Attachment A
NARRATIVE PROPOSAL SUBMISSION QUESTIONNAIRE
AHCCCS RFP YH22-0055

SUBMISSION REQUIREMENT B1: METHOD OF APPROACH

1. Proposed Program Model – Bridge Facility

1.1. Describe how the Offeror will identify and engage eligible members of the population of persons with an SMI designation and experiencing homelessness for the Bridge Facility. Describe how the program will reduce programmatic and administrative barriers to eligible individuals. Describe how the Offeror will coordinate with other systems of care (e.g., Continuum of Care Coordinated Entry, discharging residential or behavioral health facilities) to identify and engage the target population.

Copa Health Inc. (Copa), in collaboration with the Central Arizona Shelter Services (CASS), proposes to develop the Bridge to Success Transitional Housing facility (Bridge Housing Facility) program and an Integrated Outpatient Clinic in response to Request For Proposal YH22-0055 (RFP). The uniqueness of our approach will include a transitional facility designed to support persons with SMI or SMI status, will offer integrated physical and behavioral health services, and will provide additional collaboration with the individual after housing is located to ensure they succeed.

Barriers and Impact

Currently, most Homeless Shelters and Transitional Facilities do not have an adequate operational infrastructure to effectively serve persons with SMI or SMI status as well as comorbid medical conditions and substance use disorders. Copa programs and the CASS shelter services continuously collaborate with individuals with a mental illness and comorbid substance use issues who are homeless, experience housing instability, discharged from jails, or psychiatric inpatient facilities and psychiatric urgent care centers. Too often individuals are unable to rapidly access housing due to the current limited availability of placements in a supported housing setting with a sufficient level of support; this typically defaults to a homeless shelter setting referral for services. Many individuals decline homeless shelters because they feel vulnerable to exploitation and harm by other homeless individuals without a mental illness. In our experience, persons with SMI or SMI status and are also homeless experience significant challenges. It is difficult to provide services or supports to an individual who does not have a predictable location, no means of reliable communication and no way to store and take medications. This often results in an unfortunate cascade of physical and mental health issues which are often accompanied by substance use.

Copa and its affiliates Marc Community Resources and Partners in Recovery have successfully impacted the lives of more than 15,000 Arizonans in need of a comprehensive continuum of educational, supported vocational, psychosocial rehabilitative activities through supportive housing, outpatient clinic services, and community based in-home supports. The unified Copa draws on the strength of each organization's experience to elevate the performance of every area of its operations. Copa currently serves over 9000 persons with SMI or SMI status. Over 1500 (17%) of those individuals are either homeless or have repeated housing instability. Founded over 37 years ago, CASS is the largest and longest serving homeless emergency shelter provider in Arizona. Both the adult and family shelters operate at full capacity 24/7, 365 days of the year. Serving the entire Phoenix metropolitan area, CASS is a regional solution to homelessness, working to fill service gaps and help thousands of people transform their lives, get a roof over their head, a job, and a chance at a new life.

Copa and CASS recognize establishing a trusting relationship is the first step in engaging a person in services and supports. Establishing a relationship will be purposeful but at the pace the individual determines. All programs are based on principles of harm reduction and utilize a trauma-informed care approach. Copa's program philosophy is based on the following principles: The individual is treated with dignity; the individual is expected to take responsibility for their own behavior; individuals have a voice and choice; the focus is reducing harm; and there are no pre-defined outcomes. Programs are recovery oriented, strengths-based, and individualized.

Six principles underlie a strengths-based approach: 1) People with psychiatric disabilities can recover, reclaim, and

transform their lives. 2) The focus is on individual strengths rather than weaknesses. 3) The community is viewed as an oasis of resources. 4) The person is the director of the helping process. 5) Relationships are primary and essential. 6) All staff are trained in these principles and in Motivational Interviewing, Stages of Change, and the Recovery Philosophy. Interventions start where the person is at and focus on where the person wants to be. The Copa and CASS Team understands and responds to the need for emotional and physical safety for both staff and individuals and is committed to helping survivors recover and rebuild their sense of control over their lives. We continuously train and refresh our workforce in the principles of trauma-informed care and strengths-based and recovery-oriented models.

Client Identification

With respect to the identification of individuals who would benefit from the program, the Copa and CASS Team will establish referral relationships with all the Maricopa County Homeless Shelters and require that all clients go through Coordinated Entry, whether prior to entering the shelter, or after entering the shelter. Referrals may also originate from residential or behavioral health facilities, psychiatric hospitals, and jail transition teams for individuals who are either experiencing homelessness or becoming homeless. Referrals will be responded to within 24 hours and may be expedited depending upon urgent need. Intakes to the facility can be conducted at the referral facility or on-site at the transitional housing facility. Because each individual must accept living at the Bridge Housing Facility, protocols will be in place to allow the person to make an informed decision.

The target population includes persons with SMI or SMI status or who require a SMI assessment and determination, Copa and CASS with guidance from Arizona Health Care Cost Containment System (AHCCCS) will provide a clear list of criteria for referrals. In addition, all potential referral agencies will receive ongoing training on the referral protocol and criteria. For persons who do not have SMI status, a relationship was established with Crisis Preparation and Recovery (CPR) to assist in the rapid determination of SMI status. CPR offers a variety of services including SMI evaluations, outpatient counseling, medication management, crisis interventions, transitional care, Critical Incident Stress Management (CISM) trainings, and disaster/crisis management consulting. CPR takes most major insurance plans including AHCCCS/Mercy Maricopa Integrated Care (MMIC), Noridian, United, Aetna, Cigna, TriCare, and HealthNet/Mental Health Network (MHN).

Program Model

CASS will operate the Bridge Housing Facility for up to 70 persons with SMI or SMI status experiencing homelessness. CASS has both the depth and breadth of experience needed to operate both emergency and transitional shelter for persons with SMI or SMI status and already does so at its main shelters, including the 470-bed adult shelter located on the Human Services Campus and a 100-bed family shelter in North Phoenix. CASS also provides extensive housing and case management services to all populations experiencing homelessness. This includes specialized case management to those with either more intensive or specialized needs, including the 30% of clients who are chronically homeless, the 30% who are over age 55, veterans, youth, families, and children.

CASS is considered a low barrier shelter model, meaning clients can access shelter without restrictions on their sobriety, income, or having to accept services. The business model, however, is a progressive engagement and housing first model that seeks to engage clients. Thus, all clients will be encouraged to work with a case manager and supported to secure permanent housing, to work on a housing plan, to find work when possible, and to secure benefits. CASS' progressive case management model provides the level of services to clients based on their needs. A trauma-informed environment is another critical component of the shelter design. CASS is in the process of becoming a trauma-informed certified shelter, which is a 15-month process and involves training of every staff person, including all executives, managers, and front-line staff. The certification is expected on or about February 2023. In addition, integrating day-treatment, therapy groups, and specialized daily programming for seniors to include financial literacy, as well as therapeutic art activities. Copa also employs a trauma-informed approach and have provided training to all staff in this approach. Copa also employs a trauma-informed approach to care and will provide day treatment, individual and group

therapy and a variety of other supports using this model. Other on-site programs will include support and 12-step programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc.

Copa and CASS provide the combined organizational structure, experience, services, supports, training, and treatment framework that recognizes the emotional, physical, and social impact of mental health disorders. The overarching goal of the program will be to assist the individual in obtaining and succeeding in independent supported housing. The first objective will be to provide the individual with a safe structure, healthy meals, and a caring and supportive staff. The second objective will be to engage the individual and introduce them to the benefits, services, and supports they are entitled to receive. While in the Bridge Housing Facility they will be assisted in connecting or reconnecting with their community outpatient teams and needed medical services or if they choose, they will be enrolled in Copa services and supports. Individuals will always have a choice of providers and will be supported in connecting or reconnecting with their provider of choice. The third objective will be assisting and supporting the individual to engage in the available and needed services. The fourth objective will be to introduce the individual to the housing opportunities they want to pursue, focusing on the Housing First model and helping each person to find permanent housing; this will be conducted by the Housing Specialists and Peer Support Specialists from both agencies. Once a location has been achieved the Housing and Peer Support Specialists will assist with move-in and resource identification to personalize the apartment/house. The fifth objective will be to provide evidence-based services such as Critical Time Intervention to ensure that the individual is successful and retains their housing.

In 2021, Copa implemented a program which targeted 25 individuals who had high utilization of hospitals, emergency rooms and crisis services. Many of the individuals were homeless or had significant housing instabilities. Copa conducted Social Determinants of Health (SDOH) and Adverse Childhood Experiences (ACEs) assessments and discovered housing stability needs were not being met and client services required the use of a trauma informed approach. Peer support staff were assigned to each individual and individuals were provided Critical Time Intention services - which are described in detail in other sections of this proposal. The results were remarkable. When comparing utilization six months prior, to intervention with their current utilization patterns, we discovered a 66% reduction in hospitalizations, a 100% reduction in 30-day hospital readmissions, a reduction in crisis calls, and a 72.8% reduction in crisis services dispatches.

Length of Stay
The length of stay in the Bridge Housing Facility will be determined by the individual's willingness to move to an independent or a supported housing location, the availability of alternative independent or supportive housing and financial resources the individual has to finance their housing. Peer Support Specialists, Housing Specialists and Benefits Specialists from Copa and CASS will assist individuals with benefits, housing applications, supports in coordination with other members of their clinical teams. The general length of stay target will be 120 days in the Bridge Housing Facility; longer lengths of stay, up to two years, will be considered on an individual basis.

1.2. Describe any other specific subpopulations or issues to be addressed (i.e., gender, age groups, demographics, substance abuse, or other co-occurring disorders) in working with the target population. Please include any demographics or statistics available to support the response. Include strategies for serving persons with disabilities, transgender residents, or other diverse populations and how the Offeror will ensure cultural competency in service delivery.

General Demographics
Copa and CASS serve interconnected populations that are impacted by homelessness, SMI, and other complex needs. Copa provides clinical and support services to over 11,000 persons with SMI or SMI status, severe emotional disturbance (SED), and co-occurring disorders (COD). Among those served, 3,182 (29%) are age 55 or older; 145 (1%) are veterans; and 2,056 (19%) are homeless or with inadequate housing. The current demographic breakdown of Copa clients is as

follows: 72% White, 12% Hispanic/Latino, 8% Black/African American, 1% American Indian/Alaska Native, 1% Asian, and 0.2% Native Hawaiian/Pacific Islander.

While Copa is the largest provider of services to persons with SMI or SMI status in Maricopa County, CASS is the largest homeless emergency shelter provider in Arizona. CASS annually serves over 5,600 persons at the adult and family shelters with over 210,000 bed nights. On average, 1,400 return to permanent housing and 2,200 are empowered by case management. CASS also serves many vulnerable and medically fragile individuals: in FY 2021, 2,285 (63%) reported disabling conditions; 1,421 (39%) reported mental health diagnoses; 954 (26%) reported chronic health conditions; 1,033 (29%) were age 55 or older; 182 (5%) were veterans; and 1,140 (32%) were chronically homeless. The demographic breakdown of CASS' target population is as follows: 40% White, 29% Black/African American, 22% Hispanic/Latino, and 6% Native American. All CASS clients meet HUD income guidelines for extremely low income.

The number of homeless persons with SMI or SMI status in Maricopa County continues to rise, including homeless persons who travel from other counties to Maricopa County. Like many other metro areas, downtown Phoenix and Mesa are a repository for homeless individuals of the region. The count of individuals experiencing homelessness [Point In Time (PIT) Count] increased by 5% from 2018 to 2019, and 12% from 2019 to 2020. The number of people who meet the chronic homelessness definition significantly increased over the years. From 2015 to 2020, the total number of chronically homeless increased by 119%. By 2020 the chronic unsheltered number increased by 28% since 2019 while the chronic sheltered number decreased by 16%. The HUD definition of chronic homelessness is: (1) a person who lives in a place not meant for human habitation, Safe Haven, or Emergency Shelter, (2) has a disability, and (3) has been homeless continuously for one year or more in the last three years, where the combined length of time homeless is at least 12 months. When a head of household meets this definition, all household members are counted as chronically homeless. From 2017 to 2020, unsheltered homelessness in the Maricopa County region increased by 83%. In the Central subregion (Phoenix), the growth rate for unsheltered homelessness was 58%. In the East Valley, unsheltered homelessness increased by 129% and in the West Valley, it went up by 219%. The partners will utilize the definition of homelessness provided in the RFP to determine eligibility for this program.

