Section A: Arizona has a total area of 113,998 square miles, making it the 6th largest state in the United States. Arizona is divided into 15 counties, about one-quarter of the state is made up of Indian reservations that serve as the home to 22 federally recognized Native American tribes, including the Navajo Nation. On April 4, 2020, Governor Douglas A. Ducey, announced that President Trump in coordination with the Federal Emergency Management Agency (FEMA) approved Arizona's request for a Presidential Major Declaration for the State.

	Population*	Average of Persons Below Poverty Level**	Median Household Income	Percent Elderly (Over 65yrs)*	Percent Disabled (Under 65 yrs)*	Percent Pre-Disaster Unemployment*
National	308,745,538	12.3%	$55,322	16%	8.6%	4.0%
Arizona	7,278,717	14%	$56,213	17.5%	8.6%	4.9%

* US Census Quick Facts Arizona 2014-2018 and Vintage Population Estimates for July 1, 2019.
**Arizona Department of Economic Security

The Arizona Department of Health Services has confirmed, as of April 8, 2020 there have been 2,726 confirmed cases of COVID-19 in the State of Arizona, of which 80 people have died. The confirmed COVID-19 cases by age group are less than 20 years old (83); 20-44 years old (980), 45-54 years old (513), 65-64 years old (475), 65 years and older (670), and unknown (5). These numbers are anticipated to continue to grow as the disease spreads. Also, the COVID-19 pandemic has affected all fifteen of our counties and eighteen of twenty-two Tribal Nations.

The COVID-19 pandemic has, and continues to cause, unprecedented disruption of normal community functions and services including disruption to, and an increased demand for, medical services, supplies and equipment; disruptions to and an increased demand for essential community services; and threats to the health and safety to all Arizonans. The health emergency has also caused loss of employment, risk of losing homes, cars and other items. The Arizona Department of Economic Security reported the week of March 24, 2020, approximately 75,000 unemployment applications were received for one week. The average number received prior to COVID-19 was 3,000 per week.

In 2018, the Arizona Health Care Cost Containment System (AHCCCS) conducted a statewide substance abuse prevention needs assessment to develop, evaluate, and plan substance abuse activities statewide. Major findings included an increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse. Barriers to treatment include the lack of appropriate/available treatment (e.g. long waiting lists or lack of services in underfunded regions), stigma associated with accessing treatment, the cost and complexity of receiving treatment, and the reduction of mental health services and supports in schools and universities across the State. Suicide rates in Arizona are significantly higher than the national average, which bolsters the finding, that the mental health needs of our State require enhanced support (AHCCCS, 2018). An additional major finding was a lack of social support and/or someone to turn to/talk to is a protective factor for substance use

and/or misuse to which many Arizonans do not have access. Increasing social isolation was a repeated theme across all regions and subpopulations (AHCCCS, 2018).

Data that informed the needs assessment included data from the 2015-2016 National Survey of Drug Use and Health (NSDUH), which estimated the prevalence of past year major depressive disorder (MDE) and serious mental illness (SMI). In Arizona, an estimated 310,000 (6.0%) of the adult population 18 or older experienced past year MDE and 208,000 (4.0%) of the adult population met the criteria for SMI. According to data from the NSDUH, the prevalence of MDE peaked for those aged 12 to 17, with an estimated 11.7% of youth reporting past year MDE. The 2017 Youth Risk Behavior Survey (YRBS) also estimated the percentage of high school students that "felt sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities, during the 12 months before the survey." According to these data, high school students in Arizona were significantly more likely to report poor mental health than youth nationally (36.4% vs 31.5%). As of March 1, 2020, there were 1,517,228 individuals in Arizona diagnosed with SMI who were currently enrolled in AHCCCS care plans. (AHCCCS, 2020).

The **Population of Focus** (POF) is individuals with a Serious Mental Illness (SMI), individuals with Substance Use Disorder (SUD), and/or individuals with co-occurring SMI and SUDs. Additionally, the program will also focus on meeting the needs of individuals with mental health disorders that are less severe than SMI, including those in the healthcare profession and their families throughout the State of Arizona affected by COVID-19.

