ZóCALO Health

Healing with our gente

Early Outcomes from the Community-Anchored Care Model

Program Outcomes and Impact Summary

Fiscal Year 2024–2025

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Letter from the Head of Behavioral Health

To our partners, community leaders, and supporters:

This past year has reaffirmed why Zócalo Health exists: too many Latino families continue to face barriers that make accessing behavioral health care confusing, fragmented, or out of reach. Our founders, Erik Cárdenas and Mariza Hardin, built Zócalo with a clear purpose—to ensure that no one has to navigate the healthcare system alone, and that care can feel familiar, human, and grounded in culture and community.

As you review this outcomes report, you will see early evidence of how that purpose translates into practice. You will see how Zócalo Health's Community-Anchored Care Model reached adults across California who are balancing work, caregiving responsibilities, chronic stress, and unmet social needs—many of whom have historically been underidentified or disengaged from behavioral health care. You will see how bilingual clinicians, Promotoras de Salud, and integrated care teams worked together to support members not only in initiating care, but in staying engaged long enough to experience meaningful clinical improvement.

What the data alone cannot fully capture is the context in which this work occurs. Many of the members served during this pilot are individuals who have long been "invisible" in traditional healthcare systems—people who move in and out of coverage, face language and transportation barriers, or have had little prior exposure to behavioral health services. These are also the members at highest risk for fragmented care, avoidable emergency utilization, and worsening health outcomes. That they showed up, stayed engaged, and trusted our teams speaks to the importance of care models designed around real-world lives rather than idealized pathways.

Many of the communities we serve are navigating periods of heightened stress and uncertainty that shape when and how people seek care, making trust, continuity, and flexibility essential to effective behavioral health delivery.

The Community-Anchored Care Model—integrating behavioral health, primary care, and social support—was built to replace fragmentation with continuity. By centering trusted community relationships, embedding measurement-based care, and coordinating across disciplines, the model aligns closely with emerging federal priorities, including the CMS Innovation in Behavioral Health (IBH) Model. It reflects a growing recognition that improving behavioral health outcomes in Medicaid populations requires not only access, but sustained engagement, cultural credibility, and accountability over time.

The findings presented in this report represent an early but important step. They reflect the dedication of our clinicians, Promotoras de Salud, and care teams, as well as the trust placed in us by our members. They also point to what is possible when culturally centered care design is paired with rigorous clinical practice and intentional measurement.

I am deeply grateful to our care teams, community partners, and the health plans who have supported this work, and to the collaborators and investors who recognize the long-term value of reaching populations that systems too often overlook. We look forward to continuing this work, strengthening the evidence base, and expanding the impact of community-anchored, integrated behavioral health care.

Sophia Pages, LMFT

Head of Behavioral Health

Executive Summary

This report presents early outcomes from Zócalo Health's Community-Anchored Care Model, a pilot implemented during fiscal year 2024–2025 to address persistent gaps in behavioral health access and engagement among Medicaid populations in California's Central Valley and Central Coast.

924

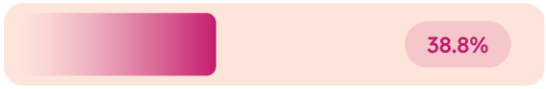
adults screened for behavioral health needs using standardized tools (PHQ-9, GAD-7)

188

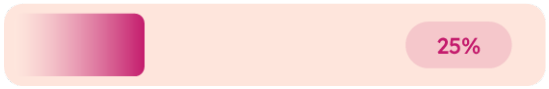
individuals initiated psychotherapy after a positive screen

attended two or more appointments — exceeding the 50% rate reported for Latinos nationally and comparable to the 66% general population rate

conversion rate from positive screen to treatment initiation



completed six or more appointments (a full course of treatment)



screened positive for depression or anxiety (n≈230)

Clinical Impact

Sustained engagement was associated with clinically meaningful symptom improvement. For each increase in adherence tier beyond the first visit:

PHQ-9 scores (depression) decreased by 1.23 points

GAD-7 scores (anxiety) decreased by 0.91 points

Item-level analyses demonstrated reductions in core depressive symptoms (low mood, feelings of failure, suicidal ideation) and anxiety symptoms (nervousness, uncontrollable worry) from baseline through the fourth assessment.

Spanish-speaking and Latino members demonstrated engagement rates comparable to or exceeding national benchmarks — a reversal of national patterns in which these groups typically show lower treatment completion. This suggests that system design, not population characteristics, may be the primary driver of behavioral health disparities.

Population Complexity

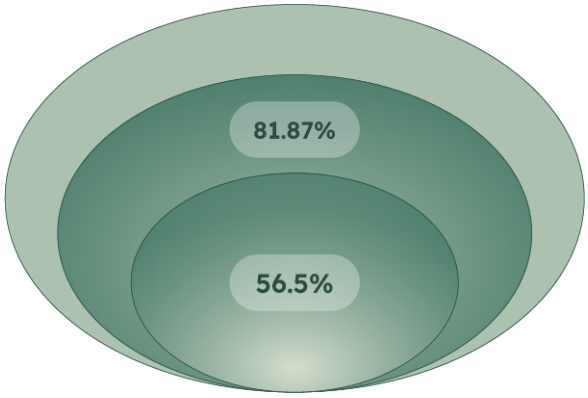
The population served faces significant social barriers alongside behavioral health needs:

Spanish-speaking and Latino members demonstrated engagement rates comparable to or exceeding national benchmarks — a reversal of national patterns in which these groups typically show lower treatment completion. This suggests that system design, not population characteristics, may be the primary driver of behavioral health disparities.

reported one or more unmet social needs (top needs: food insecurity, transportation)