Sub-population

Another critical issue which we intend to address is co-occurring substance use. With nearly 7,500 homeless individuals on the streets in Maricopa County according to the 2020 PIT Count (the 2021 PIT survey was not conducted due to the Covid Epidemic), the metro area faces interlinked problems with substance use that comprise "homelessness". This is evident in the population served by Copa and CASS. persons with SMI or SMI status, and chronic substance use, who comprise a significant portion of the homeless (as much as 25% of the homeless adult population according to the 2020 PIT Count), housing is more than just a basic need: it is also a significant barrier to participation in community life. Comparing data from 2015 to 2020 the number of individuals identified during the street count with a mental illness increased from 523 in 2015 to 965 in 2020. For individuals with substance use both primary and secondary to mental illness, the number went from 420 in 2015 to 1,110 in 2020. Unfortunately, this number is a significant underestimate on the number of individuals with mental illness or substance use disorders, as on any given day there are at least 400 individuals in Community Psychiatric Inpatient Hospitals and another 200 in Psychiatric Urgent Care Centers, many of whom arrived homeless and will return to that state when discharged. There is also a large population of individuals with mental illness and substance use who are in jail and will be homeless when they are released. The number of persons in Maricopa County with severe psychiatric disabilities who are without a fixed residence has been estimated at 2,000, half of whom carry "dual diagnoses" of mental illness and substance abuse.

Within the population currently served by Copa, there are a sizable number of individuals who are chronically homeless or have housing instability and are intermittently homeless. The majority of the population also have comorbid chronic medical conditions. The program intends to address the substance use issue by using a Harm Reduction approach. Data indicates that over 2,500 of the 9,000 individuals served by Copa have a co-occurring substance use disorder so we are

familiar with the specialized treatment and support needed by this population. Copa and CASS intend to use the definition of the target population provided in the RFP to determine eligibility for this program.

Cultural Competency in Service Delivery
As service providers and employers, Copa and CASS are enriched by clients and employees with diverse heritages and beliefs. Both facilitate agency wide cultural competency by recruiting, promoting and supporting a culturally and linguistically diverse governance, leadership and workforce who are responsive to populations in each service area. Employees receive training related to cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, as well as socioeconomic status; employees accord appropriate respect to the fundamental rights, dignity, and worth of all people.

Additional strategies will be incorporated in this project to serve persons with disabilities, transgender residents, and other diverse populations to ensure cultural competency in service delivery. CASS recently hired a Director of Social Justice, Racial Equity and Diversity who is leading the agency's efforts to build programs and practices in the agency, as well as efforts to address inequities in homelessness and housing.

The demographic make-up of the target population includes a diverse spectrum related to gender, age groups, race/ethnicity, and other demographics. Similar to homeless numbers across the nation, Maricopa County shelter clients are overrepresented among the African American and Native American communities. Copa and CASS both serve a diverse population of individuals representing the county distribution of racial and ethnic diversity and both have a diverse group of employees that matches the population demographics. Sixty percent (60%) of Copa's and CASS' workforce identify as Black, Indigenous, and People of Color (BIPOC).

Services are accessible to clients facing language barriers. Client Rights and Responsibilities and Non-Discrimination statements are posted in English and Spanish, and an orientation/resource guide is offered in English and Spanish. For other languages, staff use the MMIC (Mercy Maricopa Integrated Care) translation phone system, VOIANCE 1-877-756-4839 for communication, as well as being available to clients with limited English proficiency (LEP). Both agencies comply with all federal and state laws concerning the employment of persons with disabilities and regulations and guidance issued by the EEOC. Copa and CASS facilities are ADA compliant and allow for the provision of services to individuals with mobility, sensory impairments, and other physical disabilities. Copa and CASS also provide treatment to individuals with service animals and others needing reasonable accommodations.

Copa and CASS both value diversity, inclusion, equity, appreciation, and respect for difference and these values are demonstrated through the inclusion of national diversity standards, diverse clients, and diverse employee force. These strategies will be incorporated in this project to serve persons with disabilities, transgender residents, and other diverse populations to ensure cultural competency in service delivery.

1.3. Describe the specific service needs and resources required to successfully serve the target population(s) of the Bridge Facility. Provide any data or documentation used to inform the targeted population and/or proposed service model to be implemented.

Integrated Service Need
The need for integrated physical and behavioral health services for persons with SMI or SMI status and are homeless is crucial to their health. In 2006, the National Association of State Mental Health Program Directors (NASMHPD) published a landmark report based on the first multi-state study of excessive mortality among persons with SMI or SMI status. While many individual studies had long documented that persons with SMI or SMI status die at a younger age than the general population, the NASMHPD report was the first to describe a nationwide public health tragedy in this population. The study concluded that persons with SMI or SMI status die, on average, 25 years younger than their general

population counterparts (in Arizona, one of the cross-state study sites, the gap in premature mortality is more than 30 years). Most chilling was the finding that upwards of 60% of these deaths are due to manageable and preventable health conditions routinely addressed in primary healthcare settings, including diabetes, cardiovascular and respiratory disease. Persons with SMI or SMI status, particularly those who are homeless, rarely participate in the health care services that are available to all. Finally, the study noted that the conditions contributing to disease burden in the population of persons with SMI or SMI status are driven by behavioral risk factors – smoking, poor nutrition/obesity, lack of exercise – that are modifiable and can be changed through targeted and effective health promotion and physical care services.

These findings, however, are not unique to persons with psychiatric challenges. Lower socioeconomic status is, in general, linked with higher rates of chronic stress, heart disease, diabetes and cancer; communities of color and those that are disadvantaged historically experience higher levels of disease burden and mortality (IOM, 2001). Increasingly, science and policymakers are highlighting the robust connection between socioeconomic status and health and the contributions of environment, homelessness, social structure, resource distribution, exposure to violence, poverty, literacy and health literacy to disparities in healthcare access and ultimately poor health outcomes. These factors are known collectively as "social determinants of health outcome" and disproportionately affect communities and populations that are economically disadvantaged or distinguished by subpopulation differences (HHS, 2011). One recent Harvard study examined the distribution of death due to chronic disease against communities with higher prevalence or risk exposures and concluded that while many millions of Americans enjoy good health and expectations for long life, for many others the levels of community and individual health mirror those found in low-income developing countries (Murray, 2006). Braveman, et. al. (2005) reported that modifiable social factors—including income, education, wealth, and childhood and neighborhood socioeconomic conditions may be more important in explaining health differences by race or ethnicity.

Persons with SMI or SMI status, who are homeless, experience a cascade of risk factors, environmental, and socioeconomic conditions that place the group at significantly elevated risk. In fact, the NASMHPD report suggests that the diagnosis and experience of serious mental illness itself is a key driver of excess disease and death. Most persons with SMI or SMI status I in Arizona live at or near poverty. Draine, Salzer, Culhane, & Hadley (2002) reported that most people with mental illness and substance abuse disorders live in poverty most of the time. With their main source of income being a monthly check from Supplemental Security Income (SSI) (in Arizona that is currently $794 a month) and/or Social Security Disability Insurance (SSDI) (McCabe, Edgar, Mancuso, King, & Ross 1993) (which is $800-$1800 a month), they have difficulty renting even a modest, one bedroom apartment (Cook, 2002). Living close to the poverty line means that the person is vulnerable to homelessness and if addicted to drugs, they may spend half or more of their disability income on drugs. The current average rental rate for a one-bedroom apartment in Arizona is $750/month, not including utilities, while their average income is less than $10,000 per year. Others earn slightly more due to SSI/SSDI benefits but live in near-poverty and are unwilling to seek employment due to the risk of losing their benefits. Druss (2002), Chassin (1998) and others noted that the clustering of economic risk, lower quality housing, lack of access to quality food, and a variety of person, provider and health care system factors result in lower access to care and inferior quality and poorer healthcare outcomes for the population of persons with SMI or SMI status, particularly those who are homeless. Copa's Population Health and Quality Management data mirrors these national findings. For example, the vast majority of mortalities among persons with SMI or SMI status served by Copa are by natural causes due to chronic disease and medical conditions. Research consistently shows the costs for treating individuals with chronic medical and comorbid mental health/substance use disorders are two to three times higher than the cost for individuals without those conditions. Much of the added cost occurs in the high usage of emergency and inpatient services as well as costs to the criminal justice system.

Based on data collected through Copa's Population Health program, we repeatedly observe that the usage of these high-cost services is directly correlated with unstable housing. While today we have more effective medications, therapies and integrated care, without stable and supportive housing, these essential elements of treatment cannot be reliably

used to support recovery. Recent research by the Morrison Institute in Arizona (2021) revealed that when individuals who have unstable housing, including homelessness, have sufficient supports and housing, their service costs are reduced by nearly 30%. Housing is an essential component of health care and needs to be available as part of the treatment system.

Copa implemented a supported housing program over two years ago and it was targeted to individuals with high utilization of inpatient and crisis services. Prior to initiation of these services, 48.8% were either homeless or had unstable housing, 2) 58% needed help with their Activities of Daily Living (ADLs), 3) 46.5% reported being lonely, and 4) 18.8 % indicated they had food and water insecurity, over 50% had chronic medical conditions primarily Diabetes, Hypertension and Obesity and 13% had a Substance Use Disorders. and 5) 3% have Intellectual Disabilities. The combination of Social Vulnerability and Social Determinant factors predicts individuals will have higher utilization of crisis and hospital services.

Since the individuals were enrolled in the program and received housing support, Crisis Phone calls were reduced 62.5%, Crisis Mobile contacts were reduced 58.99%, and hospitalizations decreased 28.2%. An ongoing satisfaction survey is being conducted and the vast majority of individuals are extremely satisfied with the living arrangements and program. Some individuals have described it as “having a new lease on life”. This program is an example of the Centers for Medicare & Medicaid (CMS) Triple Aim as it improves the health of the individuals Copa serves, supports the customer experience of care (quality and patient experience), and reduces cost. It also is an example of the AHCCCS Whole Health Program by reducing homelessness and social isolation that can impact individual’s health outcomes

Copa intends to address the afore mentioned risk factors by providing an onsite Integrated Outpatient Clinic which will be licensed by the Arizona Department of Health and able to provide both behavioral health and primary care ambulatory services at the same location. The project site is within half a mile from the Valleywise Health Center for convenient referrals for specialty and follow up care.

The project facility will include a licensed “medical suite” in addition to space for behavioral health staff and services. There are no doors or locked areas separating the behavioral health and medical staff and offices, which lays a strong platform for enhanced communication and care coordination. Copa will staff a mid-level practitioner and a medical assistant within the suite on a staggered weekly schedule that allows for enrollment ramp-up.

Copa will also provide on-site Primary Care Services. Copa practitioners will focus on ambulatory care sensitive conditions; conditions for which outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. These include specific interventions, medication and education for angina, asthma, chronic obstructive pulmonary disease, diabetes, heart disease and pulmonary edema, and hypertension. Copa will facilitate medically necessary referrals, coordinate and provide access to services, including long-term care. The Health Team has multiple options for community-based referrals, including those offering sliding fee scale primary care, dental and eye/ear/nose care. Gynecologic exams (pap, rectal, etc.), screenings for breast cancer and colon cancer and other services requiring greater privacy and infrastructure support or more complicated and specialty care needs will be referred to the network of Valleywise Health Centers and other community healthcare providers, including Federally Qualified Health Centers (FQHCs), that offer sliding fee scale services.

The partners fully understand that the venture and proposed services do not meet the definition of the IMD (Institution of Medical Disease). The partners in this venture understand the Bridge Housing Facility will not be a licensed Outpatient Treatment Center; however, Copa and CASS will offer on-site supportive services at the Bridge Housing Facility provided by off-site licensed providers including those offered by off-site or co-located licensed outpatient facilities of Copa and the CASS off-site licensed outpatient clinic. All support service will be voluntary and individualized based on the

individuals' identified needs and input. Support services will include a focus on securing appropriate community-based housing. Individuals shall have their choice of outpatient providers and shall not be limited to outpatient clinical services or off-site services of Copa or CASS. Currently both Copa and CASS provide services to individuals who are enrolled in other outpatient clinics thru their shelter, housing, employment, and counseling services. Home-based services provided on-site shall be limited to individuals of the Bridge Housing Facility. We will make available appropriate public and private space for home-based supportive services to be provided within the facility by other outpatient providers to meet the needs of the individuals. Services will include but are not limited to: independent living skills (self-care, life skills education, budgeting, healthy meal planning, personal hygiene, housekeeping, shopping, transportation resources and how to use public transportation, social and recreational activities), medication education, peer and family supports, community resources linkages, meaningful daily activities, community safety, employment assistance, case management, assistance with housing searches, placement assistance, rental and move in assistance, assistance with securing identification cards and other documents, assistance with applying for benefits, substance use and support services (referrals to community resources) health and wellness education and coordination with off-site medical services/care as indicated, attendant care and home health for Arizona Long Term Care System (ALTCS) members, coordination of care and referrals to community resources that are client driven and conducted in collaboration with the outpatient adult recovery team.

