PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Brittnie Stanton, SMI PSH Manager
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AHCCCS Fidelity Reviewers

Method

On February 3-5, 2020, T.J. Eggsware and Annette Robertson completed a review of the Community Bridges, Inc. (CBI) Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services, in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Community Bridges, Inc. (CBI) operates several locations in Arizona. Services include: crisis stabilization, Assertive Community Treatment, integrated healthcare, and supportive housing. CBI receives PSH referrals from clinics and other programs at CBI. Due to the nature of PSH referrals from external clinics, information was gathered from La Frontera-EMPACT Comunidad and Lifewell Behavioral Wellness Windsor clinics, with a focus on co-served members.

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

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

- Program overview with the Senior Director of Housing and Community Integration and Seriously Mentally Ill (SMI) PSH Manager;
- Individual interview with the SMI PSH Manager;
- Group interview with three CBI PSH Navigators who provide direct services;
- Interviews with eight members who participate in the CBI PSH program;
- Group interviews with three Case Managers (CM) and a Rehabilitation Specialist at Lifewell Behavioral Wellness Windsor, and two CMs and a Housing Specialist (HS) at La Frontera-EMPACT Comunidad;
- Review of ten randomly selected records, including co-served members from the clinics included in this review;
- Review of documents, including: clinical oversight and PSH meeting agendas, PowerPoint slides with information on CBI's PSH Navigator

phase model and strength based approach to treatment, Housing Quality Standards (HQS) reports, leases, tenant housing costs, re-engagement checklist, program referral forms, *Supportive Services* flyer, PSH member survey, and the Regional Behavioral Health Authority (RBHA) *2019-2020 RBHA Member Handbook*.

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:

- CBI PSH tenants had a choice of unit based on interviewee reports. Members interviewed affirmed that CBI PSH staff supported their choice in housing. CBI staff ask members about their preferences and provide assistance to explore available options.
- The majority of housed CBI PSH members live in settings where there is no overlap in housing management and PSH services.
- Based on data provided, the majority of housed PSH members appear to live in integrated settings in the community.
- A majority of CBI PSH members reside in settings where tenancy is not linked to services. CBI staff speaks to landlords with member permission and in an advocacy role if tenants experience lease or maintenance issues.
- Based on data provided, the majority of housed CBI PSH members pay 30% or less of their income toward housing costs.
- Treatment plans at the clinics visited and at CBI appear to reflect member goals. Members said that their plans list their goals.

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

- System partners should collaborate to establish, preserve and improve relationships with property managers over issues such as working with rent assistance programs, prospective tenant income requirements, and member background issues to increase members' options.
- The PSH program should continue its efforts to track and obtain copies of housing documents. With current leases on file, staff will be better informed to guide tenants when/if issues arise. Continue efforts to ensure all members reside in settings that meet HQS.
- Educate staff and members how choices of the services members select do or do not select impact other services. For example, if terminating clinic services is allowed, what is the impact on applicable subsidies and/or PSH services.
- Optimally, behavioral health services should be provided through an integrated team. If an integrated provider is not possible, separate service providers should coordinate treatment.
- PSH staff should be available to respond to member crisis phone calls and in the community outside of regular business hours. PSH staff are better positioned to respond to and support members than staff from general crisis lines or CBI's Access to Care line.

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 that whether members are ready for PSH can be subject to opinion. Staff said many members feel they are ready for independent living but when they have a *placement* they are not successful due to lack of furniture, lack of natural supports, or are not accustomed to budgeting money toward housing costs. Clinic staff said that members who are homeless or those who identify a wish to change an undesirable or unsafe living situation are good candidates for PSH. The RBHA's *2019-2020 Member Handbook* housing services section states that "Permanent Supportive Housing is a service for members with a Serious Mental Illness that helps them find and keep their housing." Some members may experience constricted choice in housing. It appears some clinic staff offer treatment settings if staff determines a member is not ready for independent living. Some clinic staff reported screening members' readiness for independent housing. Clinic staff said that they take this approach due to their concern that members may be evicted if they are not ready to be independent.	• PSH staff and system partners should work with clinic staff to ensure they are aware that members only need to express a desire for safe and affordable housing to be referred. • Clinic or referring agency staff should educate members about the range of options without screening for readiness to live independently. Offer services and engage members to support them in the setting of their choice. PSH services should be structured to meet the needs of members with the most significant housing challenges.
1.1.b	Extent to which tenants have choice of unit within the housing model.	1 or 4 4	Members interviewed said that PSH staff discussed their preferences and offered housing options. One member said that PSH staff will take members to tour multiple units. CBI staff said that they ask members about their preference of location and	• Continue efforts to educate property owners about the benefits of the PSH program, including advocating for income qualifications based on the tenant's portion of the rent, and working to ensure

