PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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Method

On March 6-8, 2017, T.J. Eggsware and Jeni Serrano 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 Maricopa County.

Southwest Behavioral & Health Services (SB&H) services include: counseling, case management, psychiatric evaluations/medication monitoring, skills training, health and wellness, behavior coaching, assisted medication administration, Level II and III residential treatment, community living, and homelessness support. The PSH program at SB&H is identified as The Link, and is described as integrated home support. Approximately 84% of members are housed, and about 40% of all members have a subsidy obtained through the Regional Behavioral Health Authority (RBHA), or other sources. Around 16% of members are homeless. Members are referred to the PSH program through routes that include: members apply for a scattered site housing voucher through the RBHA, are put on a waitlist, and when issued a voucher are offered services from a list that includes SB&H and other providers (or elect to have no provider or services); members who need assistance with their housing search and/or members who request in-home supports may be directly referred by clinic staff; and members may be referred internally through other SB&H programs (e.g., transitioning from residential). Due to the nature of the referrals, most of which originate at external clinics, information gathered at the Partners in Recovery (PIR) Metro clinic and Terros Townley clinic 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:

- Group interview with one Housing Specialist (HS) and five Case Managers (CM) at the PIR Metro clinic;
- Group interview with one Housing Specialist (HS), one Clinical Coordinator (CC) and four CMs at the Terros Townley clinic;

- Group interview with Director – Community Resilience, The Link Behavioral Health Professional (BHP) Lead, two Program Coordinators, and a Senior Team Lead;
- Group interview with three Link staff (i.e., Direct Service Staff), two Community Behavioral Health Specialists (i.e., Behavioral Health Technicians) and one Recovery Support Specialist (i.e., Peer Support Specialist);
- Group interviews with seven members participating in The Link Program;
- Review of ten randomly selected agency tenant records, including co-served members from The Link and partner clinics;
- Review of leases and Housing Quality Standards (HQS) inspections; and,
- Review of agency documents, including: job descriptions*, Income, Rent & Utility Calculation Worksheets, General Handbook and Program Orientation for Persons in Services*, *General Handbook & Program Orientation The Link: Integrated Home Support*, *Program Description The Link: Integrated Home Support Permanent Supported Housing*, program brochure and flyer, club/group handouts, and PSH Fidelity Feedback Group flyer.

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

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

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- In addition to increased engagement with landlords to expand the pool of potential housing for PSH members, SB&H staff reported they increased their marketing and collaboration efforts, promoting services externally (e.g., with probation officers, jail staff). SB&H staff reported they took the lead in the system to establish a provider group meeting where all PSH providers get together to brainstorm and share resources. SB&H staff reported that a shared file accessible and modifiable by other providers was created with housing resources and information about specific landlords/complexes. (For example, whether they take pets, rental cost, if utilities are included, if individuals with felonies are accepted, if individuals with histories of evictions are accepted.)
- Staff at SB&H implemented the use of *Income, Rent & Utility Calculation Worksheets* to gather information about tenant housing costs. Based on data provided, about 66% of PSH tenants pay 30% or less of their income toward rental costs; about 47% of all housed members receive a subsidy.
- SB&H staff and most members interviewed confirmed that the majority of tenants are in units integrated in the community, and once referred to The Link program, members appear to have choice of unit.
- PSH staff is available 24 hours/seven days a week, with office hours Monday through Sunday. An after hours on-call phone number is

reportedly provided to all members, and those interviewed were aware of the resource.

- The program has ample staff. The caseload ratio of members to staff is approximately 9:1. In addition to 23 direct service staff, The Link Program has 12 other staff positions, including: three Behavioral Health Professionals, one Community Nurse, two Program Coordinators, one Field Operations Manager, three Senior Team Leads, and two Administrative Support staff.

