Bernalillo County Behavioral Health Initiative (BHI) Peer Case Management Program Evaluation:
Crossroads for Women (CRFW) and Centro Sávila (CS)

EVALUATION REPORT

FALL 2023

Prepared by Pivot Evaluation
Rose Matzkin, MPH • Denise Garcia, MS • Curt Mearns, PhD
pivoteval.com

Contents

Contents

Who are the organizations mentioned, and what is Program Evaluation?

What is the BHI?

The current Bernalillo County Behavioral Health Initiative (BHI) developed out of the Department of Behavioral Health Services (DBHS) in by negotiated agreement with the City of Albuquerque, via their joint strategic plan to address behavioral health in a shared geographic jurisdiction. The County Manager's office administers the BHI directly through strategic funding for several behavioral health service providers in the County, and contracts with external evaluators to conduct process and outcome evaluations regarding service provider metrics, objectives, and goals. This document refers to BHI generically as the staff the County Manager assigns to manage the funding opportunities.

Who is Pivot Evaluation?

Pivot is an Albuquerque-based organization of four Program Evaluators specializing in local projects related to education, public health, social services, and economic development. BHI contracted with Pivot Evaluation to conduct outcome evaluations of two Peer Case Management (PCM) providers: Crossroads for Women (CRFW) and Centro Savila (CS). Though Pivot and BHI initially planned for a two-year outcome evaluation timeframe, the PCM contracts for these providers expired sooner, prompting this report before the parties developed and implemented a full complement of outcome measures. This report attempts to address outcomes from existing sources. Should either organization receive continued funding, improved outcome measures could immediately be implemented following the 2-year plan.

Who are Crossroads for Women and Centro Savila?

CRFW and Centro Sávila are grassroots community organizations that provide behavioral health services to people experiencing acute and/or chronic challenges, regardless of their ability to pay. **CRFW's mission is "to provide comprehensive, integrated services to empower women emerging from incarceration to achieve safe, healthy, and fulfilling lives in the community, for themselves and their children."** In addition to women returning from incarceration, CRFW provides services to women experiencing poverty, substance use, homelessness, and co-occurring challenges (and

some men as well). **Centro Savila's mission is "to improve the mental health of [the] community by ensuring access to linguistically and culturally relevant, quality mental health and prevention services, education and healthcare professional development."** Centro Sávila provides low and no-cost mental health resources to individuals and families, including outpatient therapy, support groups, and case management.

CRFW's and Centro Sávila's service populations may overlap to a small degree, and neither would turn anyone away unless other better suited organizations exist and have capacity. Crossroads for Women functions mostly as a recovery organization, while Centro Savila has been scaling up to provide a spectrum of services from prevention to recovery. Both CRFW and Centro Sávila provide other extensive services in addition to PCM, to best meet their clients' needs and promote positive client outcomes. Through PCM and other services, clients have progressed on and secured employment, housing, legal aid, government benefits, social-relational skills, and other foundational necessities for physical and behavioral health. Both organizations managed to survive the Behavioral Health shake up under Governor Martinez's administration and the Covid pandemic, demonstrating their community commitment and organizational strength.

How did Pivot conduct Program Evaluation?

Pivot Evaluation began working with these organizations in January 2022 with an anticipated two-year evaluation plan. Pivot evaluators began by revisiting and revising each organization's Logic Model, to clarify program descriptions and expectations, and lay the foundation for evaluation questions and processes. Pivot further gathered data to confirm various process implementation features. The logic model development and the collection of implementation data informs Pivot's outcome evaluations by linking program activities to the outcomes. Pivot developed plans in collaboration with each provider, including multiple meetings and email exchanges to confirm that Pivot's approach honored the providers' perspectives, resources, and interests in participating as an active partner in this evaluation. Finally, Pivot collected data from each organization and conducted qualitative and quantitative analyses of their service provision, generating the findings detailed in this report.

As Pivot began gathering data, it became evident that service provider contracts would expire before the two-year plan could be executed (CRFW's BHI contract for PCM ended in March 2022 and Centro Sávila ended in June 2022). Therefore, Pivot staff members shuffled their plans to collect existing data and provide a report in time for future funding decisions. Should these organizations be refunded, the original two-year plans will provide improved outcome analysis.

Why Evaluate Peer Case Management?

The intention of this report is not to simply give service providers a report card or give BHI a thumbs up/thumbs down about continuing their funding. Instead, this report aims to explore the value of PCM services in our community, illuminate the challenges of PCM service provision, and provide insights regarding future opportunities, understanding, and improvements. Pivot shares findings with the BHI as well as the service providers and service populations involved, to collaborate on complex problems that require everyone's commitment and involvement to improve.

For everyone involved in this report, community behavioral health is more than just a job. This is especially true for Peer Case Managers with lived experience and other service provider staff, but also for BHI, Pivot, and all staff involved. We live here. Our taxes fund BHI. We have known people with behavioral health challenges, have been people with behavioral health concerns, and have seen people struggling with behavioral health in our city. Quality program evaluation allows service organizations to improve their processes while recording various community successes.

▸ What did Pivot's evaluation discover about BHI-funded peer services overall?

Pivot explored several concepts throughout evaluating BHI-funded PCM programs that pertain to BHI contracting overall and could benefit from future evaluation as well.

1. **BHI requests specialist skills from a generalist population when contracting for peer services.** Peer staff are currently required in BHI contracting to perform multiple tasks that go beyond the scope of direct peer services. For example, BHI contracting encourages and/or requires provider organizations to develop alternative funding options for program sustainability, which may include billing services to Medicaid and seeking additional grant funding. Additionally, evaluation collaboration with Pivot required providers to navigate their databases in specific and sometimes new or challenging ways, to retrieve data useful for analytical purposes and not simply relevant to routine operations. Pivot's evaluation found that accommodating tasks beyond an organization's existing practices can be demanding of staff time and capacity, and potentially taxing on staff wellbeing and ability to prioritize the service provision intended. However, collaborating on non-service tasks can also be a fantastic opportunity for supportive relationship development between BHI and providers, and for skill development and learning among nonprofit staff.

   The gap between county expectations and provider staff skills is an opportunity for BHI to recognize the scope of their requests and structure or support their requirements accordingly. Many staff, especially peer service staff, join nonprofits because they have excellent skills and capacity to provide direct services. However, they may not have experience in other specialized skillsets such as database management, grant writing, and clinical case notation, especially if they come from a marginalized or underserved educational or professional background. BHI should appreciate this opportunity for providers to advance their staff skills and continue to create meaningful employment for people with lived experience in the areas they serve.

   Support from BHI could take the form of additional funding for specialized staff and staff training, or additional contract time to implement new non-service tasks and processes. BHI could also fund data system upgrades, or provide a category of flexible funding for providers to use as needed for technical skill development. BHI may also consider creating dedicated county staff roles for Medicaid assistance, grant writing assistance, etc. BHI may consider the ways it can provide structure and support to service organizations any time it requires labor that exceeds routine service provision. BHI can identify tasks that exceed routine service by collaborating on contract development with providers and evaluators.

2. **Community Based Organizations need funding for data systems improvement.** This evaluation found that both organizations struggled with their data systems. Pivot collaborated with CRFW and Centro Sávila regarding their databases, what data gets recorded and how, how to retrieve data for reporting, etc. While at least some of these data activities are within

the scope of Pivot's technical assistance, it became clear that providers would benefit from more dedicated time and effort regarding data system management. Pivot strived to make reasonable data requests to providers, yet some metrics were still technical and demanding for providers to produce. Service providers typically use their databases to facilitate daily interactions, not to aggregate information for comprehensive analyses. Pivot suggests that BHI consider the effort and learning curve required on providers' parts to accommodate program evaluation data requests, and what resources may benefit the process. In terms of data skills and database management, providers may benefit from training, updating systems (with associated research and costs), and dedicated data process analysis/evaluation. Ultimately, having mastery of their own data and data tools benefits providers beyond participating in program evaluation, and can be a valuable investment on BHI's part in local agency capacity.

3. **Peer-lead organizations demonstrate a long-term community commitment which is an invaluable opportunity for BHI.**
   Peer-lead organizations may face unique challenges and learning curves when expanding their programming through grant funding. These organizations often start as grassroots initiatives focused on direct service through face-to-face interaction and material resource provision. Peers with lived experience are amazing advocates for people going through similar situations but may experience unique challenges in the workplace. Running peer services may involve triggering situations, learning new skills on the fly, and the stress of pursuing approval and funding for work that is deeply personal, especially when the program loses funding or struggles to operate. Pivot encourages funders to maintain high standards and expectations for all fundees including peer services but focus just as much on what kinds of supports will help these organizations succeed. Understand that these agencies are likely **works in progress**, and relatively malleable relative to for-profit agencies. Context and collaboration will be just as important as performance targets and compliance during developmental phases. Pivot acknowledges that BHI is already highly receptive and supportive of its funded services. Pivot looks forward to further exploring how BHI can strengthen these organizations to reach the full potential of all involved.

4. **BHI may consider further evaluating the systemic contexts in which service providers operate, and how BHI influences Bernalillo County's network of care.**
   CRFW and Centro Sávila provide extensive services but do not exist in a vacuum. Service providers are both responsive to and an influence on local social dynamics, economics, policies, and the overall local system of networked care. BHI is invested in funding individual programs and organizations and does so in the service of strengthening a service continuum for Bernalillo County. Pivot recognizes these environmental and systemic contexts, and referenced them in the logic models drafted for this evaluation. However, the current evaluation mostly focused on PCM as a standalone program. In future evaluations, understanding how service providers interact in the fabric of Bernalillo County's community of care would clarify implications for program and organizations, and for BHI as a local funder.

What is Crossroads for Women Peer Case Management, and how is it evaluated?

Pivot began this evaluation by meeting with BHI and CRFW to understand CRFW's program. After reviewing organizational documents and meeting with staff, Pivot created the following program description (logic model, Figure 1). This model underwent several modifications based on CRFW feedback and Pivot conceptualizations, resulting in the following confirmed version. The logic model specifies what will be evaluated in the Outputs Outcomes boxes.

Figure 1. Crossroads for Women Logic Model

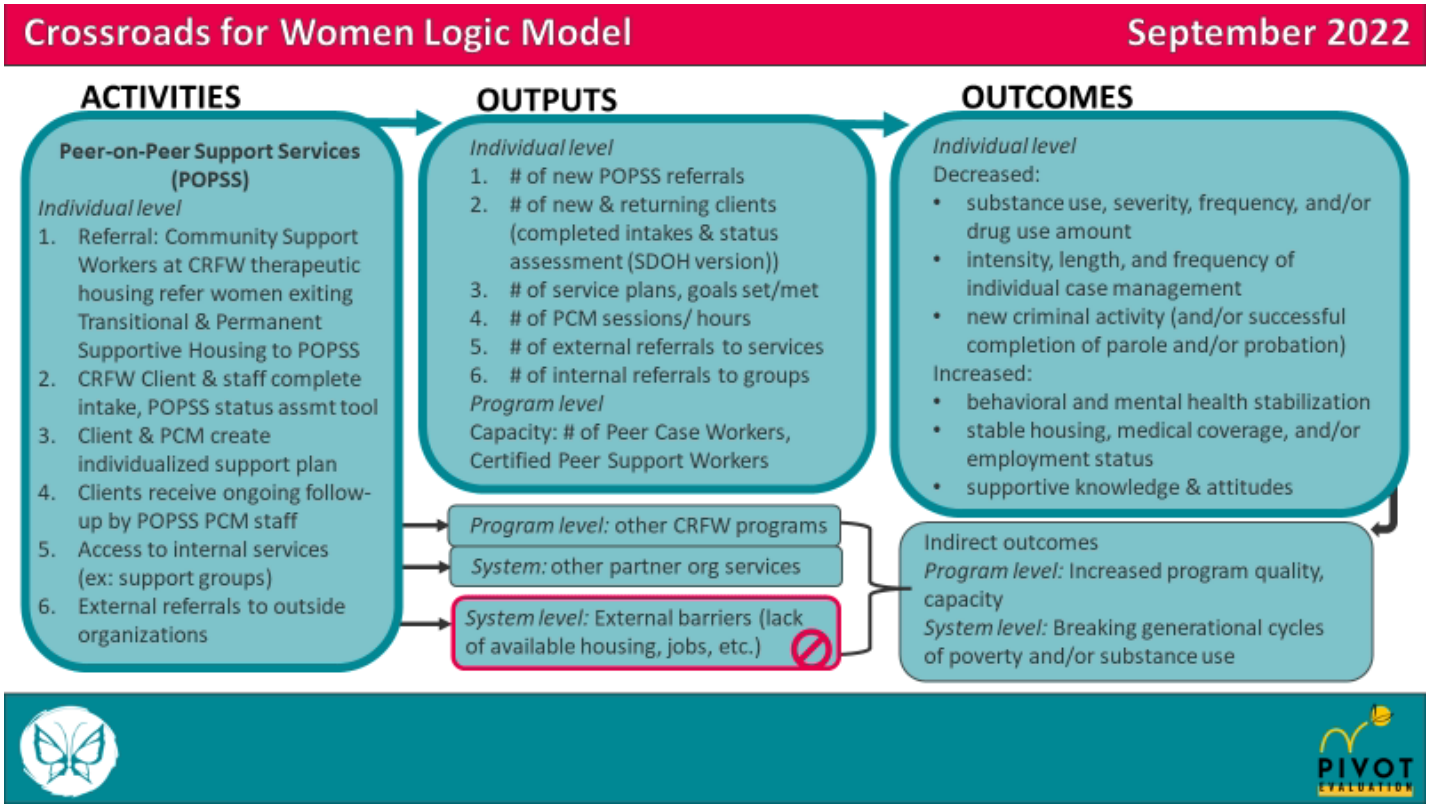
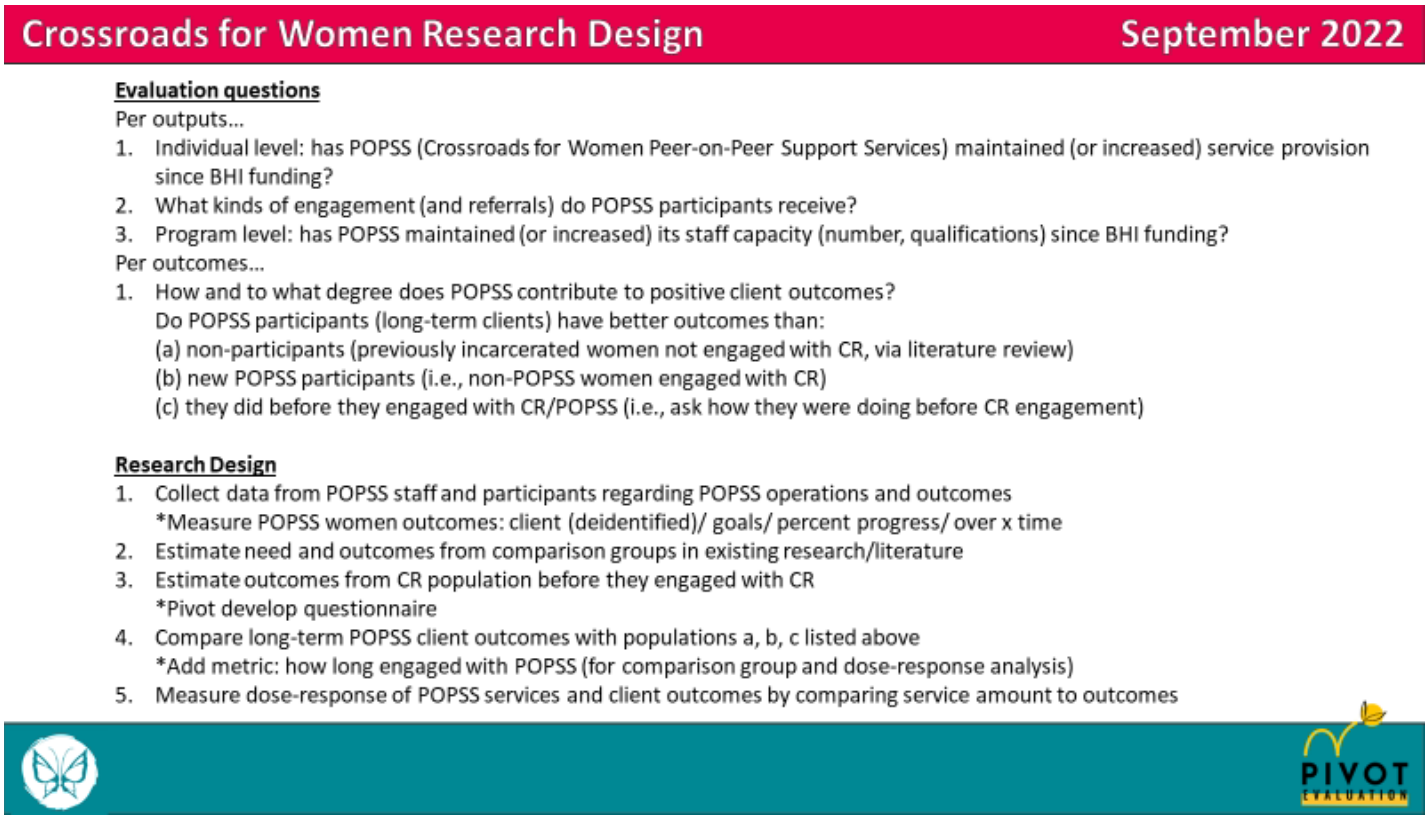


Figure 2. Crossroads for Women Research Design



CRFW Evaluation Questions

Pivot planned to proceed with the following evaluation questions (Figure 2) and separated the questions into two basic groups: process and outcome. Process questions include who participated and what did program staff do with the participants. Outcome questions focused on how participant lives or behavior changed.

Process Evaluation questions:

1. Has POPSS (Crossroads for Women Peer-on-Peer Support Services) maintained (or increased) service provision since BHI funding?
2. What kinds of engagement (and referrals) do POPSS participants receive?
3. Has POPSS maintained (or increased) its staff capacity (number, qualifications) since BHI funding?

Outcome evaluation questions:

4. How and to what degree does POPSS contribute to positive client outcomes? Do POPSS participants (long-term clients) have better outcomes than non-participants? (Previously incarcerated women not engaged with CRFW, studied via literature review.)

The following sections include a brief summary of results to the above questions, followed by detailed findings, which include data and discussion.

What did this study find? (Crossroads for Women brief summary results.)

Following are the brief summary responses to the evaluation questions. For detailed findings, see the subsequent section "What did the study find? (Crossroads for Women full detailed results.)".

1. **Has POPSS (Crossroads for Women Peer-on-Peer Support Services) maintained (or increased) service provision since BHI funding?**
   No; however, the total number of individuals served over the funding period was significant. CRFW's PCM program, called POPSS and sometimes referred to as "aftercare" by CRFW staff, serves previously incarcerated women exiting CRFW's transitional housing program. CRFW currently runs two therapeutic transitional housing sites, one in Albuquerque and one in Los Lunas.

   CFRW peer case management service provision increased from serving 75 individuals in its first funding year (April 2019-March 2020) to a high of 108 at the pandemic peak (funding year two). Since then, records show annual decreases to 48 and 38 in funding years three and -four. This decline in participation subsequent to the pandemic decline is similar to Pivot findings with previous evaluations, where data files from other organizations provided widely differing data.

   CRFW staff also explained multiple factors affecting the variance in service counts across years, including the following:

   - Clients decreased engagement due to burnout with increased data collection, including the Social Determinant of Health (SDOH) data collected with increased frequency for the BHI contract;
   - CRFW experienced staffing shortages resulting in one staff member running PCM alone for three months; and
   - Engagement ***increased*** during COVID when CRFW relied solely on phone and video contact, due to the ease of engaging virtually instead of in-person. Engagement since decreased as some CRFW members have been slow to return to in-person case management. CRFW staff explained that they encourage people to engage in-person when feasible to promote the community, but still facilitate some virtual meetings as needed.

   Another potential explanation is that as the marketing-induced opioid epidemic begins to resolve, fewer individuals will have criminal justice interactions; therefore, reducing (but not eliminating) need for these services. However, evaluators observe that opioid settlement money has not been distributed widely yet, so such an early resolution due to this cause would be unlikely. Further engagement with CRFW staff and clients in future evaluation may clarify different causal reasons for engagement patterns.

2. **What kinds of engagement (and referrals) do POPSS participants receive?**
   CFRW offers three critically important intervention types: emotional support, institutional support, and direct support. The list begins with emotional support for a reason. When dealing with the mass of life challenges these women face, they experience an unavoidable emotional toll. The daily mountain of challenges these women encounter, including mental illness, addiction and withdrawal, homelessness, and violence, would terrify most folks in the general population. Providing emotional support helps most of these women face their daily challenges. CFRW also

provides institutional support to help participants address legal and administrative challenges associated with various social safety net opportunities (e.g. housing, Medicaid, driver's license, etc.). Institutional support helps participants learn to self-advocate and understand how to interact with governmental bodies. Direct support includes a variety of life skills such as personal finance education, resume building, and referrals/appointments to many other community resources to address medical, legal, and other needs.

One third of the 167 total participants during BHI funding used between six and 41 PCM visits, while 50% used just five or fewer visits. And, 16% had more than 41 visits per year. Sixty-five percent of participants exit the program in less than a year and six months. These engagement rates illustrate the variation in client need, with some members only needing or being able to access a handful of sessions for a short duration of time, while others form ongoing service relationships through POPSS.

3. **Has POPSS maintained (or increased) its staff capacity (number and qualifications) since BHI funding?**
   CRFW increased its staff capacity over the course of BHI funding, starting from 1.5 FTE Certified Peer Support Workers (CPSWs) in the first year of funding. In Year two, CRFW increased to two CPSWs and .5 FTE Peer Support Worker (non-certified). In Year three, CRFW increased to two CPSWs and two Peer Support Workers (after a period of short staffing with one CPSW running PCM for a period of three months). In Year four, CRFW retained two CPSWs and one Peer Case Manager.

   Peers with lived experience show tremendous capacity in personal and professional growth, accomplishing emotionally and mentally demanding work every day. Pivot recommends that grantors to peer services maintain high standards and expectations, while focusing on providing the supports and accommodations necessary for these organizations to reach their service potential. "Meeting agencies where they're at" can help BHI support grassroots organizations, peers in the workforce, and Bernalillo's community of care.

4. **How and to what degree does POPSS contribute to positive client outcomes? Do POPSS participants have better outcomes than non-participants? (Previously incarcerated women not engaged with CRFW, studied via literature review.)**
   The outcomes evaluated in this report are nebulous, and heavily influenced by many factors both inside and outside CRFW's influence. By comparing participant and non-participant outcomes, Pivot can make inferences about CRFW's supportive role in women's recovery but cannot quantify exactly how much CRFW contributes to outcomes among populations of the women they serve. Initially Pivot planned to facilitate outcome comparisons between long-term POPSS clients and new/short-term POPSS clients, but limitations in the project structure made it more feasible to compare POPSS outcomes with examples from research literature (see Limitations section below for details).

   Research literature confirms that engaging in supportive services including peer services can help formerly incarcerated women in many different domains of recovery. Recovery can range from decreasing recidivism and substance use to increasing housing, employment, supportive relationships, and simply the opportunity to feel normal and enjoy life. This literature review

supports the conclusion that women engaged in CRFW/POPSS experience more positive outcomes than previously incarcerated women not engaged in services.

What did the study find? (Crossroads for Women full detailed results.)

This section details the results Pivot collected to address the study's evaluation questions and offers a full discussion of the finding's implications. Before proceeding, it is important to note that the data CRFW provided at the interim and at the end of the study did not match well. Some of the mismatches resulted from CRFW upgrading their data collection processes, while Pivot could not determine the source of other mismatches. Therefore, two data collection periods existed: 1) from April 2019 to October 2022, and 2) from October 2022 through March 2023. Tables below indicate the periods for which results represent.

CRFW staff named their PCM service activities POPSS ("Peer on Peer Support Services"). Pivot began by collecting data to address the following process evaluation questions regarding CRFW's service provision to POPSS PCM members over the course of BHI funding:

1. **Has POPSS PCM (Crossroads for Women Peer-on-Peer Support Services) maintained (or increased) service provision since BHI funding?**
2. **What kinds of engagement (and referrals) do POPSS PCM participants receive?**

Pivot collected data from CRFW at two time points and received results spanning two different instruments: CRFW's old client service plan and new client service plan. In 2022, Pivot collected data from CRFW's first three funding years (April 2019-September 2022, referred to as Data Collection 1 (or DC1 in this report). Data Collection 2 (DC2) contained the remainder of CRFW's final grant year from 10/1/2022-3/31/2023. In total, CRFW's BHI contract evaluated in this report extended from 4/1/2019-3/31/2023 (four years), while Pivot was contracted for evaluation since January 2022 for the final 15 months of CRFW's funding period. Pivot encountered discrepancies between the format and content of DC1 and DC2, making it hard to link all CRFW's data across the entire funding period. However, some of the discrepancy was due to CRFW making interim improvements in its data collection processes. For the sake of relevance and feasibility, this report focuses on data from CRFW's new client service plan, the plan currently in use when Pivot was engaged in the evaluation.

Table 1. Number of POPSS Participants per Year.

April 2019-March 2020	April 2020-March 2021	April 2021-March 2022	April 2022-March 2023	**Total**
75	108	48	38	**167**

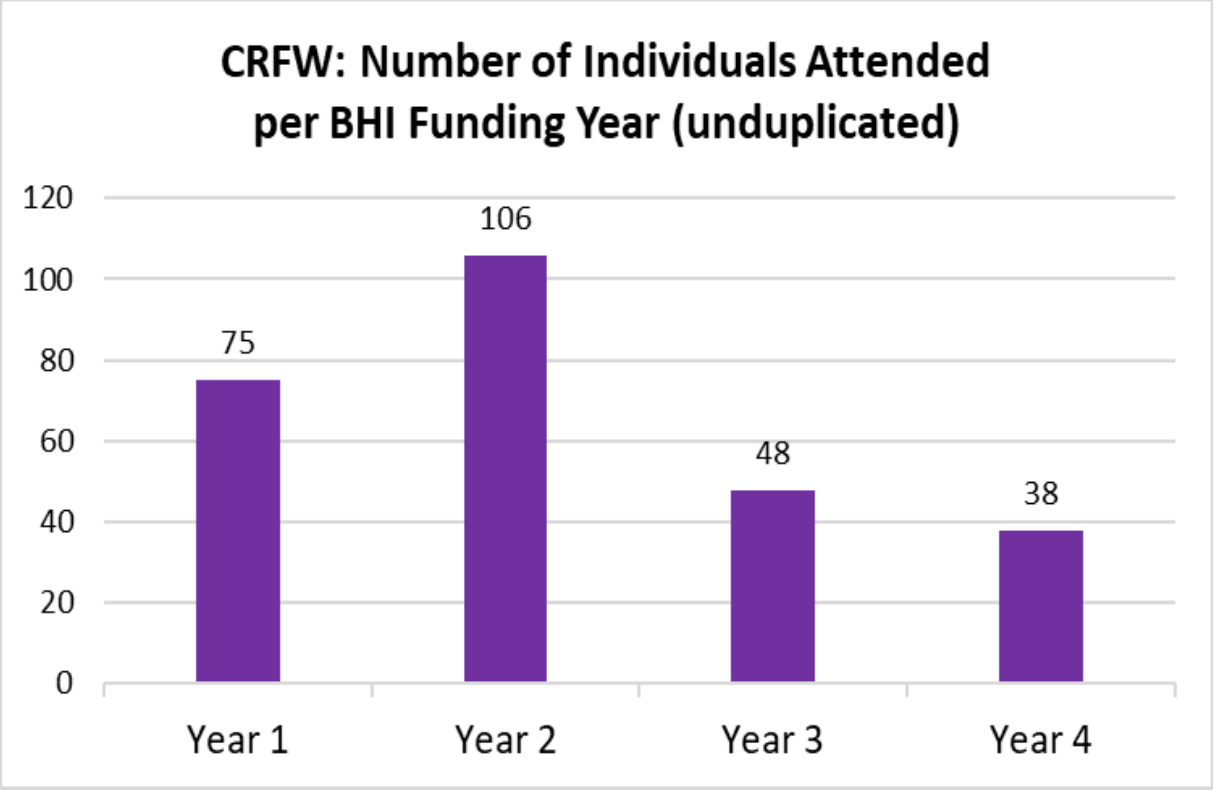
The annual participation counts do not show a linear growth progression, and show the highest engagement during the height of the COVID pandemic. This led us to ask…

What do CRFW's participant counts mean?

