PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: March 14, 2022

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From: Nicole Eastin, BS
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AHCCCS Fidelity Reviewers

Method

On January 18 – 20, 2022, Nicole Eastin and Vanessa Gonzalez completed a review of the Community Bridges, Inc. Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

Community Bridges, Inc. (CBI) provides several targeted services which include the following: crisis stabilization, inpatient medical detoxification, ACT teams and integrated healthcare at outpatient service centers throughout Arizona, veterans programming, and adolescent services.

Due to the system structure of separate treatment providers, information gathered at the Community Partners Integrated Healthcare and Community Bridges, Inc. Mesa Heritage clinics were included in the review as sample referral sources. Data from these clinics was included in the review process, with a focus on co-served members. However, some data obtained reflects services provided by other partner clinics.

On October 1, 2021, Arizona Behavioral Health Corporation became the statewide housing administrator for the new AHCCCS Housing Program (AHP). The housing subsidy portion is subcontracted with HOM, Inc.

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

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

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

- Program overview with the CBI Behavioral Health Program Clinical Lead.
- Interview with the SMI PSH Manager.
- Group interview with three CBI PSH Navigators that provide direct services.
- Group interview with three Case Managers (CM) at CBI Mesa Heritage clinic, and one CM and the Housing Specialist from Community Partners Integrated Health clinic.
- Interviews with three members that are participating in the CBI PSH program.
- Interview with two Housing Department staff from Mercy Care Regional Behavioral Health Authority (RBHA).
- Review of agency documents including intake, re-engagement, and exit processes, member leases and safety inspection documents, *CBI PSH Supportive Services Flyer* and *Welcome Packet*, *PSH Team Meeting Agenda* and *Sign In Sheets*, *Clinical Oversight documentation* and training documents*, Internal and External Referral Packet Request and workflow, Guide to Arizona Residential Landlord and Tenant Act, Southwest Fair Housing Council FAQ Flyer, CBI Supported Housing Survey,* review of the CBI PSH website, *"Frequently Used Numbers", PSH Staff Schedule,* and CBI PSH Job Descriptions.
- Review of ten randomly selected records, including co-served members.

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.

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- The CBI PSH tenants have a choice of unit. Tenants select units in the communities where they want and choose with whom they live. Tenants control staff entry into their units.
- Based on data provided, most housed CBI PSH members live in integrated settings in the community.
- The members' service plans reflect member goals. Identified needs and objectives are individualized, with language that varied member-to-member. Additionally, the services provided by PSH staff varied by member and seemed to be flexible based on members' changing needs and/or preferences.
- The majority of housed CBI PSH members live in settings where there is no overlap in housing management and PSH services.

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

- The PSH program should continue its efforts to track and obtain copies of housing documents. With current leases on file, staff will be better informed to guide tenants if issues arise. Seek to ensure all members reside in settings where they have legal rights to tenancy (i.e., a lease) in units that meet Housing Quality Standards.
- PSH staff and system partners should collaborate with clinic staff to provide training in avoiding imposition of housing readiness criteria and instead provide members seeking housing with information on how to access available housing options, including independent housing. When skill deficits are assessed, clinic staff should offer wrap around services to support success in the member's stated housing goal.
- System partners should collaborate and educate staff and members on how choices of the services members do or do not select impact other services. For example, if terminating clinic services is allowed, discuss the potential impact on applicable subsidies and/or PSH services.
- PSH staff should be available to respond to members in the community when in crisis outside regular business hours. PSH staff are better positioned to respond to and support members than staff from general crisis lines or CBI's Access to Care line.
- Optimally, behavioral health services should be provided through an integrated team. Service providers should coordinate treatment when integration is not possible. Although there is integration within the CBI agency, coordination between the PSH program and other provider clinics have the opportunity for increased coordination of member care.

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 2.5	PSH staff will advocate for members with housing vouchers wanting to go into a sober living environment, by requesting the voucher holder to place a pause on the voucher until the member is wanting to move forward with independent living. PSH staff reported that members choose to live in independent housing, halfway houses, community living placements, and faith-based programs. Clinic staff reported PSH services are ideal for members that need additional support in areas such as skills training which builds independence, wrap around services, and members that have difficulty staying housed or are chronically homeless. Clinic staff also reported it is up to the members where they live. However, some clinic staff screen members readiness for independent housing. When a member is using substances, staff offer treatment settings rather than referring to a PSH provider for independent living. In addition, if a member is residing in a higher level of care, staff assess to determine if the member is capable of independent living. Some clinic staff were unaware of other PSH programs other than CBI to refer members when there is a waitlist for the CBI PSH	● PSH staff and system partners should work with clinic staff to ensure understanding that members only need to express a desire for safe and affordable housing to be referred to a PSH program. ● Clinic or referring staff should inform members of the different housing types available. When supports are needed in independent settings, provide a range of services to members to help maintain housing stability.

