PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Christopher Bartz, Recovery Services Administrator I

From: T.J. Eggsware, BSW, MA, LAC
Jeni Serrano, BS
ADHS Fidelity Reviewers

Method

On December 1-2, 2015, T.J. Eggsware and Jeni Serrano completed a review of the RI International Permanent Supportive Housing (PSH) Program. 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.

The agency branding changed to RI International from Recovery Innovations, but the agency has operated in Arizona since 1990. Beginning in the early 2000s, the agency began hiring many individuals with a lived experience of recovery; Peer Recovery Coaches currently provide services in the Community Building program, which is one of many programs through RI International. RI International offers services through two Wellness City locations in Arizona; additional services include individual peer support services, peer employment training (PET), crisis supports, and transitional housing. This review focuses on the Community Building permanent supportive housing program at RI International. This program is identified as a PSH service provider, and the housing subsidy provided to tenants is funded by the Regional Behavioral Health Authority (RBHA) through a block grant. RI International manages the program waitlist separately from other subsidy or voucher programs managed by the RBHA. Due to the nature of the referrals, which originate at external clinics, information gathered at the Southwest Network (SWN) Highland and Bethany Village clinics were included in the review, with a focus on co-served members.

The individuals served through the agency are referred to as "citizens" or "participants", 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:

- Agency overview discussion with the Director of Peer Delivered Services, Recovery Services Administrator (i.e., Program Administrator), and Team Leader
- Individual interview with the Recovery Services Administrator
- Group interview with four Recovery Coaches and the Housing Specialist
- Group interview with ten tenants who participate in the Community Building program
- Review of agency documents including: the *Advance Directions In Case of Emergency Situation in Your Apartment* form, the agency *Wellness City Referral*

Form, the program *Welcome Agreement*, as well as other housing and agency forms completed during the intake (i.e., welcome, or welcome home meeting)
- Group interview with three staff at the SWN Highland clinic and three staff at the SWN Bethany Village clinic
- Review of eight records at clinics and RI international; records were provided for all program tenants for housing quality standards (HQS) and lease agreements

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:

- Community Building staff interviews and documentation provided for this review suggest staff are well-trained and knowledgeable about the evidence-based practice of PSH and the principles of Housing First.
- Functional separation exists between housing management companies and the PSH agency; when service staff interact with housing management (i.e., landlords) it is to advocate with or on behalf of tenants, or to facilitate tenant communication with housing management at the request of the tenant.
- The Community Building housing program allows for tenant choice and tenant privacy; staff and tenants confirm that scattered site units are integrated in the community. Tenants select units of their choice in the communities they want to live in; tenants can live with whom they chose, and service staff do not have keys for entry.
- The agency seeks to orient and educate members about the Community Building program. This effort starts at a welcome meeting, where members are introduced to the housing program and housing supports. The program seeks to support members in their housing search, discussing preferences, identifying priorities in spending, and using tools such as a rental calculation worksheet so when members are searching for a residence they will know their 30% portion in advance.
- Tenant leases, copies of Housing Assistance Payments Contracts (HAP Contract), and HQS are maintained by the Community Building program.
- Previously, the Community Building program was time limited. In the agency's effort to align with the PSH model, tenancy is no longer time limited; tenants report they are aware of the change and confirm the change has helped to ease the stress of feeling like they need to move again.
- RI International uses outcome tracking for many services provided; the data points are related to members housed, members employed, members involved in social activities, etc.

