**PERMANENT SUPPORTIVE HOUSING (PSH)**
**FIDELITY REPORT**

Date: January 3, 2025

To: David Covington, Chief Executive Officer & President
Veannisa Rico – Arizona Housing Program Director

From: Kristy Crawford, MA, MBA
Allison Treu, BS
AHCCCS Fidelity Reviewers

## 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 Recovery Innovations (RI) International Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

RI International is a global organization specializing in behavioral health services, focusing on recovery-oriented programs for individuals with mental health and substance use challenges. Serving diverse communities, the agency offers a wide range of services, including crisis stabilization, peer support, and permanent supportive housing, emphasizing member empowerment and collaboration.

The individuals served through the agency are referred to as *clients,* but for the purpose of this report, the term *tenant* or *member* will be used. At the time of the review, the program was serving 48 members.

Due to the system structure of separate treatment providers, information gathered at the Copa Health West Valley and Southwest Behavioral Health Services Buckeye outpatient behavioral health provider sites (clinics) were included in the review as sample referral sources. However, some data obtained reflects services provided by other partner clinics as well.

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

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

- Group Interview with agency Program Director and Vice President Outpatient Operations.
- Interview with the PSH Program Supervisor.
- Group interview with three PSH direct service staff.
- Group interview with three Case Managers from Southwest Behavioral Health Services clinic, two Case Managers and the Housing Specialist from Copa Health West Valley clinic.
- Interviews with five members that are participating in the PSH program.
- Closeout discussion with the Program Director, Vice President Outpatient Operations, and Program Supervisor.
- Review of agency documents including intake procedures, eligibility criteria, program rules, program brochure, member leases, and evidence of team coordination.
- Review of 10 randomly selected member records. The sample included members from the following health plans: the contractor with a Regional Behavioral Health Agreement, and Arizona Long Term Care.

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. The degree of fidelity to the PSH model is assessed 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.

**Summary & Key Recommendations**

The agency demonstrated strengths in the following program areas:

- Exploration of Tenant Preferences: Program members report having the ability to choose desired services and service intensity. PSH tenants are offered choices in housing and do not experience pressure to accept units that do not meet individual needs and preferences.
- Integrated Housing: The PSH program assists members in securing scattered-site housing that is fully integrated within the community.
- Tenancy Rights: Members maintain full rights to their housing, and tenancy is not contingent upon engagement in clinical services.
- Service Options: Members are able to individualize service plan goals and modify service plans within the PSH program and their assigned clinics. Services provided by RI staff varied by member and seemed to be flexible based on members' changing needs

and/or preferences

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

- Housing Quality Standards (HQS): Ensure all housing units, including market-rate units, meet HQS standards. Consider implementing procedures for HQS inspections, with trained staff conducting inspections for the PSH program. Track renewal dates and maintain updated records to address member concerns promptly.
- Collaboration and Housing First Model: Collaborate with clinic staff to enhance understanding of the Housing First model and the role of PSH. Align needs assessments to identify skills and services that support independent living, with referrals based on members' preferences for safe, affordable housing.
- Prioritization Process: The PSH program should formalize a procedure to prioritize support for those members/tenants with the most significant housing challenges.
- Caseload Sizes: Ideally, the ratio of members/tenants to service staff is no more than 15:1. With the current program structure of a Housing Specialist with primary duties of managing housing searches, and tenancy documents, a fourth service staff seems necessary to achieve the ideal member to staff ratio.
- Behavioral Health Services are Team Based: Ideally, PSH services are provided in collaboration with outpatient behavioral health clinics. The treatment model followed by Assertive Community Treatment is a good example of how PSH services can be integrated into a member's treatment team. Collaborate with system partners to create a culture of providers that coordinate on behalf of members rather than operating in silos.

