2019-2020

Evaluation Plan for Centro Sávila

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Introduction

Since 2011, Centro Sávila (CS) has served South Valley communities by providing high quality behavioral health services, assistance in navigating the healthcare system, as well as community support services regardless of ability to pay. CS's staff aims to encourage a peaceful and respectful healing space that is accessible to all members of the community.

CS has a Medicaid enrollment program, with offices throughout the city, which helps individuals navigate the enrollment process. The organization also provides services through other key programs, including the Critical Time Intervention (CTI) program that aims at minimizing the long-term impact of early childhood trauma through family counseling. It is also part of the Bernalillo County Pathways program, providing navigators to help fill individuals' unmet needs and, in so doing, help improve health outcomes and reduce health disparities. All of CS's programs share a commitment to empowering clients by taking a systemic perspective and engaging community and individual resources to encourage and maintain positive mental and behavioral health.

CS addresses culturally appropriate care and advocacy. In the short amount of time that CS has been open, the organization has experienced extraordinary growth including opening a new location in Albuquerque's International District, the Hopkins Center. In response to the needs of its clients, the organization has started new and maintained existing programs with city and county governments and other organizations in the community. The focus of this project is to conduct an evaluation of CS to map its internal organizational structure in the context of its ongoing growth process.

Previous CS evaluations have demonstrated that many of the South Valley's and International District's residents are low-income with high participation in public assistance programs when compared to the broader population of Albuquerque and the United States. These two communities also experience higher instances of limited English proficiency among residents who lack health insurance and are more likely to be undocumented immigrants than populations in other parts of the city. Language and transportation barriers only compound the dearth of mental health service providers available in the underserved communities of the South Valley and International District. Mental health service providers that work in these communities most often do not offer services in languages other than English which limits the effectiveness of sliding-scale payment options, counseling services, and clients' ability to learn of, or access, related services beneficial to potential overall treatment plans.

Successive evaluations have built upon previous years' survey instruments to provide CS with survey tools intended to build capacity for internal evaluation to assess if, and how, the organization is achieving its stated goals and to monitor client satisfaction with services. Interviews with staff and clients conducted by previous evaluation teams have led to recommendations for CS to develop a community engagement strategy, defining clear procedures for interns and clinicians regarding supervision, setting scheduling and training expectations for interns, and creating clearer administrative processes for professional training, the client wait list, and billing.

Continued growth at CS has required that the organization's logic model be updated with each successive evaluation. The initial logic model identifying CS 's needs, inputs (resources and activities),

outputs, and outcomes has been adapted to account for short term and long term outcomes in its most recent iteration.

Purpose of Evaluation

This evaluation has two aims:

- First, to assess how CS's (CS) long term goals align with its activities and resources by creating a logic model for the organization as a whole, and for its three largest programs: the Critical Time Intervention (CTI), Case Management Program, and Clinical programs.
- Second, to determine how the staff perceives the ongoing organizational transition regarding the following dimensions:
    - How does the staff perceive their department/program to fit in the long term goals of CS?
    - How does the staff perceive their individual contributions to be (or not) part of the organization's goals?
    - What are manager's and staff's perceptions of how different departments/units collaborate?
    - Identify barriers and strengths that inhibit or foster collaboration and communication within the organization.

The logic model will reflect the organization's targeted transition aims, as well as provide a big picture overview of the organizational structure of CS and how the vision for the organization fits into the organizational structure, processes and relationships.

Logic Model

Program: Centro Savila **Logic Model**
Situation: UNM Evaluation Lab

Inputs

Human Capital
- Clients
- Leadership Team
- Counseling Staff
- Interns
- Administrative Staff

Physical Capital
- CS South Valley
- La Plazita
- Hopkins
- International District
- West Side Shelter

Financial Capital
- Client Donations
- Government & Private Grants
- Health Insurance Payments/Medicaid/Medicare

Social Capital
- Reputation
- Funding Agencies
- Community & Governmental Partnerships

Organization

Departments

Board of Directors, Executive Director, Director of Operations

Case Management
Enrollment specialists, peer support workers, & pathways navigators help clients manage systems & meet basic needs

Finance & HR Director
Director & Accountant positions currently vacant
Billing Specialist is part of Administrative

Clinical
Provides preventative primary mental health care

Development, Evaluation, & Policy
Proposed department in the planning stages

Programs

Enrollment
Bilingual health insurance outreach, education, & enrollment

Pathways
Systems navigation & case management to assist clients in meeting basic needs

Peer Support
Provides recovery coaching to patients struggling with mental health and substance use

CTI
Provides instensive case management services to youth & their families

Voca
Provides trauma-informed therapy & case management to victims of violent crime w/o health insurance

Suicide Prevention
Screens for suicide risk & provides clinical therapy & education for individuals w/suicidal ideations

Substance Abuse
Clinical therapy & educational services for individuals dealing with substance use

CTI
Provides instensive therapeutic services to youth & their families

Activities

Strategy

"A democratic, community engaged, and responsive system"

Build programs that target the specific populations government and foundations want to target

Case Management Team data collection utilized to diagnose systemic gaps and barriers to effect policy and systems change

Action

Spaces for leadership have to be created and acknowledged at all levels

Collaborate with other organizations

Fill vacant managerial & finance positions

Define programs according to funding

Align internal systems & processes to enable, growth (IT, accounting, policies & procedures, mission statement)

Funding

Overcome gaps in funding

Braided Funding

Optimize billing structure

Growth

Grow own leaders

Planned expansion into new geographic areas

Outputs

Service model built around greatest inequities (SDH)

Establishment of public/private partnerships

Holistic approach

Structured process established for advocacy

Service environment works to overcome systemic barriers influencing disparities in access to health care.

Maintain a sustainable and properly staffed organization

Insectoral collaboration (among internal departments & external organizations)

Departments & Staff aligned with organization's goals.

Outcomes

Short Term

Services mitigate systemic barriers to health care for vulnerable populations

Funding and partnerships aligned with CS goals

Services provided regardless of ability to pay

Community engagement for systems change

Long Term

Participate in changing the political and economic forces that contribute to the lived experiences of individuals and have effects for individuals living under those systems.

Eliminate barriers in structural institutions like governmental, education, and health systems that are contributors to poor health outcomes.

Work toward improvements to social support systems and community connectiveness as a way to address mental heath disparities

Improve individual level mental health, agency, and empowerment through building trust.

"A healthy engaged, equitable, community"

Assumptions

Centro Sávila is founded on the belief there are structural, social, and political implications that effect an individual's health. In the U.S, people of color lead shorter lives, receive worse medical care, live in hazardous conditions, and occupy more menial jobs. Additionally, the health care system continues to reproduce and reflect systems of inequality throughout U.S. American society. The current health care system is not structured to take on these systems of inequality and perpetuates them as a result. Political forces have created and allowed the market economy to produce a privatized healthcare system and market driven health goods and services. Privatized medicine restricts access for people belonging to already marginalized groups. Centro Sávila works to address the multiple and multilayered influences on health which include factors such as social, environmental, education, economics, or access to care.