	For example, within apartment programs, tenants are offered a choice of units		take members to visit locations, sometimes at different times of the day so the member has a better-informed decision. Additionally, for members that choose to live on the street but have a voucher, staff will assist to transfer vouchers to the member's area of choice. CBI staff said that the voucher may limit the member to a one bedroom unit or certain areas. Some members said due to their circumstances they accepted the first option available. Choice is constrained due to market factors. Members with histories of legal issues or evictions have fewer options. PSH staff reported fewer landlords accept voucher program assistance, such as at recently renovated properties or properties that have changed ownership. Some units are priced just above voucher limits. Staff said an increasing number of landlords require at the time of application proof of income to cover up to two and a half month's rent, rather than the tenants' portion, which disqualifies many potential tenants. PSH staff said some landlords who are familiar with CBI's PSH services make accommodations to the proof of income requirement for CBI's tenants.	members are treated fairly during the application process.
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	Members can be placed on waitlists through the RBHA and other voucher programs. CBI does not manage a separate waitlist. Members cannot be on the RBHA scattered site or community living housing list and a treatment setting list simultaneously. Some clinic staff said that members may be on a waitlist for scattered site housing assistance but need treatment. Clinic staff said that the option to be placed on a treatment setting waitlist at the same time as independent housing waitlist may be helpful. Members could then receive treatment while waiting for their	

			name to reach the top of the list for scattered housing. Members are not put to the bottom of wait lists if they decline an option. Depending on the voucher, staff said members have between 30 and 180 days to search for a unit. Members must demonstrate they are actively searching for a unit to be granted an extension.	
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 at one clinic reported that clinic team approval is needed for tenants to add someone to their lease, in some circumstances, when members receive a subsidy. Some voucher administrative agencies ask clinic teams to approve or deny additions to leases. Some clinic staff ask that newly housed tenants wait for a period of six months before adding someone to their lease. Staff said that some members ask to add new acquaintances to their living situation. Those short-term relationships can be detrimental, resulting in eviction. Clinic staff said some members are not forthcoming with their landlord or staff about long-term or permanent visitors. Staff at a clinic said they encourage members to inform their landlords if they have a visitor staying with them. Staff at one clinic reported that housing voucher administrative agency staff must be informed if tenants want to add someone to their lease. Staff said that if asked, clinic staff will indicate if they agree with the tenant adding someone to their lease and if the clinic staff disagreed, it would be up to the housing voucher administrative agency to make the determination. CBI staff reported that they review leases with tenants if they have frequent visitors. CBI staff said that if tenants want to add someone to their lease,	• If tenants ask to have someone join their living situation, staff can discuss with the member the pros and cons of adding someone to their living situation. Clinic team approval should not be required. Review the lease with the tenant and with their permission talk with the landlord to determine the parameters to add someone to their living situation.

			the tenant needs to meet with clinic staff. CBI staff does not have an approval role for tenants to add roommates. A few housed members, 3%, are in treatment or temporary settings where they do not have control over the composition of the settings, including some in shared bedrooms.	
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	Staff and tenants said that housing management or landlords do not have any role in providing social services. Some members said that landlords treat tenants who receive voucher assistance differently. One member said a landlord told the tenant not to talk to certain neighbors. Some members said that there are landlords who need training on what guidelines the landlords should follow if accepting vouchers. A small number of members, 3%, are in treatment or temporary setting where tenancy is linked to the services at the facility, where management and services overlap. Based on data provided, 2% of tenants reside at a location where CBI agency staff and behavioral health services are offered on-site.	• Monitor tenant reports of community landlords impinging on members' rights of tenancy. Offer guidance to members how to address the issues if they arise. Advocate to landlords on behalf of members if they request assistance.
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	PSH staff has no direct role in housing management functions. Staff and members reported that PSH staff does not collect rent from tenants, does not enforce leases, and does not report lease infractions to landlords. A small number of members, 3%, are in treatment or temporary settings where services and management roles overlap. CBI staff speaks to	