PSH FIDELITY SCALE

| Item # | Item | Rating | Rating Rationale | Recommendations |
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| **Dimension 1<br>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<br><br>4 | Members are offered a choice in housing type and location, as reported by both clinic and PSH staff. Clinic staff engage in open discussions about housing preferences, inform members of available options, and assist with housing searches and applications, including subsidy programs to expand choices. Members confirmed they are supported in finding housing that aligns with their preferences. No housing readiness requirements or referrals for PSH are needed to access assistance. | |
| 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<br><br>4 | Based on interviews with PSH staff, clinic staff, and members, members have a choice of unit within the housing model including community living placement (CLP) locations. At PSH intake, members share their ideal housing situation, and staff base the housing search on these preferences, emphasizing tenant choice as a core principle. Members view units before committing and can decline options. Constraints imposed by market factors include high rental prices, low income, criminal backgrounds, and landlords' willingness to work with housing programs. PSH staff advocate for members and ultimately, members retain the freedom to wait for a preferred unit or proceed with available options. | |
| 1.1.c | Extent to which tenants can wait for | 1 – 4<br><br>4 | PSH staff reported that members can decline housing options offered and that the program will continue to assist them. PSH staff report | |

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| | the unit of their choice without losing their place on eligibility lists | | members. can wait for a preferred unit without losing eligibility. The PSH program does not maintain a waitlist.<br><br>Members with a housing voucher can decline units without losing their housing subsidy voucher, and PSH staff assist members with continued housing search. The eligibility lists for subsidized housing prioritizes members based on the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT). | |
| **1.2 Choice of Living Arrangements** | | | | |
| 1.2.a | Extent to which tenants control the composition of their household | 1, 2.5, or 4<br><br>4 | Members control the composition of their household. Members decide whether to live alone, add household members, or have roommates. PSH staff reported educating members on potential barriers of adding household members to leases such as landlords requiring background and financial checks for additional household members. In cases such as live-in aides, the PSH program collaborates with HOM Inc., the voucher administrator, and clinical providers to secure necessary approvals. | |
| **Dimension 2**<br>**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<br><br>4 | Tenants, clinic staff, and PSH staff stated that housing management and landlords have no authority or role in delivering clinical or social services to members. | |

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| 2.1.b | Extent to which service providers do not have any responsibility for housing management functions | 1, 2.5, or 4<br><br>4 | PSH staff and clinic staff report having no responsibility for collecting rent, enforcing lease requirements, serving evictions, or other housing management functions. PSH staff support members by offering assistance if issues arise by facilitating communication with landlords. Per staff they follow the SAMHSA model, maintaining a clear separation of property management, housing support, and clinical services. | |
| 2.1.c | Extent to which social and clinical service providers are based off site (not at the housing units) | 1 – 4<br><br>4 | Clinic and PSH staff reported that social and clinical service providers are based off-site. Agency, and other service providers, do not maintain offices, workspaces, or conduct group activities at residential complexes. PSH services are mobile and are brought to members' homes at their request. Members receive services through outpatient behavioral health clinics and other providers located away from their residences. | |
| **Dimension 3**<br>**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<br><br>4 | PSH and clinic staff work collaboratively to help members understand the cost of living, provide budgeting support. Members with housing vouchers typically pay 30% of their income toward rent. Of the data provided the average reported percentage was 29.53%. Data showed members without vouchers may pay significantly more, such as one member using 80-90% of income for rent. Staff expressed concerns about the challenges of finding affordable housing, even for those with vouchers. | |

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| **3.2 Safety and Quality** | | | | |
| 3.2.a | Whether housing meets HUD's Housing Quality Standards | 1, 2.5, or 4<br><br>2.5 | PSH staff assist members with addressing issues that may prevent HQS compliance, including assisting with maintenance requests. Staff expressed commitment to helping members maintain HQS compliance to retain their housing stability. For example, a member with hoarding who refused to engage with both the clinical team and PSH staff, had their voucher forfeited despite extensive support from both teams.<br><br>Data provided to reviewers showed that 79% of housed members had current and passing Housing Quality Standards (HQS) inspection reports. HQS inspections for six tenants were expired or not located in the records provided. PSH staff reported that members who do not hold housing subsidy vouchers do not receive HQS inspections. | • Work to ensure that all tenants are housed in units that meet HQS, not just tenants that have a rental subsidy. Develop procedures to ensure market rate units meet HQS. Some programs have trained staff that conduct HQS inspections for the PSH program. Some programs track renewal dates and coordinate in order to ensure most recent copies are obtained and to be available to members when concerns arise.<br>• 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. |
| **Dimension 4**<br>**4.1 Housing Integration** | | | | |
| **4.1 Community Integration** | | | | |
| 4.1.a | Extent to which housing units are integrated | 1 – 4<br><br>4 | Based on data provided, housing units are spread throughout the community, with members integrated and scattered across various locations. Units are not clustered. Per data, one member is in a unit set aside for people meeting disability related eligibility criteria. Staff prioritize member choice, assisting with applications, searching for housing within budget limits, and accompanying members to view potential units. | |
| **Dimension 5**<br>**Rights of Tenancy** | | | | |
| **5.1 Tenant Rights** | | | | |