External Factors

Economic and geographical barriers, linguistic and cultural barriers, systemic barriers (race, ethnicity, gender, sexual orientation, ability, immigration status), political climate, multiple colonizations, disparities in access to health care, funding barriers and limitations, public funding for behavioral health, local economy

CS is experiencing rapid growth in the number and types of service programs it offers to the community and is working toward defining an organizational structure that aligns with its mission and goals. This logic model represents CS's organizational structure as it currently exists while implementing the plans for restructuring that will enable the organization to increase access to for underserved communities, overcome funding gaps, and avoid mission stray.

CS's growth model is premised on extending access to much needed behavioral health services while maintaining its social justice model of care. Restructuring and growth will create opportunities for CS staff to move into leadership positions and grow with the organization. To achieve these goals CS has begun a planned restructuring of departments and programs to align with its vision and mission. Through the restructuring process every department will have a program manager or director overseeing the clinical portion of the program and a lead person working on administrative functions such as preparing invoices and reports. To improve accounting functions CS plans to hire an entry-level accountant with the intention the incumbent will have an opportunity to move into a CFO position in the future. Additionally, a development, evaluation, and policy department is planned with the current internal evaluator expected to move into the director position for the area. The Clinical Team has added four additional clinicians with the intent of increasing direct service to thirty-five additional clients per clinician. Initial results have demonstrated this can be achieved without a decrease in service level to clients. CS has secured funding to begin the search process for service side vacancies, however, only one of four administrative positions is currently funded.

CS leadership understands the organization's current funding gaps and is working to overcome them in a manner that will not compromise its vision and mission. A braided funding model is under development through which CS increases program options to underserved communities while working toward systemic change to improve health outcomes. Expanding needed services that CS has the capacity to successfully deliver provides the organization opportunities to secure new streams of funding through governmental contracts and private foundations. These funding opportunities need to be carefully vetted to ensure service delivery is not disrupted by unrealistic quantitative goals required within a contract.

Managing growth and the restructuring of the organization has to ensure the service model addresses the social determinants of health using a holistic approach that includes advocacy and addressing systemic barriers affecting health outcomes for vulnerable populations. CS aims for community engagement that works toward changing political, economic, and social systems with the goal of realizing its vision for a "healthy, engaged, and equitable community."

Literature Review

CS serves the predominantly Latino community in Albuquerque's South Valley neighborhood with high quality behavioral health care, assistance in navigating the healthcare system, and community support services. Culturally appropriate services within a social justice model are provided regardless of a person's ability to pay. Clients may be victims of crime or have experienced a range of personal or social trauma. It is for these reasons CS practices a trauma informed care within a collaborative model. CS is focused on working through the social and structural challenges their clients face by

addressing geographical barriers and the social and environmental effects on client health and behavior.

Social justice-oriented care

In the U.S, people of color lead shorter lives, receive worse medical care, live in hazardous conditions, and occupy more menial jobs (Barr, 2008). Additionally, the health care system continues to reproduce and reflect systems of inequality throughout U.S. society (Minkler, 1997). The current health care system is not set up to take on these systems of inequality and perpetuates them as a result. Political forces have created and allowed the market economy to produce a privatized healthcare system and market driven health goods and services. Privatized medicine restricts access for people belonging to already marginalized groups. Social justice-oriented health organizations, (Askew Buxton, Chandler- Altendorc, & Puente, 2012) have worked to address the multiple and multilayered influences on health which include factors such as social, environmental, education, economics, or access to care. Yakushko & Chronister (2005) outline the multiple ecological levels effecting the mental health needs of immigrant women and discuss the various interventions and counseling strategies at each level to systematically explore multiple sociocultural and systematic influences. Within the individual system, micro system, and meso system there are multiple factors influencing the mental health of immigrant women. Identified factors include acculturation, immigration stress, relations with nuclear and extended family, and shifting gender roles. The article highlights oppression as the primary stress contributed by the ecosystem and macro system.

Culturally appropriate care

To effectively treat patients with varied experiences it is important that counseling services acknowledge the unique factors of the individual's life. This is particularly true for immigrant women. Yakushko & Chronister (2005) highlights recommendations for interventions at both the meso and micro levels and recommends that counselors should understand the impact of the multiple contexts on immigrant women's lives. Individual level efforts should address the women's pre and post immigration experiences as well as the factors that led them to immigrate. Stories of migration are an important part of the counseling experience. Councilors should follow the immigrant women's lead in identifying what experiences need further exploration. Also important is assessing the women's acculturation process and their comfort with counseling. Micro level counseling interventions would include providing the women with information about the boundaries of mental health services, primarily privacy. Micro system level interventions would include assessing changes in women's family structure and shifting gender roles. Mesosystemic and Exosystemic level interventions would investigate the quality of the relationships in a woman's different contexts (work, home, school, and social), how to use multiple sources of social support, and where women can find resources in the community. These interventions should also set up concrete behavioral goals, include home visits, and provide outreach in women's communities. Macrosystemic level counseling interventions should include a councilor's awareness and education of discrimination and prejudice that migrant women face as well as the shifting gender and cultural roles they may be experiencing. Understanding the multiple levels that influence immigrant women's mental health is as important as informed counseling interventions.

Additional research has strengthened the rationale for culturally appropriate care. Chung, Chi-Ying, Bemak, and Grabosky (2011) conducted a workshop for counselors and psychologists on immigrant rights, advocacy, and social justice. Their workshop illuminated the many forces at play for migrant Latinos. Their workshop looked at using the pre and post migration stories in therapy and how host

society stereotypes and myths about the migrating population are harmful. They educated the providers about their Multi-Level Model of Psychotherapy (MLM) in tandem with Multicultural Social Justice Career Counseling so counselors and psychologists can provide culturally responsive services and become advocates for immigrant clients.

According to Chung, Chi-Ying, Bemak, and Grabosky (2011), immigrant adjustment involves both the host community and newly arrived immigrants. The MLM requires mental health service providers to incorporate aspects of role changes from pre to post migration which is beyond the scope of traditional therapy services offered to immigrants. Chung, Chi-Ying, Bemak, and Grabosky (2011) provide a five level integrated therapy model which includes mental health education, individual, group, and family counseling interventions, cultural empowerment, integration of indigenous and Western healing practices, and multicultural social justice career counseling to offset barriers to employment often faced by new immigrants.

Language is another crucial factor to consider in culturally appropriate care.
Sue et al. (1991) found that for people whose primary language was not English, counselor-client matching for ethnicity and language predicted longer time in treatment (more sessions) with better outcomes. While language matching is important it is also important to acknowledge the individual differences of any particular language community and not make assumptions about a group because of language.