76.2%
Primarily female

~70%
ages 25–54

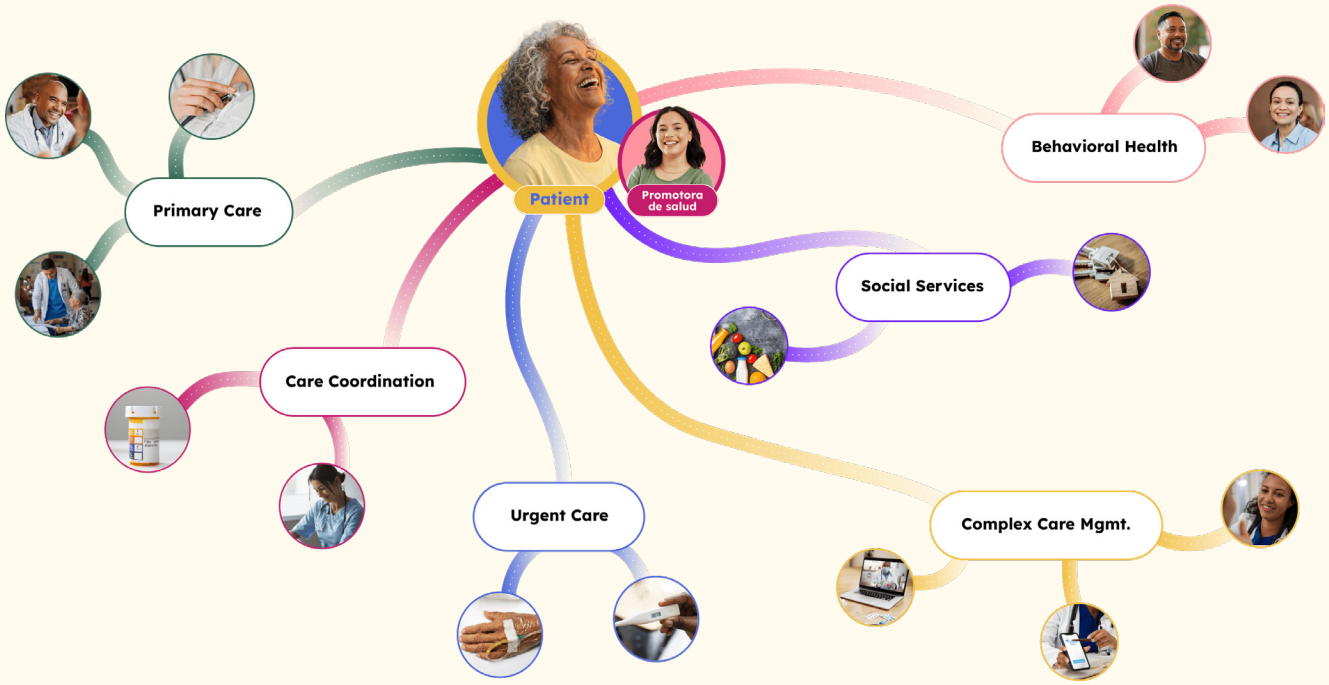


81.87% self-identified as Latino or Hispanic; 56.5% preferred services in Spanish

Concentrated in rural and semi-urban regions designated as Behavioral Health Professional Shortage Areas.

The Model

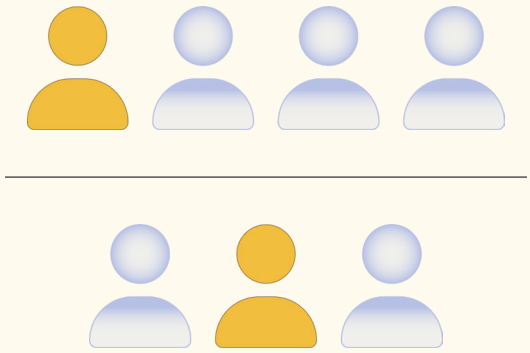
Zócalo Health's Community-Anchored Care Model integrates behavioral health, primary care, and social support through teams led by Promotoras de Salud — bilingual community health workers embedded in and trusted by the communities they serve. The model replaces passive referrals with proactive outreach, culturally aligned engagement, and measurement-based care to support sustained participation and clinical improvement.

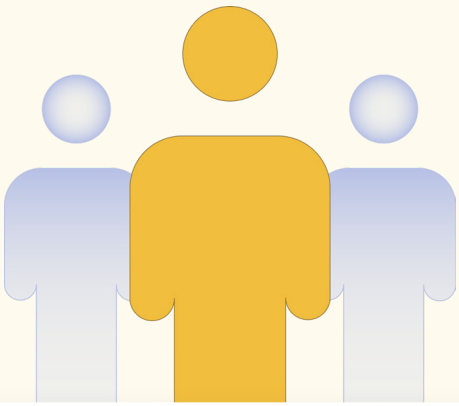


These early findings suggest that culturally centered, community-anchored, integrated behavioral health care can meaningfully narrow long-standing disparities in treatment engagement and outcomes for high-need Medicaid populations.

The Challenge

Detection and Completion Gaps in Medicaid Behavioral Health





Mental health needs are high across the U.S., particularly among Medicare and Medicaid populations. **1 in 4** Medicare beneficiaries and **1 in 3** Medicaid adults live with a mental illness — yet only half receive treatment.

Medicaid is one of the nation's most diverse programs: nearly half of enrollees are people of color, including almost **1 in 3** who identify as Hispanic. These realities highlight the need for culturally centered behavioral health care.

People receiving Medicaid are more likely to experience daily stressors such as housing instability, food insecurity, unsafe neighborhoods, and unreliable transportation. These pressures are not merely contextual — they are upstream drivers of behavioral health challenges including depression, anxiety, and crisis escalation.[1,2]

Unfortunately, the behavioral health needs of many Medicaid members remain unidentified and untreated. This challenge is magnified in states where Medicaid populations include a large share of Latino members. In California's Medi-Cal program, for example, Latino members make up approximately half of all enrollees.[8] In markets like this, the "typical Medicaid member experience" is inseparable from language and culture.

Yet national data consistently show that Latino adults are less likely to receive behavioral health treatment than the general population, even when distress and impairment are present.3,4 The gap does not reflect a lack of resilience; it is a predictable outcome of a care delivery system that silos medical and behavioral health treatments, and is poorly equipped to authentically engage in culturally, linguistically, and contextually relevant ways.

That leads to two compounding gaps:a detection gap, in which need goes unrecognized, and a treatment completion gap, in which care is not sustained long enough to be effective.

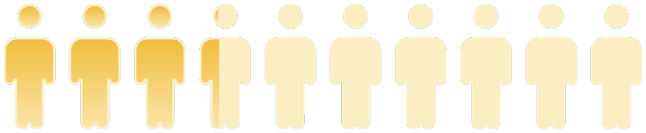
The Detection Gap

Behavioral health needs rarely present with a clear label. Instead, they often surface as headaches, insomnia, chronic pain, irritability, or fatigue. Many of these “chief complaints” are interpreted literally, especially when visits are short and continuity is limited.[4]

Nearly **2/3** of antidepressant prescriptions are written **without standardized depression screening.**

Standard screening workflows also fail many Medicaid members. Screening may be inconsistent, relying predominantly on a self-administered tool[5] that presumes literacy. Screeners are often administered in rushed settings and disconnected from a clear pathway to follow-up care.[6] When the “next step” after a positive screen is a passive referral into a scarce specialty network, detection becomes an endpoint rather than the beginning of care.

