PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: January 8, 2016

To: Dan Wheeler, Director, Community Living Services

From: Georgia Harris, MAEd
Karen Voyer-Caravona, MA, LMSW
ADHS Fidelity Reviewers

Method

On Tuesday-Thursday, December 1–3, 2015, Georgia Harris and Karen Voyer-Caravona completed a review of the 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 treatment, transportation, community living and housing. While Lifewell serves as housing management to some properties in the community, Lifewell's Community Living Program is the focus of this review. Although the Regional Behavioral Health Authority (RBHA) has identified Lifewell as a permanent supportive housing provider and subject to a PSH fidelity review, the agency acknowledges that its housing program is more closely aligned with the local Community Living Placement (CLP) model, rather than the evidenced-based practice of PSH. Lifewell provided a roster of 78 current tenants. Lifewell housing services staff provides supportive housing services to 58 tenants. Of these, 54 reside in apartments (15 tenants) and house model dwellings (39 tenants) that are set aside for people with disabilities. A remaining four tenants live in scattered site units that are integrated in the community. Lifewell issued scattered-site vouchers to those tenants as a special circumstance, after the Lifewell leased apartment building where they lived was sold and demolished. If the tenants currently receiving those vouchers return them, the vouchers will not be directed to current or prospective Lifewell tenants but will instead be recycled back into the RBHA scattered-site voucher program and offered to the next person on the scattered-site wait list.

In order to effectively review PSH services in Maricopa County, the review process begins with the referral process and includes evaluating the working collaboration between the PSH provider and the referring clinics with whom they work to provide services. For the purposes of this review at Lifewell, two referring clinics, Lifewell South Central and Southwest Network Hampton, were visited for data gathering.

The individuals served through the agency are referred to as members or tenants, and those terms will be used in this report. Although the agency uses the term "housing providers", for the purposes of this report and consistency with the PSH protocol, the term "property manager" will be used in this report.

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

- Interview with the Director of Community Living Services and the Director of Quality Management;
- Group interview with three direct housing services staff;
- Group interviews with eight case managers from two clinics;
- Group interview with five members who are participating in the PSH program;
- Review of agency documents including intake procedures, eligibility criteria, wait list and criteria, team coordination and program rules; and
- Review of 20 randomly selected member records, including ten clinic records and ten agency records.

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:

- Service staff have no role in property management: Lifewell service staff do not participate in any way with property management tasks such as delivery of eviction notices, rent collection or reporting violations of leases. While staff accept information from property managers concerning possible lease infractions or evictions, their interventions are focused on eviction prevention and identifying and resolving barriers to housing stability.
- Service staff do not have offices located at housing sites: Lifewell service staff do not maintain offices in houses or apartment complexes where tenants reside, nor do they conduct groups at housing sites. Services are provided at units at member request.
- Tenants control staff entry into units: Lifewell service staff only enter units when invited to do so by the tenant, and do not have keys to units. If service staff are concerned about a tenant's well-being, they will attempt to obtain information from the clinical team or informal supports, and if they have reason to believe that the tenant is at immediate risk, will contact the police and request a wellness check. Per

Arizona landlord/tenant law, property managers do not enter units without providing 48 hours written notice.

- Opportunity to modify services: Lifewell policy includes staffing each tenant receiving housing support services every 30 days. Clinic staff commended Lifewell for regularly updating tenant service plans, and evidence was found in tenant electronic records of regular updates to numerous service plans.

