PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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Introduction

Arizona Health Care Cost Containment System has contracted with Western Interstate Commission for Higher Education - Behavioral Health Program to conduct Fidelity Reviews using the Substance Abuse and Mental Health Services Administration (SAMHSA) Permanent Supportive Housing Fidelity Scale, an evidence-based practice (EBP). Permanent Supportive Housing refers specifically to the EBP of helping members with a serious mental illness (SMI) find and maintain safe and affordable housing in integrated communities, not those with disability-related eligibility criteria.

Method

On November 27 – 29, 2023, Fidelity Reviewers completed a review of the Community Bridges Inc. (CBI) Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Community Bridges Inc. provides several targeted services which include the following: permanent supportive housing, crisis stabilization, inpatient medical detoxification, veteran and adolescent services, Assertive Community Treatment, and integrated healthcare at outpatient service centers throughout Arizona.

Due to the system structure of separate treatment providers, information gathered at the La Frontera EMPACT Comunidad and CBI Mesa Heritage clinics were included in the review as sample referral sources. However, some data obtained reflects services provided by other partner clinics, as well.

This review was conducted remotely, using videoconferencing and telephone to interview staff and members.

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

During the fidelity review, reviewers participated in the following activities:

- Program overview with CBI's PSH Program Manager and Serious Mental Illness Services Manager.
- Individual interview with the PSH Program Manager.
- Group interviews with three CBI PSH direct service staff.
- Group interview with one Case Manager and two Housing Specialists from La Frontera EMPACT Comunidad clinic, and one Case Manager from Community Bridges Mesa Heritage clinic.
- Interviews with three members that are participating in the PSH program.
- Closeout discussion with Program Manager and representative(s) from the contractor with a Regional Behavioral Health Agreement.
- Review of agency documents including intake procedures; PSH internal and external referral documents; eligibility criteria; member leases and safety inspection documents; PSH program meeting minutes; CBI PSH Supportive Service Flyer; and CBI PSH Job Descriptions.
- Review of 10 randomly selected member records, including charts of interviewed members/tenants.

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 review. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- CBI PSH members are offered choice in housing and do not experience pressure to accept units that do not meet their preference or needs.
- Less than 5% of members served by the CBI PSH program reside where supportive services may be provided on-site.
- All tenants are living in an integrated setting in their community, rather than in settings set aside for the disabled.
- Nearly all tenants control the composition of their household and are not required to seek permission to add roommates.

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

- Ensure the PSH program acquires the necessary documents to support members in their rights to tenancy. By maintaining current leases

on record, staff are able to readily access the document to inform members of legal requirements and be informed on processes for reporting maintenance issues or file complaints.

- Members have few options to provide program planning and input, and no anonymous outlet to provide feedback or suggestions to improve PSH services. Develop opportunities and strategies to incorporate member input specific to PSH program services.
- Increase coordination of care with clinical teams to improve member care. Ideally, PSH programs and behavioral health services are delivered by an integrated team to improve member care.
- The PSH program does not provide services 24/7 and does not have an on-call phone for members to reach after hours. Consider adding an on-call phone for member emergencies and adding staff to weekend shifts to ensure all members are getting the services they need.

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., recovery home, private landlord apartment)	1, 2.5 or 4 4	According to clinic staff interviewed, members choose the type of housing they want to pursue. Clinical teams interviewed report that it is always member choice; however, if staff believe the member needs a higher level of care, they will suggest it as an option, but will honor the member's preference. Members interviewed reported having choice in the type of housing they wish to reside in.	
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	PSH staff reported assisting members in selecting the ideal unit by prioritizing members' preferences, including location. Records reviewed indicated members requesting specifics such as having a patio, being in a neighborhood close to family, and finding a house rather than an apartment. PSH and clinic staff identified barriers such as low income and the availability of affordable housing.	
1.1.c	Extent to which tenants can wait for the unit of their	1 – 4 4	PSH staff reported that members can decline housing options offered and that the program will continue to assist them. Both clinic and PSH staff indicated assisting members with housing voucher	

