PERMANENT SUPPORTIVE HOUSING
FIDELITY REPORT

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To: Dr. Shar Najafi-Piper, Chief Executive Officer

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Introduction

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

Method

On May 19 – 22, 2025, Fidelity Specialists completed a review of the Copa Health HOPE PSH program. This review is intended to provide specific feedback in the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in the central region of Arizona.

Copa Health provides a multitude of services throughout the region, including integrated healthcare, permanent supportive housing, residential services, employment related services, day program activities, and counseling, among others, for individuals with intellectual developmental disabilities and/or mental health conditions. Copa Health operates two housing programs, HOPE and SHAPE. The HOPE program provides permanent supportive housing, while SHAPE focuses on housing and employment. This report focuses solely on the HOPE program. The individuals served by the agency are referred to as *members,* but for the purpose of this report, the term *tenant* or *member* will be used. At the time of the review, the HOPE program was serving 33 members.

Due to the system structure of separate treatment providers, information gathered at the Copa Health Metro and Southwest Network Northern Star clinics were included in the review as sample referral sources. Some data obtained reflects services provided by other partner clinics as well.

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

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

- Group program overview via videoconference with the agency Senior Director of Housing Programs, Vice President of Housing and Community Support Services, and Senior Program Manager.
- Individual videoconference interview with the PSH Program Manager.
- Group videoconference interview with two PSH Housing Specialists.
- Group videoconference interview with two Case Managers and one Housing Specialist from Copa Health Metro clinic.
- Group videoconference interview with one Case Manager and the Housing Specialist from Southwest Network Northern Star clinic.
- Individual phone interviews with three members that are participating in the PSH program.
- Closeout discussion with the agency Senior Director of Housing Programs, Vice President of Housing and Community Support Services, and Senior Program Manager; and a representative from the contractor with a Regional Behavioral Health Agreement.
- Review of agency documents including intake procedures, eligibility, and discharge criteria, PSH referral packet, member leases, Program Manager job description, and select agency policies.
- Review of 10 randomly selected member records, including charts of interviewed members/tenants. Remote review of member records from the two partnering clinics, including a sample of co-served members. The sample included members from the following health plans: the contractor with a Regional Behavioral Health Agreement, Arizona Long Term Care, and Other (Medicare, Private, or other source of coverage).

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing (PSH) model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the PSH model along 7 dimensions: Choice of Housing; Functional Separation of Housing and Services; Decent, Safe and Affordable Housing; Housing Integration; Right of Tenants, Access of Housing; and Flexible, Voluntary Services. The PSH Fidelity Scale has 23 program-specific items. Most items are rated on a 4-point scale, ranging from 1 (meaning *not implemented*) to 4 (meaning *fully implemented*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) are rated on a 3-point scale with 2.5 indicating partial implementation. Four items (1.1b,5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

The PSH Fidelity Scale was completed following the review. A copy of the completed scale with comments is attached as part of this report.

Summary and Key Recommendations

The agency demonstrated strengths in the following program areas:

- Tenants are offered a choice of unit within the housing model and may decline units without losing their eligibility. Staff encourage tenants to view properties before signing leases and respect member preferences in unit selection.
- Clear boundaries exist between property management and service provision. PSH staff do not engage in rent collection, lease enforcement, or serving evictions, ensuring that services remain voluntary and tenant rights are protected.
- The program consistently places members in scattered-site units within the general community, with no clustering of individuals

based on disability or program participation.
- Tenants are not required to engage in services to maintain housing. PSH staff clearly communicate that services are optional, and tailor supports to member preferences. Members may disengage without impacting their tenancy.

