

**PERMANENT SUPPORTIVE HOUSING (PSH)  
FIDELITY REPORT**

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To: Dan Wheeler, Director of Community Living Services

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ADHS Fidelity Reviewers

**Method**

On March 11-12, 2015 T.J. Eggsware and Jeni Serrano completed a review of Lifewell Behavioral Wellness' Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services, in an effort to improve the overall quality of behavioral health services in Maricopa County

Lifewell provides services including outpatient counseling, vocational rehabilitation, residential, transportation community living and housing. Although Lifewell serves as housing management to some properties in the community, Life well's Community Living Program is the focus of this review. Lifewell supportive housing staff provides supportive housing services to 86 tenants who reside in apartments and house model settings.

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

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

- Orientation and overview of housing and support services at the agency.
- Individual interview with the PSH program administrator (i.e., Director of Community Living).
- Group interview with three PSH program direct service staff, referred to at the agency as clinical staff.
- Group interviews with three case managers at Choices Arcadia and two case managers at Partners in Recovery Arrowhead.
- Group interview with eight tenants who are participating in the PSH program.
- Review of agency documents including intake documents, policies and procedures, PSH program description, organizational structure, team coordination and housing data for tenants served.
- Review of 14 records at Lifewell and clinics with shared members, including charts of some tenants interviewed.

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:

- Lifewell has taken steps to learn more about the PSH model. Rather than making dramatic shifts, the program planned and made incremental changes over the prior year, with increased focus in the prior month and a half to two months leading up to the review. The steps taken by Lifewell may serve as examples for other programs with similar structural challenges in the system just beginning to make changes to align with the PSH model.
  - The Director of Community Living services and the Housing and Compliance Manager reviewed the SAMHSA material and targeted items where the program could make changes in order to more closely align with the PSH model. Functional separation of housing and supportive services was an early focus. They reviewed the changes with agency administration in May, 2014 to raise awareness of necessary changes, developed a PowerPoint presentation and online training to help staff learn more about the PSH model, and policies were adjusted to clarify what items do not apply to PSH services.
  - The Director of Community Living reviewed the changes with staff during supervision and other meetings. The gradual changes allowed for training of staff and tenants to adjust to new staffing structures, which occurred in August, 2014.
  - Program staff, and most tenants, report increased satisfaction with recent changes in housing support services, and they stated the changes allow for increased tenant control and independence. Program staff report that they strive to inform tenants and partner agency staff that PSH is housing and not a level of care.
- Lifewell has copies of most tenant leases and the majority of HQS inspections.
- Tenants pay 30% or less for rental costs.
- The service plans at Lifewell are individualized by member, and although similar themes are present, standard content is not used across plans.
- Clinic interviewed who are aware of scattered site housing in the system report positively of member satisfaction, timeliness, and ease of access.

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

- House model residences do not align with the PSH model. House model settings do not allow for member choice of living arrangements and are not integrated settings. The majority of Lifewell tenants reside in a house model setting. The Regional Behavioral Health Authority (RBHA) should coordinate with providers who manage or service house model settings, and other stakeholders (e.g., Arizona Department of Health Services, and property owners) for strategic planning to systematically adapt, transition or eliminate house model settings.
  - The system has a process where members are often assigned to a room at a house, may not have other timely options, and seem compelled to take the first option available due to their situation (e.g., inpatient, facing homelessness). However, many tenants report they want to live in their own independent residence and do not view the house settings as a permanent situation.

