PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: May 31, 2018

To: John Moore, Chief Executive Officer;
Jill Rowland, Chief Operations Officer, Behavioral Health Services;

From: Karen Voyer-Caravona, MA, LMSW
Annette Robertson, LMSW
AHCCCS Fidelity Reviewers

Method

On April 30 – May 2, 2018, Karen Voyer-Caravona and Annette Robertson completed a review of the Marc Community Resources' Permanent Supportive Housing Program (PSH), known as the Hope Network. 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.

In operation since the 1950s, Marc Community Resources, Inc. (Marc) is a non-profit agency that provides educational, rehabilitative, therapeutic, and social services to people with physical and/or behavioral health challenges. Hope Network program provides PSH services to Maricopa County residents experiencing a Serious Mental Illness (SMI), with offices located at 3737 North 7th Street in Phoenix, Arizona. The staff report that the program assists prospective tenants in their housing search, and provides support services to tenants with community resources necessary for retaining housing and self-sufficiency. Through partnerships with other agencies and system partners, they engage in ongoing provision of furniture vouchers, home starter kits, and assistance with application fees and moving expenses. At the time of review, Hope Network program was serving 72 members, 64 of whom were housed.

In order to effectively review PSH services in Maricopa County, the review process also includes evaluating the working collaboration between the PSH provider and the referring clinics with whom they work to provide services. For the purposes of this review at Marc, the two referring clinics included were the Lifewell Oak and Partners in Recovery Metro clinics.

The individuals served through the agency are referred to as "members" or "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:

- Orientation of the agency with Director of Community Transition, Supportive Housing and Forensic Recovery Services; Associate Director of Supportive Housing Services, and Hope Program Manager;

- Group interview with the Director of Community Transition, Supportive Housing and Forensic Recovery Services and Associate Director of Supportive Housing Services;
- Group interview with three Housing Specialists, including one who also performs intakes;
- Individual interviewers with Housing Specialists at PIR Metro and Lifewell Oak clinics;
- Group interviews with eight members who are participating in the PSH program;
- Review of ten randomly selected records, including shared clinic records of shared members; and
- A review of agency provided documents including: available tenant leases and copies of Housing Quality Standards reports, *Social Determinants of Health Screening Tool*; *Hope – Permanent Supportive Housing Services* referral form; *Marc Community Resources – Behavioral Health Services Discharge Planning and Process*; *Follow Up to Non-Contact* protocol; Member Forum flier/agendas for August 2017 and February 2018; *Hope Program Description*; and *Marc Community Resources Organizational Chart.*

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:

- Choice of Housing: Members are supported at clinics to pursue the housing type of their choice; when enrolled in the Hope program, HSs assist them in locating and renting housing that meets their needs. System partners agree that members should determine household composition that conforms to the terms of a standard lease agreement.
- Functional separation: Functional separation appears to exist between property management and support services staff. The reviewers saw evidence in member records of property managers and HSs cooperating in their respective roles and responsibilities toward eviction prevention with such matters pertaining to nonpayment of rent and upkeep of the unit. Records showed that HS attended lease signings and at times explained their roles to property managers.
- Housing integration: Tenant units appear to be well-integrated throughout the Phoenix metro area. Some unintentional clustering of units may occur due to shrinking stock of affordable housing and landlords that accept vouchers, combined with individual tenant barriers such as felony and eviction histories.
- Housing readiness: Clinics support members who choose to live independently despite disability status, encouraging use of formal and natural supports available in the community. Clinic HSs spoke highly of the positive nature of PSH services on housing retention.

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

- Decent, safe, and affordable housing: Tenants who do not qualify for subsidy voucher or other low-income housing programs often pay well over 50% of their income in rent. Most often this housing is not subject to HQS and timely attention to housing maintenance and repairs may not be an immediate priority. System partners should be actively engaged in identifying and supporting solutions to the shrinking supply of safe and affordable housing in the Phoenix and the surrounding suburban area.
- Rights of tenancy: Some members live with friends or family temporarily out of necessity or long-term by choice. Paying rent without being added to the lease agreement does not guarantee rights of tenancy, however. The agency should research and consider using written agreements sometimes used between members and their families and/or friends with whom they live that outline basic rights, expectations, and responsibilities for residency in the unit.
- Opportunity to modify services: Clinic service plans should be modified to reflect changes in the member services plans; at a minimum, service plans should be reviewed every six months to discuss progress and makes updates or revisions.
- Flexibility of service intensity and service options: The evidenced-based model of PSH is designed for members with the most significant challenges to housing retention, including psychiatric symptoms and behavioral patterns that may compromise their connection to resources and supports that could mitigate the risk for loss of housing. The agency should continue evaluating its approach to offering what appears to be time-limited services provided in linear stages of intensity, that ultimately push to graduation; the program may benefit from further technical assistance in this area.