			landlords with member permission and in an advocacy role if tenants experience lease or maintenance issues. Members gave examples of PSH staff meeting with landlords to resolve plumbing issues.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Most CBI PSH tenants reside in independent settings where social service staff is based off-site. A small number of members, 3%, reside in staffed temporary or treatment settings. Based on data provided, 2% of tenants reside at a location where CBI agency staff and behavioral health services are offered on-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 4	Based on data provided, nearly 83% of housed CBI PSH members pay 30% or less of their income toward housing costs and. Based on data provided, about 7% of tenants pay more than 50% of their income toward housing costs.	• Continue to explore more affordable housing and/or ways to increase the income for members paying more than 30% of their income for housing costs.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 2.5	There was evidence at the PSH program that 75% of tenants reside in settings that meet Housing and Urban Development's (HUD) HQS. Inspections are completed in units where members that receive a subsidy reside. PSH staff can offer to have a certified CBI staff perform inspections in units where other members reside.	• Continue efforts to help PSH members to reside in settings that meet HQS. • Obtain copies of HQS and track renewal dates to support tenants plan for inspections.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Based on interviewee reports, housing data provided, and review of addresses where multiple CBI PSH members reside, the majority of tenants	

			live in integrated settings in the community. Due to market factors addressed earlier in this report, some unintentional clustering may occur. At some properties CBI tenants occupy 3% - 7% of units.	
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	Review of leases on file with CBI showed that many tenants, 63%, have a lease. However, leases were not available or were not current for all housed members. Some lease terms expired and it was not clear if they were renewed. Some leases specify conversion to month-to-month, but certain leases stipulate a higher month-to-month rental fee. Some tenants living with family members or friends have no lease. The few members in treatment or temporary settings have no lease.	• Review and track 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 benefits of a long-term or annual lease rather than allowing their lease to convert to a month-to-month agreement. • Continue to advocate for those tenants living with family, friends, or acquaintances without a lease to obtain one.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Based on interviewee reports and housing data provided, the majority of housed CBI PSH members reside in settings where tenancy is not contingent on compliance with program provisions. A small number of housed members, 3%, reside in staffed transitional or treatment settings where tenancy is contingent on treatment participation or program rules. Staff at clinics said they were unaware of any additional requirements for members to maintain tenancy other than following their lease terms. Clinic staff said that they encourage members to follow their lease terms. PSH staff said that there are no additional rules through CBI that tenants must follow. However, in one member record reviewed, PSH staff documented that the member needed to participate in treatment to remain on the CBI	• Ensure all CBI PSH staff are aware that there are no program requirements for members.

			caseload. Although it appears staff informed the member that PSH services were contingent on participation, it does not seem tenancy is contingent on participation.	
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	Some clinic staff reported screening members' readiness for housing and referring to treatment settings rather than independent living. Other clinic staff reported that whether members are ready for PSH can be subject to opinion but that they cannot discriminate and the decision whether members are ready for independent living is not up to clinic staff to determine. No members interviewed said that they were required to participate in a residential or similar treatment program before seeking independent living. PSH staff gave an example of supporting a member to receive residential substance use treatment and to maintain their voucher assistance.	• Focus independent living readiness screenings on how individualized services can support independent living, if that is the member's first choice. Members should not have to prove readiness. • Educate clinic staff about the *housing first* approach and the positive effects of safe and secure housing on a member's ability to address issues, such as substance use.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 4	The RBHA website notes that "housing subsidies are available to homeless adults who have been determined to have a serious mental illness and are enrolled members of Mercy Care RBHA" and that "supportive services are available to all adults who have been determined to have a serious mental illness and are enrolled members of Mercy Care RBHA." The description of PSH is separate from the reference to housing subsidies. Staff at one clinic were not familiar with the *housing first* approach. Staff said that it was not the clinic team's determination to refer members to PSH. Clinic staff said that they use the Vulnerability Index - Service Prioritization Decision	• In order to continue to prioritize members with the most significant housing challenges, it may be necessary to evaluate if PSH is appropriate for members who score bellow an eight on the VI-SPDAT at the time of referral if the PSH program member census grows, or if the program becomes understaffed.

