2017-2018

Evaluation Plan for Centro Sávila

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1. Introduction

Established in 2011, Centro Sávila serves South Valley communities by providing high quality behavioral health care, assistance in navigating the healthcare system, and community support services. Services offered are culturally appropriate and available regardless of ability to pay. Centro Sávila's staff aims to cultivate a peaceful and respectful healing space that is accessible to all, especially to marginalized populations such as impoverished, Spanish-speaking, or undocumented individuals. Centro Sávila has a Medicaid enrollment program, with stations throughout the city, which helps individuals navigate the enrollment process. The organization is also launching a Critical Time Intervention (CTI) program that hopes to minimize the long-term impact of ACEs through family counseling. Centro Sávila is also involved in the Bernalillo County Pathways program, providing navigators that help fill individuals' unmet needs and, in so doing, help improve health outcomes and reduce health disparities. The program that will be the focus of this evaluation is Centro Sávila's clinical program.

In October 2017, Samaritan Counseling announced that it would be closing its doors. Samaritan Counseling has asked Centro Sávila to take charge of their St. Joseph's program, which serves clients in Albuquerque's International District. While the merger is not finalized, this would broaden Centro Sávila's efforts to provide holistic, affordable, and culturally and linguistically appropriate care to the immigrant and underserved populations in La Mesa and Trumbull Village neighborhoods in Southeast Albuquerque. St. Joseph's shares Centro Sávila's commitment to empowering clients by taking a systemic perspective and engaging community and individual resources to encourage and maintain positive mental and behavioral health.

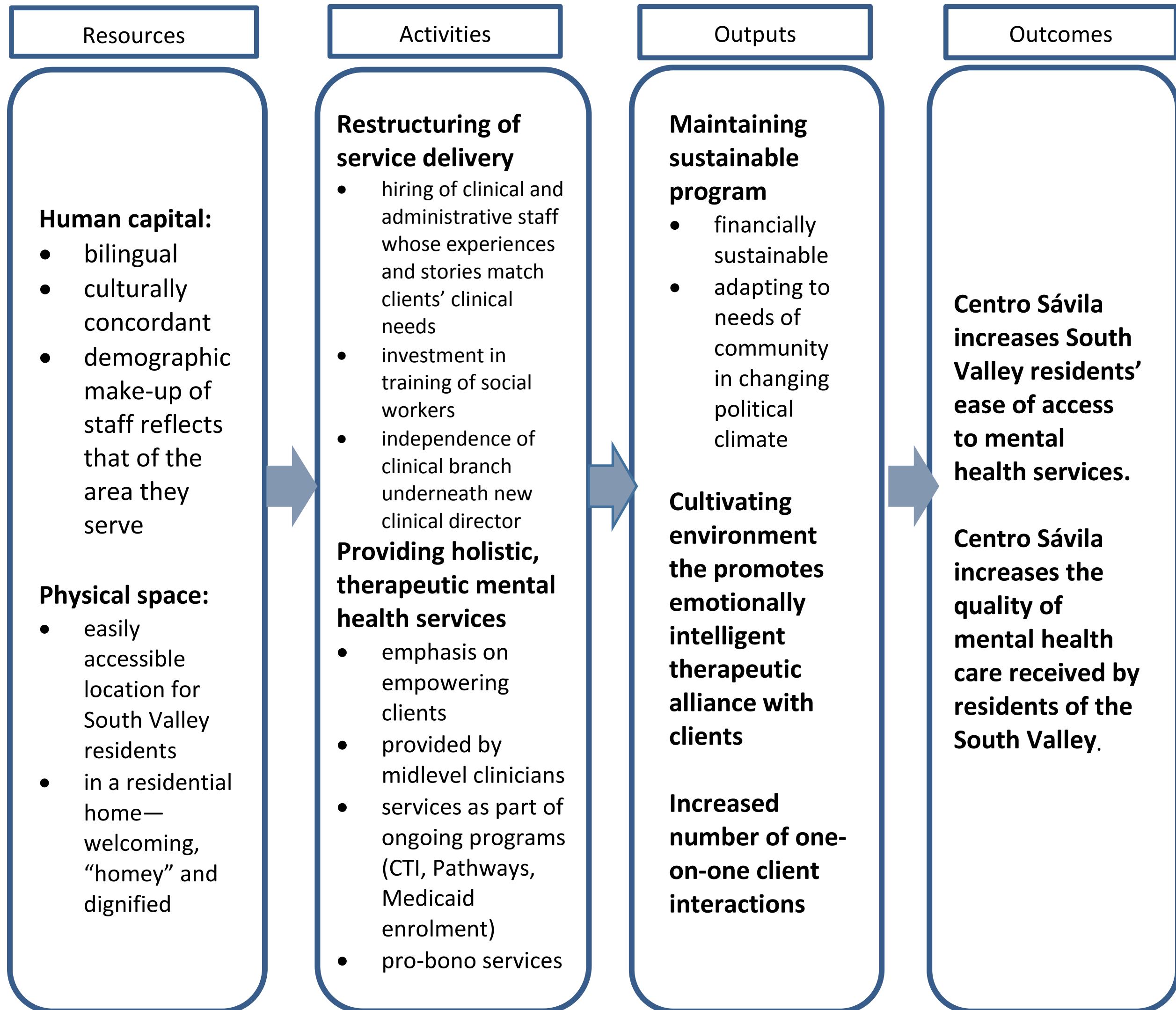
2. Purpose of Evaluation

The primary aim of this evaluation is to assess the extent to which Centro Sávila is meeting its organizational goals of (1) ensuring access to behavioral health care for underserved and immigrant population of the South Valley and International District, (2) providing culturally and linguistically appropriate care for these populations, and to determine (3) whether clinicians' experiences with patients are consistent with Centro Sávila's goals.

The team will employ qualitative methods to collect data from Centro Sávila's staff and clients regarding their experiences with the organization. Based on these qualitative findings, we will be able to provide a preliminary assessment of what is working, what is not, and our program recommendations. To the extent that our team can provide recommendations and develop a survey instrument for future use, this evaluation's ultimate purpose is to build Centro Sávila's evaluation capacity and provide broad suggestions that supplement Centro Sávila staff's own expertise.

3. Logic Model

FIGURE 1: LOGIC MODEL, Centro Sávila Clinical Program



Centro Sávila’s clinical program goals are to increase South Valley residents’ access as well as quality of behavioral health care that is respectful, empowering, and culturally and linguistically appropriate.