Copa and CASS Benefits Specialists will be available and are skilled in working with persons with SMI or SMI status to identify available health coverage options through Medicaid, Medicare and commercial Third-Party Liability (TPL) payers contracted with Mercy Care and other Health Care Entities. Benefit Specialists will also conduct eligibility screenings for sliding fee services and Safety Net Care Pool recently approved by the Center for Medicaid Services (CMS). Benefit Specialists can explore options, costs and coverage, and help create a package across multiple funding streams that together provide a robust health benefit; Copa and CASS Benefit Specialists currently process applications for the ALTCS. Copa and CASS are also developing a stronger network for alternative and complementary service referrals using the NowPow program, the closed loop referral system. This includes cultural empowerment supports, based on participant preferences and cultural practices that are familiar and part of their heritage.

Benefits Specialists have a critical role in the service and support process and establish rapport and credibility with clients and providers by providing customer service in a professional manner. Benefits Specialists screen persons to determine eligibility for Medicaid or other health care resource assistance and re-determines continued eligibility. They are also responsible for accurately completing and interpreting insurance verification and benefits and notifying clients, family members, office management, and business office staff of insurance coverage issues that may result in coverage reduction. In addition, they perform quality checks on all eligibility AHCCCS applications initiated and ensure they are processed for all clients who lose AHCCCS coverage and process eligibility case files within the required timeframes established by the respective funding source.

CASS will provide 24/7, 365 days a year services at the Bridge Housing Facility in a trauma-informed environment and with a trauma-informed trained staff. CASS will also provide housing navigation including Rapid Re-Housing (RRH), Permanent Supportive Housing (PSH), along with flexible financial support and move-in kits. Specialized case management will be provided to those with either more intensive or specialized needs, including the 30% of clients who are chronically homeless, the 30% who are over age 55, and veterans. CASS recently became an AHCCCS provider and will be in a position to provide licensed behavioral health services at the new shelter when it opens. In addition, day treatment programs and therapy groups will be an important part of the shelter model, which services will be delivered by both CASS and Copa Health.

1.4. Describe any evidence-based models or innovative practices the Offeror will utilize to ensure Bridge Facility residents are engaged voluntarily in member-focused services and assisted to community based permanent housing or appropriate services within the transitional time frame goals.

The partners plan to implement a variety of evidence-based practices. These include 1) establishing an Integrated Outpatient Clinic that will make available physical and behavioral health services in one location. 2) bridge shelter housing 3) housing support services based on the Critical Time Intervention model which has proven to be highly effective in transitioning individuals from homelessness, 4) a robust supported housing approach and team, 5) a variety of trauma-informed counseling services and 5) Peer Housing Support Specialists.

Integrated Outpatient Services
A seminal article was published in 2011 "Mental Disorders and Medical Comorbidity," by Benjamin G. Druss and Elizabeth Reisinger Walker. The authors conducted a literature review to identify the rate of comorbidity in adults between medical and mental health conditions; associated mortality, quality of care, and cost burdens of comorbidity; and current evidence-based approaches for addressing comorbidity.

About 68% of adults with a mental health disorder also have at least one comorbid medical problem, and 29% of people with medical disorders have a comorbid mental health condition. The combination is commonly associated with functional impairments, decreased length and quality of life, and increased costs. Having mental health or a medical disorder is a risk factor for developing a second comorbid disorder, such that having a medical disorder may lead to developing a mental disorder and having a mental disorder may lead to developing a medical disorder.

Individuals who are homeless or have housing instability are even more likely to have comorbidities. In Copa's data system, it was identified that 1,044 individuals have housing instabilities which means they are intermittently homeless and 436 individuals who are chronically homeless, and over 70% have chronic medical conditions. In addition, due to the challenges locating the same individuals, they frequently miss medical or psychiatric appointments. Over the last year, this group accounted for 3,781 missed appointments. They are likely to miss over 30% of scheduled appointments which results in inconsistent care and therefore insufficient to treat their chronic conditions.

Studies reviewed included epidemiological, claims-based, clinical trials, and systematic reviews and meta-analyses. Comorbidity was defined as the co-occurrence of mental and physical health disorders in the same person, regardless of the chronological order in which the conditions presented or the causal pathway linking the conditions. Researchers defined mental health disorders as including depression, anxiety, schizophrenia, and bipolar disorder. Physical health disorders were not defined as a specific set of conditions, but the authors noted that diabetes, cardiovascular disease, and pulmonary as are commonly comorbid with psychiatric disorders. The report's authors found that the following conditions can exacerbate comorbid conditions: 1) Exposure to early trauma and chronic stress is a risk factor for both mental and medical disorders. 2) Low-income and poor educational attainment are associated with developing both mental health and medical disorders. 3) Tobacco use, excessive alcohol use, illicit drug use, lack of physical activity, and poor nutrition are responsible for much of the high rates of comorbidity and early death related to chronic diseases, and 4) Psychotropic medications can worsen comorbid mental or medical problems.

Authors noted that research indicated the problem of comorbidity is "a mismatch between a clinical reality in which medical conditions and mental health conditions are overlapping and interrelated, and a health care system in which the providers, clinics, and treatment are separated. Evidence-based treatment models for improving quality in this population are often not implemented because of barriers erected by the fragmented system." Through their research review, authors were able to identify organizational and financial models for caring for individuals with comorbid conditions. As such, Copa proposes to open a licensed Integrated Outpatient Clinic that will be able to provide both behavioral health and primary care ambulatory services. In addition to the direct Primary Care Physician (PCP) availability the project site is within a half a mile from the Valleywise Health Center for convenient referrals for specialty and follow up care. The project facility will include a licensed "medical suite" in additional to space for behavioral health staff and services. There are no doors or locked areas separating the behavioral health and medical staff and offices,

which lays a strong platform for enhanced communication and care coordination. Copa Health will staff a mid-level practitioner and a medical assistant within the suite on a staggered weekly schedule that allows for enrollment ramp-up.

Copa and CASS currently provide a full range of services required in the RFP and needed to serve the targeted population. These include independent living skills (self-care, life skills education, budgeting, healthy meal planning, personal hygiene, housekeeping, shopping, transportation resources and how to use public transportation, social and recreational activities), medication education, peer and family supports, community resources linkages, meaningful daily activities, community safety, employment assistance, case management, assistance with housing searches, placement assistance, rental and move in assistance, assistance with securing identification cards and other documents, assistance with applying for benefits, substance use and support services (referrals to community resources), health and wellness education and coordination with off-site medical services/care as indicated, attendant Care and home health for ALTCS members, coordination of care and referrals to community resources that are consumer driven and conducted in collaboration with the outpatient adult recovery teams.

Copa's integrated care services for individuals with mental health challenges delivers a model of person-centered care that meets people where they are, guiding them to where they want to be. We use evidence-based practices and caring professionals to transform lives. We empower Arizonans to achieve their best health and a life of meaning and purpose. We deliver care teams that include psychiatric services, psychiatric nurses, primary care physicians, and medical assistants, and we partner with pharmacies so clients can receive multiple services in one familiar setting. Clients can receive preventative health screenings, physical exams, flu shots, and guidance. There is close collaboration with pharmacies and Benefit Specialists to expedite the process and ensure clients receive needed care without delay.

Copa staff coordinate with community primary care physicians (PCPs) and specialists. Copa's approach targets the risk factors that cause heart disease, stroke, diabetes, and other unwanted chronic health conditions. Medical practitioners deliver comprehensive diagnostic evaluations, and medication education services utilizing a high-touch model. Copa's outpatient treatment is managed by highly qualified Behavioral Health Medical Practitioners (BHMP) whose scope of practice includes prescribing psychotropic medication, ongoing medication monitoring, and other research-based interventions to reduce unwanted symptoms.

One innovation we intend to introduce involves having the ability of the individuals to pick up their prescriptions at the Outpatient Clinic location at the Bridge Housing Facility. This option will be available to any Bridge Housing Facility resident who chooses to use this service and can be offered to any agency from which they receive their services. This program will ensure individuals are able to obtain their prescribed medications in a convenient manner. We will utilize the pharmacy residing within the Copa Arrowhead location to fill all prescriptions which will be delivered to the Bridge Housing Facility Clinical site for distribution. The Arrowhead Pharmacy offers compliance friendly medications sets for tracking doses. In practice, the bubble-packaged medications have dosage packets to help keep track of medications needed throughout the day. Bubble-packaged medications offer a quick visual check to see if a medication was taken. The pharmacy team members can be reached at any time to assist in unknown events. In addition, Health and Wellness programs offer fun and engaging educational and action-oriented services that support positive life changes in diet, fitness, stress and sleep. Copa's health coaching staff is certified in physical fitness, nutrition and Stanford Chronic Disease Self-Management in order to offer services with proven results. From fitness centers and walking groups to cooking classes and yoga, the Health and Wellness program helps clients get to where they want to be, one step at a time.

Case Management

Copa and CASS Case Managers are trained system navigators and advocates whose primary job is to assist clients in identifying services that assist the person to achieve their goals. Case managers work collaboratively with the integrated care team to engage, educate, communicate, and coordinate care with service participants, their family, behavioral

health, medical and dental providers, community resources and others in ensuring that all services prescribed in the Integrated Service Plan (ISP) are implemented. The case manager completes the following functions for the benefit of clients: 1) Develops, maintains, and manages the Integrated Service Plan (ISP) within required timeframes. 2) Adjusts the ISP and service delivery as needed based on progress/lack of progress in the specified health, wellness and behavioral health goals. 3) Provides assistance in maintaining, monitoring and modifying covered behavioral health and healthcare services and community resource needs. 4) Maintains the person's comprehensive clinical record, including documentation of activities performed as part of the service delivery process (e.g., assessments, provision of services, coordination of care, discharge planning). 5) Coordinates and communicates with Clinical Coordinators, Integrated Care Coordinators, nursing and medical and psychiatric practitioners for individuals exhibiting urgent or emergent medical and/or psychiatric symptoms. 6) Participates in regular care team meetings and staffings and documents actions to modify service delivery based on progress, social determinants of health, health literacy, health care activation, current gaps in care, the Health Risk Assessment and level of self-management of chronic conditions. 7) Provides continuous screenings and evaluations of treatment effectiveness for service referrals, including counseling, residential and supportive services and community resources. 8) Makes recommendations for initial and concurrent authorization of service referrals. 9) Participates in and supports fidelity of integrated care practice, including training, performance measurement and enhanced communication protocols for Integrated Care teams. 10) Serves as the primary point of contact for the caseload, providing direct services including, but not limited to telephone or face to face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning. 11) Provides assistance in finding necessary community resources other than covered services to meet basic needs. 12) Ensures referrals to and provision of all covered services identified on the service plan within Copa timeframes; ensures continuity of care between levels of care and across multiple providers, services and supports. 13) Provides outreach, re-engagement and follow-up services including, but not limited to, crisis and missed appointments. 14) Screens and assesses all persons on caseload for financial entitlements (AHCCCS, SSI/SSD etc.); completes AHCCCS applications on all clients on caseload meeting criteria. 15) Provides or arranges for transportation as appropriate and determined by the care team.

Community Day Services

Community Day Services will be available and designed to assist individuals to maximize their independence and choices through building personal, social and pre-employment competencies to live full and productive lives. Services provide community integration opportunities and experiential learning opportunities to increase daily living skills, social skills, use/availability of community resources, pre-vocational skills, community engagement and awareness. Individuals participate in volunteerism, recreational activities, social skills practice, broadening educational activities and community involvement. Individuals can choose part-time or full-time programs. Individuals are offered activity choices providing skill reinforcement/education in five major areas of human development: cognitive, social/emotional, gross motor, fine motor, and self-help.