CFRW service provision increased from serving 75 individuals in its first funding year (April 2019-March 2020) to a high of 108 at the pandemic peak (funding year two). Since then, records show annual decreases to 48 and 38 in funding years three and four (Figure 3). This finding is similar to Pivot experiences with previous evaluations where data files from other organizations provided widely differing data.

The first year of the pandemic saw the largest service population of the four years observed. The most recent two years saw the smallest service populations. The extraordinary demand for services during the pandemic raises a number of questions the evaluation could not address - due to timing of events. Did the pandemic somehow create a pause in daily routines that allowed people to address needs? Did this surge in opportunistic help seeking behavior deplete an otherwise regular pipeline of service-seeking individuals? Is the decline in service-seeking a result of revised opioid distribution following nationwide prosecution of corporate misdeeds? Pivot concludes that the unpredictable wild fluctuations in service requests in year two could not have happened without this funding opportunity. The fluctuations of participation indicate supporting a higher level of program activity than the minimal level exhibited by the most recent year's participation.

Figure 3. Number of Participant Sessions by Year



CRFW staff also explained multiple factors affecting the variance in service counts across years, including the following:

- Clients decreased engagement due to burnout with increased data collection, including the Social Determinant of Health (SDOH) data collected with increased frequency for the BHI contract;
- CRFW experienced staffing shortages resulted in one staff member running PCM alone for three months; and
- Engagement increased during COVID when CRFW relied solely on phone and video contact, due to the ease of engaging virtually instead of in-person. Engagement since decreased as some CRFW members have been slow to return to in-person case management.

Further engagement with CRFW staff and clients in future evaluation may clarify different causal reasons for engagement patterns.

What do POPSS participants do?

CRFW's BHI funding was initially framed as "Intensive Case Management." True intensive case management often entails 12-hour to all-day on-call availability and several hours per week for each client dedicated to structured sessions. This kind of case management is often not feasible for either the case manager or the clients, depending on worker caseloads and client capacity. Early in the evaluation collaboration with Pivot, CRFW staff stated that their PCM has functioned more as crisis intervention case management, in which clients reach out the most at times of greatest need, for help on specific issues. CRFW staff described services as a "crisis intervention living room model" (with "**living room model**" denoting the drop-in, as-needed basis of services). Indeed, CRFW is currently in the process of transitioning its POPSS PCM (which is specifically for clients exiting CRFW supportive housing) to Peer Drop-In services (available to anyone as needed).

Though POPSS has functioned as a component of transitional housing "aftercare" to continue supporting women after they leave CRFW housing, CRFW staff stated these women usually don't need additional intensive case management. CRFW clients get case management/intensive case management while in CRFW's residential programs, and no longer want or need that level of engagement upon exiting. Staff said they have found that their clients are all different, and each woman creates their own recovery path. For all clients, CRFW aims to provide a holistic and trauma-informed approach to services including PCM.

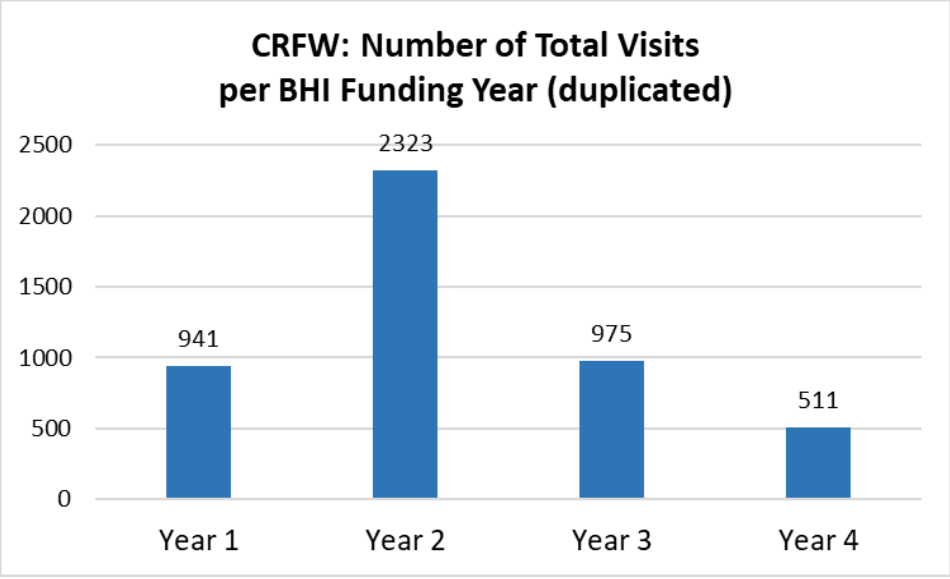
Regarding the types of engagement and referrals participants receive, this topic can be answered from a number of perspectives. One could group the services based on who the domains of services case managers recommend. From this perspective there are three types of services: emotional support, institutional support, and direct support. When dealing with the mass of life challenges these women face, they experience an unavoidable emotional toll. The daily mountain of challenges these women encounter, including mental illness, addiction and withdrawal, homelessness, and violence, would terrify most folks in the general population. Providing emotional support helps most of these women face their daily challenges. CRFW also provides institutional support to help participants address legal and administrative challenges associated with various social safety net opportunities (e.g.

housing, Medicaid, driver's license, etc.). Institutional support helps participants learn to self-advocate and understand how to interact with governmental bodies. Direct support includes a variety of life skills such as personal finance education, resume building, and referrals/appointments to many other community resources to address medical, legal, and other needs.

From a topical perspective, Pivot could easily categorize the following topics (also domains in the SDOH instrument): Housing, Social, Educational/Vocational, Medical, Substance Use, Mental Health, and Legal needs. Pivot uses the first perspective due to its clarity and simplicity and its ability to inform program planning.

CRFW saw 75 individuals for a total of 941 visits in year one, 108 individuals for a total of 2323 visits in year two, 48 individuals for a total of 975 visits in year three, and for year four saw 38 individuals for a total of 511 visits, resulting in 167 individuals served with 4,750 visits across the entire funding period (Figure 4). In data collection period one, CRFW had previously reported 4270 visits from 295 participants, and since revised their client database by discharging clients who had been completely inactive/out of communication for at least six months. This revision was prompted by an audit, which also contributed to CRFW updating their service plan (from the old to new service plan instrument). CRFW staff also began discharging clients from the POPSS PCM program to intake them into Peer Drop-In based services (PDI) upon confirmation that BHI would begin funding PDI in 2023. These factors all contribute to the discrepancy between DC1 and DC2 participation counts, and the erratic pattern of PCM engagement.

Figure 4. Total Number of Peer Case Management Visits



Service agencies also often face a challenge when attempting to count those receiving services and those participating in a cursory fashion. Counting both remains important and even cursory participation requires staff time. Further, such participation may lead to stronger engagement at a later date. Sorting the two groups is a matter of developing an operational definition. Sometimes those are obvious to staff and sometimes the program evaluation organization can facilitate an empirical solution. Other explanations for count differences may result from time frame differences between

the data sets. Program staff generally have little experience pulling these sorts of data sets. Future data set draws should likely include evaluation organization assistance.

One third of the 167 total participants during BHI funding used between six and 41 PCM visits, while 50% used just five or fewer visits, and 15% had more than 41 visits per year (Figure 4). Sixty-five percent of participants exit the program in less than a year and six months. These engagement rates illustrate the variation in client need, with some members only needing or being able to access a handful of sessions for a short duration of time, while others form ongoing service relationships through POPSS.

Table 2. Visit Frequency Across the Entire Funding Period

N Visits	Percent of Participants
5 or less	52
6-21	18
22-41	14
42-103	11
104-662	4

N Visits = 4750

Given these attendance patterns of people engaged in POPSS, evaluators wondered what variation in services participants seek from CRFW's POPSS PCM?

What services do POPSS participants seek from PCM?

To answer this question, Pivot looked at POPSS participants' goals, which CRFW records via individual service plans. CRFW initially used a service plan that addressed strengths, short-term goals, small steps to goals, and help needed for goals, all in open-ended comment format. Based on audit feedback from August 2021, CRFW modified the service plan. This report refers to and focusses on this new service plan (Table 3). CRFW expanded the old service plan to include goal progress, new goals identified, resources needed, goal barriers, goal plans, goal steps, goal timing/deadlines, and why the goal is important. CRFW staff stated that these revisions were in response to auditors pushing for more "S.M.A.R.T." style objectives (specific, measurable, achievable, relevant, and time-bound).

Though CRFW made service plan changes based on the audit, they also discussed some challenges with the process. CRFW staff stated that the above changes may not reflect how POPSS actually works for participants. Some items seem redundant, overcomplicating the service plan. Furthermore, staff were concerned that this increased level of repetitive paperwork discouraged clients from engaging in services.

All parties would benefit from a few process distinctions. First, service plans and response to intervention remain focal to documentation requiring participant perspective. Second, services the participant used versus those offered supply key information not only to the therapist for client management, but for management's understanding effectiveness of available options. Third, man-

agement has a fiduciary duty to record services provided for contractual reasons. However, these are all distinct functions and should never be combined into a single data collection form or interface.

Service plans with statements about services provided could indicate problematic late documentation, or worse, late planning. For clinical purposes, a completely separate interface would document services offered, provided, and referrals recommended. Staff suggested that in a crisis, perhaps they could fill out an updated service plan based on communication with their client, without directly going through all the service plan items with the client. Crisis planning would be an additional form or interface that would save time if correctly linked to the original service plan. Next, peer case managers must have a method to document outcomes as they are observed. Technically, documenting outcomes would be a separate function; however, recording outcomes requires a link to each clinical screen, so peer case managers can record outcomes when they observe them. Finally, management's ability to link client outcomes to various services and patterns of service participation would occur at the administrative level and not require any additional form or interface.

While there are no specific data collection standards applicable here, a number of principles apply. First, the longer any data collection instrument (i.e., the more questions it has) the less accurate (valid) the data. This is usually due to fatigue of the respondents and resulting blank or arbitrary responses. Second, obvious redundancy confuses and frustrates respondents also adding to inaccurate reporting. Third, pre-grouping by having choice selections accompanied by text or comment field guides respondents to produce more accurate and interpretable responses.

CRFW staff record goals in each client's service plan. Currently, the goals are recorded as open-ended text responses in CRFW's database. However, many goals fall within common categories, and grouping these categories in the database would reduce the data entry burden on staff and enable counts and analyses of goals by category. For example, in the following Table 3. Ad Hoc Categorization of Goal Statements evaluators categorized client goals by SDOH topic.

Pivot recommends CRFW follows the clinical audit service plan example by modifying their data entry to require at least one multiple choice selection of main topic per client goal (such as from a drop-down menu of options), with an optional text box for additional details. In the example below, a main selection would be "housing," with additional personalized details about the client's budget, location, or other preferences. Pivot recommends this approach (standardized main options with accompanying open-ended details) for most CRFW data points, described as follows in this report. This will improve data entry and analysis quality and reduce data entry time commitment.

New Service Plan Goals (Service plans from: October 20, 2022-March 31, 2023)
CRFW clients listed the following service plans goals from 10/20/22-3/31/23 (total respondents n=17). Evaluators sorted the goals by SDOH category and frequency (bold footer). The team added a category for "Other" goals outside the SDOH categories, which CRFW could further formalize as Spiritual, Material, Transportation, etc. as needed based on the kinds of goals clients often present. Some goals presented sorting challenges. For example, case management is not a goal, but a type of intervention to reach a goal. Note that such a small sample size (n=17) offers limited generalizable insights regarding CRFW client goals.

Table 3. Ad Hoc Categorization of Goal Statements

Housing	Social	Educational/ Vocational	Medical	Substance Use	Mental Health	Legal	[Other]
Housing		Vocational	Get healthy	Substance use treatment	Case management	Get through pretrial	[Spiritual] get baptized
Housing		Go back to school	Improve health	Stay clean		Complete probation	[Material] clothes
Housing		Continue with education				Get driver's license	[Transit] fix car
Housing		Specialized health care certification					
Housing		Hold job					
Housing		Create income					
Housing							
Housing							
Housing							
Housing							
Housing							
11/17	**0/17**	**6/17**	**2/17**	**2/17**	**1/17**	**3/17**	**3/17**

In this sample none of the participants presented with initial social goals. This could be because social situations such as conflict and loneliness, while stressful, are not crises requiring primary attention. It is also possible that this variation is due simply to representing a small sample size, and it is possible that more responses from more women would indicate a broader breadth of primary goal categories. Finally, attempting to categorize participant goals raised a new consideration for evaluators: It is possible that goals apparently categorized in one area may be highly motivated by another area. For example, a woman may want to get sober, *so she can regain custody of her children*. Or, a woman may want to improve her health, *so that she can work again*. In the first example, is this a substance use goal, or a social goal? Is the second example a health goal or vocation goal? The service plan needs to clarify these distinctions for client clarity as well as program evaluation purposes.

CRFW staff record these goals as open-ended entries (free text fields) without any standardization built into their system. To qualitatively analyze goal themes, Pivot sorted the goals into SDOH categories as described in the table above. This type of after-the-fact categorization by an outside entity introduces limitations, as opposed to the standardized data entry categorization defined by an organization itself (CRFW). Sorting open-ended comments is both time-consuming and subjective. Analysts may categorize a goal differently than the program participant initially intended, an error that is more easily caught and addressed if Peer Case Managers categorize participant goals on the "front end" while discussing them with participants. This particular data set is also limited by its small response size (n=17). Therefore, use caution when drawing generalizable conclusions from these results. To CRFW's credit, the N here is small because they recently improved their intakes forms and other data collection.

Results show that the most frequent initial goals are housing (i.e., getting housing) and Educational/Vocational, with a focus on vocational (get certified, hold a job, create income). This makes sense on a practical level: One finding Pivot encounters across many service providers is that their clients have to establish housing first, and a source of income, to be able to make progress with any other goals. After Housing and Vocational, the next frequent initial goals are Legal, Medical, and Substance related. Note that these results could be presented more concisely with the use of standardized response categories.

Standardizing CRFW goals and goal rationales would ensure that participants' responses are accurately interpreted, and create the opportunity for more context-rich and organizationally significant analysis to come.

Finally, Pivot recommends that CRFW consider creating distinctions between participants' overall goals, and their objectives. For example, in the Table 3 above some responses indicate true goals that are an end in themselves, such as "*get housing*" and "*stay clean*". Others may be better characterized as objectives, which are means to an end but not the end itself. For example, "*substance use treatment*" and "case management" are activities someone can do to get closer to their goal of sobriety or other life improvements.

How do you distinguish between objectives and goals?

It can be hard to tell which aims should count as objectives versus goals. People often refer to SMART (specific, measurable, achievable, relevant, and time-bound) goals, but Pivot considers the SMART framework to be better suited for *objectives*. Pivot's rule of thumb is to consider the following points:

- The reason goals are so difficult is that few people have thought about or discussed different types of goals. Some goals can be thought of as multi-level, such as "getting sober, so I can get my children back". Other goals have clear end points such as "getting to the moon and back safely". While other goals maintain or keep going, such as living sober, or staying healthy. **The goal of some goals is to keep going. The maintain or keep going type goals do not fit the SMART format.**
    - There is a rule of trinity in business that all service providers must balance for their clients. "You can have it fast, cheap, or high quality. Choose any two!" Getting to the moon and

back safely breaks this rule, because the US Government had unlimited resources. When setting goals, remember that most of your clients have limited resources. This fact alone limits goal attainment in many ways difficult for a clinician to predict.

  - Additionally, setting time bound goals for clients when those goals have significant components OUTSIDE client control may lead to client backwards progress.

- Does it make sense for a goal to be "S.M.A.R.T."? Here are three considerations:
  - Is there any evidence suggesting a timeframe? Evidence for quitting any addiction is that people exhibit wide variation in periods before success. Setting arbitrary time-frames may lead to unnecessary guilt, sense of failure, and early giving up on the goal. Similarly, getting a job depends on many factors out of participant control. Why hold the participant to a timeframe when so many elements are out of their control?
  - It is perfectly acceptable to "hedge" difficult goals. Writing a goal to reduce substance use during a period emphasizes the difficulty of the task while insisting on progress. Applying for three jobs in a period produces action the client has control over. Often authors refer to these sorts of statements as short-term goals.
- To distinguish between goals and objectives consider the following:
  - Is it an end in itself (the overall goal) or a means to an end (an objective)?
  - The point of an objective is to complete it, such as detox from a drug, get your GED, or exercise weekly.

How can CRFW distinguish between objectives and goals at an organizational level?

As an organization, CRFW also has overall goals, and specific objectives. The logic model Pivot designed with CRFW shows this distinction in the program outputs versus outcomes (Figure 1). Outputs are the measurement of organizational objectives: they measure SMART data or "bean counting" such as participation counts, service hours, and referrals. Outcomes are the measurement of organizational goals — they measure progress along broad improvements such as client health, program growth, and systemic change. The outputs contribute to the outcomes: for example, CRFW may want to increase PCM hours and referrals in the service of improving client health, if they believe that more services will correspond to more wellbeing. Incidentally, creating these linkages is the basis of an organization's Theory of Change (the basic assumptions an organization makes about how and why its services improve participant situations). Examining these linkages and their relationships is the basis of program evaluation.

Why standardize data collection categories?

Standardizing the goal categories would make data entry easier for CRFW staff, as it eliminates any individual decision-making regarding the wording and formatting of main goal text. Standardized goal categories would allow CRFW to quantify goal types and analyze goal information. CRFW could better answer questions such as, "Which client goals are more frequent?", "do common goals change over time" (in response to economic recessions, housing policies, etc.), "which types

of goals do clients have success achieving", etc. This type of information is crucial to the success of CRFW as an organization. Client goal statistics provide feedback about client needs and trends, justify spending in some areas and not others, and can be communicated to funders and the public to illustrate CRFW's role in solving intractable social quandaries.

How could CRFW select standardized categories?

Pivot further recommends standardizing client goal categories using the same groups already defined by other CRFW tools. Using consistent categories across tools and data collection points allows for more in-depth inquiries and analyses about CRFW client needs, experiences, and outcomes across client engagement. CRFW could keep client records regarding initial goal establishment and progress in each category over time. These data could answer questions including "which goals are associated with higher or lower client engagement", "which goals take longer or shorter to achieve/progress", "how do clients change goals over time", etc. However, this brings us to the following:

A note on current and potential CRFW instruments.

Currently, CRFW measures categories of client needs and progress using the Social Determinant of Health (SDOH) questionnaire (see Appendix). The SDOH includes categories for Housing, Social, Educational/Vocational, Medical, Substance Use, Mental Health, and Legal needs. These categories would cover most or all of CRFW's clients' service plan goals. CRFW could include an option for "other" service plan goal type with open-ended details (such as for spiritual or creative goals), though non-SDOH goals may also fall outside the scope of CRFW's services.

CRFW may also consider using other tools besides the SDOH to measure client progress in relevant categories. The SDOH is problematic when used as a measure of ongoing client progress. Social *determinants* of health are inherently precedent proxies for estimating the health expectations of a population, not diagnostic criteria for assessing the barriers and achievements of individuals. The SDOH tool is not validated for use in the way it is applied by social service organizations such as CRFW. Pivot has analyzed SDOH data from multiple social service organizations, and has not yet identified any meaningful results regarding client progress and outcomes (see following tables). Finally, the SDOH tool identifies static point-in-time conditions, and does not account for progress along a continuum. Stringing together SDOH results over time can indicate progress, such as if a client SDOH at one time indicates a lack of housing and SDOH re-assessment six months later indicates stable housing. However, again this is a somewhat clumsy proxy for progress and not an intended use of the tool.

The Table 4 of results from a different study at Tiny Home Village shows that changes are generally in the negative direction. That is, things appear to get worse after the intervention. However, most of these differences can be attributed to random variation rather than the intervention. Only harm appears to show a reliable negative impact of the intervention. Cohen's d is generally interpreted as 0.4 and below amount to small effects. However, Pivot interprets results in Table 4 as problematic given context, methodological concerns, and additional information.

Table 4. SDOH Change Scores from Tiny Home Village Participants

Change In:	T, Sig	Mean Difference	N	Cohen's d
Food	-1.68, ns	-0.48	29	-0.31
Transportation	-0.63, ns	-0.17	29	-0.12
Harm	-2.10, p< .05	-0.51	29	-0.39
Medical	0.33, ns	0.07	29	0.06
Behavioral Health	0.00, ns	0.00	29	0.00
Substance Use	-0.97 ns	-0.21	28	-0.18

Pivot conducted statistical analyses of SDOH results from other social service providers contracted with BHI. These providers also use the SDOH as a progress indicator in the same way as CRFW. In all three evaluations Pivot found that values changing from pre to post go negative over time. Pivot considers the current SDOH administration method flawed because perspective of baseline conditions may shift depending on current situations. Indeed, a retrospective pretest post-test design may solve the changing perspectives over time problem. However, without any psychometric validation, such a change may only delay a determination of SDOH instrument's poor validity and reliability.

CRFW may consider implementing the Arizona Self-Sufficiency Matrix (ASSM, see Appendix D), a tool specifically designed to assess ongoing client progress along a continuum for each life domain category. The ASSM includes 18 domains (more specialized than the SDOH) with an optional 19th domain that can be filled in as needed. Domains include analogs to the SDOH categories, as well as more specific areas that may or may not be applicable for each client (such as childcare, child education, and disability). Each domain has a rubric of five progressive steps from crisis to sustainability/thriving, with full descriptions for each step. Clients can identify which areas are personal goals for them, and their progress along the rubric for each area. Client also may not need to "optimize" every area—for example, progress from crisis to manageability in the realms of mental health, family dynamics, or income may be sufficient depending on each client's needs or perspective.

How does CRFW help PCM participants reach their goals?

PCM clients receive help from CRFW on their goal progress in several ways. PCM (like PDI) is both a service in itself, and a bridge to other services. Ideally, in PCM sessions clients may experience several benefits to their supportive knowledge, attitudes, and behaviors.

Improvements in knowledge:

- Increased knowledge about strengths, resources, opportunities, life skills, etc.
- Affirmation and solidarity regarding life challenges, such as mental health, substance use, institutional barriers, etc. (i.e., knowing people like them have recovered, improved, and thrived).

Improvements in attitudes:

- Increased self-esteem, self-efficacy, and hope, as they make progress on goals.
- Increased positive attitudes about life challenges, other people, goals, etc.
- Overall increased feelings of connection and wellbeing (improved mental health).

Improvements in behaviors:

- Supportive relationship development (with PCM staff and other participants).
- Increased self-care and mental/physical health behaviors.
- Decreased unsustainable coping behavior (such as substance use) and criminality.

Perhaps the most significantly unique aspect of peer services is that peer workers model all the above capacities with clients in real relationship dynamics. Clients can see themselves in peer workers, can literally see people like themselves thriving, happy, sober, and doing meaningful work. In addition to PCM sessions with clients, CRFW also offers a plethora of other supportive services "in house", which they may refer clients to as applicable depending on their individual goals.

CRFW has an extensive main facility with spaces for meetings/conferences, classrooms, childcare, bathrooms, a playground, kitchens, offices, and a secondhand shop (CRFW members can often "shop" for free as needed). The facility is newly renovated and decorated, with art, murals, and sunny windows enlivening the space throughout. CRFW also maintains the two transitional housing sites (one in Albuquerque and one in Los Lunas) for women returning from incarceration, who make up the participants of POPSS PCM. CRFW provides food, hygiene kits, educational/vocational sessions, and other material and mental/emotional support resources. CRFW is able to offer many of these and other "wraparound" supports to its members. Table 5 shows attendance of POPSS women at several different CRFW in-house groups over the course of BHI funding:

Table 5. CRFW Group Attendance throughout BHI Funding (April 2019-March 2023).

Activity Type	Percent
Art Group	4.4
Community Activity	9.2
Community Meal	2
Discussion Group	12.4
Expressive Arts	0.3
Group Outing	0.1
Group Therapy	0.3
Health/Fitness	0.2
Life Skills	2.9
Mental Health	4.8
Psychosocial Rehabilitation	7.9
Social Group	36.3
Substance Abuse	8.9
Tenant Meeting	0
Therapeutic Group	5.2
Vocational Group	5.2
Total	**4750**

The "Attendance" column shows the entire attendance for sessions of each group over the funding period. It includes "duplicates," meaning if one person attended the same group multiple times, each time they came is counted. Pivot had to hand sort and interpret free response activity items requiring judgement calls in the sorting process. Therefore, Pivot recommends standardizing the main group categories to facilitate better and easier data collection and analysis (as with goal categories discussed above).

How does POPSS help participants with needs beyond CRFW's scope of services?

Even though CRFW offers extensive services, sometimes participants need help with goals that are outside CRFW's service scope. CRFW continually maintains and expands its community outreach to better connect participants with the services they need outside CRFW. CRFW refers POPSS participants to outside services based on the needs and barriers they face while making progress on their goals. POPSS participants included the following information about their goal needs, plans, and barriers in their CRFW service plans (Table 6). Note that while the following tables illuminate some participant experiences, the small number of responses (small n) indicate these responses may be optional for clients to complete, and offer limited generalizable insights about POPSS experiences overall.

Table 6. What resources do you need to achieve your goal? (n=20)*

Resources listed	Frequency
Case Management, VOC, SA treatment, BH treatment	2
CFRW	1
Community Centers	1
Counseling	1
Encouragement	1
Financial assistance	1
Housing	2
Housing allowing pets	1
Housing (options and assistance with applications)	4
Maya's Place (CRFW transitional housing)	1
NMHU advisors	1
Phone	1
Religious institutions	1
Small business start-up info	1
Time Management	1
Veterinarian care	1
Vocational	1

* Multiple response allowed.

The resources and barriers participants list (Table 7) range from frequent ("housing") to infrequent ("Veterinarian care"), and from the material ("Transportation") to the immaterial ("myself", "my stubbornness", "I always feel like I am missing out on something").

Table 7. What are your barriers to achieving your goals? (n=16 responses)

Accessible housing
Depression
Homelessness, lack of treatment
Housing (moving housing), applying for school
I always feel like I am missing out on something. No strong support system.
I don't know where I applied to already
Lack of funding for business start-up and advertising
More income
Myself
My stubbornness
Nothing
Sobriety (losing my sobriety), relapsing, ex-boyfriend
Sobriety (maintaining sobriety), depression
Transportation
Transportation, money for replacement ID to get Social Security card
Working a lot, pretrial

CRFW staff referred on POPSS participants based their needs and barriers to the following external resources (Table 8):

Table 8. External Client Referrals (Referrals from CRFW to other organizations)

Referral Organization	Frequency
[Left blank]	1
Give ABQ	3
IL	3
Indigo Psychiatric Services	3
Talking Circles Therapy and Wellness	2
ASAP	1
Awake and Aware, LLC	1
Barrett House	1
Bernalillo County Housing	2
CNM	1
Counseling And Psychotherapy Institute	1
CYFD Childcare Assistance	1
Domestic Violence Resource Center	1
DOPE Community Outreach	1
East Central Center	1
ERAP	1
First Choice Community Health Center-Alamosa	1
Haven Behavioral Health	1
Help New Mexico	1
Hope Works	1
John Marshall Health & Social Services Center	1
Keyway Properties, Inc.	1

Legal	1
Los Griegos Center	1
Medical: Give ABQ	1
New Mexico Solutions	1
PNM Cares	1
Rio Grande Presbyterian Church	1
Rio Metro Job Access	1
Sage Neuroscience Center	1
Sandra Montoya	1
Second Judicial District Court – Downtown Courthouse Location	1
Southwest Family Guidance Center	1
Susan M. Buechele, LCSW	1
The Storehouse New Mexico	1
Tiny Homes Village	1
Under His Construction	1
Voc	1
Walsh Counseling Services	1
Zia Health & Wellness	1
Total number of referrals	48

CRFW met with 33 individuals a total of 46 times (46 total visits) to facilitate the above 48 referrals. CRFW's referrals addressed the following topics/needs (Table 9):

Table 9. Referral Purpose

Referral Purpose/Need	Percent of Referrals
Housing	28.3
Mental Health Services	28.3
Food	4.3
Other - Furniture	4.3
Blank	2.2
Economic relief fund, ERAP	2.2
Employment Training	2.2
Expungement	2.2
Humidifier	2.2
Legal	2.2
Medical	2.2
Other - Childcare	2.2
Other - Domestic Violence situation	2.2
Other - IOP	2.2
Other - M.A.T. services	2.2
Other - Tax Help	2.2
Other - Utilities Assistance	2.2
Student Loans / housing	2.2
Transportation	2.2
Wheelchair	2.2
Total	**100**

While this external resource list has few documented referrals, likely due to a non-required field, it shows great depth and knowledge of the available resources. A less effective approach would show five or fewer referral options. The breadth displayed in this list show program staff have great knowledge of the resources available and attempt to directly link participants to resources that match their needs.