- When potential lease violations or other issues arise in house model settings, program staff may feel compelled to report a tenant's actions to housing management or police in order to protect other tenants of the residence. This compromises rights of tenancy and the separation of housing and services.
- Occurrences of interpersonal conflict are cited by tenants, program staff, clinic staff, and documented in records when people are forced to live together. Examples include: acts of physical aggression in a house model setting, cited as a reason for increased stress and subsequent hospitalization for another tenant; tenant isolation in their rooms to avoid contact with other tenants; tenants residing in a location with a past intimate acquaintance leading to conflict.
- Training on PSH throughout the system and community is recommended.
  - Clinic staff, housing management agencies, hospital staff, advocates, and guardians are not formally informed of the reason for staffing changes at house model programs to support system transition to the PSH model.
  - The RBHA should require staff at hospitals to obtain training on PSH. When members are hospitalized, coordination between inpatient social workers and case management staff occurs, but the efforts can breakdown easily due to pressures to discharge members quickly or not clarifying the purpose of integrated staffing. This can cause staff and members to bow to inpatient staff recommendations.
  - The way clinic staff learn about scattered site housing is not consistent; some hear about the option from secondhand sources or come across the applications looking for other forms on the RBHA's website. Clinic staff are not all aware that the scattered site housing includes supportive housing services. They appear to view the one page application, rental subsidy and timeliness of processing as primary benefits when describing the program. If referral sources are not adequately informed of supportive housing services, they cannot properly orient members.
- Member choice in housing and supports is constricted due to pre-assessment at the clinics, which is sometimes influenced by hospital staff who reportedly tend to prefer discharges to staffed treatment settings. Explore system barriers to clinic staff being able to develop individualized service plans with members, so they have the primary voice in the process.
- Lifewell should not report potential lease violations to housing management but rather work with tenants, provide education, and raise their awareness of how behaviors could lead to lease violation and eviction. Functional separation of housing management and supportive services must be maintained.
- As the system implements PSH, track tenant outcomes (e.g., length of time successfully housed, utilization of crisis services, substance use status) for those tenants in PSH services. This could include tracking members before and after PSH admission as well as comparing PSH tenants with data for other members not in PSH (i.e., residential or flex care). This could also include comparison of tenants in higher fidelity PSH programs and those in lower fidelity PSH programs. This information may be useful in training and education efforts as the PSH model is implemented; share success stories during trainings and education efforts with staff and the community. Engage providers and members in problem-solving when barriers are identified.

**PSH FIDELITY SCALE**

Item #	Item	Rating	Rating Rationale	Recommendations
<b>Dimension 1 Choice of Housing</b>				
<b>1.1 Housing Options</b>				
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 (1)	<p>Member choice is limited in the system; their input is sought, but clinic staff assessment, sometimes influenced by inpatient staff for members who are hospitalized, strongly influences where members are eventually housed. If certain issues are identified during assessment (e.g., substance use challenges, not taking medication as prescribed, no history of independent living), it is likely the person is referred to some type of treatment placement, such as residential or flex care.</p> <p>The emergence of scattered site housing is new to the system, and clinic staff knowledge of the program varies. Clinic staff report no formal training or overview of scattered site housing in relation to other housing or treatment services; they are not fully aware of how services are provided in scattered site housing. As a result, those assessed as independent with few in home supports needed are more likely to be referred.</p>	<ul style="list-style-type: none"> <li>• Conduct formal trainings on PSH at all levels of the system, open to anyone who might influence the process such as hospital staff, advocates, guardians, case management staff, and psychiatrists. Clearly outline the scattered site option, including program structure, how the option aligns with PSH, referral process, how the wait list is managed at the RBHA, and who would make a good candidate.</li> </ul>
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are	1 or 4 (1)	After the clinical team assessment, members are assigned to a provider by the RBHA and assigned a unit that they can accept or decline. If a person declines the option it could result in delayed placement, prolonged hospitalization, or homelessness. In some cases members voice a desire to live alone, or request a specific area of town (near family or other supports) but feel pressure to accept the option offered. In some cases when Lifewell has more than one open bed,	<ul style="list-style-type: none"> <li>• Offer members a variety of options, driven by their preference, including offering a choice of units.</li> <li>• Review system options to adapt, transition (i.e., as step down short term or transitional placement), or eliminate the house model settings.</li> </ul>