			program. Those clinic staff take on the task of helping members locate and maintain housing. PSH staff reported miscommunication within the agency regarding the necessity of members needing a housing voucher to be referred.	
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	Clinic and PSH staff, and members stated that there is choice when it comes to the members' preference of location and choice of unit. One member said they wanted to reside near their family members and was able to secure an apartment very close. PSH staff reported the choice is 100% members choice, and PSH staff are there to help and do not make the decision for the members. PSH staff report educating members on being specific when choosing the unit best fit for their needs. For example, when having knee problems, requesting a unit on the first floor, and completing a walk-through of the unit prior to signing the lease to ensure it is the unit they want. Choice is constrained due to market factors. PSH staff reported that fewer landlords accept members with past evictions, or a criminal history. Additionally, the trend of fewer landlords accepting housing vouchers continues. Rent increases have been debilitating to members' access to affordable housing.	
1.1.c	Extent to which tenants can wait for the unit of their choice without	1 – 4 4	Clinic staff, members, and CBI PSH staff all indicated members can wait for the unit of their choice. PSH staff stated that members can decline a unit without risking discharge from the program or placed to the bottom of wait lists. Depending on	

	losing their place on eligibility lists		the voucher, staff said members have between 90-120 days to secure a unit. Members can request an extension when unable to secure housing in the time allotted. PSH staff reported they assist members with extensions and advocate on their behalf with the voucher administrator. One clinic staff reported a member turned down several apartment complexes due to the "crime rate" in the area and was able to continue to search for a unit where they felt safe.	
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	Members, clinic staff, and CBI PSH staff reported members are able to control the composition of their household. PSH staff advised they will educate members on the pros and cons of adding someone else to their voucher and assist when needed. One member stated they were able to add their significant other to their voucher and ultimately secured housing. PSH staff reported a member required a caregiver and was able to switch a one-bedroom voucher to a two-bedroom. Per data received, less than 1% 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.	
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	1, 2.5, or 4 4	Tenants and staff reported housing management or landlords do not have any authority or role in providing clinical or social services to members. PSH staff reported speaking with landlords if issues arise at the request of the tenant. One clinic staff conducted a staffing with the voucher holder for a	

	providing social services		member with high traffic. Housing management was not included in that staffing.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Per interviews conducted, service providers do not have any responsibility for housing management functions. PSH staff and clinical staff stated there were no instances of CBI PSH staff having authority to collect rent, enforce lease requirements, serve evictions, or other management functions. For the purposes of this review, the CBI PSH program does not have staff in management or landlord positions.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Most CBI PSH tenants reside in independent settings where social service staff is based off-site. A small number of members, less than 1%, reside where supportive services are 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	Per the data provided by PSH staff, 68% of housed members receive a housing subsidy. There were eleven members without rental data provided. Seven members are paying fair market rate, between 46 - 109% of their income. Twenty-two members have no income currently, thus do not have any responsibility for rent. Tenants on average pay nearly 19% of their income toward rent. Of the members interviewed, all reported paying less than 30% of their income toward rent.	• To the extent possible, with consideration of market factors, continue to work with tenants that are paying over 30% of income toward housing to find more affordable units. Assist them in applying to housing assistance programs and explore employment opportunities to help mitigate rental costs.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing	1, 2.5, or 4 1	Data provided to reviewers shows the CBI PSH program has 45% current and passing Housing Quality Standards (HQS) inspections on record. PSH staff have the opportunity to offer a certified	• Staff should develop procedures to collect copies of current HQS reports. If feasible, voucher administrators should share current