B1: The overarching goal of the Arizona Emergency COVID-19 Project is to address the increased need for substance abuse, mental health, and crisis support services to Arizonans that have been impacted by the COVID-19 pandemic. The first phase of the project will be a planning phase to inventory resources available to Arizonans, which will include the Emergency COVID-19 funding, to ensure service gaps, barriers, and potential overlap has been addressed before project implementation. This step is one of the most important steps to ensure available resources are being coordinated appropriately to address the substance use and mental health needs cohesively in the state. While Arizona is able to address immediate needs that are occurring system wide utilizing existing resources, a coordinated approach will allow the state to engage in long term planning utilizing information and data provided by other state agencies or entities, and state stakeholders that are also involved in addressing the impacts from COVID-19.

Once planning has been concluded, Arizona will be in a in better place to address identified priorities with these funds, which may include, but is not limited to, the following items:

- Increase infrastructure of current crisis services (e.g. crisis phone lines) in Arizona through adding additional treatment services and/or infrastructure to address the increased need for services,
- Assess the need of telehealth/teleconference software to address the needs of the target populations,
- Deliver recovery support services, including rapid re-housing, to improve access to, and retention in services.

Throughout the implementation of the Arizona Emergency COVID-19 Project, outreach services will be provided utilizing the existing substance use, mental health, and crisis system to ensure individuals are met where they are, and to increase overall service utilization. Outreach services could include marketing of resources statewide, through various media mediums such as posters,

PSAs, billboard, social media, flyers, etc. The marketing of the proposed mobile application in Goal 2 will also allow for greater connection of hard to reach populations to service providers.

As part of the **screening and assessment** process, members receiving services will participate in a comprehensive assessment, with emphasis on the unique qualities and culture of the individual. The following elements outlined in the AHCCCS Medical Policy Manual (AMPM), Behavioral Health Assessments and Treatment/Service Planning policy, will be adhered to: the model shall be strength-based, member-centered, family-friendly, culturally and linguistically appropriate, and clinically supervised. The model incorporates the concept of a "team," established for each member receiving behavioral health services. For individuals being assessed for a SMI determination, the AMPM policy, Serious Mental Illness Eligibility Determination, will be adhered to. This policy also outlines requirements associated with referral for a SMI Evaluation and SMI Eligibility.

In addition, behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services. All Contractors will adhere to AMPM, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

Current providers are well connected within their communities, and are currently charged with ensuring there is a complete continuum of services and care being provided to their members. Case management services will be utilized to manage all aspects of a members' care, ensure all services are being provided according to the members' needs, and to ensure services are being provided in a comprehensive manner. Additionally, individuals who may not be in need of direct substance abuse, mental health, and crisis services but who may be in need of **recovery support services,** or general assistance services due to COVID-19 such as housing, food assistance, and utility assistance, will be connected with support service entities throughout the state by utilizing the proposed mobile application.

All Contractors will be encouraged to promote the use of Telehealth to support the adequate provider network. AHCCCS has requirements outlined in the AMPM, Telehealth. AHCCCS covers medically necessary, non-experimental, and cost-effective Telehealth services provided by AHCCCS registered providers. There are no geographic restrictions for Telehealth; services delivered via Telehealth are covered by AHCCCS in rural and urban regions.

One significant issue is safely discharging individuals who meet the POF (including mental health court order evaluation) and have been diagnosed with COVID-19 to a lower level of care. This would lower the risk of the individuals' support system from being infected. This is causing the psychiatric inpatient facilities to have limited beds for individuals who are in need of the level of care. A portion of the funds will be used to pay for rapid rehousing rental assistance, wrap around behavioral health services through telehealth or direct services, personal protective equipment to keep both the individual and the direct service provider safe.

The Arizona Emergency COVID-19 Project will meet the required activities of the grant by meeting the following proposed goals and objectives:

Goal 1: Develop and implement a comprehensive plan of evidence-based mental health and/or substance use disorder treatment services for individuals impacted by the COVID-19 pandemic.

Objective 1.1: By September 30, 2020, work with other state agencies, state stakeholders, and any other entities that are involved in addressing the COVID-19 pandemic in Arizona to develop a plan that addresses Arizona's specific needs for substance abuse, mental health, and crisis services during the pandemic, as well as population specific practices/interventions to make the greatest impact within the state's most vulnerable populations.

Goal 2: Improve access and connection to services for Arizonans that are at greater risk for developing substance use disorders, mental health disorders (including individuals diagnosed with a SMI), and/or co-occurring disorders due to the COVID-19 pandemic.

