PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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Introduction

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

Method

On November 18 – 21, 2024, Fidelity Reviewers completed a review of the Southwest Behavioral and Health Services (SB&H) In-Home Permanent Supportive Housing (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.

SB&H provides a variety of services, including outpatient behavioral health treatment, psychiatric and primary care services, residential housing, intensive inpatient care for individuals in crisis, and supportive housing services. The In-Home PSH team is made up of Behavioral Health Professionals who assist with intake and treatment planning, as well as provide therapeutic services within the PSH program.

Due to the system structure of separate treatment providers, information gathered at the Southwest Network Saguaro and Lifewell Behavioral Wellness Oak outpatient behavioral health provider (clinic) were included in the review as sample referral sources. Some data obtained reflects services provided by other partner clinics, as well. The individuals served through the agency are referred to as *members,* but for the purpose of this report, the term *tenant* or *member* will be used.

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

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

- Individual interview by videoconference with the In-Home PSH Services Program Director.
- Group interview by videoconference with three direct In-Home PSH staff.
- Individual interview by videoconference with one Clinical Coordinator from Southwest Network.
- Group interview by videoconference with one Case Manager and one Housing Specialist from Lifewell Behavioral Wellness.
- Phone interviews with four members that are participating in the PSH program.
- Closeout discussion with In-Home PSH Services Program Director and two representatives from the contractor with a Regional Behavioral Health Agreement.
- Review of agency documents including *In-Home Program Handbook,* program flyers and brochure, Support Safety Plan, team meeting notes, intake procedures, job descriptions, organization chart, policies and procedures, eligibility criteria, member leases and safety inspection documents, and program rules.
- Review of 10 randomly selected member records, including charts of interviewed members/tenants. The sample included members from the following health plan: contractor with a Regional Behavioral Health Agreement.

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 4-point scale with 2.5 indicating partial implementation. Four items (1.1b,5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

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

<u>Summary & Key Recommendations</u>

The agency demonstrated strengths in the following program areas:

- The In-Home PSH tenants confirmed being offered choices in units and did not experience pressure to accept units that did not meet individual needs and preferences.
- Members can individualize service plan goals and modify service plans within the PSH program and their assigned clinics. Services provided by In-Home staff varied by member and appeared to be flexible based on members' changing needs and/or preferences. Service plans were updated every three months in which clinical teams were invited to participate. Services centered around helping members to maintain housing after attainment.
- A noticeable improvement in outpatient behavioral health providers' understanding of *Housing First* principles was noticed during interviews, particularly recognizing that members only need to express a desire for safe and affordable housing to be referred to PSH services. Providers are supporting members in choosing housing options that align with their preferences. To sustain and

enhance this progress, provide ongoing training on the EBP of PSH. Cover all stages of PSH implementation, from referral to housing search, and maintaining housing. Given staff turnover across the behavioral health system, regular training may help preserve knowledge and support new and less experienced clinical staff.
- Members have access to 24/7 support from PSH staff. Staff are available to respond to crises in the community outside regular business hours and can adjust their schedules to meet members' needs.

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

- Ensure documents necessary to support member tenancy and safe housing, i.e., copies of member leases and Housing Quality Standards inspections, are consistently obtained by the program. Establish a reliable practice for gathering and maintaining this information to facilitate easy access and effectively support and advocate for tenants' safe and affordable housing.
- Expand opportunities and strategies to gather and incorporate member input specific to the PSH program design and service provision, as members/tenants currently have limited options to contribute to program planning.
- Behavioral health services are delivered through an integrated team. Improved coordination between the PSH program and other provider clinics could enhance member care, with the opportunity for more flexible scheduling and advance planning of meetings.