The challenge to documenting referrals likely stems from the intermittent nature of referral opportunities. A referral opportunity likely arises after a participant has engaged. They may later express some need and the Peer Worker may make the referral in the hallway and never record it. Since referrals are a central feature of the CPCW model, documenting those is an essential part of reporting to the County contract manager. One example of a process change is to have tablets posted around the facility, so staff can securely log in and quickly enter the referral.

3. **Has POPSS maintained (or increased) its staff capacity (number and qualifications) since BHI funding?**

CRFW increased its staff capacity over the course of BHI funding, starting from 1.5 FTE Certified Peer Support Workers (CPSWs) in the first year of funding. In Year two, CRFW increased to two CPSWs and .5 FTE Peer Support Worker (non-certified). In Year three, CRFW increased to two CPSWs and two Peer Support Workers (after a period of short staffing with one CPSW running PCM for a period of three months). In Year four, CRFW retained two CPSWs and one Peer Case Manager. CRFW will adjust staffing as needed to support its PDI program going forward.

In a time when many businesses struggled to stay afloat let alone expand (during COVID), CRFW increased its service provision as well as number of staff and staff certifications (CPSWs). CRFW modified service provision to accommodate remote PCM (via phone calls and zoom) with striking success. PCM is often traditionally carried out in person, and Pivot evaluators would expect CRFW's service population to have increased challenges in accessing consistent cell phone service or video call capability. The way CRFW increased services during COVID and has since sustained increases in staff capacity speaks to the resilience and flexibility of both CRFW Peer Case Workers and service participants.

Finally, Pivot acknowledges that peers with lived experience of homelessness, mental illness, substance addiction, and other significant life challenges demonstrate tremendous capacity in their work at CRFW every day. Adapting from a survival mindset to not only recovery but pursuing professional excellence and growth is a significant accomplishment in itself. Their work runs the gamut from social/emotional labor, to mental logistics, to physical activity, and is constantly both changing and growing. CRFW staff engage in contexts that could easily be triggering or distressing, while maintaining a flame of hope, support, and sisterhood for each woman they serve.

It is normal for any organization to run into challenges throughout grant management and program evaluation. For peer-led organizations especially, if staff have experienced under-resourced educational or professional backgrounds, they may be less adept with program administration and research. This is not a personal or organizational weakness, but an opportunity for local funders to support those who are "walking the talk" of recovery and growth.

Pivot recommends that grantors to peer services maintain high standards and expectations, while focusing on providing the supports and accommodations necessary for these organizations to reach their service potential. Instead of falling back on punitive or one-size-fits-all practices, grantors have the chance to foster a learning environment with grantees, increasing their capacity over time. Ultimately, BHI funds individual providers to strengthen Bernalillo's networked community of care. "Meeting agencies where they're at" can help BHI support grassroots organizations with community commitment, peers in the workforce gaining access to higher paying jobs, and an improved and sustainable overall system of support.

4. **How and to what degree does POPSS contribute to positive client outcomes? Do POPSS participants have better outcomes than non-participants?**

What outcomes do POPSS participants experience?

Quantifying outcomes for this kind of open-ended peer service is challenging, considering the following:

- Each client may have different goals and outcomes;
- What counts as "success" or positive outcomes may be different for each client;
- Positive outcomes may be qualitative and subtle, such as improvements in social coping, relationships, self-talk/positive attitudes, etc.;
- Clients may experience multiple "relapses" in the process of positive outcomes (such as using substances on the road to sobriety, experiencing relationship fallout in the process of healing relationships, experiencing housing instability while working towards stable housing, etc.);
- CRFW clients often experience multiple "intersecting" life challenges that complicate their efforts to improve any single goal/outcome; and
- Client experiences and outcomes are influenced by myriad factors outside of CRFW's scope of services/influence.

The logic model that Pivot developed with CRFW emphasizes how some outcomes are outside CRFW's influence, and all are affected by confounding social and environmental factors. When discussing measures of success with CRFW staff, the lead staff member of POPSS described success as women getting housing, staying out of incarceration, and reducing substance use. These three pillars are foundational to CRFW's clients' success, though clients may achieve them in different ways and different timeframes. CRFW staff stressed that even though their BHI funding and this evaluation project have timelines, their program does not have a cutoff date for successful outcomes, and they keep working with women as long as needed.

SDOH Outcomes

One obvious outcome observers could look for is a change in the SDOH scores. However, as discussed previously the current instrument and administration technique does not yield any useful information.

There is a method called a retrospective pre-post survey which may improve instrument performance. Retrospective pre-post surveys ask people about their experiences before and after an intervention, but only ask them **after** they have completed the intervention. This way, respondents have a more informed perspective about the entire subject and more context for their experiences regarding the intervention. This method is particularly useful when respondent perceptions shift over time. For example, in training contexts, people often don't know how much information they lack until they

sit through a training. In this behavioral health context, participants may be trying to keep a positive outlook in hopes of a better situation and deny the challenging circumstances they live in. But once they have participated in an intervention or set of interventions, they may see that a significant change has happened after all. If any of the organizations attempted to collect data in this manner, it would eliminate at least one and perhaps many administrations of the instrument per participant. Over the course of BHI funding, Peer Case Managers administered the SDOH with clients at intake, every 30 days, and exit, and reported that clients were burned out with completing the assessment so often.

The data file supplied included 163 individuals with 570 records. Many participants took the instrument multiple times. Part of the reason for this is that it is common for participants to self-discharge when they feel they no longer need services. Usually, participants determine this before the program staff. When participants self-discharge, they do not complete exit surveys and discharge requirements. To compensate, program staff periodically check-in so they can monitor progress. That periodic check-in leads to multiple administrations of the same instrument. An individual participating over a number of years may complete the instrument over a dozen times. 45 individuals began recently and only completed the instrument once.

The best analysis determines the number of days between the first and last completion-dates for each participant, and then calculates a difference score to see if there was an improvement adjusted by time (Table 10). The question is, "would the longer someone is engaged with the intervention, show a greater improvement in their SDOH?" However, the results apparently show no program impact at all.

There are a limited number of possible valid conclusions. First, a critic may be tempted to say there is no program effect. However, a second interpretation is that the SDOH instrument is not adequate to the task of determining program effects (i.e. it's not a useful metric). Third, it may be that the administration is the problem. Some topics that require a retrospective pre-post test to compensate for moving expectations. Using a retrospective pre-post test method could show more reliable results by holding expectations constant relative to experiences. A retrospective implementation would also reduce the number of times participant need to respond to the instrument. Table 10 shows individual change in SDOH divided by number of days between pre and post. This method standardizes the amount of change per day of program participation. This method eliminated the negative change finding in most cases. However, only mental health showed an improvement, though extremely small.

Table 10. SDOH change for CFRW participants*

Statistics*	Housing Difference	Social Difference	Vocational/ Educational Difference	Substance Use Difference	Mental Health Difference
N	79	79	79	79	79
Average Change	0.000 (ns)	-0.002 (ns)	0.000 (ns)	0.001 (ns)	0.006 ($p < .05$)
Standard Deviation	0.025	0.044	0.013	0.010	0.035

* Adjusted for number of days in program

The analysis in Table 10 used a mathematical approach: Adjusting for time in the program by dividing individual effects by N number of days in the program. However, another way to state the question is to ask, "Are higher improvements in scores over time associated (correlated) with more time in the program?" After correlating the number of days between SDOH administrations and the change scores, results show extremely low correlations, and none of those appear to pass the standard of a chance finding (not statistically significant). Table 11 shows the strongest correlation at $r = 0.15$. However, this is interpreted (proportional reduction in error) by squaring the number, so had this value been statistically significant, it would indicate a 2.3% program effect. Such effects are generally considered unmeaningful in the field. This is really the most sensitive analysis, and it shows nothing.

Table 11. Correlations: SDOH Elements with Number of Days between Pre and Post.

Days Pre-Post	Housing Difference	Social Difference	Vocational / Education Difference	Substance Use Difference	Mental Health Difference
Pearson Correlation	0.133	0.047	0.002	-0.040	0.055
Sig. (1-tailed)	(ns)	(ns)	(ns)	(ns)	(ns)
N	118	118	118	118	118

b. Listwise N=79

Discharge

Days to discharge has the potential to be an important outcome measure that indicates intervention effectiveness and associated treatment costs. The longer it takes for participants to reach their goals the more expensive the program becomes and the more cost to society (having residents not engaged in society). The following table shows that 95% of participants are discharged in just under 1yr and seven months (the sum of the mean and SD); however, half are discharged in less than 6 months.

Days to discharge is such an important measure, it should never be used as an accountability measure. As an internal monitoring measure, program staff can put the measure to great use. The logic hear follows Campbell's law which states, "The more any quantitative social indicator is used for social

decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor." Using this measure as an internal monitoring tool minimizes social distortion pressures.

Table 12. Days to Discharge by Year*

Discharge Year	2019	2020	2021	2022	All years combined
Median	184	147	170	175	169
Mean	282.4	215.7	223.4	342.1	258
Standard Deviation	287.2	299.3	219.2	454.6	320
Count	89	127	111	86	413

* Data not available for entire funding period.

However, interpretation of Days to Discharge currently lacks important distinctions that would make such monitoring useful. Specifically, the reasons in the table below are not mutually exclusive and exhaustive. For example, what is the difference between Completed Program and Graduated? Another example is Left For Housing Opportunity Before Completing Program which may or may not be a desirable out come if the intervention plan goals were to address substance use. Then there is the challenge of grading alternate outcomes relative to goals. Left For Housing Opportunity Before Completing Program would be considered a better outcome than a substance use relapse if the goal was to address substance use. On the other hand, it would be a desired outcome if that was a service plan goal.

It would also be important for CRFW to reconsider the terms they use for discharge reasons/categories (listed in Table 13). Currently, the categories do not appear to be a genuine reflection of CRFW's process, goals, and values. Namely, some are very negative, binary, and prescriptive — such as "non-compliance" and "absconded". This kind of language may not be problematic for internal CRFW use, as all staff are aware of the context around client experiences and CRFW administration. However, to an outside entity (such as funders and evaluators) without compassionate context, this kind of language may unintentionally mischaracterize CRFW's clients. It would also be challenging for non-CRFW personnel to understand differences between categories. Many of the following appear to be somewhat duplicates (such as "completed program" vs. "graduated") and/or require definition (how does CRFW define "absconded"? "compassionate discharge"? etc.). Some categories seem to indicate solely negative exit situations, such as "criminal activity" and "violence". Few appear to indicate an unequivocally positive outcome ("completed program" and "graduated"), while descriptions such as "mental health issues" and "needs other level of care" should not be considered positive or negative, to avoid stigmatizing these situations. Currently, CRFW's exit categories could lead to misinterpretations of member exit contexts, and a disproportionate exaggeration of negative exits. Pivot expressed these concerns to CRFW during the evaluation collaboration, and they acknowledged reconsidering administrative terms as they see fit. Clearly positive outcomes represent 33.4% of discharge reasons at minimum. However, with better classification, this number could rise.

Table 13. Discharge Reason* (April 2019-September 2022, DC1)

Discharge Reason	Percent
Program Non-Compliance	32.7
Non-compliance with project	0.5
Absconded	10.7
Opted-Out	5.1
Left For Housing Opportunity Before Completing Program	6.5
Compassionate Discharge	3.6
Completed Program (canned response)	19.4
Graduated (canned response)	14.0
Criminal Activity (reincarcerated)	1.7
Probation Ended	1.5
Violence	1.0
Parole Revoked	0.7
Needs Other Level Of Care	2.2
Mental Health Issues	0.2
Other	0.2
Total	**413**

* Data not available for entire funding period.

Goal Outcomes

Goal attainment is a critical outcome measure for clients and for county reporting. Yet the database contains no clear attainment indicators. Pivot inferred CRFW client goal progress by observing the sequence of goals clients cite in their service plans over time. CRFW does not keep track of each client's ongoing progress with each goal, but instead records clients' initial goals at intake and then subsequent goals that arise over the course of case management. Pivot categorized and counted goals CRFW participants tend to set on their service plans, indicating what kinds of needs and resources CRFW clients find most relevant. Interpreting goals requires caution as goals women set on CRFW service plans may reflect an understanding of CRFW capabilities rather than a woman's overall life goals and priorities. For example, if a client is already familiar with CRFW's scope, they

may set a service plan goal that they think CRFW can help with. Still, Pivot can draw directly from the goal type frequency and make inferences about key participant successes. Presumably the initial goals are most urgent and may be the reason clients engaged in services at all.

What progress did CRFW make on their initial goals?

The Table 14 includes client responses to the prompt, "What progress have you made on previous goals?" As with client goals above, Evaluators grouped these responses into categories by topic. Once again, we remind the reader that the goals as currently recorded do not lend themselves to analysis; evaluators attempted to categorize open-ended goals, but some do not neatly fit (such as categorizing "daily chores" as Housing goal progress). Pivot recommends standardizing the topic categories in alignment with CRFW's other client instruments (currently the SDOH questionnaire). Categories should differentiate between responses of "N/A" (not applicable) and "none" with clear definitions of each. Note that such a small sample size (n=17) offers limited generalizable insights regarding CRFW client goals.

Table 14. What progress have you made on previous goals? (n=17)

Housing	Social	Educational/ Vocational	Medical	Substance Use	Mental Health	Legal	[Other]
Daily Chores		Got a job		Continued sobriety	Advancing therapy steps	Addressing legal issues	N/A
		Got a job		Continued sobriety	Attend aftercare		N/A
		Progress on small business		Continued sobriety	Attending CFRW		None
		Saving money					None
							Some
1/17	**0/17**	**4/17**	**0/17**	**3/17**	**3/17**	**1/17**	**5/17**

Interestingly, even though clients listed Housing as their most frequent initial goal, no goal progress indicates getting housing in the interim. However, clients list progress in areas that are supported by having stable housing, such as substance use and mental health. Clients also note getting jobs and saving money, correlating with needing jobs and income as an initial goal.

What follow-up goals do clients set during service provision?

Table 15 details subsequent goals identified by POPSS participants in later service plans. Note that such a small sample size (n=9) offers limited generalizable insights regarding CRFW client goals.

Table 15. What new goals do you want to accomplish and/or achieve? Please be specific:

Housing	Social	Educational/ Vocational	Medical	Substance Use	Mental Health	Legal	[Other]
Getting an apartment		Finding a job	I need help completing my disability paperwork and faxing it in		Get back into counseling		Blank
I need to start packing my apartment		Try to take computer back and attempt GED classes					Blank
I would [complete an] abatement of rent form							[Fun] Finding a hobby
3/10	**0/10**	**2/10**	**1/10**	**0/10**	**1/10**	**0/10**	**3/10**

In general, there are not a lot of repeats of clients' initial goals. Overall, there are few responses (n=10) and no outstanding response patterns. However, fewer people state Housing (getting housing) as a goal, as well as fewer noting Educational/Vocational goals (especially foundational Vocational goals such as getting a job). Evaluators considered if the data indicates that CRFW clients do tend to achieve the goals they initially came in with, and can progress over time to secondary goals of less urgency. A couple of secondary goals suggest this shift from crisis response to life enrichment, such as "finding a hobby" and "get back into counseling." Upon review, CRFW staff confirmed that this data does represent a pattern of participant goal success and progression to different, new goals over time.

Though we can make some inferences about goal progress from CRFW's existing data, Pivot recommends considering a consistent instrument specifically designed for supporting and tracking client goal progression, such as the ASSM (see Appendix). It would be important to use a tool that is not only validated for goal data collection, but that participants feel is actually supportive to their experience. The data collection should actually *help* participants reach their goals, not just provide information for the organization. ASSM is a good example of this. Each goal category includes a rubric with examples of what progress looks like in each life domain, ranging from crisis management to flourishing.

For people whose only experiences so far in a certain domain have related to survival/crisis coping, the progression of examples models what growth can look like in many areas of life. At the same time, clients can choose their own targets along each continuum.

Sometimes introducing a new instrument for the purpose of program evaluation creates a "confounding factor" regarding program outcomes, i.e., are the outcomes influenced by the addition of *evaluation* activities as opposed to being the result of *program* activities alone. In this case, introducing the ASSM would facilitate better program evaluation, but it is not a dedicated evaluation tool that would introduce a confounding factor. It is a clinical tool that would contribute to program activities and only incidentally be useful for evaluation data collection.

The above charts provide a lot of anecdotal information about the kinds of goals CRFW participants set and work on.

Why are these goals important for POPSS participants?

The final service plan item addresses why POPSS participants strive for the above goals — why these goals are important to them. Participant responses in the Table 16 do not directly contribute to understanding of POPSS outcomes, but they provide an illuminating look into these women's lives and the reasons they engage in POPSS at all.

Table 16. Why is this goal important to reach? (n=17)

Housing
• I want my own space. • So I can have independent living. • So myself and my family have a steady home to live in. • To not be in the streets.
Social
• [I] can work on rebuilding family without being incarcerated. • To better the lives of [myself] and [my] children. • I want/need a better life/relationship with my family. I want to succeed in all the positive things in life. • They[?] make me feel better.
Educational/Vocational
• Because with the new certification I will be able to spend less time on my feet then in my current position. • I need more money in my savings so I can live a good life. • I really would like to be a teacher and teach at the college level mathematics. • So that I can have a successful career and to be able to comfortably support myself without struggling.

Medical
• So I can live healthy, and me and my puppy are out of the streets.
Substance Use
• I like my sober life and being responsible. • I need to live a better life with sobriety as my main goal. I don't want to depend on alcohol to live.
Mental Health
• I want to be cleansed and have a fresh start. • So that I can have a future and get my life back.
Legal
• So that he can have this on his record.

Participants cite a breadth of reasons for stating particular goals in every life domain. CRFW participants are inspired to achieve their goals by all aspects of their lives. Furthermore, while clients did not explicitly cite social goals in their service plans, social outcomes are some of the main reasons why clients pursue their goals: to support their relationships, families, and children. Insights from the above table can help program staff guide the services they offer, to appeal to their participants' deepest motivations to better themselves and their lives.

Do POPSS participants experience better outcomes than a comparison group?

Making comparisons across groups clarifies whether outcomes are typical, or exceptional for the group being studied. In this case, Pivot sought to compare the outcomes of POPSS participants with non-participants, to see if POPSS outcomes tend to show more improvement. When the only difference between groups is program participation (whether they participated or not), comparing outcomes also helps verify that the program contributed to participants' success.

Initially Pivot planned to facilitate outcome comparisons between long-term POPSS clients and new/short-term POPSS clients, but limitations in the project structure made it more feasible to compare POPSS outcomes with examples from research literature (see Limitations section below for details). The following literature review addresses CRFW outcome areas of interest, demonstrating both the need for interventions supporting each outcome and the results typically experienced by populations comparable to CRFW's clients. By comparing participant and non-participant outcomes, the study makes inferences about CRFW's supportive role in women's recovery, but cannot quantify exactly how much CRFW contributes to outcomes among populations of the women they serve.

What outcomes did this study evaluate?
At the individual level: do previously incarcerated women who are not engaged in POPSS experience…

1. **Decreased substance use** (severity, frequency, and/or drug use amount).
   Many women experiencing incarceration also experience co-occurring substance use disorders and mental health treatment needs (https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.3.317). Personalized social service support like PCM can help formerly incarcerated women recover from substance use (https://link.springer.com/article/10.1007/s11469-022-00902-1). However, previously incarcerated individuals face significant barriers to treatment and often do not get structured support to decrease substance use. (https://link.springer.com/article/10.1186/s13722-018-0120-6). These data support the conclusion that women engaging in POPSS are more likely to have positive outcomes related to substance use than non-participants.

2. **Decreased case management reliance** (intensity, length, or frequency of PCM).
   Research evidence supports the significance of PCM in formerly incarcerated women's success. "Avoiding recidivism is only one aspect of success for this population. Becoming self-reliant, helping family members and others, persevering through challenges, and being able to enjoy a 'normal' life are further identified as indicators of success.... [F]indings support and clarify theories of social support / social bonds for formerly incarcerated women, highlighting the importance of peer support for their successful reentry" (link abbreviated, see full link in References). However, reducing reliance on PCM over time can indicate growth of women's overall support network and personal connections. CRFW attendance trends indicate a gradual decrease in service provision over the course of BHI funding, showing a decrease in participant engagement with formal PCM. These data support the hypothesis that CRFW helps women access PCM while building additional supports to facilitate a decrease in service formality / intensity / frequency.

3. **Decreased new criminal activity** (and/or successful completion of parole and/or probation).
   Decreasing recidivism is a significant personal and systemic goal for POPSS participants and CRFW staff. However, recidivism is complicated by co-occurring challenges: "Women who are drug dependent, have less education, or have more extensive criminal histories are more likely to fail on parole and to recidivate more quickly" (https://www.tandfonline.com/doi/pdf/10.1080/07418820902870486). Many women engaging in CRFW services experience co-occurring challenges, putting them at higher risk for recidivism. However, services have been shown to reduce recidivism (https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=44c6925bb097eb649dced19d93d6e368434dc825). As a specific example, "Among poor women offenders specifically, we find providing state-sponsored support to address short-term needs (e.g., housing) reduces the odds of recidivism by 83%" (https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1745-9133.2004.tb00035.x).

   These data support the hypothesis that for CRFW's service population, engaging in services is likely to support improved recidivism outcomes.

4. **Increased behavioral and mental health stabilization.**
   Mental health is an important domain for women exiting incarceration, and has not so far been adequately addressed by conventional prison resources or treatment designed for men (https://www.jstor.org/stable/44953828). Among a study of southern women, "mental health and substance abuse treatment during reentry was essential to prevent relapse" (link abbreviated, see full link in References). CRFW participants receive support for mental health and substance use, as well as referrals to outside mental health resources such as therapy, groups, and

restorative activities. These data suggest that women engaged in services such as CRFW can expect to have better mental health outcomes than women exiting from incarceration not engaged in services.

5. **Increased stable housing, medical coverage, and/or employment status.**
Former incarceration creates significant barriers to housing, employment, and medical access. Women exiting incarceration experience high levels of basic needs (https://www.tandfonline.com/doi/abs/10.1080/01488376.2011.582017). For housing and employment, landlords and employers may reject formerly incarcerated applicants if aware of their criminal record. "Formerly incarcerated women are significantly less likely than non-formerly incarcerated women to receive a positive response from potential employers and face a number of mental, financial, and physical barriers to seeking and retaining employment" (https://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1001&context=werc). "Homelessness and incarceration are closely linked among women, and rates of these marginalizing circumstances are increasing" (https://journals.sagepub.com/doi/abs/10.1177/1557085114537870). Housing instability among previously incarcerated people can also exacerbate substance use (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8133692/). Regarding medical coverage, one study found that "83.0% [of previously incarcerated women studied] did not have a primary care provider [before program engagement]… Conditions more prevalent than in the general population included psychiatric disorders (94.0%), [and] substance use (90.0%)" (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5511582/).

   Focused vocational interventions that factor in recovery and a person-first, strengths-based approach can resonate with women exiting incarceration (https://onlinelibrary.wiley.com/doi/abs/10.1002/cdq.12078). Multiple POPSS participants reported success in getting jobs and saving money, and CRFW offers several employment resources including vocational classes, skill building, and resume help. CRFW helps women with transitional housing (providing housing for POPSS women and facilitating referrals to other housing resources), and refers women to medical care available in the community for their specific needs. These results suggest that POPSS participants are more likely to have positive outcomes regarding employment, housing, and medical coverage than non-participants.

6. **Increased supportive knowledge & attitudes.**
Peer services can help participants gain supportive knowledge and attitudes, both explicitly (through coaching, classes, resources, etc.) and implicitly (through modeling peers' behavior and identifying with peers' positive attributes). Social Learning Theory explains the strength of peer-based services with populations who may not have had extensive opportunities to benefit from other positive role models (link abbreviated, see full link in References). Becoming a peer worker can also increase supportive knowledge and attitudes; among formerly incarcerated women, "helping others benefits the helper by boosting self-esteem, increasing prosocial activity, and enhancing social connectedness" (https://r2com-network.org/wp-content/uploads/2023/04/Heidemannetal_G_2016_Wounded_Healers.pdf). Another study concluded "the helper/wounded healer orientation has a positive relationship with higher self-esteem and greater satisfaction with life, and a negative relationship with having a criminal attitude and the forecast of rearrest" (https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&-

doi=6b6c77f1fffd0cfecd0f17718c6aeff7c69ebeb3). This supportive symbiosis is at the heart of peer services such as POPSS.

Evidence previously cited in this literature review establishes that formerly incarcerated women experience elevated mental unwellness and educational deficits compared with non-incarcerated populations. Conversely, feedback from POPSS participants (and CRFW public reviews detailed in the following section) confirm that CRFW clients experience significant skill building and camaraderie. These data suggest that engagement in PCM encourages improved knowledge and attitude outcomes, especially when the peer organization provides personalized, strengths-based, and trauma-informed services, as does CRFW.

Unfortunately, formerly incarcerated women face many disadvantages compared with non-incarcerated populations, and are often victimized and/or marginalized before, during, and after incarceration. Research literature confirms that engaging in supportive services including peer services can help formerly incarcerated women in many different domains of recovery. Recovery can range from decreasing recidivism and substance use to increasing housing, employment, supportive relationships, and simply the opportunity to feel normal and enjoy life. This literature review supports the conclusion that women engaged in CRFW/POPSS experience more positive outcomes than previously incarcerated women not engaged in services.

Recidivism remains one of the most difficult and, therefore, most costly outcome measures. First, when most people think of recidivism, they think of a lifetime without a new offense which means without relapse if it is drug related. However, tracking groups of people over a lifetime is difficult because of the mobility economic conditions impose. Furthermore, simple contact methods change such as disposable phones and email addresses. So, when researchers study recidivism, they have to develop a timeframe for the study, which is completely driven by funding. Therefore, the most common recidivism measure is only six months, a period most people find uninteresting. One feature in New Mexico that makes this work a little easier is the New Mexico Sentencing Commission database of convicted offenders. This resource compiles all data sources statewide to help predict prison bed space for contracting purposes. The database is not absolutely current, due to the time required to assemble data; however, the lag is usually not more than 2 years (shorter than many state and federal databases). This resource can be put to use for other purposes to facilitate understanding recidivism but must include direct negotiations with the New Mexico Sentencing Commission.

What do program participants think of CRFW?

Collecting participant feedback is an important part of program evaluation, and can be approached in several different ways. One measure of whether participants like a service is to simply observe participation trends, namely, do people keep coming back. However, this can be complicated if services are mandatory (such as court-ordered treatments) or clients do not have other options aside from a single agency. Organizations can also solicit direct feedback such as via a satisfaction survey. CRWF previously administered a satisfaction survey with clients but discontinued it due to weaknesses in the instrument (wording, survey length, etc.) and their desire to reduce the direct data collection burden on clients. (Part of Pivot's process evaluation with CRFW involved modifying or eliminating ineffective data instruments to ease administrative burden while maintaining sufficient and key reporting elements.) Some of clients' service plan responses detailed above speak indirectly to their experience with CRFW. Some clients cite Case Management as a goal (i.e., engage in Case

Management) and some cite CRFW and Case Management as things they need to achieve their goals (see sections "What services do POPSS participants seek from PCM?" and "How does CRFW help PCM participants reach their goals?" above).

Additionally, Pivot conducted a brief summary qualitative analysis of online reviews to supplement the other data included in this evaluation. CRFW has a Google reviews rating of 4.8/5 stars from n=91 reviews, ranging from eight years ago to one week ago as of the time of this writing. About half the reviews (n=43) are from more than three years ago, with the rest from present to three years prior. Most of the reviews are highly favorable (5 stars) with a few respondents leaving 1 star highly dissatisfied reviews, and a few leaving mid-range reviews (2-3 stars). As with many review forums, there can be a bias to review either exceptionally positive or exceptionally negative impressions; people who had a "just OK" experience may be less motivated to gush, or complain.