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 4	Clinic HSs reported that members determine the type of housing sought. HSs said that they review with members the types of housing available, including pros and cons that may apply to their situation. Though clinical teams may believe a member is unable to live independently successfully, they will support member choice and attempt to ensure supports such as PSH are in place, so that members have the best chance of succeeding in the housing of their choice. Staff also said that some members determine for themselves that they are not ready for independent living and prefer to live in congregate care or settings with some level of on-site staff presence. Staff said that members can change their minds at any time about their preferred housing type and will be supported. Members interviewed reported having a choice in housing type, and records reviewed also reflected this.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs,	1 or 4 4	When members are referred to the Hope Network Program, most of them have chosen to pursue independent community based housing. Staff and members reported that members are encouraged to select from a variety of units. Records reviewed showed that members in housing searches usually viewed multiple units before signing a lease. All staff and members interviewed acknowledged that choice of units was often constricted by a	• Hope HSs should educate members that they have the option to pursue the unit that best meets their needs and preferences and do not need to accept the first unit offered. • Collaborate with housing advocates and stakeholders outside the behavioral health system to increase the availability of affordable housing options for members

	tenants are offered a choice of units		combination of such factors as low or lack of income; felony or eviction histories; and market factors such as rising rents. Additionally, staff and members stated that landlords are either not accepting vouchers or renew voucher program agreements from certain voucher administrators due to rents arriving late. For this reason, some members interviewed said that they selected the first unit made available to them out of fear of losing the unit to another tenant, rather than continuing the search for a unit that better suits their needs. This was also reflected in several records reviewed. For a variety of reasons, including financial and caregiving relationships, some members may have opted to live with family or friends, with independent housing a distant goal.	who do not receive subsidy vouchers.
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	Thirty-six members enrolled in the Hope program receive some sort of subsidy housing voucher from several sources: the Regional Behavioral Health Authority (RHBA) affiliated voucher administrators (HOM Inc. (18) and Biltmore Properties (9)), the city of Tempe (3), Bridge to Permanency (3), or Section 8 (3). Clinic and agency staff interviewed agreed that housing searches are significantly more challenged for these members due to the issues identified in the previous item (1.1.b). Indeed, some records reviewed showed that tenants were referred for Hope PSH services as a result of their inability to renew their leases when informed that landlords had decided to terminate participation in the voucher program. Several other records showed repeated instances of property owners reporting that they no longer accepted vouchers, which staff said may extend housing searches, especially for members with no income. Staff said that for this reason voucher	

			administrators appeared to be more helpful renewing vouchers approaching expiration. Staff said some members may take 90 days or more to locate a suitable unit with a landlord willing to accept the voucher. Neither staff nor members interviewed expressed concerns about losing their voucher/loss of eligibility due to difficulty locating a unit.	
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	Clinic and agency staff reported that members determine housing composition regardless of whether they use a voucher or pay market rate for their unit. Staff said that as long all tenants are on the lease legally and the voucher administrator is also aware, tenants can live with whom they wish. Staff acknowledged that members may sometimes wish to live with friends or partners who pose a risk to their recovery, safety, and tenancy; however, they will not give a recommendation for approval to the voucher administrator. Instead, clinic and agency staff said they will attempt to engage the member in an honest discussion about the pros and cons of a particular roommate. Staff said that in some cases, after such discussions, members will decide for themselves against adding an individual 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	1, 2.5, or 4 4	All staff and members interviewed said that property managers do not have any role in providing clinical or social services to members. Other than one member residing in a temporary living placement (TLP), while seeking to rent a unit with a voucher, and another in Flexcare, no tenants resided in a location where landlords had	

	providing social services		any role other than property management.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Neither clinic nor Hope HSs have a role in housing management duties, such as collecting rent reporting lease violations. Staff said that Hope HSs receive reports from landlords of members owing rent or not maintaining their apartment, but respond using eviction preventions strategies through the offering of support, service referrals, education on tenant responsibilities and lease agreements, and assistance with obtaining community resources. Clinic and Hope HSs have also been contacted by landlords to report when tenants are at risk for being evicted due to voucher payments not being received on time by the voucher administrator.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	With the exception of one tenant residing in halfway/recovery house and another living in a Flexcare home, no members enrolled in the Hope program live in locations where clinical or social service providers maintain on-site offices. Hope HSs may provide services in housing units if those services meet members' needs and upon their request, such as assistance with budgeting or organizing furniture.	
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	Clinic and agency staff interviewed reported that all tenants of subsidy voucher units pay 30% or less of their income in rent. Some tenants with income pay substantially less than 30%. Voucher subsidized tenants without income pay nothing in rent. HSs try to encourage members to find rental options that include utilities, although many properties do not.	● Continue to work with tenants who are paying over 30% of income for rent to find new units or assistance programs to help mitigate their rental costs.