Support is given for individuals to access shopping, transportation, recreation, community events, sporting events and museums. Each program location features Smart Boards, iPads, sensory equipment rooms, music therapy and professionally instructed Zumba classes. Day programs teach proper nutrition, the importance of exercise, how to manage one's health, money skills and cooking. Many of the individuals who participate in Copa's Day programs have a health and wellness goal to enhance their quality of life. Person-centered planning teams meet periodically through the year to discuss an individual's choices, assessment, goals and future plans along with what services are needed to support these accomplishments. Along with the assessment results, an individual program plan guides future services. One by one, skills are acquired, independence is increased, and accomplishments abound. Close to 20% of those served split their week between day and employment services. Becoming more self-sufficient through work skill development is a goal of Copa Health Day Services. Transitioning more than ten percent of those served into a work setting is an annual program goal.

Employment Related Services

Another innovation, Copa will offer Employment Related Services (ERS) to anyone interested in pursuing gainful employment. ERS is committed to helping people with disabilities expand their independence by obtaining and maintaining employment. Copa achieves this through a variety of training models including career planning, pre-employment training, computer training, document imaging training, community and center based "real" work training, job development and placement. The program helps with competitive and supported employment, with Employment Specialists co-located in six valley locations. Copa assists people with varying levels of disabilities. Services are provided both across the community in integrated employment settings according to their hours and at Copa facility-based programs. This allows the individual served and their ISP Team or Recovery Vision Team to determine the frequency of services.

Employment Related Services accepts referrals from Rehabilitation Services Administration (VR), Division of Developmental Disabilities (DDD), Regional Behavioral Health Authority (currently Mercy Maricopa Integrated Care), Mercy Care, Evercare, Bridgeway Health, Arizona Complete Health, United Health Care, Magellan and private pay. We can do single case agreements and welcome the opportunity to work with new funding sources. ERS also offers the following:

Copa Academy Course Offerings are operationalized by Copa's Employment Related Services department partnership with LearnKey/Brighton College to offer online or in-person job training courses. Courses include Information Technology, Microsoft Office Specialist 365, Autodesk Computer Aided Design, Medical Assistant, Adobe Web & Graphic Design, Paralegal Certification, and Business & Accounting. Copa Employment Related Services offers clients a wide array of job training and employment opportunities serving both individuals and the businesses Copa supports. The primary goal is to provide needed supports that enable clients to gain meaningful employment within the community.
A Copa Community Enclave typically includes the following: A Copa supervised team of clients that perform customer directed activities either at the business site or at one of Copa's ERS locations (2 in Mesa and 1 in West Phoenix). The types of work vary based on the customer requirements. Community Enclaves provide food service, janitorial, and manufacturing/assembly types of services, however, the type of effort an enclave can perform is flexible and varied. Benefits of the Community Enclave provide significant advantages to clients and the customers an enclave supports.

The enclave provides clients with an opportunity to gain experience, new skills, confidence and stamina, and the potential of employment. The customer realizes a work team focused on the successful completion of a work project at a cost-effective rate. Transportation to the work site is provided by Copa. Also, Copa has the capacity to perform work activities at one of its ERS sites in Mesa and Phoenix customized to the needs of the customer. Copa currently has 27 community enclaves providing real work experience and training, including: Wire assembly services at the Boeing Apache Helicopter plant in Mesa, management and operation of the Rendezvous Cafe and golf cart cleaning at Leisure World, concession work at spring training games for the Cubs, Diamondbacks, Rockies, and Oakland A's as well as Arizona State venue sports and concerts, meal preparation and delivery to jails for the Mesa Police Departments, gum removal services for Mesa Public Schools, janitorial services for WM Grace Properties, snack bar services at City of Mesa Main and Red Mountain Public Libraries, and laundry services at Social Spin Laundromat.

Substance Abuse Recovery Program

The Copa Substance Use program employs Licensed Counseling staff and Licensed Independent Substance Abuse Counselors assigned to each clinic. Copa uses the SAMHSA Evidence-Based model of Integrated Mental Health/Substance Use Treatment which emphasizes treating both Mental Health and Substance Use issues simultaneously. The essential features of integrated treatment include 1) engagement, outreach and case management, 2) a comprehensive range of services to accommodate individuals at varying levels of severity, 3) an emphasis on engaging and motivating the person to commit to treatment, 4) conceptualizing people passing through stages or phases of treatment, 5) modification of pharmacological approaches and 5) and ongoing assessment and treatment plan modification.

Copa recognizes that no single treatment methodology is appropriate for all individuals, so we have available a variety of methods with the integrated treatment format. Matching interventions, and services to each person's particular issues and needs is critical to their ultimate success in returning to productive functioning in the family, workplace, and society. The variety of services begin with motivational interviewing, trauma-informed care, cognitive behavioral approaches, acceptance and commitment therapy and a variety of other techniques. All methods employ a Harm Reduction model. Because individuals with substance use issues may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible. Substance Use Counselors work with the individual's clinical team to develop an individual treatment and services plan that is assessed continually and modified as necessary. Since the individual may require varying combinations of services and treatment components during the course of treatment and recovery the counselors adjust services and frequency of treatment based on these changing needs.

Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction. In therapy, individuals address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. In addition to counseling or psychotherapy, a patient at times may require medication (such as Suboxone) which can be prescribed by the Copa Psychiatry staff.

Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Because people often leave treatment prematurely, we include strategies to engage and keep individuals in treatment by frequent contact and drop-in appointments when necessary.

Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment and even if the person appears unwilling at first to enter treatment or drops out of treatment, we continually attempt to re-engage the person in services. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Substance use addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. As such, we continuously explore innovative ways to engage the individual in care.

Supported Housing

Copa, through Marc Community resources and Partners in Recovery, has been involved in supported housing since its founding. Copa and other housing providers in Maricopa County took part in a Substance Abuse and Mental Health Services Administration (SAMHSA) national study (Rog, 2004) that measured housing and residential living satisfaction. Copa's Director of Population Health served as the principal investigator for the Arizona project site. The results revealed superior satisfaction for the supported housing approach. The Supported Housing model was found to be superior to the residential continuum model for the following reasons: 1) The residential model assumes that there is a series of residential settings, varying in their provision of service, staff supervision, and restrictiveness. As individuals improve, they are expected to move sequentially through the continuum, eventually graduating to independent living. In fact, Maricopa County has the same problem that most of the country has with the residential model, there is not a full continuum of residential levels and consequently individuals get backed-up in levels of care because the next level of care is not available. 2) The residential model is a "readiness approach" which the research has proven is unnecessary and inefficient. 3) Individuals strongly prefer supported housing over residential placements. Tanzman (1993) found that about 70% of individuals showed that the preferred housing arrangement was for a person to live in their own house or apartment. Residential facilities such as group homes were consistently among the least popular options.

Both Copa's and CASS' supported housing models address these issues by assisting the individual to attain a better level of self-sufficiency by applying the needed community resources, assisting in locating and enrolling the individual in

mental health and substance abuse programs and assisting the individual in enrolling in supported education or employment programs. We recognize that person and environment congruence, conceptualized as the degree to which the individual's needs, capacities, and aspirations are consistent with the resources, demands and opportunities of the community living situation, can be a deciding factor in an individual's success in retaining housing (Coulton et al., 2001). While housing and supports are complex variables that are difficult to isolate experimentally, the overwhelming evidence affirms that the Supported Housing model is an effective method to reduce homelessness, increase housing stability and improve quality of life with individuals with a variety of psychiatric and substance abuse disorders (Eichler, Gowdy, & Etzel-Wise, 2004: Ogilvie, 1997; Parkinson et al., 1999: Ridgway & Rapp, 1997. Rog (2004) concluded that, as compared with usual services, supported housing increased housing stability, reduced homelessness, and reduced hospitalization. Tsemberis and Eisenberg (2000) in a study of the Pathways to Housing program concluded that individuals with severe psychiatric disabilities and addictions can obtain and maintain independent housing when provided with the opportunity and sufficient supports. Copa works with Sam Tsemberis, renowned author and clinical psychologist, and the Pathways Housing First program to establish the current program and will continue to use them as an ongoing resource.

Copa and CASS are using the Housing First model with fidelity. The Housing first model has several common elements: 1) It is person-centered, and strength-based. Everyone receives the services and supports that they need to succeed and do not have to receive a pre-planned packaged program. 2) It employs a harm-reduction approach in that individuals begin where they are now consistent with their stage of change. 3) The models use a recovery-based approach in which the individual is empowered to decide the type and amount of care and support they want. Both Supported Housing programs are also consistent with the Arizona Department of Health Services' (ADHS) Nine (9) Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems adopted by the Department of Behavioral Health Services (DBHS) and the SAMSHA evidence-based practice guidelines for housing supportive services.

Copa and CASS have a cadre of Housing Specialists that assist individuals with attaining and retaining housing. Individuals are not required to follow a set program sequence; rather, they can move between these programs to receive the right level of support as needs change. Programs include Lighthouse Homes, Supported Community Housing, Hope, Shape, Community Transitions Services, In-Home Supports, Community Navigations Services, Peer and Family Support Services. The Housing Specialist collaborates with the Integrated Clinical Team to identify individuals in need of housing and housing support services. They provide education, coordination, and resources to the care team and service participants in the range of housing options available, ensuring maximum choice to the extent possible. The Housing Specialist serves as campus knowledge expert and point of contact on housing issues, options, housing providers and supportive service agencies, including: Access to furniture resources and start-up kits; Housing options for difficult to place and legally-involved individuals; Language barriers and physical mobility issues in community housing; Landlord tenant rights and responsibilities; Permanent Supportive Housing Evidence Based Practice model; Regional Behavioral Health Authority (RBHA) housing tools including the Service Prioritization Decision Assistance Tool (SPDAT) and housing application process. They track individuals placed on housing waitlists and ensure care team follow-up to secure and maintain housing, they participate in treatment team meetings, and they participate in hospital staffings and housing intakes as well as any additional discharge meetings pertaining to housing. They provide direct housing support services as needed and train care team clients in supportive services delivery and meeting individual needs to ensure housing stability (e.g., eviction prevention, food boxes, furnishings). In addition, the Housing Specialist documents all client events and services in accordance with policies, procedures, and clinical protocols and coordinates with the clinical care team to assist clients/family in the choosing, locating, obtaining, and keeping appropriate housing.

Supported Community Housing program is designed for persons with SMI or SMI status as an independent living environment. The goal is for individuals to receive intermittent supports, while learning what is needed for them to transition into the community and achieve the greatest level of independence. The Intensive Supportive Services (ISS) program is designed for those discharged from the hospital setting into the community with high-risk behaviors

requiring additional supports for treatment. Individuals may receive services within another provider's setting or within their own home. The goal is to reduce the level of support services and transition individuals into a more independent environment. Staff work closely with the clinical team to ensure supports enhance the individual's recovery process. Lighthouse Homes modeling via Community Living provides housing and support services for individuals to assist them with successfully living in an unlicensed Copa owned or leased home by providing the supports necessary to achieve their recovery goals. This program is designed to tightly integrate the overall delivery of care for persons with SMI or SMI status to focus on their whole health and wellness to realize a longer, healthier and more fulfilling life in the community. A coordinated approach to care means fewer emergency room and urgent care visits, medical inpatient admissions, behavioral health admissions and long-term care admissions, leading to improved outcomes and reduced costs.

The Hope Program provides supportive services using the Substance Abuse and Mental Health Services Administration (SAMHSA) evidenced-based protocol to individuals transitioning from homelessness or inadequate housing to independent housing. The program uses peer housing support specialists to provide services under the supervision of a behavioral health technician and clinical guidance of behavioral health professional with the aim of connecting the individual to sustainable supportive housing and services that will increase the resiliency of the person served by increasing independent living skills, connecting the person to the community and natural resources, connecting with the person's clinical team, and focusing on health and wellness for the mind, body and spirit.

Supported Housing and Permanent Employment (SHAPE) program has a dual emphasis on housing and employment to rapidly implement services to assist individuals in achieving and sustaining independent living in the housing of their choice, while providing services and supports that assist them in maintaining jobs of their choice in the community. The program utilizes principles of respect, choice, empowerment, natural supports, strengths-based, recovery, resilience and hope. The program also actively collaborates with Housing, Employment and Clinical Providers.