Language has been found to be a predictor for the type of treatments patients prefer however there may be additional individual factors to consider. Fernandez y Garcia, et al. (2011) looked at the effect of language preference on Hispanic individual's treatment preferences for depression. The key finding of their study was that Spanish-speaking Hispanics are less likely to prefer treatment options that include antidepressants than English-speaking Hispanic and non-Hispanic white respondents. However, older age and a history of depression were also found as significant mediators for treatment preference. Therefore, it is important to have options for patients although there might be a preference for counseling therapy only.

Collaborative Care
Dwight-Johnson, et. al, (2010) studied the effectiveness of collaborative care in addressing depression treatment preferences among low-income Latinos. This study looked at treatment preferences among low-income Latino patients in public-sector primary care clinics. The study tested whether a collaborative care intervention including patient education, and allowing patients to choose between medication, therapy, or both, would increase the likelihood patients received their preferred treatment. The results revealed patients preferred counseling or counseling plus medication over antidepressant medication alone. This finding highlights the importance of providing counseling and access to medical treatment in an integrated care setting. In addition to those findings it was revealed there was little to no preference between group or individual treatment. Finally, the study further revealed that when barriers to treatment and access were removed there was improved adherence to the treatment plan including: individual education sessions, telephone sessions, transportation assistance, and family involvement.

In a systematic literature review by Garcia, et al. (2017) regarding studies that were looking at collaborative care for depression among patients with limited English proficiency and mostly Latino immigrants, the authors found utilizing a collaborative care model delivered by bilingual providers is

an effective treatment for depression in patients with limited English proficiency (LEP). This literature review cites many studies which have found that patients with LEP suffer from high rates of untreated depression. The review covers articles published between January 1, 2000 and June 10, 2017 and evaluates the effectiveness of the collaborative care model in treating depression among LEP patients versus traditional care models. The collaborative care model emphasizes individualized care, consistent case management, and regular screening for patients. When the model is deployed for LEP patients, in conjunction with bilingual providers, care is improved significantly for this population. Studies report between 10% and 27% more Spanish-speaking patients show improvement in their symptoms when treated in a collaborative care model. The authors recommend screening of LEP patients for depressive symptoms and providing referrals for care in a culturally sensitive manner.

Trauma Informed Care

Posttraumatic stress disorder (PTSD) is a widespread problem in primary care however it may be under diagnosed and thus undertreated because providers do not have adequate knowledge about its symptoms and treatment. Few studies have looked at the diagnosis and treatment of PTSD for uninsured Latinos, however, Meredith et. al. (2014) conducted a randomized controlled trial of care management for PTSD among predominantly Latino patients in safety net health centers. Federally Qualified Health Care Centers (FQHC) act as a "safety net" for low income and underserved patients. The findings revealed that barriers at patient, clinician and system levels need to be addressed. An intervention was designed which included six components (five of which are currently being done at CS): 1) patient education and activation; 2) dissemination of non-medical community resources; 3) patient screening and evaluation for PTSD diagnosis 4) clinician education on practice guidelines; 5) structured cross-disciplinary communication, to include regular meetings between care managers, clinicians, and specialty mental health providers, as well as care managers. Meredith et. al. (2014) found the six-step intervention was significantly associated with reduced anxiety and depression symptoms; decreased disability; improved quality of care and more anxiety-free days. However, there was no significant effect on PTSD symptoms, although this report suggests that finding could be due to the small number of patients with PTSD in the study.

Geographical Barriers

Racial and ethnic disparities in mental health care access in the United States are well documented. A critical factor in mental health care access is a local area's organization and supply of mental health care providers. Cook, Doksum, Chen, Carle, & Alegria (2013) found that increased county-level supply of mental health care providers was significantly associated with greater use of any mental health services and any specialty care, and these positive associations were greater for Latinos and African-Americans compared to non-Latino Whites. Expanding the mental health care workforce holds promise for reducing racial/ethnic disparities in mental health care access.

Socioecological Model of Health

As a framework for health promotion, the socioecological model of health provides a comprehensive examination of social and environmental effects on an individual's health and behavior. McLeroy et al. (1988) adapted a social ecological model applicable to health promotion, identifying five levels of influence on health behavior:

1. Intrapersonal factors- Characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, etc. This includes the developmental history of the individual.

2. Interpersonal processes and primary groups-formal and informal social network and social support systems, including the family, work group, and friendship networks.
3. Institutional factors- social institutions with organizational characteristics, and formal and informal rules and regulations for operation.
4. Community factors- relationships among organizations, instructions, and informal networks within defined boundaries.
5. Public policy- local, state, and national laws and policies (McLeroy et al., 1988, p.355).

By dividing the environment into analytic levels, attention is called to various social and environmental influences at each level, providing a variety of possibilities for intervention (McLeroy et al., 1988) as well as helps to visualize the multilayers of influence on health outcomes. Maximum health benefits are reached through a comprehensive multi-leveled approach, addressing the various influences on a health outcome. Health is a multifaceted concept; human environments are complex and multidimensional; health promotions are most effective using a multileveled approach; people-environment relationships are characterized by cycles of mutual influence.

CS is founded on the belief there are structural, social, and political implications that effect an individual's health. The strength of CS lies in its ability to address the complexities of social, political, and environmental effects on health and behavior. CS is grounded in a foundational belief of the importance of culturally appropriate care within a collaborative care model and offers clients a variety of options in treatment including individual and group therapy sessions. CS has been strategic in addressing geographic barriers by ensuring sites are accessible via public transportation. Additionally, they work to eliminate barriers through insurance enrollment, allowing anybody to receive services regardless of their ability to pay, providing child care during therapy sessions, and work on increasing access to other social services, reducing food insecurity, and access to housing. Providing options, education, and working to reduce barriers positions CS to increase adherence to treatment plans and improve patient outcomes.

Context

Previous evaluations have considered the socioeconomic, health, immigration, and language contexts in which CS operates. The 2016-2017 evaluation concentrated primarily on the socioeconomic, health, and immigration contexts in which CS operates relationally between the South Valley, Albuquerque, and the United States. The following year the evaluation team included the socioeconomic, language, and immigration contexts of Albuquerque's International District to compliment the organization's service expansion into the district. Last year's evaluation documented the number of mental health service providers operating in Albuquerque's South Valley in an effort to determine if structural barriers including language, ability to pay, or transportation reinforced or overcame barriers to accessing services offered by the providers. As a result of the growth experienced by CS, and the related ongoing restructuring of the organization, this year we contextualize CS within the broader mental health treatment environment in New Mexico. In particular we utilize the 2018 "National Mental Health Services Survey" (N-MHSS) to situate CS relationally within the New Mexico mental health treatment facility environment.