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

- The PSH program does not retain Housing Quality Standards (HQS) inspection documentation for housed members, including those placed without a subsidy. Implement a protocol to obtain and maintain documentation of HQS or equivalent inspections, either through direct coordination with voucher administrators or by developing an internal checklist for non-subsidized placements.
- Strengthen lease collection and tracking procedures. Require lease documentation at the move-in and develop a follow-up system for outstanding leases. Collaborate with clinical teams to assist in documentation retrieval.
- Enhance coordination between PSH program staff and behavioral health providers to support integrated, team-based care. Establish regular communication protocols and collaborative planning with clinical teams to ensure services are aligned and responsive to tenant needs. When possible, move toward an integrated service delivery model in which housing and behavioral health staff function as a unified team to improve the continuity of member care and outcomes.
- Improve communication about after-hours crisis contacts and availability. Member interviews show limited awareness of after-hours support options.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., recovery home, private landlord apartment)	1, 2.5, or 4 2.5	Clinic staff reported that members are informed of available housing options and are supported in making housing-related decisions. Staff described presenting various types of housing, including conventional apartments and transitional placements. In some instances, treatment-based programs or transitional living programs (TLPs) are discussed based on the member's history (e.g., substance use or no previous experience living independently) but the final housing choice rests with the members. When members first express a need for housing, clinic staff focus on their ability to choose from a range of housing types, ideally including at least one integrated unit in the community. Clinic staff from one location struggled to identify the housing options that are discussed with members, while staff from the other location reported meeting with members to explain the differences between scattered site housing options, community living placement options, and project-based housing. Tenant interviews reflect inconsistency in the implementation of these practices. While some tenants noted that housing types were explained and choices were provided, others described being offered only apartments or being directed to options based on availability or specific eligibility factors such as income or criminal history. A few tenants stated they were not asked about	• Ensure that clinical teams receive ongoing training and education in PSH and *Housing First* principles. Members seeking independent housing benefit from being supported through identification of needs and offering of relevant wraparound supports and resources. • Strengthen coordination with all referring clinics and housing partners to ensure that tenants are routinely informed of all available housing options, not just program-specific or project-based units. Incorporate a standardized housing preference form at intake to document tenant preferences (e.g., location, unit type, roommates, accessibility needs) and use it to guide housing referrals. Provide refresher training to clinic and PSH staff on how to present housing options without steering or imposing readiness criteria.

			preferences such as living in a house versus an apartment.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 4	Interviews with PSH and clinic staff, as well as tenants, indicate that members are offered a choice of unit within the housing model. At one clinic, staff reported that members are presented with multiple unit options and encouraged to view them prior to lease signing. The other clinic described a process in which scattered-site voucher holders work with HOM, Inc. and are supported by a HOM Inc. Occupancy Specialist to select units. Clinic staff confirmed that members are offered choices during this process. For Community Living Placements, units are offered based on availability; members may decline and remain on the waitlist for future placements. PSH staff report facilitating choice by arranging and attending unit tours. While most members referred to the PSH program are seeking independent living options, staff reported choice within CLPs may be limited by location and availability. Several tenants described being given a choice of unit and the ability to decline a unit. One tenant noted the importance of seeing the unit in advance due to concerns with certain property managers. Another tenant highlighted the ability to decline group housing options due to family needs.	
1.1.c	Extent to which tenants can wait for the unit	1 – 4 3	Both clinic and PSH staff reported that members can wait for a preferred housing unit without being penalized or removed from the eligibility list.	• Inform and educate members of their ability to decline housing options without losing position on waitlists.

	of their choice without losing their place on eligibility lists		When members decline a unit, they are permitted to continue their housing search. If additional time is needed, PSH staff collaborate with the clinical team or the voucher administrator to request an extension. The PSH program does not maintain a waitlist. PSH staff indicated members can decline two units before the voucher administrator moves the member to the bottom of the waitlist. Per interviews, the voucher administrator sometimes discourages clinic staff from supporting members declining units, citing uncertainty about when alternative units will become available. Of the three members interviewed, two reported they are on multiple waitlists for low-income properties, and both indicated they have not yet been notified of any available units.	• Work with partners and housing administrators to revise current housing placement practices to align more closely with *Housing First* principles by allowing tenants to wait for a unit of their choice. Removing restrictions such as being moved to the bottom of the list after a set number of units declined supports greater tenant autonomy and promotes long-term housing stability by ensuring individuals can make informed choices about where they live.
1.2 Choice of Living Arrangements				
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 2.5	PSH and clinic staff report that discussions about preferred living arrangements, such as living alone or with a roommate, are ongoing but first occur when members identify housing as a need. Staff make efforts to honor member preferences; however, the final arrangement often depends on unit availability, income level, and eligibility requirements. PSH staff reported that members must obtain approval from the voucher administrator to add individuals to their voucher, typically permitted once annually at renewal. Upon member request, PSH staff can help prepare for upcoming renewals but do not routinely attend renewal meetings.	• Educate tenants on their rights to choose household members and provide guidance on the formal process for adding someone to their lease or voucher. PSH staff should proactively discuss the benefits, risks, and implications of shared housing, including how to navigate landlord or subsidy program requirements, so tenants can make informed decisions. • Optimally, PSH staff attend all lease renewal meetings with tenants to provide support and advocacy as well as assist with the process if the