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

- The program should continue efforts to obtain rental payment information, leases or residency agreements, HQS reports and other housing related documents for all members who receive supported housing services through the program. Track the term of the lease for members, so service staff can proactively assist tenants with lease renewals or relocation services.
- Treatment plans at clinics and SB&H should reflect individual member goals, needs, and objectives, and be modified as statuses change. As much as possible, use the words of the members as they author their plans.
- Build on existing opportunities for individuals with a lived experience of mental illness to shape services design and provision.
- In PSH, 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, it is recommended that all involved providers hold regular planning sessions to coordinate care in order to work more fluidly as a team, and to prevent duplication of efforts or conflicting approaches. Ongoing coordination with clinic CMs and other involved providers, including soliciting input into the service planning process and sharing of written documentation, is encouraged if an integrated health record or services through an integrated team cannot be implemented.
- The Link program should continue to enhance PSH materials and resources to distinguish those supports from other agency services, including the use of multimedia to market PSH services. For example, it appears PSH is not listed on the agency website. Consider noting that the agency offers PSH services with links to PSH resources, The Link program, the supervisor's contact information, etc.

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)	Staff at one clinic reported they do not screen members for independent living readiness, and all members are eligible for PSH services. However, staff at the second clinic reported they know members are ready for PSH services when they are: stepping down (e.g., from Flex Care treatment), ready to live on their own, able to take medications without prompting, able to attend to activities of daily living, able to budget money, attending groups, attending appointments, receiving a voucher, and stable.	• Provide training to differentiate the evidence-based practice of 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. Optimally, members are educated about all available housing options, they make the choice of what option to pursue, and clinical teams assess how best to support members in the choice the member selects.
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)	The majority of tenants had a choice of unit based on data provided and staff report. Nearly half of all tenants have a subsidy through the RBHA system or other source. When searching for a residence, The Link staff reportedly encourage tenants to consider multiple units rather than accepting the first available to ensue they will be satisfied with the unit. Some members live independently in their own residence with no subsidy where they reportedly own a home, or were able to choose a unit on the open market. A minority of housed members are in transitional living, or community living settings where there was restriction on the unit offered, with likely no alternative option immediately available. Market factors can limit the housing options for members with felony conviction histories or eviction histories. Also, some landlords no longer	• System partners should continue to educate clinic staff on the RBHA affiliated scattered-site housing program, and whether members are assigned a unit or have a choice of unit where the voucher is accepted.

			accept vouchers, and some tenants have had to move due to rent increases beyond what vouchers pay. Clinic staff seemed unclear regarding member choice of unit. Staff at one clinic reported members who receive a voucher through the RBHA referral process (i.e., scattered site) can choose from a unit. However, at another clinic, staff reported that for all RBHA affiliated housing, even with scattered site vouchers, members are assigned a unit and can choose to accept or decline the option.	
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 at SB&H, and clinic staff can directly refer members who are housed if they need in-home support or experience issues that could lead to eviction. Clinic staff reported they are not aware of members' status on voucher/subsidy waitlists between the time they submit the application and the time the member is issued a voucher. Members who receive a housing voucher are given 30 days to find a housing unit, and two extensions can be arranged if more time is needed. There was no evidence members are removed from waitlists if they elect to wait for the unit of their choice. Although, one staff reported they heard of people being taken off the list, positing it was likely a clinical team decision, not staff from the RBHA making the determination. The staff stated that if a person declined multiple options, RBHA staff would ask clinic staff for a status update.	• Clarify how RBHA affiliated waitlists are managed with clinic and PSH staff, members, and community partners. Consider providing periodic updates on waitlist statuses.
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)	Staff and most members interviewed confirmed that tenants have control over the composition of their household. If a member has a subsidy, it was reported that generally tenants can add others to their lease if the person can pass a background check and demonstrate their ability to meet lease	• The Link program staff can advocate in an effort to empower tenants to have full control over the composition of their household. Staff at the clinic and PSH agency can work together with the tenant