This logic model captures Centro Sávila’s efforts to emphasize the importance of training staff and treating patients with contextual understanding of the structures and systems, locally and nationally, in which Centro Sávila operates. Centro Sávila prioritizes hiring staff who are culturally and linguistically concordant with the population that they serve in the South Valley, and creating a nurturing and respectful space, both in terms of its physicality and its organizational culture. This can be seen in the logic model’s focus on physical space and human capital as important resources for the organization. This is

also evident in the prioritization of cultivating an environment that promotes emotionally intelligent therapeutic alliances as an organizational output.

As an organization, Centro Sávila operates within the context not only of intersecting aspects of health care systems, but also in the context of intersecting historical and political forces that shape the lives and treatment needs of the patients they serve. The South Valley and International District are areas that experience high levels of poverty, low levels of health care coverage, and many residents are not US citizens. The economic disadvantage and other forms of marginalization experienced by residents can be traced back to the historical trauma embedded in these areas as a result of the violent colonialism by Spain and America. Contemporary economic and health care policy only serves to widen these inequalities. New Mexico's behavioral health care system has undergone a series of upheavals in the last two decades. Each successive shift in policy has further disadvantaged marginalized populations seeking behavioral health services and constrained the providers of those services.

4. Context

The economic structure in Centro Sávila's service areas helps us understand residents' standard of living and its relationship to community health. Residents in the South Valley and International District have lower household income, higher poverty rates, and higher participation in federal income support programs, compared to the rest of the city and nationally.

For example, the estimated median annual household income[1] for the United States was $55,332. This income is $17,683 higher than the median household income in the South Valley and nearly $30,000 higher than the median household income in the International District. (See Figure 2.)

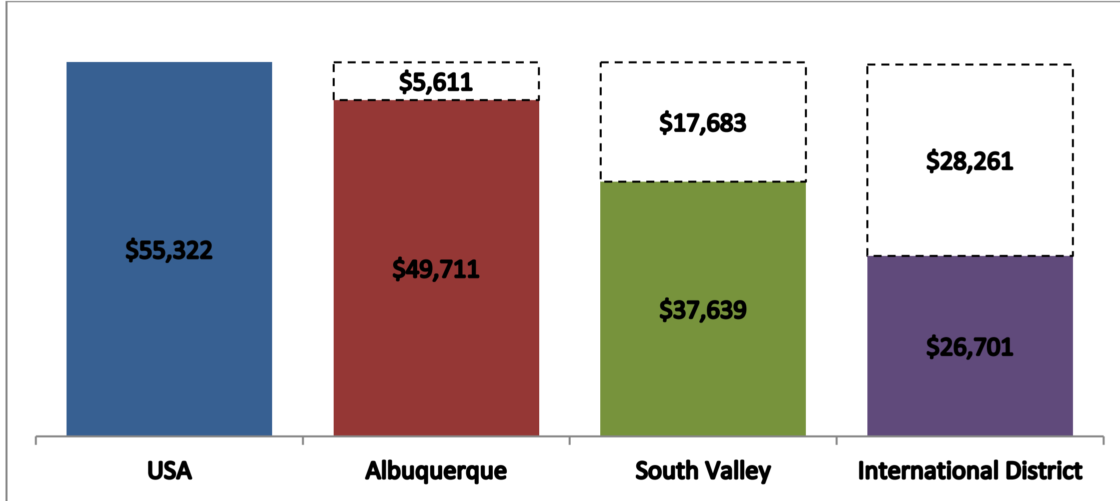
People in the neighborhoods served by Centro Sávila are also disproportionately likely to be poor. The national average of people with incomes below the poverty level is about 15%. While the percentage of people living below the poverty line is slightly higher in Albuquerque than the national average, it is much higher in the South Valley and International District. Over a quarter of South Valley residents and more than a third of International District residents have incomes below the federal poverty level. (See Figure 3.)

As a result, participation in public assistance programs, except in the case of cash public assistance, is much higher in these two neighborhoods compared to city and national averages. 11% of South Valley residents and 9% of International District residents receive supplemental security income (SSI), compared to a national average of 5%. Residents of these two neighborhoods also participate in the Supplemental Nutrition Assistance Program (SNAP) at rates that mirror the levels of poverty in these

[1] Median is a term intuitively referring to the "middle" value in a data set. It is a better measure than mean (average) when the data is skewed. When there are very high or very low values, outliers can drive the mean in the direction of those outliers. For this reason, we focus on median income.

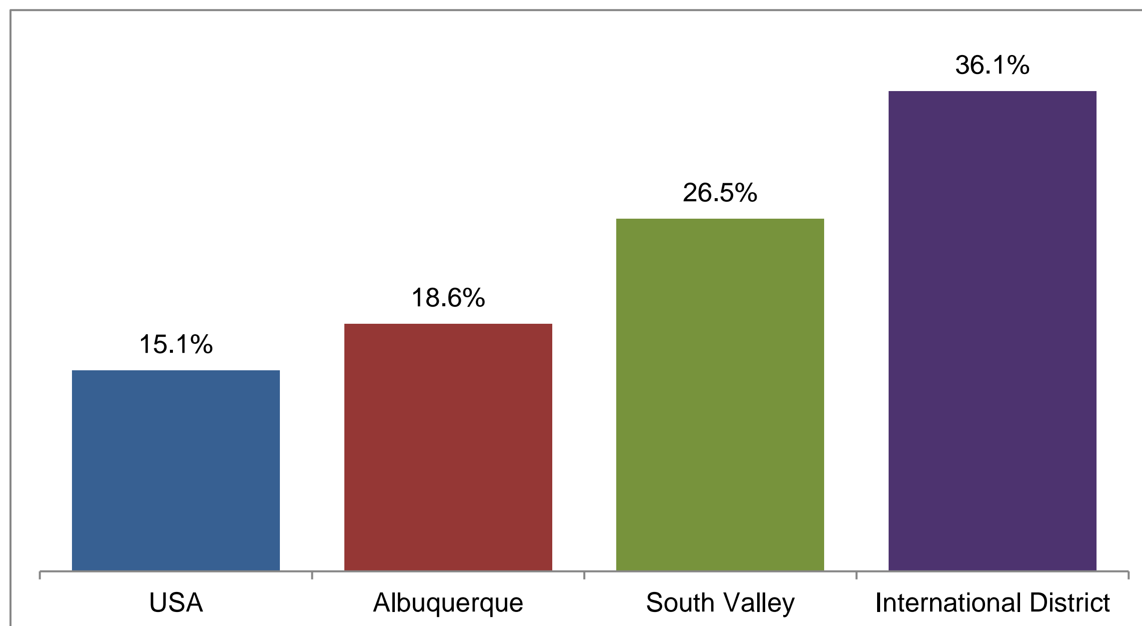
areas. Over a quarter of South Valley residents and nearly a third of International District residents participate in SNAP, compared to 13% nationwide and 16% in Albuquerque. (See Figures 4 and 5).