			Assistance Tool (VI-SPDAT) and submit referral information to the RBHA. Staff at the other clinic seemed more familiar with the term *housing first* and said that a staff is scheduled to attend training on the topic. Clinic staff said that their first goal is to get members housed. Staff seemed to value members addressing or resolving substance use issues before independent living. CBI staff confirmed that they follow the *housing first* approach. CBI staff said that there are no other PSH program entry requirements other than a referral from clinic staff. Members learn about the CBI PSH program through clinic staff, during briefings if they are issued a voucher, or other CBI programs. CBI street outreach teams search for and engage individuals experiencing homelessness. Those contacts may identify potential PSH member referrals. CBI developed a *Lifeguard* process where members living unsheltered on the streets with no voucher are identified. CBI staff coordinates referrals to PSH and the community Coordinated Entry program. If members are identified for PSH through other CBI programs, CBI PSH staff request referral paperwork from the member's treating clinic, if applicable. CBI staff stated that some new members may have a VI-SPDAT score below eight, the threshold per the tool when an assessment for PSH/housing first should occur. CBI staff said that members with a VI-SPDAT score of lower than eight may have entered the PSH program with a higher score.	
6.2 Privacy				
6.2.a	Extent to which tenants control	1 – 4	CBI PSH staff do not hold copies of tenants' keys. The majority of housed PSH tenants control entry	

	staff entry into the unit	4	to their units. Housing management and maintenance may enter with notice and tenant permission. A small number of members reside in staffed transitional or treatment settings where they do not fully control entry to their living space.	
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	Service plans in the records reviewed at the clinics seem to be written using a mix of member stated goals and clinic staff phrasing. For example, some service plans included text that members want to continue with clinic services or keep in contact with clinic staff. Some of the clinic plans reviewed indicated CBI as the member's PSH provider. Members interviewed said that their clinic plans reflect their goals.	• Ensure clinic staff approach service planning to identify individualized member goals, needs and objectives.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic staff reported service plans are updated at least annually, or when a member adds or completes a service. Some members' clinic plans in records reviewed were updated multiple times during the year, but other plans were updated every ten to 13 months.	• At clinics, monitor member treatment plan revision due dates. Update plans if members experience significant changes in goals or needs.
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Members said that their CBI treatment plans reflect their goals and that CBI staff assist them with their goals. The format prompts members to identify their reason for participation, short and long-term goals. The information in those areas in the records reviewed at CBI seemed to reflect first person member goals. Members' needs and objectives seemed individualized on the CBI treatment plans reviewed. Staff at one clinic said that members do not close out from clinic services but transition to	• Educate staff and members how choices of the services members do or do not select, impact other services. For example, if terminating clinic services, the impact on applicable subsidies and/or PSH services. Consider developing a simple decision flow chart that tracks how modifying services from one provider can impact other supports. PSH and clinic services are not integrated, so scenarios where members close from one or both providers impact whether members are able to choose the

			Navigation. Those members can continue CBI services and maintain their voucher, if applicable. Staff at the second clinic said that members need to maintain clinic services to continue CBI services. Clinic staff were uncertain if members can close from CBI and maintain their housing subsidy. CBI staff were uncertain and doubtful that members can end their clinic service and continue PSH support services. CBI staff said that members can end services at CBI or their clinic, and continue to receive voucher assistance.	services they receive.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	Some CBI PSH treatment plans in reviewed records were completed about a month after the previous plan. Other plans were revised about four or five months after the prior plan and some were updated about annually. Documented services in records include assisting members with: obtaining food boxes, resources to furnish their units, shopping, meal planning, applying for benefits, transportation to appointments, and how to address maintenance issues with property management. Staff said that the PSH program discusses high-need member services and strategies to address challenges. CBI staff provided examples of training and supervision topics provided to PSH staff, including: self-care, assessing and steps to take when interacting with members who may be a danger to self or danger to others, assessments and client rights, coordination with clinic staff and other formal supports, motivational interviewing, working with members to identify strengths, documentation expectations and PSH. The PSH program recently developed a Navigator phase level system. Per agency materials, the	• Continue to evaluate what training or resources PSH program staff can receive to support members with the most significant housing challenges maintain safe and affordable housing. For example, training on best practices in co-occurring treatment for members who experience substance use challenges, and supported employment services. • Ensure members have choice over services, including when they elect to withdraw as they accomplish their goals. Ensure that the Navigator phase level system does not dictate to staff or members that graduation or discharge from PSH should occur. PSH members are not required to participate in services. Staff should engage members in services that are flexible to meet the changing needs of members. • Ensure outreach to members is documented. • Consider how turnover of PSH staff may affect service implementation. Evaluate PSH staff retention practices. • Ensure PSH staff have access to vehicles so