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| 5.1.a | Extent to which tenants have legal rights to the housing unit | 1 or 4<br><br>4 | According to members, PSH providers, and clinic staff, members have full legal rights to their housing units. PSH staff assist members with lease signing and ensure they obtain copies of their leases. Leases are securely stored in paper files, separate from the electronic health record (EHR) system, and contain standard provisions consistent with typical tenancy agreements. | |
| 5.1.b | Extent to which tenancy is contingent on compliance with program provisions | 1, 2.5, or 4<br><br>4 | Based on housing data provided, less than 4% of tenants reside in settings in which tenancy is contingent on compliance with program provisions. Members reported having no additional rules beyond those outlined in their leases, which typically include standard conditions such as prohibiting violence, criminal activity, drug use, and domestic violence. For example, one member noted that their lease includes quarterly inspections conducted by a private landlord, while another shared that household income restrictions apply to their lease. PSH staff assist this tenant in understanding and following these specific terms. | |
| **Dimension 6<br>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<br><br>3 | PSH staff reported utilizing the *Housing First* approach. Members are not required to demonstrate housing readiness to access housing. Housing support is provided without preconditions. Eligibility for housing choice vouchers is based on AHCCCS enrollment, an SMI designation, and a VI-SPDAT score of 8 or higher, reflecting higher needs such as frequent incarceration, hospitalizations, or homelessness. | • Provide training to clinical teams to avoid imposition of housing readiness criteria and instead provide members seeking housing with information on how to access available housing options, including independent housing.<br>• 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 |

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| | | | Clinical teams noted that while sobriety is not a requirement, it is highly encouraged as it may affect housing stability under Section 8 voucher rules. Members are also encouraged to maintain medication compliance and attend scheduled appointments. Lack of income is not a barrier to accessing housing, although it may limit immediate availability. Shared housing programs may require members to demonstrate some level of readiness. | members' needs would be an appropriate measure if the purpose were to identify skills and services needed to support the member in being successful in living independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs. |
| 6.1.b | Extent to which tenants with obstacles to housing stability have priority | 1, 2.5, or 4<br><br>2.5 | PSH and clinic staff report members with obstacles to housing stability are systemically prioritized using the VI-SPDAT tool which assesses vulnerability and need.<br><br>PSH staff report that while referrals and VI-SPDAT scores are needed for services, individual member appointments are scheduled based on first come first served. Staff work to address challenges by ensuring members feel validated, respected, and supported, emphasizing clear communication and honoring commitments to maintain trust.<br><br>Clinic staff reported prioritization for members with housing obstacles depending on factors like housing type, sobriety requirements, and member engagement. VI-SPDAT scores guide urgency, but first-come, first-served practices and appointment attendance often influence support. Members with severe needs, such as grave medical concerns, have been prioritized in the past and housed within 60 days, demonstrating responsiveness to critical cases. | • PSH is specifically designed to support individuals with significant behavioral health challenges in living independently in the housing of their choice through a combination of affordability tools and wrap around supports that are available upon request. In the EBP of PSH, individuals that are the most vulnerable to housing instability/homelessness are prioritized for housing supports.<br>• Ensure that clinic staff assisting members with accessing permanent supportive housing and services across all provider clinics have a common and accurate understanding of eligibility and prioritization for PSH services. Lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results.<br>• Formalize a procedure to prioritize support for those members/tenants with the most significant housing challenges. |
| **6.2 Privacy** | | | | |