Community Transition Services provide comprehensive supportive and stabilization services to clients who experience frequent inpatient psychiatric hospitalizations and are frequently homeless on discharge. The program assists clients during the course of a 90-day period by coordinating stabilization efforts from the onset of hospitalization through the transfer of care to their community-based clinical team. During the transition process the peer support partners utilize interventions focused on evidence-based treatment, wellness and recovery, and person-centered supports to aid participants in achieving long-term community stability resulting in a reduction in hospital readmissions.
The program's approach is centered on collaboration among the individual, the hospital team, the community-based clinical team, Mercy Care and the Community Transition Team, all of whom share the common goal of identifying and connecting participants to the natural and formal supports that lead to long-term community stabilization. The program's highly individualized and flexible approach is specifically designed to help persons who are considered prone to frequent psychiatric hospitalizations develop the hope and resilience necessary to live meaningfully in the community of their choice.

In-Home Supports offer individuals an option to continue living in their homes while participating in their community. Most feel it is a far better option than being hospitalized or living in a group home. This program uses an individualized approach and staff collaborate with the individual on a continued path to recovery. Services are provided by behavioral health technicians, behavioral health paraprofessionals and recovery coaches in coordination with the client's clinical team and those the individual chooses.

Community Navigation Services are designed to navigate the complexities of the behavioral health and the criminal justice system. The overall goal is to connect individuals with community resources, supports, and services. The program's customized approach provides a partnership between the individual and the navigator to connect to the appropriate next steps towards self-sufficiency, reduction of recidivism, positive support systems, resources to housing, employment and the connection or re-connection to integrated health care. Individuals referred to this program are

AHCCCS eligible individuals experiencing behavioral health and/or substance use challenges [General Mental Health and Substance Use (GMHSU)], individuals experiencing chronic homelessness, and persons with SMI or SMI status. Individuals can be referred by the clinical team for peer support and navigation of the criminal justice system. Referrals can come from those recently released from incarceration, court referrals, other community providers, and self-referral. Resource navigators receive calls from service clients seeking help for needs from housing to VA benefits.

Service navigators explore possibilities for the service clients utilizing a Resource Connection Guide provided by the Coalition that includes activating the military/veteran community and service providers to find what the person needs in a timely manner. Resources can include employment, family and social support, financial benefits, education, housing, legal, mental health and substance abuse services, physical health, and spirituality.

Peer Specialists engage and create peer to peer relationships and role model the evidence of recovery. Peer Specialists assist the person by actively identifying their needs and strengths and helping the person navigate in the system. They actively engage the person by making all necessary community visits (home, jail, residential, SCH, hospitals, homeless shelters) to facilitate various living skills development and support the person as they develop assertiveness and advocacy skills.

Copa Peer Specialists attend medical/psychiatric appointments with the person and promote growth, educations, knowledge, support, and connections within the team. We also have an active peer support training program with eleven graduating classes a year. The average class is 15 –20 clients, however, classes are currently limited to 10 due to the COVID pandemic. Our two class instructors were recently certified in Applied Suicide Intervention Skills Training (ASIST) and will offer ASIST Training to staff and to graduates of Peer Support.

Family Support Services provide services to individuals and families to improve their lives. Services include an evaluation of the client's needs, referrals to education and support programs that assist families in need, conducting family-centered and strength- based interventions directed at establishing a trusting relationship. Services support and enhance practices that will improve family functioning and improve the family's ability to effectively interact and care for their loved ones while fully incorporating the nine guiding principles for recovery in the adult behavioral health system.

Critical Time Intervention

Copa will implement the evidence-based Critical Time Intervention (CIT) model to assist individuals transitioning from homelessness, Urgent Care Centers and Psychiatric Hospitals who do not have a current residence or sufficient supports in the community. Individuals who are identified as lacking a residence while homeless or in homeless shelters, urgent care centers, psychiatric hospitals or jails will be referred to the Integrated Outpatient Clinic. The clinic will assist them in finding community housing where they will receive services and supports from the team while the supported housing staff will pursue permanent supportive housing options. While in the transitional housing unit they will be assisted in connecting or reconnecting with their community outpatient teams or will be enrolled in the Copa team. Benefits Specialists will assist individuals with housing and financial application in coordination with their clinical teams. Individuals who are connected with clinical services at other providers can still access the Integrated Clinic services after the clinic coordinates services with their existing clinical teams.

Psychiatric Hospitals and Emergency Rooms are receiving significant attention from Medicaid, Medicare and private insurance plans primarily due to the increased cost associated with hospital care and the perception that many of the readmissions are the result of quality-of-care concerns with the discharge planning and/or the community care the individual receives when discharged. Many individuals begin or continue their path into homelessness after these transitions.

The discharge planning process and care transition have opposing forces based on the hospital mission to discharge the person when hospital services are no longer medically necessary and the available array of community services, the person's health literacy and the person's ability or desire to adhere to the discharge plan instructions during the transition.

Research indicates that the reasons for admission and readmissions include the following factors: The community resources needed to support the person are either not available or not responsive, the person lacks stable housing, the person does not understand what they need to do to remain healthy or the person simply chooses not to adhere to the discharge instructions. Individuals who are frequently readmitted often receive discharge plans that contain the same locations and services that repeatedly failed because they did not consider factors that led to readmissions, and they are placed in the same location with the same services that previously failed to support them in the community. Any approach to reduce readmissions must deal with these factors. In addition, research has shown that one of the most effective ways to reduce unnecessary admissions and readmissions, particularly those due to social determinate issues such as lack of housing or housing instability, is to provide education while the person resides in the inpatient setting, develop a transition plan that effectively deals with the person's reason for admissions and provide transitional support in the community to ensure the transition plan is followed and the person is connected with community services and supports needed to succeed. One of the most promising lines of research is the work of Cheryl Forchuk and her colleagues in Ontario, Canada who developed a Transitional Discharge Model (TDM) (2008, 2021). The model strategically targets discharge planning issues and the gap between hospital and community services.

Known as the "Bridge to Discharge" program, Forchuk's model addressed the traditional boundaries between hospital and community settings that impede care transitions by assigning an inpatient team of professional and peer support staff to work with the individual while they are in the hospital and remain with them in the community until a therapeutic relationship is formed with a community mental health provider.

The Transitional Discharge Model is an essential component of the COPA Supported Housing programs. The philosophy underlying this model was further articulated in the evidence-based program Critical Time Intervention (CTI). The CTI model uses the following principles outlined in the integrated treatment literature which make it a natural platform for treatment and support: treatment intensity, stages of change, motivational interventions, and harm reduction (Carey, 1996). The CTI Training Manual shows several areas have been identified as crucial in facilitating stability, community assimilation, and the prevention of the cycle of homelessness. These five areas include psychiatric treatment and medication management, money management, substance abuse treatment, housing, crisis management and prevention, and family interventions. Additional attention to vocational training and other life skills are added according to each person's individual needs and desires.

CTI was developed at New York Presbyterian Hospital and Columbia University. It is specifically designed to complement rather than parallel the existing service system for mentally ill people in the community, so that services are not duplicated. CTI is a time-limited intervention. The phases of CTI include 1) Transition to Community; 2) Try-Out; and 3) Transfer of Care. While the typical CTI approach can last up to nine months, the program time frame can be contracted to meet the progress of the individual in attaining community stability. Copa has found that the timeline is dependent on the person and their complexity. Homeless individuals who are entering require more time to establish connections than individuals who are transitioning from sub-standard housing. Copa has been successfully using this model for the past six years in transitioning individuals from homelessness to stable housing and in the hospital transition program

Evidence-Based and Trauma-Informed Counseling Services

Evidence-based Counseling services will be available through the Integrated Copa clinic for all residents and their families. Copa has a cadre of 30 licensed behavioral health professionals who conduct both individual and group

therapy. Copa provides ongoing training for therapists in several evidence-based techniques. These include 1) Cognitive Behavioral Therapy (CBT), which is used for many diagnoses and needs (depression, anxiety, grief, social issues, problem solving) and is the foundation for general counseling. The duration of CBT is driven by the goals of the participant and should have a clearly defined discharge plan. 2) Integrated Dual Disorders Treatment (IDDT) is specifically for people with dual diagnoses, meaning substance use and mental health diagnoses. 3) Solution Focused Brief Therapy (SFBT) is specifically for people who want to find solutions to a specific issue or concern. Treatment is for people with depression, anxiety, social, or behavioral issues. Treatment can last between 1-12 sessions, but is not for general counseling needs. 4) Dialectical Behavioral Therapy (DBT) is used specifically to treat borderline personality disorder. Treatment consists of group skills training and individual therapy. This is a long-term therapy and requires a time commitment to complete treatment. 5) Eye Movement Desensitization and Reprocessing (EMDR) is used to specifically treat trauma/posttraumatic stress disorder (PTSD). The duration is driven by the goals of the participant and should have a clearly defined discharge plan. 6) Cognitive Enhancement Therapy (CET) helps to enhance mental capacities that produce awareness and meaningful social interactions. It is specifically for people diagnosed with Schizophrenia, and related cognitive disorders (schizoaffective and autism spectrum). 7) Copa also provides Applied Behavioral Analysis (ABA) services which has proven to be highly effective in changing maladaptive behavioral responses.

Peer Housing Support Specialists
Copa and CASS recognize the importance of peers in housing support services and in the successful recovery of the individual served. Early on Copa implemented a robust Peer Housing Support Program to address these issues. Currently, Copa has 250 Certified Peer Specialists who play a vital role within the interdisciplinary team model to provide support and education to clients.

The Copa and Peer Housing Support Program provides a variety of evidence-based practices and support programs to persons with SMI or SMI status with the goal of restoring, enhancing, or maintaining functioning. CASS has a diverse staff with lived experience, and Copa will help CASS develop its peer program and certification of staff.

An early example of involving peer support in Copa's housing programs was Marc Community Resources' partnership with the Arizona Behavioral Health Corporation (ABHC) award of a six-year SAMHSA Grant to develop a supported housing program in Maricopa County. Over 600 individuals obtained and 87% sustained independent housing during the course of the grant. The grant used Certified Peer Housing Support Specialists to provide services to individuals who were homeless. When the grant ended, Mercy Care continued to support this program. After a site visit from SAMHSA, SAMHSA reported that this was a model program and it was noted in their report to Congress. During Community Development Week 2011 (week of May 10th), Marc Community Resources was presented the award of Homeless Provider of the Year by the City of Phoenix, Mayor Phil Gordon and Councilman Brian Jefferies.

Copa was also instrumental in developing the statewide Family and Peer Housing Support Career Academy that continues to provide training and certification to family and peer clients to increase their roles in providing support throughout systems of care. Since its inception, over five hundred individuals have been enrolled and trained in this program. In addition, Copa created a peer run information and referral program where clients or their families can call to assist them in navigating what can be sometimes an extremely complicated system. Copa will bring this knowledge, experience, and approach to the Transitional Housing program.

Copa in partnership with Paz de Cristo in Mesa provides peer Support services to clients visiting Paz. Copa assists on average 200 Paz clients per month. These services include: 1) Assisting vulnerable people with access to mental health services; 2) Utilizing the Homeless Management Information System (HMIS) to help homeless individuals find shelter/transitional housing; 3) Helping individuals identify employment opportunities thru Copa Health's Employment Related Services program, 4) Food, showers, and any other supports needed to assist this population of vulnerable people and provide City of Mesa Community Court support services as assigned by the Presiding Judge. Copa will utilize

a similar set of Peer Support services to the general population of people needing affordable housing and services as part of an overall transitional housing strategy.

1.5. Describe the daily and total experience of a typical participant in the program from intake to program exit or a successful transition to community housing. On what grounds would the Offeror terminate a participant's access to the shelter either temporarily or permanently?

Intake
Upon arrival at the Bridge Housing Facility individuals will be greeted by CASS shelter intake staff. Staff will explain shelter guidelines and intake paperwork, giving participants copies of all paperwork. An explanation of services will also be provided. Clients will also be asked to fill out requisite paperwork with the beginnings of a basic housing plan and an explanation of the various case management and housing services available. This is important as CASS is a Housing First Provider and clients will be encouraged to work with a Housing Navigator from day one to begin working on a plan for permanent housing. Case management and Peer Support services are also core to the shelter model's effectiveness; thus, clients will be made aware of these services and hours of availability. Clients will also be oriented to the services available via CASS and the Copa clinic, including behavioral and medical health services.