	offered a choice of units		a person is offered the choice of two options at the program. If a person states a desire to move, they may occasionally move to another opening at Lifewell or return to the RBHA managed waitlist.	
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 (3)	<p>Although members often indicate their desire to live independently, this choice is not always offered or available, and clinic staff are not all informed of scattered site housing.</p> <p>Generally, if residential treatment is not determined necessary, members are referred for community housing. If members decline the first option offered they return to the waitlist managed by the RBHA and may experience a delay before another option is available.</p>	<ul style="list-style-type: none"> <li>• The system needs to increase scattered site options and ensure clinic staff receive training to adequately orient members to all housing supports and options.</li> <li>• The system needs to review whether management of waitlists can be transitioned to PSH providers, potentially freeing up RBHA housing staff to dedicate more time as a resource to providers as the system transitions to the PSH model.</li> </ul>
<b>1.2 Choice of Living Arrangements</b>				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 (2.5)	The majority of Lifewell tenants (65%) reside in house model settings in their own bedrooms but with roommates not of their choosing. Only one of seven tenants interviewed prefers to have a roommate. The remaining 35% of tenants reside in their own apartments. Tenants with roommates cite challenges such as interpersonal conflicts, some acts of violence, some acts of substance use, and not knowing the roommates before moving in to the residence.	<ul style="list-style-type: none"> <li>• If house model settings remain a primary option in the system, the RBHA and Lifewell should collaborate to identify opportunities where tenants can have a choice in selecting roommates (e.g., meeting potential roommates during tours).</li> </ul>
<b>Dimension 2</b>				
<b>Functional Separation of Housing and Services</b>				
<b>2.1 Functional Separation</b>				
2.1.a	Extent to which housing management providers do not have any authority or formal role in	1, 2.5, or 4 (2.5)	<p>The majority of the tenants served through Lifewell supportive services have leases through Lifewell’s housing management department, accounting for 72% and the remaining 28% with a separate housing management agency.</p> <p>Lifewell attempts to distinguish housing</p>	<ul style="list-style-type: none"> <li>• Lifewell should continue to monitor the separation of housing and social services to ensure a clear separation exists.</li> <li>• The agency should discontinue the practice of inviting housing management to clinical staffings. It is a blurring of the roles of services and management to include</li> </ul>

	providing social services		<p>management and housing supportive services in dealings with tenants and other agencies. Once members are referred, Lifewell housing management staff coordinate tours with tenants, inform Lifewell supportive service staff, and if the tenant accepts the unit, housing management arranges the lease signing. Supportive service staff meet with tenants after lease signing to complete clinical intake paperwork and offer supportive services.</p> <p>Lifewell housing management staff attends portions of staffings when tenancy-related issues arise, reporting issues of concern with the goal of the person maintaining their housing. Housing management staff do not attend portions of staffings when clinical issues are discussed and plans to address behaviors are developed.</p> <p>The agency developed two release forms, one for housing management to share housing information with the service staff, and one for the service staff to share certain information with housing management. Both releases are required to share information between the two departments at Lifewell.</p>	<p>housing management to any part of clinical staffings.</p> <ul style="list-style-type: none"> <li>• The release forms to authorize disclosure of information does not make it acceptable to blur the roles of housing management and services. Service staff should attend lease signings to obtain copies of leases. Service providers should not share information with housing management.</li> </ul>
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 (2.5)	<p>Lifewell supportive service staff encourage and guide tenants to inform housing management of issues such as damage to the property, repairs in the residence, to request work orders, and to report or address interpersonal conflicts with other tenants. Examples of tenants contacting housing management to address issues in their residences are documented in tenant records and referenced by staff at clinics and Lifewell.</p> <p>Lifewell supportive service staff generally don't</p>	<ul style="list-style-type: none"> <li>• Lifewell supportive service staff should not report potential lease violations to housing management. Supportive service staff should encourage, educate and empower tenants to interact with housing management rather than doing it for them.</li> </ul>

