PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: February 26, 2021

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

Method

On January 25 – 27, 2021, Annette Robertson and Karen Voyer-Caravona completed a review of the Resilient Health 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.

Resilient Health, formerly known as PSA Behavioral Health Agency, offers behavioral health services to youth, family, and individuals diagnosed with a Serious Mental Illness (SMI) including Permanent Supportive Housing (PSH). The program brochure describes providing individualized assistance to individuals in their home and the community to teach independent living skills aimed at maintaining housing, and personal wellness. The program has a capacity of serving 250 members but at the time of review was serving 285 members.

Due to the system structure with separate treatment providers, information gathered at the Lifewell Oak and Southwest Network Estrella clinics was included in the review as sample referral sources. However, records reviewed, and members interviewed during the review at Resilient Health were not exclusively served at those clinics.

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

March 11, 2020 the Governor of Arizona made a Declaration of Emergency and an Executive Order in response to the pandemic, Coronavirus 2019 (COVID-19). Among others, recommendations were made to practice social distancing of six feet to avoid spreading the disease as well as limiting gathering of groups of more than ten people. This review was conducted during the pandemic and adjustments were made to the review process to observe the Governor's requests and to reduce burden on providers, including reducing the sample size of member records reviewed, conducting staff and member interviews telephonically or videoconferencing, remote access to provider electronic health records when available, and other adjustments as needed to follow public health guidance.

During the fidelity review process, reviewers participated in the following activities:

- Overview of the agency with the Housing Director and the Permanent Supportive Housing Services Program Manager.
- Interview with the PSH Services Program Manager.
- Interviews with three PSH Housing Specialists.
- Interviews with one Case Manager from one partner clinic, and two Case Managers and a Housing Specialist from another.
- Individual phone interviews with three members participating in the PSH program.
- Review of 15 randomly selected records, including charts of interviewed member/tenants.
- Review of agency documents including program brochure, intake procedures, (org chart, job descriptions for program staff, policies for PSHS, Program Description for Supported Living – PSHS 2020,

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 members in the program experience functional separation between housing management and social services.
- RH staff coordinate with member clinics and document their efforts in member records.
- Members of the program are very happy with the services received, with program staff, and can choose the services they want upon entry to the program.
- Members reside where they can control entry to their household.

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

- Assessment of members' needs, at the clinics, when requesting assistance independent housing should be done for the purpose of developing a plan for supporting the member in retaining that independent housing, rather than screening them out of the referral process.

- Documents necessary to support member tenancy and safe housing, leases and HQS inspection, are not obtained by the program. Work to gather leases and HQS for all members in the program to support and educate them when/if issues arise relating to such.
- Services do not appear to extend beyond obtaining housing. Ensure the program goes beyond assisting members in finding affordable housing by offering supports and services to retaining recently secured housing.
- The program does not involve PSH participants in program design and delivery. Establish a process for member/tenant participation in program design and delivery.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 (2.5) 4	Clinic staff stated that members are able to choose the type of housing desired and that PSH is available to assist members with finding affordable housing. Lack of affordable housing choices available do constrain member choice in housing type. Resilient Health Permanent Supportive Housing (RH) staff and clinic staff recognize the limited availability of affordable independent housing in the service area. PSH staff believe the public health emergency has exacerbated the affordable housing shortage and report to continue to build relationships with property managers. Limited available options and long waitlist for financial assistance to make housing more affordable also constrain choice in housing type. Waitlists for programs offering rental subsidies can range from a few months to several years, depending on the member's situation. If a member is temporarily housed, or housed vicariously, they may be removed from a housing subsidy waitlist, as several waitlists prioritize unhoused members.	• Continue efforts to build and preserve relationships with property managers to improve staff's ability to advocate for tenants over issues such as late rental payment and income requirements. • System partners should advocate at the municipal, state, and federal level for policies supporting the creation of affordable housing, including housing for people at extremely low income, throughout the community.
1.1.b	Extent to which tenants have choice of unit within the housing model. For example,	1 or 4 4	Clinic staff interviewed stated that members are allowed choice in unit being offered which may include choice between a ground or second floor unit.	