	choice without losing their place on eligibility lists		(i.e., rental subsidy) extensions when necessary. Members with a housing voucher typically have 30 days to secure a unit; however, members can request extensions up to three times to locate housing based on preference. Records reviewed showed both clinic and PSH staff assisting members with vouchers searching for housing of their choice. Members occasionally declined available units based on their preferences and were able to continue searching.	
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	Per data received, less than 5% of members engaged in the CBI PSH program are in treatment or temporary settings where they do not have control of the composition of their household, including shared bedrooms. Per record review, PSH staff assisted one member with completing a reasonable accommodation request with the voucher holder to remain in the home even though one family member moved out.	
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	Interviews with clinic staff, PSH staff, and members indicate property managers do not have any role in providing clinical or social services to members. Of the housed members, less than 5% reside in settings where there may be overlap between housing management and service staff affiliated with the residence, such as halfway houses and group homes.	
2.1.b	Extent to which service	1, 2.5, or 4	Per information gathered from interviews conducted, service providers do not have any	

	providers do not have any responsibility for housing management functions	4	responsibility for housing management functions. Clinic and PSH staff denied collecting rent, serving evictions, and are not tasked to report lease violations.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Clinic and PSH staff offices are not located where members reside. Less than 5% of members reside where supportive services may be provided by on-site staff.	
Dimension 3 Decent, Safe and Affordable Housing				
3.1 Housing Affordability				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 3	PSH and clinic staff reported that members pay 30% of their income toward rent when they hold a housing voucher. Members without a housing voucher pay more. According to data provided, the average percentage of income paid toward rent was 22.54%; however, income data for 11 members was missing. One member interviewed reported paying 80% of their income toward rent while on a waitlist for a housing voucher. According to data provided, one member was paying 90% of their income towards rent. One PSH staff stated members are not required to disclose income information to the PSH program, but the team finds the information beneficial when assisting with budgeting, locating affordable housing, and requesting financial assistance. Records reviewed were consistent with staff report that the program does not practice	• To the extent possible with consideration for market factors, continue to work with tenants that are paying over 30% of income toward housing to find more affordable units. Consider assisting tenants in applying to assistance programs or finding employment to help mitigate rental costs. • Seek to maintain documentation of rent to income data to better support members in budgeting as a step to maintain housing.

			maintaining financial information which could be used to better serve members.	
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 2.5	Data provided to reviewers showed the PSH program has 86% current and passing Housing Quality Standards (HQS) inspection reports on record for housed members. PSH staff reported members that do not hold housing subsidy vouchers do not receive HQS inspections. The program reported accompanying members in market rate housing walkthroughs, prior to lease signing, when requested.	• Work to ensure that all tenants are housed in units that meet HQS, not just tenants that have a rental subsidy. Develop procedures to ensure market rate units meet HQS. Some programs have trained staff that conduct HQS inspections for the PSH program. Some programs track renewal dates and coordinate in order to ensure most recent copies are obtained and to be available to members when concerns arise. • Consider developing procedures for staff to collect copies of current HQS reports. If feasible, voucher administrator can share current HQS reports with PSH service providers as components to supporting tenant self-advocacy and eviction prevention.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Based on housing data provided, and reports from clinic and PSH staff, housed tenants within the PSH program live in units that are integrated within their communities. Few members are housed in units that have been set aside for people meeting disability-related eligibility criteria.	
Dimension 5 **Rights of Tenancy**				