Figure 1. Source: National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities.

According to the 2018 (N-MHSS), out of 58 total mental health facilities in New Mexico, a state with a population of over 2 million residents, only 32 of those facilities offer treatment services in Spanish. (see figure 1). As cited in the literature review therapy provided in a client's native language is twice as effective than when provided in English only. New Mexico is a Hispanic majority state, with an increasing number of immigrants from Central and South America. This is problematic for clients who wish to receive services in their preferred language. Additionally, language is but one factor within a culturally appropriate care model and additional cultural considerations, such as social, economic, and immigration status, need to be made.

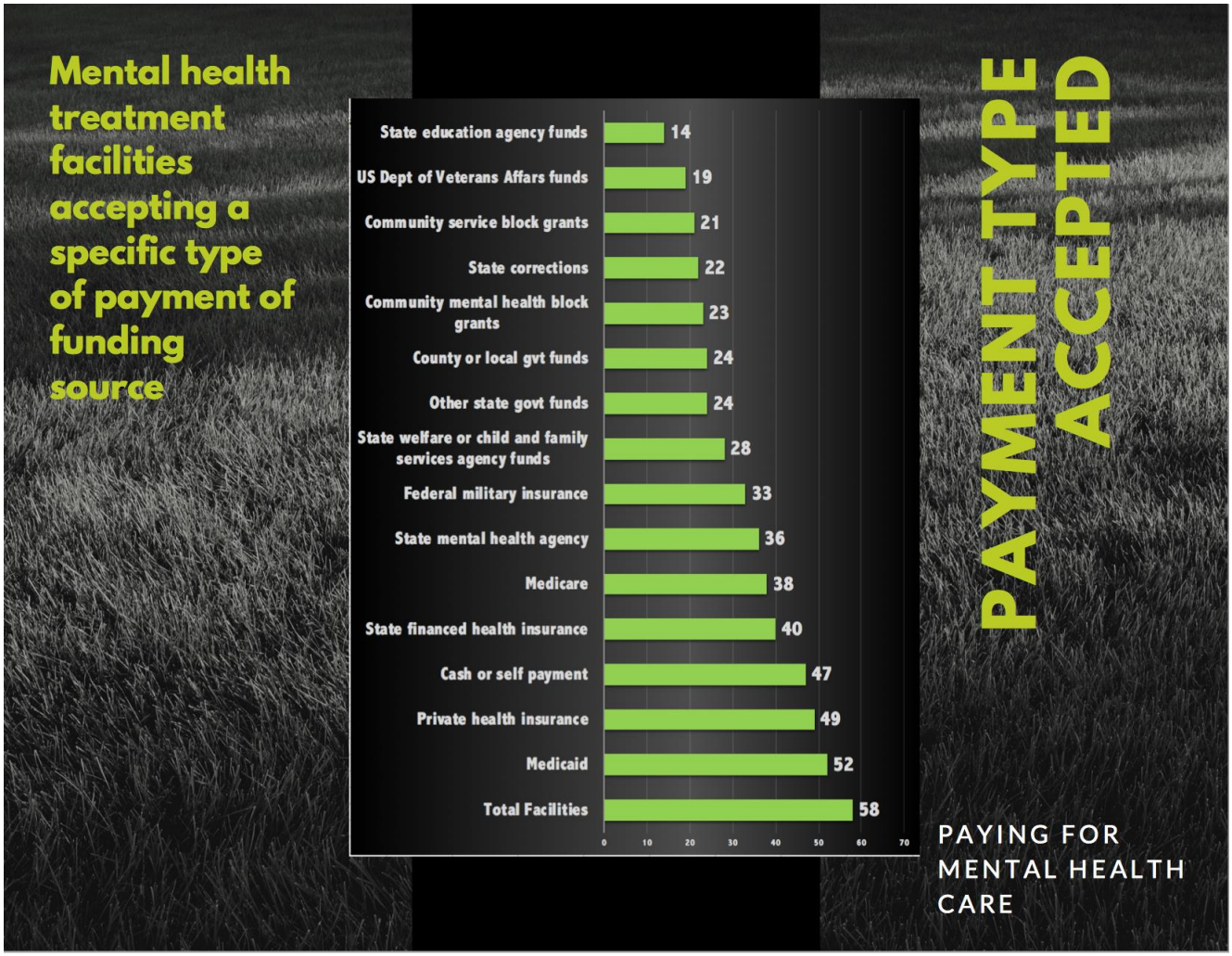

Figure 2. Source: National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities.

Access to services can be largely dependant on an individuals ability to pay or services. Newly immigrated people do not have access to health coverage and are in need of services. However, when we look at figure 2, we can see that out of the total facilities none are listed as taking no method of payment and only 47 of those take cash. While many facilities take Medicaid and private insurance less than half accept payment from community mental health block grants. Individuals who have difficulty gaining the funds to pay may also and possibly have a much higher need for mental health care because of the stress associated with financial hardships and the situations that surround that

intervention team in plae when it is needed.