	Quality Standards		CBI staff to perform inspections of units where members reside.	HQS reports with PSH service providers, as components to supporting tenant self-advocacy and eviction prevention. • Consider utilizing the CBI certified staff to conduct HQS inspections for the PSH program.
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, the majority of tenants with the CBI PSH program live in housing units where less than 25% of all units have been set aside for people meeting disability-related eligibility criteria. There is some unintentional clustering at some large complexes that accept individuals with eviction or criminal histories.	
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	Data provided by CBI showed many tenants, 78%, have a lease. Of the ten member records reviewed, five had current leases, three leases were expired, one lease was not available, and one member was unhoused. PSH staff reported that having a copy of members' leases on file is a top priority. PSH staff advise members living with family, friends, or in another setting to have a rental agreement. Members interviewed reported having a copy of their lease.	• PSH agencies should obtain and maintain current copies of all leases. For scattered site units, explore the feasibility of having voucher administrators being able to provide copies of leases to the PSH provider. Leases are an important tool to support tenant advocacy and eviction prevention. Members participating in PSH services should be educated on the benefits of sharing leases with the PSH services provider. Some PSH programs attend lease signings with members, providing an opportunity to advocate for the member as well as obtain a copy of the lease.

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, the majority of housed CBI PSH members, 91%, reside in settings where tenancy is not contingent on compliance with program provisions. A small number of housed members, less than 1%, reside in staffed transitional or treatment settings where tenancy is contingent on treatment participation or program rules.	
Dimension 6 **Access to Housing**				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	CBI staff confirmed practicing a *Housing First* approach and that there is no other PSH program entry requirements other than a referral from clinic staff. Reviewers were informed of a recent member struggling with substance use being supported by PSH staff in securing independent housing, allowing the member to focus on treatment goals and recovery steps. PSH staff reported preferring the members have all necessary documents to support housing search, such as current identification, birth certificate, and a social security card. When members do not have those items, PSH staff will assist in obtaining. Staff at one clinic reported familiarity with the *housing first* model, however stated it is not implemented here in Phoenix and that members are rarely housed first. Instead, members need to exhibit skills to live independently and are offered treatment for substance use before being referred. At one clinic the prescriber utilizes a questionnaire with the members to determine readiness to live independently. One clinic staff was unsure of the *housing first* approach but reports to refer members to programs they request. One member stated they had to prove their ability to live	• Ensure PSH staff are trained and understand the principals of the *Housing First* approach. • PSH staff and system partners should collaborate with clinic staff to increase understanding of the *Housing First* model and how PSH supports that. Assessing members' needs would be an appropriate measure if the purpose were to identify skills and services needed to support the member in being successful in living independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs.

			independently to the clinic before a referral was made to the PSH program.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 4	CBI PSH program staff reported members at highest risk are prioritized and require a score of eight or higher on the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). It was also reported by PHS staff that they work to educate community providers on the *Housing First* model and suggest other resources for members that are referred below a score of eight on the VI-SPDAT. PSH staff did not identify unhoused members specifically as a priority population. It was reported that the AHCCCS Housing Program is no longer requiring the VI-SDAT to qualify for housing programs and it is unclear how members most at risk will be prioritized.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	Members interviewed reported having privacy in units. CBI PSH staff and clinic staff do not hold copies of tenant keys and confirmed that members control entry and have privacy in their units.	
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	CBI PSH and clinic staff report members can choose the services they want at program entry. Members stated that they are the authors of their service plans with the help of clinic staff. Some clinic staff may recommend certain PSH providers over another provider as evidenced by staff at one clinic not being aware of other PSH programs available to members. The potential exists that members choice of receiving PSH services is limited when the suggested PSH program is currently not accepting new referrals. It was	

			reported by CBI PSH staff that in June 2021 the program paused all intakes into the program, mainly due to staffing shortages.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Members interviewed reported the ability to add, remove, and modify their treatment goals as needed. Based on records reviewed, treatment plans appear to be updated annually. Two-member treatment plans were updated after members requested a service to be added. PSH staff expressed concerns of low staffing rates at clinics which could impact members' ability to request services, update treatment plans and obtain referrals for those services requested.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 3	CBI PSH staff reported that members have a choice of opting out of services with the PSH provider without risking their subsidy. Of the records reviewed, service plans with the PSH provider appeared to be written in the members' voice, based on need, and objectives were individualized. In the *CBI Welcome Packet*, there is a *"Choice of Services Form"* in which members sign stating they understand that the status of their housing and/or housing voucher is not contingent upon participation with CBI PSH program, and participation with the program is voluntary. PSH staff reported members can close services with them at any time and there is no time limit to participating in the PSH program. PSH staff will continue to assess approximately every three months and highlight what has been going well pertaining to the services requested by the member and discuss the potential of graduating the program. In one record reviewed, PSH staff had a conversation with a successfully housed	• Educate staff and members on how choices of the services members select do or do not impact other services. For example, if terminating clinic services is allowed, the impact on applicable subsidies and/or PSH services. Consider developing a simple decision flow chart that tracks how modifying services from one provider can impact other supports. PSH and clinic services are not all integrated, so scenarios where members close from one, or both, providers may impact whether members are able to choose the services they receive.