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

- The current program structure cannot fully support the tenant's choice of unit, choice of household composition and community integration. The RBHA should evaluate if CLP programs should be classified as PSH agencies.
    - Choice of housing type and housing unit: Although most clinical staff seemed aware of the primacy of member choice, choice remains constricted at the clinic level. Clinic staff reported a lack of available affordable, market rate housing; inconsistent information about the types of RBHA contract housing available; and confusion about how to access housing not contracted by the RBHA. Members who are difficult to house, such as those with felony convictions, are often referred to whatever program or property manager will accept them. At the agency level, members referred for housing to Lifewell are assigned a housing type and unit. The RBHA and the agency should continue efforts to educate clinic staff and others who make housing referrals on available housing options. An affordable housing portal with trained staff may assist clinical staff in accessing affordable housing programs and property managers not contracted by the RBHA. Stakeholders should coordinate long-range planning efforts to expand choice to include scattered-site housing options throughout the community.
    - Housing integration: Lifewell's Community Living Program offers 14 house models and three apartment models. With the exception of the 1800 unit apartment complex (four Lifewell tenants) none are integrated, housing only people diagnosed with an SMI and/or co-occurring disorder. Most tenants reside in house models, which do not align with the PSH model. The RBHA, agency and other key stakeholders (i.e., Arizona Department of Behavioral Health Services and property owners) should coordinate for strategic planning to systemically adapt, transition and eliminate house models.
- Housing readiness criteria: The system's level of care structure, with implied readiness standards, appears to remain an impediment to access to housing. Evidence was found in charts that members have to demonstrate success in staffed settings before stepping down to unstaffed or independent settings. Additionally, many clinic staff were unsure of how the proper implementation of PSH support services promote housing stability/recovery, or they do not trust that supports will be sufficiently administered to the members they view as "too disabled" to live independently. Though Lifewell may have little direct impact on this item, they should partner with the RBHA and clinical providers to provide training and education on the evidenced-based PSH model, with a focus on how housing services support recovery and housing stability. Existing barriers to proper implementation of this service provision should be identified and solutions developed.

People with housing obstacles are given priority: While Lifewell scored in the mid-range of the scale for this item, it was implied by staff at different system levels that an overall lack of affordable market rate housing may lead some recipients of general mental health services to seek to have themselves reclassified as SMI in order to qualify for housing. In keeping with the research supporting the PSH model, the lack of affordable housing itself, and subsequent homelessness, may exacerbate otherwise manageable psychiatric symptoms, chronic physical health problems, and

substance use resulting in increased service utilization and/or incarceration. If not already, the RBHA should be identified as an active and important voice in discussions about solutions to the lack of affordable housing across Maricopa County.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 1	When members make a request for housing assistance from their clinical teams, the case manager will fill out either a scattered site (SS) or a Community Living Placement (CLP) housing application. Scattered site housing is independent, integrated, market rate housing, with rent partially subsidized through RBHA or ABC's Homeless Housing vouchers. CLP is a type of RBHA-contracted housing, specifically set aside for individuals enrolled in the behavioral health system. Case managers said that member choice guides the type of housing applied for, but acknowledged that they may encourage members to follow their clinical team's recommendations for CLP. The reviewers found evidence that clinical teams may influence and sometimes determine the housing offered. CMs also suggest CLP because they have found that it is more readily available than scattered site and/or accessible for people who have housing barriers such as felony and eviction histories. Lifewell's housing program was designed for the level of care system's CLP model, which does not provide for choice among a range of housing types. Members who submit CLP applications may be referred to Lifewell's CLP through the RBHA. Lifewell offers two housing types: the house model and the apartment model. Lifewell staff said they operate 14 house models, which contain 4 – 5	• The RBHA and provider agencies should provide clinical staff and other stakeholders who influence the process, such as hospitals, advocates, guardians and psychiatrists, with education and training to improve knowledge and acceptance of the PSH model. Training should clearly outline the scattered-site option, including topics such as: scattered site structure, how it aligns with PSH and housing first principles, the scope of wrap-around supports, the referral process, and how the wait list is managed at the RBHA. • The RBHA and the agency should collaborate to explore mechanisms for transitioning the Community Living Program more fully to the PSH model, possibly by retiring house models and empowering Lifewell service staff to develop relationships with landlords and property managers who will accept the scattered-site vouchers (if provided by the RBHA). • Clinical teams should be empowered to assist members with finding/applying for housing options that are aligned with member preferences instead of treatment team determination of clinical needs. In PSH, housing is based solely on member preferences. An expanded view of housing