FIGURE 2: MEDIAN ANNUAL HOUSEHOLD INCOME



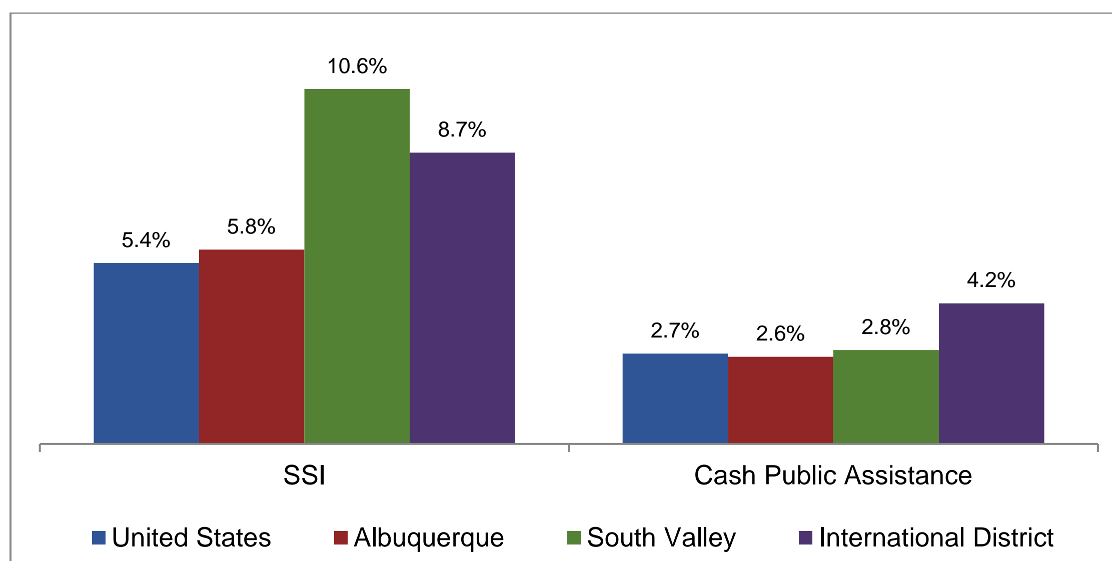
Source: 2012-2016 American Community Survey 5-Year Estimates
Note: The South Valley is identified as a census-designated place (CDP) by the U.S Census Bureau and American Community Survey. Data for the International District was compiled using the zip code 87108, which closely approximates the map of the International District provided by the City of Albuquerque Planning Department (https://www.cabq.gov/planning/documents/internationaldistrict11X17.pdf/view).

FIGURE 3: PERCENTAGE OF PEOPLE WHOSE INCOME IN PAST 12 MONTHS WAS BELOW THE OFFICIAL POVERTY LINE



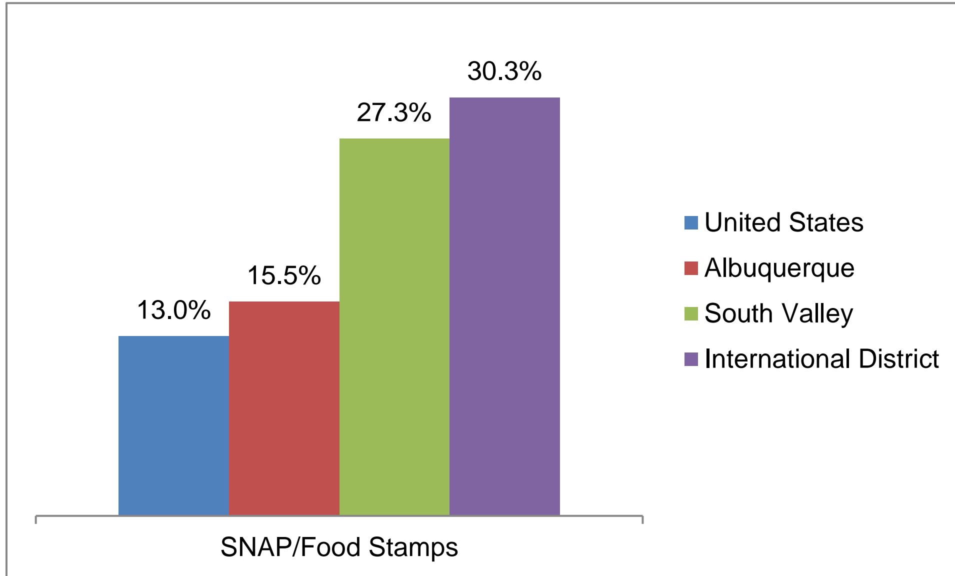
Source: 2012-2016 American Community Survey 5-Year Estimates.
Note: South Valley is identified as a census-designated place (CDP). The International District is defined using the 87108 as a proxy.

FIGURE 4: PARTICIPATION IN PUBLIC ASSISTANCE PROGRAMS



Source: 2012-2016 American Community Survey 5-Year Estimates.
Note: South Valley is identified as a census-designated place (CDP). The International District is defined using the 87108 as a proxy.