Of the favorable reviews, some commenters stated the following:

- "This place [is] my foundation for my recovery. The staff is like family."
- "Great place that supports women to change and grow for betterment of self and family!! Life saver!!"
- "They help with many things and I ever in need I will always go to them for help...such amazing people in this building...they helped my family with every problem we had n if it wasn't for them I wouldn't have things that I have today I thank the Lord for u all such amazing people..."
- "The love and support I have received from Crossroads is the only reason I am here and thriving in society today."
- "…this place taught me how to fight and how to survive after prison. I can't express how much I love and consider this place my family and safe place. Very pure and good vibes only."
- "Very friendly and not judgmental."
- "I can only say that if it weren't for crossroads for women I wouldn't be where I'm today I love what they afford. They gave me my life back and so much more."

Of unfavorable reviews, commenters said the following:

- "Went to inquire about the program but got turned away because I have only been incarcerated 3 times. Turns out 5 times is the requirement."
- "They have great groups[…]But I'm no longer feeling comfortable coming here…I have no way to wash my clothes so I've [asked] for clothes a lot. It seem[s] that they're saying I can only ask to get clothes from boutique once a week. I know [for] a fact that's not a rule. And it's not that that bothers me. It's the fact [it's] only me…So I'm no longer gonna continue my services there. First they told me I didn't qualify community connection in the beginning. Which I knew I did. [Then] at [the] last minute they say I do. But by then I already had housing. I nvr ["never"] got help with housing like I've seen them help the other woman there. I'm starting to feel I was nvr wanted there…My family is struggling. And I'm not gonna burden them anymore. Cause that's how they made me feel. I'm very hurt rn ["right now"]."

The unfavorable comments note complaints specific to the individuals' personal experiences attempting to access specific resources; they do not discuss systemic concerns against CRFW as an organization. While valid for those individuals, the reviews and comments overall suggest that CRFW functions well for most clients.

What conclusions apply to CRFW PCM?

The findings in this report, though limited, indicate that CRFW helped women improve on their life goals, over the course of BHI funding. Future evaluations would benefit from being able to better quantify CRFW outcomes (as outlined in the CRFW logic model) by describing how many women improved by how much (regarding their sobriety, health, relationships, housing, employment, etc.). These results are not currently included in the CRFW data available for this report. Pivot continues to work with CRFW on improving their data collection to better answer programmatic questions. Being able to answer outcome questions is a reasonable expectation for program data and is critical for client management and organizational development. The following sections detail the limitations encountered in this evaluation and Pivot's suggestions for future opportunities.

Going forward, CRFW will continue services with Peer Drop-In available to all members, and PCM available to housing and programming "graduates" who are familiar with CRFW and have specific goals (with both supported by BHI funding). Pivot was able to establish processes and provide suggestions to guide future organizational improvements in data collection and reporting, and future evaluation of participant outcomes and organizational contributions. Though Pivot and CRFW ran into several limitations during this evaluation collaboration, CRFW was highly responsive and supportive throughout.

What limitations apply to this evaluation?

The limitations that Pivot and CRFW encountered throughout this evaluation include the following:

1. **A shortened timeframe that was more conducive to process evaluation than the evaluation of participant outcomes and organizational contributions.** As Pivot began gathering data, it became evident that discontinuity between the time periods BHI contracted for peer services (CRFW's contract) and evaluation (Pivot's contract) meant CRFW's contract would expire before Pivot's initial two-year plan could be executed.

   Pivot, CRFW, and BHI addressed this limitation by modifying the evaluation to analyze data that CRFW already collects instead of introducing new instruments; conducting most of the evaluation communications online via video call and email for timesaving and convenience; and focusing on CRFW's process and the limited outcomes within their influence. Pivot and BHI further addressed the issue of contract timing by scheduling two-year contract periods for evaluation that align with peer service contracts.

2. **Discrepancies in client engagement data.**
   The timing of service provision and format of client records posed a challenge for measuring direct POPSS outcomes. During BHI funding, half of POPSS clients were discharged in less than 12 months, with an additional 15% discharged in the next half year. Discrepancies between the interim data Pivot collected midway through the evaluation and the final data Pivot collected at the end of CRFW's contract.

   CRFW staff provided different datasets and formats at the interim and final data collection periods of the evaluation. Pivot usually collects an interim dataset as a data collection "practice run", so that both Pivot and the service organization know what to expect and have time to address

any issues. Pivot addressed discrepancies in CRFW's datasets in various ways. Sometimes Pivot analyzed most recent instruments (such as the New Service Plan and not the incompatible Old Service Plan), other times by merging data sets and using common elements (omitting dissimilar elements) and confirming data questions with CRFW staff. This report will address potential solutions for data challenges later.

3. **Missing or incomplete data elements.**
   CRFW provided incomplete exit category data. CFRW had difficulty providing consistent data files over time. The first partial data set indicated they served 253 individuals; however, a later data file only indicated serving 167 over the full funding period. One potential explanation for the decline may be due to data extraction. It is common that service provision organizations are unfamiliar with extracting large data sets from their management system. These organizations generally work on the individual level, and likely only extract group data rarely for special requests. Service agencies often only use data for direct one-on-one case management. Therefore, they are unfamiliar with the process of pulling data files covering multiple individuals. Furthermore, evaluators may change the request slightly or communicate the request unclearly. Pivot plans to spend more time addressing with CRFW staff the data request and fulfilment process in the future.

   CRFW also did not provide data on member goal completion. Pivot and CRFW addressed these limitations by discussing CRFW's opportunities for data collection improvement. CRFW confirmed that they do collect some information on client progress and outcomes that was not shared in this evaluation period but that they would ensure is available in future evaluation collaborations.

4. **Data collection instruments that do not provide strong evidence for participant outcomes.**
   As discussed previously in this report, the instruments CRFW currently uses to measure client progress (SDOH and Service Plans) do not provide quality indicators of specific or generalizable CRWF client outcomes. Given the abbreviated evaluation timeframe, Pivot did not introduce new instruments during this evaluation. Pivot addressed the limitations in CRFW instruments by analyzing what was available and using this opportunity to suggest improvements for future data collection.

5. **Coordinating with a high-capacity organization and vulnerable population.**
   Due to the demands on staff and sensitivity of the population they serve, Pivot experienced some limitations in conducting extensive personal communications with staff and clients. CRFW staff are kept busy serving clients who may be undergoing significant challenges or even crises when they engage in services. CRFW staff work hard to ensure the privacy and safety of their clients while providing supportive services across a huge range of resources including food, hygiene, clothing, parenting, education, employment, socialization, sobriety, housing, etc. PCM participants are often women who have experienced significant traumas including violence, poverty, homelessness, and incarceration. Pivot addressed this limitation by interviewing select staff as available and collecting additional unobtrusive data, such as CRFW website information and online comments/reviews.

What does this evaluation suggest for Crossroads for Women's future development?

This program evaluation highlights several opportunities for CRFW to improve data collection practices, to better understand and communicate about their service processes and impacts. Areas for potential development are listed below.

1. **Standardize data collection categories for several data points CRFW already collects, including the following:**
    a. **Participant goals.**

Currently CRFW records participant goals as open-ended comments in participants' service plans. Pivot recommends that CRFW modify their data entry to require one multiple choice selection of main topic per client goal (such as from a drop-down menu of options), with an optional text box for additional details. Standardizing goal categories would make data entry easier for CRFW staff and allow CRFW to quantify goal types and analyze goal information. See "What services do POPSS participants seek from PCM?" and "In this sample none of the participants presented with initial social goals. This could be because social situations such as conflict and loneliness, while stressful, are not crises requiring primary attention. It is also possible that this variation is due simply to representing a small sample size, and it is possible that more responses from more women would indicate a broader breadth of primary goal categories. Finally, attempting to categorize participant goals raised a new consideration for evaluators: It is possible that goals apparently categorized in one area may be highly motivated by another area. For example, a woman may want to get sober, *so she can regain custody of her children*. Or, a woman may want to improve her health, *so that she can work again*. In the first example, is this a substance use goal, or a social goal? Is the second example a health goal or vocation goal? The service plan needs to clarify these distinctions for client clarity as well as program evaluation purposes.

CRFW staff record these goals as open-ended entries (free text fields) without any standardization built into their system. To qualitatively analyze goal themes, Pivot sorted the goals into SDOH categories as described in the table above. This type of after-the-fact categorization by an outside entity introduces limitations, as opposed to the standardized data entry categorization defined by an organization itself (CRFW). Sorting open-ended comments is both time-consuming and subjective. Analysts may categorize a goal differently than the program participant initially intended, an error that is more easily caught and addressed if Peer Case Managers categorize participant goals on the "front end" while discussing them with participants. This particular data set is also limited by its small response size (n=17). Therefore, use caution when drawing generalizable conclusions from these results. To CRFW's credit, the N here is small because they recently improved their intakes forms and other data collection.

Results show that the most frequent initial goals are housing (i.e., getting housing) and Educational/Vocational, with a focus on vocational (get certified, hold a job, create income). This makes sense on a practical level: Qne finding Pivot encounters across many service providers is that their clients have to establish housing first, and a source of income, to be able to make progress with any other goals. After Housing and Vocational, the next frequent initial goals are Legal, Medical, and Substance related. Note that these results could be presented more concisely with the use of standardized response categories.

Standardizing CRFW goals and goal rationales would ensure that participants' responses are accurately interpreted, and create the opportunity for more context-rich and organizationally significant analysis to come.

Finally, Pivot recommends that CRFW consider creating distinctions between participants' overall goals, and their objectives. For example, in the Table 3 above some responses indicate true goals that are an end in themselves, such as "get housing" and "stay clean". Others may be better characterized as objectives, which are means to an end but not the end itself. For example, "substance use treatment" and "case management" are activities someone can do to get closer to their goal of sobriety or other life improvements.

How do you distinguish between objectives and goals?
It can be hard to tell which aims should count as objectives versus goals. People often refer to SMART (specific, measurable, achievable, relevant, and time-bound) *goals*, but Pivot considers the SMART framework to be better suited for *objectives.* Pivot's rule of thumb is to consider the following points:

- The reason goals are so difficult is that few people have thought about or discussed different types of goals. Some goals can be thought of as multi-level, such as "getting sober, so I can get my children back". Other goals have clear end points such as "getting to the moon and back safely". While other goals maintain or keep going, such as living sober, or staying healthy. **The goal of some goals is to keep going. The maintain or keep going type goals do not fit the SMART format.**
    - There is a rule of trinity in business that all service providers must balance for their clients. "You can have it fast, cheap, or high quality. Choose any two!" Getting to the moon and back safely breaks this rule, because the US Government had unlimited resources. When setting goals, remember that most of your clients have limited resources. This fact alone limits goal attainment in many ways difficult for a clinician to predict.
    - Additionally, setting time bound goals for clients when those goals have significant components OUTSIDE client control may lead to client backwards progress.
- Does it make sense for a goal to be "S.M.A.R.T."? Here are three considerations:
    - Is there any evidence suggesting a timeframe? Evidence for quitting any addiction is that people exhibit wide variation in periods before success. Setting arbitrary timeframes may lead to unnecessary guilt, sense of failure, and early giving up on the goal. Similarly, getting a job depends on many factors out of participant control. Why hold the participant to a timeframe when so many elements are out of their control?
    - It is perfectly acceptable to "hedge" difficult goals. Writing a goal to reduce substance use during a period emphasizes the difficulty of the task while insisting on progress. Applying for three jobs in a period produces action the client has control over. Often authors refer to these sorts of statements as short-term goals.
- To distinguish between goals and objectives consider the following:
    - Is it an end in itself (the overall goal) or a means to an end (an objective)?

- The point of an objective is to complete it, such as detox from a drug, get your GED, or exercise weekly.

How can CRFW distinguish between objectives and goals at an organizational level?
As an organization, CRFW also has overall goals, and specific objectives. The logic model Pivot designed with CRFW shows this distinction in the program outputs versus outcomes (Figure 1). Outputs are the measurement of organizational objectives: they measure SMART data or "bean counting" such as participation counts, service hours, and referrals. Outcomes are the measurement of organizational goals — they measure progress along broad improvements such as client health, program growth, and systemic change. The outputs contribute to the outcomes: for example, CRFW may want to increase PCM hours and referrals in the service of improving client health, if they believe that more services will correspond to more wellbeing. Incidentally, creating these linkages is the basis of an organization's Theory of Change (the basic assumptions an organization makes about how and why its services improve participant situations). Examining these linkages and their relationships is the basis of program evaluation.

Why standardize data collection categories? for details.
Pivot recommends standardizing client goal categories using the same groups already defined by other CRFW tools (such as the ASSM if implemented, or SDOH). Using consistent categories across tools and data collection points allows for more in-depth inquiries and analyses about CRFW client needs, experiences, and outcomes across client engagement. CRFW could keep client records regarding initial goal establishment and progress in each category over time. These data could answer questions including "which goals are associated with higher or lower client engagement", "which goals take longer or shorter to achieve/progress", "how do clients change goals over time", etc.

b. Participant sub-goals or goal motivation.
CRFW's new Service Plan currently includes a question asking, "why is [your] goal important to reach?" Asking about motivation may clarify goal and objective distinctions. Pivot suggests that CRFW also create standardized categories for goal motivation. Standardizing CRFW goals and goal rationales would ensure that participants' responses are accurately interpreted, and create the opportunity for more context-rich and organizationally significant analysis to come.

c. Participant timeframe for goals (desired time and actual time).
CRFW currently asks participants how long they want to take to complete a goal (see table in Appendix) with responses recorded as open-ended comments. This does not allow for any analytical comparisons between goal types and desired achievement time, or desired time versus actual time. Pivot recommends creating standardized categories for both (such as, up to a week/ a week to a month/ one to three months/ three to six months, etc.).

d. Participant group attendance.
CRFW participants may attend many different kinds of groups, currently recorded as an open-ended comment. Creating an option to sort first by group type (similar to goal categories above) and then provide further detail would facilitate participation analysis.

e. Participant referrals.
Pivot suggests CRFW also create standardized categories for participant referrals, regarding how clients were initially referred to CRFW, and which organizations CRFW subsequently referred clients out to.

f. **Participant exit information.**
CRFW currently has exit categories, to which Pivot recommends the following revisions: ensure categories are mutually exclusive and exhaustive (i.e., cover all the bases with no repeats) and reconsider the terms they use for discharge reasons/categories. Currently, the categories do not appear to be a genuine reflection of CRFW's process, goals, and values. Namely, some are very negative, binary, and prescriptive—such as "non-compliance" and "absconded". This kind of language may not be problematic for internal CRFW use, as all staff are aware of the context around client experiences and CRFW administration. However, to an outside entity (such as funders or participants) without compassionate context, this kind of language may unintentionally mischaracterize CRFW's clients. It would also be challenging for non-CRFW personnel to understand differences between categories. Many of the following appear to be somewhat duplicates (such as "completed program" vs. "graduated") and/or require definition (how does CRFW define "absconded"? "compassionate discharge"? etc.). Pivot expressed these concerns to CRFW during the evaluation collaboration and they are aware of our recommendations to reconsider these administrative terms as they see fit.

2. **Improve participant outcome tracking by implementing an appropriate process or tool (ASSM or similar).**
CRFW does not keep track of each client's ongoing progress with each goal, but instead records clients' initial goals at intake and then subsequent goals that arise over the course of case management. Recording goal completion dates would improve the goal process dramatically. CRFW may consider implementing the Arizona Self-Sufficiency Matrix (ASSM, see Appendix), a tool specifically designed to assess ongoing client progress along a continuum for each life domain category. The ASSM could potentially replace or be used alongside the SDOH, a tool useful for need screening but ill-suited for goal progress tracking.

In future evaluations, Pivot would also welcome increased direct inclusion of CRFW participants and staff in evaluation activities. For this evaluation, Pivot conducted meetings and informal interviews with CRFW as needed to discuss evaluation data collection, findings, and implications. Future evaluations could benefit from both more structured staff interactions (such as staff surveys or interviews with formalized topics/ questions), and direct engagement with CRFW participants as applicable and appropriate. Pivot omitted data collection directly from participants at this time due to challenges in setting up the necessary processes in a timeframe shorter than initial expectations (direct participant engagement necessitates instrument development, IRB approval, and administration, in addition to approval and relationship-building with participants and staff). Future evaluations could include participant feedback in the form of surveys, individual and group interviews, or other creative media such as writing on an interactive poster (as Pivot has done with previous clients).

CRFW staff including their new Executive Director expressed their commitment to streamlining and improving their organizational practices, including data collection processes. CRFW and Pivot staff discussed how CRFW can make improvements with the guidance of this report and technical assistance from Pivot and BHI. CRFW staff emphasized that their goal is for increased organizational stability, sustainability, and consistency going forward.

What is Centro Sávila Peer Case Management, and how did Pivot evaluate it?

Pivot began Centro Sávila's (CS) program evaluation by meeting with its staff to understand Peer Case Management (PCM) as implemented. Pivot also met with BHI staff. After reviewing organizational documents, Pivot created the following program description (logic model). This model underwent several modifications based on Centro Sávila feedback and Pivot conceptualizations, resulting in the following confirmed version. The logic model specifies what Pivot evaluates in the Outputs and Outcomes boxes.

Figure 5. Centro Sávila's Logic Model

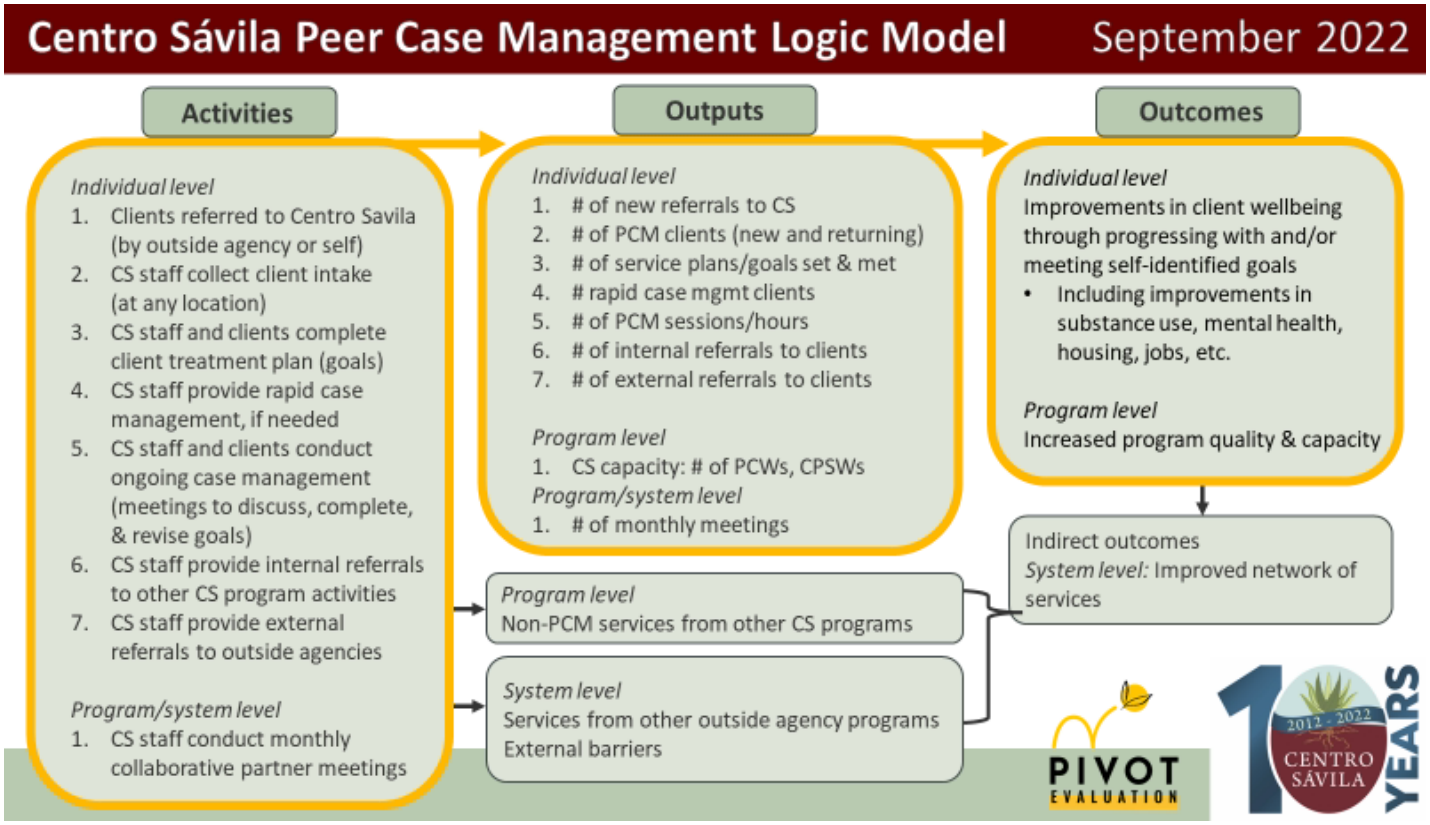
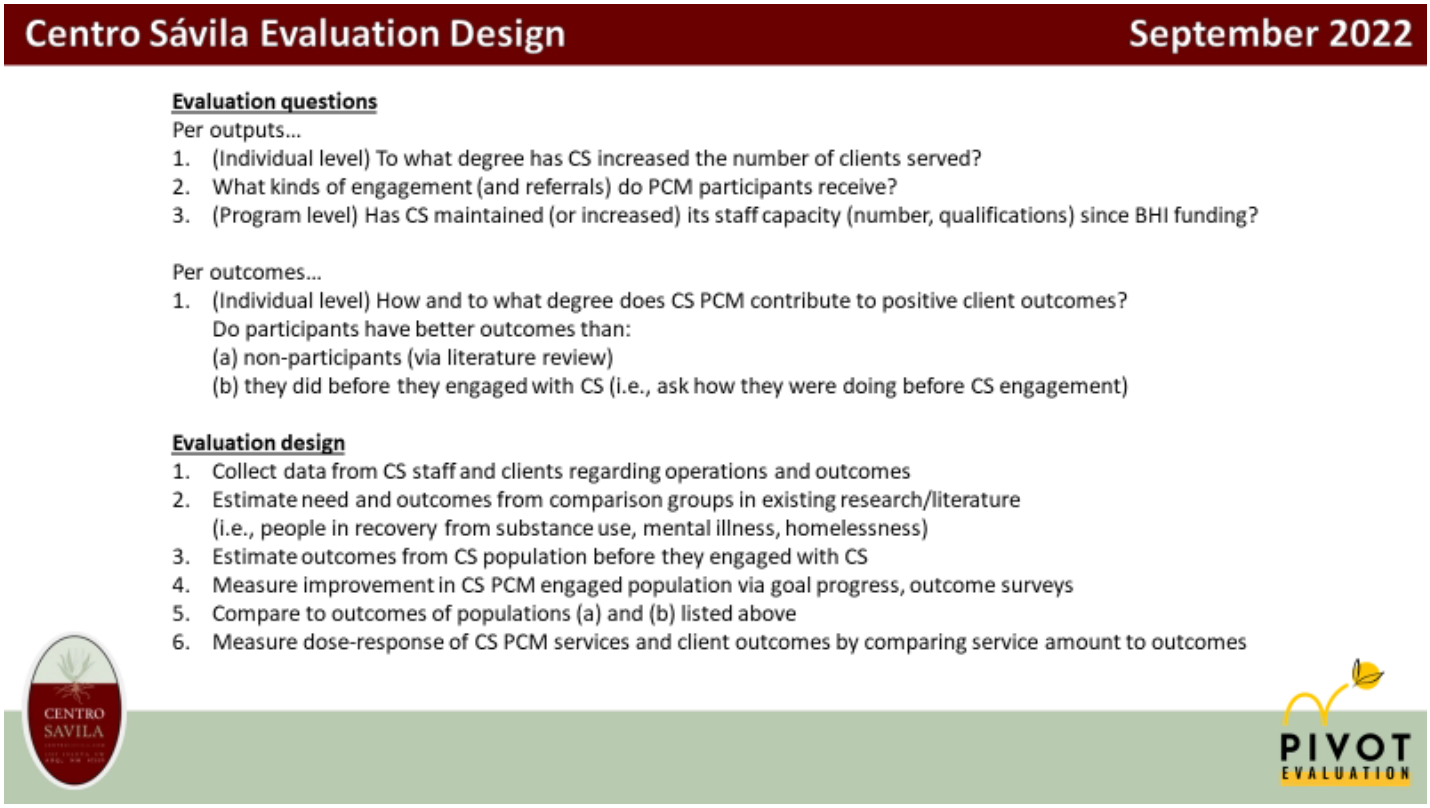


Figure 6. Centro Sávila's Evaluation Design



Centro Sávila Evaluation Questions

Pivot developed the following evaluation questions, and separated them into two basic groups: process and outcome. Process questions include who participated and what program staff did with the participants. Outcome questions focused on how participant lives or behavior changed.

Process Evaluation Questions

1. To what degree has Centro Sávila increased the number of clients served?
2. What kinds of engagement (and referrals) do PCM participants receive?
3. Has Centro Sávila maintained (or increased) its staff capacity (number, qualifications) since BHI funding?

Outcome Evaluation Questions

4. How and to what degree does Centro Sávila PCM contribute to positive client outcomes? Do PCM participants have better outcomes than a) they did before they engaged with PCM, or b) non-participants.
    - **a.** …they did before they engaged with PCM?
    - **b.** …non-participants? (via literature review.)

The following sections include a brief summary of results to the above questions, followed by detailed findings, which include data and discussion.

What did this study find? (Centro Sávila brief summary results.)

Following are the brief summary responses to the evaluation questions. For detailed findings, see the subsequent section **"What did the study find? (Centro Sávila full detailed results)"**

1. **To what degree has Centro Sávila increased the number of clients served?**
   Centro Sávila served a similar number of PCM participants across all four BHI funding years observed, with all years showing between 146-209 participants per year. While Centro Sávila (and BHI) may wish to increase future PCM service provision, several factors influence the service provision reported here and speak to the quality of Centro Sávila's services thus far, including the following:

   b. The COVID pandemic. While COVID may have made for additional service need among Centro Sávila's service population, it also introduced significant challenges in service provision for many organizations. Centro Sávila maintained pre-pandemic service numbers since COVID, a testament to the strength of its service capacity even during a crisis.
   c. The scope of BHI's funding relative to Centro Sávila's funding requirements for maintaining versus increasing service provision. Currently, 84% of Centro Sávila PCM participants do not have any insurance to pay for services, and Centro Sávila provides treatment regardless of a participant's ability to pay. Given Centro Sávila's high percentage of participants who are uninsured or unable to pay for services, Centro Sávila requires a significant amount of funding to maintain current service provision, let alone increase it.
   d. Centro Sávila is currently in the process of expanding Medicaid billing and joining the New Mexico Behavioral Health Providers Association, to increase its financial resources and opportunities. Additionally, Centro Sávila is developing the internal clinical, case management, financial and compliance structures required to become a federally designated Certified Community Behavioral Health Clinic (CCBHC).
   e. Finally, the level of engagement observed from Centro Sávila's current service population speaks to the quality of its services. Participants check in to appointments of all types at an attendance rate over 75%, indicating robust engagement with this service population. Centro Sávila's engagement rate is in stark contrast with other attendance Pivot has observed in the course of BHI service evaluations, which tends to hover around 20%. Centro Sávila's dramatically higher attendance indicates the high quality and desirability of its services among its service population, a promising indicator of current practices and future expansion potential.

2. **What kinds of engagement (and referrals) do PCM participants receive?**
   Participants in Centro Sávila Peer Case Management may engage with a Peer Case Manager over time to address any number of personal goals. Common issued addressed in Centro Sávila PCM include the following:

   - Housing
   - Food Security
   - Medical Insurance
   - Driver's License
   - Birth Certificate
   - Social Security

- Disability
- Education

(See https://www.centrosavila.org/home/services/case-management/ for additional information).

Centro Sávila offers several different services, not just Peer Case Management. They also provide therapy, benefits enrollment, and have a dedicated facility with a garden. Offering internal referrals for behavioral health services eliminates a number of barriers associated with the scarcity of providers and linguistically and culturally responsive services. They foster local partnerships with funders such as BHI, as well as other service providers and community organizations.