			requirements. However, some clinic staff reported that housing providers need to approve additions to leases (for members who receive a subsidy), and that they coordinate this approval with the clinic staff. This puts some restriction on tenant control over the composition of their household, but it does not appear tenants are forced to live with others not of their choosing. Additionally, about 12% of PSH tenants reside in settings where tenants do not fully control the composition of the household (e.g., some community living settings half-way-houses, or transitional settings).	to discuss pros, cons, potential impact, etc. to tenants of having someone join their living situation. • Work with housing providers to develop mechanisms to educate members on the process of adding others to leases, while supporting member choice in controlling the composition of their households, rather than housing providers seeking clinical approval.
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 housed members, housing management staff has no authority or role in providing social services. PSH staff interacts with landlords or housing providers if they inform service staff that tenants are struggling, and if there are issues that could lead to eviction, but it does not appear management has any role in service provision. A minority of members are in settings (e.g., transitional or with a treatment element) where there may be some overlap in service and housing management roles.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 (4)	Staff and tenants reported that The Link staff do not have any responsibility for housing management functions, are not required to act on behalf of landlords, do not report potential lease violations, do not collect rent, etc. Service staff interactions with landlords occur at the request of the tenants, when advocacy or support is needed.	

2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	For the majority of tenants, social and clinical service providers are based off-site. PSH Services are readily accessible, mobile and can be brought to tenants at their request. About 12% of members reside in settings where social service staff may be on site (e.g., group home, half-way house) or may visit frequently (e.g., CLP).	
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, tenant housing costs range from 0-30% of income for those tenants who receive a housing subsidy, which includes approximately 47% of the housed members. Six of the seven members interviewed receive rental subsidies. However, about 20% of housed members pay 50% or more of income toward 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.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 (1)	All PSH staff have been trained in Housing and Urban Development (HUD) HQS standards at least once. Completed and passed annual HQS inspections were provided for about 24% of housed members. Approximately 13% of tenants are in HUD housing. Staff reported some RBHA system affiliated housing providers had not been releasing evidence of passed HQS inspections, but were instructed to do so at a meeting about two weeks prior to the review.	• Track and obtain updated inspections as they are completed. • It may be beneficial to rely on qualified inspectors already employed at the agency, or to contract with an outside agency, to perform HQS inspections for tenants in residences not affiliated with RBHA contracted housing providers.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 (4)	The Link staff, clinical staff and tenants interviewed report most members are in integrated housing. Based on data provided, about	• Inform tenants living in settings that are not fully integrated of alternative housing options. Continue to build relationships

			80% of tenants are in integrated housing. A subset of SB&H tenants reside in areas where other members reside, including a small apartment complex and some multi-family HUD properties where it is likely other tenants are individuals with disabilities. About 14% of SB&H housed members are settings where it appears the majority of tenants are individuals with disabilities.	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)	The extent to which tenants have legal rights to housing units could not be verified for all members. About 5% of housed members reside in a home where they reportedly hold a mortgage. Current leases were provided for a minority of the remaining tenants (about 32%). Some leases provided were not current, and a small number of members are in settings where they may not have legal rights to the housing unit (e.g., with family, half-way house, group home).	• The agency should attempt to obtain tenancy documentation, including leases, addenda to leases, or residency agreements for all members. Track when tenant leases will end, expire, or terminate so that PSH service staff can proactively support tenants on the process of renewing a lease.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 (4)	A small percent of members (about 6%) reside in settings, such as half-way houses, or other transitional settings where there is some expectation that they engage in treatment. For most housed members (about 94%), tenancy is not contingent on compliance with program provisions or participation in treatment. Staff reported, and most tenants interviewed confirmed, that they are not required to participate in services through The Link in order to maintain tenancy; they can start, stop or restart services at any time they choose. One member speculated that members at least needed to comply with medications, and that some level of treatment participation was required.	• Ensure those members who are in residences with no program provisions are informed that their tenancy is not contingent on compliance with requirements other than those found in a standard lease.