Safety and Service Termination
Either before, or after, the initial orientation, on-site security will search clients' bags to ensure there are no weapons or contraband, which are not allowable on facility property. Should such items be identified, they will be confiscated, and weapons will be put into locked storage, while illegal drugs will be put into a police disposal container, to be turned into the police without client identification. CASS uses a low barrier model at its shelter locations and does not have requirements such as sobriety or medication or treatment compliance for the Bridge Housing Facility entry or continued service. Instances of service termination are rare and are issued as a last resort and in the case of violence or continued abusive actions that threaten the safety and wellbeing of other clients, staff, or the facility. Clients are offered other therapeutic interventions before being considered for service termination.

Supports and Service Exit
While in the Bridge Housing Facility, clients will be encouraged to work with a case manager and/or housing specialist to create a plan for permanent housing. Clients will be told that the expectation is that they work on a housing plan, with a targeted stay of up to 120 days, although in some instances this may extend longer. Copa resources including medical, psychiatric, benefits, day programs and vocational services will be available, and individuals will be made aware of these services and encouraged to participate if they so desire. The partners will also assist individuals in connecting with their existing providers.

Housing navigation support will be offered on day one, either by CASS or Copa housing navigators, depending on the needs of the client. One of the values of the partnership is that the partners have complementary, but different housing supports they can offer. Some clients may benefit from the Copa group home model, while others may be able to live more independently on their own, with a roommate and use CASS's Rapid Rehousing program or One Time Financial Assistance. Upon exit, follow up in home case management will be provided by one of the partners for at least one year, depending on the client's placement. Ideally, all clients will also be enrolled in ongoing behavioral health services. Transitional services including Critical Time Intervention services will be offered to assist the person in achieving success in their permanent housing situation.

1.6. What basic necessities will be provided to participants (i.e., food, toiletries, clothing, bedding, laundry, etc.) in the Bridge Facility?

The Bridge Housing Facility will supply a safe and secure housing facility which will include food services, bedding, bathing facilities, storage, laundry, access to clothing and toiletries, and other basic necessities. The facility will provide a location for the safe storage of medications and other valued property. Since the facility will house both males and females sleeping, bathing and dressing facilities will allow for privacy.

1.7. How will participants gain access to food/meals? How will food be provided since it cannot be not prepared on-site and who will prepare it? What would be the cost?

Food services will be contracted and delivered ready to serve. There will be a need to keep items warm so the facility will need equipment to maintain food temperature. Three meals will be served each day at designated times.
CASS has experience providing onsite meals to participants through its temporary senior and vulnerable adult shelter, operated from June 2020 to August 2021 in North Phoenix, as a pandemic relief shelter. All meals and snacks were provided through multiple partnerships and vendors, which allowed clients a variety of to-go food options to meet dietary needs and preferences. CASS will utilize a similar model at the Bridge Housing Facility - leveraging previous partnerships to meet client needs. The cost is approximately $5 - $10 per meal per resident.

Meals will be stored in a meal preparation kitchen in commercial refrigerators and warmers. Storage of dry goods and non-perishables will also be available. There will be designated times meals will be served and a multi-purpose room available for dining. The Bridge Housing Facility staff will be responsible for meal receipt, storage, and distribution and required to obtain a food handlers card and be trained on food safety.

1.8. Describe how 24/7 operations and access will be provided including staffing, available services, and access policies. Include strategies to address resident behaviors or needs that may present access and supervision challenges (e.g., smoking, work-related late entries).

Bridge Staffing
The Bridge Housing Facility will be staffed 24/7, 365 days a year by a minimum of three staff at all times. This includes CASS intake staff and security. During daytime hours, including on weekends, case management and housing navigation staff will be available to clients. The case management ratio will be 1:10 for every client. CASS and Copa will work in partnership to provide behavioral health navigation services inside the Bridge Housing Facility. As CASS evolves into becoming a behavioral health provider, the goal is for the case managers to be providing case management support. The partners will work closely together on this latter goal to build a more efficient and effective model for clients needing mental health services.

Clinic Staffing
The Integrated Clinic program will be comprised of a Program Director, who will be responsible for the overall administration of the program, Behavior Health Medical Professionals (Psychiatric, Primary Care, Nursing, Counseling), Behavior Health Professionals and Behavior Health Paraprofessionals. Copa will adhere to requisite service ratios embedded in clinic licensing guidelines.

The Integrated Clinic will have psychiatric and physical health care available Monday-Friday, 8:00 AM - 5:00 PM, with extended evening and weekend hours offered, as we learn the needs of the designated population. The Clinic will also have peer support and housing specialist available 7 days a week. Copa will provide a 24/7 on-call service to support crisis response outside of regularly scheduled business hours. Staff from the Clinic will be present at the Bridge Housing Facility.

Copa maintains a comprehensive set of board-approved policies that delineate Copa's purpose, its population, program descriptions, among other policies. In addition, many Copa's programs have their own procedural manuals specific for

their services delivered. Highlighted below is Copa's Referral and Entry Policy (expedited low barrier with no additional eligibility criteria or requirements beyond those in 5.3.1) which includes a policy of non-discrimination, general rules of storage of Protected Health Information (PHI), Privacy Personally, Identifiable Information, Environment of Care, Ethics and Compliance, substance use, dealing with violence and inappropriate behavior, and weapon search. Any of the below policies as well as others not mentioned can be rendered for further review, upon request.

Referral and Entry
Internal referrals are used to offer specific services to clients where there is a need for accommodation or additional support in pursuing income or housing while they are using shelter services. All new clients must complete a Welcome Center Orientation when they first arrive on campus, which includes initial paperwork and a preliminary housing plan (Referral and Entry Policy; extracted from CASS Single Adult Shelter Policies and Procedures, updated October 2021, aligned with standards 5.9 – 5.9.3 page 12).

Equal Opportunity
Copa and CASS are committed to the principles of equal employment opportunity. We prohibit unlawful discrimination against applicants or employees on the basis of race, color, religion, sex, nationalorigin, age over 40, marital status, sexual orientation, gender identity or expression, disability, military status, genetic information (including results of genetic testing), or any other status protected by applicable federal, state or local law. This prohibition includes unlawful harassment based on any of these protected classes. Unlawful harassment includes verbal or physical conduct that has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment. (Non -discrimination Policy (clients), aligned with standards US Department of Health and Human Services; Arizona Department of Administration; Substance Abuse and Mental Health Services; AHCCCS Policy and Procedures; Title XIX of Social Security Act; Title XXI; Tribal Regional Behavioral Health Authority; Violence Against Women Act).

Protected Health Information and Electronic Health Records
Copa and CASS protect the privacy and confidentiality of client health information consistent with federal and state law and regulatory requirements. Protected health information (PHI) may only be used or disclosed where law or regulation permits. When a state law is more stringent than the federal requirement, the state law is followed. It is the policy of Copa to protect Personally Identifiable Information (PII) of employees and students. The electronic restrictions and safeguards outlined in this policy provide guidance for employees, and contractors that have access to PII retained by Copa to ensure compliance with state and federal regulations. General rules of storage of PHI not contained within the Electronic Health Records (EHR) system Policy #601, date of inception 4/1/2021, aligned with standard 8.2 – 8.4 pages 43-44).

Substance Use
While drugs and alcohol are not allowed on the premises, we do house many clients who are actively using these substances. We offer a non-judgmental approach that attempts to meet clients "where they are at" with their substance abuse. Instead of denying services to clients who are using, we try to give opportunities for the clients to minimize the harms associated with substance abuse (Substance Use Policy; extracted from CASS Single Adult Shelter Policies and Procedures, updated October 2021, aligned with standard 5.3.3 and 5.4.8 page 7; 5.4.9.6 page 9).

Violence and Inappropriate Behavior
Our primary concern is housing and assisting clients who are in crisis. We do our best to help clients live within the guidelines that are necessary for maintaining the communal environment of the Bridge Housing Facility. If at all possible, we want clients to be able to continue their stay at the Bridge Housing Facility. This can sometimes be a difficult task, especially when clients act out in loud, rude or aggressive ways towards staff or other clients. It is up to staff on shift to find a balance between ensuring the safety of the Bridge Housing Facility (staff and clients) and

finding ways to assist the client in maintaining a level of appropriate behavior, so that they can remain a client (Dealing with Violence and Inappropriate Behavior; extracted from CASS Single Adult Shelter Policies and Procedures, updated October 2021, aligned with standards 5.3.3 and 5.4.8 page 7; 5.4.9.6 page 9).

Weapons
Weapons will not be accepted for check-in or allowed in the facility. The Bridge Housing Facility staff will make the determination as to what constitutes a weapon. Work tools and any other devices, which may be used in a manner that could cause serious bodily injury, must be checked in at the front desk and appropriately stored, before the client is allowed in other areas of the shelter (Weapon Policy; extracted from CASS Single Adult Shelter Policies and Procedures, updated October 2021, aligned with standard 5.4.7 page 8).

Environment of Care, Service Animals
Copa established standards for the presence of service animals, while committed to maintaining a safe work environment for employees and a safe experience for clients, while respecting the rights of individuals under state and federal law (Environment of Care; Service Animals, Copa Policy #201, date of inception 9/1/2018, aligned with standard 5.5.9 page 10).

Ethics and Compliance Reporting
Feedback is important. Clients must be provided with an opportunity to express their concerns and/or complaints. Staff has a duty to listen to and consider what is being said and provide the client with a response (Copa's Ethics and Compliance reporting).

1.9. How will the Offeror address resident service or companion animals or pets in the Bridge Facility?

The Bridge to Housing facility will allow service animals into the facility, as well as abide by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), the Fair Housing Act (FHAct), and the Arizona Fair Housing Act. The following protocol applies to service animals: Clients with a service/emotional support animal(s) must provide staff with evidence of having a Maricopa County license and proof of recent rabies vaccination. Additionally, clients must follow all guidelines by reading and signing the Service Animal Shelter Stay Agreement. Clients who do not follow the guidelines will be given warnings, and if violations continue the client can be asked to locate another placement for their animal.

CASS currently allows emotional support and assistance animals in shelter and exploring additional services for companion animals through partnerships with Lost Our Home Pet Rescue. Clients are required to assume full care for their animal, and the animal must be with them and under their control at all times. Through a community partnership with Lost Our Home Pet Rescue, clients can access veterinary and pet food resources. If a client becomes unable to meet the needs of their animal while in the facility, staff will work with them on identifying alternate temporary or permanent placement.

2. Describe how the Offeror will collaborate to meet the needs of members: 2.1. Will the Project coordinate or collaborate with other systems of care including homeless systems (Coordinated Entry and HMIS), behavioral health system, jail and/or prisons, law enforcement, outreach, crisis systems, or AHCCCS health plans (i.e., Regional Behavioral Health Authorities (RBHAs) and AHCCCS Complete Care (ACC) plans) to identify and engage members or to ensure appropriate access to community-based services?

Yes. CASS and Copa collaborate with many agencies, nonprofits and systems who interact with the homeless. CASS participates in the centralized Arizona Coordinated Entry system, use of HMIS, and community outreach partners. We partner with the behavioral health system and our longest standing partner is Mercy Care who provides CASS and Copa

with funding and limited access to their portal so we can identify CASS clients who are also members. CASS is now an AHCCCS provider and will be able to identify and engage with many more AHCCCS plans and clients. In addition, Copa has established contracts and strong collaborative relationships with all the AHCCCS Health plans. CASS and Copa case management staff engage with the jail/prison, probation and law enforcement systems for clients who are involved in those systems. CASS staff also help clients to attend Homeless Court. CASS works with outreach providers, particularly Community Bridges, Inc. (CBI) and Phoenix Rescue Mission, who conduct street outreach to homeless encampments. CASS also works with nearly every city in the region to deliver shelter and services to people from those cities. The data on each city is managed in the HMIS programs, as well as in internal data management programs.

Additionally, Copa has established relationships with Saint Vincent's to obtain food boxes to deliver from the clinic sites. We also have an outreach program at Paz de Christo to conduct intakes and provide support services. Copa develops collaborative relationships with many providers in behavioral health and hospital systems for coordination of care purposes. Copa Discharge Specialists coordinate with hospital teams and psychiatric urgent care centers to assist with discharge planning and transition services for clients (including clients experiencing homelessness). The Maricopa County Crisis System provides client referrals when they encounter Copa clients. Conversely, Copa refers clients to the Maricopa County Crisis System when emergency mobile services are required. Specifically, Copa staff work with incarcerated individuals in the coordination of services. Additionally, Copa engages with law enforcement agencies throughout Maricopa County and is often receives invitation to train officers in working with individuals who have a mental illness and developmental disability.