PCM participants experience case management sessions with Peer Case Managers focused on several main life areas, but tailored depending on each participant's personal needs and goals at the time of service, including Rapid Case Management. Centro Sávila has high PCM engagement follow-through from participants. Participants successfully keep over 75% of appointments in all appointment types from first contact to ongoing PCM sessions. Most clients (65%) engage in PCM for between one month and one year. Participants receive referrals to and from Centro Sávila from a wide array of other diverse services and resources, implying a high level of connectivity between Centro Sávila and other community providers.

3. **Has Centro Sávila maintained (or increased) its staff capacity (number, qualifications) since BHI funding?**
   Over the course of BHI funding, Centro Sávila has experienced some turnover (five staff members leaving), but hired and trained more staff (eight individuals) for a total increase of three more CPSW certified staff since the duration of BHI funding.

4. **How and to what degree does Centro Sávila PCM contribute to positive client outcomes? (Do Centro Sávila PCM participants have better outcomes than non-participants?)**
   Participants work on making progress on their goals in PCM sessions with Centro Sávila peer staff. Participant discharge information indicates that at least 30% of participants exit PCM with positive progress. Pivot's ability to draw further conclusions about Centro Sávila contributions to participant outcomes was limited by a lack of data on client goal progress throughout PCM. Pivot suggests that Centro Sávila consider using instruments to track more closely individual participants' goal progress and attainment. For example, Centro Sávila may wish to consider using the ASSM self-sufficiency matrix to establish and monitor goals with participants (see Appendix).

   Centro Sávila also measures three specific outcomes of interest (mental health/distress, alcohol consumption, and other substance use) with a brief survey, which PCM staff administer with participants multiple times over the course of PCM. Pivot calculated the change in outcomes to determine whether participants experience more positive indicators the longer they engage with Centro Sávila. The majority of participants reported reductions in distress, implying improvements in mental health since engaging in PCM sessions. Most respondents report no change in substance use (a 0 change score), and notably none report an increase in substance use since engaging with PCM. These results indicate that people engaging in PCM tend to experience substance use maintenance or improvement. The vast majority of participants indicate no change in alcohol consumption (n=108) while several indicate reductions in alcohol (n=14) and a few indicate increases in alcohol consumption (n=4).

Centro Sávila's outcome instrument results indicate that the majority of sustained PCM participants experience improvements in their mental health and substance use throughout their engagement with PCM (see "**Do PCM participants have better outcomes than they did before they engaged with PCM?**" below). In addition to PCM participants' pre-post test results, literature review suggests that engaging in services supportive to mental health and substance recovery such as Centro Sávila PCM promote positive outcomes among participants.

▸ What did the study find? (Centro Sávila full detailed results)

This section details the results Pivot collected to address the study's evaluation questions and offers a full discussion of the finding's implications. Pivot began by collecting data to address the first process evaluation question regarding Centro Sávila's PCM members over the course of BHI funding:

1. **To what degree has Centro Sávila increased the number of clients served?**
   In total, Centro Sávila's BHI contract evaluated in this report extended from 7/1/2019-6/31/2023 (four years), while Pivot was contracted for evaluation since January 2022. **Table 17, Table 18, Table 19, Table 20, Table 21,** and **Table 22** show the number of Centro Sávila clients who entered into PCM for each year of BHI PCM funding, and their demographics.

Table 17. Number of PCM Clients Approved for PCM per Fiscal Year

Fiscal Year	Number	Percent
July 2019 - June 2020	153	21.8
July 2020 - June 2021	209	29.7
July 2021 - June 2022	146	20.8
July 2022 - June 2023	195	27.7
Total	**703**	**100%**

Table 18. PCM Age Categories (percentage)

Age Category	July 2019 - June 2020	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023
0-18 Children	7.2	9.1	4.8	1.0
19-25 Adults	11.1	10.5	11.6	12.3
26-34 Adults	13.1	12.0	17.8	20.0
36-54 Adults	34.6	44.5	39.7	41.0
55-64 Adults	19.0	13.4	12.3	16.9
65+	15.0	10.5	13.7	8.7
Total number of individuals	**153**	**209**	**146**	**195**

Figure 7 illustrates the relationships between PCM participation and age, with most participants falling between the ages of 20 to 60.

Figure 7. Variation in PCM Participation by Participant Age

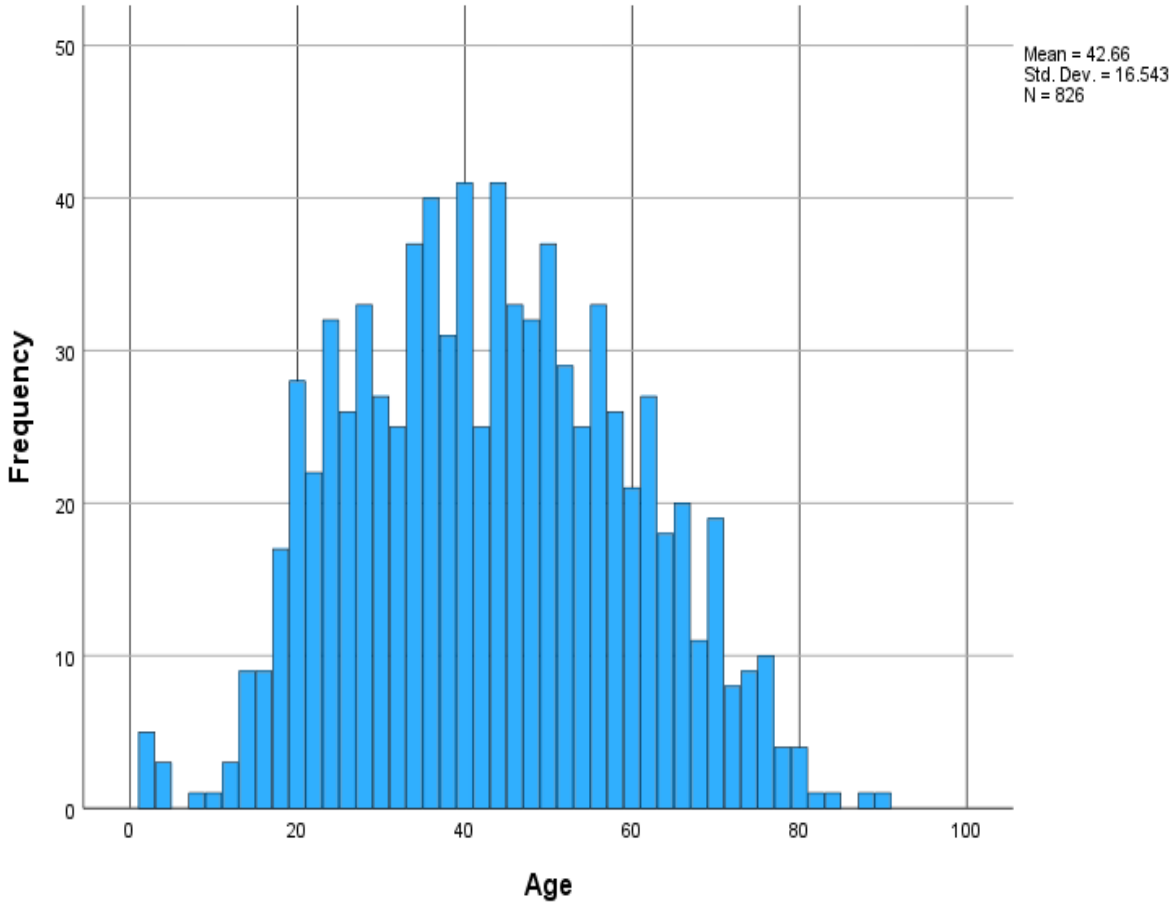


Table 19. PCM Racial Categories (percentage)

Race	July 2019 - June 2020	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023
American Indian or Alaska Native	0.7	4.3	2.1	1.5
Asian	0.0	1.0	2.7	4.6
Black of African American	2.6	1.0	1.4	3.1
Hispanic	34.6	56.9	63.0	59.0
Latino	0.0	0.5	0.0	4.1
Other Race	2.0	1.0	2.7	0.5
White	13.7	11.5	15.1	13.3
Declined to specify	46.4	23.0	13.0	13.3
Unknown	0.0	1.0	0.0	0.5
Total number of individuals	**153**	**209**	**146**	**195**

Table 20. PCM Ethnicity Categories (percentage)

Ethnicity	July 2019 - June 2020	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023
Declined to Specify	35.9	18.7	11.6	4.6
Hispanic or Latino	54.2	65.1	70.5	76.4
Not Hispanic or Latino	9.8	14.8	17.8	18.5
Unknown	0.0	1.4	0.0	0.5
Total number of individuals	**153**	**209**	**146**	**195**

Table 21. PCM Sex Categories (percentage)

Sex	July 2019 - June 2020	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023
Female	51.0	57.9	70.5	73.3
Male	49.0	42.1	29.5	26.7
Total number of individuals	**153**	**209**	**146**	**195**

Table 22. PCM Income Categories (percentage)

Income Level	July 2019 - June 2020	July 2020 - June 2021	July 2021 - June 2022	July 2022 - June 2023
$0-$20,000	9.8%	40.2%	69.9%	68.7%
$20,000-$40,000	2.6%	5.3%	11.6%	13.3%
$40,000-$65,000	1.3%	0.5%	2.1%	2.1%
Not Declared	86.3%	54.1%	16.4%	15.9%
Total number of individuals	**153**	**209**	**146**	**195**

What else do we know about PCM participant finances?

BHI and Centro Sávila have both indicated a desire to bill more Centro Sávila services to Medicaid. Billing Medicaid would provide another source of ongoing Centro Sávila funding (aside from BHI). However, billing services to Medicaid requires additional costs, processes and risks other billing does not. The following **Table 23** describes payment sources for Centro Sávila services and shows that 84% of participants have no payment assistance. This 84% includes individuals supported by the COVID-19 public Health Emergency Order, so future payor breakdowns may show an increase in those with no insurance.

Table 23. Primary Payor Type Across All Four Years

Payer Type 1	Percent
Medicaid	15%
Medicare - New Mexico	0%
No insurance	84%
Private Insurance	1%
Total	**826**

The following **Table 24** shows that clients in PCM are not shifted from being uninsured to getting some type of insurance, whether Medicaid, Medicare, or private insurance. Exactly 700 individuals had no payer type 2.

Table 24. Two Payor Situations Across All Four Years

Payer Type 1	Payer Type 2			
	No Insurance	Medicaid	Private Insurance	Total
No Insurance	61	5	2	68
Medicaid	52	1	0	53
Medicare - NM	1	0	0	1
Private Insurance	4	0	0	4
Total	118	6	2	126

What can we conclude about Centro Sávila's service provision?

Overall, Centro Sávila experienced a similar number of PCM participants across all four BHI funding years. Centro Sávila PCM had a slightly higher number of participants in July 2020-June 2021, the first full fiscal year since the COVID pandemic onset. This elevated number of PCM participants could be due to an increased need for services among Centro Sávila' service population while dealing with the effects of the pandemic. Slight variation in participant counts across years could also be due to random fluctuations. In this case, the result shows a flat trend in participation across BHI funding, with all years showing about 150-200 participants per year.

Centro Sávila's demographic records confirm that PCM participants are most often low-income white or Hispanic adults. The first two years of BHI funding reflect a mostly even division between male and female participants. In the final two years, female participants outnumber males at about 70% females to 30% males. Further future observation of participant demographics could determine if this discrepancy is part of a trend, or random variation as well.

Over the course of 2019-2023 BHI funding, Centro Sávila has maintained but not increased the number of clients served with Peer Case Management. While Centro Sávila (and BHI) may wish to increase future PCM service provision, several factors influence the service provision reported here and speak to the quality of Centro Sávila's services thus far, including the following:

a. The COVID pandemic. While COVID may have made for additional service need among Centro Sávila's service population, it also introduced significant challenges in service provision for many organizations. Centro Sávila maintained pre-pandemic service numbers since COVID, a testament to the strength of its service capacity even during a crisis.

b. The scope of BHI's funding relative to Centro Sávila's funding requirements for maintaining versus increasing service provision. Currently, 84% of Centro Sávila PCM participants do not have any insurance to pay for services, and Centro Sávila provides treatment regardless of participant ability to pay. As Pivot has discussed elsewhere, "there is no business model for behavioral health," meaning organizations like Centro Sávila depend on public funding because the people who need their services most are likely not in a position to pay for them. As Centro Sávila's Executive Director Dr. Wagner put it, "behavioral health is not an

industry, it's a human right." Given Centro Sávila's high percentage of participants who are uninsured or unable to pay for services, Centro Sávila requires a significant amount of funding to maintain current service provision, let alone increase it.

c. Centro Sávila is currently in the process of expanding Medicaid billing and joining the New Mexico Behavioral Health Providers Association, to increase its financial resources and opportunities. Additionally, Centro Sávila is developing the internal clinical, case management, financial and compliance structures required to become a federally designated Certified Community Behavioral Health Clinic (CCBHC).

d. Finally, the level of engagement observed from Centro Sávila's current service population speaks to the quality of its services. Participants check in to appointments of all types at an attendance rate over 75%, indicating robust engagement with this service population. Centro Sávila's engagement rate is in stark contrast with other attendance Pivot has observed in the course of BHI service evaluations, which tends to hover around 20%. For example, when evaluating Peer Drop-In services in a previous study, Pivot found that only 20% of participants counted as "engaged" in services per providers' attendance definitions, and these 20% accounted for about 80% of attendance overall. Centro Sávila's dramatically higher attendance indicates the high quality and desirability of its services among its service population, a promising indicator of current practices and future expansion potential.

Evaluators next analyzed participation data to address the second evaluation question.

2. **What kinds of engagement (and referrals) do PCM participants receive?**
   Evaluators addressed this question by analyzing several aspects of PCM participation including what brings individuals to Centro Sávila PCM, what participants do in PCM, how long participants engage in Centro Sávila PCM, and what we know about discharges from PCM.

What brings participants to Centro Sávila PCM?

The following **Table 25** shows referral sources to Centro Sávila PCM (i.e., how participants heard about or were directed to Centro Sávila PCM). These categories are not standardized or mutually exclusive, as evident by variations and errors in referral source names. Centro Sávila data systems could save data entry time and improve usefulness if they used standard organization names with preset categories, such as "Law Enforcement," "Hospital/Medical," "Government Services," "Nonprofit Services," "Internal Referral," "Word of Mouth," etc. Creating standardized "buckets" to sort referrals into could ease the data entry process and allow for easier analysis of referral frequencies by overall type.

Knowing which types of referral sources are more or less frequent can help Centro Sávila focus its outreach and tailor its services. Centro Sávila could cross examine referral sources with client needs to see if referral sources reliably predict needs (such as people exiting hospitals needing to set up health insurance and primary care, people referred from law or legal entities needing legal navigation, etc.). Finally, Centro Sávila could conduct specific networking with various referral source organizations depending on their level of overlapping engagement with Centro Sávila participants.

Table 25. Referrals to Centro Sávila PCM Across All Four Years

Referral Source	Number of Individuals Referred	Percent
[Blank]	353	42.7
Albuquerque Community Safety	1	0.1
ABQ Health Care for the Homeless	3	0.3
All Faiths Receiving Home	2	0.2
Amistad	1	0.1
APD COAST Team	5	0.6
APS	11	1.3
BCBS	3	0.4
Bernalillo County	1	0.1
Casa Aliento	1	0.1
Casa de Salud	5	0.6
Catholic Charities	2	0.2
Centro de Igualdad y Derechos	3	0.4
Clinica La Esperanza	1	0.1
CNM	1	0.1
Comadre a Comadre	1	0.1
Crossroads for Woman	1	0.1
CYFD Protective Service Division	6	0.7
East Central Ministries	1	0.1
EMR Referral	7	0.8
Encuento Comunitario	3	0.4
Enlace Comunitario	16	1.9
ERAP	3	0.4
Faith Works	1	0.1
Families ASAP	1	0.1
First Choice Community Healthcare	7	0.7
Housing Authority	1	0.1
Insurance Referral	4	0.5
Internal Referral	43	5.2
Juvenile Probation Office	1	0.1
La Plazita Institute	1	0.1
Legal Referral	3	0.4
Lutheran Family Services	1	0.1

Referral Source	Number of Individuals Referred	Percent
Mexican Consulate	3	0.4
Midtown Public Health Office	1	0.1
New Mexico Immigrant Law Center	10	1.2
NM Department of Health	1	0.1
NM Works	1	0.1
NMCAN	4	0.5
One Hope Centro de Vida	3	0.4
Online Referral	5	0.6
Parole Officer	3	0.4
Planned Parenthood	3	0.4
Presbyterian Hospital	7	0.8
Primary Care Provider	1	0.1
Public Defender's Office	1	0.1
Public Health Office	2	0.2
Raymond Sanchez Community Center	1	0.1
Referred by a person	1	0.1
Sage Neuroscience	1	0.1
Santa Fe Indian Hospital	1	0.1
Self	107	13
Senior Citizen Center	2	0.2
Simplemente Salud	3	0.4
Social Security	1	0.1
Southwest Family Guidance Center	2	0.2
Super 8 Motel	1	0.1
Unknown	1	0.1
UNM Hospital	29	3.5
UNM SE Heights Clinic	3	0.4
UNM- Southeast Heights Clinic	1	0.1
Violence Intervention Program	4	0.5
Walk-in	40	4.8
WECH	19	2.3
WEHC	2	0.2
Word of mouth	68	8.2
Total	**826**	**100**

What do PCM participants do in Case Management?

Participants in Centro Sávila Peer Case Management may engage with a Peer Case Manager over time to address any number of personal goals. Common issued addressed in Centro Sávila PCM include the following:

- Housing
- Food Security
- Medical Insurance
- Driver's License
- Birth Certificate
- Social Security
- Disability
- Education

(See https://www.centroSávila.org/home/services/case-management/ for additional information).

Participants first make contact with Centro Sávila via a referral (detailed in the table above). Participants then complete an Intake & Assessment, make a Service Plan with their Case Manager, and commence PCM sessions. **Table 26, Table 27, and Table 28** detail the percentage of participants who engaged with each step of the process, and the attendance statistics. Participants check in to appointments of all types at an attendance rate over 75%, indicating robust engagement with this service population. As mentioned above, Centro Sávila's engagement rate is in stark contrast with other attendance Pivot has observed in the course of BHI service evaluations, which tends to hover around 20%.

Table 26. PCM Appointment Attendance Across All Four Years

Appointment Type	No Show	Canceled	Checked In
Contact Note	13%	1%	86%
Universal Intake & Assessment	12%	9%	79%
Rapid Case Management	12%	9%	79%
Case Management Service Plan	6%	11%	84%
Case Management Appointment	19%	4%	77%

Table 27. PCM Appointment Statistics

Attendance Statistics	Contact Note	Intake & Assessment	Rapid PCM	PCM Service Plan	PCM Appointment
Mean	0.11	1.09	0.08	0.08	2.43
Median	0	1	0	0	0
Mode	0	1	0	0	0
Std. Deviation	0.905	0.566	0.519	0.35	8.867
Minimum	0	0	0	0	0
Maximum	20	10	12	6	135
Total Number of Sessions*	**1677**	**1677**	**1677**	**1677**	**1677**

*N=826

Some participants experience rapid case management, in which they meet with a Peer Case Manager immediately to address urgent or crisis needs. The following table shows the number and percents of individuals who accessed Rapid Case Management.

Table 28. Centro Sávila Rapid Case Management Participation

Rapid PCM?	Number of Individuals	Percent
Blank	12	1.5
No	741	89.7
Yes	73	8.8
Total	**826**	**100**

PCM clients receive help from Centro Sávila on their goal progress in several ways. PCM (like PDI) is both a service in itself, and a bridge to other services. Ideally, in PCM sessions clients may experience several benefits to their supportive knowledge, attitudes, and behaviors.

Improvements in knowledge

- Increased knowledge about strengths, resources, opportunities, life skills, etc.
- Affirmation and solidarity regarding life challenges, such as mental health, substance use, institutional barriers, etc. (i.e., knowing people like them have recovered, improved, and thrived).

Improvements in attitudes

- Increased self-esteem, self-efficacy, and hope, as they make progress on goals.
- Increased positive attitudes about life challenges, other people, goals, etc.
- Overall increased feelings of connection and wellbeing (improved mental health).

Improvements in behaviors

- Supportive relationship development (with PCM staff and other participants).
- Increased self-care and mental/physical health behaviors.
- Decreased unsustainable coping behavior (such as substance use) and criminality.

Perhaps the most significantly unique aspect of peer services is that peer workers model all the above capacities with clients in real relationship dynamics. Clients can see themselves in peer workers, can literally see people like themselves thriving, happy, sober, and doing meaningful work.

What other Centro Sávila services are available to PCM participants?

Centro Sávila's full spectrum of services fills a gap that most behavioral health professionals refuse to fill: the non-white and non-affluent population. Centro Sávila offers several different services, not just PCM. They also provide therapy, benefits enrollment, and have a dedicated facility with a garden. They foster local partnerships with funders such as BHI, as well as other service providers and community organizations. Data about internal referrals was not available at this writing.

What referrals to other external services do participants experience through Centro Sávila PCM?

64% of PCM participants received at least one referral from Centro Sávila PCM. Of the people who had referrals, 62% received two or three referrals.

Figure 8. Distribution of number of referrals to other organizations

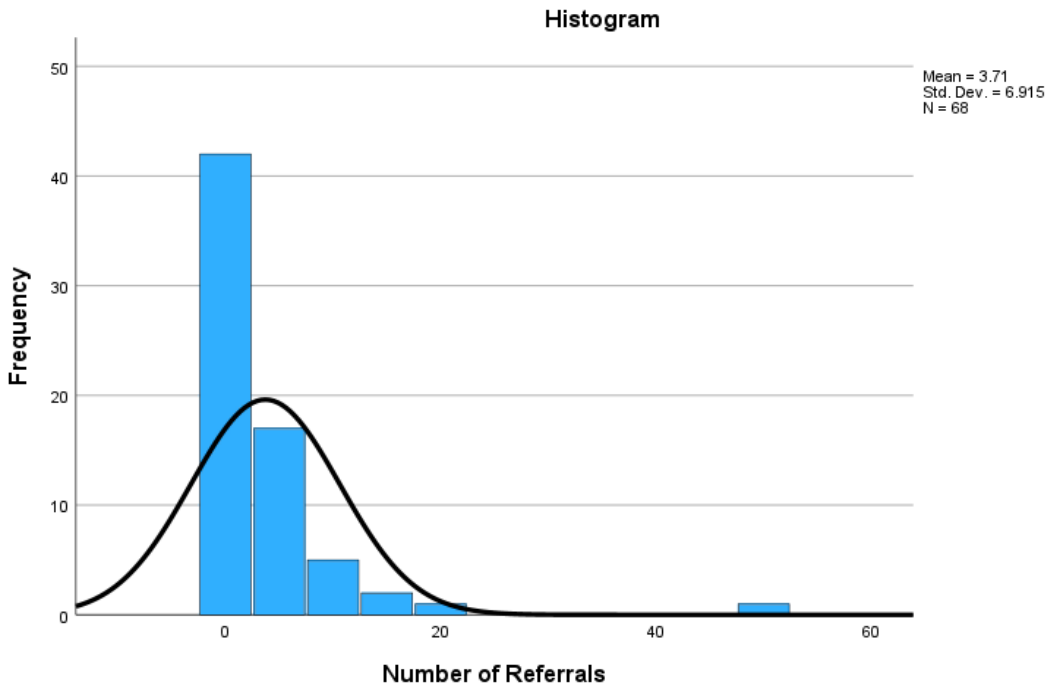


Table 29 lists the percentage of PCM clients referred to programs outside of Centro Sávila. Currently, some terms in the table below are clearly duplicates (see highlighted examples). Pivot displays the full table to emphasize that clinicians can speed data entry when the data system uses standard terms.

As with previous data tables, the evaluators suggest that PCM staff create standardized dropdown or select options for the most commonly used terms and consider creating overall category "buckets" for referral types.