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)	The Link staff and tenants interviewed reported that members are not required to demonstrate readiness prior to housing. Staff at one clinic reported that part of their job was to gauge member readiness, including substance use and past hospitalizations, which could impact different options offered, such as: 24 hour co-occurring, Flex Care treatment, outpatient programs, counseling, and day programs. One clinic staff noted they could do a better job adhering to a *Housing First* approach, but overall staff seemed to be familiar with the term. They clarified that the option pursued depends on what members agree to; ultimately the decision falls to the member. However, at the second clinic, no staff were familiar with the term *Housing First*, and when asked if tenants were required to demonstrate readiness, staff reported that they will not put members in a situation if they can't take care of themselves, or set them up to fail.	• Educate clinic staff on a *Housing First* approach; eliminate screening for readiness or a continuum of care approach where members are expected to graduate or step-down from treatment settings.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (2.5)	Clinic staff can directly refer members to The Link program for PSH services, whether or not they have a voucher. Clinic staff reported that when members apply for RBHA affiliated housing (e.g., scattered site or CLP) staff completes a Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT), and members are prioritized if their score is eight or higher. One clinic staff reported their belief that if a member has a high VI-SPDAT score they may move up over someone with lower score. Clinic staff reported that around August 2016 members had to have the qualifying VI-SPDAT score and meet the HUD definition of homeless to apply for scattered site	• With the current system structure, the agency has limited capacity to fully align housing priority with the EBP criteria. However, PSH services are not just limited to members who qualify for RBHA affiliated housing vouchers, so The Link staff should continue their efforts to explore other independent housing options, promoting the benefits of PSH services and developing relationships with landlords and housing providers.

			housing; if members did not meet eligibility requirements they were dropped off the waitlist. Per the RBHA website, Permanent Supportive Housing is available for enrolled homeless adults determined to have a SMI, who have a qualifying VI-SPDAT, and who meet the definition of homelessness that includes: a nighttime residence that is not sustainable or appropriate, residing in a location not meant for human habitation, a temporary living shelter, and members being discharged from an institution and they were admitted to the institution as homeless. Clinic staff reported many members without stable housing are staying with family (or "couch surfing"), which doesn't qualify as homeless. Due to limited transitional setting options (i.e., Transitional Living Program), programs at capacity, and needing a housing placement plan prior to accessing some transitional housing, staff speculated members may stop trying to obtain housing or fall out of contact with clinic services. Clinic staff reported that the resolution to ending homelessness is usually when members go to the hospital since they are likely to get housing faster, even before people that are homeless.	
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; staff does not hold keys to units. About 12% of housed members reside in settings where they may not have full control over entry to their unit (e.g., group home, half-way house, transitional living).	• Work with members in settings where they do not have full control over entry to their unit to explore alternative options, or ensure 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)	Plans completed at least once in the prior year were located in clinic files reviewed, and generally seemed to identify member goals using the words of the members. However, in some cases, objectives or needs identified appeared to be written from the clinical team perspective, using clinical jargon, often with a focus chiefly on symptom management (e.g., maintain mental stability).	• Ongoing staff training should occur regarding how to work with members to develop personalized needs and objectives. All service plans should be individualized and directly reflect the expressed goals, needs, and action steps for achieving those goals. Identity and resolve barriers to plans not reflecting specific services provided.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (1)	Clinic staff reported that service plans are updated at least annually but can be modified earlier if needed when there is a change in service, or someone requests a goal change. In clinic files reviewed, some plans were updated without any identified modification, often with a new date and same plan as the previous one. Other plans had minor adjustments, and some were not updated when homeless members obtained housing. Some clinic plans did not indicate services through The Link program, or plans to coordinate treatment.	• Ensure service plans are modified to reflect the current status, goals, needs, and services. The Link and clinic staff should obtain input from each other when modifying plans at each provider if an integrated single plan is not an option. This collaboration may prompt staff to revise plans for their prospective agency when members have a change in status necessitating a service plan review.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	Per The Link staff report, once enrolled, tenants are able to choose the services they receive, and can decline participation in PSH services at any time and remain housed. It appears they must maintain services through the clinic RBHA system in order to maintain housing subsidy supports. Member plans are developed at admission to The Link by staff, and are revised after 90 days, and every six months thereafter. On The Link plans reviewed, some goals seemed to be written from the prospective of staff rather than in the member's words. For example, some plans contained variations of obtaining and maintaining	• 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).