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., recovery home, private landlord apartment)	1, 2.5 or 4 4	Based on interviews, members receive support to pursue their preferred housing options. At one clinic, the Housing Specialist position was vacant, leaving the clinical team responsible for meeting with members to assess their housing needs and preferences. Staff at this clinic were not fully aware of all the services provided by a PSH program. Staff assist with completing the Vulnerability Index Service Priority Decision Assistance Tool (VI-SPDAT), applying for low-income housing vouchers and subsidies, providing housing options including an integrated unit, and referring members to PSH programs, emphasizing that the final decision remains with the members. At another clinic, staff reported meeting with members to assess their current situation and needs, explain various housing options including an integrated unit, and provide education on those options. The team may recommend services they believe best suit the members' needs, but they also refer members to PSH programs for additional support, emphasizing that the final decision for housing choice rests with the member. Records reviewed showed that referring partners offered a range of housing options,	

			supported members in selecting their preferred setting, completed PSH program referrals, and assisted with applying to housing voucher waitlists. Members who were referred to the PSH program for housing search reported having the ability to choose among different housing types with one of them being an integrated unit in the community.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 4	PSH staff report that members have the freedom to choose their preferred housing units. PSH staff accompany members to view potential units, and when a member declines a unit, the search continues until they find a suitable option. Clinic staff from both locations confirmed that members are actively involved in selecting their units. One clinic staff shared an example of a member who declined several community living placements and continued searching for a residence. Another staff described assisting a member that requested to move from the third floor to the first floor of their apartment complex. Staff assisted the member by coordinating with the housing voucher administrator and landlord to facilitate the move. Additionally, one member reported that while apartments were limited when utilizing a housing choice voucher, they were still able to decline an unsuitable unit and continue searching for one that aligned with their preferences.	

1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 - 4 4	Both PSH and clinic staff confirmed that members can decline housing options without jeopardizing their eligibility. Members with housing vouchers typically have 30 to 90 days to secure housing. Staff also have the ability to collaborate with the voucher administrator to request extensions and advocate needs on behalf of members.	
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	Members, clinic staff, and PSH staff reported that members have the ability to determine the composition of their household. PSH staff reported that they educate members on the advantages and disadvantages of adding someone to their lease and assist members that choose to go through the process. Staff at one clinic reported voucher administrators will reach out to the clinical team to ask about a potential person the member is requesting to add to the lease for insight and approval. One member shared that they are currently working with PSH staff and the voucher administrator to request a two-bedroom apartment to accommodate a caregiver. According to the data provided, approximately 28% of members participating in the PSH program are in treatment or temporary settings where they do not have control over their household composition, including situations involving shared bedrooms.	• Continue assisting members living in environments where they lack control over household composition in finding independent housing, if that aligns with their personal living goals. • When tenants ask to have someone join their living situation, staff can discuss with the member the pros and cons of adding someone to their living situation. Clinical team approval should not be required, whether or not members receive a subsidy. Empower and advocate for members' self-determination in choosing the composition of their households.
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	Based on interviews with members, PSH and clinic staff, property managers are not involved in delivering clinical or social services to tenants. Of the 32 housed members, 19% reside in settings where there may be an overlap between housing management and other provider staff delivering social services, such as behavioral health residential facilities.	
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 4	Interviews revealed that service providers are not responsible for housing management duties. Clinic and PSH staff stated they do not manage rent collection, eviction processes, or report lease violations.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 - 4 4	Clinic and PSH staff reported they do not have offices at locations where members reside. Approximately 81% of PSH tenants live in settings independent from social service staff and providers. Roughly 19% of members 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 3	Member records reviewed indicate that clinic and PSH staff actively support members in achieving employment goals by assisting with resume writing, sharing upcoming job fairs, and assisting with job applications. Staff expressed that some members fear losing benefits if they start working. To address this, staff utilize the	• For tenants paying more than 50% of income toward rent, explore more affordable housing options based on their preference. Any housing that costs 50% of a tenants' income is generally considered a financial burden. Some tenants in the program