	within apartment programs, tenants are offered a choice of units		Program staff reported getting member input into housing type sought and educating members on the limits and benefits of different types. This was confirmed in records reviewed. One staff reported gathering information on cross streets and then accompanying members to those areas to identify resources and potential barriers to the area. Staff said that choice may be limited by the voucher type. Additionally, some landlords require two months' rent plus administrative fees at lease signing thus eliminating low-income members from qualifying. One record showed a landlord accepting rental subsidy vouchers, however, had minimum income qualifications of twice the rental amount rather than twice the tenant portion after subsidy. PSH staff interviewed stated the public health emergency has negatively impacted choice of unit due to increased competition for the available affordable housing. One record reviewed documented a member accepting a second-floor apartment but expressing health impacts from use of stairs after the fact. The member requested moving to a ground level apartment in the complex and was told by property management that a letter from a medical doctor was required or they needed to wait until the lease ended to change apartments within the complex. Records showed clinic medical staff recommended the member request documentation from their primary care physician. RH staff did not appear to take an advocacy role and discharged the member shortly thereafter.	
1.1.c	Extent to which tenants can wait for the unit of	1 – 4 4	RH staff report no waitlist for PSH services. Members can wait for the unit of their choice without risk of discharge from the program.	

	their choice without losing their place on eligibility lists		Waitlists may occur when members apply for a voucher for subsidized housing. Members may apply and be placed on multiple housing subsidy waitlists concurrently. Clinic staff interviewed reported that if members find temporary housing while on a subsidized housing waitlist, they may be removed from a waitlist designed specifically for the unhoused, even if that housing is substandard, temporary, or not supportive of their recovery. Members are allowed a reasonable amount of time to find housing if granted a voucher. Records showed clinic staff working to support a member extending a voucher nearing expiration.	
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	Clinic and RH staff interviewed reported that tenants must include members of their household when applying to housing subsidy programs in order for them to be considered. Subsidy vouchers have a variety of rules that may limit household composition. Any household members being considered need to pass background checks, etc., at the property management level to be eligible to be added to a lease. RH staff report assisting a few members in the past year in roommate matching as a way to obtain affordable housing by sharing housing expenses. Members determine the roommate. Resilient staff report having discussions relating to shared financial responsibility with rent and utilities with all parties. Limits to tenant control of household composition may exist beyond those commonly imposed on the private market. It was reported that some voucher administrators require clinical team approval for tenants' requests to add significant others/family	• Control of household composition should be that of the tenants. Ensure tenants are informed of the processes to add others to leases. Advocate for members to have control of their household composition instead of allowing clinical teams to decide.

			to their lease. In at least one instance described to reviewers, the clinical team denied the request. Additionally, one member record showed clinic staff informing a member that the clinical team must approve any roommate before being added to the lease.	
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	Clinic staff interviewed reported that housing management staff do not provide social services to tenants. Occasionally, housing management staff may contact clinic Housing Specialists to inform them of notices given to tenants when the tenant does not appear to be making an effort to reduce risk of losing housing. Few members in the program reside in transitional properties that may also offer supportive services.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Clinic staff interviewed reported not being responsible for delivering notices to tenants, or any other housing management functions. Clinic staff report contact with the voucher administrator when tenants' housing is at risk to discuss supportive services available. RH staff may be contacted by property managers when problem behaviors place a tenant at risk for lease violations. Staff reported using these instances as an opportunity to educate tenants on the terms of their lease and how to be a good neighbor.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Clinic staff stated that they were not aware of any housing units that had social or clinical services on site. RH staff identified several properties that had social services on site for tenant use, but only one tenant resides in those properties. RH does not maintain offices at any apartment complex or housing site.	