Screening rates in community/FQHC settings:

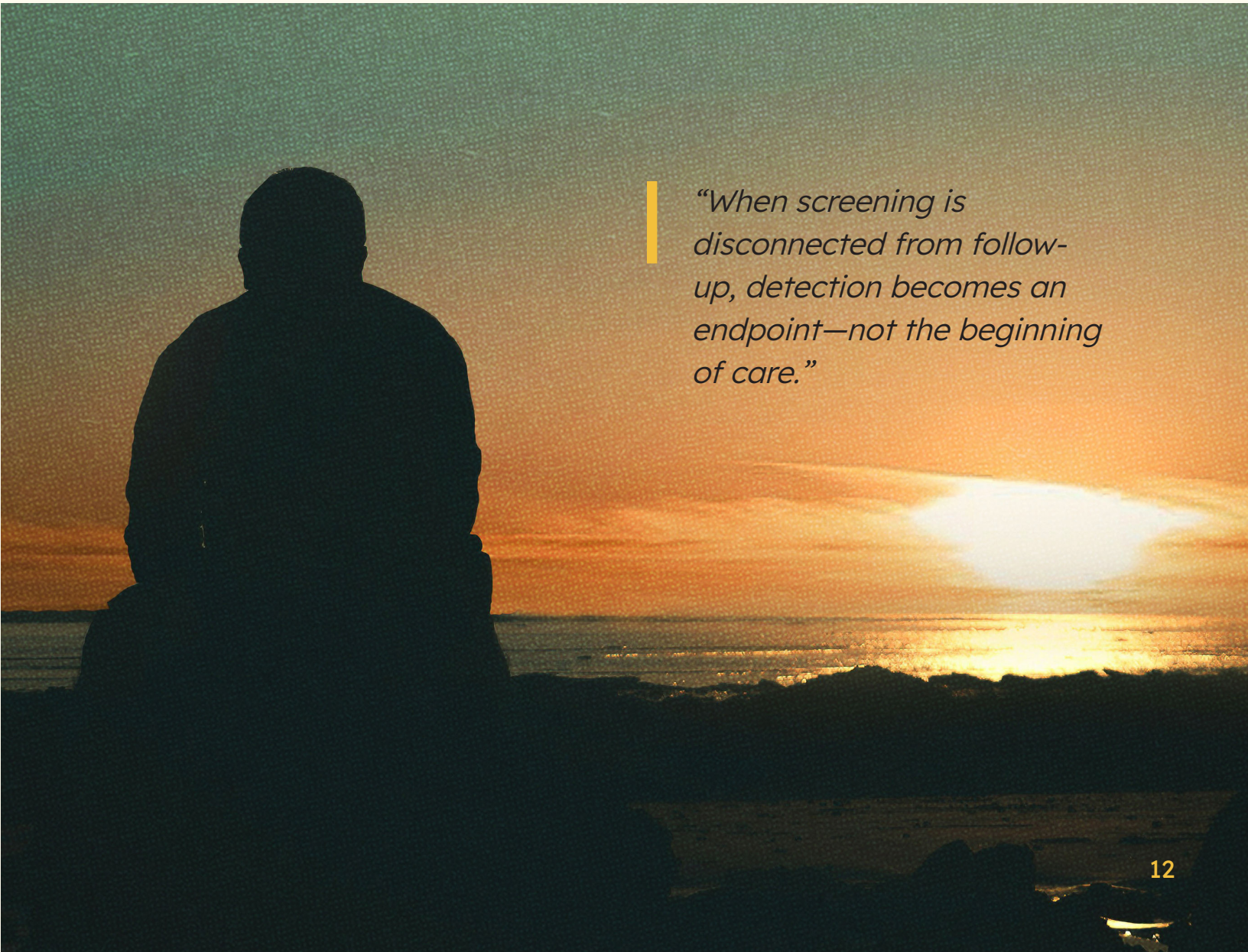


< 4 in 10 Latino adults screened

6 in 10 White adults screened

For Latino Medicaid members, detection failures are often intensified by language discordance and poor cultural fit. Screening tools, instructions, and conversations are frequently not delivered in a member's preferred language. Just as English varies widely by region and community, Spanish also varies significantly, including Spanish as a second language spoken by Indigenous peoples of Mexico and Central America. These language challenges are compounded when rushed staff cannot explain what the screening questions mean or why they matter. In this environment, members are likely to minimize symptoms, avoid disclosure, or disengage entirely.[3,4]

The outcome is predictable: need remains hidden, and "non-adherent" or "vulnerable" become the system's default explanations without a behavioral health plan that tracks symptoms over time and adjusts treatment intensity accordingly.

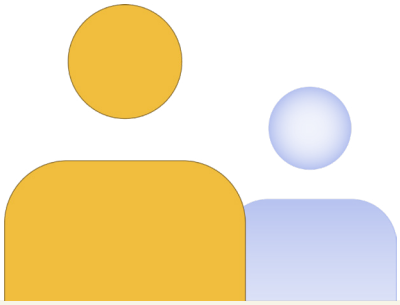


"When screening is disconnected from follow-up, detection becomes an endpoint—not the beginning of care."

The Treatment Completion Gap

Even when a behavioral health need is identified, follow-through often breaks down at the handoff from screening to the first appointment, and again after one or two visits. Medicaid members are navigating transportation constraints and unstable or irregular work schedules, complex childcare arrangements, and competing survival priorities such as housing and food instability. Under usual care, the logical outcome is poor-to-nonexistent engagement.[6]

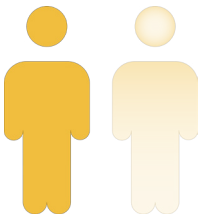
Breakdown at First Appointment



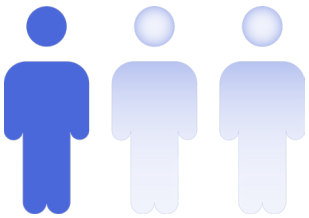
1 in 2 minority patients referred for mental health care never attend their first appointment — due to stigma, cost, language barriers, and lack of trust.

(Guerrero et al., 2021; Shimotsu et al., 2015)

For Latino members, completion gaps are often intensified by behavioral health stigma and fear of judgment. Indeed, the very existence of culturally bound expressions of distress — such as ataque de nervios — reflects a cultural expectation that emotional suffering manifest as physical illness. When services are not bilingual, not culturally credible, or not designed around family dynamics and real-life barriers, early dropout is not a "patient problem." It is a design problem.[3,4]



1 in 2 White adults with poor mental health receive treatment



Only 1 in 3 Black and Hispanic adults receive treatment

(KFF, 2023)

This matters because behavioral health treatment is dose-dependent. If members do not remain connected long enough to receive a clinically meaningful course of care, outcomes will not improve — regardless of the strength of the underlying intervention.