Table 29. PCM Referrals to other programs or providers

Referrals out from PCM	Percent
Blank	1.4
Health & Wellness Fair at the Alamosa Community Center	0.7
International District Winter Fest	0.4
2021 Thanksgiving Grocery Giveaway - Western Sky Community Care	1.1
9th Annual Job Fair (Senator Michael Padilla)	0.7
9th Annual Senator Michael Padilla Job Fair	0.4
Albuquerque Health Care for the Homeless	0.4
Albuquerque Housing Authority	0.7
Albuquerque Housing Authority Section 8	0.4
Albuquerque Outreach Center (AOC)	0.4
Albuquerque, NM: Affordable Housing for Subsidized Family, Disabled and Elderly Housing List	0.4
Amanda Santiago	0.4
Amazon	0.4
American Airlines / Customer Service Part time	0.4
American Furniture	0.4
APH, Inc. 2022 Annual Gala	0.4
APS Spring Wellness Festival	0.4
Artisan	0.7
Ashley Furniture	0.4
Assurance Wireless	1.1
Barelas Community Center	0.4
Barrett House	0.4
BCBS of Arizona	0.4
Beds4Kidz	0.4

Referrals out from PCM	Percent
Bernalillo County	1.1
Bernalillo County Emergency Rental Assistance	0.4
Bernalillo County Housing	0.7
Bernalillo County Housing / Section 8 Voucher	0.4
Bernalillo County Tiny Homes	0.4
BHSD Listening Session	0.4
Big Lots	0.7
Bosque Women's Care	0.4
Brentwood	0.7
Catholic Charities	0.4
CDS	0.4
Center Law & Poverty	0.4
Chuze Fitness	0.4
City of Albuquerque	0.4
Clinical Research	0.4
CNM Hiring Event	0.4
Community Career Fair (Goodwill)	0.4
Community Light House	0.4
Con Fuerza y Querencia 2022 Acequia Culture Youth Leadership Institute	0.7
Counseling ABQ	0.4
Coursera	0.4
Test.gov	0.4
COVID Test.gov	0.4
Crime Victim Reparation Commission	0.4
Crime Victims Reparation Commission	0.4
Crossroads	0.4
Crossroads for Women	0.4
Day's Inn	0.4

Referrals out from PCM	Percent
Defined Fitness	0.4
Department of Health (Vital Records)	0.4
El Puente De Encuentros Fellowship	0.4
Emergency Broadband Benefit Program	0.7
Emergency Rental Assistance Program	0.4
Enchantment Counseling	1.4
Encuentro	0.4
Engender	0.7
ENLACE Comunitario	1.1
eVetRecs	0.4
First Choice Community Healthcare	0.4
First Choice South Valley	0.4
Flexible work opportunity to support ERAP application reviews	0.7
Four Hills Studios	1.1
GiveAbq (Adelante)	0.4
Good Shepard Center	0.4
Good Will NM	0.4
Goodwill Community Career Fair 07/14/2021	0.4
Goodwill Industries of New Mexico	0.7
Greater Albuquerque Habitat for Humanity	0.4
Haven House	0.4
Hawthorn Hotel	0.4
Heading Home	0.7
Health & Wellness Fair at the Alamosa Community Center	1.1
Health Care for the Homeless	0.7
Health Fair	0.4
Hilton	0.4
Home Instead	0.7

Referrals out from PCM	Percent
Home Wise	0.4
Hope Village	0.7
Hope Village / Hope Center	0.4
Hopeworks	0.4
HSD/ISD	0.4
HUD VASH	0.4
Human Service Department	0.4
Human Services Department / Child Support	0.4
ID Community Block Parties Collaborative	0.4
Immigrant Well Being (IWP)	0.7
Indeed/USPS	0.4
Integrative Elements NM	0.4
Internal Revenue Service	0.7
International District Winter Fest	0.4
John Marchall	0.4
John Marshall Health and Social Services	0.4
John Marshall Health and Social Services Center	0.4
Johns Marshall Health and Social Services Center	0.4
Joy Junction	0.4
La Cosecha	2.2
La Plazita Insitute	0.4
Landlord Hotline	0.4
Las Vegas, NM Public Housing	0.4
Legal Aid	0.4
LICSW independent	0.4
LLA with Hopeworks	0.4
Love Inc. of Albuquerque	0.4
Lovelace Medical Group	0.7

Referrals out from PCM	Percent
March Health Fairs	0.4
March Health Fairs / UNM Health Sciences	0.4
Matts detox	0.4
Medicaid (BCBS)	0.4
Medicare	0.4
Medicare.gov	0.4
Mesa Ridge	0.7
MFA	0.4
MVD New Mexico	0.7
New Mexico Aging and Long-Term Services Department	0.4
New Mexico Department of Motor Vehicle	0.4
New Mexico Department of Vocational Rehabilitation	0.4
New Mexico Department of Workforce Solutions	0.4
New Mexico Division of Vocational Rehabilatation	0.4
New Mexico Division of Vocational Rehabilitation	0.4
New Mexico Higher Education Department	0.4
New Mexico Immigrant Law Center	0.4
New Mexico Lions Eye Bank	0.4
New Mexico Motor Vehicle Department	0.4
New Mexico Neurology Associates, P.C.	0.4
New Mexico Pain Center	0.4
New Mexico Retiree Health Care Authority	0.4
Next Door	0.4
NM Human Service Department	0.4
NM Legal Aid	0.4
NM Rent Help	0.4
NMDOH	0.4
NMDVR	0.4

Referrals out from PCM	Percent
NMHOMEFUND.ORG	0.4
NMMVD	0.4
NMMVD Direct	0.4
Nutrition Workshops En Espanol in March/April/May at CABQ Senior Centers	0.4
Office of the Superintendent of Insurance Focus Group	0.4
One Albuquerque	0.4
OneAlbuqurque Equity & Inclusion	0.4
Onyx Supportive Living	0.4
Our Humanity Health Literacy Project	0.4
OY drug program.	0.4
PHS	0.4
PNM	1.1
PNM Call Center	0.4
PNM Utility Bill Assistance Events	0.7
Presbyterian	0.7
Presbyterian Centennial Care	0.7
Presbyterian Centennial Medicaid Plans	0.4
Presbyterian Rust Medical Center	0.4
Public Employees Retirement Association of New Mexico (PERA)	0.4
Referred to Private practice	0.4
Refugee Well-being Project	0.4
Rent Help NM	0.4
Resource Fair	0.4
Roadrunner Food Bank	1.1
S.A.F.E. House	0.4
Sage Neuro Science Center	0.4
Sage Neuroscience	0.4

Referrals out from PCM	Percent
Salivation Army Angel Tree Program	0.4
Salvation Army	0.7
Salvation Army Angel Tree Program 2021	0.4
Sam's Club	0.4
Santa Fe Community College	0.4
Santa Fe Magistrate Court	0.4
SE Heights Clinic	0.4
Section 8	0.4
Social Security Administration	2.9
South West	0.4
SSA	0.4
State Bar Workshops and Legal Clinics	0.4
Steelbridge Thrift Store	0.4
Sterling Downtown	1.1
SW Family Guidance Center	0.4
Tammy Ellison Counseling	0.4
Tax Revenue New Mexico	0.4
Taxation & Revenue New Mexico	0.4
Taxation Revenue New Mexico	0.7
Tertulia	0.7
Texas Medicaid	0.4
THE BERNALILLO COUNTY HOUSING DEPARTMENT	0.4
The Law Office of Victoria Lucero, LLC	0.7
The New Mexico Immigrant Law Center (NMILC)	0.4
The Thrift Store Where Everything is Free - Donate Today!	0.4
The Treehouse	0.4
Tiny Home Village	0.4
Turning Point recovery center	0.4

Referrals out from PCM	Percent
Turquoise Lodge Hospital	0.4
United Way	0.4
UNITED WAY OF CENTRAL NEW MEXICO	0.4
University of New Mexico Medical Group	0.4
UNM Care	0.7
UNM Children's Psychiatric Hospital	0.4
UNM Vaccinate with Confidence Survey	0.4
UNM Volunteer for Research Study	0.4
UVNR	0.4
VA Reginal Office	0.4
Veterans Affairs	0.4
VFW AUXILIARY DEPARTMENT of MISSOURI	0.4
Village in the Bosque	0.4
Vista Del Sol Y Enlace Comunitario	0.4
VitalChek	0.4
WESST	0.4
Western Sky Thanksgiving Grocery Giveaway	0.4
Women's Therapy	0.4
Work Force Solutions	0.4
YesNM	0.4
YESNM	0.7
Total	**100**

N=278

How long do participants engage in PCM?

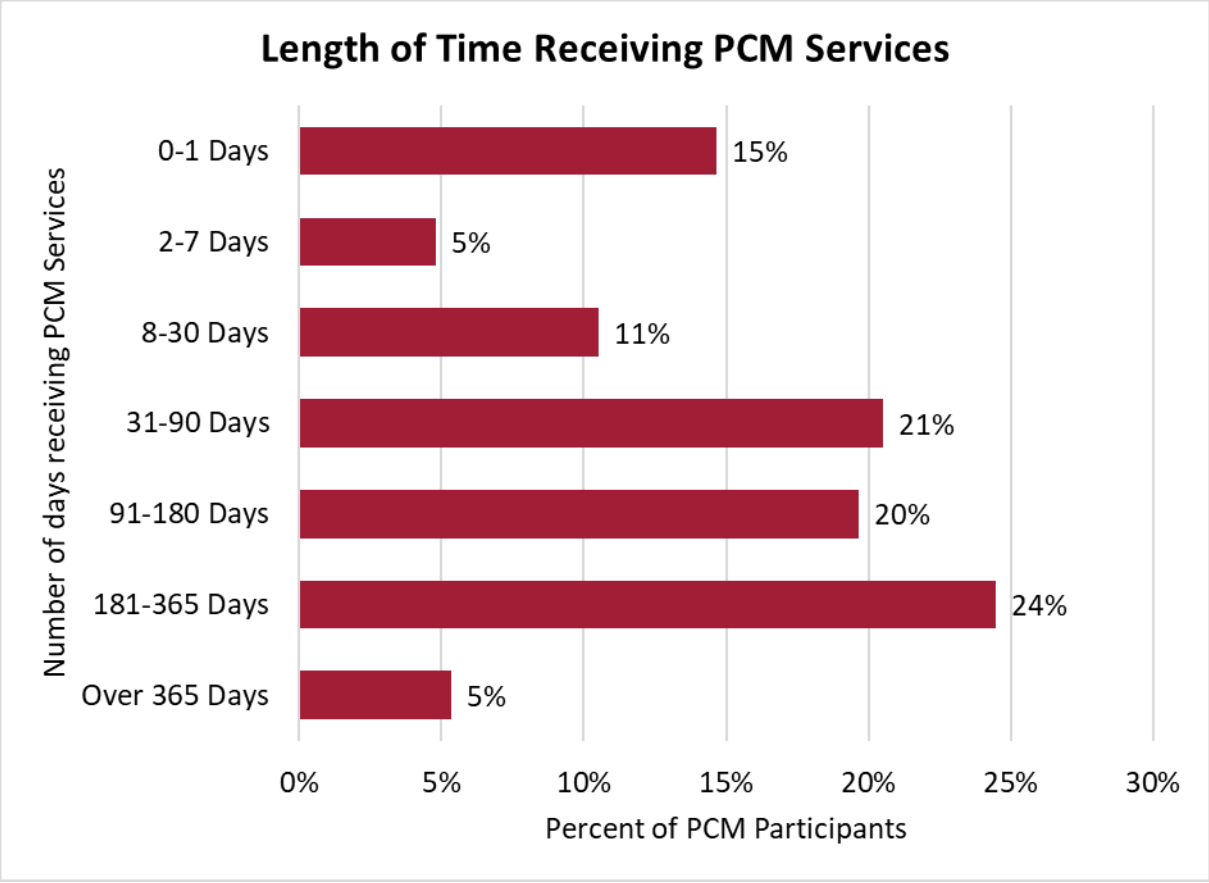
Evaluators calculated the length of service per client from the PCM approval date to the PCM discharge date (**Table 30** below).

Table 30. Average number of days receiving PCM service at Centro Sávila

	Number of clients	Number of days				
		Mean	Median	Mode	Minimum	Maximum
July 2019 - June 2020	153	138	101	0	0	648
July 2020 - June 2021	209	119	84	0	0	781
July 2021 - June 2022	146	138	88	0	0	640
July 2022 - June 2023	195	109	78	0	0	365

The following **Figure 9** shows the percentage of participants who were discharged either the same day or the next day, within a week, within a month, three months, six months, a year, or after one year. Participants who are still active are not included in this graph, as their discharge date is unknown.

Figure 9. PCM Participants categorized by time of services until discharged.



N= 580

When participants discontinue PCM, they are discharged with a description of the discharge reason or context. The following **Table 31** illustrates discharge information for PCM participants.

Table 31. PCM Discharge Information

Discharge reason	Number of Individuals	Percent
0 (Active)	131	16
Clerical error	34	4
Discharged	320	39
Disengaged	73	9
Partial progress	28	3
Positive discharge	222	27
Program transfer	9	1
Referred out	9	1
Total	**826**	**100**

In the above **Table 31**, multiple categories do not have clear definitions or distinctions. For example, the difference between "discharged" and "disengaged" is unclear. "Partial progress" could be a subset of "positive discharge," and there is no category for "full progress" (i.e., completed all goals). "Positive discharge" could mean a participant completed all goals, or it could also indicate a participant moved away on good terms. Pivot suggests that Centro Sávila make their discharge information categories **standardized, exhaustive, and mutually exclusive.** Centro Sávila's information already appears to be standardized (i.e., staff select from a preset of categories), so minimal additional effort to make these categories exhaustive and mutually exclusive would significantly benefit Centro Sávila's discharge data process, and opportunities for future analysis.

PCM participants experience case management sessions with Peer Case Managers focused on several main life areas, but tailored depending on each participant's personal needs and goals at the time of service. Participants may also receive Rapid Case Management as needed for urgent concerns. Centro Sávila has high PCM engagement follow-through from participants: clients attend over 75% of all types of scheduled appointments as planned. Most clients (65%) engage in PCM for between one month and one year. Participants receive referrals to and from Centro Sávila from a wide array of other diverse services and resources, implying a high level of connectivity between Centro Sávila and other community providers. Further, Centro Sávila has decentralized their office to provide increased community access in the South Valley, and International District, together with accompanying clients as they navigate various systems.

Pivot suggests creating standardized categories for referral types, to better understand Centro Sávila's role in the network of care and their participants' needs. Standardized categories would allow for analyzing the frequency of different referral types and sources. The results of referral analysis would facilitate focused networking among providers, outreach to service populations, and further development of Centro Sávila's internal service provision.

Evaluators addressed the next evaluation question by collecting information about Centro Sávila's staff capacity since BHI funding.

3. **Has Centro Sávila maintained (or increased) its staff capacity (number, qualifications) since BHI funding?**
   The following **Table 32** addresses the number of Peer Case managers who were hired within the grant period. One case manager was hired prior to July 2019, but received their CPSW Certification during the grant period.

Table 32. Case managers hired or trained since hire for Certified Peer Social Worker

Year	Case Managers currently certified or obtaining CPSW Certification	Case Managers who left Centro Sávila	Change in Case Manager Numbers
Pre- July 2019	1	0	+1
July 2019- June 2020	1	3	-2
July 2020 - June 2021	5	1	+4
July 2021 - June 2022	0	1	-1
July 2022 - June 2023	1	0	+1
Total	**8**	**5**	**+3**

Over the course of BHI funding, Centro Sávila has experienced some turnover (five staff leaving), but hired and trained more staff (eight individuals) for a total increase of three more CPSW certified staff since the duration of BHI funding.

Finally, Evaluators addressed participants' goal progress since engaging with Centro Sávila PCM.

4. **How and to what degree does Centro Sávila PCM contribute to positive client outcomes?**
   To answer this question, evaluators collected data from Centro Sávila regarding PCM participant outcomes. However, the methodological challenge includes two parts: 1) to determine whether participants experienced positive outcomes, and 2) to determine how much of the positive outcome results from Centro Sávila's influence. To measure PCM's contribution to positive outcomes, Pivot considered potential comparisons between the outcomes of people who

participated in Centro Sávila PCM and those who did not. This kind of comparison also poses a challenge, as it is inherently hard to collect data about people who are *not* engaged in services. Highly structured scientific studies such as randomized controlled trials can designate different comparison groups to study. However, for social services evaluations such as this one it is neither feasible nor ethical to designate a group to be denied services. Instead, we have to simulate a proxy group to stand in for the comparison to PCM participants.

In this case, Pivot facilitated the following proxy comparisons:

1. We can compare the experiences of current PCM participants with their own experiences from before they engaged in Centro Sávila PCM. This method is called a retrospective pre-posttest, meaning we ask current participants to tell us retrospectively about their experiences from before they started services. We can then compare their experiences pre-services with the experiences they report now since service engagement. In this case, Centro Sávila already had an outcome instrument in use that asks about participants' experiences over the past days to year (instrument questions below). To use this one instrument as a pre-posttest, Centro Sávila provided Pivot with responses from participants who had just begun services, and then again once they had been engaged in services. The initial response (with answers pertaining to the days-year preceding service engagement) serves as the pretest, with later responses serving as the posttest.
2. We can compare PCM participants' experiences to those of people with similar demographics and challenges by reviewing research literature to see their reported outcomes. By comparing the outcomes of PCM participants with this literature "group," we can determine if Centro Sávila PCM appears to enhance positive participant outcomes beyond what is typically expected from people in similar situations.

To begin outcome comparisons, Pivot focused on the results of using retrospective pre-posttests with current PCM participants.

Do PCM participants have better outcomes than they did before they engaged with PCM?

PCM participants identify their own goals, which often fall under the range of topics including improvements in substance use, mental health, housing, jobs, etc. Participants set an average of 2 goals each. The following **Table 33** shows the percentages of times topics were addressed in the total amount of goals (counting all the goals, including multiple goals per person). One limitation to note is that evaluators did not count similar goals with the same dates.

Table 33. Percentage of goals clinicians report (an individual may have more than one goal)

Goal Categories	Percentage of Goals per Category
Behavioral Health	23
Childcare	3
Education	36
Employment	11
Food	8
Healthcare / Insurance	27
Housing	42
Income	3
Legal	29
Other	4
Public Benefits	8
Transportation	3
Utilities	7

N = 482, 344 had no goals listed in the data file.

Participants work on making progress on their goals in PCM sessions with the assistance and encouragement of Centro Sávila peer staff. Participant discharge information (see section above) indicates that at least 30% of participants exit PCM with positive progress. However, Centro Sávila did not provide Pivot with information on actual participant goal outcomes for this evaluation. Pivot suggests that Centro Sávila consider using processes or instruments to more closely track individual participants' goal progress and attainment. For example, Centro Sávila may wish to consider using the ASSM self-sufficiency matrix to establish and monitor goals with participants over time (see Appendix). Centro Sávila could also simply keep track of goals "in process" or "completed" per participant.

Centro Sávila measures three specific outcomes of interest with a brief survey, which PCM staff administer with participants multiple times over the course of PCM. In collaboration with Pivot, Centro Sávila determined to administer the outcomes instrument at the beginning of PCM to establish a pre-service baseline for comparison to later results. PCM staff then administer the outcome instrument with participants again after several month of sessions. Pivot calculated the change in outcomes to determine whether participants experience more positive indicators the longer they engage with Centro Sávila.

Centro Sávila Outcome Instrument

1. On a 0–10 scale where 0 means no sadness or distress and 10 means the worst sadness or distress imaginable, how would you rate your sadness or distress at its worst over the past three days? (numerical responses 0-10)
2. How many times in the past year have you used an illegal drug or used a prescription

medication for non-medical reasons? (where a response of ≥1 is considered positive) (numerical responses open-ended)

3. Over the last 2 weeks, how often have you consumed alcohol?
    a. Not at all (0)
    b. Several days (1)
    c. More than half the days (2)
    d. Nearly every day (3)

The following **Table 34** shows responses to Outcome Question 1 (distress levels) at pretest and posttest (the percent of respondents who gave each numerical response).

Table 34: Pretest and Posttest Responses to Centro Sávila Outcome Question 1 (Distress Levels)

On a 0–10 scale where 0 means no sadness or distress and 10 means the worst sadness or distress imaginable, how would you rate your sadness or distress at its worst over the past three days?	**Outcome Pretest**	**Outcome Posttest**
0	19.7	40.9
1	5.5	18.1
2	11.5	10.1
3	13.3	11.4
4	7.8	5.4
5	11	4.7
6	7.8	1.3
7	9.2	5.4
8	8.3	1.3
9	1.8	1.3
10	4.1	0
Total	**100**	**100**

The following **Table 35** shows the number of individuals (frequency) who reported each level of *change* in their distress from Outcome Question 1. The more negative the change number, the greater the reduction in distress reported between pre and post test. More negative numbers indicate more improvement and "0" indicates no change in distress levels between surveys. The majority of participants reported improvements in distress, implying improvements in mental health since engaging in PCM sessions.

Though some people report more distress since engaging in PCM, it is important to note that this may not be an inherently "bad" outcome. There are many reasons why a person may identify their subjective wellbeing as lower even as they work on improving their lives, including the following:

1. As people reduce forms of self-medication such as substance use, they may feel more of the distressing emotions that the substances were dulling. While it may feel unpleasant, these experiences can be part of overall recovery.
2. As people engage more intentionally and interactively about their mental health they may become more self-aware of their experiences, including distressing emotions. Having the language and audience to describe and discuss mental health can "surface" these feelings in a way that may be challenging, but again part of overall healing and increased mindfulness.
3. As people engage in working on other life goals such as education and employment, working on these goals can be stressful! Finding a job or applying to schools can be hard, engaging in legal systems can be stressful, and PCM participants may feel the emotional effects of putting in this work.

PCM provides a safe environment to process challenging feelings and experiences. One significant step in recovery is the ability to manage negative emotions with the understanding that feeling "bad" is not always a problem if it's part of developing new emotional skills.

Table 35. Outcome 1 Pre-Post Difference

Q1 Sadness or Distress Change	Frequency	Percent
-10	3	2.4
-9	1	0.8
-8	5	4
-7	2	1.6
-6	7	5.6
-5	9	7.2
-4	2	1.6
-3	7	5.6
-2	14	11.2
-1	16	12.8
0	40	32
1	10	8
2	5	4
3	2	1.6
4	1	0.8
6	1	0.8
Total	**125**	**100**

N=826

The following **Table 36** shows responses to Outcome Question 2 (illegal drug use) at pretest and posttest (the percent of respondents who gave each numerical response).

Table 36: Pretest and Posttest Responses to Centro Sávila Outcome Question 2 (Illegal Drugs)

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	**Outcome Pre-test**	**Outcome Posttest**
0	94.4	98.1
1	0	0.6
2	1.4	0
3	0.5	0
4	0.5	0
5	0.5	0.6
7	0.5	0
8	0.5	0
9	0	0.6
10	0.5	0
30	0.5	0
100	0.5	0
180	0.5	0
Total	**100**	**100**

Table 36 shows that the vast majority of participants report no drug use at pretest or post-test. The following **Table 37** shows each respondent's *change* in illegal drug use over the past year. As with **Table 35** above, negative change numbers indicate beneficial change, in this case reduction in illegal substance use. Most respondents report no change in substance use (a 0 change score), and notably *none* report an increase in substance use since engaging with PCM. Two outlier change results (-180 and -100) could reflect dramatic decreases in substance use, however Pivot also approaches outlying results with caution in case they are the product of human error (for example if Centro Sávila staff entered data as "100" by accident when they meant "10"). These results indicate that people engaging in PCM tend to experience substance use maintenance or improvement.

Table 37. Outcome 2 Pre-Post Difference

Q2 Used Illegal Drug or Prescription Medication Change	Frequency	Percent
-180	1	0.8
-100	1	0.8
-8	1	0.8
-4	1	0.8
-3	1	0.8
-2	2	1.6
0	122	94.6
Total	**129**	**100**

Finally, the following **Table 38** shows responses to Outcome Question 3 (alcohol use) at pretest and posttest (the percent of respondents who gave each numerical response).

Table 38: Pretest and Posttest Responses to Centro Sávila Outcome Question 3 (Alcohol Use)

Over the last two weeks, how often have you consumed alcohol? Not at all (0); Several days (1); More than half the days (2); Nearly every day (3)	Outcome Pretest	Outcome Post-test
0	87.2	94.7
1	8.7	4
2	1.8	0
3	2.3	1.3
Total	**100**	**100**

Table 39 shows *changes* in the amount of alcohol that respondents report consuming in the past two weeks. The more negative change numbers indicate higher decreases in alcohol consumption, with -3 indicating a complete reduction in alcohol consumption from "nearly every day" at pretest to "not at all" at posttest. The vast majority of participants indicate no change (n=108) while several indicate reductions in alcohol (n=14) and a few indicate increases in alcohol consumption (n=4). These results show that most people engaging in Centro Sávila PCM tend to maintain or improve their consumption of alcohol.

One important thing to note for these alcohol results and the substance results above is that a "no change" score of 0 does not necessarily mean an individual was using substances at pretest and still are. Instead, 0 change may indicate that respondents used no substances at pre-test or post-test, as is the case with the majority of respondents for both alcohol and drugs. Additionally, while seeing a small number of participants report alcohol increases may seem to be a poor outcome, from an evaluative perspective it provides some validation of this data collection. Seeing that participants are honest about reporting results in both directions provides more confidence that the other results, which demonstrate more positive change, are trustworthy.

Table 39. Outcome 3 Pre-Post Difference

Q3 Consumed Alcohol Change	**Frequency**	**Percent**
-3	2	1.6
-1	12	9.5
0	108	85.7
1	3	2.4
3	1	0.8
Total	**126**	**100**

N=826

Centro Sávila's outcome instrument results indicate that the majority of sustained PCM participants experience improvements in their levels of distress and substance use throughout their engagement with PCM.

Do PCM participants have better outcomes than non-participants? (Via literature review.)

To answer this question, evaluators reviewed research literature that described outcomes among people experiencing mental health challenges and/or co-occurring substance use (Centro Sávila's service population of focus).

Evaluators reviewed research to examine whether people experiencing mental illness and/or substance use who are not engaged in supportive services such as PCM experience…

1. **Goal progress and/or attainment of their self-identified goals**
   Focused outpatient care for behavioral health and substance use is "associated with better…substance use, symptom and social functioning outcomes" **(https://www.jsad.com/doi/abs/10.15288/jsa.2000.61.704)**. Adults with both mental health and substance-related challenges often do not receive treatment for both conditions, and are more likely to receive treatment for mental health than addiction (**https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.56.8.954)**. People without formal diagnoses are also less likely to engage in ongoing services than people with an established diagnosis, even if they have equivalent ongoing needs.

(https://jamanetwork.com/journals/jamapsychiatry/fullarticle/210048). "Not affording the cost of care was the most common barrier to both types of treatments [mental health and substance use], but more commonly reported as a barrier to mental health treatment" (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3840086/). Centro Sávila offers services regardless of a client's ability to pay, reducing cost barriers for all clients. Organizations such as Centro Sávila that offer low-barrier comprehensive services addressing both behavioral and substance challenges therefore fill a needed gap in services, and increase the likelihood of participants' success. These data suggest that people experiencing mental health and substance use challenges who engage in services such as Centro Sávila PCM are more likely to make progress on their goals than people not engaged in services, especially for goals regarding behavioral health management and substance use recovery.

2. **Improvements in mental health/ levels of distress**
   Mental health challenges can often get worse instead of better for people who do not access services. "The price of hopelessness, emotional instability, and chronic uncertainty can only lead to poor behavioral health, taking away the opportunity for recovery" (https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.01472). Even with services, changes in behavioral health can be difficult to predict due to high diversity in participants' knowledge, attitudes, behaviors, and beliefs about themselves, the service efficacy, and the complex nature of behavioral health itself. Having practitioners with diverse backgrounds and approaches can help clients feel more comfortable and engage more with mental health services. (https://www.ingentaconnect.com/content/wk/yco/2017/00000030/00000005/art00004). Peer service organizations such as Centro Sávila employ staff with diverse lived experience to work with racially and financially marginalized populations. This literature supports the conclusion that the people who participate in Centro Sávila PCM are more likely to experience improvements in mental health than those with similar demographics who do not have access to similar resources.

3. **Reductions in illegal substance use**
   Studies "demonstrate the persistence of substance use and related psychological problems, but also show that continuing care services…[is] associated with better outcomes" (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2885543/). "Intervention strategies to address substance-use disorders have improved over recent decades, but have had limited success in achieving total recovery and have limited coverage in LMICs [low- and middle-income countries]," arguably also the case in lower-income or under-resourced areas in high-income countries (https://www.nature.com/articles/nature16032). ("Relative to countries of similar size and wealth, the US has had higher rates of death from unintentional poisonings, the majority of which were due to drug overdoses," https://jamanetwork.com/journals/jama/article-abstract/2646703.) Material and emotional support from immediate family members can help people decrease or cease substance use, but many people may not have family time and financial resources available, especially long-term (link abbreviated, see full link in References). In lieu of family, relationships with peers with shared experiences may be a close connection during recovery. Together, the studies mentioned in this section suggest that engaging in substance recovery services, especially in under-resourced areas and among peers with shared backgrounds such as in Centro Sávila PCM, is more likely to promote recovery and reductions in substance use than going without such services.

4. **Reductions in alcohol consumption**
   Mental health is strongly related to alcohol consumption, across different types of comorbidities (link abbreviated, see full link in References), ages (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0228667), and social conditions (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3177969/). Drawing from this correlation and the studies previously cited in this section, it follows that alcohol outcomes are likely in relationship with both other substance use outcomes and behavioral health outcomes for people in recovery. Participating in treatment among these three domains (mental health, substance use, and alcohol consumption) is likely to have synergistic positive outcomes. While Centro Sávila PCM is not specifically a substance treatment, peers encourage participants in their recovery, provide additional resources and referrals for other services, and model the possibility for recovery and wellbeing. Taken together, the studies mentioned in this section suggest that people who engage in services such as PCM are more likely to experience positive alcohol outcomes including reductions in consumption than those who do not engage in services.

In addition to PCM participants' pre-posttest results, the literature review above suggests that engaging in services supportive to mental health and substance recovery such as Centro Sávila PCM increases positive outcomes among participants.

What conclusions apply to Centro Sávila Peer Case Management?

The findings in this report, though limited, indicate that over the course of BHI funding Centro Sávila maintained its service population (despite COVID disruptions) and increased its staff capacity. PCM helped participants improve outcomes related to mental health/distress, alcohol consumption, and other substance use. Future evaluations would benefit from being able to better quantify the outcomes of PCM participants' personal goals, in addition to the outcomes of interest measured in Centro Sávila's outcomes instrument. While Centro Sávila currently measures improvements in mental health/distress, substance use, and alcohol consumption, staff did not report on participant progress or completion of self-identified PCM goals. Self-identified goals are likely to include mental health and substance recovery as well, but may also encompass broader topics such as housing, legal aid, documentation, etc.

The following sections detail the limitations encountered in this evaluation and Pivot's suggestions for future opportunities. Though Pivot and Centro Sávila ran into several limitations during this evaluation collaboration, Centro Sávila was highly responsive and collaborative throughout.

What limitations apply to this evaluation?

The limitations that Pivot and Centro Sávila encountered throughout this evaluation include the following:

1. A shortened timeframe that was more conducive to process evaluation than the evaluation of participant outcomes. As Pivot began gathering data, it became evident that discontinuity between the time periods BHI contracted for peer services (Centro Sávila's contract) and evaluation (Pivot's contract) meant Centro Sávila's contract would expire before Pivot's initial two-year plan could be executed.

   Pivot, Centro Sávila, and BHI addressed this limitation by modifying the evaluation to analyze data that Centro Sávila already collects instead of introducing new instruments; conducting most of the evaluation communications online via video call and email for timesaving and convenience; and focusing on Centro Sávila's process and the limited outcomes within their influence. Pivot and BHI further addressed the issue of contract timing by scheduling two-year contract periods for evaluation that align with peer service contracts.

2. Centro Sávila collaborated with Pivot on outcome measurements and provided pre- and post-test results of their outcome instrument (three questions on mental distress, alcohol use, and other substance use). The pre-post format allowed Pivot to calculate change scores and demonstrate whether PCM participants reported improvements or regressions of these outcomes of interest. However, Centro Sávila's outcome instrument only collects self-reports from participants, which many consider soft evidence of effectiveness.