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| 6.2.a | Extent to which tenants control staff entry into the unit | 1 – 4<br><br>4 | Members maintain full control over staff entry into their units. Staff do not hold keys and must be invited in by the members. For members who are unreachable, staff coordinate with clinical teams, emergency contacts, and landlords. In cases such as inpatient stays, staff assist in creating safety plans for issues like unattended pets. Well-being checks are conducted in collaboration with clinical teams and non-emergency services as needed, as outlined in the members' welcome agreement. | |
| **Dimension 7**<br>**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<br><br>4 | Staff from both clinics reported that members are the primary authors of their service plans and have the option to choose the services they want at program entry. Core services including psychiatric evaluations and case management are required as well as a referral from a clinic to access the PSH program. Staff provide service options, empowering members to select services based on their preferences and needs.<br><br>A review of 10 member records revealed that two members had specific housing goals included in their clinic service plans, both articulated in the members' own words. Members interviewed reported having flexible options of services with their respective clinics. | |
| 7.1.b | Extent to which tenants have the opportunity to | 1 or 4<br><br>4 | Clinic staff report members can modify their service selection at any time. Service plans are typically updated annually or mid-year, but modifications can occur as needed. Barriers to timely updates include missed appointments | |

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| | modify service selection | | and challenges in accessing individual or specialty counseling. | |
| | | | **7.2 Service Options** | |
| 7.2.a | Extent to which tenants are able to choose the services they receive | 1 – 4<br><br>4 | PSH staff report members have the flexibility to choose the services they receive, including the option to decline services entirely. The PSH program and housing voucher administrators do not mandate service levels. Members can self-refer and opt out of clinical services after being housed. PSH service plans reviewed were unique and individualized to the needs of each member.<br><br>Of the member records reviewed, six contained current service plans, while service plans for four members could not be found. | |
| 7.2.b | Extent to which services can be changed to meet tenants' changing needs and preferences | 1 – 4<br><br>4 | PSH services are flexible and tailored to meet members' changing needs and preferences. There is no standard service package; instead, services are based on the members' treatment plan and can be revised as often as needed, with annual updates required. Members can choose and adjust services, which may include housing searches, independent living skills, budgeting, and transportation support. Some members choose in-person services, while others desire supports delivered by phone. The PSH program emphasizes independence, working with members on discharge planning and goal setting as service intensity decreases. Some members take advantage of additional services at RI, such as group counseling or intensive outpatient programs, are available through the larger agency. Members can remain connected to PSH services for as long as they need or desire support. | |

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| | | | One record reviewed focused solely on wellness and healthy eating skills, with no mention of housing-related services. In contrast, other records included independent living skills such as communicating with property managers about lease violations, budgeting assistance for members behind on rent, peer support to encourage community engagement, home visits, and phone check-ins for members established in their homes. | |
| **7.3 Consumer- Driven Services** | | | | |
| 7.3.a | Extent to which services are consumer driven | 1 – 4<br><br>2 | While member input and feedback is gathered through satisfaction surveys, suggestion boxes, and town hall meetings, these are agency wide and not specific to PSH program participants. PSH staff will assist members with grievances and complaints by documenting concerns and providing relevant contact information. Staff and members denied program specific opportunities for formal feedback. | • Explore opportunities that allow tenant/member input on service design and service provision. Member input can be obtained in many ways, such as interviews by peers and involvement in quality assurance activities, and information gathered is then used to inform service design decisions<br>• Consider creating a survey specific to members enrolled in the PSHS program. Some programs deliver these to members during community visits and provide a sealable envelope to support participation with the assurance of anonymity. 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<br><br>3 | The program has a maximum capacity of 60 members with 48 currently enrolled. The team is comprised of one Peer Support Specialist (PSS), Behavioral Health Technician (BHT), Housing Specialist, and Program Supervisor.<br><br>Per staff, the Housing Specialist oversees safe and supportive housing for all members and | • Hire staff to provide adequate member coverage of changing needs and to be readily available. The optimum caseload size for PSH service providers is 15 members to every staff, providing flexibility and responsiveness to support members in retaining housing. |