Why This Matters Economically

Untreated depression and anxiety increase the total cost of care through downstream utilization: more emergency department visits, higher inpatient risk, and worsened management of chronic conditions.[4,6] Behavioral health needs also interfere with medication adherence and self-management, particularly when members face material hardship and unstable living conditions.[1,2]

For Medicaid leaders accountable for quality, utilization, and equity, behavioral health is not a specialty carve-out. It is a core lever for improving population outcomes and preventing avoidable, high-cost events.[6]

Closing the engagement gap, especially in Latino-majority Medicaid markets, is therefore both an equity imperative and an operational priority.

The consequences are both clinical and economic. Untreated depression and anxiety contribute to higher total cost of care through increased emergency department use, elevated inpatient risk, and poorer management of chronic medical conditions.[1],[7] Behavioral health needs also interfere with medication adherence and self-management, particularly when members are experiencing material hardship and unstable living conditions.[3],[4]

Barriers to Behavioral Health Access

Language

Language barriers and lack of bilingual clinicians

Geography

Geographic and transportation barriers

Stigma

Stigma and cultural beliefs about mental health

Capacity

Competing demands (work, childcare, immigration concerns)

Inequity

Structural racism and discrimination in healthcare settings

Fragmentation

Fragmented care systems that do not coordinate behavioral & medical needs

How the System Perpetuates These Gaps

Insufficient Measurement & Accountability

The cumulative effect of the preceding is that care systems fail to track the full patient journey: detection → first appointment → retention → symptom improvement. Without measurement-based care and operational accountability, disparities remain invisible, and improvement remains episodic rather than systematic.[6]

Insufficient Outreach & Engagement

Traditional models typically use a passive referral process: diagnosis → a curated list of providers and numbers → hope. “Integration” efforts usually focus on administrative alignment among care providers rather than with the lived realities of individuals needing care. Without proactive outreach to engage community members, respecting the complexity of their lives, disparities in treatment initiation and follow-through remain the norm.[3,6]

Fragmented & Siloed Care

Behavioral health, primary care, and social needs support are typically delivered as separate, parallel tracks in U.S. Healthcare, producing friction at every step: multiple phone numbers, multiple appointments with associated paperwork, unclear ownership, and no single team accountable for outcomes.[6]

Absence of Social Care Integration

Social stressors and behavioral health are closely linked; treating one without addressing the other reduces retention and undermines outcomes. Medicaid programs recognize this connection and increasingly pursue strategies to address social risk alongside health needs.[1,2]

Cultural Mismatches

For Latino Medicaid members, system fragmentation is amplified by workforce gaps in bilingual care, limited culturally responsive options, and reliance on ad hoc interpretation. These are not minor inconveniences; they directly shape whether members disclose symptoms, accept care, and stay engaged[3,4]

In short, the system often expects the highest-need members to do the most navigation. That is the opposite of what high-complexity populations require.

The Business Implication

For health plans and delivery organizations responsible for outcomes in high-need Medicaid populations, standard models are structurally misaligned with the realities of social risk and cultural diversity. Closing the behavioral health gap requires a redesigned approach one that is proactive, culturally and linguistically responsive, integrates social barriers into care delivery, and measures outcomes over time.[1,3,6]

Bridging the Gaps

The Zócalo Solution

To address detection and completion gaps in Latino-majority Medicaid markets, Zócalo Health implemented the Community-Anchored Care Model—an integrated approach combining Promotoras de Salud–led outreach, bilingual clinical care, and measurement-based follow-up. The model is designed to reduce navigation burden, improve cultural and linguistic fit, and support continuity long enough to achieve meaningful symptom improvement. The next section describes the model's components and how they connect to the engagement and outcome metrics presented in this report.

At its core, the model is built to make care feel familiar and trustworthy, delivered in-language and in context, with accountability to measurable improvement.

ZóCALO Health

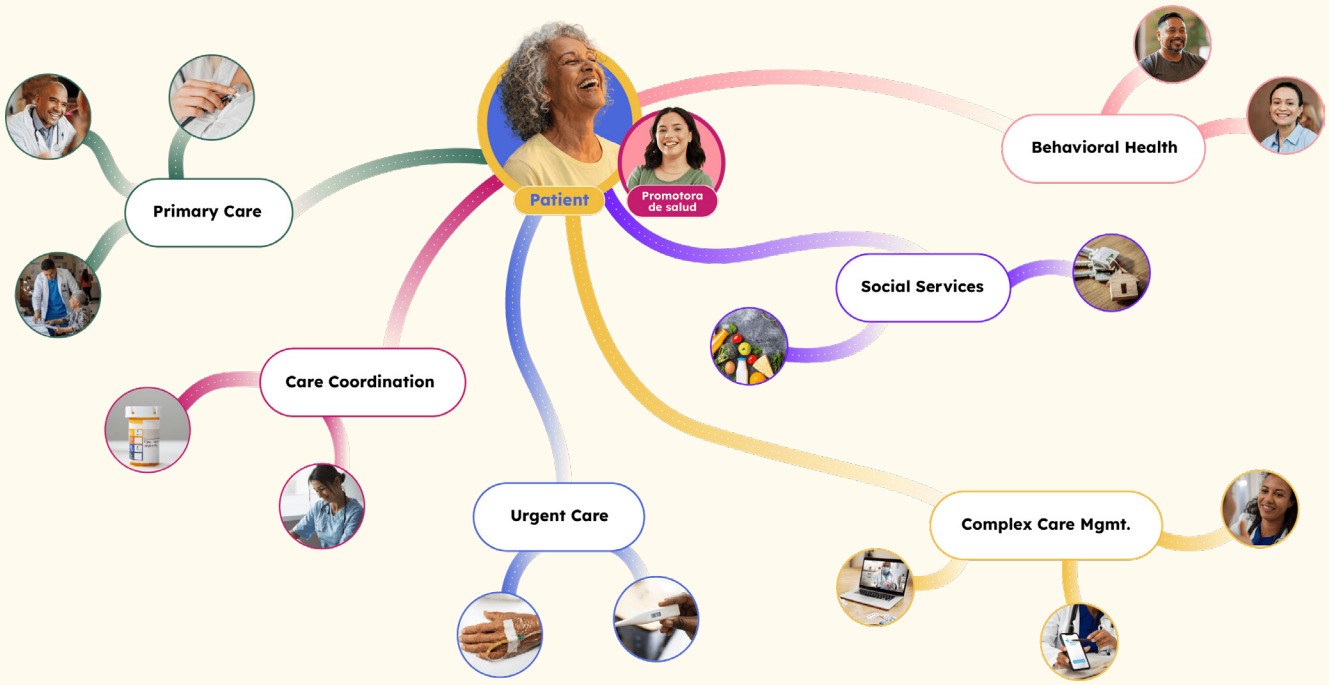
Our Model

The Community-Anchored Care Model

"Promotoras bridge the gap between care & community—helping patients overcome the practical, cultural, and logistical barriers that affect health."