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

- System-wide training efforts surrounding effective implementation of the PSH model should continue; staff should be educated on available housing options, so they can adequately orient members in order to support member choice. The way members are introduced to housing support services, or other treatment services, is influenced by the clinical team recommendation and options discussed. It is not clear if staff receive detailed and ongoing training on housing options or services as changes occur in the system. Some staff report they learned about housing resources and supports through an overview in new hire training, but most of their learning is experiential, or hearsay from other staff or even from members. Clinic staff seem open to additional training, guidance and clarification to expand their knowledge of housing options and support services. Training and education should address: supporting members' choice, expanded options, maintaining tenancy, screening for tenancy related criteria (e.g., ability to pay rent, ability to care for apartment, respecting rights of other tenants, following crime free and drug free ordinances), which would generally be allowable, versus screening members based on functional or readiness criteria.
- The RI International Community Building program manages its waitlist separately from other RBHA voucher or subsidy programs. Since both utilize the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) to prioritize their housing support waitlists, they should coordinate training and guidance for clinic staff to clarify prioritization of members for PSH services. Some clinic staff are familiar with the VI-SPDAT as a tool to prioritize members for voucher programs, but are unable to provide specifics on how prioritization is applied. The RBHA and RI Community Building staff should continue system efforts to educate staff and the community on the Housing First approach. Community Building staff should continue efforts to educate referral sources that member participation in services is not mandated to access or maintain housing so they are able to orient members to the program.
- RI International should continue efforts to educate system partners about the Community Building program and how it compares with other similar programs (i.e., scattered site housing offered through the RBHA). Some clinic staff are unsure how to refer members to the Community Building program, but note there is a number they can call to request the referral form. Many members forgot they had applied when they were informed by clinic staff an opportunity for housing subsidy and supportive service was offered through the RI International Community Building program.
- In PSH, all behavioral health services are provided through an integrated team. If this is not possible due to the current structure of the system with separate service providers, it is recommended that the full clinical team and PSH service provider hold regular planning sessions to coordinate care in order to work more fluidly as a team, and to prevent duplication of efforts or conflicting approaches. Ongoing coordination with clinic Case Managers (CM), soliciting input into the service planning process and sharing of written documentation is encouraged if an integrated health record cannot be implemented. An integrated team may aid clinic staff in learning more about the PSH model through direct experience working with members living independently with supports.
- The Community Building program at RI International should explore opportunities to develop boards, committees, or other opportunities for tenants to have a voice in service design at the program, not only their individual service plans or services they receive directly.

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)	Though members are not assigned a type of housing, options offered appear to be restricted at the referral source, due in part to clinic team assessment of member needs rather than member's choice, as well as reportedly extended waitlists for subsidy programs, limited affordable options in the system, or the perception members with higher assessed level of need should be directed toward treatment settings. Clinic staff (i.e., referral source) report member choice should drive the search for housing, and some staff are familiar with a housing first approach as a concept (i.e., if a person has housing, it makes it easier to address other needs); however, it is not clear if the culture of the system fully supports member choice. Some staff still express their belief that other parameters should be applied to people who receive government assistance (e.g., mandatory drug testing, stricter guidelines about services provided to "addicts"). Some staff report clinical team recommendation influences what options are pursued, whether independent housing or treatment settings; one staff reported if a member is actively using substances they would not apply for subsidy programs until a person received substance abuse treatment. In some cases, clinic staff may refer members to	• The RBHA and Community Building staff should continue efforts to train and educate clinic staff about a Housing First approach and the PSH model due to their role as referral sources; PSH programs should consider tenant preferences for type of housing at intake or entry into programs. When possible, solicit members to share their stories of success as a means to highlight the benefits of PSH services. • Community Building staff should continue efforts to train and educate other RI International staff about a Housing First approach and the PSH model. Members should not be exposed to another screening through RI International before being accepted in the Community Building program.

			Flex-Care (i.e., short term supportive housing/treatment setting) and scattered site programs concurrently. Clinic staff report they were directed to refer members to PSH programs if they are completing Flex-Care applications and members are assessed to have a lower level of need (i.e., they are not appropriate for treatment but are for PSH). RBHA staff report the RBHA does not dictate to providers where members should be referred. There is recent evidence of RI International staff discussing whether potential tenants are appropriate for independent living prior to being accepted formally into the Community Building program, adding a second layer of screening prior to program entry.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 (4)	Tenants choose among multiple units once a member enters the Community Building program; a subsidy is provided based on tenant income. Tenants search for scattered site housing, with assistance from staff, or on their own based on their preference. Tenants are able to choose a unit in the community that agrees to work with the program, with the only constraint being the unit must meet the fair market rental rate (e.g., $735 for one-bedroom).	
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)	Based on report and documentation, efforts are made by Community Building staff to work with members to proactively discuss housing barriers early in the search process, beginning at the welcome meeting (i.e., intake). There is no RBHA influence over waitlist based on agency staff and RBHA staff report. Some clinic staff were unsure how to assist members in applying for the Community Building	• Community Building staff should continue efforts to implement the use of standardized prioritization tools, and to educate referral sources on how the program waitlist is managed so they can inform members. • Rather than a separate arm of the agency managing the waitlist, consider managing the list directly through the Community