FIGURE 5: PARTICIPATION IN PUBLIC ASSISTANCE PROGRAMS—SNAP/FOOD STAMPS



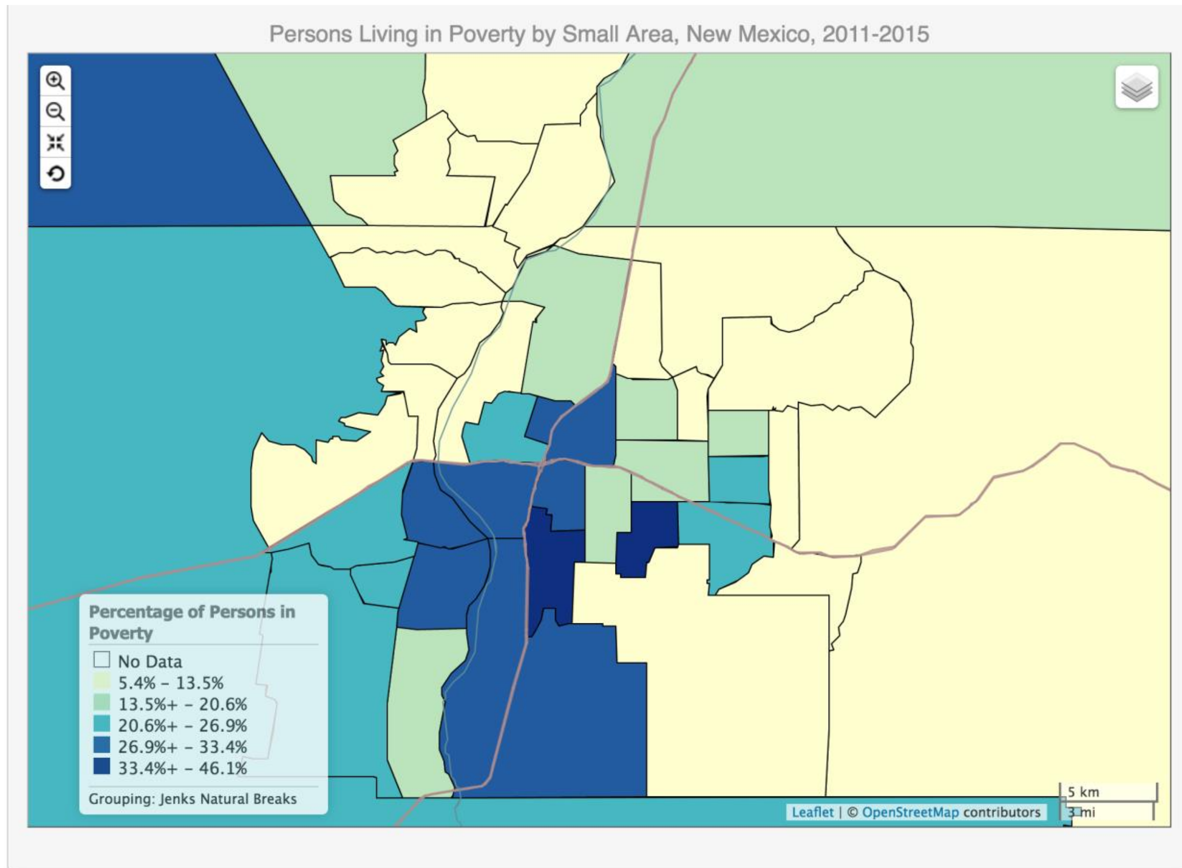
Source: 2012-2016 American Community Survey 5-Year Estimates.
Note: South Valley is identified as a census-designated place (CDP). The International District is defined using the 87108 as a proxy.

The neighborhoods with the highest concentration of poverty in the Albuquerque metropolitan area include the International District, the South Valley and the West Mesa. (See Figure 6.)

Over half of South Valley residents, and over 40% of International District residents speak a language other than English at home. This compares with 30% of Albuquerque residents who speak a language other than English, and 21% for the United States as a whole. 17% of South Valley residents and 16% of International District residents report that they speak English less than "very well." These rates are nearly double the rates who report speaking English less than very well in Albuquerque and the United States as a whole. (See Figure 7.) This linguistic landscape underlines the importance of providing linguistically appropriate services in both the South Valley and the International District.

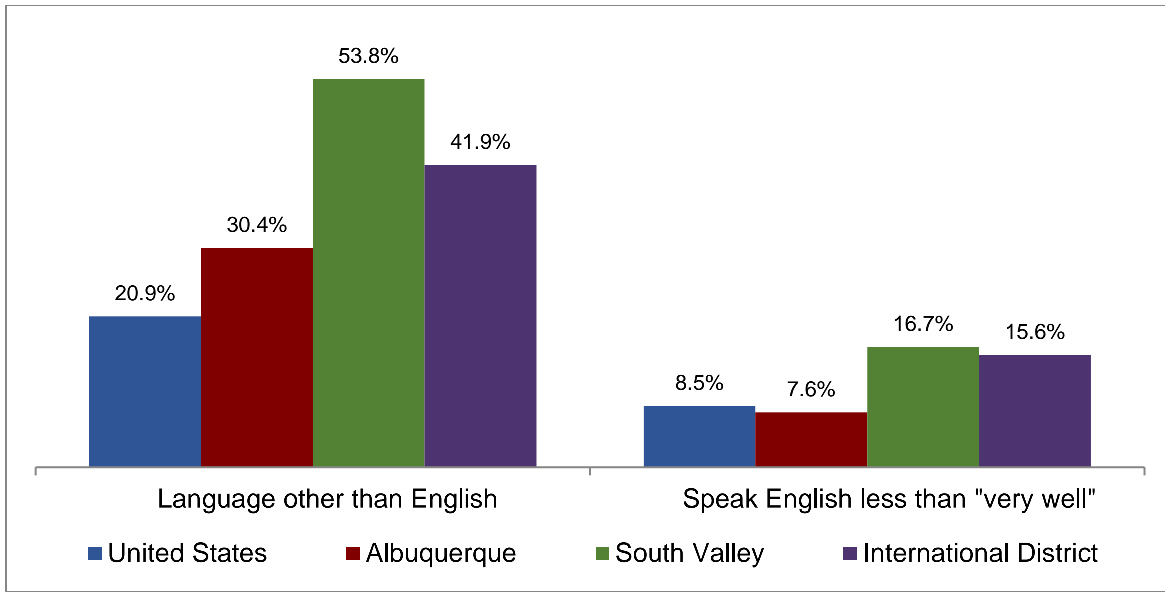
Compared with the United States and Albuquerque, the South Valley and International District have nearly twice the percentage of people who are foreign-born, non-citizens. 11% of South Valley residents and approximately 15% of International District residents are foreign-born non-citizens. In the United States as a whole, 7% of the population are foreign-born non-citizens and in Albuquerque, 6% of the population are foreign-born non-citizens. (See Figure 8.)