Team-Based Care Model

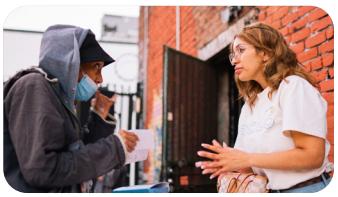
Zócalo Health's Community-Anchored Care Model integrates behavioral health, primary care, and social support through a team led by Promotoras de Salud, community health workers embedded in and trusted by the communities they serve. The Community-Anchored Care Model was designed to address persistent gaps in behavioral health detection, engagement, and continuity of care for Latino and other historically underserved populations.



In place of passive referrals to specialty services, the Community-Anchored Care Model actively pursues members. Our Promotoras de Salud use culturally aligned entry points, coordinate team-based care, and ensure regular assessment to drive measurement-informed treatment over time. Placing the Promotoras de Salud at the core of our model allows care to be both relational and clinically rigorous. It supports whole-person health while reducing the fragmentation that often undermines engagement and outcomes.

Core Model Principles

Zócalo Health's Community-Anchored Care Model integrates behavioral health, primary care, and social support through a team led by Promotoras de Salud, community health workers embedded in and trusted by the communities they serve. The Community-Anchored Care Model was designed to address persistent gaps in behavioral health detection, engagement, and continuity of care for Latino and other historically underserved populations.



Community-based Entry

Promotoras de Salud are members' first point of contact, providing culturally congruent outreach, screening, and navigation in their preferred language.

Data-Informed Practice

Standardized tools (PHQ-9, GAD-7, PRAPARE) are administered at intake and throughout care to track needs and guide clinical decision-making.

Care Integration

Behavioral, medical, and social needs are addressed together through coordinated, team-based care and shared care planning grounded in best practices in interprofessional collaboration.

Trauma-informed, Relationship-based Care

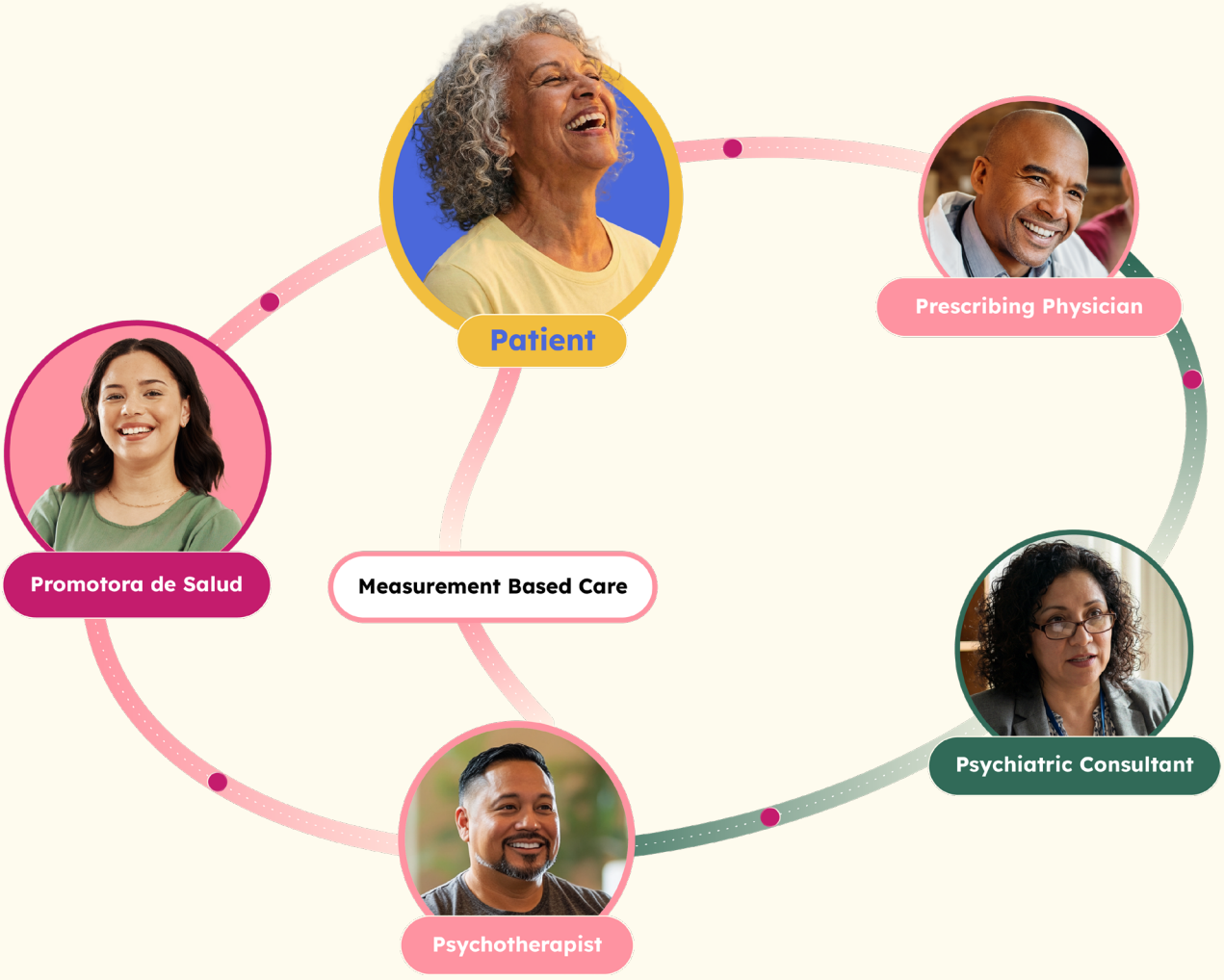
Care is designed to build trust, emotional safety, and collaboration, recognizing how chronic stress and trauma shape health, engagement, and follow-through.

Adaptive, Member-centered Engagement

Behavioral health services are delivered virtually, while Promotoras de Salud provide in-person, community-based outreach and navigation. Scheduling, follow-up, and care pathways are designed to reduce barriers to participation.