			Clinic staff reported that when tenants wish to add someone to their household (e.g., a roommate or partner), the voucher administrator seeks input and approval from the clinical team. In some cases, approval may be influenced by staff assessments regarding safety, vulnerability, or risk of exploitation. Tenants currently housed in shared settings often have their own bedroom but do not select their roommates. Several tenants confirm that while they express preferences, they do not always have control over the final household composition. Per the data received, 24 of the members engaged in the PSH program are housed. Of those, approximately 58% live in independent settings and control the composition of their household. The remaining 42% of members reside in halfway homes or with family and/or friends, where they must accept a predetermined household.	tenant desires to add a person to their lease.
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management providers do not have any authority or formal role in providing social services	1, 2.5, or 4 4	PSH and clinic staff confirm a clear functional separation between housing management and service provision. Property managers handle lease enforcement, maintenance, and rent collection, with no involvement from clinical or support services. PSH staff focus on case coordination, treatment planning, and housing support, independent of property decisions. Among housed members, three reside in halfway or supervised housing where some overlap may exist. For all other members, housing	

			management and service delivery remain fully distinct.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Clinical and PSH staff do not engage in rent collection, enforce lease terms, issue warnings or notices, or participate in eviction processes. PSH staff support tenants in maintaining housing stability through case management, coordination with voucher administrators, and assistance with navigating lease responsibilities, but they do not act as enforcers of housing rules.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Both PSH and clinic staff report that social and clinical services are delivered off-site, with no staff based at residential units. Clinical support, including psychiatric and case management services, is accessed through outpatient clinics, maintaining a clear separation between housing and treatment. Approximately 88% of tenants live in settings independent from social service staff. Approximately 12% of tenants live in units where on-site staff may offer supportive services.	
Dimension 3 Decent, Safe and Affordable Housing				
3.1 Housing Affordability				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 2	PSH and clinic staff reported that members with housing vouchers typically pay 30% of their income toward rent. However, staff noted at least one voucher holder is paying 42% of their income, indicating a possible exception. Tenants without subsidies pay significantly more. According to data for 24 housed members, 12 members (50%) are paying 40% or more of their income toward housing. Income-to-rent data was unavailable for 3 members (13%).	• For tenants paying more than 50% of their income toward rent, explore more affordable housing options based on their preference, or discuss ways they can reduce that burden by increasing income, i.e., seeking employment or utilizing community resources. Any housing that costs 50% of a tenant's income is generally considered a financial burden. Some tenants in the program may choose to

			PSH staff explained that some members are placed in market-rate units before subsidies become available. In these cases, affordability becomes a concern, and staff assist members with applying for financial assistance and adjusting their budgets.	maintain this housing due to individual preferences such as being located near family, supports, or employment. • Seek to maintain documentation of rent-to-income data to better support tenants in budgeting as a strategy for housing retention.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Per the data provided, the PSH program does not hold copies of Housing Quality Standards (HQS) inspection reports for housed members. The data indicates that three members are currently housed and have a rental subsidy which requires a current and passing HQS. An additional member was awarded a subsidy but is currently in the housing search process. No HQS inspection documentation is available for any housed members, including those placed without a subsidy. PSH staff reported that housing inspections are typically managed by the voucher administrators (e.g., HOM Inc.), but the program has not retained or verified copies of these inspections. Although PSH staff are not qualified to complete HQS inspections, they assist members with or without vouchers in inspecting their units prior to moving in. When safety or quality issues are identified, staff assist members in reporting them with property management.	• Continue efforts to retain copies of the most recent HQS inspection reports. Establish clear procedures to ensure all tenants in the PSH program, including those in market-rate housing, reside in units that meet safe and decent housing standards. • Consider developing procedures for staff to collect copies of current HQS reports. Work with voucher administrators and other entities to collaboratively share current HQS reports with PSH service providers as a best practice to support tenant self-advocacy and eviction prevention. • Explore options to ensure the safety of tenants units. Some programs train and certify staff to conduct HQS in addition to providing advocacy for maintenance and safety outlined in leases.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				