FIGURE 6: PERCENTAGE OF PEOPLE LIVING BELOW FEDERAL POVERTY LEVEL IN ALBUQUERQUE METROPOLITAN AREA



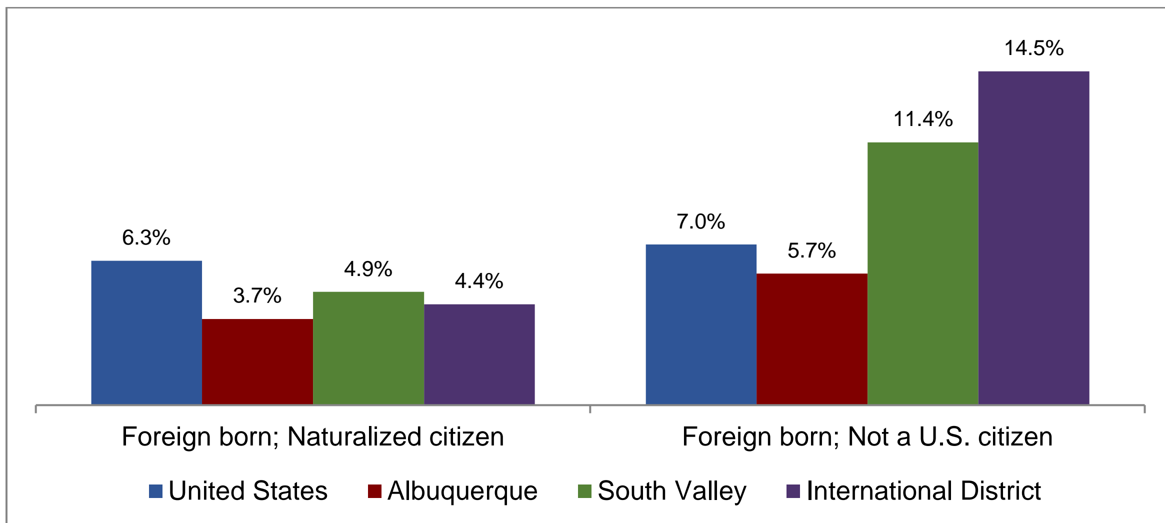
Source: New Mexico's Indicator-Based Information System (NM-IBIS), retrieved from Health Topics, Social Determinants of Health, Economic Stability, Persons Living in Poverty:
http://ibis.health.state.nm.us/topic/population/socialdeterminants/EconomicStability.html

FIGURE 7: LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH



Source: 2012-2016 American Community Survey 5-Year Estimates.
Note: South Valley is identified as a census-designated place (CDP). The International District is defined using the 87108 as a proxy.

FIGURE 8: IMMIGRATION AND CITIZENSHIP

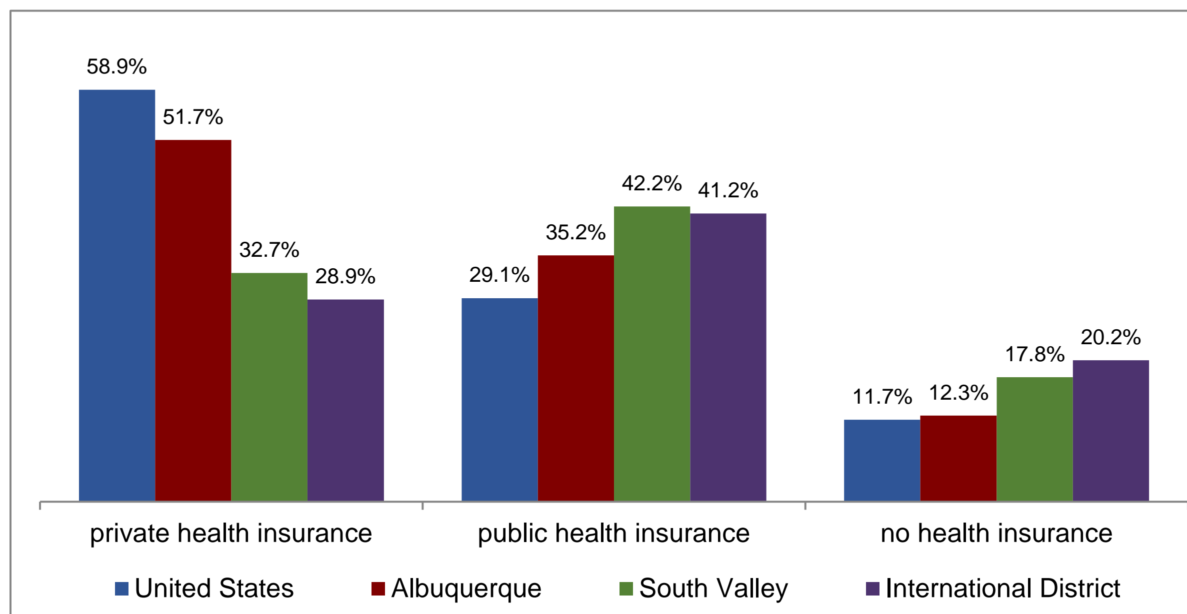


Source: 2010-2014 American Community Survey 5-Year Estimates.
Note: South Valley is identified as a census-designated place (CDP). The International District is defined using the 87108 as a proxy.

The percentage of people with private health insurance in the South Valley and International District (at about 30%) is nearly half of the percentage of people with private health insurance in Albuquerque and nationally. These areas also have a higher percentage of residents with public health insurance or no health insurance. The South Valley and International District each have about 40% of residents with public health

insurance, compared with 35% with public health insurance in Albuquerque and 29% with public health insurance nationally. Also, nearly a fifth of residents in the South Valley and International District do not have health insurance at all, compared with only about 12 percent without health insurance in Albuquerque and the United States. (see Figure 9.)

FIGURE 9: HEALTH INSURANCE COVERAGE

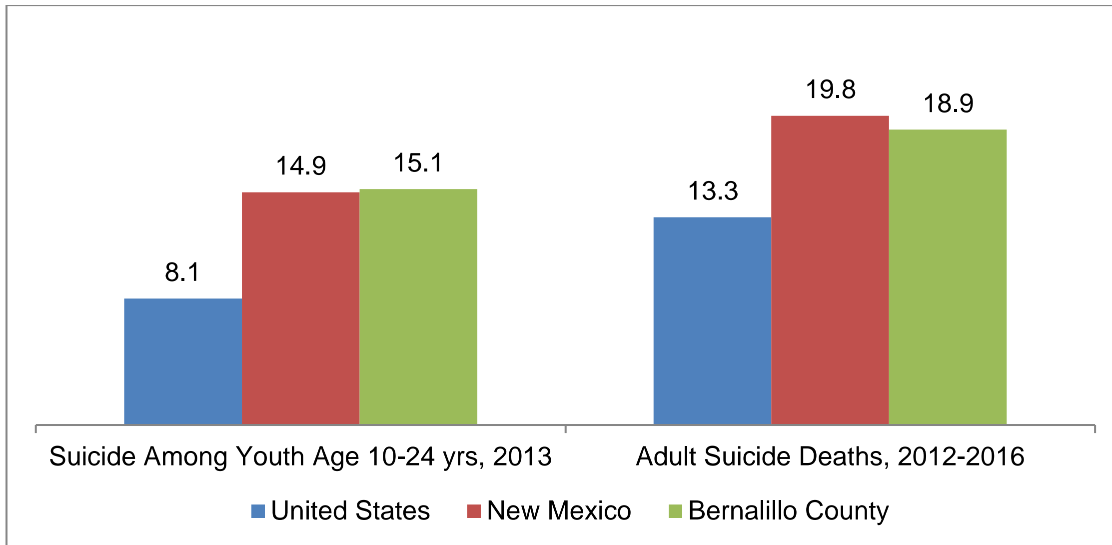


Source: 2012-2016 American Community Survey 5-Year Estimates
Note: South Valley is identified as a census-designated place (CDP). The International District is defined using the 87108 as a proxy.