2.1.1. Does the Offeror currently participate in the Maricopa Health Regional Continuum of Care? Describe the Offeror's participation.

Yes, CASS participates in the Maricopa County Continuum of Care. As a member of the Maricopa County Continuum of Care, CASS enters all client data and progress into the Homeless Management Information System (HMIS). HMIS is the repository for ongoing client data that provides a history on each client who has presented as homeless. Members of CASS staff also participate on the Continuum of Care Committee and various subcommittees, including the Data Subcommittee and Coordinated Entry Subcommittee. While Copa is not a member of the Continuum of Care committee, Copa actively tracks their activities and deliberations.

2.1.2. Does the Offeror currently participate in the Maricopa Homeless Management Information System (HMIS)? If so, how does the Offeror utilize this tool and related information?

Yes, both Copa and CASS participate in the HMIS. The partners use HMIS to track information including bed nights and length of stay, participation in case management, walk-in case management interactions, insurance information, and bus passes received. To measure program effectiveness, also utilized is the HMIS-Advanced Reporting Tool (ART), outcome reports and other available reports to compare and evaluate the proposed outputs and outcomes with the actuals. This data is used in combination with qualitative data from the case management team to inform program design, adjust to any changing needs in the population over time, and identify possible new collaborative partnerships that are needed. The Bridge Housing Facility staff maintain and track clients' shelter from intake and then check them in each day. Case managers note all significant interactions with clients and with other providers regarding clients' cases. The partnered agencies do not share client information without a signed release of information, scanned and stored in HMIS.

2.2. Describe how the Offeror will engage and partner with health plans and Medicaid providers to coordinate behavioral health services, promote member choice, and ensure appropriate support for member's service plan goals.

Copa contracts with all AHCCCS/Arizona Medicaid Health Plans. Funding comes from primarily two sources; the Department of Developmental Disabilities funds the services provided to Copa's Intellectual Disability members and the Regional Behavioral Health Authority (RHBA), Mercy Care, funds the services provided to Copa's behavioral health service clients. Copa actively works to remain in compliance with the health plan requirements and coordinate care with all providers. As such, treatment teams involve health plan staff and Copa (treatment/service) team meetings consult to best coordinate clients' behavioral health services.

Copa also works with health plans to promote client choice through the following principles: The individual's decision to use is accepted; the individual is treated with dignity; the individual is expected to take responsibility for their own behavior; individuals have a voice and choice; the focus is reducing harm, not consumption; and there are no pre-defined outcomes. In addition, all programs are recovery oriented, strengths-based, and individualized. In addition, based on the person's request, all family members and supportive individuals that have been identified are invited to the treatment planning team to further ensure appropriate support for the member's service plan goals. CASS's involvement will add additional levels of partnership with health plans, as CASS was recently licensed as an AHCCCS provider. Once CASS begins to bill for services, the organization will be able to identify and engage with many more AHCCCS plans and members. During the pandemic, CASS also set up a program in HMIS to collect client insurance information.

2.3. Describe how the Offeror will establish and promote housing opportunities for Bridge Facility residents) The awarded offeror will work with the ADOA selected contractor to provide input in the Bridge Facility design. Based upon the Offeror's experience in serving the target population or providing similar housing or service, what physical requirements, design features, or other site improvements would you require to support the Bridge Facility objectives and/or to enhance resident experience and outcomes related to the Bridge Facility?

CASS and Copa follow the Housing First model. While CASS and Copa Health have not included any expenses in the budget, we will make such financial assistance (from external sources through Rapid Rehousing and other housing grants) available to the Bridge to Success Transitional Housing Facility members. CASS operates three housing programs to meet the unique, individuals need of each community member in need: Rapid Rehousing (RRH), Homelessness Prevention and One-Time Financial Assistance. The Rapid Rehousing Program helps individuals experiencing homelessness who stay in our shelter transition to permanent housing.

The Homeless Prevention Program provides individuals with monetary support to prevent them from becoming homeless, including move-in cost support, travel assistance to move in with family, eviction prevention, and in-kind support for moving in, including move-in kits. The Financial Assistance Program provides one-time assistance to help clients quickly end their homelessness, including deposits, rental assistance, utilities arrears, and transportation to family members in another state. Beyond CASS's own internal housing programs, we maintain active partnerships with Human Services Campus, Inc., A New Leaf, Ozanam Manor, CBI, United Healthcare, and many others to make sure our clients are able to find the right housing program for them.

In addition to having its own housing stock, Copa can leverage ABC Housing resources, Home Inc., and all housing resources available throughout Maricopa County. Both Copa and CASS also have relationships with dozens property owners and housing partners who can assist with identifying permanent housing solutions. Case managers also work closely with agency partners on the Human Services Campus, where the CASS main shelter and administrative offices are located.

As such, Copa health offers move-in boxes to its members. Copa Health currently has NT19 funding from Mercy Care to create move-in boxes with basic necessities for homeless persons with SMI or SMI status, moving into an apartment. Members in Copa Health's employment training program assemble the move-in boxes and receive a training

stipend equal to minimum wage. If this NT19 funding continues, we intend to make this benefit available to the members at the Bridge facility. Housing start-up kits will be made available to individuals served at the Bridge Housing Facility contingent upon ongoing funding.

3. Proposed Program Model – Licensed Clinic. The Licensed Clinic is a co-located but distinct service setting from the Bridge Facility. The following questions relate to the operation and program model associated specifically with the Licensed Clinic. 3.1. Describe the proposed, separate and distinct but co-located Licensed Clinic, including the prosed AHCCCS-registered provider type and associated clinical services to be offered at the proposed Licensed Clinic. Provide any data or programmatic justification for the service need in the community or geographic area. Will the facility specialize in services for specific population(s) or demographic(s)? Describe any unique services or strategies, subject to members' choice, to coordinate or support Bridge.

The co-located Outpatient Integrated Clinic will be licensed by the Arizona Department of Health and registered with AHCCCS as an Integrated Clinic Provider Type IC. Whether the clinic will be physically attached (prompting co-location) to the Bridge Housing Facility or a separate building will be determined post contract award, in discussions with the architects and based on ADHS licensing requirements. The clinic will be able to provide both behavioral health and primary care ambulatory services including psychiatric services, psychiatric nurses, primary care physicians and nurse practitioners and medical assistants. Copa will also partner with pharmacies so clients can receive multiple services in one familiar setting. Copa Health staff will coordinate with community primary care physicians (PCPs) and specialists. The clinic will include a licensed "medical suite" in addition to space for behavioral health staff and services. Copa will staff a mid-level practitioner and a medical assistant within the suite on a staggered weekly schedule that allows for enrollment ramp-up. The clinic will also be staffed with case managers, benefit and housing specialists and peer support staff. These constellation of clinic staff will be able to provide a wide variety of behavioral and physical health services both on-site and out of office.

The justification for this service is based on the findings that a proportion of persons with SMI or SMI status who are homeless and using shelter services. As such, individuals require additional services that shelters are unable to provide. Many, if not most, individuals also have comorbid chronic medical conditions and a significant number have a substance use disorder. The population we intend to serve will be connected with the full array of services that are needed. We deliver care teams that include psychiatric services, psychiatric nurses, primary care physicians, and medical assistants, and we partner with pharmacies so members can receive multiple services in one familiar setting. Members can receive preventative health screenings, physical exams, flu shots, and guidance. There is close collaboration with pharmacies and benefits specialists to expedite the process to ensure members get the care they need without delay. Copa Health staff coordinate with community primary care physicians (PCPs) and specialists. Our approach targets the risk factors that cause heart disease, stroke, diabetes, and other unwanted chronic health conditions. Medical practitioners deliver comprehensive diagnostic evaluations, and medication education services utilizing a high-touch model. Our outpatient treatment is managed by highly qualified Behavioral Health Medical Practitioners (BHMP) whose scope of practice includes prescribing psychotropic medication, ongoing medication monitoring, and other research-based interventions to reduce unwanted symptoms.

3.2. Describe any licensing, approvals, contracting or other steps the Offeror will need to complete in order to provide the proposed services?

Licensed Clinic

Copa will obtain the appropriate City of Phoenix and Maricopa County Department of Health zoning assignment permits and business operations licenses, as well as Certification of Occupancy documents. Copa will secure an Outpatient Treatment Center License (OTC) with an Integrated Care (IC) designation from the Arizona Department of Health Services (ADHS) Bureau of Medical Facilities Licensing (BMFL); ADHS-BMFL application submission and administrative review are outlined in Arizona Administrative Code Title 9.

Post submission of an administratively complete application, ADHS-BMFL schedules an Initial On-site Survey of the facility that includes the following inspections: Environmental, Conspicuous Postings, Client Records (format), Facility Records, Employee Records, Policies (Service and Administrative). The surveyor will issue a deficiency free report and license. If deficiencies are noted, the surveyor will issue a Statement of Deficiencies (SOD) and request a Corrective Action Plan (CAP) be submitted. Upon acceptance of a CAP (if applicable), the license will be issued. The timing of license inspection and issuance is largely dependent upon ADHS-BMFL Surveyors' schedules and availability. The ADHS-BMFL License process will take three (3) to five (5) months.

3.3. The proposed Licensed Clinic site is anticipated to be approximately 2,500 square feet. What physical accommodations, service settings or facilities does the Offeror require within this footprint in order to be both programmatically and cost effective?

The Integrated Clinic design must allow for the provision of services to individuals with mobility, sensory impairments, and other physical disabilities and have designated space for physical health and nursing services (procedures, exams, medication storage, etc.). The clinic license requires Copa to ensure compliance with Arizona Administrative Code Title 9, including physical accommodation and access requirements listed in the City of Phoenix Building Construction Code (PBCC). The design will also include flexible space to provide an opportunity for on-site groups and activities, as well as private space for evidenced based counseling.

4. Accountability. Describe how Offeror will ensure legal, financial, and programmatic accountability and reporting as described in the scope of work. Address each of the following. 4.1. Legal Compliance - Describe how the Offeror will ensure compliance with all shelter and clinical legal standards and requirements. Describe Offeror's processes and procedures for receiving and resolving complaints or grievances from program participants or other program stakeholders.

Licensed Clinic
Copa has a robust Corporate Compliance and Risk Management Department. The department will develop Outpatient Treatment Center (clinic) policies and procedures that align with federal, state, local and contractual guidelines. Demographic and service outcome reports will be compiled by the Digital Technology Department as well as Key Project Personnel and shared for discussion and analysis by the Quality Management (QM) Committee. Committee members will be comprised of clinical, medical, compliance, and program staff with diverse experience and credentials, including social work, counseling, psychiatry, primary care, nursing, healthcare operations, corporate compliance, and quality management. After review by the QM Committee, data will be reported out to all leadership staff during the monthly Business and QM Meeting. Data will be retained, organized, and made available for review by any internal or external stakeholders or oversight entities.

Consistent with the RFP, the following project evaluation criteria include the following factors: readiness activities, including formative and summative evaluation data, will be collected and reported for the four-year proposed funding timeframe. If program evaluation and/or data tracking results in the finding of deficiencies in performance goals, the Quality Management (QM) Department will work with Program Leadership to develop a plan to address areas that do not align with process measures. Program Leadership and Staff will be responsible for implementing the plan.
The QM Department will conduct follow-up evaluation audits, and additional actions (i.e., training, supervision, additional resources, etc.) will be instituted to ensure fidelity and activities align with proposed objectives, relevant policies, procedures, and protocols. Reports will be provided to Key Project Personnel to monitor ongoing impact and performance. Real-time reports allow for rapid iteration and operational adjustments to improve performance, if necessary. The QM Department will be responsible for mandatory external reporting activities. Copa and CASS will submit reports as required. Reports will outline information relevant to program-specific goals and progress on

strategies; core performance measurement data; the impact of the overall project; goal and strategies outlined in the program; objectives and accomplishments; barriers encountered; and any responses to summary questions requested by the oversight body.

Similarly, CASS has policies and procedures set up for fiscal accountability; data integrity; grant implementation and oversight; reporting to governments and funders; as well as compliance with shelter operational rules and the fair housing act. About 50% of the CASS budget is from federal, state, and local governments and systems; thus, CASS has procedures and inter-department reports and training to ensure all departments are in compliance with contractual guidelines. Audits are also conducted throughout the year by multiple government partners to validate the integrity of documentation, fiscal records, and our client reporting.