			permanent supportive housing as parts of similarly phrased goal statements for different members.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (2)	Most members interviewed said they felt in control of their services plans. Per SB&H staff report, The Link services can include: transportation, skills training, personal care assistance, supportive housing, case management, counseling (if tenants choose, by PSH staff), peer support, nursing services, behavioral health promotion, group and individual activities, and employment support services (through PSH or other SB&H staff at the Community Resilience Center). On The Link plans, staff documented the identified needs using the same language as member goals rather than working with members to identify an individualized statement related to the goal. For example, if a member's goal was to maintain safe and stable independent living and to find full time employment, the need was to maintain safe and stable independent living and find full time employment. The service plans covered a broad array of service categories, but often the same phrasing and categories were listed out from person to person. Individualized information related to meaningful community activity, coping skills, or informal support network, was listed toward the bottom of the plans after multiple other standard service notes were listed. Actual services provided documented in files related to obtaining food boxes with or for tenants, home visits, or discussing current status. Staff assisted one member one time to look for an apartment, and in another case provided apartment names which	• Ongoing training should occur regarding how to work with members to develop personalized goals and needs/objectives. • Ensure outreach and engagement occurs and is documented when members are not in contact with the team or PSH staff.

			the member reportedly was to contact. In some SB&H records, limited outreach to tenants or clinic staff was documented, with lapses of a month or more in some cases.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 - 4 (3)	Tenants have limited formal mechanisms for shaping the design and content of PSH services. Tenant satisfaction is measured through individual feedback. The Link staff engages members to complete a Session Rating Scale (SRS) and Outcome Rating Scale (ORS) when they have contact with members. SB&H started a fidelity review group around January 2017, which is an advisory board that is member run. The agency also employs members, with four staff identified in those roles.	• The agency should build on the member run forum and develop other opportunities to solicit input from those receiving services, and for tenants to drive services, including the design, assessment and implementation of services. Seek opportunities for individuals with lived experience to fill leadership positions. For example, involve individuals with a lived experience in quality assurance activities (at all levels in the organization).
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	At time of review, The Link Program has 23 direct service staff serving approximately 206 SMI members, and ten General Mental Health (GMH) members who were factored into the caseload ratio. The caseload ratio of members to staff is approximately 9:1.	
7.4.b	Behavioral health services are team based	1 – 4 (2)	All members receive services from at least two distinct providers (i.e., a clinic and The Link) rather than an integrated team that is expected to provide the full spectrum of services. In addition, some tenants receive services through other providers (e.g., to address substance use). It is not clear if staff are aware of all service providers involved in member treatment. Though Link staff interviewed estimated they have weekly contact with clinic staff, occasional contact with clinic staff was documented in records reviewed, usually at the beginning of services	• 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, it is recommended that staff hold regular planning sessions to coordinate care in order to work more fluidly as a team, to minimize duplication of services, to prevent the possibility of working at cross-purposes, etc. Soliciting input, and sharing of service plans and other documentation is encouraged if an integrated health record cannot be

			through The Link, when members experienced some type of issue (e.g., high traffic in the home) or when members were not in contact with The Link staff. The Link staff reported they are not always informed when members CM's change. CM contact with The Link staff was not documented in clinic files, or occurred sporadically. Some clinic staff interviewed reported they had regular contact with The Link staff, but others reported they had no contact. One was unaware their co-served member was participating in The Link program. Staff at each agency complete separate service plans. Per report, The Link invite CMs to service planning meetings, and track when clinic plans are completed so they can plan in advance to request updates. However, evidence of that reciprocal level of coordination was not documented consistently in all clinic or The Link records. On some SB&H plans it was noted the document was faxed to the clinic CM.	implemented.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (4)	SB&H agency staff reported that The Link Program provides services 24 hours a day, seven days a week. Staff work shifts covering Monday through Sunday. An on-call phone is available for the hours of 5 p.m. to 8 a.m. Coverage is rotated among Behavioral Health Technician (BHT) staff who meet a certain productivity level, and a supervisor serves as backup. Staff reported they resolve most issues over the phone, but can go into the field to support members outside of normal business hours, though no recent examples of community-based after hour crisis services were cited. Members reported staff are generally responsive, and they are aware of the on-call number through the program.	• Ensure members are reminded of on-call contacts if staff are not available during holidays.

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	2
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	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		2.88
Total Score		21.8
Highest Possible Score		28