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 1	Clinic staff interviewed reported that members with a voucher pay 30% of their income towards rent. Some member leases include utilities, and others do not. Per data provided, 30% of members enrolled with in the RH PSH program have a voucher for subsidized housing. RH staff work to link tenants to community resources to support maintaining affordable housing such as food banks, organizations that assist with utilities, as well as other resources. However, members residing in market rate housing may pay 100% of their income toward rent, relying on family support for the remaining rent balance and for basic needs. Some members seek roommates to lower rent costs, but staff reported that roommate matching is not well developed; one staff said that roommates rarely work out long term. Some tenants living with family have agreements drawn up identifying monthly rent responsibility. Rent to income data was provided for 71 of the 285 members enrolled in the program at the time of the review. Of that data provided, it appears those tenants pay an average of 48% of their income towards rent.	• For tenants paying more than 50% of income toward rent, explore more affordable housing options based on their preference. Any housing that costs 50% of a tenants' income is generally considered a financial burden. Some tenants in the program may choose to maintain this housing due to individual preferences, i.e., near family, supports, or employment. • System partners should regularly engage members in discussions about employment as a means of increasing income, offering referral to state vocation rehabilitation and supported employment providers.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Per data provided to the reviewers by the agency, no tenants, including those within the sample of 15, have current Housing Quality Standards (HQS) inspections on file at the agency. RH staff reported that units that are subsidized must pass a Housing Quality Standard inspection prior to tenant move in. Thirty percent of members are identified as living in subsidized housing. Two different records	• Support members' rights to view the apartment in which they will be residing upon lease signing. • Work to ensure that all tenants are housed in units that meet HQS, not just tenants that have a subsidy. Develop procedures to track market rate units that meet HQS. Some programs have trained staff that

			reviewed showed members accepting a unit unseen, without an opportunity to assess quality. RH staff reported some HQS inspections were delayed due to the public health emergency, but now inspections appear to be occurring on schedule.	conduct HQS inspections for the PSH program.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Clinic staff all agreed that most of the housing for members with vouchers were in complexes and neighborhoods with low-income households but were unaware of the disability status of members of the surrounding community. Unintentional clustering of individuals with disabilities likely occurs due to the lack of affordable housing in the service area and the limited income of persons with a disability.	• System partners should explore options for increasing the availability of small single site complexes, duplexes, or single-family homes with no more than five tenants to prevent unintentional clustering of persons with a disability.
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	Few leases were available to review for the members sampled. Of those provided, most leases were standard lease agreements showing rights of tenancy rolling over to month-to-month upon completion of the lease term. Some leases had expired. Some members sampled did not have leases because they live with family or are in temporary housing or shelter programs that do not have leases. One tenant had a formal written agreement created over 12 months ago with family outlining rent due. Records showed the HS supported the tenant in securing the written agreement. Data provided to reviewers indicates the agency keeps very few leases on file to support	• Ensure that all tenants have a copy of their lease and understand the terms of the agreement. Review lease terms when related issues arise to educate and inform tenants of their responsibilities and rights. • Consider tracking leases and term end dates so that PSH staff can proactively plan with tenants to renew their lease, explore other options, and to understand the conditions of the lease if converted to month-to-month. Educate tenants on the flexibilities of what the month-to-month lease allows. Then, advocate for tenants' choice between the two options. Some

			tenants when notices are received, or lease violations arise. Clinic staff reported that members participating in the PSH program with secured housing had leases. Members interviewed reported having a lease, however, some were unsure where their copy was located at the time. RH staff report attempting to attend lease signing or request copies after members have signed.	tenants may prefer the stability and reassurance of a 12-month lease, rather than month-to-month.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Most members reside in setting where tenancy is not contingent on adhering to program rules or treatment. Members interviewed reported only being required to following rules on their individual leases and that there were no special requirements of program rules.	
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	At the clinic level, it appears there is some screening of members after they express a desire for housing. One record showed that staff assessed a member's ability to complete basic living skills and then discussed with the clinical team before the member was referred. Other records showed similar judgements regarding a member's ability to live independently. Clinic staff reported consultation with the clinical team is done to gain information on past history of members, used in determining treatment. Planning and discussions about which wrap around supports to offer the members to support their decision to live independently were not documented. A few members on the program's roster were referred through Project Haven at CASS. Regardless, referral is dependent on the clinical team, or CASS staff, as members cannot self-refer to the PSH program as reported by RH staff.	• PSH staff and system partners should collaborate with clinic staff to increase understanding of the Housing First model and how PSH supports that. Assessing members' needs would be an appropriate measure if the purpose were to identify skills and services needed to support the member in being successful in living independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	RH staff stated that unhoused members are prioritized for some voucher subsidies and that if an unhoused member is referred to the program, RH staff identify them as a priority. Clinic staff, however, did not identify unhoused persons as being a priority population. Staff reported housing was more widely prioritized for those members discharging from inpatient hospitals or as a step down from a treatment program. RH staff stated that any member can be referred to and receive PSH services, including those without a voucher seeking safe and affordable housing.	• PSH is specifically designed to support individuals with significant behavioral health challenges in living independently in the housing of their choice; through a combination of affordability tools and wrap around supports that are available upon request. Those who are the most vulnerable to housing instability/homelessness are prioritized for housing. • Clinical staff would benefit from training in the *Housing First* approach.
6.2 Privacy				