			program, though a referral form is posted on the RI International website and includes a check box for Housing Services as a requested service, and a phone number for the Recovery Services Administrator is listed. Based on clinic documentation, RI International staff contact clinic staff to inform them an opportunity for housing through the Community Building program is available for the member; some tenants in the program report they forgot they applied by the time they were selected for participation, but others waited a short time before receiving support.	Building program staff; see also comments and recommendations for item 6.1.a, Extent to which tenants are required to demonstrate housing readiness to gain access to housing units. • On the Wellness City Referral Form consider listing the Community Building program as a specific check box option as a referral reason; consider posting links to the referral form where Community Building information is posted on the agency website.
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 (4)	Tenants choose the members of their household or can choose to live alone and have a private bedroom. If a tenant elects to live with another person, that person is responsible for half of the rent, is listed on the lease, and must meet applicable requirements through housing management for approval as a tenant. The Community Building subsidy applies to half of the rent paid by the Community Building tenant.	
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)	Housing management staff has no authority or role in providing social services; landlords would generally not be invited to planning sessions unless it was at the request of the tenant. Service staff interactions with landlords are also at the request of tenants, and only when advocacy or support is needed. Even in the initial housing search, potential tenants can elect to receive Community Building service staff support or search for apartments on their own. After meeting with	

			service staff to discuss their preferences, the benefits of disclosure is discussed.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 (4)	Service providers have no direct role in housing management functions, do not collect rent, enforce lease requirements, initiate evictions, etc. The Community Building program maintains housing services that are separate from service files and include move-in information, leases, HAP contract, and HQS inspections. However, one Community Building form indicates if tenants sublet their apartment or allow people to live with them, it "can and will lead to the termination of housing assistance" if the tenant does not inform Community Building and have the person on the tenant's lease. This seems to blur the service and housing management roles, implying a link between housing services and the ability to terminate housing assistance, likely making it unaffordable for some tenants to maintain tenancy. However, there was no evidence tenants had been evicted under these circumstances.	• Consider revising the fourth item on the agency *Welcome Agreement* that references the termination of housing assistance; the program should consider all potential ramifications of making the change if it elects to proceed with adjusting the form.
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	Social and clinical service providers are based off site. Services are readily accessible, mobile, and can be brought to tenants at their request.	
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)	Tenant's payments toward housing costs are based on their income; the agency facilitates a subsidy through HAP contracts. Tenant housing costs range from 0 to 34% based on data provided. The majority of tenants pay 30% or less; two tenants pay about 31% and another pays about 34%. Members with no income pay zero rent.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 (4)	Under an agreement for services entered on January 1, 2015, RI International partnered with Housing Operations and Management Inc. (HOM) to conduct HQS inspections. HQS inspections were made available for review in housing service records maintained by the Community Building program. The majority of tenant units passed inspections. Two failed due to the inspectors not being able to access the units; one failed due to the tenant being unprepared for a bed bug treatment, but a reschedule date was noted. Of 51 members of the Community Building program who are tenants, 94% of their units met HQS.	• Continue to work with tenants to discuss the benefits of allowing HQS inspections, or to prepare for repairs if the need should arise.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 (4)	Tenants reside in scattered site residences. The only parameters are that the housing must meet fair market rental rate, and that only market forces (e.g., crime free and drug free properties not leasing to individuals with felonies) may limit options. There are few examples of tenants living in complexes where other members reside, and there was no evidence identified during the review of clustering people with disabilities.	
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 (4)	Leases were reviewed in tenant housing records, and the majority of tenants have current leases with few exceptions (e.g., for tenants whose leases reportedly were on a month to month basis). As a result, tenants appear to have full legal rights of tenancy. In addition, the program maintains copies of HAP contracts.	
5.1b	Extent to which tenancy is contingent on compliance with program provisions.	1, 2.5, or 4 (2.5)	Community Building staff report there are no program rules requiring tenants to participate in ongoing services, and no rules beyond regular conditions outlined in leases. Though agency documents in member records imply that a certain frequency of contact with Recovery Coaches will occur, some forms reference weekly contact and more recent forms indicate monthly contact or more frequently if the tenant chooses. Clinic staff report members must participate in 10 – 12 hours of treatment in order to maintain housing; group participation through RI International or other providers to address identified needs (e.g., substance use) were cited as examples. Although, clinic staff report failure to comply with this requirement was not known to have led to any tenant evictions. Community Building staff may request HQS inspections; they report it almost always is due to ensure housing management is meeting their obligations to tenants. There were no examples of inspections requested to address a tenant behavior issue. Based on documentation at clinics, some members were reluctant to accept housing support through Community Building due to the belief that service participation was mandated. It is not clear how widely that belief is, nor is it clear if some members in the system are dissuaded from	• Continue efforts to educate referral sources that participation in services is not mandated to access or maintain Community Building housing support, so they are able to orient members to the program.