5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 1	PSH staff interviewed reported independently housed members have full rights of tenancy, and PSH staff assist with the lease signing process, as well as with obtaining copies of the lease. Staff reported members living with family do not have leases and the PSH program is not responsible for ensuring housing agreements are generated in those circumstances. Copies of leases are not kept in the members' electronic health records, but rather in a separate online file. Members interviewed reported having a copy of their lease and understanding their rights. Staff interviewed at one clinic reported obtaining housing documents, such as member leases and holding a weekly housing group to educate members about their housing rights, which includes reviewing leases with members. According to data provided, 57% of members had a lease on file with the PSH agency at the time of the review. Records reviewed indicated that of the eight members that renewed a lease or that had obtained new leases, the PSH staff were directly involved in three.	• PSH programs obtain and maintain current copies of leases for 90%, or more, of housed members. Ideally, PSH programs accompany members during new lease signings and lease-ups. Work with members to support them during these times, consequently obtaining a copy of the lease to be used later as a reference when educating tenants on their rights and responsibilities with the intent to maintain stable housing and prevent evictions. • Explore options of formal agreements so that members living with family or friends know their responsibilities and expectations as either tenant or landlord. • Consider improving access to copies of tenant leases by including them in the electronic health record, rather than in a separate file. • Consider tracking lease term end dates. PSH staff can then plan with tenants to accompany lease renewals and provide support to understand responsibilities and lease conditions with the intention to maintain stable housing and prevent eviction.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Based on housing data provided, less than 5% of PSH tenants reside in settings where tenancy is contingent on compliance with program 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 4	CBI staff confirmed practicing a *Housing First* approach, in addition to a *Harm Reduction* when working with members of the PSH program. Members are not required to demonstrate housing readiness to gain access to housing units and only need a referral from the clinical team. Staff at one clinic were able to articulate the *Housing First* approach and denied screening members for referral. Staff at another clinic were unfamiliar with the approach, however, reported referring members to services based on member preferences and do not screen for eligibility. Records reviewed showed no indication of clinic staff screening members after expressing a desire for housing. Most referrals were based on clinic staff educating members of PSH services and connecting them to the provider of their choice.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 1	PSH staff reported members referred to the CBI PSH program must be an adult determined to have a Serious Mental Illness designation and enrolled with Mercy Care. The PSH program does not have a waitlist for services. In the event the agency needed to move to a waitlist, they would prioritize referrals based on the Vulnerability Index Service Priority Decision Assistance Tool scoring eight (8) or higher. To be accepted, PSH staff indicated members must already be housed and requesting additional assistance to maintain housing, and/or must have an income, housing voucher, or on a housing voucher waitlist. For the majority of members that are not on housing voucher waitlists, the PSH program requests that the clinical team assist the member with that process prior to accepting them	• PSH is specifically designed to support individuals with significant behavioral health challenges in living independently in the housing of their choice; through a combination of affordability tools and wrap around supports that are available upon request. In the EBP of PSH, individuals that are the most vulnerable to housing instability/homelessness are prioritized for housing supports.

			into the program. PSH staff indicated there have been a few members that have come to the program needing housing without a financial source, voucher, or already on a housing voucher waitlist. Staff interviewed reported no members on the PSH roster were enrolled in the program at the time of the review without a voucher. Per data received, of housed members, there were nine housed (9) members that did not hold housing vouchers. There were two (2) members who lost their housing while using a housing voucher and enrolled in the program. Members that are not engaging with the PSH program are not assigned to a specific direct PSH staff in order to prioritize the members willing and ready to engage in services. Staff at one clinic reported members do not need to be housed, have income or a voucher to be referred, and that PSH programs will assist members with applying to different housing programs. Based on ten randomly selected member records, all ten had a housing voucher.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	PSH and clinic staff reported that members of the program control entry to their units. None of the members interviewed reported having issues of program staff entering their units without permission. Few members in the program live in settings where staff may enter units, i.e., half-way houses, staffed community living placements, or group homes.	
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 staff interviewed stated that members are the creators of their treatment plans with the assistance of clinic staff and can select the services they desire when they join the program. Members interviewed said they have a choice of services at the clinic level. Clinic staff stated members do not need to demonstrate readiness to be referred to PSH programs. Reviewers were unable to access all clinic treatment plans as the PSH program does not hold referral documents from clinical teams in the PSH electronic health record. Of the clinic treatment plans reviewed, plans reflected the member's need for housing; however, not all treatment plans were written in the member's voice.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic staff interviewed reported treatment plans are updated at least annually and members are able to modify their service plan whenever they want. Members interviewed reported being able to modify their treatment plan as their goals change.	
7.2 Service Options				

7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 2	PSH staff reported using generalized treatment plan goals for members to include contact or participation with the PSH program, transportation, housing, independent living skills, and meaningful activity. Based on the interviews with PSH staff, service plans are updated annually. Based on the ten-member records reviewed, PSH treatment plans were not consistent with the members' current status, and five plans were expired or not present. Services identified on treatment plans did not correlate to address the member's needs. Service plans and goals were not always written in the member's voice, records stating "client will" or "member will".	• Provide training to PSH staff regarding how to work with members to develop personalized needs and/or objectives. Match specific PSH services to directly address or support the member to address those needs.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 2	PSH staff reported conducting at least one home visit a month, or more as needed with each member on their assigned caseload. Based on interviews and documents reviewed, clinical teams were frequently involved in addressing housing needs of members rather than the PSH program. Members interviewed said they update their treatment plan once a year. Members reported the PSH program assisting them with accessing food boxes, budgeting, grocery shopping, and housing groups.	• PSH programs do more than assist members in obtaining housing. PSH program provide services to support members to retain housing at their preferred intensity. PSH programs are designed for those with the most significant challenges to housing stability and retention, and who often need long-term services and support. • Consider providing additional training to staff on how to engage members to address other areas of vulnerability, concern, or prior issues. Staff may benefit from training in *motivational interviewing* and co-occurring disorders to better support the needs of tenants whose tenancy may be at risk due to relapse or ongoing substance misuse.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are	1 – 4 1	PSH staff reported a survey used for home visits is available to obtain member input, although the program has not enacted using it. One member	• Explore additional ways to solicit and incorporate member input on program design and service provision. For example,