4.1.a	Extent to which housing units are integrated	1 – 4 4	According to the data provided by PSH staff, the program supports 33 members, with 24 currently housed. Most housed members live independently (54%), with family or friends (33%), and 13% of members reside in halfway or supervised housing settings that may meet disability-related eligibility criteria. Two members are currently housed in the same supervised housing program, which is temporary and not reflective of the broader housing model range seen within the program.	
Dimension 5 Rights of Tenancy				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 1	According to interviews with clinic and PSH staff, most members have leases; however, the extent to which tenants maintain full legal rights of tenancy varies depending on the living arrangements. PSH staff report that members in independent housing typically have lease agreements, but obtaining copies of those leases for documentation purposes remains a challenge. Staff stated that efforts are made to collect lease copies during intake or move-in, and the team collaborates with clinic staff to retrieve missing documentation when possible. Data provided by the PSH program shows that nine leases were obtained from a requested sample of 20, representing 45% of housed members reviewed.	• PSH programs obtain and maintain current copies of leases for 90%, or more, of housed members. Ideally, PSH programs accompany members during new lease signings, and renewals. Work with members to offer support during these times, consequently obtaining a copy of the lease to be used later as a reference when educating tenants on their rights and responsibilities with the intent to maintain stable housing and prevent eviction. • Develop a lease verification checklist and designate PSH staff to conduct regular audits of lease documentation for all housed members. Use these audits to identify gaps which would indicate a need for follow up with members or landlords, and to ensure documentation is current. Include

				lease renewal dates to allow for proactive planning and discussions with tenants. When leases are not available (e.g., informal living situations), implement a standardized housing agreement form to clarify tenancy terms and promote stability.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Based on housing data provided, approximately 88% of members reside in settings where tenancy is not dependent on compliance with program or treatment participation. The remaining members (12%) live in halfway houses or staffed transitional settings where tenancy is contingent on participation and program rules.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	Clinic and PSH staff report that members are not required to complete transitional programs or demonstrate long-term treatment compliance prior to housing placement. Members only need a referral from the clinical team to initiate PSH services. PSH staff report that the program follows a *Housing First* approach, offering housing without preconditions; however, staff were unable to clearly define or articulate what the *Housing First* model entails. Staff at one clinic reported members must be actively engaged in clinical services to be referred for housing. This includes maintaining an open case with the clinic and demonstrating basic follow-through with treatment or housing planning. Staff at another clinic were familiar with the *Housing First* model and denied screening members prior to referral.	• Ideally, PSH staff and system partners collaborate with clinic staff to increase their understanding of the *Housing First* model and how PSH fits in. Assessing members' needs would be an appropriate measure if the purpose was to identify skills and services needed to support the member in being successful in living independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs.

			Clinic records reviewed showed no evidence of formal readiness assessments. Most referrals appeared to occur after clinic staff educated members about the PSH program.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	PSH staff report that referrals are generally processed according to the order in which they were received. While the program supports members with significant housing barriers, there is no formal prioritization system in place. The team does not routinely receive or complete the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT). Additionally, PSH staff are not trained on the VI-SPDAT and do not have access to the Homeless Management Information System, which further limits their ability to systematically identify or track the most vulnerable members. PSH staff report there are 34 referrals waiting to be processed for enrollment into the HOPE or SHAPE housing programs. While there is no formal waitlist, referrals are typically contacted within a week. Intakes are conducted by a single PSH staff, with capacity for up to three intakes per day. PSH staff were unsure how the voucher administrator prioritizes applicants or manages their waitlist process. Staff from both clinics also reported that referrals for members that have difficulty maintaining housing are not prioritized. Staff are encouraged to submit PSH referrals on the same day they are requested, reflecting the same first-come, first-served approach utilized by the PSH program.	• PSH is specifically designed to support individuals with significant behavioral health challenges in living independently in the housing of their choice through a combination of affordability tools and wraparound supports that are available upon request. In the EBP of PSH, individuals that are the most vulnerable to housing instability/homelessness are prioritized for housing supports. • Ensure staff across all referring clinics who assist members with accessing permanent supportive housing and services have an accurate and common understanding of eligibility and prioritization of PSH services. A lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results. • Formalize a procedure to prioritize support for those members/tenants with the most significant housing challenges. This ensures the PSH program itself builds internal consistency in alignment with *Housing First* principles.