			Disability Benefits 101 website to educate members about the relationship between employment, benefits, and health coverage, enabling them to make informed decisions. Staff also help members complete applications for Social Security benefits, nutrition and utility assistance, food boxes, subsidies, and rental vouchers. Additionally, staff provide guidance on budgeting practices to help manage the rent-to-income ratio. Staff also engage members in discussions about options to make housing more affordable, such as living with a roommate, though many members express a preference for living alone. According to data provided for 32 housed members, 12 members have no rent responsibility reported due to living arrangements with family or friends, residing in residential treatment facilities, receiving vouchers or subsidies, or owning their property outright, e.g., no mortgage. Approximately 41% of members pay more than 30% of their income toward rent with the highest paying 90%.	may choose to maintain this housing due to individual preferences, i.e., near family, supports, or employment. • System partners should continue to collaborate on strategies to expand affordable, community-based housing options, including building and sustaining partnerships with local and state housing authorities and housing developers.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	PSH staff reported accompanying members on new unit walkthroughs upon request, monitoring housing safety and conditions during home visits, and reminding members of upcoming annual home inspections for units requiring a Housing Quality Standards (HQS) inspection. While the PSH program does not have staff designated to perform unit inspections, staff are trained to understand HQS requirements and evaluate all member homes	• Work to ensure that all tenants are housed in units that meet HQS, not just tenants that have a rental subsidy. Develop procedures to ensure market rate units meet HQS. Some programs have trained staff that conduct HQS inspections for the PSH program. Some programs track renewal dates and coordinate in order

			including those without housing subsidy vouchers. The PSH program does not receive copies of all inspection reports. Instead, staff may be notified by voucher administrators about whether a unit has passed or failed inspection and provide assistance as needed. According to the data provided, 41% of housed tenants have a current and passing HQS inspection.	to ensure most recent copies are obtained and to be available to members when concerns arise.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 - 4 3	According to data provided by PSH staff, the program supports 37 members, with 32 currently housed. Most housed members live independently (53%), with family or friends (19%), and 28% of members reside in settings that meet disability-related eligibility criteria.	• Continue efforts toward community integration, ensuring that fewer than 25% of housed PSH tenants reside in units designated for individuals meeting disability-related eligibility criteria.
Dimension 5 Rights of Tenancy				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 1	Interviews with clinic and PSH staff indicate that most members have leases. PSH staff reported that members retain full tenancy rights, particularly those in independent living settings that possess copies of their leases. While PSH staff actively attempt to obtain lease copies from members and seek assistance from the clinical team in this effort, they are not always successful. Staff also discuss and encourage members living with family, friends, or in other arrangements to establish rental agreements, though most members decline. *Meeting notes* from the PSH team further highlighted efforts to	• PSH programs obtain and maintain current copies of leases for 90%, or more, of housed members. Educate members on the benefits of the PSH program maintaining a copy of tenant leases in order to confirm and advocate for tenants' legal rights of tenancy. • Continue efforts to educate members, and their family and friends with whom they reside, of the benefits and protections the written housing agreement may offer. Living with

			promote rental agreements for members in such living situations. Data provided by the PSH program revealed that the agency holds few lease copies, which limits the ability of the program to support tenants when notices or lease violations occur. Approximately 42% of members have a current lease on file with the PSH agency.	family/friends does not guarantee rights of tenancy. • Consider tracking lease term end dates. PSH staff can then plan with tenants to accompany lease renewals and provide support to understand responsibilities and lease conditions with the intention to maintain stable housing and prevent eviction.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Based on housing data provided, approximately 78% of PSH members reside in settings where tenancy is not contingent on compliance with program provisions.	
Dimension 6 **Access to Housing**				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 - 4 4	PSH staff confirmed the use of a *Housing First* approach, emphasizing that there are no additional entry requirements for the PSH program beyond a referral from a provider clinic. Staff reported accepting all referrals and tailoring services to meet the identified needs of each member. Members can also self-refer to the program, with the PSH team coordinating with their clinical providers to complete a referral packet. Staff at one clinic emphasized that no matter a member's challenges, they deserve access to housing. They assist with housing applications based on member interests and ensure members receive education and options tailored to their needs and preferences. Members are	