			bedrooms. Lifewell operates three apartment model locations. Two complexes contain eight units each. One complex contains nine units. Lifewell owns eight units within an 1800 unit complex. All apartments except one are single occupancy. Assignment to these housing types is entirely dependent upon availability.	beyond RBHA programs is vital.
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 1	Tenants in Lifewell housing are assigned units; CMs and Lifewell staff said that it was rare for more than one unit to be available at a time. Occasionally, property managers work with tenants who wish to switch houses, bedrooms within houses or apartment units, but this is dependent on availability.	• Offer member a variety of options, driven by their preferences, including choice of unit. • With the current agency structure, service staff should continue efforts to help tenants advocate for choice of unit with property managers when opportunities to move into preferred units exist. • The RBHA and the agency should review options to adapt, transition (i.e., such as step down, short term, transitional placement, or housing specific to families), or eliminate the house model settings.
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	System stakeholders did not present a uniform understanding of the RBHA's waitlist procedures. Both the RBHA and Lifewell reported that members do not lose their place on the waitlist if they decline a housing referral in favor of waiting for another option. However, CMs reported that members will lose their spot on the waitlist if they decline a referral more than two or three times. Some CMs said they advise members to accept whatever is available, although one CM said that she encourages members to try and wait for a unit that is acceptable to them because people are more motivated to stay housed if they are happy in their living arrangements.	• The RBHA should clarify the waitlist procedures with clinical teams and provide regular updates on the status of all member housing applications.
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	Tenants of Lifewell housing must accept a pre-determined household. Tenants living in a house model may have four to five roommates, but will have their own bedroom. Most apartment model tenants live in one bedroom, single occupancy units without roommates, which is the preferred living arrangement for many, but not all, tenants. Occasionally, members living in house models are able to work with property managers to switch locations in order to share houses with friends who are also enrolled in the RBHA system. Lifewell said they have advocated for tenants to be able to live with whom they prefer. Lifewell staff also said that it is up to apartment property managers if tenants of single occupancy apartments can add others to their lease. Lifewell said that they are prepared to support this arrangement since it is a typical lease situation. Lifewell said that clinical teams may have different recommendations regarding composition of household but that the agency does not require approval of who lives there.	• Within the current CLP house model settings of Lifewell's Community Living Program, the agency should continue efforts to assist tenants in advocating for control of the composition of their household when those opportunities exist, such as switching roommates, or interviewing potential new tenants for a house model. • Staff should seek clarification from property managers and clinical staff regarding policies pertaining to the addition of non-RBHA enrolled individuals (such as friends, domestic partners/spouses, or parents/adult siblings) to lease agreements.
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 2.5	Lifewell CLP properties are managed by two property managers. Lifewell's property management department manages 11 sites while Biltmore Properties manages six. Property managers are responsible for scheduling tours of units, leases, property maintenance, rent collection, housing quality standards inspections (HQS) and evictions. Although Lifewell staff interviewed said that property managers do not attend staffings, evidence was found in some records of property managers attending staffings where tenant behavior is discussed.	• Lifewell should carefully monitor and evaluate the separation of property management and support/clinical services to ensure there is no overlap in functions. • Lifewell should discontinue the practice of inviting property managers to clinical staffings because it represents a blurring of service and property management roles.

2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Lifewell staff do not have a role in housing management functions. While property managers notify Lifewell direct service staff of problems such overdue rent or disruptive behavior, direct service staff engage members in eviction prevention, the consequences of breaking the terms of lease agreements, and identification of issues that may be contributing to problems in functioning.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Lifewell direct service staff do not keep clinical or social service offices at houses or apartment complexes. Staff provide services to members in their homes or at locations in the community per member request. While members generally prefer to live in unstaffed housing arrangements in the community, some members said that they wished that Lifewell service staff visited their homes more often.	• Though staff workspaces are located offsite and do not intrude upon tenant privacy, review current staff scheduling practices to ensure that staff's ability to engage with tenants is optimal.
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	Lifewell was able to verify the rent to income ratio for the 58 tenants receiving housing support services, providing copies of lease agreements and rent calculation data. Those tenants pay an average of 16.13% of their income toward rent; 24 of those 58 tenants pay no rent due to lack of income. One tenant residing in a house model pays 34.3% of income toward rent.	•
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 4	Lifewell was able to verify HQS inspections for all 58 tenants receiving Lifewell housing support services. A review of HQS inspection reports showed evidence that units sometimes failed inspections, but that repairs were made and units passed upon re-inspection.	

Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 1	Of the Lifewell CLP properties, the 14 house models and the two smaller apartment complexes house only tenants enrolled in the behavioral health system. Lifewell manages eight units within an apartment complex of 1800 units (.4%). Lifewell tenants in this setting appear to be integrated. The scattered site tenants are in community integrated units. Overall, 13.7% (8 members, those living in scattered site units and within the large apartment community described above) of 58 tenants enrolled in the program live in integrated settings.	• Increasing the availability of scattered site options in the system would increase integration of housing units. If this is not an option for Lifewell's Community Living Program, the agency should explore long-range planning to expand the apartment model options, which, especially when incorporated in larger multi-housing settings, provide greater integration. House models could be preserved for other needed uses such as short-term and transitional housing for members coming out of the hospital, correctional settings or in need of immediate shelter due to emergency or situations.
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	Lifewell staff reported that members sign standard lease agreements under Arizona Landlord/Tenant law, and that leases do not contain provisions specific to people with disabilities. Lifewell provided leases for all 58 tenants receiving housing support services. A review of provided leases indicate that tenants enter into standard leases that resemble those held by people without disabilities.	
5.1.b	Extent to which tenancy is contingent on compliance with program	1, 2.5, or 4 4	Members are not required to accept Lifewell housing support services in order to reside in units, nor are they required to participate in clinical treatment groups or counseling. According to staff, tenancy is contingent on following lease	