			member. The member remained open as they were not ready to close services. Staff at one clinic reported members must be engaged in case management services as well as the psychiatrist. Staff reported being informed by the RBHA that when members are not engaged in services, they will lose their voucher and/or be taken off the housing voucher waitlist.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 4	Of the records reviewed, most CBI PSH service plans were updated every one to seven months. Goals were updated pertaining to change in members housing and supportive service needs. One record showed a service plan was not updated for over one year nor did it indicate a housing goal. Some documented services in records included assisting members with lease signing, eviction prevention, transportation, budgeting, locating food, furniture, and clothing resources, supporting recovery, supporting healthy coping skills, and social security disability coordination assistance. Treatment plans contained similar activities to support members maintaining housing. Staff stated that PSH staff meets regularly to discuss high risk member services and strategies to address challenges. The CBI PSH team consists of two full-time staff including the PSH Manager, and two part-time staff. Although there has been recent staff turnover and several vacancies on the CBI PSH team, records reviewed indicated members were still provided services consistently. Members interviewed also mentioned staff shortages, however stated having no issues contacting PSH staff and that staff are available to assist when needed.	

			In one record reviewed, the member's lease was not renewed and the PSH staff was diligent in assisting that member with the necessary paperwork for the voucher holder, Home Inc., and coordinated with potential new landlords for availability of a new apartment.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	The anonymous *CBI Supported Housing Survey* is offered to members to complete after each PSH staff visit. One member reported completing the survey after each visit with PSH staff. PSH staff advised one member completed the survey and requested the ability to shadow a PSH Navigator as they were interested in becoming a Peer Support Specialist themselves. The PSH program was able to accommodate that member and provide insight of what a PSH Navigator position entailed. PSH staff reported that most staff that provide direct services have lived experience of substance use and/or mental health recovery, stating that the experience offers staff the ability to connect and identify with the members they are serving. Due to the public health emergency, the CBI PSH program has not held any member community forums this year.	• Gather input from participants on how they would prefer to be involved in program design and implementation. Provide examples of potential avenues from which they could participate such as serving on sub-committees to the agency board of directors, participating in quality management activities, or other processes that impact service design and provision to the PSH program. • 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, two Navigators (one part-time, one full-time), a Case Manager (part-time) and the PSH Manager (full-time) delivered PSH services to 71 members, a member to staff ratio of about 24:1. Staff reported caseload sizes range from five to about thirty, depending on the staff.	• Hire 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 retaining housing.

7.4.b	Behavioral health services are team based	1 – 4 3	At one clinic, based on interviews and records reviewed, service planning is not integrated. Clinic staff report PSH staff are not a part of service planning. Records reviewed lacked evidence of coordination of care between clinic and PSH staff. One clinic staff reported it would be helpful to receive weekly updates regarding members in the PSH program to increase coordination and member care. However, at the second clinic, service plans are integrated with all agency programs that the member is enrolled in, whether that is outpatient, inpatient, or PSH services. Per records reviewed, coordination of care was more frequent when members were receiving case management and PSH services from CBI, rather than other provider clinics. In one record reviewed, the member was receiving outpatient care and PSH services with CBI. The PSH staff coordinated care in person with Case Managers and the Nurse from the members' assigned CBI team. Emails sent by PSH staff to the CBI outpatient team regarding updates with the member were in the records reviewed.	• Consider scheduling regular planning sessions between the PSH provider 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.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 2	PSH staff reported, due to staff vacancies, the PSH program is providing services Monday - Friday 7am - 5pm, accommodating member needs on the weekends by appointment only. One member reported ability to contact the PSH Manager by phone on weekends and holidays when needed. PSH staff provide members with a *"Frequently Used Number Sheet"* that includes the Maricopa Crisis Line, Warm Line, Access to Care Line ran by Peer Supports, members' natural supports, property management and maintenance after hours contact line, and remind members that they	• Ideally, PSH services are available 24-hours a day, seven days a week including the ability to respond to members in the 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.

			can contact their assigned clinic on-call staff when needed.	

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	2.5
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	4
Average Score for Dimension		3.63
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	4
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.67
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	3
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	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	3
7.4.b: Behavioral health services are team based	1-4	3
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	2
Average Score for Dimension		3.13
Total Score		22.93

Highest Possible Score		28