6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	RH and clinic staff reported that members of the program control entry to their units. None of the members interviewed reported having issues of program staff entering their units without their permission. Few members in the program live in settings where staff may enter units, i.e., half-way houses, staffed community living placements, or group homes.	
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	At the clinic level, members interviewed reported they could choose the services they wanted at program entry. Service plans examined by reviewers showed a variety of services being offered to members. Members interviewed reported being able to choose the services they want at the clinic level; this was confirmed by RH staff.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	Staff at one clinic reported that members are able to add services to their treatment plan every six months. Staff at another clinic said services are reviewed yearly but members can add services at any time. Yet, all members interviewed reported delays in communication and getting services they want. One member said they were planning to transfer out of the clinic due to lack of follow through. RH staff stated changes made due to public health guidance have impacted members by restricting access to their clinical teams because of changes in work settings, i.e., working from home. RH staff expressed concern for unhoused members especially being impacted as some clinics are requiring all in-person contacts to be scheduled by appointment, thereby denying members entry into the clinics, and requiring them	• At clinics, ensure members are able to speak with case management staff when arriving without an appointment, especially those unhoused. Lack of member resources should be considered, i.e., phone availability, transportation, physical disability limitations, when developing plans to meet with members, phone or in person, to discuss their needs. While following public health guidance, flexibility needs to be prioritized to support members to find and retain safe and affordable housing in an effort to support their recovery.

			to return another day to speak to clinical team members. Records reviewed varied and appeared to be dependent on individual case managers. Some records showed changes to service plans after members expressed a need, i.e., assistance with funds to prevent eviction, while others showed needs expressed by members, i.e., counseling, but services not being added.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Review of records indicate most members attended an intake appointment with the program within two weeks of referral by clinic staff. Upon intake, all members developed a service plan that included general goals of seeking housing and increasing knowledge of resources to support maintaining affordable housing, e.g., location of food banks. Some service plans included additional goals identified by members, however, clarified that finding housing was the priority. One member record showed RH staff assisting a member in job search alongside housing search efforts. Some clinic and RH staff were unsure if members could decline case management services at the clinic level. One interviewee stated that there was a clinic specifically designated for members that did not want case management services, *Navigator Clinic,* but may want to engage in other services, i.e., a voucher administered by the RBHA. RH staff stated that services through the program are voluntary and members can close at any time.	• Ensure members are informed early in the process if their specific housing subsidy voucher is tied to the RBHA and if they can close out of those services or move to a Navigator Clinic without losing their subsidy.
7.2.b	Extent to which services can be changed to meet tenants'	1 – 4 2	Members of the PSH program can participate in an array of services for assistance and support within the housing program and in other programs such as Art Awakenings, and counseling services. One	• While in the housing search process, work with members through Motivational Interviewing to identify deficient skills or