	provisions.		provisions.	
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 2	Lifewell's Community Living Program does not apply readiness standards to housing. However, evidence in member records and clinic staff interviews with indicate that sometimes members are required to demonstrate readiness in order to gain access to housing units. CMs interviewed described housing options by level of care; several acknowledged considerable confusion in differentiating between the options, and how to apply for them. Some CMs described scattered-site housing as being most appropriate for high-functioning individuals who can self-administer medication, cook for themselves or do not require daily home visits from staff. One CM reported not referring "aged" people to scattered site housing. Some member clinic service plans showed that members could step down to CLP upon demonstrating success in staffed or semi-staffed residential settings despite stated preferences for independent housing in the community.	• Clinical staff should participate in more detailed training and education on the PSH model. Topics should cover: Housing First principles, member choice, and how properly-implemented wrap around services support successful tenancy in integrated, community settings, aligning with a recovery philosophy. Direct service staff should encourage greater acceptance of the evidenced-based and recovery-oriented approaches that emphasize member strengths, the power of the therapeutic relationship to enhance motivation for change, and the connection to formal and informal community resources to support successful integrated community living. Clinical teams and other service providers who do not "buy-in" to Housing First principles and PSH are less likely to faithfully support its implementation or honor member choice. • The RBHA should continue efforts to clarify the referral process and the range of housing options for clinical teams and other providers who influence choice. Whenever possible, all stakeholders should use shared language and terms to refer to housing options.
6.1.b	Extent to which tenants with obstacles to	1, 2.5, or 4	Lifewell's Community Living Program does not have a role in prioritizing housing recipients. Per clinic and agency interviews, the RBHA system	• The RBHA should provide guidance and tools for assisting clinical teams with general mental health members in

	housing stability have priority	2.5	prioritizes hospitalized and homeless individuals. CMs interviewed discussed frustration with insufficient affordable housing for low income people and some members actively seek to have themselves reclassified as SMI from general mental health (GMH) in order to qualify for housing.	identifying and accessing income eligible and affordable housing options available in Maricopa County, such as those provided through City of Phoenix, the Housing Authority of Maricopa County, Native American Connections, and UMOM. • The RBHA and clinics should consider engaging stakeholders outside the mental health system in discussions on the relationship between housing stability and mental health. Housing advocates such as the Arizona Coalition for Homelessness may be natural partners in advancing the cause of affordable housing in Maricopa County.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 4	Lifewell staff enter housing units only when invited to do so and do not have keys to units. Property managers follow entry requirements in accord with landlord/tenant law and must notify tenants 48 hours in advance if they need to gain entry to units for HQS inspections or repairs. Lifewell staff said that clinical teams have contacted them with concerns about tenant safety and whereabouts. When Lifewell staff have concerns about tenant safety and well-being, they visit units and knock on doors. If they get no response, are unable to confirm the tenant's safety, and concern persists, they contact the police for a wellness check.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they	1 or 4 1	While CMs reported that tenants drive service plans, the reviewers found repeated evidence of clinical jargon rather than goals written in the words of tenants. Needs and objectives were	• The RBHA, clinics and agency should continue to offer education and training to ensure that tenants are the primary authors of their service plans. Service plans