CASS' various compliance responsibilities are currently overseen by the CEO, the Executive VP, and the Finance Director. CASS in the process of hiring a new, full-time Compliance Director who will report to the CEO and oversee risk assessment for the agency, as well as all government contracts, data systems and teams, as well as build systems for ongoing CASS internal audits of all departments. Copa and CASS will meet on a regular basis to coordinate quality improvement and reporting activities.

Complaints And Grievances
Both Copa and CASS are organizations with strong values of responsibility and integrity. We encourage employees and stakeholders to feel comfortable in approaching a supervisor or management in instances where there are treatment concerns or a belief that violations of policies or standards have occurred. Copa and CASS have processes for clients to submit a complaint or file a grievance which is then handled and addressed promptly by the appropriate party. CASS also holds monthly town halls with clients at the adult shelter to listen to concerns and challenges, and then CASS staff make shelter adjustments or address the concerns. Client input in the form of surveys is also sought on a weekly basis; weekly input is important given client turnover and to be able to address any ongoing concerns. For Copa, in situations where individuals prefer to place an anonymous report in confidence, they have access to use a hotline, hosted by a third-party regulatory compliance provider (EthicsPoint). Information collected by EthicsPoint (EP) is electronically sent to a designated representative of Copa's Compliance and Risk Department for investigation and follow-up.

Service recipients, advocates, friends, or family members of a service recipient may use the EP portal to alert Copa of concerns. However, for an immediate response, individuals are given the option to first contact the supervisor at the service location or call Copa's main number and ask to speak with a representative from the Quality Management Department. Grievance and complaint processes are posted conspicuously at each service location; forms are accessible in client waiting areas; and all information is accessible via Copa's website. Regardless of how Copa receives a report, all complaints and grievances are elevated to the appropriate party and addressed in accordance with Copa policies. Process oversight, monitoring, and recipient follow-up is the responsibility of Copa's Corporate Compliance and Risk Management Department. The department ensures adherence to all federal, state, local, and contractual guidelines.

4.2. Operational and Programmatic Performance 4.2.1. Describe any proposed programmatic outcomes or success anticipated by the proposed program and how it will be measured and documented.

As reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD), Arizona had an estimated 10,979 experiencing homelessness on any given day (2020). Of that, total over 809 were family households, 2,086 individuals experiencing chronic homelessness, and 1,100 were individuals experiencing substance use both primary and secondary to mental illness (Point in Time Homeless Street Count, 2020). This increase has been due to a lack of capacity in shelters and affordable housing capacity in the community. Copa and its affiliates Marc Community Resources and Partners in Recovery have successfully impacted the lives of more than 15,000 Arizonans in need of a comprehensive continuum of educational, supported vocational, psychosocial rehabilitative activities through

supportive housing, outpatient clinic services, and community based in-home supports. The unified Copa draws on the strength of each organization's experience to elevate the performance of every area of its operations.

Programmatic Goals and Outcomes
During the contract period, all clients will receive an orientation upon intake, along with a preliminary housing plan. CASS will measure the length of stay, bed nights and services provided, as well as the number of clients engaged in case management, who have a positive exit and who attain permanent housing. The goal will be to engage every client in case management, but realistically, we project that 60% or more will engage in these services. Positive exits and the attainment of permanent housing will also be measured, and we project at least 70% of those cases managed will have a positive exit and/or attain permanent housing. The Bridge Housing Facility will integrate Copa's outpatient services to persons with SMI or SMI status. The Bridge Housing Facility believes that entry or return to homelessness will be substantially reduced by striving towards the following outcomes consistent with contract-funded standards.

Outcome - Health, well-being, and recovery, Individuals and families are supported to explore and address their physical health, social, emotional, and mental well-being needs. Demonstrated Evidence: Staff supports clients to explore and document their holistic needs, goals, and aspirations to support their health, wellbeing, and recovery in a person-centered way; Staff empowers clients to partner as equals with their health, mental health practitioner(s) to identify their mental and physical health care needs and the treatments and interventions appropriate to the individual; Staff support clients in creating an agreed upon plans to ensure desired treatment, interventions, and care arrangements (for themselves, their family, their home, their pets, etc.) are addressed during times of crisis. Alignment with standard: Copa implements a programmatic model to provide bridge housing and appropriate supportive services necessary to connect persons with SMI or SMI status and experiencing homelessness to community-based permanent housing and services.

Outcome - A home and financial security; Staff supports individuals to acquire affordable housing where they feel safe, secure, and comfortable. Demonstrated Evidence: Client's support plan clearly documents relevant goals around housing, occupational and vocational needs and aspirations, strategies co-designed to support the person to achieve their desired housing, occupational and vocational goals, and progress with housing, occupational and vocational; clients are supported and empowered by staff to set (and renew) financial goals that help them to budget, manage and resolve issues that may affect their financial security; and Staff supports the member to find a suitable, stable and affordable home of their choosing. Alignment with standard: Copa makes available appropriate public and private space for home based supportive services to be provided within the Bridge Housing Facility by outpatient providers to meet the needs of the targeted population.

Data Collection and Reporting
Copa will be responsible for the oversight and fidelity of all data collection, maintenance, and reporting. Copa in collaboration with CASS will submit reports on a quarterly basis and work with AHCCCS to establish benchmarks and metrics for programmatic evaluation and monitoring of goals and performance standards.

CASS staff are trained to enter client information into HMIS and work with both the adult and family Coordinated Entry systems. CASS can extract real-time, by name data reports from HMIS, so information is readily accessible. HMIS data will also be used to assess outcomes and make adjustments based on the data. Where possible we will also use HMIS to track outcomes in compliance with HUD standards. Data pertaining to project implementation will be collected from multiple sources including but not limited to: client demographics (limited to reported gender, income status interest of care, and program goal and outcome), HMIS entry, stakeholder survey, Self Sufficiency Index, and client satisfaction surveys.

Key metrics to be tracked and reported will include: 1) Daily shelter occupancy and utilization, 2) Length of stay by member and aggregate, 3) Utilization of supportive services by client, 4) Program population demographics including race/ethnicity (including possible demographic disparities), age, mental health status (SMI v. GMH/SUD), family status or household members, gender, referral source, or other fields that may be added at a later time, 5) Resident exit destinations including number of new clients placed in housing and reasons for clients leaving the Bridge Housing Facility without housing, 6) Number of persons leaving and remaining in the program during the reporting period, 7) Grievance and appeals data, 8) Waitlist information including numbers, referral source and length of time on waitlist, 9) Number and percentage of persons enrolled in AHCCCS and connected with provider and release of information, and 10) Client satisfaction surveys.

4.2.2. How will the Offeror provide security or ensure the safety of residents in the Bridge Facility and Licensed Clinic? What operational or programmatic measures will be implemented to ensure that the Project will be a good neighbor and does not increase the impact of either the Bridge Facility or Licensed Clinic operations or its residents or members on the neighborhood (including ASH)?

The Bridge Housing Facility will have 24/7 security from staff who are trained security workers receive CASS-specific training on de-escalation, harm reduction, and Trauma-Informed Care philosophy. Security staff works closely with staff, especially our on-site Behavioral Health Case Managers, to meet clients where they are and to reduce incidents. As a matter of practice, security guards are only involved in an incident when there is a threat to the physical safety of staff or another client. CASS staff are the primary mediators for incidents. The Integrated Clinic will have security features built into the areas in order to alert staff of potential issues. These same features have proven to be effective in Copa's other clinics and we do not anticipate the need for a security guard at the clinic.

4.3. Financial Accountability and Reporting. 4.3.1. Describe strategies, controls, and processes for ensuring financial accountability for the Bridge Facility or Licensed Clinic.
Copa has been awarded federal, state and local grants and been the recipient of RFP awards and, over the decades of its existence has consistently demonstrated a high level of financial accountability related to grants and RFP awards. Copa has a large accounting staff, including CPAs, which work within a very robust internal control environment, including strict adherence to segregation of duties and completing monthly checklists that ensure all accounts are reconciled, transactions are approved and material errors or irregularities are avoided or detected in a timely manner.

Annual budgets are approved by an active board that also receives and approves the monthly financial statements and industry standard financial ratios. An independent firm, selected and monitored by the Board's Enterprise Risk, Audit and Finance Committee (ERAFC), audits Copa's financial statements annually and has never issued anything but a clean, unmodified opinion. The ERAFC governance members meet directly with the external auditors, without accounting staff present, to obtain candid feedback regarding the performance and competency of accounting staff and, without exception, the auditors have been extremely complimentary of the organization's financial accountability.
Integrity and Accountability are two of Copa's six core values that all employees are graded on through annual performance reviews. In addition, Copa's employee handbook outlines a strict code of conduct and behaviors that are mandatory including the expectation of avoiding all fraud, waste or abuse. For those that might be otherwise hesitant to report a concern, Copa subscribes to an independent outside service that allows for anonymous reporting via phone or the internet.

CASS' finance Director is an accountant with more than 30 years of experience in budgets and accounting. Finances are reconciled monthly, and the Board Finance Committee meets to review those records. The Board also reviews all finances at its 6 annual meetings. Agency policies and controls are also set up for checks, balances and controls. This includes funding received which is logged by a separate department before it is deposited by the finance department. CASS will establish a separate deposit account for funding of this program. Additionally, CASS has extensive experience

in managing millions of dollars annually in complex federal and local government funds, including Emergency Solution Grant (ESG) and Community Block Grant (CDBG) funds. CASS' Data Quality Coordinator and Program Director work together to oversee data reports and ensure reports are submitted on a timely basis as required pursuant to contracts. They implement and monitor strategies, policies, and processes to meet contractual requirements and ensure that all reports and documentation are submitted on a timely basis.

4.3.2. Operational funding for the Bridge Facility is available for startup and first two operational years of the project. (See Scope of Work section for complete description of funding) Describe how the Offeror will identify and secure ongoing funding for the program operation after this time. Describe in detail the process to be implemented should the operator be incapable of administering the program or experience a disruption to the continuity of operations. Neither AHCCCS nor ASH, shall be liable for operating the Bridge Facility. How will the Operator ensure participants are appropriately transitioned to another facility or program?

CASS' funding model for this program involves plans to both sustain current programming and grow innovative solutions through our diverse portfolio of funders. CASS intends to continue its work with collaborative funders to achieve this, building on the success of the past 37 years managing complex and multiple governments and private funding sources. More than 50% of CASS' funding comes from these government sources. Private funders, including individual donors, in-kind donations, and fundraising events make up the other half of the CASS budget. Recently, the agency has put a greater focus on private sector fundraising and individual giving. CASS prides itself on being a good steward of foundation, corporate, and individual donations, with 86% of agency funds directly supporting services for those experiencing homelessness. In addition, we are now an AHCCCS provider and will soon pilot services; this additional source of revenue will help us to diversify our funding even further.

The longer-term sustainable revenue plan for the increased operating costs will shift to the following: 1) approximately 33% from local, state, and national government funders; 2) 33% from AHCCCS case management billable services and health care partners who are willing to support CASS for recuperative care for clients discharged from their care; and 3) 33% from private funders.

4.3.3. Does the Offeror anticipate any program income from the Project including any Medicaid revenue sources for services through MCOs/AHCCCS? If so, describe the anticipated activities or reimbursable services to be provided.
Copa has extensive experience billing Medicaid, Medicare and private insurance for services provided to persons with SMI or SMI status in Maricopa County. CASS successfully obtained grants to support its past and current homeless shelters and is in the process of perfecting its Medicaid billing capabilities. Copa and CASS will structure daily Full Time Employee (FTE) deployment to maximize medically necessary engagement and billing to minimize the funding shortfall. If awarded the contract, our two organizations will also work with the state to apply for America Rescue Plan Act (ARPA) funding and other city, county, state, federal and private grants to offset operational deficits.

4.4. Stakeholder Feedback - Describe how the Offeror will coordinate and inform its policies, operations, procedures, and practices based on feedback from Bridge Facility residents or other stakeholders including AHCCCS, MCOs, supportive service providers and/or peers or community advocates.

All stakeholders will be involved in the data samplings and reporting. Interim and final evaluation reports will be provided to participant groups in debriefing forums, to partners' board members, MCOs, supportive service providers, community advocates, and funding agencies.