but reported they will support the member's stated preference. However, there was evidence the team's assessment, with input from the Psychiatrist, often influences the options offered or pursued.	offered to members. Focus efforts on first housing members, based on their stated preferences, then by engaging them in services to maintain the housing.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (2.5)	There is no eligibility requirement for tenants referred for services only (i.e., no voucher/subsidy). Clinic staff interviewed stated they must complete the VI-SPDAT for all members referred for RBHA affiliated scattered site housing services. Staff stated they believe members are prioritized if they are homeless with a qualifying VI-SPDAT score. Per the RBHA website, housing subsidies are available to homeless adults enrolled with MMIC who have been determined to have a serious mental illness, with a qualifying VI-SPDAT score. The RBHA defines homelessness as individuals or families who don't have a fixed, sustainable or appropriate nighttime residence. Those include: members residing places not intended to be habitable by humans, transitional living, and members who are homeless and enter into an institution (e.g., residential, hospital) and are ready for discharge.	• With the current system structure, AHCCMS has limited capacity to fully align housing priority with the EBP criteria. However, PSH services are not just limited to members who qualify for RBHA affiliated housing vouchers. Agency staff should also focus efforts on exploring other independent housing options, promoting the benefits of PSH services, advocating for members to expand housing access and availability, and by developing relationships with landlords and housing providers.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 (4)	Staff and tenants reported that staff do not have keys to tenant apartments and do not enter their units without permission. A small number of members reside in settings where they may not fully control access to their unit (e.g., flex-care, boarding home).	

Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they want at program entry.	1 or 4 (1)	Clinic staff interviewed reported that the choice to refer to AHCCMS is usually selected by the staff submitting the referral, most often due to established relationships, a recent provider presentation, or selected from a list of similar service providers accompanied by a RBHA voucher. Clinic plans reviewed included clinical jargon, some primarily focused on symptom management, and goals that did not appear to reflect the voices of the members. Some plans did not reference housing support services.	• Clinical staff should provide tenants with a list of PSH providers to choose from. AHCCMS may consider including their fidelity review results, as well as other agency PSH documents on their website so clinic staff or members can access the information in order to make a more informed decision when selecting a provider. • Ongoing training should occur regarding how to work with members to develop personalized goals and objectives.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (1)	Clinic staff reported that tenants have the opportunity to modify service selection as often as needed; however, reviewers found no evidence of this in the records. Clinic plans are usually updated annually per report, but revised annual plans were not located in all records reviewed. Additionally, it did not appear plans were revised to reflect housing support services provided.	• AHCCMS should encourage direct staff to review tenant needs and interests in support of modifying their service plans and assure that it is documented in tenant files. Some PSH agencies elect to use a service plan addendum to provide clinic staff supportive housing specific information.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	AHCCMS staff works with members during intake to create a service plan. Service plans reviewed for this review appeared to reflect members individualized goals and objectives and appeared to be in the voice of the members. Tenants referred for services only can stop services through AHCCMS if they choose. For tenants referred through the RBHA scattered site housing list, tenants can choose to accept AHCCMS services, and are free to stop and start services without risking tenancy. Some clinic and AHCCMS staff interviewed reported members cannot close	• System partners should collaborate to develop mechanisms for tenants to choose from an array of services, including the option of not having services (e.g., to ask for case management or refuse case management). • Clarify with staff the issue of whether vouchers and tenancy can be maintained if a member closes from RBHA services.