	want at program entry.		usually rote and identical across member service plans, focused on medication compliance, keeping appointments and socialization. According to Lifewell, service plans are developed by behavioral health staff with the participation of tenants and/or their guardians. As with clinic service plans, Lifewell service plans often appeared staff directed. Staff said that they usually meet with new tenants at the lease signing to explain the nature of clinical and housing support services offered. Tenants can request services then or at any time they experience a need while living in Lifewell CLP. Tenants interviewed said they decide what goes on their Lifewell service plan.	should be individualized, and barriers to this should be identified. Needs and objectives should be meaningful to the member/tenant rather than solely focused on psychiatric stability and compliance with treatment.
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Tenants have the opportunity to review their service plan at a monthly scheduled Lifewell staffing. Tenants can also modify service selections at any time upon request. The reviewers found evidence that most tenant service plans were updated every 30 – 60 days with needs and objectives closed or attained or new ones added. Most CMs reported that Lifewell does a "very good job" of notifying and inviting them to monthly staffings and providing them updates to housing service plans.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	Tenants have their choice of services, as well as the right to decline Lifewell housing support and clinical services. However, most staff said that tenants must remain enrolled in the RBHA system and agree to meet periodically with the clinic Psychiatrist in order to keep their units. CMs said connection with clinical teams and the clinic Psychiatrist varied depending on the tenant's level of care designation.	• The RBHA should consider expanding the scope of CLP to include a provision that may extend housing access for a period of time after disenrollment. Efforts may include exploring alternative funding sources that do not require enrollment in the RBHA system for eligibility.

7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 4	While the service mix on most plans appeared predictable, focusing on activities of daily living, independent living skills, and self-administration of medication, the reviewers also found evidence that some Lifewell service plans were updated to address treatment needs such as grief counseling, assistance with independent living needs such as obtaining a mobile phone and cellular service, purchasing a television, and initiating music lessons. Members interviewed said they felt in control of their Lifewell services plans and that they review their plans with Lifewell staff and CMs monthly.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 1	Neither staff nor tenants interviewed describe significant opportunities for tenants as a group to provide meaningful input in program design or provision of service. Staff said tenants direct their individual services and tenants have the right to refuse Lifewell housing support services. Tenant surveys are collected on a quarterly basis and given to the Program Manager, but there was no indication of how the survey data was used.	• The agency and the RBHA should consider developing opportunities for expanding the collective tenant voice in the design and implementation of PSH services. Collaboration with Consumer Operated Services or other peer driven organizations on community forums, focus groups, or the gathering of peer community surveys should be considered. • Within the present CLP model in place at Lifewell, explore developing a tenant advisory council for gathering input relevant to long-range planning decisions that arise as the system moves forward with PSH and other needed housing options.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	Staff interviewed reported caseloads of under 15 tenants. However, the majority of caseloads consist of tenants of Flex Care placements. Staff reported CLP caseloads ranging from one to four tenants. Staff said that they spend most of their	• Program Managers for Lifewell's Community Living Program should carefully monitor service staff caseloads, so that the needs of CLP tenants are not sacrificed for those of Flex Care tenants.

			time at Flex Care sites. If CLP tenants have an emergency requiring staff attention then a temp or on-call staff is directed to cover the Flex Care site. Although members reported that they liked the feeling of independence provided in units without on-site staff, some members said that they wanted more face-to-face contact with staff to assist with needs such as transportation, budgeting and shopping. One member expressed concern that some more disabled members need more support and assistance and would benefit from staff checking on them daily. However, most members agree that they take it upon themselves to look out for and help each other, repeating, "we are like a family."	
7.4.b	Behavioral health services are team based	1 – 4 2	Most referrals for Lifewell CLP originate from supportive clinical teams which are primarily responsible for case management and psychiatric services. Other services, such as individual substance abuse treatment, domestic violence counseling, and supported employment, are often brokered to outside providers. In such cases, clinical documentation of services and communication between providers may be poorly integrated. Lifewell housing service plans and other documentation were not consistently found in most member clinical records. One CM reported that Lifewell service staff did a very good job of providing notification of monthly tenant staffings and updates to Lifewell service plans. However, another CM said that Lifewell was referring members to services rather than going through the clinical team for the referral. Since the previous PSH fidelity review, Lifewell	• Review system wide options to integrate service planning under a primary agency when multiple agencies provide services to avoid duplication of services and improve continuity of care. The RBHA, clinical teams and Lifewell should clarify who is responsible for service referrals and under what conditions. • When integrated service plans are not used, Lifewell and clinics should share assessments and plans for co-served members.

			Behavioral Health has acquired several clinical teams. Housing service plans for members receiving case management through Lifewell clinics are integrated into the Individual Service Plan and all related housing documentation is available in the clinical record.	
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 4	Lifewell staff said that services are available to tenants 24 hours a day, seven days a week. Staff said one tenant needs overnight support at 2 a.m. due to wandering behaviors.	

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
Average Score for Dimension		1.88
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	2.5
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		3.5
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	1

Average Score for Dimension		1
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	4
Average Score for Dimension		4
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	2
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		2.83
7. Flexible, Voluntary Services		
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: 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	1

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		2.88
Total Score		20.09
Highest Possible Score		28