			Clinic staff were unaware of how voucher administrators prioritized members.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit	1 – 4 4	PSH and clinic staff report that tenants have control over access to their units. The PSH program does not retain keys to member units and only enters when invited. Staff emphasize that they respect tenant privacy and schedule visits in advance. Approximately 12% of housed members reside in settings such as halfway houses and supervised housing, where tenants may have limited control over staff entry, as facility policies often allow staff access to units.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they want at program entry	1 or 4 4	Clinic staff report that service plans are developed in collaboration with members and are based on their stated needs and goals. Staff confirm that members have the opportunity to provide input during service planning meetings and that plans are updated regularly. The degree of member authorship varies. Some clinic staff describe writing service plans using clinical language and then reviewing them with the member for approval. Based on the clinic member records reviewed, 83% of service plans included goals related to obtaining or maintaining housing. While plans generally reflect members' housing needs, not all are written in the member's voice or directly authored by them. In some cases, plans appear	

			templated or staff-generated, with member participation occurring after the initial draft.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Clinic staff report that members can request changes to their service plans at any time, and staff typically accommodate those requests. Service plans are reviewed at least annually, with updates occurring when members' goals change or new needs arise. However, the timing and frequency of updates often depend on member engagement or staff availability rather than a routine or structured process for offering plan modifications. When these barriers are encountered, plans may remain unchanged even when a member's living situation or priorities have shifted. Clinic records reviewed show that some treatment plans were updated following changes in housing status, but this practice was not consistent across all records reviewed.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 4	PSH staff report that tenants are offered a range of services and may choose whether or not to engage in them. Participation is voluntary, and members are not required to remain enrolled with the clinic or any specific program to retain housing. Staff confirm that tenants can select the supports most relevant to them—such as case management, employment assistance, or independent living skills—and decline others without penalty. Tenants may also choose not to participate in any services, and staff respect this decision; however, members must discharge from the PSH program, with the option to re-enroll at a later date. PSH	

			staff shared examples of members that have disengaged from PSH services after securing housing without any impact on their tenancy. While continued engagement is encouraged, housing is not contingent on participation. PSH service plans reviewed were written in the members' voice and reflected their stated needs. Most plans contained similar goals, indicating limited individualization.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	PSH staff reported that service plans are created at intake and guided by member needs. Members may modify the type, frequency, or intensity of services at any time; however, there is no formal process for regularly reviewing or updating service plans. Revisions to service plans are typically driven by member requests, with the level of engagement by PSH staff adjusting in response to member changes in housing, employment, or behavioral health needs. PSH service plans were present in 100% of the records reviewed. Most plans included goals that aligned with members' current needs; however, at least two members that had been housed since entering the program had an outdated primary goal to obtain housing. Plans showed limited variation across tenants, indicating a degree of standardization rather than individualized support delivery.	• Evaluate the expectation of short-term services within the program. PSH is designed for individuals with significant challenges to housing stability who may benefit from long-term, flexible support. While members should be able to modify services as needed, the absence of a formal process for regularly reviewing and updating service plans may result in outdated or overly standardized goals. Consider implementing periodic check-ins or plan reviews to ensure services remain relevant and individualized. For some tenants, especially those with a history of eviction or chronic homelessness, proactive engagement—even at decreasing intensity—can help sustain housing and prevent crises. • Consider providing additional training to staff on how to engage members to address other areas of vulnerability, concern, or prior issues that led to eviction or homelessness in an effort to support housing retention.