Objective 2.1: By September 30, 2020, develop and implement infrastructure through a mobile application, or "app" that will be available for all Arizonans to screen for potential substance use and mental health disorders (including SMI), individuals who may be in crisis, and then connect these individuals to service providers in their areas. The app will also provide referral information to other related recovery supports for children and adults impacted by the COVID-19 pandemic such as housing, food assistance, etc. that are currently available in Arizona.

Goal 3: Increase evidence-based practice (EBP) and population appropriate practices and service utilization for Arizonans that are experiencing substance use disorders, mental health disorders (including SMI), and/or co-occurring disorders due to the COVID-19 pandemic.

Objective 3.1: By September 30, 2020, identify Arizona service providers in areas that are experiencing the greatest need for additional services related to the COVID-19 emergency, and increase the utilization of evidence based treatment services including Medication Assisted Treatment (MAT), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), and use of the American Society for Addiction Medicine (ASAM) Continuum tool to meet the needs of individuals in their service areas.

Arizona will implement **Evidence-Based Practices** (EBPs) to reduce disparities as they have been proven through controlled research studies to be effective for the POF described in Section A. Additionally, we will ensure that the services are culturally competent, delivered in an effective, understandable and respectful manner, compatible with service recipients' preferred language and cultural beliefs. The following EBPs will be implemented as part of the Arizona Emergency COVID-19 Project:

Motivational Interviewing (MI): MI is a semi directive, member-centered counseling style that elicits behavior change by helping members explore and resolve ambivalence. It facilitates the development of the trusting relationship and the decision to make a change. Research has proven to be effective for mental health and substance use treatment. Provider staff will use motivational interviewing techniques to build rapport and engage individuals beginning during outreach and continuing throughout the course of treatment.

The American Society of Addiction Medicine (ASAM) Criteria: Project staff will utilize the ASAM Criteria 3rd edition dimensions and philosophy of assessment when assessing individuals who have a substance use or co-occurring disorder. The ASAM Criteria is an ongoing, multi-dimensional, person-centered, holistic treatment philosophy of care. The ASAM Criteria requires clinicians to effectively assess utilizing the criteria through assessment at individual's admission, service planning, treatment and discharge or transfer to higher or lower levels of care. Through utilizing the ASAM Criteria, provider staff will recognize the dimensional interaction and holistic treatment approach that is essential to effective integrated treatment. Under the ASAM Criteria an individual's care is delivered along a flexible continuum, tailored to the needs of the individual, and guided by a collaboratively developed treatment

plan. Utilizing The ASAM Criteria will allow individuals to feel engaged and that they have a voice in their treatment planning

Medication-Assisted Treatment (MAT): SAMHSA describes MAT as the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorder or co-occurring disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery. (https://www.samhsa.gov/medication-assisted-treatment/treatment#counseling-behavioral-therapies)

Cognitive Behavioral Therapy (CBT): This model of therapy helps individuals with SUD, mental health, and/or co-occurring to recognize and challenge dysfunctional thoughts and behaviors that can lead to a start replacing negative ways of thinking into positive ones.

For treatment activities, AHCCCS understands the importance of implementing an EBP as intended in order to maintain a high degree of fidelity. AHCCCS does not intend to modify implementation of the EBPs in any significant way that could jeopardize the success of the project. AHCCCS will also finalize EBPs to be utilized by the fourth month of the grant.

AHCCCS ensures the provision of an array of short-term crisis stabilization and behavioral health services across Arizona's urban, rural and frontier communities. Crisis services are available to all individuals in Arizona, at any time, irrespective of Medicaid eligibility status. Crisis services include a full continuum of crisis intervention services including but not limited to 24/7/365 crisis telephone services, mobile crisis response teams, and 23 hour substance use disorder/psychiatric crisis receiving and stabilization settings.

Arizona's robust network of crisis providers ensures that individuals experiencing a behavioral health emergency are served quickly and appropriately within their communities. Interventions are solution and recovery-oriented and focused on stabilizing the individual within their community and returning them to their baseline of functioning, while simultaneously ensuring that individuals receive the appropriate follow-up services to mitigate future emergencies through preventive treatment or connection to community services. Arizona's crisis system is a national leader and "best-practice" state in the provision of crisis care. A description of the current array of crisis services is detailed below:

Crisis Telephone: AHCCCS funds the 24/7/365 operation of three regional crisis phone numbers. Calls to the crisis lines are answered live by a trained crisis specialist within three rings (18 seconds) or less and have patch capabilities to and from 911 and the National Suicide Prevention Lifeline (NSPL). The crisis lines serve as the "front door" to Arizona's crisis system by providing direct telephonic intervention and stabilization services to callers and serving as a hub in triaging and facilitating connections to additional support, such as mobile crisis teams and facility based crisis care. https://azahcccs.gov/BehavioralHealth/crisis.html

Non-emergency behavioral health telephonic support is available via peer-run Warmlines. Warmlines offer peer-to-peer support and compassion for callers who need someone to talk with. Warmline staff are AZ credentialed peers who have dealt with behavioral health and/or substance use challenges. Staff offer callers active listening skills related to a broad range of issues surrounding wellness and recovery and make referrals to treatment resources and crisis services. Additional specialty telephonic behavioral health support lines exist for teens, veterans and tribal members such as NAZCARE Warmline (Northern AZ); Crisis Response Network (CRN) Warmline (Central AZ); and Hope, Inc Warmline (Southern AZ).

Connection to 211(Resource and Referral and COVID-19 outreach): CRN, Arizona's largest crisis call operator also owns and administers Arizona 2-1-1. Arizona was recently leveraged by Governor Ducey through the Arizona Department of Economic Security to provide a COVID-19 questions and answers line for Arizona residents. The line is available from 8:00am-8:00pm in English and Spanish and provides COVID-19 related health and wellness information and linkage to community resources, in addition to behavioral health and substance use crisis and treatment services.

Mobile Crisis Response Teams: AHCCCS ensures the provision of 24/7/365 community-based mobile crisis response teams who travel to the place where the individual is experiencing the crisis and provide face to face assessment and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress. Mobile crisis teams attempt to stabilize the individual within the community to reduce the need for hospitalization, inpatient treatment or incarceration. In instances where further care is appropriate, mobile teams will provide transportation to facility-based care at a local crisis receiving/stabilization center. Mobile teams must respond on-site with an average response time of 60 minutes or less (urban), or 90 minutes or less (rural) from dispatch. Mobile crisis teams also respond in partnership with law enforcement and public safety personnel, with an average response time of 30 minutes or less.

Crisis Stabilization Settings: AHCCCS provides an array of short-term crisis stabilization services, available 24/7/365 to resolve the crisis and return the individual to the community, instead of transitioning to a more restrictive level of care. Crisis stabilization settings must accept all crisis referrals, adhere to a "no wrong door" approach for referrals, and ensure streamlined practices for swift and easy transfer of individuals from law enforcement and public safety personnel. Services include: (1) 24 hour substance use disorder/psychiatric crisis stabilization services including 23 hour crisis stabilization/observation capacity/detox, including access to Medication Assisted treatment (MAT). (2) An array of a facility based care and treatment in the following settings: Licensed Level I acute and sub-acute facilities; Behavioral Health Residential facilities; and Outpatient clinics offering 24 hours per day, seven days per week access. Additionally, AHCCCS ensures the use of home-like settings such as apartments and single family homes where individuals experiencing a psychiatric crisis can stay to receive support and crisis respite services in the community before returning home.

B2:

Key Activity	**Responsible Party**	**May– July**	**Aug – Oct**	**Nov – Jan**	**Feb- April**	**May– July**	**Aug – Oct**
		2020				**2021**	
Finalize Contract: Lead Evaluator	Project Director (PD)	X					
Finalize contracts with all Contractors	Project Director	X					

Finalize a comprehensive implementation plan	PD, Evaluator, Contractors, Providers	X					
Project Implementation (by month 04)	PD, Evaluator, Contractors, Providers	X					
Trainings (as identified)	PD, Evaluator, Contractors, Providers	X	X	X	X	X	X
GPRA Collection (intake, 6-month, and discharge)	Evaluator, Contractors, Providers		X	X	X	X	X
Collection of and evaluation of process and performance objectives	PD, Evaluator, Contractors, Providers		X	X	X	X	X
Monthly process narratives	PD, Evaluator, Contractors, Providers		X	X	X	X	X
Monthly grant meetings	PD, Evaluator, Contractors, Providers		X	X	X	X	X
SAMHSA: Mid Point Progress Report	PD and Evaluator			X			
SAMHSA: End of grant progress report	PD and Evaluator						X