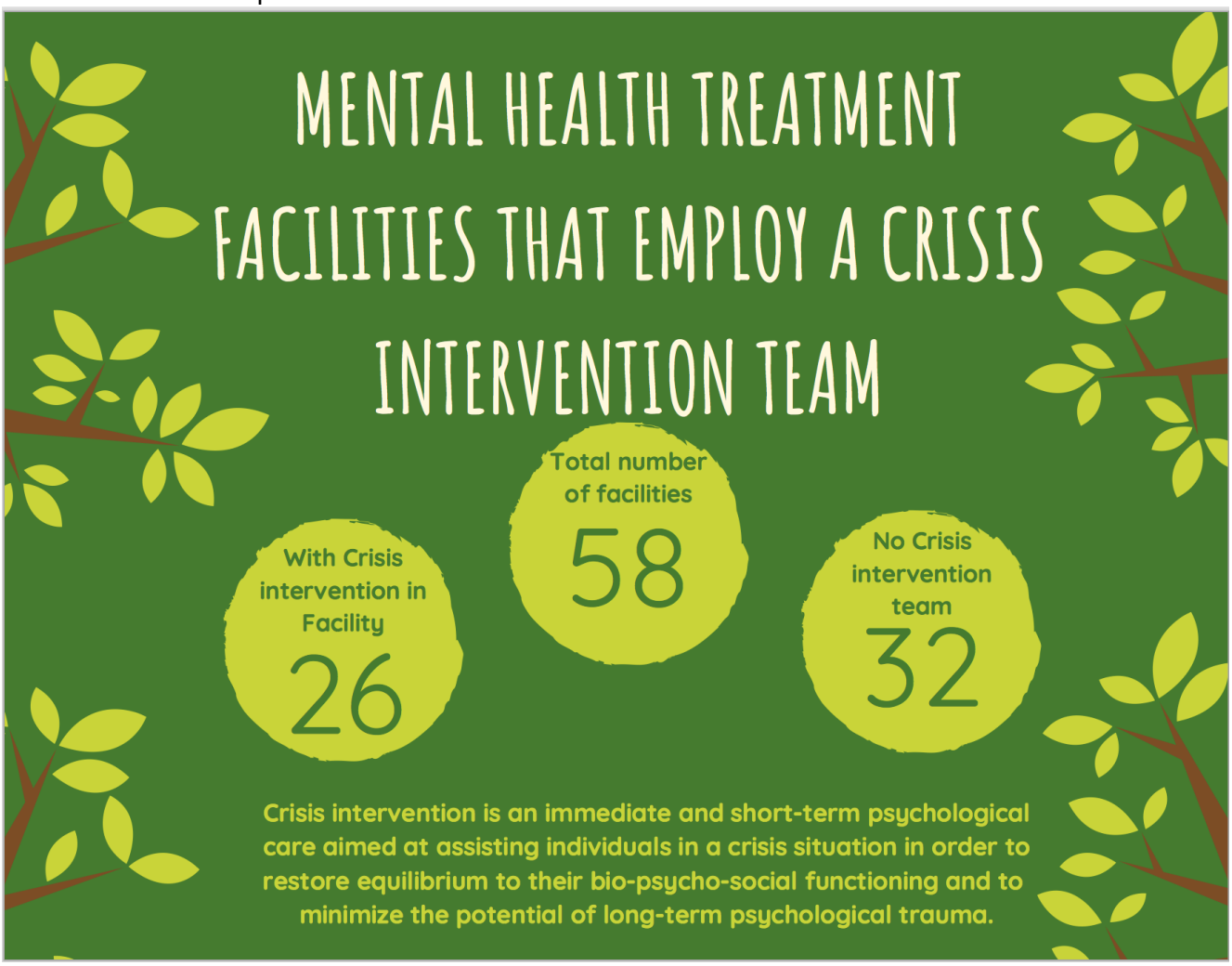

Figure 3. Source: National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities.

Crisis intervention is an important element in sufficent mental health care and imporving mental health outcomes. Oftentimes the trauma inflicted in a crisis can be mitigated through timely intervention. Mental health facilities wo truly wish to do the work of improving mental health outcomes for those most affected by violent crime and trauma should have a crisis intervention team in place. However, as figure 3 shows, out of the 58 mental health treatment facilities in New Mexico only 26 have a crisis intervention team in place to to address these needs.

Figure 4. Source: National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities.

Particular populations are more at risk than others for negative health outcomes. It is important to have tailored interventions that meet the needs of these vulnerable populations. Figure 4 outlines those vulnerable populations and shows how many facilities in the state of New Mexico have programs designed to meet their individual needs. With the high prevalence of substance abuse with mental illness in the state it is unfortunate that only about half of the mental health treatment facilities offer programs specifically for co-occurring substance abuse and mental disorders.

Figure 5. Source: National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities.

CS has been successful in providing behavioral health and case management services that address systemic socioeconomic, cultural, and language barriers to underserved communities in Albuquerque. CS is working to address barriers and gaps within the mental health treatment landscape of New Mexico. CS 's services and reach are unique as they address populations and health issues that do not receive adequate attention within the current health system. CS works to provide treatment in culturally appropriate ways in addition to addressing language barriers for the residents of the communities they serve. CS offers services regardless of ability to pay. This is important especially for clients who are newly immigrated or unable for various reasons, to access health care coverage. CS is an outlier in treating clients without the means to pay for treatment. Their case management services work toward overcoming financial barriers by offering services that assist clients in navigating the insurance enrollment and public benefits systems. CS offers trauma informed care through a variety of services including systems navigation and case management through the Pathways program, intensive case management for youth through the Critical Time Intervention program, trauma informed therapy and case management to victims of violent crimes without health insurance through the VOCA program, and interventions for persons with suicidal ideations through their Suicide Prevention program. CS provides programs for multiple various behavioral health needs and works to address the treatment disparities vulnerable populations face. CS fills the gap in the community that addresses co-occurring substance abuse disorders. They also

serve the at risk group of transitional age young adults, particularly as the reenter society form incarceration. Otherwise this group is severely underserved with only 16 facilities offering treatment specifically for this population. CS 's recent growth includes the onboarding of several peer support case managers in addition to four direct service clinicians. Peer support is an important and powerful, yet underutilized, tool within mental health facilities in New Mexico. As a part of its growth model and restructuring process, CS plans to create a development, evaluation, and policy department to work toward community engagement to enact systems change that eliminates governmental, education, and health barriers negatively impacting health outcomes.

Evaluation Team

Claudia Diaz Fuentes, PhD:
Dr. Diaz is the director of UNM's Evaluation Lab and oversees student work as part of the evaluation team. She received her PhD from the Pardee RAND Graduate School. Her research focuses on utilization and access to care among Spanish-speaking Hispanics in the United States. In particular, her interests include the role of the demand for screening and treatment of several prevalent conditions among Hispanics, such as mental health illnesses, breast cancer and musculoskeletal and respiratory illnesses, and the long-term impact of these conditions on income security. Claudia started teaching introductory economics and intermediate microeconomics in her home country (El Salvador), where she also recently taught time series econometrics. Her teaching interests also include health, development and labor economics.

William G. Wagner PhD, LISW:
Dr. Wagner is the founder and executive director of CS. He is a clinical social worker, a program administrator and a cultural/medical anthropologist. He is fascinated with the ways that people make meaning of their worlds and the ways in which identities are constructed and maintained. He works to build systems of support that help people to live healthy, equitable and connected lives.

Guiovanna Aguirre, MBA:
Guiovanna joined CS as the Business Operations Manager in November 2014, she transitioned into the Director of Operations in 2017. She provides support and leadership to all CS staff, student interns, volunteers, and community. Guiovanna is responsible for the organization's overall business accountabilities as well as the day-to-day operations at all three locations, while ensuring daily operations run smoothly.

Guiovanna is a native New Mexican, she has several years of experience working in the nonprofit community. She received an MBA from the Anderson School of Management at the University of New Mexico in 2013. Aside from her administrative duties, she serves on the Board of Directors for La Cosecha C.S.A and is the Board President for Proyecto Educacion. Working at CS has given Guiovanna a deep appreciation of how the nonprofit sector seeks to improve the quality of life for the communities they serve.

Martha Alejandra Becerra:
Martha was born and raised in Albuquerque, New Mexico and is CS's Evaluation Coordinator. As a first-generation college student, she received her undergraduate degree in Finance and International

Management from UNM's Anderson School of Business in December of 2017 and is currently a second-year Master of Public Policy student. She intends to use her education to help create a better New Mexico and aspires to do so through her interest in education policy and economic development.