7.3 Consumer-Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 3	PSH staff report prioritizing member preference in service delivery, and two of the PSH staff are peers with lived or living experience who support member engagement. While members are encouraged to provide feedback, formal opportunities for involvement at the program level are limited. Attempts to implement a member forum and advisory council were unsuccessful due to low participation, with barriers such as transportation, childcare, and limited interest. In response, staff implemented a physical survey that is provided to members quarterly.	• Gather input from members on how they would prefer to be involved in program design and implementation. Provide examples of potential avenues in which they can choose to participate, such as serving on subcommittees to the agency board of directors, participating in quality management activities, or other processes that impact service design and provision within the PSH program.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	At the time of the review, 33 members were enrolled in the PSH program. The team consisted of four full-time Housing Specialists, including one on medical leave; and one Program Coordinator, resulting in a member-to-staff ratio of approximately 11:1. PSH staff reported that caseloads are evenly distributed, with Housing Specialists supporting no more than 15 members each. The Program Coordinator does not carry a caseload. The team was actively processing 34 referrals, and staff indicated the ability to complete up to three intakes per day.	
7.4.b	Behavioral health services are team based	1 – 4 2	Services delivered by PSH staff are focused on independent living skills and housing support. The PSH program does not provide clinical services such as psychiatry or substance use treatment; PSH staff refer members to their clinical team or to external supports such as 12-step meetings and	• Identify and address communication barriers between PSH staff and behavioral health providers by soliciting feedback from clinical teams. To strengthen coordination, implement regularly scheduled joint

			coordinate wraparound services upon member request. PSH staff regularly coordinate with clinical teams through weekly or monthly summaries sent by email or fax. Additional communication occurs as needed via email, phone, or virtual staffing. PSH staff report participating in up to three staffing monthly, typically prompted by member non-engagement, potential discharge, or limited progress toward goals. Per interviews, clinic participation in staffing's is inconsistent and varies by clinic; some case managers reportedly do not respond to coordination attempts. The majority (70%) of records reviewed showed evidence of PSH staff coordinating with members' clinical teams at least once monthly, and some (30%) showed more frequent, weekly coordination. In addition, 30% of records showed evidence of PSH staff meeting with or scheduling staffing with clinical teams. Coordination with external partners occurs as needed to support members in meeting their treatment goals. Staff report barriers with system integration, including challenges when members are enrolled in both HOPE and other housing programs, requiring discharges for proper alignment.	staffing's—such as monthly or bi-monthly meetings—to promote shared planning, address member needs proactively, and improve consistency in service delivery. • Explore options of an integrated service plan being developed so that members that receive both clinic and HOPE PSH services from Copa Health have one unified plan. This may result in all involved service staff contributing to the same comprehensive plan. • Obtain input from other service providers when modifying plans when an integrated plan is not an option. Share updated plans when completed. This collaboration may prompt staff to revise member plans at their program when there is a change in status and would raise awareness of member-stated goals.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 2	PSH staff report that services are available Monday through Friday during standard business hours, with occasional flexibility to provide support in the evenings or on weekends depending on staff capacity. Additionally, PSH staff provide after-hours, on-call support. This	• Ensure all members are informed of PSH staff on-call availability. Consider including the hours of PSH staff availability and how to contact staff after hours in the program brochure. In the EBP of PSH, members are able

			responsibility is shared with the agency's SHAPE program and rotates between programs every two weeks. Staff report that members rarely use the on-call line and, as a result, have not had to provide after-hours support. During intake, members are provided with a contact sheet that includes staff contact information and the 24-hour on-call number. Members experiencing a housing crisis after hours may contact the on-call line for assistance with locating an available shelter or bed. Staff noted that crisis plans are developed by members in collaboration with their clinical teams; per interviews, the PSH program does not create a separate crisis plan, but a copy of the clinical team's plan is maintained in the PSH program's electronic health record. Members interviewed were not aware of any after-hours support from the PSH program or the option to receive services on weekends.	to contact program on-call staff as a primary resource in the event of a crisis. PSH staff are better positioned to respond to and support members in the community, including outside of regular business hours, than staff from general crisis lines.

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	2.5
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	3
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		3
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	2
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		1.5
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1

5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.5
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.17
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	4
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	3
7.3.a: Extent to which services are consumer driven	1-4	3
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	2
Average Score for Dimension		3.25
Total Score		21.42
Highest Possible Score		28