   PCM participants also determine their own self-identified goals for PCM. Centro Sávila provided Pivot with a record of participants' initial goals set, but not information about individuals' goal progress and/or completion. This additional data would be helpful for further evaluation to explore the full range of goal topics important to PCM participants, and to either corroborate or challenge the outcome instrument responses. Centro Sávila may be able to improve their individual goal tracking by considering instruments such as the ASSM that include individual goal categories and a rubric defining progress for each (see ASSM in Appendix).

What does this evaluation suggest for Centro Sávila's future development?

This program evaluation highlights opportunities for Centro Sávila to improve data collection practices, to better understand and communicate about their service processes and impacts. Areas for potential development are listed below.

1. **Standardize data collection categories for data points Centro Sávila already collects, including the following:**
   a. **Participant goals**
      Centro Sávila may consider modifying its data entry to require one multiple choice selection of main topic per client goal (such as from a drop-down menu of options), with an optional text box for additional details. Standardizing goal categories would make data entry easier for Centro Sávila staff and allow Centro Sávila to quantify goal types and analyze goal information (see "A note on goals and goal standardization" below).

b. **Participant referrals**
Pivot suggests Centro Sávila also create standardized categories for participant referrals, regarding how clients were initially referred to Centro Sávila, and which organizations Centro Sávila subsequently referred clients out to.

c. **Participant exit information**
Centro Sávila currently has exit categories which overlap and miss important options. The following questions offer examples of the current challenges. It would be challenging for non-Centro Sávila personnel to understand some of the differences between categories, which would benefit from distinction and definition. What is the difference between "partial progress" and "positive discharge"? Are all discharges other than "positive discharge" negative? If "program transfer" and "referred out" are forms of discharge, what does the category simply called "discharged" mean? etc. Developing mutually exclusive and exhaustive categories for discharge reasons/categories will speed data entry and improve data quality and use.

2. **Improve participant outcome tracking by implementing an appropriate process or tool (ASSM or similar)**
Centro Sávila did not provide information for this evaluation on individuals' self-identified PCM goals. Centro Sávila may consider implementing the Arizona Self-Sufficiency Matrix (ASSM, see Appendix), a tool specifically designed to assess ongoing client progress along a continuum for each life domain category. The ASSM could potentially replace or be used alongside current Centro Sávila data collection instruments.

3. **Stabilize staffing**
Centro Sávila administration needs to identify the causes of staff turnover and address them. It is highly likely that solutions involve County recognition of competitive salaries and acknowledge the need for Centro Sávila to pay competitive wages which will impact amounts the County funding opportunity would need to offer.

In future evaluations, Pivot would also welcome increased direct inclusion of Centro Sávila participants and staff in evaluation activities. For this evaluation, Pivot conducted meetings and informal interviews with Centro Sávila as needed to discuss evaluation data collection, findings, and implications. Future evaluations could benefit from both more structured staff interactions (such as staff surveys or interviews with formalized topics/ questions), and direct engagement with Centro Sávila participants as applicable and appropriate. Pivot omitted data collection directly from participants at this time due to challenges in setting up the necessary processes in a timeframe shorter than initial expectations (direct participant engagement necessitates instrument development, IRB approval, and administration, in addition to approval and relationship-building with participants and staff). Future evaluations could include participant feedback in the form of surveys, individual and group interviews, or other creative media such as writing on an interactive poster (as Pivot has done with previous clients).

A note on goals and goal standardization

How do you distinguish between objectives and goals?
It can be hard to tell which aims should count as objectives versus goals. People often refer to SMART (specific, measurable, achievable, relevant, and time-bound) goals, but Pivot considers the SMART framework to be better suited for objectives. Pivot's rule of thumb is to consider the following points:

- The reason goals are so difficult is that few people have thought about or discussed different types of goals. Some goals can be thought of as multi-level, such as "getting sober, so I can get my children back". Other goals have clear end points such as "getting to the moon and back safely". While other goals maintain or keep going, such as living sober, or staying healthy. The goal of some goals is to keep going. The maintain or keep going type goals do not fit the SMART format.
- There is a rule of trinity in business that all service providers must balance for their clients. "You can have it fast, cheap, or high quality. Choose any two!" Getting to the moon and back safely breaks this rule, because the US Government had unlimited resources. When setting goals, remember that most of your clients have limited resources. This fact alone limits goal attainment in many ways difficult for a clinician to predict.
- Additionally, setting time bound goals for clients when those goals have significant components OUTSIDE client control may lead to client backwards progress.

Does it make sense for a goal to be "SMART"? Here are three considerations:

- Is there any evidence suggesting a timeframe? Evidence for quitting any addiction is that people exhibit wide variation in periods before success. Setting arbitrary timeframes may lead to unnecessary guilt, sense of failure, and early giving up on the goal. Similarly, getting a job depends on many factors out of participant control. Why hold the participant to a timeframe when so many elements are out of their control?
- It is perfectly acceptable to "hedge" difficult goals. Writing a goal to reduce substance use during a period emphasizes the difficulty of the task while insisting on progress. Applying for three jobs in a period produces action the client has control over. Often authors refer to these sorts of statements as short-term goals.
- To distinguish between goals and objectives consider the following:
    - Is it an end in itself (the overall goal) or a means to an end (an objective)?
    - The point of an objective is to complete it, such as detox from a drug, get your GED, or exercise weekly.

How can agencies distinguish between objectives and goals at an organizational level?
Organizations also have overall goals, and specific objectives. The logic model Pivot designed with Centro Sávila shows this distinction in the program outputs versus outcomes. Outputs are the measurement of organizational objectives: they measure SMART data or "bean counting" such as participation counts, service hours, and referrals. Outcomes are the measurement of organizational goals — they measure progress along broad improvements such as client health, program growth, and systemic change. The outputs contribute to the outcomes: for example, Centro Sávila may want to increase PCM hours and referrals in the service of improving client health, if they believe that more services will correspond to more wellbeing. Incidentally, creating these linkages is the basis

of an organization's Theory of Change (the basic assumptions an organization makes about how and why its services improve participant situations). Examining these linkages and their relationships is the basis of program evaluation.

Why standardize data collection categories?
Standardizing the goal categories would make data entry easier for Centro Sávila staff, as it eliminates any individual decision-making regarding the wording and formatting of main goal text. Standardized goal categories would allow Centro Sávila to quantify goal types and analyze goal information. Centro Sávila could better answer questions such as, "Which client goals are more frequent?", "do common goals change over time" (in response to economic recessions, housing policies, etc.), "which types of goals do clients have success achieving", etc. This type of information is crucial to the success of Centro Sávila as an organization. Client goal statistics provide feedback about client needs and trends, justify spending in some areas and not others, and can be communicated to funders and the public to illustrate Centro Sávila's role in solving intractable social quandaries.

How can agencies select standardized categories?
Agencies may standardize client goal categories using the same groups already defined by their other instruments. Using consistent categories across tools and data collection points allows for more in-depth inquiries and analyses about client needs, experiences, and outcomes across client engagement. Centro Sávila could keep client records regarding initial goal establishment and progress in each category over time. These data could answer questions including "which goals are associated with higher or lower client engagement", "which goals take longer or shorter to achieve/progress", "how do clients change goals over time", etc.

Centro Sávila meets the needs of its service population by filling a typical gap in the services available to low-income people of color experiencing challenges with their mental health and substance use. Centro Sávila "meets them where they're at" with bilingual community-focused peer services available regardless of ability to pay. Centro Sávila is also highly networked in the Albuquerque community and continues to grow from its grassroots beginnings into an increasingly comprehensive and sustainable agency. The recommendations provided in this section would help augment Centro Sávila's processes to enable more understanding and development. Centro Sávila has already established robust organizational practices, participant services, and a culture of learning and growth, and achieved many successes for itself as a vital community resource and for the populations it serves.

References

1. Centro Sávila. https://www.centrosavila.org/home/
2. Crossroads for Women. https://crossroadsabq.org/
3. What is the Living Room model for people experiencing a mental health crisis? https://smiadviser.org/knowledge_post/what-is-the-living-room-model-for-people-experiencing-a-mental-health-crisis
4. Lifetime Use of Mental Health and Substance Abuse Treatment Services by Incarcerated Women Felons. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.3.317
5. Predictors of Post-release Drug Use Recovery Among Previously Incarcerated Women: the Mediating Effect of Social Services. https://link.springer.com/article/10.1007/s11469-022-00902-1
6. Barriers to addiction treatment among formerly incarcerated adults with substance use disorders. https://link.springer.com/article/10.1186/s13722-018-0120-6
7. A HIGHER HURDLE: Barriers to Employment for Formerly Incarcerated Women. https://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1001&context=werc
8. Housing, Relationships, and Substance Use among Formerly Incarcerated Females. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8133692/
9. SUCCESSFUL REENTRY AMONG FORMERLY INCARCERATED WOMEN: A MIXED METHODS ANALYSIS. https://d1wqtxts1xzle7.cloudfront.net/32109410/G_Heidemann_Dissertation.pdf20131018-13767-u4p2pn-libre-libre.pdf?1382134861=&response-content-disposition=inline%3B+filename%3DSuccessful_Reentry_Among_Formerly_Incarc.pdf&Expires=1693008757&Signature=GB2WEz1p6W0F4BcY6sS9ptSQ9JV9vfrlZaaTJaq3TESjPstKa7k1GTOE7YDpiJMEvq95fZaZtqS89v2bisRJbnsMRekfZPgtUsiaT~~gn8vtr-kIgfV26g-1m7XIAVUL2Lm1pyi8XsS0HQQQovzIUo58IC5ZTmkV8Ah-jZZdw-Fcd4LUmuhv-TPY-t9CfthFJj-BVKqheXcHXFbIPWXxNm~WyyNvpVwjE9o8ZGFiKMz~Lpj6jDziXTBi9SEai-UN8vVOI-k~6SxJWk6Au6bPxJ0zZdhAsE4U11ivmQ7VYH6VtQUqEnnmoGJggCMnccM-Ka4TwnT5U9Be1Aftn~3fQY~BuA__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA
10. More Than a Job Club, Sister: Career Intervention for Women Following Incarceration. https://onlinelibrary.wiley.com/doi/abs/10.1002/cdq.12078
11. Addressing Unmet Needs in Incarcerated Women With Co-occurring Disorders. https://www.tandfonline.com/doi/abs/10.1080/01488376.2011.582017
12. Women Coming Home: Long Term Patterns of Recidivism. https://www.tandfonline.com/doi/pdf/10.1080/07418820902870486
13. EXAMINING THE PREDICTORS OF RECIDIVISM AMONG MEN AND WOMEN RELEASED FROM PRISON IN OHIO. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=44c6925bb097eb649dced19d93d6e368434dc825
14. POVERTY, STATE CAPITAL, AND RECIDIVISM AMONG WOMEN OFFENDERS. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1745-9133.2004.tb00035.x
15. Gender-Appropriate Mental Health Services for Incarcerated Women: Issues and Challenges. https://www.jstor.org/stable/44953828
16. Unmet Mental Health and Social Service Needs of Formerly Incarcerated Women Living with HIV in the Deep South. https://www.researchgate.net/profile/Courtenay-Sprague/publication/324632538_Unmet_Mental_Health_and_Social_Service_Needs_of_Formerly_Incarcer-

ated_Women_Living_with_HIV_in_the_Deep_South/links/5b7d81db4585151fd127af49/Unmet-Mental-Health-and-Social-Service-Needs-of-Formerly-Incarcerated-Women-Living-with-HIV-in-the-Deep-South.pdf

17. Does a Primary Health Clinic for Formerly Incarcerated Women Increase Linkage to Care? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5511582/
18. Safer in Jail? A Comparison of Victimization History and Psychological Adjustment Between Previously Homeless and Non-Homeless Incarcerated Women. https://journals.sagepub.com/doi/abs/10.1177/1557085114537870
19. Social Learning Theory of Identificatory Processes. https://d1wqtxts1xzle7.cloudfront.net/43540100/Bandura1969HSTR-libre.pdf?1457523504=&response-content-disposition=inline%3B+filename%3DBanduras_theory.pdf&Expires=1693005528&Signature=NNaQ33p-J9143lhS8eH7lJ~3QkFKXZY1ZvT9cDlG8qNy~VDpC9RKORLnqlhx8AgbRBjVSue-2Aed6P-v1Dvklm78Fwlhfm0plPf811HNKEPna1RyPP53lbntLz8zjJbwtFiYpI9WQ43gsXk5yMpLsyNzn-BaeTxEctiLf~0nmo7WJYagtadFBluOC33p76EG8HyFuVIJRmc57GbJac8PTpvC9AB~qVq2O-jmrz8xdE3m6xSOnUq0qbUm1F1llAkIv1jIGULSnVYuJ23PXg0Y9JStW-B0mnSOPQJbo1TV-vgqX5~8rpB6hX3KRfZgVdhWJnqgf44Jko2rkaJnnbgGkBXGI~Q__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA
20. Wounded healers: How formerly incarcerated women help themselves by helping others. https://r2com-network.org/wp-content/uploads/2023/04/Heidemannetal_G_2016_Wounded_Healers.pdf
21. An Examination of the Impact of Formerly Incarcerated Persons Helping Others. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=6b6c77f1fffd0cfecd0f17718c6aeff7c69ebeb3
22. Use of Mental Health Care and Substance Abuse Treatment Among Adults With Co-occurring Disorders. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.56.8.954
23. Understanding Mental Health Treatment in Persons Without Mental Diagnoses. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/210048
24. Specialty mental health care improves patients' outcomes: findings from a nationwide program to monitor the quality of care for patients with substance use disorders. https://www.jsad.com/doi/abs/10.15288/jsa.2000.61.704
25. Comparing Barriers to Mental Health Treatment and Substance Use Disorder Treatment among Individuals with Comorbid Major Depression and Substance Use Disorders. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3840086/
26. Perspectives about mental health, illness, and recovery. https://www.ingentaconnect.com/content/wk/yco/2017/00000030/00000005/art00004
27. Transforming Mental Health And Addiction Services. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.01472
28. Predictors of Longitudinal Substance Use and Mental Health Outcomes for Patients in Two Integrated Service Delivery Systems. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2885543/
29. Global research challenges and opportunities for mental health and substance-use disorders. https://www.nature.com/articles/nature16032
30. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. https://jamanetwork.com/journals/jama/article-abstract/2646703
31. Family Support and Substance Use Outcomes for Persons With Mental Illness and Substance Use

Disorders. https://watermark.silverchair.com/27-1-93.pdf?token=AQECAHi208BE49Ooan9k-khW_Ercy7Dm3ZL_9Cf3qfKAc485ysgAAA4EwggN9BgkqhkiG9w0BBwagggNu-MIIDagIBADCCA2MGCSqGSIb3DQEHATAeBglghkgBZQMEAS4wEQQM_RAT-M6AY4NDvsSD6AgEQgIIDNHF8xE6zttJKv1eWay9U7zzNSkwWFIcdAs7lglFm3gwIV-jylKb3YGKHb_aGZW3Ptcr4zaw7Ba9F8HX5GaDgRRz3KKydQpaqraUmsn4Guqu8s-jwTg2ZnZbpo-dQRLPtrU6hNsEHPPR2Tgt98x11uwPW0Ez51UuAktmPpiprI2V1NLd-KptS73Q2dslArRF63mG3eZqQqputn4ephh_b384vXDBxBtpZc8KzL0vjbZ2x75RsDrf36ps-Bwu7fSlDT9BJRLaxrNFAwvsX2cZ1hDnB6a6vV2hnfMbA_tXJ44WvhAhDZmLqZPz6q-tivURK-6lE-PuWAOy6qzU7XkcagmvM9VvaYtsX19iv7vOizQenIZWCz_EoqXL6CVL-jNF_dRF64biNv4syQiLnKaFiPX7m913J-m0wAsLRVaFDux0oskhL7-Pnve071nL2HAKZo_Lz6PcVXDMPoJvZxNNZqkEXDDR_lqyHMpyvo0O-MJrylUPLwybOpqfCAWz2g9WY-4IP-SEIf_qPXwAIyaDB4_RGYlyPxORqIhKq5OVf0WxYDwT04CJlYOIp3rebMxl6cAaZ-pWuNHJXPXytlch9WStOJY1mAzzUVbiHCUUhzI8S9LzdIelmwpiXrs2dzeSTbRNcJ4Kf-nax6ghqhOjuHJwgenPsYNjC84D4iW1GaBMvvcUmjb77n7oux0gojymDtqWHCPoepV-waVxOAyKtsuXpXcF__n_Kq1-BQNHlV-FGlrODuWf-nOlCaRvQX5jFbKnYfr4j_k7B-9cmNl8VGeXCv3D-rSLib4hZDpdVHanab_jZxFMyZbB4Z9mM6bFEKdpFsWzILqXpvAUA-pxiPWFhEa62RU0V1-NuRkYSUaPRk7KiKGvLgKcvzZ3cgtLdE5Do0iKqSckt-w7MqBL6d-53kr_nqAAs9l8prS7QjZMhRsgCzhhE3k-PIqaxCkciD5F_u45hicAJdZbTVEr239-fDaBareG-Wo3829iR6EFMfi6f2V8VntpAQW5PDc00EhU9fqeRS6HCW69TfijDvzbbJ3dudod0i7lHwju4d-D8UOfwmgRXfYbL-pQevZCcrrLBHuwG8a1evkK9wIulFM

32. Relapse to alcohol and drug use among individuals diagnosed with co-occurring mental health and substance use disorders: A review. https://d1wqtxts1xzle7.cloudfront.net/43724358/Relapse_to_alcohol_and_drug_use_among_in20160314-29826-w0791q-libre.pdf?1457984830=&response-content-disposition=inline%3B+filename%3DRelapse_to_alcohol_and_drug_use_among_in.pdf&Expires=1698359947&Signature=FLM4iJncWhOuBiNofqSvK-MQuE91p2~yK1VpFsvAZJ4G2z7E4qWwTarFwkuOJIJVnzdXPDzjAXI6AQOQUu0gQ-Adfl0MhUbHD7UnDMJnAp6BBtBuqF0em1m~sS3IhKxwYkzP6ldorluPkLiz4Nyj2BZqG-PyUiokYKko5zzoFvYanjIohK2I4iGjhiGBapKkd8Yq50ILKwCF5VHtCptPmbRUAA-~eV4E-Zl2JS6hxTE33I~XoX1LgmfgN4R~R-PItuzi~DRGZsdDv26RkQTR~gvNlfIkqHnUP9ZrM-bh3nK-L-3O7BsGABGRsCVzvefOhSfgpqfM9XKRLUG3JJQkJMffN7g__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA
33. The association between early life mental health and alcohol use behaviours in adulthood: A systematic review. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0228667
34. Mental Health, not Social Support, Mediates the Forgiveness–Alcohol Outcome Relationship. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3177969/

Appendix A:
Observed Differences from Previous Reports

Pivot would like to emphasize that the differences from ISR methods may be entirely appropriate relative to ISR's own contractual obligations.

While ISR acknowledges that PCM is interwoven with other additional services; nevertheless, they include many if not all features of each organization outside PCM opportunity. Pivot limited its work to PCM opportunity only, as that is the contract BHI funded and requested the evaluation in this case. ISR spent a considerable time documenting processes for the entirety of Crossroads for Women and Centro Savila. Pivot's evaluation focused solely on the PCM opportunity.

Pivot elected to forgo direct interaction with participants out of respect for their vulnerable nature and the insufficient time to develop suitable methods. Pivot does plan to develop those methods in the future. Evaluators observed that few individuals in the general public would reveal the level of detail requested of these individuals, and that disparity seemed like an equity issue that should be managed carefully.

ISR and Pivot logic models differ significantly. Pivot used multiple sources (e.g. ISR logic model, RFP response proposals, additional program documents) to develop draft logic models, then Pivot asked program staff to review and critique the draft. As a result, Pivot developed a document that could accurately guide data requests, analysis, interview content, along with what features were the responsibility of other entities (e.g. staff training and quality, evidence-based practices). This method led both organizations to sign off on both logic models as representative at that point in time. As Pivot developed updated logic models, both organizations acknowledged regularly changing processes to better serve their populations. Regularly changing processes likely explains a significant amount of the differences observed in the two logic models.

While Pivot asked for aggregated data, both organizations offered de-identified data (requiring IRB oversight). Pivot asked for a relatively restricted data set relative to ISR's data request. Both program organizations found it difficult or impossible to link various important data elements that answer PCM participation relative to other participation. Both organizations had difficulty providing quality outcome measures. Both organizations currently continue updating systems to solve those challenges.

In summary, ISR and Pivot used very different methods to answer different evaluation questions. However, both evaluations suffer from a lack of clear and reliable outcome measures. Pivot's work continues and will expand the questions necessary to understand the benefits of these programs.

Appendix B:
Crossroads for Women (CRFW) Additional Information

A. How did Pivot gather information from CRFW for this evaluation?
Staff Meetings

Pivot evaluators conducted several meetings with CRFW staff via video call and in person. We met with staff to introduce and plan the evaluation, review and confirm all evaluation methods, materials, and procedures, answer questions throughout the evaluation, and conclude the evaluation. Towards the end of the PCM evaluation Pivot conducted a site visit at the main CRFW facility, and CRFW staff have the opportunity to review this report and submit feedback.

Dataset Collection

Pivot also requested the following data sets from CRFW. CRFW staff delivered an interim draft data set in October 2022 (Data Collection 1) and a final data set in March 2023 at the end of their BHI funding period (Data Collection 2). CRFW staff were not able to provide all points requested in DC1 due to some being outside the scope of CRFW's program or database system. CRFW collaborated with Pivot throughout regarding data availability and options, with Pivot modifying data collection as applicable.

1. # of new POPSS referrals Annually for the period of the funded project (and the year prior to funding, if available).
2. # of completed intakes & status assessments (SDOH version) unduplicated **Annually** for the period of the funded project (and the year prior if available), and the **total** Unduplicated count (funded period only).
3. # of individuals with **New** service plans Annually for the period of the funded project (and the year prior if available).
4. # of individuals with **Continuing** service plans Annually for the period of the funded project (and the year prior if available), and the total Unduplicated count (funded period only).
5. # of goals set for individuals with **New** service plans (include also average per individual, and standard deviation) **Annually** for the period of the funded project (and the year prior if available).
6. # of goals set for individuals with **Continuing** service plans (include also average per individual, and standard deviation) Annually for the period of the funded project and the year prior if available.
7. # of goals **Met** (include average goals met per individual, and standard deviation)
8. # of PCM sessions and hours Annually for the period of the funded project (and the year prior if available).
9. # of individuals referred to external services (unduplicated) **Annually** for the period of the funded project (and the year prior if available), and the **total** Unduplicated count (funded

period only)

10. # of external referrals to services (duplicated)
11. # of individuals referred to CRFW internal support groups (unduplicated) **Annually** for the period of the funded project and the year prior if available, and the **total** Unduplicated count (funded period only)
12. # of internal referrals to CRFW groups **(duplicated)**
13. # of Peer Case Workers Annually for the period of the funded project (and the year prior if available)
14. # of Certified Peer Support Workers, Annually for the period of the funded project (and the year prior if available)
15. Number of individuals exiting Crossroads transitional housing Annually for the period of the funded project (and the year prior if available)
16. Number of individuals reporting successful completion of parole and/or probation Annually for the period of the funded project (and the year prior if available).
17. Number and % of individuals reporting a decrease in overall substance use (first vs. most recent SDOH POPSS Screening tool)
18. Number and % of individuals reporting a decrease in substance severity (i.e. potency/illegality of drug) (first vs. most recent SDOH POPSS Screening tool)
19. Number of and % individuals reporting a decrease in substance frequency (first vs. most recent SDOH POPSS Screening tool)
20. Number of and % individuals reporting a decrease in drug use amount (quantity used) (first vs. most recent SDOH POPSS Screening tool)
21. Central tendency (Mean, Median, Mode) of PCM intensity (number of client needs, goals to meet), length (length of PCM meeting time), and frequency of individual case management
22. Number and % of individuals reporting a decrease in new criminal activity
23. Number and % of individuals reporting behavioral and mental health stabilization (first vs. most recent SDOH POPSS Screening tool)
24. Number and % of individuals reporting improved stable housing (first vs. most recent SDOH POPSS Screening tool)
25. Number and % of individuals reporting improved medical coverage (first vs. most recent SDOH POPSS Screening tool)
26. Number and % of individuals reporting improved supportive knowledge & attitudes (first vs. most recent SDOH POPSS Screening tool)

B. How Did Pivot analyze CRFW data?

Pivot requested aggregate results and analyzed data as it was received. Some data was provided in individual de-identified form. In these cases, Pivot developed tables producing the aggregate results originally requested. For open-ended feedback and individual responses, evaluators reviewed qualitative themes for anonymous reporting. Pivot conducted statistical analyses using SPSS software, including as applicable: frequencies, measures of central tendency, repeated measure T tests, and Pearson correlations.

C. What other results did Pivot prepare?

The following tables show CRFW information that Pivot prepared but did not include in the main sections of this report due to irrelevance to the main evaluation questions. The long tables pre-

sented here are intended to show why free response is time consuming for data entry and difficult for analysis. Elsewhere in the report, the suggested solution is to develop standard responses and then add an "Other" field with text to describe and a comment field that may be useful for clinical management.

CRFW New Service Plan Information

The following tables show information from the new Service Plan for CRFW clients.

What are the steps you will take to achieve your stated goal?

Call my caseworker more often
Call, make an appointment and go to the appointment
Client said she will reach out and ask for Help
Client stated she will work on getting all required Identity documents required to obtain employment
Client stated will continue to meet with CPSW and follow through on completing the small steps towards the full goal
Come in for scheduled appointments with CPSW, follow through with completing applications and keeping track of where applied for housing
Come in next Tuesday for appointment with CPSW to get assistance with small business information
Concentrate on finishing getting moved and then contact the Vocational dept. for an appointment to complete my schooling application
Grocery shop for better eating habits, call student loans
I will be at every appointment, call if I'm unable to make it, take advice given from my support system, follow all rules
Keep going to church and staying in the Word
Keep up with the court dates so that I can be there and plan transportation.
Make sure I have deposit, first month rent, utilities
Meet with caseworker and keep better communication
Meet with caseworker on next scheduled appointment and go from there
Whatever I need to do

Group Participation Information

The following tables show information collected about POPSS participation per group type.