			not required to demonstrate readiness to obtain housing. Records showed that clinic staff made referrals promptly, with no readiness requirements for members. Intake times varied from three to thirty days after referral.	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 4	According to interviews, PSH services are available to members based on their individualized needs. One clinical staff described prioritizing safety and shelter, reflecting a hierarchy of needs approach and affirming members' rights to housing. For members referred during a crisis—such as those experiencing frequent hospitalizations due to homelessness, facing expiring vouchers, or at risk of losing their housing—PSH staff prioritize scheduling an intake immediately and work with these members several times a week to address their urgent needs. The PSH program paused accepting referrals for approximately six months before the review due to staff turnover. During this time, the team assisted in connecting referred members to other PSH programs in the area without waitlists. At the time of the review, the agency had resumed accepting referrals and had not maintained a waitlist for one month.	
6.2 Privacy				
6.2.a	Extent to which tenants control staff	1 - 4 4	Clinic and PSH staff confirmed that tenants have control over access to their units. According to interviews, staff schedule home visits with	

	entry into the unit		members and do not enter the units without permission. In cases where staff are unable to connect with members and are concerned for their safety, they will contact the clinical team and the member's emergency contact. As a last resort, staff may request a wellness check through the landlord/property management office or law enforcement. Members interviewed confirmed that staff cannot enter their units without their consent. Most housed members live independently, either on their own or with family or friends. Approximately 19% of members reside in settings where staff affiliated with the residence may have varying levels of access, such as residential treatment facilities.	
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	PSH and clinic staff reported that members can select the services they wish to receive upon entering the program through their clinic. Members interviewed stated they choose their goals and services and actively collaborate with clinic staff to develop their service plans. A review of member records revealed that clinic service plans included living goals, with most plans written in the members’ voice.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Staff at one clinic reported updating service plans annually or when members request to add or remove services. Staff at the other clinic stated that service plans are updated every six months or as needed to reflect changes in services. Both clinics affirmed that a common	

			challenge in updating service plans is meeting with members to complete plans. One clinic indicated that service plans can be completed over the phone or via videoconference; however, a signature must be obtained from the member within 72 hours. When the signature is not received within this time frame, the service plan must be redone. Members interviewed confirmed that they can modify their service plans with the clinic as their goals evolve.	
7.2 Service Options				
7.2.a	Extent to which tenants are able to choose the services they receive	1 - 4 4	PSH staff reported that services are individualized to each member's needs, such as maintaining or securing housing, with no standard service package. Following a PSH referral, staff conduct intakes and assessments to identify member needs and accompanying services. Following the intake, service plans are updated every three months or sooner as goals change. Members choose the type and location of services, with staff reporting that 90% of their time is in the community delivering member services at locations like members residences, libraries, or parks. For members without income, staff assist with applications for housing vouchers and subsidies, facilitate community referrals, help obtain vital records, and provide employment support when that aligns with the member's goals. Reviewed records highlighted diverse supports, including	

			transporting and assisting members with housing applications, delivering food boxes, assisting the member with accessing community resources (e.g., service animal applications or legal resources), coordinating with outside agencies (e.g., pest control, internet subsidy programs), and supporting members' daily living and health (e.g., accessing vital records or scheduling and attending medical appointments). Members can opt out of services after securing housing without losing eligibility. Housing vouchers are not tied to service participation. Members interviewed confirmed they could decline behavioral health services post-housing.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 - 4 4	PSH staff reported that members can stay in the program as long as they choose to receive services. Member interviews revealed that two individuals received ongoing support from PSH staff to maintain housing after securing it through the program, while another member, already housed at referral, was supported in sustaining their housing. One long-term member is currently working with PSH staff to relocate to a safer apartment. Records showed that PSH service plans are updated every three months. These plans outline services tailored to the member's current situation, such as housing searches or maintenance, and prioritize individual needs and preferences. They also include strategies for program support aligned with the intake process and ongoing member goals.	
7.3 Consumer-Driven Services				