C1: Project Director (PD): This will be a shared position between Ms. Michelle Skurka and Mr. José Echeverria Vega. **Ms. Skurka** will dedicate 30% of her time for the oversight, planning, implementation and monitoring of the multi-systemic grant activities. Ms. Skurka holds a Masters of Social Work and has 20 years of experience working within the substance use treatment, recovery, and mental health field, both general mental health and individuals determined to have a Serious Mental Illness (including co-occurring) combined between a State and direct care level approach. Ms. Skurka is currently responsible for leading the team responsible for oversight of the AZ Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), and any SAMHSA discretionary grants. Ms. Skurka is also serves as the AZ National Treatment Network (NTN) representative for the National Associate of State and Alcohol Drug Abuse Directors (NASADAD) and has served as the Project Director for the Cooperative Agreement to Benefit Homeless Individuals – States, the Medication Assisted Treatment – Prescription Drug Opioid Addiction (MAT-PDOA). Ms. Skurka also has experience with familiarity with the different cultures and language that would occur within the POF.

Mr. Echeverría Vega will dedicate 50% of his time to the responsibilities of the PD role. Mr. Echeverria Vega holds a B.A. Community Advocacy and Social Policy and is expected to graduate in May 2020 with a Master of Public Administration. Mr. Echeverria Vega has 3 years of serving individuals within the behavioral health field. Mr. Echeverria Vega primary work has concentrated on serving individuals that are actively using substances, experiencing homelessness, and those in the LGBTQ+ community. Mr. Echeverria Vega has served as the program manager for a Human Immunodeficiency Virus Sexually Transmitted Infection

(HIV/STI) prevention department, in which he was responsible for oversight and monitoring of a Ryan White Part A/B funded project, a homeless outreach program funded through SABG, and a foundation grants related to HIV/STI prevention and treatment activities. Mr. Echeverria Vega also has experience with familiarity with the different cultures and language that would occur within the POF.

Lead Evaluator: Dr. Jane Dowling will be responsible for leading the evaluation team from Wellington Consulting Group, Ltd. Dr. Dowling has been in the role of an evaluator for over 35 years and is the President/CEO of Wellington, a research and evaluation firm. The firm has experience working with agencies within multiple states such as Arizona, New Mexico, Texas, etc and has experience with multiple grants such as MAT-PDOA, SABG, Project LAUNCH, CABHI-States, CABHI-Enhancements etc. This also includes experience working with tribal communities, veterans, and priority populations. Dr. Dowling's level of effort will be .20 FTE. This level of effort is Dr. Dowling's historical level effort on previous grant projects with AHCCCS. The team will be responsible for the overall evaluation activities ensuring completion of all required activities, deliverables and performance measure processes. Dr. Dowling and her team are committed to completing necessary evaluation tasks to make this project successful regardless of Dr. Dowling's FTE.

Other Significant Staff: Additional FTE efforts within AHCCCS and approved by the Division of Grants Administration (DGA) will be utilized for oversight and monitoring to successfully adhere to the terms of the grant. This could include administrative, programmatic, and fiscal responsibilities. DGA will ensure positive time tracking for staff specific to this grant are qualified and experienced in grant administration. AHCCCS has a positive time tracking module within its Human Resource Information System (HRIS) that allows personnel to charge a grant for activities during each pay cycle, as part of its Employee Time Record (ETE). This will be utilized for additional efforts charged to the grant up to the maximum allowable within the grant.

D1: Wellington Consulting Group (WCG) will be responsible for overall data collection, analysis and reporting. WCG staff have attended SAMHSA-sponsored training for the GPRA and will train project staff who will be administering the GPRA. WCG will enter GPRA data into SPARS. WCG will develop a web-based tracking log for providers to use in order to track administration of intake GPRA, 6-month follow-up and termination (if needed), which will be monitored to ensure follow-ups are conducted within the window to achieve the target 6-month rate. If follow-ups are due and have not been conducted, the provider will be contacted to determine the reason(s) the follow-up was not conducted when due. The Evaluator will analyze the GPRA data monthly providing AHCCCS with the number of intakes, follow-ups, and discharges. On a monthly basis an infographic will be compiled to include key performance measures: abstinence from use, housing status, employment status, criminal justice system involvement, hospitalizations, mental health functioning, access to services, retention in services, and social connectedness. Frequency analysis and descriptive statistics will be utilized to confirm patterns associated with certain risk and protective factors. Frequency analysis will be used to provide demographic information. The infographics will be sent to AHCCCS and shared with the providers. Providers will complete a web-based Monthly Process Narrative. The report will be reviewed by evaluator and AHCCCS in order to identify any QI issues that need to be addressed with a focus on disparities in access/use/outcomes. Content analysis of monthly process narratives will be utilized to identify characteristics of recruitment/retention plans, factors that