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| | | | supports the entire agency. They also serve as the primary contact for community partners and clinics, while resolving housing-related issues. The BHT reports their main responsibility is care plan updates, assessments, and biopsychosocial evaluations to ensure members' needs are met. The PSS provides community-based support and resources and facilitates engaging independent living skills activities. Despite having one vacancy on the team, staff share documentation responsibilities and maintain an average caseload of 20 members. | • Consider realigning positions such that staff are focused on the PSH program member participants, rather than split across other programs and responsibilities. |
| 7.4.b | Behavioral health services are team based | 1 – 4<br><br>2 | Individual service providers are primarily responsible for behavioral health services. Clinical teams interviewed report that coordination with the PSH provider is minimal. Clinics handle psychiatric services, housing referrals, and case management support, while PSH staff collaborate with clinics to support member needs using tools like Health Information Exchange (HIE) alerts for timely communication. Coordination occurs through phone, email, messaging platforms, and in-person meetings, with the frequency and method tailored to member needs. There are no routine summaries provided to clinical teams. Within the PSH program, all staff can teach independent living skills (ILS), engage in peer support, and lead curriculum-based groups such as the Wellness Group. During intake to the PSH program, members determine contact frequency. Critical situations such as hospitalizations involve coordination with clinical teams to ensure continuity of care. | • Obtain input from other service providers when modifying service plans when an integrated plan is not an option. Share updated plans when completed. This collaboration may prompt staff to revise member plans within their program when there is a change in status and raise awareness of member stated goals.<br>• To more closely align with the EBP, consider scheduling regular planning sessions between the PSH provider and clinic staff to coordinate member care, supporting an integrated treatment team approach. Soliciting input and sharing updated service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented. |
| 7.4.c | Extent to which services | 1 – 4 | PSH staff report services are primarily available Monday through Friday from 8:00 AM to 4:30 | • Ideally, PSH services are available 24 hours a day, seven days a week, including the |

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| | are provided 24 hours, 7 days a week | 2 | PM. Members can access after-hours support through the 24/7 Recovery Connections Line, staffed by non-PSH program personnel. While staff are available after hours and weekends with supervisor approval, such accommodations are rare. Many members also have direct contact information for staff, who can flex hours or provide additional support as needed for situational concerns.<br><br>Members interviewed were unaware of the after-hours support available to them through the Recovery Connections Line. However, members reported being able to schedule weekend or after-hours support if needed with staff. | ability to respond to members in the community after normal business hours. PSH staff may be better positioned to respond to and support members in the community outside of regular business hours than a mobile crisis team or clinical team. |

**PSH FIDELITY SCALE SCORE SHEET**

| 1. Choice of Housing | Range | Score |
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| 1.1.a: Tenants have choice of type of housing | 1,2.5,4 | 4 |
| 1.1.b: Real choice of housing unit | 1,4 | 4 |
| 1.1.c: Tenant can wait without losing their place in line | 1-4 | 4 |
| 1.2.a: Tenants have control over composition of household | 1,2.5,4 | 4 |
| Average Score for Dimension | | 4 |
| 2. Functional Separation of Housing and Services | | |
| 2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services | 1,2.5,4 | 4 |
| 2.1.b: Extent to which service providers do not have any responsibility for housing management functions | 1,2.5,4 | 4 |
| 2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units) | 1-4 | 4 |
| Average Score for Dimension | | 4 |
| 3. Decent, Safe and Affordable Housing | | |
| 3.1.a: Extent to which tenants pay a reasonable amount of their income for housing | 1-4 | 4 |
| 3.2.a: Whether housing meets HUD's Housing Quality Standards | 1,2.5,4 | 2.5 |
| Average Score for Dimension | | 3.25 |
| 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 | 4 |

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| 5.1.b: Extent to which tenancy is contingent on compliance with program provisions | 1,2.5,4 | 4 |
| Average Score for Dimension | | 4 |
| 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 | | 3.16 |
| 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 | 3 |
| 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 | | 3.13 |
| **Total Score** | | 25.54 |

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| **Highest Possible Score** | | 28 |