			report issues to housing management, but there is some overlap with housing management in that support service staff inform housing management of certain issues (e.g., when tenants are a danger to someone else, or when illegal substances are involved.) Police may also be contacted.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 (4)	<p>In the past service staff were stationed in the house model settings. In August, 2014 supportive service staff adjusted the staffing pattern and where staff are located, with services transitioned off site to other Lifewell offices. Services are readily accessible, mobile, and can be brought to tenants at their request. Tenants can also access Lifewell services in other settings outside of their homes.</p> <p>Some clinic staff voice concern with Lifewell staff no longer being on site in the homes, and they are not fully aware of the justification for the change in staffing. Lifewell report that they are making efforts to educate tenants and other agencies regarding program changes to align with the PSH model.</p>	<ul style="list-style-type: none"> <li>The RBHA and program should collaborate to ensure clinic staff/referral sources are aware of how the change in staffing location aligns with the PSH model.</li> </ul>
<b>Dimension 3</b>				
<b>Decent, Safe and Affordable Housing</b>				
<b>3.1 Housing Affordability</b>				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 (4)	Tenants in the PSH program pay 30% or less of their income for housing costs. Monthly rent accounts for approximately 18% on average of tenant income, with an additional utility allowance in some cases.	
<b>3.2 Safety and Quality</b>				
3.2.a	Whether housing meets HUD's Housing	1, 2.5, or 4 (2.5)	Lifewell provided Housing Quality Standards (HQS) inspections for 84 of 86 residences, and 70% of those units passed inspection.	<ul style="list-style-type: none"> <li>Ensure housing service staff are aware of HQS, so they can support and advocate with tenants to ensure all units meet</li> </ul>

	Quality Standards			<p>identified standards.</p> <ul style="list-style-type: none"> <li>Consider tracking reasons for failed inspections, so service staff can focus their education efforts when supporting members to maintain tenancy.</li> </ul>
<b>Dimension 4</b>				
<b>4.1 Housing Integration</b>				
<b>4.1 Community Integration</b>				
4.1.a	Extent to which housing units are integrated	1 – 4 (1)	Sixty-five percent (65%) of Lifewell PSH tenants reside in house model settings with three to four roommates, and 35% reside in apartment model settings in one of four apartment complexes. Two of the apartment settings are smaller complexes with all tenants meeting disability-related eligibility criteria. At the third complex approximately 50% of the tenants meet disability-related eligibility criteria, but the fourth complex is larger and is considered integrated. Overall, the majority of tenants live in settings where 76-100% of the tenants meet disability-related eligibility criteria.	<ul style="list-style-type: none"> <li>Increase availability of scattered site options in the system. Lifewell staff voice they prefer integrated housing over house model settings, using one of the apartment complexes as an example. Member goals appear to align more with integrated housing. Clinic staff desire more housing options to offer members.</li> <li>The program should track and compare outcomes for tenants at house model, non-integrated apartments, and integrated apartment settings.</li> </ul>
<b>Dimension 5</b>				
<b>Rights of Tenancy</b>				
<b>5.1 Tenant Rights</b>				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 (4)	Lifewell provided 99% of tenant leases for review. Lifewell housing management staff are reportedly more active in the residences than other comparable housing management agencies. Some clinic staff are skeptical members can maintain tenancy if they close from Lifewell services due to this high frequency of contact, citing concern the program might find other reasons to evict tenants. As clinic staff receive training and learn about the PSH model, these types of concerns may be alleviated.	<ul style="list-style-type: none"> <li>Lifewell supportive service staff should be familiar with lease content and how leaseholders enforce the leases, so they can effectively advocate with tenants.</li> </ul>
5.1.b	Extent to which	1, 2.5,	Tenancy is not contingent in any way on	



	tenancy is contingent on compliance with program provisions	or 4 (4)	compliance with program or treatment participation (e.g., sobriety or medication compliance). Lifewell applies no other house or program rules, and members can close services with Lifewell and remain a tenant in their residence. Lifewell staff report some tenants have elected to develop chore lists at the homes. Tenants report they are encouraged to do chores in their residences, and staff may report to case managers if not completed for a period of time. However, this does not lead to eviction.	
<b>Dimension 6</b>				
<b>Access to Housing</b>				
<b>6.1 Access</b>				
6.1.a	Extent to which tenants are required to demonstration housing readiness to gain access to housing units	1 – 4 (1)	Although Lifewell does not apply housing readiness requirements, assessment and level of care determination occurs at clinics prior to referral. There is evidence of a continuum of care approach with some members stepping down to PSH services. Clinical team recommendation is primarily driven by the team psychiatrist but may also be influenced by other clinical team staff, outside agencies (e.g., hospital staff) or supports (e.g., advocates, guardians) who may not be familiar with the PSH model or a housing first approach. Members with substance use history, behavioral issues, or those whom staff assess as not able to take medications independently are likely to be referred to residential or other staffed residences.	<ul style="list-style-type: none"> <li>The RBHA should offer training and support to referring provider staff to empower them as agents of change as the system transitions to the PSH model. Training and education should address: supporting 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.</li> </ul>
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 (4)	Members are prioritized in the system if in the hospital, but other circumstances (e.g., domestic violence situations, living with family or friends) may have longer waits. Once referred, the member is invited to tour the program, and if they accept the placement, they sign a lease and are	