Camille Velarde:
Camille Velarde raised in rural northern New Mexico, is a third year PhD Student studying health communication in Department of Communication & Journalism. She works as a TA teaching various undergraduate communication courses including public speaking, organizational communication and health communication. Currently, Camille serves as the graduate student board member for the IRB on UNM's Main campus office and works as a graduate assistant at OMBUDS for faculty.

She proudly received both her BA and MA from the University of New Mexico, where her undergraduate work focused on organizational communication which Camille applied in the field as a legal secretary for several years and minored in psychology which she applied in her master's work which was centered around mental health communication.

As a PhD student, Camille has won two top paper awards for her work titled "Critical Socioecological Model: A Critical Perspective to Historicize Health Inequities" at both the International Association of Applied Demography Conference and at Western States Communication Conference both in 2019 and has presented her work at various popular culture, health, and communication conferences. Her current research interests tend to intersect digital media and mental health.

As native New Mexican, Camille feels a connection and responsibility to the students and community she serves at the University of New Mexico which is evident in her teaching and research practices.

Joseph Gonzales:
Joseph Gonzales is a PhD student in American Studies at the University of New Mexico. He has an MBA from UNM's Anderson School of Management and has also earned an MA in American Studies at UNM. As an Evaluation Lab Fellow, Joseph looks forward to conducting collaborative evaluation with community organizations to aid in goal attainment benefitting communities who otherwise struggle for access to services. Joseph's research explores cultural productions and performances as sites of refusal and resistance that create alternative imaginaries and futurisms for intersectional communities of color.

Evaluation Activities and Timeline

This evaluation will be conducted using a CBPR approach. The evaluation team expects the approach will encourage an organizational level conversation about the ongoing transition.

The proposed activities of this evaluation are focus groups with CS leadership and staff. These are expected to occur as follows:

Initial interviews (up to 2) with CS leadership (Guiovanna Aguirre and Bill Wagner). These first interviews will provide the following information:

- An account of the ongoing transition plan as well as any documentation that will allow the team to summarize into a format that can be shared with the rest of CS staff.
- How the leadership perceive the ongoing transition to fit/expand/modify the current mission and long term goals of the organization.
- CS past and future approach to obtaining and use of financial, infrastructure and human resources.
- Determine a schedule of focus groups with staff that will inform this evaluation.
- The focus group protocols will be constructed by the evaluation team.

A focus group with management and up to 2 with staff will inform aims 1 and 2 of this evaluation

To achieve the goals of the evaluation we propose the following timeline:

October 2019
Organizational observations and write-ups – Camille Velarde meet with Alma Olivas, manager of case management programming including Pathways, CHW's, and Peer Case Managers and Joseph Gonzales met with Amanda Santiago, the CTI Program Clinical Director. Observations and write-ups were completed by October 7th.

Meetings with CS leadership were held on September 7th and October 16th to inform the scope of work. The first focus group with leadership to define the organization's growth model was held on October 30th.

November – December 2019
The second interview with CS leadership is scheduled to take place on December 5th. At this meeting the evaluation team will also identify managers and staff for focus groups and begin scheduling times and dates to conduct these focus groups. Focus groups are scheduled to be completed by December 17th.

January – March 2020
Begin coding information gathered in focus groups and analyze data results. At this time we will also ensure communication with CS remains consistent and inclusive reporting on the status of the evaluation process.

March 20, 2020
Deliver final report.

Initial Findings

CS has proven to be effective in delivering mental health services to the city and county's least served populations. This success has resulted in the organization becoming a trusted partner for the city and county as these governments strive to increase service capacity to distressed communities. Such partnerships have created opportunities for new funding streams through the United Way, City of Albuquerque, and Bernalillo County. Of note, the Pathways program has recently been approved for a three-year funding cycle that provides stability for the program in the near term. Additionally, CS

has an opportunity to build upon the knowledge and skills of established and experienced staff in this period of rapid growth to facilitate smooth transitions as new programs come on line. The executive team understands there are both opportunities and risks for the organization in this period of growth and have expressed a desire to ensure the organization remains committed to its core values.

In this period restructuring it is crucial staff and managers are aware of what changes are planned and that all areas take inventory of the potential impacts of the change on their programs and ability to deliver services. A non-centralized structure of the organization presents many challenges for any organization, particularly in times of transition. It is important for lines of communication to not only remain open, but to be utilized effectively so all groups remain informed and have the opportunity to express concern or the need for additional support. As staffing needs increase new personnel will need to be acculturated to CS to ensure they understand the decentralized model CS aims to keep. It is important that CS prepare and carry out planned hiring and training of departmental directors to oversee Case Management, Clinical Services, Finance and Human Resources, and Development, Evaluation and Policy. Implementing a mid-level managerial staff will assist CS leadership in carrying out the short- and long-term goals of the organization which include providing services to vulnerable populations without regard for ability to pay, working toward a braided funding model, and community engagement that advocates for systemic and structural changes that eliminate barriers to health services and contribute to poor health outcomes and mental health disparities.

Communication and resistance to the new growth may present threats to the organization in this period of transition. Established employees may require additional skills and resources to cope with the additional complexity that growth brings. CS leadership needs to implement and adhere to systems in order to effectively manage new work loads. Pathways is currently at max capacity as the program has taken on more than mandated. Other departments are at, or near, capacity. Mission stray may occur due to partner requests, funding requirements, or staff expectations when working within the decentralized model CS currently utilizes.

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Appendix A: Focus Group Protocols

Protocol 1

Meeting with Bill and Guiovanna – 10-30-2019

1. Intro: The goal of this meeting is for us to begin a draft of CS overall logic model.
2. To achieve that we want to spend some time discussing what are the goals of CS in the short and in the long term.
    a. What would success in the long run look like for CS?
    b. What intermediate goals would you need to achieve to get there?
3. Now let's think through each of the departments and programs at CS.

a. What is the mission of each of these units?
b. Another way to think about it is to fill in the blanks: A successful (administration/clinical/etc.) department is one that…
c. How do these missions link back to your short term and long-term goals?

Here's a list of the programs.

Administration
Clinical
Peer/ Case Management
Outreach, Education, Enrollments
Substance Use Disorder
Psycho-Education
Fundraising

4. If you were to use a "Venn diagram" to show how your programs fit into each of these departments, how would that look like?

Here's a list of programs:

Enrollment & Outreach
Critical Time Intervention (CTI)
DWI
Immigrate Well-being Project (IWP)
Tertulias Project
Pathways
Peer Case Management
Strengthening Families Program (SFP)
Strong Roots
Suicide Prevention
Victims of Crime Act (VOCA)

5. Now let's talk about the ongoing restructuring:
   a. How will the new and reformed CS look like once this process is complete?
      i. How do you think this will affect CS clients?
   b. Now, going into specifics, let's discuss the steps you've followed/will follow to complete this process.
      i. Discuss changes in staffing, infrastructure, grant seeking strategy and sustainability.