How the Model Works

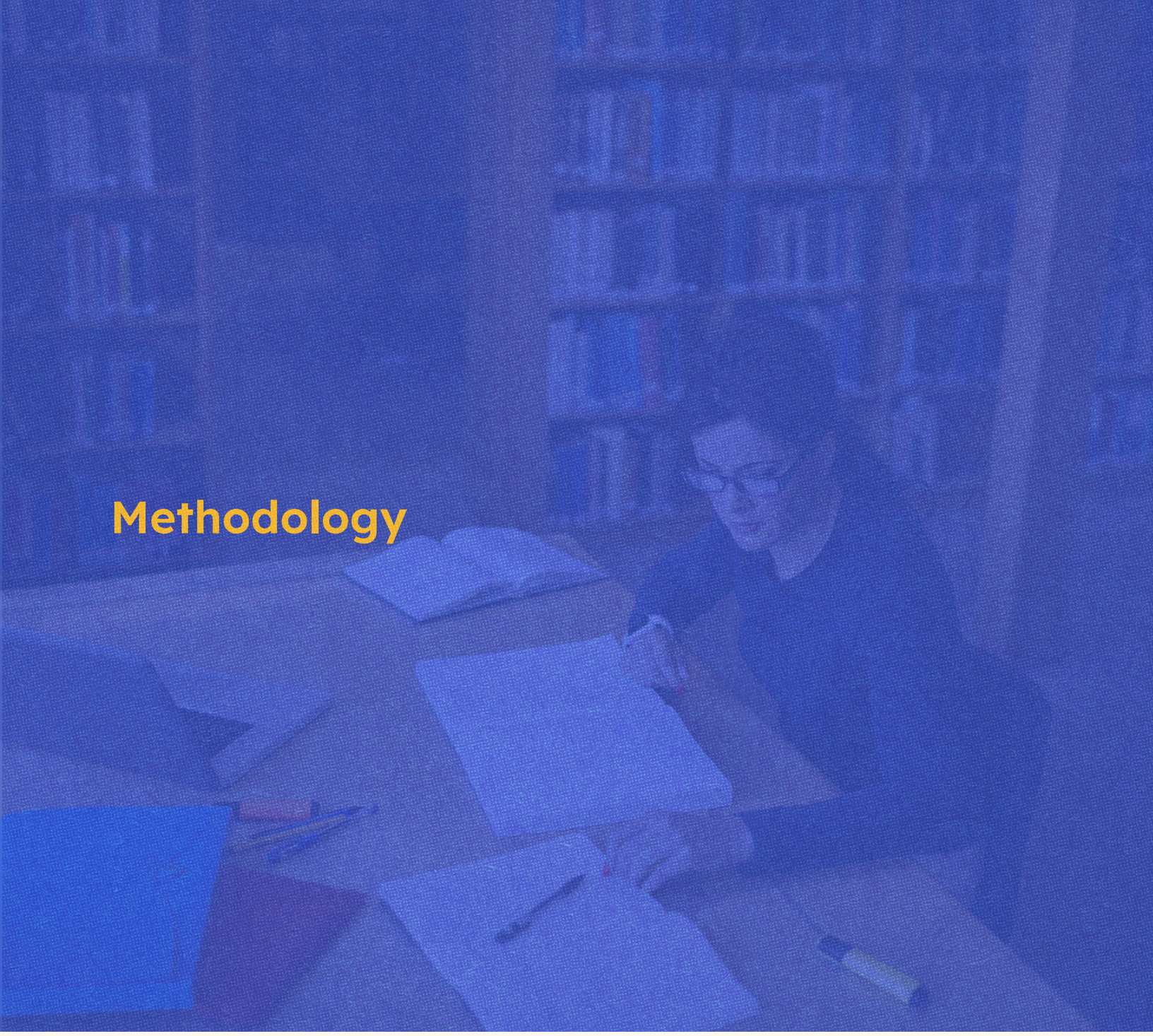
Most members enter care through a Promotora de Salud, who conducts outreach, completes initial screening, and assesses behavioral, medical, and social needs in culturally familiar ways. As trusted members of the community, Promotoras help reduce stigma, address linguistic and cultural barriers, and increase the likelihood that individuals accept and follow through with services. Care pathways also include support for social needs such as food insecurity, housing instability, transportation barriers, and benefits navigation. Shared care plans and interdisciplinary communication enable teams to address the social and medical factors that commonly interfere with behavioral health engagement and recovery.



Standardized measurement is embedded across behavioral health, medical, and social care encounters. Tools such as the PHQ-9, GAD-7, and PRAPARE are administered at intake and at regular intervals to monitor symptom change and evolving needs. Clinicians use these data to tailor treatment plans, adjust visit frequency, and identify when stepped-up support is clinically indicated.

To support continuity, care teams routinely review caseloads to identify members at risk of disengagement. Population-level dashboards and proactive outreach, often led by Promotoras de Salud, address logistical and social barriers early and support re-engagement after missed visits. This approach increases the likelihood that members remain connected long enough to receive a clinically meaningful dose of care.

By anchoring care in trusted community relationships, integrating behavioral, medical, and social support, and using continuous measurement to guide treatment, the Community-Anchored Care Model directly addresses the engagement, retention, and outcome gaps common in traditional behavioral health systems—setting the foundation for the clinical and engagement results presented in the following sections.