facilitate /hinder implementation, and challenges and barriers experienced and resolutions. This report will be used to identify effective recruitment and retention and program implementation. WCG will compile data from these reports and member-level data for the monthly provider meetings and will assist in the compilation of the midpoint and annual reports on the progress and performance on achieving the goals and objectives. The GPRA will be used and data will be collected using interviews conducted via telehealth live methods such as telephone, FaceTime, Zoom, GoToMeeting, and other live two way video methods. Data will also be collected following provider training using a web based retrospective pre survey to increase in knowledge, understanding, and skill. A three-month follow-up survey will be used with providers to determine the utility of the training and need for additional training or information to support their work. A research-based collaboration inventory will be administered at baseline, at midpoint and at the end of the project to the members of the Arizona Emergency COVID-19 Project. The Wilder Collaboration Factors Inventory will allow us to measure whether or not there is an increase in collaboration, coordination, and partnerships at the state, regional, and local levels. Table 1 presents the Performance Measures and the plan for collection. The second table presents the process objectives for the first four months of the planning phase. The plan for the outcome objectives will be finalized upon completion of the planning phase. Table 2 also includes output (O) objectives to be addressed through this project.

Table 1 Performance Measures	**Data Source**	**Data Collection Frequency**	**Responsible Staff**	**Method of Analysis**
Abstinence from use	GPRA	Intake/Baseline, 6-month Follow-up, Discharge	Staff Administering GPRA	Frequency, Percent Change, and Mean for total population and subpopulations
Housing & employment status, criminal justice system involvement, hospitalizations, mental health functioning, and social connectedness	GPRA	Intake/Baseline, 6-month Follow-up, Discharge	Staff Administering GPRA	Frequency, Percent Change, and Mean for total population and subpopulations
Access to services	GPRA	Intake/Baseline	Staff Administering GPRA	Frequency, Percent Change, and Mean for total population and subpopulations
Retention in services	GPRA	Discharge	Staff Administering GPRA	Frequency, Percent Change, and Mean for total population and subpopulations

Table 2 Abbreviated Objectives	**Data Source**	**Collection Frequency**	**Responsible Staff**	**Method of Analysis**

1.1a Identify needs for substance use, mental health & crisis services.	Needs Assessment documentation	9/30/20	Evaluator	Qualitative Review of documentation
1.1b Identify population specific practices/interventions	Log of practices to be used by population	9/30/20	Evaluator	Qualitative Review of documentation
1.1c Develop comprehensive plan of E-B mental and/or SUD treatment services	Model Developed	9/30/19	Evaluator	Qualitative Review of Model
1.1d Increase collaboration and partnerships across service providers	Wilder Collaboration Inventory	Baseline/ Bi-Annually	Evaluator	Frequency, Mean, Percent Change
2.1a Increase access and connection to services	Screening, Enrollment, Referral Logs	Monthly	Project Director / Evaluator	Frequency, Percent Change
2.1b Increase program participant awareness & knowledge of service providers	Referral Logs / Usage Logs	Monthly	Project Director / Evaluator	Frequency, Percent Change
3.1a Increase identification of service providers experiencing greatest need related to COVID-19 emergency	Service Provider Inventory	9/30/20	Evaluator	Qualitative Review of documentation
3.1b Increase utilization of evidence-based treatment services	Service Provider Inventory	Baseline/ BiAnnually	Project Director / Evaluator	Frequency Percent Change
O.1 Increase number of members screened / assessed for SUD and/or COD	Screening Assessment Log	Baseline/ Monthly	Project Director / Evaluator	Frequency, Percent Change
O.2 Increase number of eligible members receiving specific evidence-based and treatment services	E-B / Treatment Services Log	Baseline/ Monthly	Project Director / Evaluator	Frequency Percent Change
O.3 Increase number participants referred to recovery support services	Referral Log	Baseline/ Monthly	Project Director / Evaluator	Frequency, Percent Change
O.1 Increase access to crisis mental health services	Referral Log	Baseline/ Monthly	Project Director / Evaluator	Frequency, Percent Change
O.2 Increase number of participants receiving services within telehealth context	Service Provider Utilization Log	Baseline/ Monthly	Project Director / Evaluator	Frequency, Percent Change