Suicide deaths among youth in Bernalillo County, the county in which both the South Valley and International District are located, are higher than in the U.S in overall. In 2013, 15 youths for every 100,000 youths died due to suicide in Bernalillo County. The number was substantially lower for the United States (8 youths) and about the same for New Mexico. Similarly, both Bernalillo County and New Mexico have higher rates of adult deaths due to suicide. From 2012 to 2016, the annual average rate of adults who died due to suicide in Bernalillo County was 19 per 100,000 adults, compared with 13 per 100,000 for the U.S. as a whole. (See Figure 10). In 2016, approximately 10% of South Valley residents reported having suicidal thoughts in the past year, a figure nearly double the rate for New Mexico as a whole. (See Figure 11.)

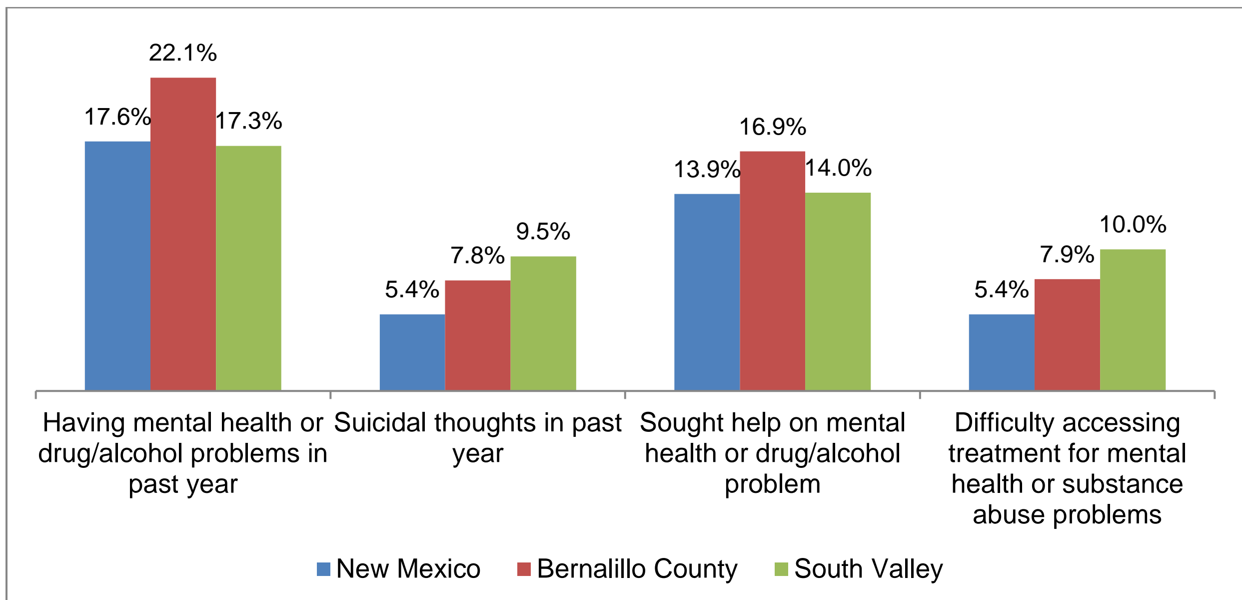
Suicidality is not the only behavioral health concern in Centro Sávila's target population. Approximately 17% of South Valley residents reported having experienced a mental health or drug or alcohol problem in the past year, and 14% reported seeking help for that problem. While these figures are comparable for New Mexico and Bernalillo County residents, South Valley residents experienced more difficulty in accessing behavioral health treatment. Of South Valley residents that reported seeking behavioral health care, 10% experienced difficulty accessing treatment, compared to 7.9% of Bernalillo County residents, and 5.4% of New Mexico residents. (See Figure 11.)

FIGURE 10: SUICIDE DEATHS PER 100,000 POPULATION



Source: New Mexico-Indicator-Based Information System, https://ibis.health.state.nm.us/indicator/view/SuicDeathYouth.Year.NM_US.html https://ibis.health.state.nm.us/indicator/view/SuicDeath.Cnty.html

FIGURE 11: EXPERIENCING MENTAL HEALTH PROBLEMS AND ACCESSING TREATMENT IN NEW MEXICO, 2016



Source: 2016 NM-OSAP New Mexico Community Survey, Bernalillo County. Data were collected using a convenience sample methodology, but with targeted time frames and venues that were selected to maximize the likelihood of collecting a reasonably representative sample of the population. The survey's data collection protocol states that

this approach is "frequently used for 'hard-to-reach' populations, however, in the case of the community survey, it is being used to add credibility and scientific rigor to the convenience samples collected by communities for the purposes of increasing their sample sizes and potentially to target critical subpopulations."

5. Evaluation Team and Other Stakeholders

Evaluation Team:

Alena Kuhlemeier: Evaluation Lab Fellow; PhD candidate in Sociology.

Ozlem Barin: Senior Fellow; MA in Economics.

Claudia Diaz Fuentes, PhD: Dr. Diaz oversees student work as part of the evaluation team.

William G. Wagner PhD, LISW: Dr. Wagner is the founder and executive director of Centro Sávila.

Guiovonna Aguirre, MBA: Director of Operations at Centro Sávila.

Israel Cilio: MSW student intern at Centro Sávila.

6. Evaluation Activities and Timeline

The evaluation questions for Centro Sávila's clinical program are:

1. How do clients' experiences in looking for and using health care services in traditional settings compare with their experiences at Centro Sávila?
2. How can these experiences inform Centro Sávila's ongoing organizational changes?
3. How do clinicians' experiences overlap or differ with respect to Centro Sávila's goals?
4. What are Centro Sávila's clinicians' perspectives regarding the organization's successes and failures in helping clients navigate barriers in access and quality of care?
5. How can clinician experiences inform Centro Sávila's ongoing organizational changes?