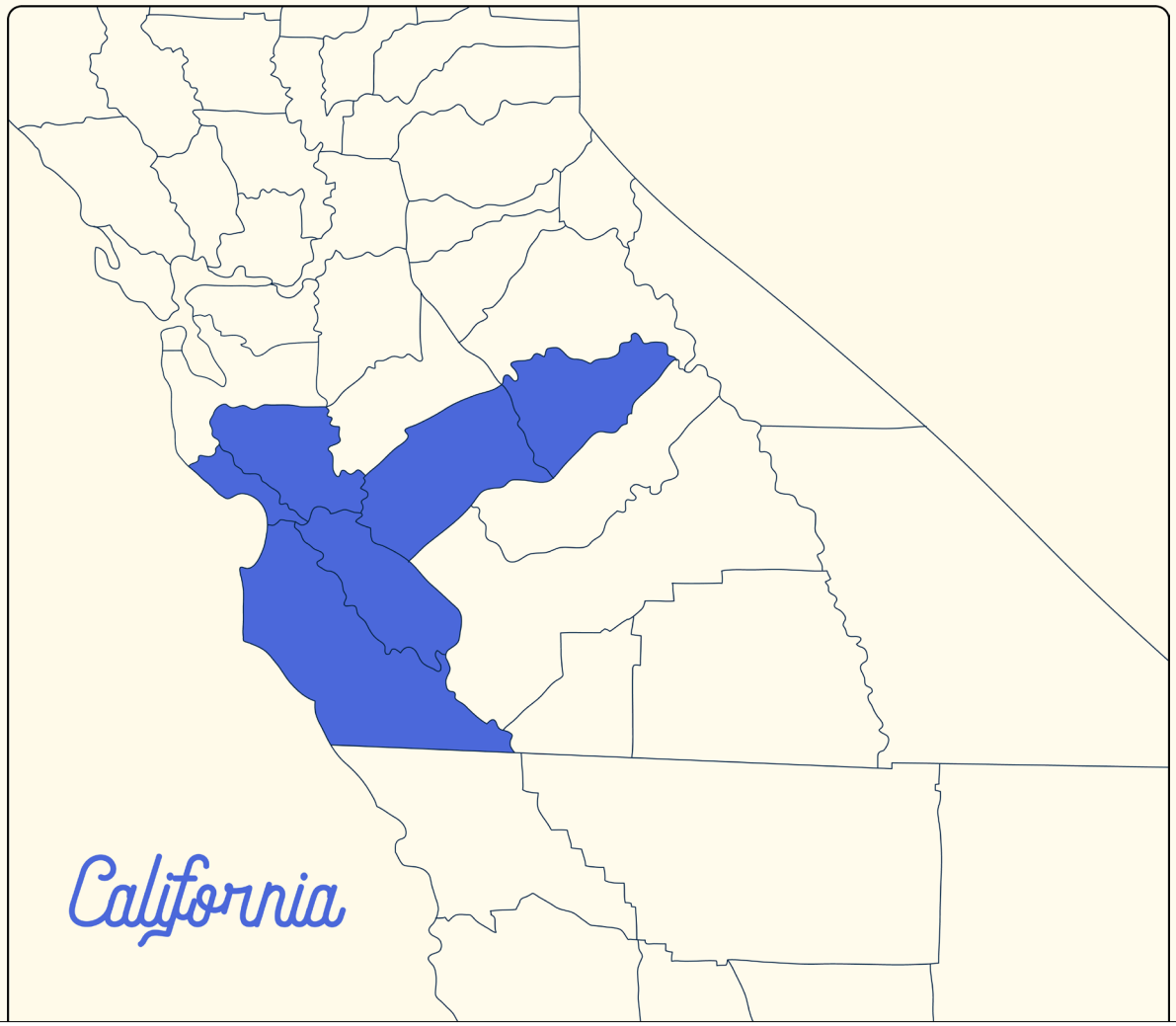
Methodology

Study Design and Timeframe

This report presents findings from a prospective, observational pilot evaluation of Zócalo Health's Community-Anchored Care Model, conducted during fiscal year 2024–2025 (program launch: October 2024). The evaluation was designed to assess early engagement, retention, and clinical outcomes associated with the model. No comparison or control group was included in this pilot phase.

Setting

The pilot was conducted in California's Central Valley and Central Coast, concentrated in rural and semi-urban regions. Core service counties included Merced, Mariposa, Santa Cruz, San Benito, Monterey, and Santa Clara. Latinos make up over 60% of the population in core counties. The coverage area is heavily composed of agricultural and essential workers residing in federally designated Behavioral Health Professional Shortage Areas with limited transportation access.



Geographic distribution of Zócalo Health behavioral health members within California's Central Valley and Central Coast, with the highest concentrations in Merced, Mariposa, Santa Cruz, San Benito, Monterey, and Santa Clara Counties.

Sample Definitions and Inclusion Criteria

The screening sample included 924 adults ages 18 and older enrolled in Medicaid (Medi-Cal) who were screened using standardized behavioral health tools as part of their engagement with Zócalo Health. Of those screened, approximately 230 (25%) met clinical thresholds for depression or anxiety and were identified as the behavioral health cohort. Of those, 188 initiated psychotherapy.

Demographic and social needs data were collected from a subsample of 193 individuals from the behavioral health cohort as part of their program intake.

Measures

The following standardized instruments were used:

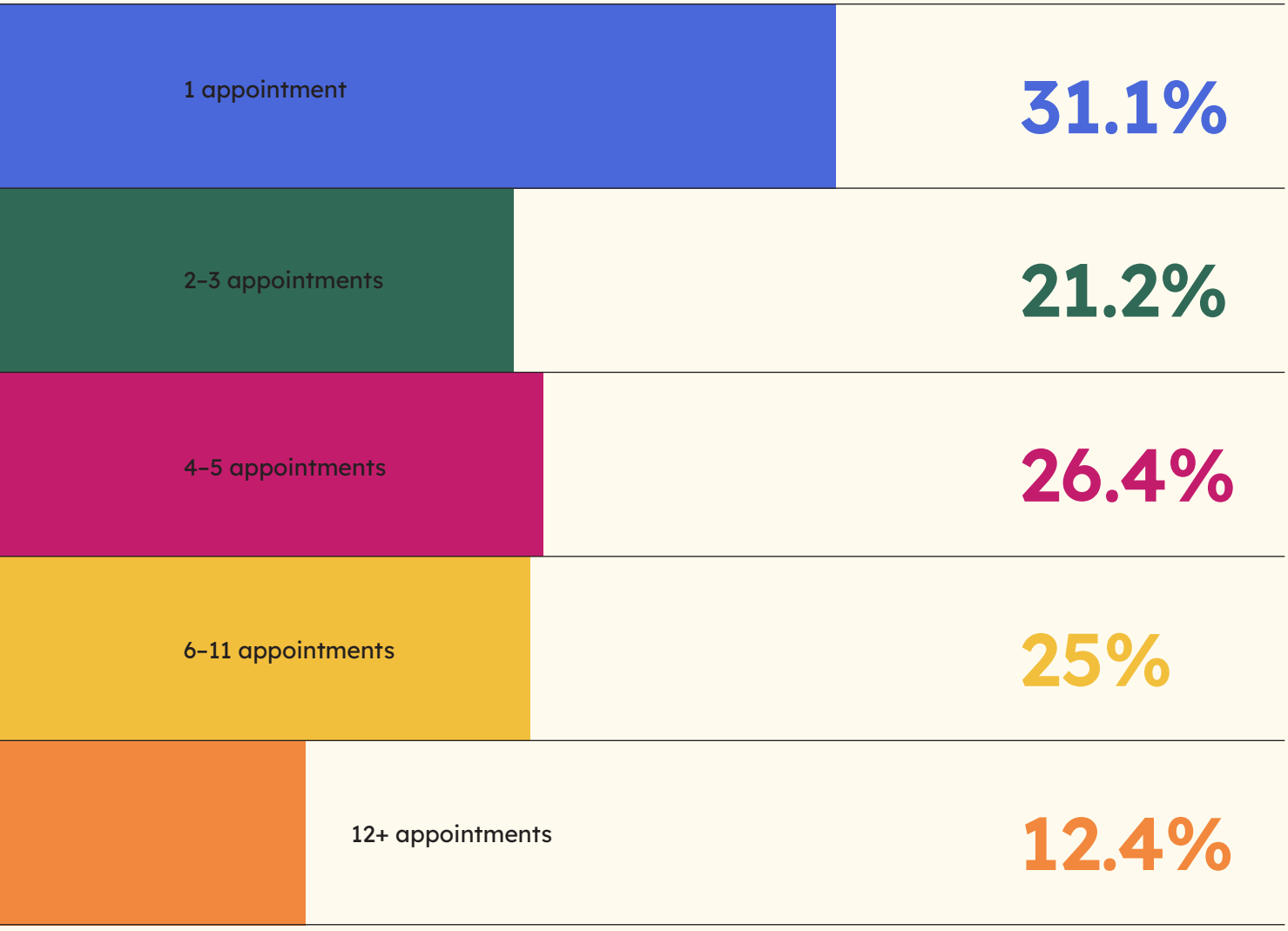
- **PHQ-9 (Patient Health Questionnaire-9)**
  Self-report measure of depressive symptom severity, administered at intake & at regular clinical intervals.