			offered support services.	
<b>6.2 Privacy</b>				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 (3)	<p>Service staff and tenants report changes over the past year that include staff no longer stationed in any residence and tenants in apartments having full, independent control of access to their residences. Tenant’s in house model settings have locks on their doors and control entry to their bedrooms; staff no longer hold copies of keys. Service staff and tenants report staff generally contact tenants in advance to schedule a time to visit, knock, and do not enter the unit unless tenants invite them.</p> <p>Staffings do not occur at house model settings unless a tenant requests, and if so, staff educate the tenant on confidentiality concerns. If a tenant resides in an apartment, they can elect to have staffings in their residence, but integrated staffings for all tenants usually occur at Lifewell service hub locations.</p> <p>Staff report that a new form was developed for use in special circumstances (e.g., suicidal ideation) to allow staff entry once the form is signed by the tenant. Additionally, staff provides supportive services to members in some residences where other tenants have closed from Lifewell services. In these situations, non-enrolled tenants do not have full control over entry to their residence.</p>	<ul style="list-style-type: none"> <li>The program should eliminate the form tenants can sign to authorize staff entry into their units.</li> </ul>
<b>Dimension 7</b>				
<b>Flexible, Voluntary Services</b>				
<b>7.1 Exploration of tenant preferences</b>				
7.1.a	Extent to which tenants choose	1 or 4 (1)	Member input in service planning is sought but is influenced by clinical team recommendation; goals	<ul style="list-style-type: none"> <li>System-wide training through the RBHA is recommended for referring clinics and at</li> </ul>

	the type of services they want at program entry		often contain clinical jargon and do not appear to be in the words of the members. Lifewell PSH admission criteria indicates that to be admitted to the program, a member must have expressed a desire to engage in supportive services to assist them in maintaining their housing. At Lifewell, supportive housing services are not transferrable; services are attached to a location and not the tenant.	the provider level to ensure tenants are the primary authors of their service plans. It is recommended to work with clinic staff to identify and resolve barriers to individualized planning. Support member choice in service selection; empower direct service staff to act as advocates on behalf of the members.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 (4)	Tenants report they work with Lifewell staff to develop service plans and tell staff what goes on the plans. Tenant goals and status is discussed during staffings, and plans are revised every one to three months. The content of plans varies from person to person and can change over time.	
<b>7.2 Service Options</b>				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 (3)	<p>Lifewell staff are expected to engage tenants at least weekly. Tenants report that staff offer services, but participation in Lifewell services is not required to maintain tenancy. Lifewell PSH discharge process indicates a tenant may be discharged from supportive services if the tenant is no longer in need of supportive services. Information provided by Lifewell, corroborated by some clinic staff during interviews, indicates some tenants are disenrolled from Lifewell services but remain tenants of Lifewell-serviced properties. At Lifewell, ten of 86 tenants are disenrolled.</p> <p>Lifewell staff report that efforts are made to ensure tenants understand the separation of housing and supportive services and if they decline services they are not going to lose their housing. However, clinic staff and tenants report their belief they must remain open with clinic case management services to remain in housing.</p>	<ul style="list-style-type: none"> <li>Lifewell service staff cite examples of tenants who elected to close services with Lifewell and then re-engaged in services by their choice. Staff report tenants appear to be more invested in the services when it is made clear their involvement is optional, and not required for tenancy. These situations may serve as examples for other programs as they transition to PSH services.</li> </ul>