Evaluation Design

To achieve this goal, we propose the following steps:

1. Conduct up to 2-3 in-depth interviews with clients of Centro Sávila's clinical program to understand their experiences accessing and receiving care at Centro Sávila, with special focus on the barriers that clients have encountered in trying to access care.

2. Conduct up to 2-3 interviews with Centro Sávila staff members. Ideally, we will conduct one interview with a current Centro Sávila clinical staff member, one interview with a former St. Joseph's staff member, and one interview with a social work student intern.
3. Based on qualitative data derived from these interviews, we will update the survey used in last year's evaluation

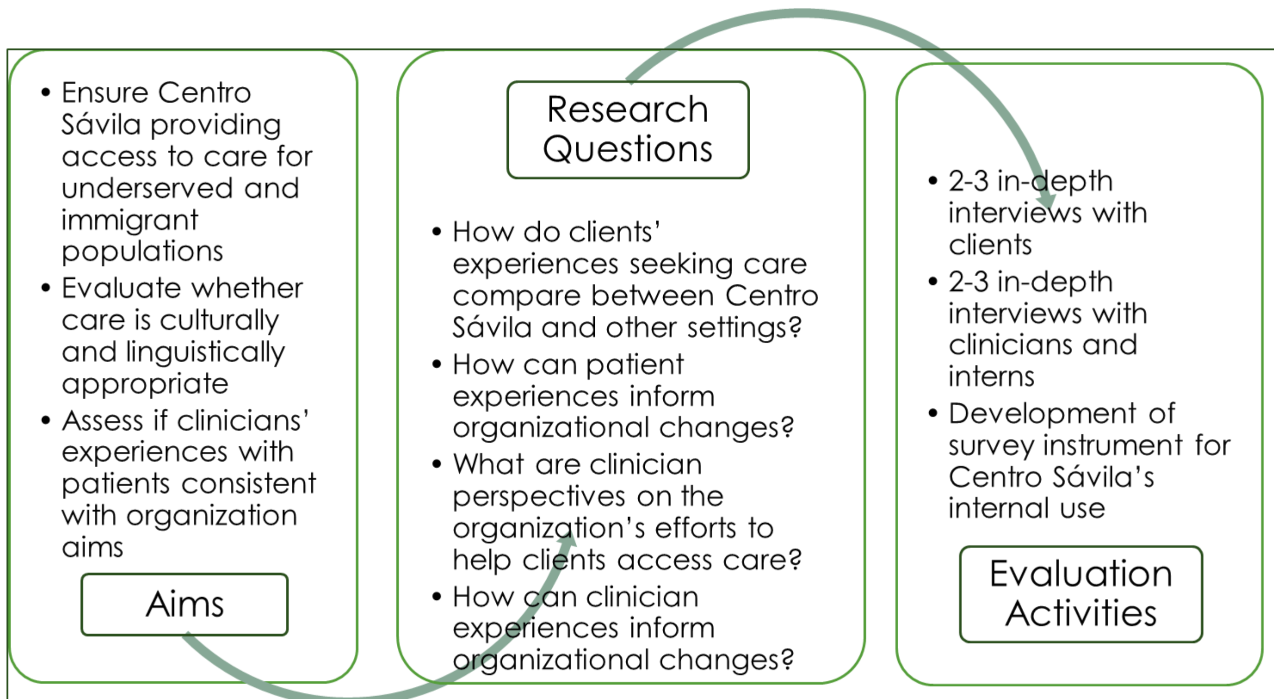
Step 1 will yield information about clients' experiences gaining access to behavioral health care at Centro Sávila. Specifically, interviews will elicit clients' experiences accessing behavioral health care outside of Centro Sávila compared to their experiences accessing care through Centro Sávila. These interviews will also seek clients' perspectives on the quality of care they receive at Centro Sávila, specifically in regard to the clinical staff's therapeutic approach and the extent to which the care they receive is culturally and linguistically appropriate.

Step 2 will yield information about the clinical staff members' perspectives on existing and needed services and how cultural relevance of services makes a difference.

Step 3 uses interview data from Steps 1 and 2, as well as existing literature and survey instruments, to develop a survey that can be administered to clients for future use by Centro Sávila. This survey instrument will represent the ultimate goal of this evaluation by building Centro Sávila's own evaluation capacity.

(See Figure 12.)

Figure 12. Evaluation Design



Data collection and analytical plan:

Qualitative interview data: Our data collection will include both audio recordings of interviews and interviewer notes, from two interviewers. All coding of data will be focused on broad themes within the data.

> *Client Interviews:* Client interviews will likely be conducted in Spanish with Spanish-speaking clients. The team lead, Claudia Diaz-Fuentes will be conducting these interviews with an assistant and coding the audio recordings of these interviews. Alena will code the two sets of interviewer notes for these interviews.
>
> *Staff Interviews:* Staff interviews will be conducted in English. Alena and Ozlem will be conducting these interviews and coding the audio recordings. Claudia will code the interviewer notes.

Survey instrument: We will use as a starting point the survey instrument that was developed for last year's evaluation as well as other empirically-tested survey instruments that have been designed to measure cultural appropriateness of health services. Based on the findings elicited from our thematic coding of the qualitative interviews and existing survey instruments we have collected, we will tailor the survey instrument to meet Centro Sávila's needs for internal evaluation. While we will not be able to beta test the survey this year, we will obtain feedback from clients regarding the survey's clarity and relevance.

References

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Appendix: Literature Review

Centro Sávila seeks to provide high-quality, culturally relevant behavioral health care to marginalized and underserved populations in Albuquerque's South Valley. Given this commitment, Centro Sávila prioritizes a system-level understanding of the barriers people face in trying to access behavioral health care. Dr. Wagner, the director of Centro Sávila argues that it is important to understand the disconnect that often exists between the behavioral health services that are offered and the needs of the individuals that Centro Sávila seeks to serve. Often, providers neither understand the particular marginalized social position inhabited by patients like the ones served by Centro Sávila nor the best ways in which to provide care. The contextual and structurally-cognizant approach taken by Centro Sávila is vital for providing the types of behavioral health services that will be most effective in addressing the needs of these patients.