			Members living in market rate units usually pay a significantly higher percentage of their income toward rent, and this is reflected in the score. Data provided to the reviewers showed that 28% of all 64 tenants pay over 30% of their income in rent; the majority pay over 50%, and two tenants paid 90%. All of those tenants live in units unsubsidized by any type of voucher, and included those living with friends or family. Two tenants of market rate units pay less than 30% of income in rent, as do about half of members living with family or friends. Many tenant records showed HSs talk to tenants about means of increasing their income and provide referrals for meeting with Benefits Specialists and SOAR counselors to pursue Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) and obtaining assistance finding employment, including through the agency's Employment Related Services program. In order to increase income necessary to pay rent, several clinic and agency service plans identified employment as either a primary or a secondary goal.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Of 64 tenant units, the agency could provide confirmation of Housing Quality Standards (HQS) for 32 (50%), all of which were voucher subsidized. All but four (11%) voucher subsidized units showed evidence of current HQS. The Flexcare and recovery home units did not have evidence of passing HQS, nor did any of the remaining market rate or family units. With respect to the latter, staff reported they have received training from internal agency property management staff on assessing for safety and maintenance issues, as well as landlord responsibilities. HSs will support	● Continue efforts to maintain copies of most recent HQS reports. ● Continue efforts to train Hope HSs in recognizing and helping tenants respond to HQS issues for properties that are not required to undergo these inspections (i.e., HUD properties).

			tenants in advocating for themselves when those units are in need of repair or maintenance.	
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Staff and members interviewed described voucher subsidized and market rate units as well integrated in the community, although some clustering of the disabled population may exist due to the lack of affordable units and the increasing number of landlords unwilling to accept vouchers. Data provided to the reviewers showed that 97% of tenants reside in integrated settings. Some members who are screened out of rental applications due to criminal or eviction histories may also be unintentionally clustered into a small number of complexes or other private landlords that will rent to them.	
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	Staff interviewed reported that tenants sign their own standard leases and have rights of tenancy. Tenants interviewed agreed with this assessment. HSs are able to obtain copies of leases at lease signing and works with voucher administrators to obtain them when necessary. The agency provided current leases for 47 (73%) of housed members. Some agreements provided, such as one for a treatment facility and one for a boarding house, could not be considered leases. Leases examined by the reviewers appeared to be standard lease agreements. None of the 11 members living with family or friends had leases reflecting rights of tenancy. Some had signed an agency developed written agreement indicating	● Maintain complete and accurate records of leasing information for at least 90% of tenants in all settings, including those living with family, friends and significant other(s). ● Living with family does not guarantee rights of tenancy. Some PSH providers from past fidelity reviews showed examples of family/friend lease agreements that use language reflecting basic rights and obligations in addition to the rent paid to use in place of a lease. Having such agreements notarized may further rights of tenancy.

			only the amount of rent to be paid monthly to their family or friend.	
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Per a review of available leases, and staff and members' report, tenancy is not contingent on provisions specific to people with disabilities, nor rules requiring compliance with treatment. However, some tenants said they suspected that rules were enforced more strictly, to the point of "nit picking" because they were voucher recipients. One member observed that the property manager had noted at the top of her lease the word "voucher" and suspected she was being flagged for heightened surveillance. Another commented that all guests and visitors seem to be labeled as "traffic" suggesting that they were there for illicit purposes. Two members (4.5%), currently tenants of Flexcare and recovery settings, must comply with some program requirements to maintain housing. Staff said that some family members may condition residency on members taking their medication and participating in treatment, but staff are not aware of specific instances.	• HSs should continue to educate members on and assist them in advocating for their rights of tenancy to ensure that they are not subject to rules or provisions not found in the leases of other tenants. • See Recommendation for Item 5.1.a. regarding rights of tenancy for members living with family or friends.
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 4	Though clinic staff acknowledged that clinical teams may anticipate that some members will struggle or be unsuccessful with independent housing, the reviewers heard nothing in interviews suggesting the imposition of readiness standards. Clinic HSs instead talked about the importance of optimizing members' chances of maintaining stable independent housing through successful community linkages such as PSH services, peer run agencies, and resources.	