			approach is meant to structure services to match members' needs. The materials indicate the goal of the phase system is to support successful program discharges as soon as possible. In one member record reviewed, PSH staff documented that the member needed to participate in treatment to remain on the CBI caseload. Staff requested the member produce evidence of an assigned primary care provider in order to confirm a reported illness. It appears staffing turnover or vacancies at the PSH program impacted service delivery. Two of the three direct staff interviewed joined the program about three months prior to the review. There were gaps in documented contact or outreach in many of the ten member records reviewed, ranging from three to seven weeks. In one record reviewed, a member described as symptomatic informed staff of a fire in his complex. It was documented that four days later the member sent multiple text messages in one day before staff visited the member in the apartment which had no electricity or water due to fire fighters needing to break in to get to fire in the ceiling. The apartment was determined uninhabitable and the member was moved to another location. PSH staff use agency vehicles and are not allowed to transport members in their personal vehicles. Staff said that on occasion there may be few agency cars available.	they can respond to member needs.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 3	CBI PSH offers a member forum. Staff reported that a forum was held August 2019, and another is scheduled for March 2020. There is a program specific survey offered to members to complete	• Explore additional ways to solicit and incorporate member input. For example, seek member perspective on the new Navigator phase model. Explore if members

			when staff interact with members. Members can submit the surveys anonymously. PSH staff said that all the staff who provide direct services have lived experience of substance use and/or mental health recovery. It is not clear to what extent people with lived experience are in administrative positions. Some members reported that PSH staff speak about their lived experiences and that those staff can better understand member experiences.	can serve on sub-committees to the agency board of directors, participate in quality management, or other processes that impact service design and provision. • Offer more frequently scheduled tenant forums so members can voice their concerns and desires for program design.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	At the time of the review, 10 Navigators and a Lead Navigator deliver PSH services to 159 members, a member to staff ratio of about 14:1. PSH staff reported caseloads of 15 members. Staff said the Lead Navigator carries a reduced caseload of members who have fewer service needs.	
7.4.b	Behavioral health services are team based	1 – 4 2	Members are served by staff from different agencies with separate records. Tenants receive their psychiatric care from the RBHA provider clinics, where some also receive integrated health services. CBI PSH staff assist with the housing search and services to maintain housing. Members may also receive services from other providers or other programs at CBI. Providers maintain separate service plans and records. Input from staff with other providers may not regularly be sought or provided when updating service plans. Examples were documented in CBI records of PSH staff encouraging members to keep in contact with clinic staff, transporting members to their clinic, or visiting clinics to meet with staff. PSH staff documented phone calls to clinic CMs, supervisors, and covering staff (i.e., Blue Dot). PSH staff provided tracking of four clinic visits from January 2019 through March 2019 to educate staff about CBI's PSH program. Staff at one clinic reported	• Optimally, behavioral health services should be provided through an integrated team. With separate providers, there are inherent barriers to this, including providers maintaining separate processes, records with possibly redundant information, etc. • Staff should obtain input from each other when modifying plans if an integrated plan is not an option. Share updated plans when completed. This collaboration may prompt staff to revise plans for their prospective agency when members have a change in status and raise awareness of stated goals. • Timely clinic coordination may free-up time for PSH staff to spend with members and reduce their need to speak with clinic supervisory or covering staff (i.e., Blue Dot).

			caseloads range from 55-60 members per CM and that PSH staff can help members when a CM or HS has other duties. A member interviewed said that PSH staff seem to have more resources available than clinic staff. One member said that there are long waitlists for some clinic services.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 2	CBI staff reported the program operates from 7:00 am to 5:00 pm seven days a week. Service hours can be adjusted, for example, if members have an appointment earlier or later in the day and require support. If members experience an issue outside of business hours, they can contact the agency operated Access to Care line. Staff who answer the line are not from the PSH program. PSH staff are not available to respond to members after hours.	• PSH members should be able to contact PSH staff as a primary resource in the event of a crisis, 24 hours a day, seven days a week. PSH staff are better positioned to respond to and support members in the community, including outside of regular business hours, than staff from general crisis lines.

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	4
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	2.5
Average Score for Dimension		3.25
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	4
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.67
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	4
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	2
Average Score for Dimension		3
Total Score		23.67
Highest Possible Score		28