For instance, providing effective behavioral health care requires understanding the system barriers that might operate to prevent people from accessing care through normal channels. New Mexico has experienced a number of dramatic upheavals in its behavioral health care system in recent years. Most of these major system-level changes have had profound negative effects on those who receive behavioral health care. Dr. Willging, a medical anthropologist, has done qualitative work throughout the state to make sense of the broad impacts that these behavioral health system restructurings have had on patients and providers. The adoption of a Medicaid Managed Care (MMC) system of behavioral health care delivery in New Mexico in 1997 mirrored a shift to this model of service delivery nationally (Willging et al. 2008). But MMC had a particularly deleterious effect for patients in New Mexico. As a poor and largely rural state, behavioral health care provision in New Mexico is made possible by federal and local funding of safety net institutions. By providing fixed monthly payments regardless of services rendered and greatly increasing the administrative burden borne by providers, the Medicaid managed care system in New Mexico prevented these safety net institutions from providing care to as many low-income clients and forced many to stop serving uninsured patients. Many of these provider organizations had to turn to non-Medicaid clients to supplement their earnings and allow them to remain financially sustainable (Willging et al. 2008).

This is a dilemma Centro Sávila has had to navigate as recently as last year. As Willging and colleagues (2015) point out, the Martinez administration's accusation that the 15 largest behavioral health agencies in the state were engaged in Medicaid fraud and the accompanying takeover of these agencies by for-profit companies from Arizona drove the New Mexican behavioral health system back into the disastrous era of the Medicaid managed care model. Centro Sávila dealt with this upheaval by bringing on a prescribing psychologist for medication management, and ended up serving a client base that was

largely insured and middle class—going against the organization's mission to provide behavioral health care to marginalized and underserved populations. To remain accountable to their mission, Centro Sávila no longer has a prescribing psychologist on staff and has worked to collaborate with other behavioral health providers in the area to provide a safety net of services (Pathways navigators, CTI program, community table) for residents of the South Valley. This network of South Valley organizations not only provide much-needed services, but by their collaboration and community involvement, destigmatize and normalize behavioral health services. Through this systems-level perspective and collaboration, Centro Sávila is in an optimal position to address disparities in behavioral health care access (Alegria et al. 2002).

To make sense of the context in which Centro Sávila operates, it is not only important to understand the behavioral health system and the provider side, it is also particularly important to understand the sociohistorical context that shapes the people they serve and the particular health issues they face. In recent decades, scholars have developed theories of historical trauma to understand how a collective trauma experienced by a population, such as colonization or genocide, has profound physical, psychological, social consequences that are transmitted across generations. This literature is well-developed in understanding high rates of substance abuse, suicidality, and depression among Native populations (Brave Heart 1999). This literature has also recently been applied to make sense of similar behavioral outcomes among Mexican American populations living in the American Southwest.

According to the most recent American Community Survey estimates, 80.2% of South Valley residents identified as Hispanic or Latino (U.S. Census Bureau 2016). Estrada (2009) points out that Mexican-Americans have borne the trauma of not only Spanish colonialism but the neo-colonialism of Anglo-Americans. Estrada (2009) argues that in this context,

> The application of the concept of historical trauma to describe this internalization process has some appeal when contextualized by 500 years of oppression and subordination of Mexican-origin peoples, which continues today through anti-Mexican sentiment and the militarization of the United States–Mexico border as a result of the immigration dispute (334).

The internalization process to which he refers is the extent to which this "physical and psychological violence, economic destruction, and cultural dispossession" gets turned inward through psychobiological stress responses and manifests as issues like interpersonal violence, poor physical and mental health, and substance abuse. While this work is largely theoretical and anecdotal given the difficulty associated with measuring and quantifying a wide-reaching concept like historical trauma, it provides a thought-provoking and important in-road into understanding how historically oppressed populations face a multiplicity of traumas.

One aspect of intergenerational trauma that is of particular concern for Centro Sávila is the way in which this trauma can be transmitted in the context of parent/child relationships and adverse childhood events (ACEs). In 1998, Felitti and colleagues found a strong, cumulative connection between number of ACEs experienced and a substantially increased risk of long-term, negative behavioral health outcomes like alcoholism, drug abuse, depression, and in a largely white, educated, and insured sample. Aside from the comparatively privileged status of many participants, the authors argue that their estimates of the relationship between ACEs and long-term health outcomes are likely to be conservative also because people tend to underreport ACEs when asked to identify childhood abuse retrospectively. The authors point out that it is also possible that individuals might not accurately report certain risk behaviors or diseases—a bias which becomes particularly salient in the case of stigmatized behavioral health issues (Felitti et al. 1998).

When historical trauma operates in the micro-context of the family in ways that disproportionately subject children to ACEs, the cycle of poor behavioral health outcomes in a community becomes cemented. The residents of the South Valley have been structurally disadvantaged by intersecting social and economic forces. Centro Sávila has secured funding to work with CYFD and other organizations in the South Valley to hire Critical Time Intervention specialists that work with kids who have been identified as having experienced ACEs. The goal of the Critical Time Intervention get parents and families involved in learning healthier ways parenting and by proactively addressing the needs of the parents and children, diminishing the profound effects on health that ACEs can have in later life.

Another particularly salient aspect of the trauma experienced by the populations that Centro Sávila serves is linked to the fear, stigma, and discrimination experienced by individuals who are undocumented. These issues can present significant barriers to accessing behavioral health care. Using data from the California Health Interview survey and based on a sample size of 31,912 non-institutionalized Californians with 1,587 undocumented Latinos, Ortega and colleagues (2007) found that undocumented Latinos had fewer physician visits than their US born counterparts, were less likely to have a usual source of care, and were more likely to report negative experiences receiving care. Foreign-born respondents that reported negative experiences receiving care believed that they would have received better care if they had been of a different ethnicity. Foreign-born Latinos agreed with this statement more often than US born Latinos, and US born Latinos agreed with this statement more often than US born whites.

Berk and Schur (2001) delved into one explanation for why undocumented Latinos might be less likely to have a consistent source of care and see a physician fewer times, on average. These authors hypothesized that fear was the key mechanism that kept undocumented immigrants from accessing health care. The authors used data from a survey of undocumented immigrants conducted in four major US cities between 1996 and 1997. Of the 973 respondents, 39% responded that they were afraid that if they sought out care, they would be denied due to their undocumented status. Overall, the authors found that fear associated with lack of documentation is “a powerful deterrent to people obtaining care they believe they need” (Berk and Schur 2001: 155). They suggest that policies that seek to punish undocumented persons create a climate of fear that severely restricts undocumented individuals’ access to care. Though Centro Sávila is particularly concerned with providing quality behavioral health care to immigrant and undocumented populations, it is also important to note that Centro Sávila fills a need in terms of reducing disparities along lines of poverty as well as race/ethnicity, documentation status, and language. Even English-speaking Latinos, especially if they are poor, experience disparities in access to mental health care and disparities in quality and cultural relevance of care (Alegria et al. 2002).