7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 (4)	Service staff provide services to tenants in their residences, at service hub locations, and in the community. Tenants report they can change their mind, can access different services as they wish, with some accessing services through a clinic, other Lifewell locations, or both. Service plans at Lifewell are revised every one to three months, and the content, including goals and services, changes based on tenant status.	
<b>7.3 Consumer- Driven Services</b>				
7.3.a	Extent to which services are consumer driven	1 – 4 (2)	There is some member input into design and provision of services. Per the Lifewell member handbook, staff contact members periodically during their service and after discharge to request information about their experiences. Staff use the information for program planning, monitoring and evaluation. Tenants report they tell Lifewell staff what goes on their service plans.	<ul style="list-style-type: none"> <li>• The program and RBHA should increase member input in service design and provision. Include tenant voice in planning and implementation as the program transitions to the PSH model.</li> <li>• At the system level, seek member input through community forums as PSH services expand.</li> </ul>
<b>7.4 Quality and Adequacy of Services</b>				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 (4)	There are multiple layers of staff who provide oversight or direct care to tenants of the PSH program; Lifewell service staff caseloads are mixed with members in PSH and flex care (short term treatment programs). Lifewell staff report PSH tenants on those caseloads range from seven to nine members, but caseloads max out at 15 members. The program administrator reports staff caseloads are under ten each.	
7.4.b	Behavioral health service are team based	1 – 4 (2)	Psychiatric and case management services are provided through a separate agency. Lifewell holds staffings every four to six weeks and invite case managers to participate, which sometimes occurs by phone. Lifewell staff report some challenges coordinating care with system partners (e.g., clinical teams, psychiatrists, hospitals) regarding PSH implementation, adding that it appears staff	<ul style="list-style-type: none"> <li>• Review system level options to integrate services through a team.</li> <li>• Review system wide options to integrate service planning under a primary agency when multiple agencies provide services to avoid duplication of paperwork. This step may help eliminate a duplication of services and ensure providers are aware of shared</li> </ul>

			<p>are not aware of the PSH model.</p> <p>Once referred to Lifewell, members are offered a variety of services at the agency if included on the Lifewell service plan. Generally, tenants are engaged to attend other Lifewell services if programs are deemed to fit the person's goals, and some tenants are involved with outside member run programs. Although the referring clinic provides an assessment and service plan at referral, Lifewell completes a separate assessment and service plan. There is duplication of efforts to maintain these key documents, and service plans are not consistently shared between the agencies.</p>	<p>efforts to support tenants.</p> <ul style="list-style-type: none"> <li>• If an integrated service plan is not used, Lifewell and clinics should share assessments and plans for co-served members.</li> </ul>
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 (4)	<p>In August, 2014 Lifewell adjusted the program staffing pattern, allowing coverage from 7AM-11:30 PM for appointments. If a tenant asks for assistance outside of those hours, the program makes accommodations, which is sometimes necessary in house model settings when roommates report interpersonal issues and request support. Tenants and staff report contact sometimes occurs on the weekend. The program provides tenants with a detailed list of program, system and community numbers. Program services are available 24 hours a day, seven days a week, and 365 days a year.</p>	

**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	1
1.1.b: Real choice of housing unit	1,4	1
1.1.c: Tenant can wait without losing their place in line	1-4	3
1.2.a: Tenants have control over composition of household	1,2,5,4	2.5
<b>Average Score for Dimension</b>		<b>1.88</b>
<b>2. Functional Separation of Housing and Services</b>		
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	2.5
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2,5,4	2.5
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
<b>Average Score for Dimension</b>		<b>3</b>
<b>3. Decent, Safe and Affordable Housing</b>		
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
<b>Average Score for Dimension</b>		<b>3.25</b>
<b>4. Housing Integration</b>		
4.1.a: Extent to which housing units are integrated	1-4	1
<b>Average Score for Dimension</b>		<b>1</b>
<b>5. Rights of Tenancy</b>		
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	4
<b>Average Score for Dimension</b>		<b>4</b>
<b>6. Access to Housing</b>		
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	4
6.2.a: Extent to which tenants control staff entry into the unit	1-4	3
<b>Average Score for Dimension</b>		<b>2.67</b>
<b>7. Flexible, Voluntary Services</b>		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
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: Extent 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	2
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
<b>Average Score for Dimension</b>		<b>3</b>
<b>Total Score</b>		<b>18.8</b>
<b>Highest Possible Score</b>		<b>28</b>