			from services through the RBHA or clinics completely and maintain the voucher or subsidy for RBHA affiliated housing. However, there appears to be some confusion about this issue because other AHCCMS staff reported members *can* close from services and maintain vouchers and tenancy.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (3)	Staff report that tenants develop an initial plan at program entry and AHCCMS staff work with the tenant to revise the service plan when a member wants to work on a new goal or has achieved a goal. The agency utilizes a recovery curriculum, but members are not required to participate. However, there was no evidence of these revised plans in records reviewed. Some AHCCMS plans reviewed for members who wanted to obtain housing focused on the agency recovery curriculum, including budgeting, and in home independent living skills training while waiting for a voucher, rather than specifically addressing the housing search via other independent avenues.	• AHCCMS plans and services should prioritize assisting members to obtain housing, or explore housing options, if that is the primary goal voiced by the member. • AHCCMS should encourage direct staff to review tenant needs and interests in support of modifying their service plans and assure that it is documented in tenant files.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 (2)	Staff and tenants report that tenant input is valued and welcomed on a one-to-one basis. Tenants are encouraged to call the Program Director directly with any concerns or input, usually regarding their individual needs or desires. The new Program Director reports she has recently started facilitating the tenant advisory board meeting and is working on increasing the attendance; however, at this time it is not clear if services at the program level are member driven. The program does not utilize tenant surveys, and staff were not able to provide any examples of how services are consumer driven.	• Expand the tenant's role in designing, assessing, and determining services. For example, involve individuals with a lived experience in quality assurance activities. Educate members about the EBP of PSH and then obtain tenant input on the agency documents that describe PSH services. • Tenant satisfaction can be measured in many ways (e.g., interviews by peers, group opportunities, and written opportunities). • Support true member control of the advisory board (e.g., the board could be chaired by a non-member but should include significant numbers of members),

				and incorporate feedback in the program design.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	Including the Program Director, AHCCMS has seven staff and serves 44 tenants. There are four direct in-home Community Service Workers (CSW), all with less than the recommended 15 tenant caseload. The program has expanded since last review and staff reported that they have hired two Clinical Coordinators (CC) that do not hold their own caseload, but rather share tenants with CSWs.	
7.4.b	Behavioral health services are team based	1 – 4 (2)	AHCCMS staff and clinic staff report that the clinical staff is responsible for all behavioral health coordination for the tenants. AHCCMS CC staff reported that they primarily coordinate with the assigned CM, with regular updates via phone calls, emails, and occasional face-to-face contact, but they are not a part of the clinical team. Staffings are offered, and collaboration can vary by clinic or CM assignment. Clinic staff reported contact with AHCCMS CCs, often by email, and reported staffings occur about monthly. However, evidence of monthly staff meetings between AHCCMS and clinic staff was not located in clinic or AHCCMS records reviewed. Some members may also be referred to other providers for specialized treatment (e.g., to address substance use). Due to multiple providers involved, it is not clear if current information is shared. For example, AHCCMS staff did not appear to be aware if clinic staff submitted scattered site housing applications for all eligible members. AHCCMS has elected to separate duties between the CSWs and CCs. The CSWs provide most direct PSH services, and the CCs conduct intakes, develop	• Ongoing collaboration efforts between AHCCMS and the clinic CMs should occur. Soliciting input into the service planning process and sharing written documentation is encouraged if an integrated health record cannot be implemented. • The RBHA should determine if there are ways to administratively monitor members with multiple providers (e.g., through claim submission) to determine if providers are coordinating services. Work with providers to address barriers to collaboration. It may be beneficial for the RBHA, the clinics, and AHCCMS direct care staff to brainstorm solutions.

			plans with PSH members, engage members in the agency recovery curriculum, and are tasked with most coordination with clinic teams.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (3)	AHCCMS staff report that they provide flexible services, and provide services 24 hours a day and seven days a week if needed. Staff reported that they can flex their time and some staff are assigned to work weekend days. Staff reported that they all carry company cell phones and answer the phone 24 hours a day, everyday. Hours are not set to 9am-5pm but as needed and can occur in the evenings and weekends. Staff reported that they have work cell phones and answer calls or text anytime of the day or night. Staff reported that if a tenant calls with a crisis overnight, then they are to call the assigned CC to further discuss and assess. During file review there was evidence of services offered in the evening and during the day on weekends, however no evidence that implied daily 24-hour coverage. Tenants interviewed reported that they were unsure of program hours, and that they try not to call in the evenings or on weekends to respect the staff's personal time.	• It is unreasonable to expect all staff to be on call 24 hours a day, every day. It is recommended that the agency develop a documented protocol for 24-hour coverage with staff rotating through the schedule.

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	1
1.1.b: Real choice of housing unit	1,4	1
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	4
Average Score for Dimension		2.5
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	2
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		2.83
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
7.1.b: Extent to which tenants have the opportunity to modify services selection.	1,4	1
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences.	1-4	3
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week.	1-4	3
Average Score for Dimension		2.38
Total Score		20.21
Highest Possible Score		28