			pursuing services through the Community Building program due to this misconception; this is a vestige of when the program was transitional and not permanent.	
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 (1)	Though clinic staff report that member preferences are considered and that members cannot be forced to go into treatment, clinical team recommendation appears to influence the process. Some staff report members with certain issues will not be referred to independent living until those issues are addressed; if members have substance use challenges, they will not apply for independent living support programs until those issues are resolved, usually through a short term treatment setting (i.e., Flex-Care). Some clinic staff report direction through the RBHA that members with a lower level of need be referred to PSH based on a level of care assessment associated with the RBHA Flex-Care application. Seeing as some staff complete Flex-Care applications and PSH program applications for the same member, some members may be directed to a treatment setting prior to accessing independent living; one staff reported they usually start with Flex-Care housing and then pursue PSH. RBHA staff report any trainings provided by the RBHA have not included a directive to clinic staff on how to stream referrals, and they do not provide feedback to teams regarding referrals to treatment or housing programs; referrals are determined by the clinical team based on member choice.	• RI International should ensure staff that make first contact with the clinics are not screening members before intake into the Community Building program. Consider transitioning this first contact and waitlist management to the Community Building program rather than relying on another department in RI International. • The RBHA should continue to differentiate treatment and housing supports through training efforts. Consider expanding live training or other direct staff technical assistance opportunities rather than relying on online training. For example, the RBHA reports Flex-Care and housing lists are compared for potential overlap (i.e., members with treatment and housing applications submitted through the RBHA). For those clinics with a high incidence of overlap in applications for housing and treatment settings, consider focused technical assistance to clarify that member choice should drive the option pursued; if a member wants to live independently, that factor alone should be the primary consideration. The shifting attitude of staff to support member choice over readiness assessment was reflected in some interviews, but further training will likely be

			RI International staff that are not a part of the Community Building program make the first contact with clinic staff when a member's opportunity for Community Building housing support arises. Based on clinic documentation and clinic staff report, these RI International staff may inquire if members are ready for independent living or support through the Community Building program (as recently as September 2015). Though these staff were trained by Community Building staff, some clinic staff still feel that RI International staff screen whether members are appropriate for independent living before being accepted in the Community Building program.	beneficial.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (2.5)	The Community Building program waitlist is managed by the RI International agency, but by a separate branch of the agency. Historically, referrals are processed on a first-come, first-served basis. As of December 1, 2015, the program formally began using the VI-SPDAT to aid in prioritizing members, but due to the recent introduction of this process, few members have a VI-SPDAT score to date. As a result, members who meet program eligibility have equal access to housing, and some members report they did not remember they had even applied for support when their name was selected for the housing support opportunity.	• The agency should prioritize members with the most significant obstacles to housing, which may include factors such as: patterns of homelessness, difficulties maintaining housing, substance use challenges, poor rental histories, frequent crisis intervention, legal issues, difficulties with addressing basic needs, and limited social supports. The use of the VI-SPDAT should aid in this effort. • As the agency continues to educate referral sources about Community Building as a PSH program, include how the member waitlist will be prioritized using the VI-SPDAT.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 (4)	Generally, service staff may not enter tenant units unless tenants invite them, and staff do not hold copies of keys to the tenant residences. The agency utilizes an *Advance Directions In Case of Emergency Situation in Your Apartment* form (revised 4/15/15) to orient tenants to the purpose and potential benefits of wellness checks. The	

			form clearly affords tenants the opportunity to opt out (i.e., wellness checks are not mandatory), or if they elect, to specify events that should occur before staff, or other designee, facilitates the wellness check by working with housing management and/or police. The form also prompts the tenant to identify others to involve in the wellness check process, if the need should arise.	
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 and Community Building staff report they solicit and include member input in the service planning process and tenants are the primary authors of their service plans; tenants report their participation in planning is solicited, and service plans at the referring clinics were consistent with tenant living situations. At the Community Building program entry welcome meeting, prospective tenants are encouraged to create their own vision of wellness, to identify goals, and select resources to work toward their goals. A program document includes a prompt for members to write down their ideas, and lists potential activities or areas for members to select from.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (4)	Tenants initiate and are offered routine opportunities to modify their service selections. Though clinic plans reviewed were usually updated only annually, Community Building uses an Individualized Service Plan (ISP) Addendum to modify services. Clinic staff are unclear if this document or other modifications to services is consistently provided, which reflects on whether	