Protocol 2

Meeting with Bill and Guiovanna – 12-5-2019

1. Intro: The goal of this meeting is for us to begin a draft of CS overall logic model.
2. To achieve that we want to spend some time discussing what are the goals of CS in the short and in the long term.
   a. What would success in the long run look like for CS?
   b. What intermediate goals would you need to achieve to get there?
3. Now let's talk about the ongoing restructuring:
   a. How do you think this will affect CS clients?
   b. How do the clients perceive the restructuring (are they aware of it)?
4. Now, going into specifics, let's discuss the steps you've followed/will follow to complete this process.

a. Discuss changes in staffing, infrastructure, grant seeking strategy and sustainability.
b. How do departments understand the growth and restructuring? Department's responsibilities in the restructuring process – what activities are they responsible for? How is each department contributing to the growth? (Note: when meeting with staff – how do the department's and the staff understand their roles, responsibilities)

5. What are the plans for hiring vacant positions as listed on the org chart? (directors/managers, accountants)
    a. What qualities would people in these positions need to have to add value to the organization?

Protocol 3 (*Draft)*
Staff focus groups – to be scheduled

1. What do you see the long-term vision and mission of CS?
2. What do you understand about the recent growth?
3. How do you feel about the staff restructuring?
4. What are your roles and responsibilities in the growth?
5. Are there needs that you see regarding the growth that have not been addressed by administration?
6. What thoughts do you have about the rate of growth?
7. How are relationships affected by the change?
8. What does good leadership look like in your field/department?

Appendix B: Focus Group Data

Focus Group 1
CS
October 30, 2019
1:10 PM

Begin the process of writing the logic model.

Focus group with the Executive Team – Bill, Guiovanna, Martha
UNM Evaluation Lab – Claudia, Camille, Joseph

Long-term picture/goals (in terms of rubric – successful CS looks like this in 5 years)

- Bill
    - Vision Statement – want to build a healthier, more engaged, and more equitable community. Everything should be moving toward these goals.
        - Listening to staff – a democratic and community engaged and responsive system.
        - Need systems change – not just a service provider, use on the ground services, that are more engaged with wants and needs of the community and barriers faced,

use case management team to diagnose systemic problems. Identify gaps, barriers through data collected to make systems change.

- Want to liaison with community partners whose main goals is to effect policy and systems change.

- Have a model built around where the greatest inequities are
  - Behavioral health – social determinants of health (SDH)
  - Have to look at diagnosis and etiology of mental health – not about causality – is about symptoms.
  - Model the structure that public health structure needs to be/look at
    - Upstream – working toward prevention (but not at the cost of the meeting people where they are at – if in crisis)
    - More intersectoral collaboration – not a silo that can serve every need. Not every need met in house – connect them with service organizations that can provide care.
      - How is advocacy performed – is there a structured process?
        - Do not have a systems change department. Are engaged with partner organizations to advocate for change – as a partnered approach.
      - CS is a safety net to the safety net – need to improve the safety net.
      - Wants all staff to know of these things that impact the things CS does.
    - Looking at the geography of where the inequities are – where are the barriers for people to access services, see people regardless of ability to pay, eliminate economic and geographical barriers, eliminate linguistic and cultural barriers
      - Address culture at systemic barrier level (gender, sexual orientation, immigration status – looking at the blind spots). Need internal structures to examine these blind spots.
      - How the colonial history of ABQ, NM and racist structures have gone unchanged over centuries and how those influence disparities in access to health care.

- Funding is currently not aligned fully with these goals.
  - Pay if you can model is not sustainable – so then need to contract with governments, and seek grants from foundations that require you to collaborate with other organizations in order to be seriously considered for funding.
    - Have to build programs that target the specific populations that government and foundations want to target.
    - Most funding contracts do not allow for administrative costs to be covered. Need to address this – the system in the U.S. is based on public/private partnerships.
  - Currently having success because providing good service – but doing good or bad work is not why an organization succeeds or fails.
    - Need to look at what has happened in behavioral health in NM over the past decades.

- We are at a point where NM residents have said "enough" and they are going to fund behavioral health. You cannot be here and ignore the fact there are people not receiving the help they need in terms of behavioral health.

- Clinical and Case Management (departments)
  - But Case Management is also a program
  - We (UNM Eval Lab) have defined org levels as Executive, Managers, and Staff
  - Claudia - We need definitions of the departments – right now we have lists. So when we approach managers and staff we can ask them what is the real work that is being done, real goals and aims of the department.
- Spaces for leadership have to be created and acknowledged at all levels – just developing departments and delegating authority to other areas.
  - Need to grow their own (leaders?) – student pipeline program – core to mission.
    - Racism and colonial process was all about exclusion – eliminating spaces for people to participate. Need to create space and support so it can be successful and not go awry.
- Claudia - What is the Tertulias Project?
  - NIH Grant – Women's support group – to be expanded and partner with One Hope Centro de Vida – 2-3 groups in International District and 1 in South Valley – support group for immigrant women.
- Strong Roots – partnership with Casa de Salud – for anyone with substance use additions – specifically Opiate pain drug addictions – CS does counseling, Casa de Salud does medical interventions.
- DWI – court mandated therapy
- Suicide Prevention – braided funding.

- Giouvianna
  - Need a clear model developed in order to expand into new geographic areas (beyond Bernalillo county)
    - Org chart – of all departments/programs so they can run effectively
    - Policies and procedures
    - Mission/vision statement
    - Funding
  - How do you overcome the gaps in funding?
    - Look at other organizations and see what they are doing and model off of that.
      - With county – look at billing structure so can see what services are being provided that can be billed and those that are not.
        - Billable hours can be unrestricted funding so can cover expenses if a funding stream is lost or expires. Need to plan for changes in funding.
  - Community engagement for systems change.
  - Define programs according to funding – how do departments overlap?
    - Is there any document that describes and defines the mission of each department – the 990 – but needs to be updated.
      - What are the corresponding aims of each department?