			The Hope program does not impose readiness standards to assist members in finding or retaining independent housing. HSs use the Social Determinants of Health (SDOH) Screening Tool to assist members in identifying needs that will be addressed in the program.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Per interview with clinic HSs, the RBHA requires an SMI diagnosis, homelessness (including living in a shelter or leaving an institution such as a psychiatric hospital or correctional setting), a Vulnerability Index – Service Priority Decision Assistance Tool (VI-SPDAT) score of 8 or above, and enrollment in the RBHA to qualify for voucher subsidies. Neither clinic HSs nor agency staff were sure how priority was ranked if VI-SPDAT scores increased beyond 8 or if the "next in line" received the next available voucher. The Hope program does not maintain a waiting list and has not considered the question of priority populations beyond what is required by the RBHA. Eligibility guidelines for the Hope program are to have an SMI diagnosis; to be homeless, or at risk for homelessness; and to have a subsidy voucher or income, such as SSI or SSDI.	● While system constraints may not allow full alignment with this area, system partners should clarify and ensure staff has a shared understanding of how priority is determined for scattered-site vouchers and community housing options.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Per clinic and agency staff, and tenant report, neither clinical staff nor HSs enter units without specific permission from tenants. Interviewed agency staff also said they do not hold keys. Tenants said that property managers must give advance notice before entering their units. Some tenants, however, said that property management has entered their units without notice. Two members live in semi-staffed settings where they do not have full control of entry.	● HSs should continue to support and educate tenants on their rights.

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	Clinic treatment plans showed goals and objectives that appeared to reflect member specific concerns. Most clinic records reviewed showed that members had a housing goal (usually finding/ retaining housing or relocating to new housing); and many also had goals related to employment to increase income in support of housing retention, and specific physical health issues. Progress notes usually were related to these goals. Most members interviewed said they decide what is on their treatment plan.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 1	Most member services plans appeared to be modified annually. Clinic and agency staff report service plans are updated at the member's request, with goals often written in rote, clinical language. Many service plans appeared to remain unchanged from year to year, showing very similar language or replicated verbatim even when circumstances have changed.	● Tenant service plans should be updated whenever there is a significant change in the tenant's life situation or goals, needs, and/or objectives; responsibility should not be placed on member to request an update to the plan.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Members and staff interviewed said that members choose the services they receive. HSs provided members with support and referrals in meeting other associated needs such as transportation during housing search; lease signings and tenant education; identification cards; benefits assistance; starter boxes, furniture, vouchers for application fees and moving costs; clothing and hygiene products; and food box referrals. For retaining RBHA affiliated vouchers, Marc staff agreed that members must remain enrolled with the RBHA. Some clinic staff interviewed were unsure if Connective level members were able to	● The agency may have limited ability to affect this area under the current system structure. If possible, considerations should be made to extend the voucher benefit for a period of time after disenrollment. Efforts may include exploring alternative funding sources that do not require enrollment in the RHBA system for eligibility.

			maintain their housing vouchers. Tenants must remain engaged with the Hope team in some way to remain open with the program and need to identify a goal.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	Hope staff said that most tenants begin with either a goal of finding housing or relocating from existing housing. Some members are referred for support in retaining current housing. Developing self-sufficiency in this area through connection to community resources and supports appears to be the focus for those members. Staff reported the discontinuation of Critical Time Intervention model (CTI), in which HSs provide more intensive services at the beginning of program participation, with a gradual tapering-off period, as the new tenant becomes more settled into the community and connected to community resources and supports. Staff indicated the agency has moved away from CTI as it did not align with the evidence-based practice of PSH. It was not clear to the reviewers when this shift occurred as CTI continues to be identified on agency website as the model used and half of the records reviewed (all opened with Hope in the last year) referenced CTI in the intake notes. In records in which it was not specifically referred, the same principles were described. Progress notes suggested that Hope continues to be conceptualized as a time-limited service to remedy an immediate housing need. The expectation appears to be that after providing members with referrals for community resources, tenants should be able to access on their own or with the support of their clinical teams (though Hope staff also described specific instances of clinical teams being unresponsive to tenant needs). One note showed	● Marc should continue evaluating aspects of their current model that appear to promote the expectation of time limited services, graduation, and transfer of services to other providers. 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 at their preferred intensity level. ● Consider whether staff would benefit from additional training in engagement on a deeper level to address other areas of vulnerability and concern, as well as recognizing and helping tenants explore issues that contribute to risk of eviction and homelessness. Those issues include budgeting and organization, responsibility for upkeep and cleanliness of unit, domestic violence, exploitation by family members and associates, and general problem solving.