Group Name	Frequency	Percent
12 Little Steps	8	0.2
2pm and 3pm groups	1	0
4 Agreements	47	1
Accu Detox	28	0.6
ACLU Storytelling Workshop	3	0.1
ACSD Meeting Group	1	0
Advocacy Group	3	0.1
After Care Event	1	0
Afternoon Meditation	291	6.1
AM Community Meeting	12	0.3
AM meeting (Butterflies)	4	0.1
Arts and Crafts	50	1.1
Baby Shower	1	0
Back to School Event	6	0.1
Birthday party	1	0
Building Confidence	12	0.3
CAB Meeting	56	1.2
Canceled: Weekend Support	1	0
Case Management 101	1	0
Case Study Participants	3	0.1
Celebrate Recovery @ Civic Plaza (took over the 11 Self Esteem Group and the 12PM group)	1	0
Circles of Hope-DBT Skills	10	0.2
Circles of Security	18	0.4
Circles of Security Parenting	2	0
Cleaning Up New Crossroads	5	0.1
Client Graduation	2	0
Closed Recovery Group	1	0
Co-Parenting	4	0.1
Community Event- Christmas Event	14	0.3
Community Meeting	4	0.1
Community Meeting AM	2	0
Community Meeting PM	1	0

Group Name	Frequency	Percent
Computer Class	13	0.3
Cooking Class	30	0.6
Cooking Group	10	0.2
Cooking with Chef Megan	1	0
Coping Skills	5	0.1
Coping Skills for Mental Health	26	0.5
Daily meditation	4	0.1
Daily Reflection FB Live	37	0.8
Daily Reflections	554	11.7
DBT	13	0.3
DBT Group	2	0
DBT Healthy Relationships	33	0.7
Department of Health Zoom	1	0
DIY Spa	15	0.3
Drugs and the Brain	28	0.6
Drugs and The Brain	6	0.1
Emotional Manipulation	31	0.7
Emotional Manipulation and DV	4	0.1
Evening Meditation	26	0.5
Exploring Theater as therapy	2	0
Expungement Event	3	0.1
Extra Credit Group	1	0
Facebook Live	166	3.5
Facebook notes	5	0.1
Facebook Post	347	7.3
Facebook Recovery Group	32	0.7
Family Facebook Post	6	0.1
Family Group	155	3.3
Family Movie Night	4	0.1
Farewell Circle	2	0
Farmers market Field Trip	3	0.1
Friday Check In	6	0.1
Friday Facebook Post	11	0.2
Game Group	3	0.1
GED	64	1.3

Group Name	Frequency	Percent
GED Catholic Charities	9	0.2
Gender and Sexuality	8	0.2
Glimpse of a Butterfly	1	0
Graduation	5	0.1
Gratitude/Positivity	3	0.1
Grief and Loss	11	0.2
Halloween Event	7	0.1
Halloween Family Bonding Event	18	0.4
Happy Birthday Celeste	4	0.1
Healing through dance	1	0
Healthy Relationships	5	0.1
Healthy Sexuality	4	0.1
Holiday MH	2	0
Home Wise Program	1	0
Hope and Positivity	4	0.1
Housing	9	0.2
Housing FB Live	67	1.4
Housing Group	8	0.2
Housing Group Tour Building	8	0.2
Housing Workshop	6	0.1
HSE	5	0.1
HSE Catholic Charities	61	1.3
HSE Programming	50	1.1
I CAN	12	0.3
Interview Workshop	2	0
JOB FAIR	2	0
Journal Through Recovery	39	0.8
Just For Today/Plan Your Week	1	0
Layers of Women	6	0.1
Legal Aide	1	0
Letting Go	19	0.4
Life on Life's Terms	290	6.1
Life on Life's Terms (Facebook Post)	7	0.1
Life On Life's Terms (Peer Group)	2	0
Life Skills	112	2.4

Group Name	Frequency	Percent
Life Skills Facebook Group	5	0.1
Life Skills FB LIVE	5	0.1
Mediation	3	0.1
Meditation	1	0
Meditation Group	2	0
Meditation/Mindfulness	15	0.3
Meeting with the County	2	0
Mental Health Awareness	28	0.6
MH Courage to Heal	11	0.2
MH seeking Safety	2	0
MH Seeking Safety	7	0.1
MH- Grief and Loss	9	0.2
Mindfulness	1	0
Mommy and Me	5	0.1
Monday Check In Group	24	0.5
Money Matters 102	1	0
Money Matters 103	1	0
Money Matters 107	1	0
Morning Meditation	18	0.4
Movie Night	7	0.1
Mural Art Group	17	0.4
Music with Meaning	7	0.1
Natures Medicine Cabinet	1	0
New Life In Recovery	1	0
Nutrition and Wellness	7	0.1
Offsite 12-Step Group	2	0
Open House Event	1	0
Our Toolbox	5	0.1
Parenting Group	6	0.1
Parenting with Love and Logic	18	0.4
Peer Lead Group	21	0.4
Peer lead group/4 agreements	1	0
Peer run group	2	0
Peer Support	5	0.1
Peer Support Group	3	0.1

Group Name	Frequency	Percent
Pinterest	16	0.3
Pinterest for Everyone	20	0.4
Plan Your Week	42	0.9
Planning Meals	2	0
PM community meeting	1	0
PM Community Meeting	4	0.1
POPSS	12	0.3
POPSS Group	3	0.1
POPSS Group (TC's)	3	0.1
POPSS Group (Zoom)	4	0.1
POPSS Group Facebook Live	4	0.1
POPSS Group on Zoom	2	0
POPSS Group Zoom (TC's)	4	0.1
POPSS Weekend Support	2	0
Pre-Weekend Support	23	0.5
Quarterly Meeting	3	0.1
Recovery	50	1.1
Recovery (Facebook)	10	0.2
Recovery Circles	1	0
Recovery Facebook Group	12	0.3
Recovery FB Live	23	0.5
Recovery Group	60	1.3
Recovery Group on Zoom	4	0.1
Recovery Group Part 2	1	0
Recovery Steps	19	0.4
Recovery Stories	24	0.5
Recovery / AA	8	0.2
Red Vest	2	0
Reducing Stress	8	0.2
Reducing Stress Through Art	9	0.2
Reintegration	10	0.2
Relapse Prevention	28	0.6
Relationships in Recovery	55	1.2
Restorative Justice Circle	1	0
Resume Workshop	3	0.1

Group Name	Frequency	Percent
Routine/During COVID-19	1	0
Seeking Safety	85	1.8
Self-Care	18	0.4
Self Esteem Group	7	0.1
Self-deception group	7	0.1
Self-Esteem	13	0.3
Skating Event	4	0.1
Smart Goals 101	1	0
Social Media and the Internet	7	0.1
Softball Game	4	0.1
Softball Game/ CRFW BBQ	1	0
Step Up Group (Group Case Management)	1	0
Step Up Meeting	1	0
Step Up Program	1	0
Stress Reduction	2	0
Substance Abuse 101	2	0
TANF Advocacy	4	0.1
TC Group- POPSS	6	0.1
TC Transitions	3	0.1
Thanksgiving Event	10	0.2
The Courage to Heal	2	0
The Layers of Women	2	0
Theater group	1	0
Transitions	27	0.6
Transitions (Zoom)	2	0
Transitions group	6	0.1
Transitions Group (Facebook Live)	3	0.1
Transitions Group (Pavilions)	3	0.1
Transitions Group (TC's)	1	0
Transitions Group Zoom	35	0.7
Transitions in Recovery	24	0.5
Transitions in Recovery (Butterflies live group)	5	0.1
Transitions in Recovery (Facebook Butterflies Group)	1	0
Transitions in Recovery (Facebook Live)	91	1.9
Transitions in Recovery (Facebook post)	7	0.1

Group Name	Frequency	Percent
Transitions in Recovery (Facebook)	39	0.8
Transitions in Recovery (ZOOM)	3	0.1
Transitions in Recovery TCs	1	0
Transitions- Zoom	5	0.1
Transitions At Maya's	1	0
Transitions (Zoom)	1	0
Typing Class	4	0.1
Understanding Mental Health	4	0.1
Virtual Vocational Group	18	0.4
Vocational	32	0.7
Vocational - Peer Support	2	0
Vocational 101	1	0
Vocational Group	124	2.6
Vocational Group FB LIVE	37	0.8
Vocational Group- Zoom	9	0.2
Vocational Skills	1	0
Vocational Workshop	3	0.1
Walk With Me	1	0
Weekend	1	0
Weekend Support	91	1.9
Weekend Support (Zoom)	2	0
Weekend Support (Facebook)	1	0
Weekend Support (Zoom)	6	0.1
Weekend Support Group	12	0.3
Weekend Support Group (Facebook Post)	3	0.1
Weekend Support Group (Facebook)	8	0.2
Weekend Support Group (Zoom)	2	0
Weekend Support Zoom	16	0.3
Weekend support (Facebook room)	2	0
Weekend support (Zoom)	2	0
Weekly Community Meeting	48	1
Wellness	1	0
WIOA orientation	1	0
Women's Health	2	0
Women Making a Change	10	0.2

Group Name	Frequency	Percent
Women Recover	59	1.2
Women Talk	14	0.3
Women's Health	16	0.3
Women's Talk	16	0.3
Women's Health	11	0.2
Zoo Social Group	1	0
Total	**4750**	**100**

POPSS Attendance April 2019-March 2023

N Visits	N Participants	Percent of Participants	Cumulative Percent of Participants
1	38	23	23
2	20	12	35
3	12	7	42
4	9	5	47
5	8	5	52
6	3	2	54
7	3	2	56
8	1	1	56
10	7	4	60
11	2	1	62
12	5	3	65
13	2	1	66
14	2	1	67
15	1	1	68
16	1	1	68
20	2	1	69
21	1	1	70
23	2	1	71
24	3	2	73
26	1	1	74
28	1	1	74
30	1	1	75
31	1	1	75
33	2	1	77
34	1	1	77
35	2	1	78
36	1	1	79
37	3	2	81
38	1	1	81
39	1	1	82
40	1	1	83
41	2	1	84
47	3	2	86
48	2	1	87

N Visits	N Participants	Percent of Participants	Cumulative Percent of Participants
50	1	1	87
51	1	1	88
56	2	1	89
57	1	1	90
58	2	1	91
63	1	1	92
67	1	1	92
70	1	1	93
89	1	1	93
91	1	1	94
103	1	1	95
113	2	1	96
126	1	1	96
134	1	1	97
250	1	1	98
275	1	1	98
339	1	1	99
348	1	1	99
662	1	1	100
	167	1	

D. What other data did Pivot collect about engagement duration?

The following table shows CRFW client discharge statistics across the entire contract period. The median is highlighted as it shows the most representative statistic in this case.

CRFW Discharges (DC1 2019-2022, n=413 individuals)

Days to Discharge (Service engagement duration)	
Mean	258.5
Median	169
Mode	184
Std. Deviation	320.8
Minimum	0
Maximum	3085

The following table shows the frequencies of individuals CRFW automatically discharged due to a lack of contact or updates to their service plans. Standardizing operational definitions for different discharge reasons/types will help CRFW and the County distinguish between various outcomes. For example, clients discharged due to lack of contact, discharged due to being asked to leave for inappropriate behavior, and discharged due to improving their situation such that they no longer need CRFW's support.

CRFW Overall Days to Discharge (2019-2023)

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
0	3	0.73	0.73
3	3	0.73	1.45
4	2	0.48	1.94
5	2	0.48	2.42
6	1	0.24	2.66
7	3	0.73	3.39
9	4	0.97	4.36
11	1	0.24	4.60
12	2	0.48	5.08
13	1	0.24	5.33
14	3	0.73	6.05
15	1	0.24	6.30
16	1	0.24	6.54
19	1	0.24	6.78
20	1	0.24	7.02
21	2	0.48	7.51
29	1	0.24	7.75
30	1	0.24	7.99
31	1	0.24	8.23
32	2	0.48	8.72
35	2	0.48	9.20
37	2	0.48	9.69
38	3	0.73	10.41

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
39	3	0.73	11.14
40	3	0.73	11.86
41	2	0.48	12.35
42	2	0.48	12.83
43	1	0.24	13.08
44	1	0.24	13.32
46	3	0.73	14.04
48	1	0.24	14.29
49	2	0.48	14.77
50	2	0.48	15.25
52	5	1.21	16.46
53	2	0.48	16.95
54	2	0.48	17.43
55	3	0.73	18.16
56	3	0.73	18.89
57	3	0.73	19.61
58	2	0.48	20.10
60	2	0.48	20.58
62	1	0.24	20.82
63	4	0.97	21.79
64	1	0.24	22.03
66	2	0.48	22.52
68	3	0.73	23.24
69	2	0.48	23.73
71	1	0.24	23.97
72	1	0.24	24.21
75	1	0.24	24.46
77	3	0.73	25.18

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
79	2	0.48	25.67
80	1	0.24	25.91
81	1	0.24	26.15
82	2	0.48	26.63
84	2	0.48	27.12
87	1	0.24	27.36
88	2	0.48	27.85
89	6	1.45	29.30
90	7	1.69	30.99
91	5	1.21	32.20
92	3	0.73	32.93
93	2	0.48	33.41
94	2	0.48	33.90
95	1	0.24	34.14
96	2	0.48	34.62
97	2	0.48	35.11
98	3	0.73	35.84
99	2	0.48	36.32
100	3	0.73	37.05
103	1	0.24	37.29
104	4	0.97	38.26
105	3	0.73	38.98
106	1	0.24	39.23
107	1	0.24	39.47
113	1	0.24	39.71
114	2	0.48	40.19
115	1	0.24	40.44
116	2	0.48	40.92

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
117	1	0.24	41.16
118	2	0.48	41.65
120	1	0.24	41.89
121	1	0.24	42.13
124	1	0.24	42.37
125	1	0.24	42.62
127	1	0.24	42.86
133	1	0.24	43.10
135	1	0.24	43.34
137	1	0.24	43.58
138	1	0.24	43.83
139	1	0.24	44.07
140	1	0.24	44.31
143	1	0.24	44.55
145	1	0.24	44.79
146	2	0.48	45.28
147	3	0.73	46.00
148	1	0.24	46.25
149	2	0.48	46.73
150	1	0.24	46.97
152	1	0.24	47.22
153	1	0.24	47.46
154	2	0.48	47.94
155	1	0.24	48.18
157	2	0.48	48.67
159	1	0.24	48.91
160	2	0.48	49.39
166	1	0.24	49.64

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
167	1	0.24	49.88
169	2	0.48	50.36
*Note half of participants have 169 days or fewer to discharge.			
170	2	0.48	50.85
171	2	0.48	51.33
172	1	0.24	51.57
173	1	0.24	51.82
175	3	0.73	52.54
177	2	0.48	53.03
178	1	0.24	53.27
179	3	0.73	54.00
180	2	0.48	54.48
181	3	0.73	55.21
182	5	1.21	56.42
183	4	0.97	57.38
184	9	2.18	59.56
185	2	0.48	60.05
189	2	0.48	60.53
190	1	0.24	60.77
197	2	0.48	61.26
199	2	0.48	61.74
202	1	0.24	61.99
203	1	0.24	62.23
204	1	0.24	62.47
205	3	0.73	63.20
209	1	0.24	63.44
212	1	0.24	63.68
216	1	0.24	63.92

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
218	1	0.24	64.16
220	1	0.24	64.41
222	1	0.24	64.65
223	1	0.24	64.89
226	1	0.24	65.13
232	2	0.48	65.62
237	2	0.48	66.10
241	1	0.24	66.34
247	1	0.24	66.59
248	2	0.48	67.07
249	1	0.24	67.31
251	1	0.24	67.55
252	2	0.48	68.04
256	1	0.24	68.28
259	1	0.24	68.52
263	1	0.24	68.77
271	1	0.24	69.01
273	2	0.48	69.49
275	2	0.48	69.98
276	1	0.24	70.22
277	1	0.24	70.46
278	1	0.24	70.70
279	1	0.24	70.94
280	2	0.48	71.43
281	1	0.24	71.67
284	2	0.48	72.15
287	1	0.24	72.40
288	1	0.24	72.64

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
292	1	0.24	72.88
293	1	0.24	73.12
295	1	0.24	73.37
299	1	0.24	73.61
302	1	0.24	73.85
308	1	0.24	74.09
309	1	0.24	74.33
314	1	0.24	74.58
316	1	0.24	74.82
*75% of participants have 316 days or fewer to discharge.			
318	1	0.24	75.06
322	4	0.97	76.03
325	1	0.24	76.27
327	1	0.24	76.51
328	1	0.24	76.76
330	1	0.24	77.00
331	1	0.24	77.24
335	1	0.24	77.48
339	2	0.48	77.97
340	1	0.24	78.21
341	1	0.24	78.45
342	1	0.24	78.69
343	1	0.24	78.93
347	1	0.24	79.18
350	1	0.24	79.42
362	1	0.24	79.66
363	1	0.24	79.90
365	4	0.97	80.87

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
*80% of clients discharge in less than one year of service.			
366	2	0.48	81.36
367	2	0.48	81.84
369	1	0.24	82.08
370	2	0.48	82.57
378	1	0.24	82.81
382	1	0.24	83.05
383	1	0.24	83.29
394	1	0.24	83.54
406	1	0.24	83.78
411	1	0.24	84.02
421	1	0.24	84.26
427	1	0.24	84.50
428	1	0.24	84.75
446	1	0.24	84.99
447	1	0.24	85.23
449	1	0.24	85.47
451	1	0.24	85.71
454	1	0.24	85.96
464	1	0.24	86.20
471	1	0.24	86.44
475	1	0.24	86.68
478	1	0.24	86.92
497	1	0.24	87.17
524	1	0.24	87.41
525	1	0.24	87.65
532	1	0.24	87.89
537	1	0.24	88.14

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
547	1	0.24	88.38
560	1	0.24	88.62
582	1	0.24	88.86
588	1	0.24	89.10
589	1	0.24	89.35
603	1	0.24	89.59
609	1	0.24	89.83
619	1	0.24	90.07
627	1	0.24	90.31
636	1	0.24	90.56
649	1	0.24	90.80
657	1	0.24	91.04
666	1	0.24	91.28
705	1	0.24	91.53
*Only an additional 10% of clients are retained within a second year of service.			
740	1	0.24	91.77
765	1	0.24	92.01
772	1	0.24	92.25
778	1	0.24	92.49
787	1	0.24	92.74
798	1	0.24	92.98
800	1	0.24	93.22
802	1	0.24	93.46
816	1	0.24	93.70
819	1	0.24	93.95
826	1	0.24	94.19
832	1	0.24	94.43
851	1	0.24	94.67

Days to Discharge (Service engagement duration)	Frequency (Number of people per duration)	Percent	Cumulative Percent
883	1	0.24	94.92
903	1	0.24	95.16
913	1	0.24	95.40
938	1	0.24	95.64
944	1	0.24	95.88
945	1	0.24	96.13
960	1	0.24	96.37
976	1	0.24	96.61
1049	1	0.24	96.85
1061	1	0.24	97.09
*An additional 7% of clients are added within a third year of service.			
1098	1	0.24	97.34
1142	1	0.24	97.58
1161	1	0.24	97.82
1183	1	0.24	98.06
1315	1	0.24	98.31
1330	1	0.24	98.55
1377	1	0.24	98.79
1417	2	0.48	99.27
1534	1	0.24	99.52
2285	1	0.24	99.76
3085	1	0.24	100.00
Total	**413**	**100**	**100**

Pivot calculated full days to discharge information for each individual funded year as well as the entire funding period overall, but decided to only include the overall period in this report. Tables for each year showed similar trends to the overall results, with slight discrepancies in engagement that would be expected as they were proportional to the other annual engagement data in this report.

Discharge Details by Year (2019-2022)
The median is highlighted as it shows the most representative statistic in this case.

Days to Discharge (Duration of Engagement) 2019 (since April) n=89

Mean	282.3933
Median	184
Mode	89
Std. Deviation	287.2398
Minimum	4
Maximum	1161

Days to Discharge (Duration of Engagement) 2020 n=127

Mean	215.7323
Median	147
Mode	105
Std. Deviation	299.3008
Minimum	0
Maximum	2285

Days to Discharge (Duration of Engagement) 2021 n=111

Mean	223.3514
Median	170
Mode	184
Std. Deviation	219.2478
Minimum	0
Maximum	945

Days to Discharge (Duration of Engagement) 2022 n=86

Mean	342.0814
Median	175
Mode	90
Std. Deviation	454.5812
Minimum	3
Maximum	3085

E. What data collection instruments did CRFW use during BHI funding?

Updated CRFW Client Service Plan

POPSS Service Plan Effective August 2021

Client Name
Address
Date of visit
What progress have you made on previous goals?
What new goals do you want to accomplish and or achieve? Please be specific:
What resources do you need to acheive your goal?
What are your barriers to achieving your goals?
What is your plan to achieve your stated goal?
What are the steps you will take to achieve your stated goal?
Why is this goal important to reach?
When would you like to reach the stated goal?
Comments

Social Determinants of Health (SDOH) Questionnaire

POPSS Aftercare Program
zNoGroup ZParticipation
POPSS Screening Tool II

Client Name

zNoGroup ZParticipation

Date Inventory Performed

Housing/Independant Living

What is you living situation today?

- ○ I have a steady place to live.
- ○ I have a place to live today, but I am worried about losing it in the future.
- ○ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, on the streets, in a car, abandoned building, park, or other place not mean to for human habitation)

Think about the place that you live. Do you have any problems with the following (Choose All that Apply)

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke Detectors missing or not working
- ☐ Water Leaks
- ☐ None of the Above

Within the last 12 months, have you worried that your food would run out before you got money to buy more?

○ Often True ○ Sometimes True ○ Never True

Within the last 12 months, the food you bought just didn't last and you didn't have money to get more.

○ Often True ○ Sometimes True ○ Never True

In the past 12 months, has a lack of reliable transportation kept you from getting to medical appointments, meetings, work, or from getting things needed for daily living?

○ Yes ○ No

In the past 12 months, has the eletric, gas, or water company threatned to shut off service at your home?

○ Yes ○ No

If for any reason you need support wtih day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc, do you get the help you need?

○ I don't need any help ○ I get all the help I need ○ I could use a little more help ○ I could use a lot

Beause of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visitng a doctor's office or shopping?

○ Yes ○ No

Family/Social

Is your physical safety threatened by family or friends?

○ Never ○ Rarely ○ Sometimes ○ Fairly Often ○ Frequently

Does anyone, including friends or family, insult or talk down to you?

○ Never ○ Rarely ○ Sometimes ○ Fairly Often ○ Frequently

Does anyone, including friends and family, threaten you with harm?

○ Never ○ Rarely ○ Sometimes ○ Fairly Often ○ Frequently

Does anyone, including friends and family, scream or curse at you?

○ Never ○ Rarely ○ Sometimes ○ Fairly Often ○ Frequently

Vocational/Educational

How hard is it for you to pay for he very basics like food, housing, medical care, and heating?

○ Very Hard ○ Somewhat Hard ○ Not Hard at All

Do you want support finding or keeping work or a job?

○ Yes, help finding work ○ Yes, help keeping work ○ I don't need need or want help

Do you speak any language other than English at home?

○ Yes ○ No

Do you want help with school or training? For example, starting or completing job training, or getting a highschool diploma, GED or equivalent.

○ Yes ○ No

Medical

In the last 30 days, other than activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7

On average, how many minutes did you usually spend exercising at this level on one of those days?

☐ 0
☐ 10
☐ 20
☐ 30
☐ 40
☐ 50
☐ 60
☐ 90
☐ 120
☐ 150 or more

Have you had any emergency room visits recently?

○ yes ○ no

If yes, when was your last ER visit?

○ Within the past 30 days ○ 1-2 months ago ○ 3-6 months ago ○ more than 6 months ago

Substance Use

How many times in the past 12 months have you had 4 or more drinks in a day?

○ Never ○ Once or Twice ○ Monthly ○ Weekly ○ Daily or Almost Daily

How many times in the past 12 months have you used tobacco products like cigarettes, cigars, snuff, chew, electronic cigarettes?

○ Never ○ Once or Twice ○ Monthly ○ Weekly ○ Daily or Almost Daily

How many times in the past year have you used prescription drugs for non-medical reasons?

○ Never ○ Once or Twice ○ Monthly ○ Weekly ○ Daily or Almost Daily

How many times in the past year have you used illegal drugs?

○ Never ○ Once or Twice ○ Monthly ○ Weekly ○ Daily or Almost Daily

Mental Health

How often do you feel lonely or isolated from those around you?

○ Never ○ Rarely ○ Sometimes ○ Often ○ Always

Over the past two weeks, how often have you been bothered by feeling little pleasure or interest in doing things?

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

In the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day

Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress?

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very Much

Because of a physical, mental, or emotional condition, do you have serious difficulty

concentrating, remembering, or making decisions?

○ Yes ○ No

Legal

How many times have you been arrested?

How many times have you been incarcerated?

How many times have you been booked into MDC?

Do you have any legal issues pending?

○ yes ○ no

If yes, please describe any legal issues that you have pending.

Appendix C:
Centro Sávila Additional Information

A. How did Pivot gather information from Centro Sávila for this evaluation?
Staff Meetings

Pivot evaluators conducted several meetings with Centro Sávila staff via video call and in person. We met with staff to introduce and plan the evaluation, review and confirm all evaluation methods, materials, and procedures, and answer questions throughout the evaluation. Centro Sávila staff have also had the opportunity to review this report and submit feedback.

Dataset Collection

Pivot requested the following data sets from Centro Sávila. Centro Sávila staff delivered an interim draft data set in October 2022 and a final data set in June 2023 at the end of their BHI funding period. Centro Sávila collaborated with Pivot throughout regarding data availability and options, with Pivot modifying data collection as applicable. Pivot modified the final data request significantly to accommodate Centro Sávila's current data processes and availability.

Interim Data Collection Request (2022)

Outputs

1. # of new referrals to Centro Sávila Annually for the period of the funded project (and the year prior, if available) and the total Unduplicated count (funded period only).
2. # of **new** Centro Sávila Clients (unduplicated) Annually for the period of the funded project (and the year prior if available).
3. # of **continuing** Centro Sávila Clients (unduplicated) Annually for the period of the funded project (and the year prior if available), and the total Unduplicated count (funded period only).
4. # of goals set for individuals with **New** service plans (include also average goals per individual, and standard deviation) Annually for the period of the funded project (and the year prior if available).
5. # of goals set for individuals with **Continuing** service plans (include also average goals per individual, and standard deviation) Annually for the period of the funded project (and the year prior if available).
6. Categorization of **types** of goals and the number of goals set within each category.
7. # of goals **Met** by category (include also average goals per individual, and standard deviation) Annually for the period of the funded project (and the year prior if available).
8. # rapid case management clients Annually for the period of the funded project (and the year prior if available).
9. # of PCM sessions and hours Annually for the period of the funded project (and the year prior if available).
10. # of individuals referred to external services (unduplicated) Annually for the period of the funded project (and the year prior if available), and the total Unduplicated count (funded period only)

11. # of external referrals to services (duplicated)
12. # of individuals referred internally to other Centro Sávila services (unduplicated) Annually for the period of the funded project (and the year prior if available), and the total Unduplicated count (funded period only)
13. # of internal Centro Sávila referrals (duplicated)

Capacity

1. # of Peer Case Workers Annually for the period of the funded project (and the year prior if available)
2. # of Certified Peer Support Workers, Annually for the period of the funded project (and the year prior if available)
3. # of monthly partner meetings Annually for the period of the funded project (and the year prior if available)

Outcomes

Improvements in client wellbeing through progressing with and/or meeting self-identified goals

- # of goals Met Annually (include also average goals per individual, and standard deviation) for the period of the funded project (and the year prior if available).

Decreased

- Number and % of individuals reporting a decrease in depression (pre vs. post inhouse outcome survey)
- Number and % of individuals reporting a decrease in SUD use (pre vs. post inhouse outcome survey)
- Number of and % individuals reporting a decrease in alcohol consumption (pre vs. post inhouse outcome survey)

Increased

- Number and % of individuals served over the funding period ((# served in year after funding – # served in year prior to funding) plus (# served in 2nd year after funding – # served in year prior to funding) plus (same formula for additional funding years))/ # served in year prior to funding
- Program quality

Final Data Collection Request (2023)

Capacity

1. A file (or multiple linkable files) showing deidentified employees during the contract period, their start dates, any position shifts (e.g. upgrades), status at the end of the grant, qualifications of record (e.g. CPSW).
2. # of monthly partner meetings Annually for the period of the funded project (and the year prior if available)

Outputs

3. A file (or multiple linkable files) showing deidentified individual participation data including: anyone served in the grant period plus the year prior, associated demographic info (age, gender, ethnicity), date of each service, the first contact date, the referrals source (how they got to Centro Sávila), associated goals descriptions, goal status at the end of the grant period, types of services provided and associated hours, an indicator if outside referrals were made and to which orgs, an indicator if inside referrals were made and for which services.

Outcomes

4. A file showing deidentified individual results of the in-house outcome survey Pre and post. (This file can be difficult to produce. If you give us a deidentified file with research ID numbers, we can sort out the best Pre-post to use.)

B. How Did Pivot analyze Centro Sávila data?

Pivot requested aggregate results and analyzed data as it was received. Some data was provided in individual de-identified form. In these cases, Pivot developed tables producing the aggregate results originally requested. For open-ended feedback and individual responses, evaluators reviewed qualitative themes for anonymous reporting. Pivot conducted statistical analyses using SPSS software, including as applicable: frequencies, measures of central tendency, repeated measure T tests, and Pearson correlations.

Appendix D:

Potential Instrument (The Arizona Self-Sufficiency Matrix Questionnaire)

Self-Sufficiency Matrix Participant Name _____ DOB __/__/____ Assessment Date __/__/____ Initial Interim Exit

(If using ServicePoint) Program Name _____ HMIS ID _____

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.		
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.		
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		
Child Care	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.		
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.		
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.		
Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) have medical coverage.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.		
Family /Social Relations	Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable and communication is consistently open.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.		
Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.		
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.	Parenting skills are well developed.		
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more that 12 months and/or no felony criminal history.		
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.		
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.		
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Disabilities	In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity – asymptomatic – condition controlled by services or medication	Thriving – no identified disability.		
Other: (Optional)	In Crisis	Vulnerable	Safe	Building Capacity	Empowered		