7.3.a	Extent to which services are consumer driven	1 - 4 2	PSH staff reported that a member forum was not in place at the time of the review due to limited staff capacity and low demand from members to reinstate. PSH staff indicated that an agency-wide satisfaction survey is conducted quarterly to gather member feedback, but there is no satisfaction survey specific to the In-Home PSH program. Staff also reported having at least one peer on the team who can advocate from a peer perspective. Members interviewed expressed little or no awareness of a satisfaction survey. One-member shared feeling heard when communicating directly with PSH staff about their questions and feedback but noted the absence of a formal mechanism for providing input.	• Offer members a formal opportunity that allows them to anonymously submit questions, concerns, and suggestions for program design and service provision. • Consider options to facilitate member/tenant forums using videoconference and/or conference calls so that members can voice their concerns and desires for program design. • Consider revising the agency satisfaction survey to include housing specific items. Consultation with other PSH providers on survey formats may be helpful.
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, the team consisted of six full-time PSH direct staff. PSH staff reported serving both SMI and General Mental Health (GMH) members, with a total of 62 members currently in the program. The overall member-to-staff ratio, including GMH members, averaged approximately 11:1. One staff member reported managing a caseload of 20 members due to staff turnover, while another had 17. Three new PSH direct staff have been hired in the past month and are gradually building their caseloads.	
7.4.b	Behavioral health services are team based	1 - 4 2	PSH staff reported that in addition to housing services, members receive external support such as counseling and psychiatric services through their clinic or from the SB&H outpatient clinic. PSH staff collaborate with clinical teams by inviting them to participate in intakes and	• Ideally, all behavioral health services are delivered through an integrated team. Separate providers create barriers to integration, such as distinct intake processes, different electronic record systems, and redundancy in

			quarterly staffing meetings for shared members to review and update service plan goals. When case managers cannot attend, service plans are sent to the clinical team for review, signed, and then returned. PSH staff also maintain regular contact with clinical teams to provide updates on members' progress or to seek assistance when members cannot be reached. Communication methods include email, phone, or in-person visits to the clinic. Staff at one clinic indicated that SB&H staff invite them to intakes and staffings but are sometimes inflexible with scheduling, occasionally providing only one or two-day notice, which makes it challenging to attend. Staff at the other clinic confirmed receiving invitations for intakes and staffing meetings, as well as outreach for care coordination. Records reviewed showed evidence of PSH staff coordinating with members' case managers, including inviting them to intakes or staffing meetings, contacting housing voucher administrators, collaborating with therapists, and sharing communication forms with primary care physicians.	information collection and record-keeping. Consider scheduling regular planning sessions in advance between the PSH provider and clinic staff to improve coordination of member care. For example, during intake, schedule the next three-month service plan update, followed by the subsequent update after the next staffing.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 - 4 4	According to PSH staff and the *In-Home Program Handbook*, services are available Monday through Friday from 8 a.m. to 5 p.m., with on-call or emergency support available during evenings and weekends. Staff reported rotating on-call assignments every two weeks, with supervisory staff always available to assist with on-call needs. Members are informed about on-call services during intake, through the program	

			handbook, and when reviewing their safety plans with staff. Staff reported working staggered hours to offer flexibility to members. For instance, some staff volunteer to adjust their schedules to provide services from 10 a.m. to 6 p.m. for members needing later appointments. Members interviewed expressed awareness of the program's on-call services. One-member shared feeling comfortable reaching out to staff outside of business hours, even for non-emergencies, stating that staff consistently responded.	

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	4
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		3.6
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	3
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	3
Average Score for Dimension		3
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		2.50
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	4
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	4
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		4
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	4
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	4
Average Score for Dimension		3.50
Total Score		22.60
Highest Possible Score		28