- Goal is to have one person from each department at each location
    - Not clear if there will be overlap in management between departments
    - Locations
        - CS South Valley
        - La Casita
        - Hopkins

Focus Group 2
Hopkins Center
December 5, 2019
10:15 AM

Focus group with the Executive Team – Guiovanna, Martha, Bill (arrived 10:50 AM)

Guiovanna:
Restructuring:

1. Each team now has a program manager or director.
    a. Identify roles for those individuals.
    b. Getting ideas from partner orgs.
        i. Mentorship with Enlace E.D. and using as a model.
            1. Program manager/director (overseeing clinical portion of the program) and a lead person (working on invoices and reporting of the program – admin functions).
                a. Supporting each other.
        ii. Audit – get a booking or accountant on staff focused on the financial part of the organization.
            1. Guiovanna cannot keep up with all accounting functions – monthly recons, payroll, journal transactions.
                a. Hire an entry level accountant so they can move into a CFO position and leading that area.
                b. Martha moving into director position and leading development and growth.
2. How will it affect current staff and clients?
    a. Current staff – provide opportunities for leadership who've been with the org for a while and would like to enter admin roles.
    b. Client – will be able to provide more direct services. Will allow more individuals to come in for case management.
        i. Can evaluate the program and see what capacity is – what one individual can see in one year – how many clients – don't have this data yet.
        ii. Idea of change with hiring of 4 more clinical staff – through pathways program – target to see 35 individuals per year. But Margita and Paula (?) were easily seeing double those numbers. Are very experienced. New individuals have varied experience and may not be able for that size caseload. Goal is 30 individuals per hire.
3. How do you see departments perceiving the restricting?
    a. Have had several methods of communication – email to staff and 3 staff meetings to introduce changes. Based on feedback from staff does not think they are doing a good

job of communication changes. In meetings with case management team there are many questions and things to not seem clear.

4. Claudia – what is the strategy or vision for CS in 6 months? Her understanding is that they want each area led by director and lead under supervision of Guiovanna and Bill. Do they have clarity about how they are creating the lines in the sand between departments?
    a. Have begun with case mgt team – everyone will have a case mgr when they come in. Will be triaged and assigned to different programs. But have new case mgrs..
    b. Clinical department – needs a director – currently split between Jackie, Amanda, and Bill who operate very differently. Talks with Bill about who can move into clinical director direction position. Bill cannot do this anymore due to size of the program.
5. What are each departments responsibilities in the restructuring process?
    a. Director or manager of each program to make sure everyone who comes in gets an appointment (Claudia – this sounds like vision – what is part in restructuring)
        i. Working with Jackie and Amanda regarding how they see these changes
        ii. Each area is now in their own space – communication between programs and locations was not there.
        iii. Having regular staff meetings which have been happening now.
        iv. Need to delegate to program mgrs./directors to have better communication – having staff meetings to let them know how this delegating process will go. Created a universal intake package for all of CS. A lot of questions and clarification asked by staff – trying to be as detailed or inclusive as possible.
            1. Claudia – question if a little bit of the confusion is working through the strategic plan and how leadership working through the strategic plan has opened up new questions in developing the strategic plan – how is this feedback loop work.
                a. At beginning of that process. Started planning and now getting questions about that plan.
                b. Should leadership present the changes or have someone else present it? Bc does not think staff is getting what is trying to be communicated.
                c. CS has committees – to talk about the changes and safety in each space for staff and clients. Committees for PNP – review. Committee on self-care – ensure staff is taking care of self. Marketing and communications committee – revamp with new logos and marketing materials.
                    i. Each committee has a team lead that reports back in staff meetings.
                    ii. Bill – there has been a massive expansion. Going to apply for ~$1 million from county for facilities. Propose offices on Coors and Blake that are still in south valley but are a different community. Also growing into Valencia county. One time capital outlay. Has a decent shot of getting some or all what ask for. Opportunity to get more space. Metaphor – family that has gone through a lot of change and now coming back together and a lot is coming up. A lot of growth = a lot of change = and a lot fear of change, anxiety, questions. These are

people's livelihoods so worry about security and safety. Trust can break down quickly when these shifts happen. Moving into new roles so staff can incorporate the shared vision. People see different things based on the different spheres they are in. Staff needs of doing job in different spheres and worries about a paradigm shift about expectations of what they are supposed to do. Bill has a sense that people are anxious. Space change (new office) is a big source of anxiety. Concern on all levels that CS is growing too fast.

d. Claudia – what do envision for the size of CS?
    i. Bill – based on vision – simple – "a healthy and engage community." Based on role of health care. Is it govt or community's role. CS is taking on govt contracts. Before they could say they were safety net for the safety and not the safety net. Now with govt contracts – is part of the outsourcing of public health with govt. If CS can create a sustainable system through growth in a meaningful way should continue to grow – (Claudia – CS should continue to grow if it maintains it's values?) Yes, cannot just be about numbers and provide shitty service. Does not want this to be the model for growth. Many groups saying they are doing case mgt but are only doing referrals. Want case mgt with advocacy and system navigation. Cannot have a contract that give unrealistic quantitative goals that disrupts the quality of service delivery. Has shown CS has good results in delivery service but have to be wary of contracts they take on to meet the values of CS. And staff are worried roles and procedures may change so staff are not happy in their work.

2. Board meeting – Bill – board said CS is growing so fast they don't know what direction CS is going.
    a. Meeting in which Bill had to provide vision for 2025.
    b. Need a strategic plan but also going through staff meetings (family therapy) where people are airing grievances and concerns. Unsure how restructuring affects friendships and relationships with people they work with.
    c. Strategy is going to people rather than coming to CS leadership.
    d. Giving people promotions can create issues – why didn't I get the promotion? Or I don't want that person as a supervisor?
    e. Strategic plan – one of the challenges of the model is that they are not under one roof. How do you keep the structure and the freedom to get the work that needs to be done. Place they need to focus on is refocusing on communication. Instead of all attention out to community, funders, or growth. And needs to turn that focus back inward toward CS staff.

f. Opportunities – funding, etc. are now coming to CS and they have to act quickly. This type of growth is pulling Bill and Guiovanna from their regular duties.

3. Claudia – plan for financial stability?
    a. Bill – that is the role of govt – have a dept of health and it's well funded. CS does not have that.
    b. Funding streams – fee for service. Goes directly to pay for the service. VOCA – govt grants give about 10% for admin. Pay for admin from gen operations when they get a grant for that. Kellogg $50K and Sandia foundation $20K. Pays for one admin.
        i. Need to add a couple more admin positions. Can't cover everything needed.
        ii. Have critical mass in services that can take advantage of other funding – Comprehensive Community Support Services (CCSS). Bill does not like CCSS for what they represent – dumping money into case mgt – shrank pool of case mgt and get training from the state. But now CS is invited to this club and can do CCSS and bill Medicaid and create new jobs at CS. Trying not only to be a service provide but create a culture of practice of people who care about culturally and language appropriate care/service. Risk of institutional level is that service side grows does not grow too fast that admin side cannot keep up.
            1. Guiovanna – let's put is on paper, agree on how CS moves forward and give a timeline.
            2. Claudia – is there a timeline for the vacancies to be filled?
            3. Guiovanna – only have funding for 1 of 4 admin positions. But have funding for service side vacancies.
            4. Bill – when you're part of govt state and local govt doesn't want to pay for things feds pay for. Cannot depend on funding – is set up to org to position where they can bill for services.