	changing needs and preferences		record showed an HS assisting with a job search. Schedules of group offerings were provided to reviewers. Most records showed updates to service plans while members were in the housing search process. HSs appeared to regularly administer a tool to assess members' ability to conduct daily living skills activities, however, did not appear to use that information to modify general services delivered or drive adjustments to service plans. Records did not show services added after members obtained housing. The public health emergency has allowed staff the opportunity to assist members with the use of telehealth services. Documentation in member records showed staff supporting member's decisions on use of telehealth, as well as delivering technology support. Staff reported the agency purchased mobile phones with video capacity and a service plan for some members of the program in order to support them in obtaining affordable housing and staying connected with the clinical teams. The program appears to focus on assisting members in finding housing. With a high turnover rate of program participants in the past 12 months, 80%, it is difficult to see how the program supports tenants in retaining safe and affordable housing. Little evidence was found in records reviewed documenting supportive services being delivered to members in retaining independent housing.	resources lacking to help members retain stable housing in the long term. Coordinate with clinical teams to develop a plan for how to best support the member. • Evaluate aspects of the current model that promote the expectation of time limited services, i.e., graduation after members are housed. PSH programs should include services to support members to attain and *retain* housing at their preferred intensity. PSH programs are designed for those with the most significant challenges to housing stability and retention and who often need long-term service and supports. • Consider providing training to staff on engaging members to address other areas of vulnerability, concern (e.g., co-occurring disorders), or prior issues that led to eviction or homelessness.
7.3 Consumer-Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	The agency offers an annual survey to participants of all programming to gather input and satisfaction with services. There is not a PSH specific survey,	• Gather input from participants on how they would prefer to be involved in program design and implementation. Provide

			however, staff said that a suggestion box is located in the lobby for member input. Resilient staff reported that persons with lived psychiatric recovery are part of the PSH team.	examples of potential avenues from which they could participate such as serving on sub-committees to the agency board of directors, participating in quality management activities, or other processes that impact service design and provision to the PSH program.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 2	At the time of the review, the program had 285 members, however, initially reviewers were told the team was serving 299 members. Staff report having ten Housing Specialists, five of whom are certified Peer Supports, for an average member to staff ratio of 29:1. Housing Specialists have a range of 24 – 38 members assigned to their caseload. Staff interviewed reported to be currently working with 15- 25 individuals each to find housing.	• Hire staff to provide adequate member coverage of changing needs and to be readily available. Optimum caseload size for PSH services providers is 15 members to every staff, providing flexibility and responsiveness to support members in retaining housing. • Offer exit interviews and solicit input from current staff to improve retention.
7.4.b	Behavioral health services are team based	1 – 4 2	Members receive psychiatric and case management services from the integrated health clinic that referred them to the RH program. Members may also receive services from other programs to supplement their recovery needs. Each provider keeps separate member records. Records reviewed did not indicate service plans created by the PSH program were shared with other providers. Records reviewed did show evidence of coordination of care between referring clinics and the PSH program. Some members appeared to have significantly more coordination between clinical and RH staff than others served by the program. PSH staff appeared to coordinate with either the assigned case manager or the housing specialist, but rarely both. RH staff indicated they do experience delays in coordination and suspect	• Ideally, all behavioral health services are provided by an integrated team. Due to the current structure of the system with separate service providers, this is not possible. Consider scheduling regular planning sessions between the PSH provider, clinic staff, and the member to coordinate member care. Soliciting input and sharing updated service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented. • Improve coordination upon referral to prevent delays in housing search efforts for members with a voucher. The PSH program should develop a tracking system of which vouchers members have applied for and the correlating guidelines to those vouchers that may limit housing search.

			it is due to turnover of staff at the clinics. RH staff reported including leadership in emails to ensure the clinical team is current on member activities. Additionally, RH staff report the public health emergency appears to have negatively impacted response times in coordinating with clinical teams, noting that it seems to be tied to staff working from home. RH staff stated delays in housing search for members occurs when the voucher type awarded is unknown. Some vouchers have specific guidelines which may limit where a voucher can be utilized. Most members interviewed felt RH and clinic staff coordinated well and kept them informed.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 3	RH PSH staff work regular office hours and can adjust to meet member needs. PSH staff rotate responsibility for answering an on-call phone after hours, weekends, holidays. Two staff are scheduled at a time for on-call coverage. RH on-call staff will meet with members in the community but if members are having a mental health crisis, staff will coordinate with the local mobile crisis team to respond.	• Ideally, PSH services are available 24-hours a day, seven days a week including the ability to respond to members in the community after normal business hours. PSH staff may be better positioned to respond to and support members in the community outside of regular business hours than a mobile crisis team.

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	4
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		3.63
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	1
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		1
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.17
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	1
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	2
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	2
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		20.68
Highest Possible Score		28