			services are provided through an integrated team.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	At RI International efforts are made to support tenant choice, which was substantiated through interviews with members and agency staff, as well as agency documents. Agency staff report tenants may choose from an array of services through the program, and members can elect to not participate. Some tenants report service involvement is strongly encouraged, others report participation is not required, and some members report as long as they are doing something, such as activities at the clinic it is acceptable. Members sign agency documents at program entry, which indicates their understanding that as part of their services through Community Building, their Recovery Coach can meet with them in their homes at least monthly, or more often if the tenant chooses. This seems to imply that some level of contact is required. Earlier versions of the same form indicate weekly contact would occur, but the form was revised. Agency staff report that if tenants decline to allow these contacts, they will honor the choice and request phone check-ins as an option. RI International documents indicate members agree to work on chosen goals and activities, and clinic staff report their belief tenants must engage in 10-12 hours of services through RI International in order to maintain tenancy. Community Building staff report the service participation requirement no longer applies. Clinic staff and Community Building staff agree members must maintain services through the RBHA in order to maintain housing supports; some tenants report they must remain open with RI International to stay in their	• Continue efforts to educate referral sources that participation in RI International services is not mandated in order to be a member in the Community Building program. • Consider revising agency documentation that may imply some level of participation in services through RI International is required to maintain tenancy; see also recommendation for 5.1.b • The Community Building program should consider expanding the scope of the subsidy program to include a provision extending the subsidy for a period of time if members elect to close from RBHA services.

			housing. As a result, it appears tenants can select services they receive, but choosing no services is not an option.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (4)	Housing services are provided by Recovery Coaches, and tenants can access other services through the agency; the service mix is highly flexible and can adapt type, location, intensity and frequency based on tenants' changing needs or preferences. The adjustments in services can be made through Individual Recovery Journal Notes (i.e., progress notes), a Solutions Planning Sheet, or an ISP Addendum used to enhance the annual treatment plan completed at the clinics.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 (3)	Many RI International staff are individuals with a lived experience of mental illness or substance use. Peer Recovery Coaches provide housing support services to tenants in the Community Building program. Tenant satisfaction is measured primarily through individual feedback using surveys, satisfaction check-ins with staff as services are provided with a tenant feedback section on the Individual Recovery Journal Note, and through pre-survey during the intake (i.e., welcome meeting). There is no formal advisory council, boards or other settings where tenant input is directly solicited at the Community Building program level, but the program appears invested in supporting member choice based on review of agency materials and interviews.	• The Community Building program should explore opportunities to develop boards, committees, or other opportunities for tenants to drive services. When asked how services could be improved, some members reported they would like to see RI International transition to provide clinic services from the Wellness City location, and others report they would like to have class listings mailed out so members did not have to go to the Wellness City locations to pick them up.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	Community Building staff includes four Recovery Coaches, Housing Specialist, Recovery Services Administrator, and Team Leader to provide support services to 60 tenants; Recovery Coach caseloads are 15 tenants to each staff member.	

7.4.b	Behavioral health services are team based	1 – 4 (2)	Members receive services through clinics to access case management, appointments with Psychiatrists and Nurses, and may be referred to multiple external providers, including RI International; multiple providers are involved in providing services. Community Building staff state they primarily coordinate with the CM, with regular updates via phone calls, emails, and periodic planning sessions. Clinic staff report most collaboration with RI International staff occurs when members first enter the PSH program, with inconsistent contact in some cases, unless issues of concern arise. It appears the frequency of formal coordination can vary by clinic, CM assignment, or RI International staff. There is some indication treatment plans or other documents may be shared, but clinic staff are not aware if service information is consistently relayed. Also, it does not appear clinic staff and RI International staff consistently seek input from each other when developing service plans with members.	• Preferably, all behavioral health services are provided through an integrated team. If this is not possible due to the current structure of the system with separate service providers, it is recommended the full clinical team and PSH service provider hold regular planning sessions to coordinate care in order to work more fluidly as a team, even if full integration cannot be achieved. Ongoing coordination with the clinic CM, soliciting input into the service planning process, and sharing of written documentation is encouraged if an integrated health record cannot be implemented.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (4)	The main RI International number switches over at 5:00 PM to the agency crisis center in Peoria, AZ. Staff answering the phones have contact information for Community Building staff who are on call 24 hours a day, seven days a week and can facilitate support through the program or other services, as needed. If a tenant requests assistance on the weekend, the program Team Leader and Recovery Services Administrator are available. One member cited an example of staff Housing Specialist support over the weekend when she moved residences.	

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	4
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	4
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	4
Average Score for Dimension		4
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	4

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	2.5
Average Score for Dimension		3.25
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	1
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		2.5
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	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	4
7.3.a: Extent to which services are consumer driven	1-4	3
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week.	1-4	4
Average Score for Dimension		3.5
Total Score		24.88
Highest Possible Score		28