	consumer driven		interviewed said there was a meeting about voicing what members wanted. No PSH staff identified this meeting where input is sought from members enrolled in the program. There is a suggestion box at the CBI office where the program is located but has never received suggestions pertaining to the PSH program.	explore if members can serve on sub-committees to the agency board of directors, participate in quality management, or other processes that impact service design and provision. • Offer members an opportunity that allows them to anonymously submit questions, concerns, and suggestions for program improvement. Consider options to facilitate member/tenant forums using videoconference and/or conference calls so that members can voice their concerns and desires for program design.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 3	At the time of the review, the team consisted of two full-time Navigators and two full-time Case Managers. Based on data provided, the team serves 63 members for an average member-to-staff ratio of 16:1. Not every member is allocated to a PSH staff, instead, those members receive phone calls from the team to see how they are doing. The PSH Manager does not carry a caseload. The team is in the process of onboarding three more staff.	• Continue efforts of hiring staff to provide adequate member coverage of changing needs and to be readily available. Optimum caseload size for PSH services providers is 15 members to every staff, providing flexibility and responsiveness to support members in obtaining and retaining housing. • All members have a dedicated PSH staff assigned to ensure the quality and adequacy of the services are monitored and maintained.
7.4.b	Behavioral health services are team based	1 – 4 1	PSH staff reported coordinating care with clinical teams weekly or as needed. Clinical teams are not included in the PSH intake and service planning. There was little indication in the PSH records reviewed that PSH and clinic staff coordinated care. Three records showed no documented care coordination with the members clinical team over a three-month period. While seven PSH member records showed one to three documented care	• Consider scheduling regular planning sessions between the PSH program and clinic staff to coordinate member care. Soliciting input and sharing updated service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented.

			coordination with the member's clinical team. Lack of knowledge on members housing related status for both the clinical teams and PSH program was evident based on documentation and interviews. Clinical team records showed coordination with housing voucher administrators regarding recertification and attempting to assist one member on the verge of eviction. Meetings with a housing voucher administrator were conducted with another member and the clinical team due to challenges the member was having with their housing but did not include the PSH program. Based on PSH record reviews, the team was unaware of these situations. Clinic staff interviewed reported lack of coordination with the PSH program and that only when there are problems, such as eviction, does the program reach out. Service plans are not integrated, and clinical teams reported not being involved in service plan meetings, or knowing what services the members are receiving from the PSH program. For the CBI clinical team, service plans are located in the same electronic health record at the agency, however, staff reported they would have to look those up to see the services the member is requesting. Clinical staff inform themselves on services members are receiving from the PSH program by reading the documentation of services in the shared electronic health record. Clinic staff reported weekly updates regarding members in the PSH program to increase coordination and member care would be beneficial.	• PSH programs ideally communicate with clinical teams on a frequent basis to enhance member care. • Ideally, system partners collaborate to create a culture of a team of providers that coordinate care on behalf of members rather than operating in silos.
7.4.c	Extent to which services are provided 24	1 – 4 1	According to PSH staff, the program provides services Monday – Friday, 7am-5pm and staff work four ten-hour days, as well as holidays. There is no	• Ideally, PSH services are available 24 hours a day, seven days a week, including the ability to respond to members in the

	hours, 7 days a week		on-call phone for emergency communication for PSH members. Members and clinic staff interviewed were not aware of PSH services being available in the evenings or weekends. PSH staff reported that clinical teams offer after-hour services and members reach out to their clinics and general crisis lines when needed.	community after normal business hours. PSH staff may be better positioned to respond to and support members in the community outside of regular business hours than a mobile crisis team or from their clinics.

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	4
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	4
Average Score for Dimension		4
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	2.5
Average Score for Dimension		2.75
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	4
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	1
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3
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	2
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	2
7.3.a: Extent to which services are consumer driven	1-4	1
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	3
7.4.b: Behavioral health services are team based	1-4	1
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	1
Average Score for Dimension		2.25
Total Score		22.50

Highest Possible Score		28