			that when a tenant asked for assistance with budgeting, organization, and help making nutritious meals, the Hope HS made a referral to the agency's in-home supports program; this suggests that HSs do not provide that level of support. It also appeared that HSs initiated discussions with tenants regarding graduation from the program, documenting housing goals as completed, even when other chronic or emerging issues appeared to pose a risk to housing stability. Some of those issues included nonpayment of rent, reengagement with an abusive ex-partner, and an adult child moving in to the unit without authorization and draining the tenant's limited resources. No documentation in the records showed that these concerns had been resolved or addressed with the clinical team at the time a recommendation for graduation from Hope was sought. Members interviewed did not come to a consensus on whether or not services were time-limited, with one member clearly stating they were not and another expressing much anxiety that they were. Most members interviewed, however, agreed that case managers are often overwhelmed by high caseloads and inconsistently available to them, and that turnover remains high.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 3	Several HSs at Hope identify as people with the lived experience of serious mental illness and/or substance abuse. Tenants have the opportunity to give direct feedback about services at the PSH Member Forum, which appears to be offered quarterly, with, per sign-in sheets provided to the reviewers, between three to seven tenants usually attending. Staff said that the agency promotes an open door policy, provides tenants with staff phone numbers in their orientation packet, and	● Continue efforts to create opportunities for members/tenants to participate in collective decision making within the agency. Consider strategies that encourage the Member Forum to evolve into a Tenant Advisory Council in which members actively participate in shaping policy, decision making, education, quality assurance, and advocacy. ● Consistently offer members an opportunity

			has a formal complaint process. Staff also reported and several records showed that some members were invited to meet individually with program leadership to share their opinions about the quality of services and areas for potential improvement.	that allows them to anonymously submit questions, concerns, and suggestions for program improvement.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 3	Staff reported caseload sizes were challenged by the program being short-staffed but two new HSs were recently hired. At the time of the review, four full time HSs and one HS/Intake staff served 72 members. Staff reported the goal is for all full time HSs to carry a caseload of no more than 15 and the for HS/Intake staff to carry a PSH caseload of no more than ten. The two new HSs are developing caseloads, with some members transitioning to them from the larger caseload of other HSs. Staff interviewed reported caseloads of 11, 18 and 29. Calculating for four full time and one 2/3 time HSs, the member to staff 15.5 to one.	● Maintain caseloads of no more than 15 members per staff. ● Maintain adequate staffing in an effort to minimize the negative effects of staff time constraints when members' seeking safe affordable housing is a priority.
7.4.b	Behavioral health services are team based	1 – 4 2	In the current system structure, individual CMs are responsible for all behavioral health coordination for tenants. Clinic member service plans were found in member records, along with annual assessments, and the agency requests copies of annual updates. The agency creates its own member service plan; those plans were not seen in clinic member records. Evidence was found in member electronic clinic and agency records of communications occurring through email, over the phone, and monthly summaries. Face-to-face contacts occasionally occur, such as staffings, intakes, housing briefings, and when an HS was documented to have attended a member appointment with the team Psychiatrist. However, the team approach is largely missing. Hope HSs	● Based on the structure of the system, housing programs are handled as a specialty service referral, rather than an integral part of psychiatric case management services. Therefore, it may not be possible for Marc to provide services through a team. The RBHA, provider clinics, and PSH providers should explore the possibilities for integrating housing providers/specialists into supportive and connective level teams for improved coordination of care. For the time being, Marc should continue efforts to coordinate as much as possible with the assigned SMI treatment teams.

			are not assigned to clinical team or regularly participate in weekly treatment teams meetings. Per the record review, CMs may or may not respond to HS emails requesting recommendations regarding members' graduation from the Hope program. In fact, though monthly summaries were located in clinic records, the language reflected tasks completed, was often generic across multiple members, and in some lacked details. In another record, progress notes showed confusion that a member was enrolled with both Marc and a second PSH provider at the same time. No communication was evidenced between Hope staff and behavioral health providers outside the clinic teams. Even when Hope tenants receive concurrent services through other Marc programs the reviewers saw no evidence that any coordination of care occurs between those staff.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 2	Services are not provided 24 hours a day, seven days a week. Hope services operate between 8 a.m. – 4 p.m., Monday through Friday, although HSs can provide 24-hr over the phone general support and can flex their hours to assist members with particular needs after regular business hours, including evenings and weekends. Staff said HSs educate tenants on the crisis line, the warm line, and accessing their clinical team.	• Explore the potential for providing after hours services through the PSH program.

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	4
Average Score for Dimension		4
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	4
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		3.5
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	3
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	2
Average Score for Dimension		2.5
Total Score		22.5

Highest Possible Score		28