- **GAD-7 (Generalized Anxiety Disorder-7)**
  Self-report measure of anxiety symptom severity, administered at intake & at regular clinical intervals.

- **PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks, & Experiences)**
  Standardized social determinants of health screening tool used to identify unmet social needs at intake.

Adherence Tiers

Treatment engagement was categorized into adherence tiers based on cumulative appointment counts:



Statistical Methods

Descriptive statistics were used to characterize the sample demographics, social needs prevalence, screening outcomes, and engagement patterns. Engagement and retention were assessed by calculating the proportion of individuals who initiated psychotherapy following a positive screen and the distribution of appointment counts across adherence tiers.
Clinical outcomes were evaluated using regression modeling to estimate the association between adherence tier and symptom change. Specifically, ordinal regression models examined whether each incremental increase in adherence tier was associated with reductions in PHQ-9 (depression) and GAD-7 (anxiety) scores. Item-level analyses were conducted to assess changes in specific depressive and anxiety symptoms from baseline (first assessment) through the fourth assessment.

National benchmarks for Latino treatment retention (50% attending two or more appointments) and general population retention (66%) were used as reference comparisons to contextualize engagement findings.

Limitations

This evaluation reflects early findings from a single organization operating within a specific geographic and Medicaid payer context, which may limit generalizability.

Key limitations include:

- Observational design without a comparison group; improvements cannot be causally attributed to the model
- Self-report outcome measures (PHQ-9, GAD-7, PRAPARE) subject to reporting bias
- Short follow-up period; durability of engagement and symptom gains not yet established
- Incomplete follow-up assessment data introducing potential selection effects

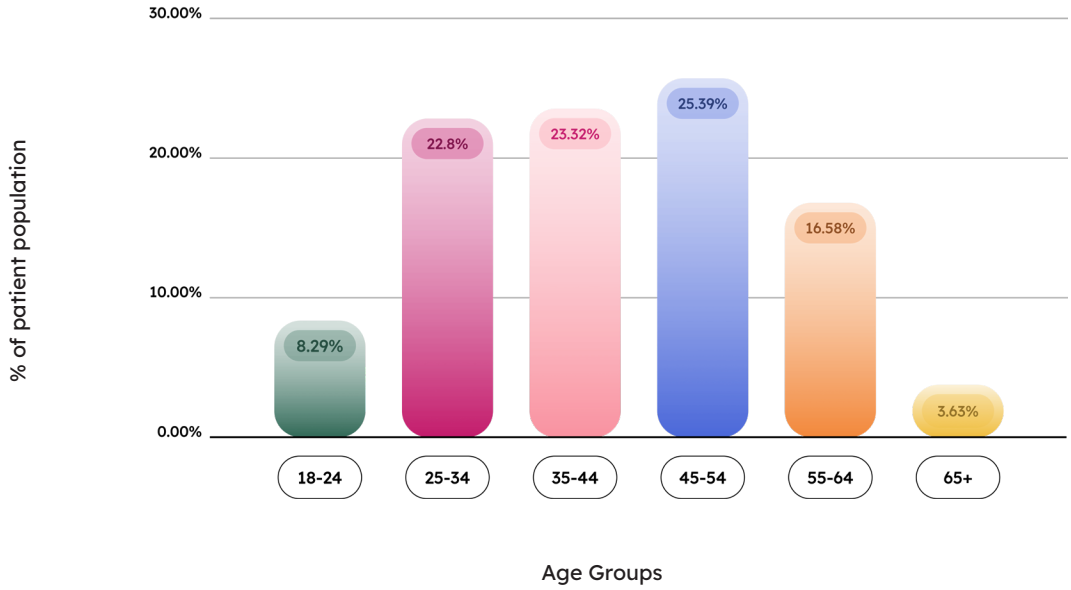
Program Outcomes

Member Profile

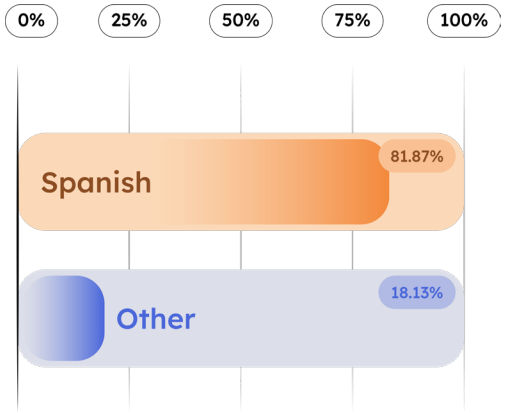
Demographic information was collected from a subsample (N=193) of the approximately 230 individuals screening positive for depression or anxiety as part of their intake into the “Behavioral Health” program. Behavioral health members were primarily female, most (~70%) between the ages of 25 and 54. The vast majority self-identified as Latino or Hispanic, and over half (56.5%) preferred to receive services in Spanish.

Sex Distribution of Behavioral Health Members

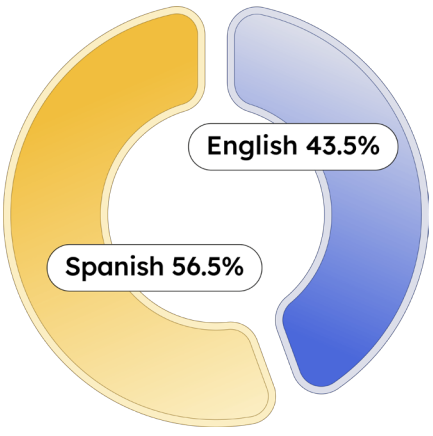
Age Distribution of Behavioral Health Members



Ethnicity Distribution



Preferred Language Distribution



Social Complexity

Among behavioral health members, 72.6% reported one or more unmet social needs. The most frequently reported needs were food insecurity and transportation.

Top Needs:

> ***72.6%*** *reported* ***≥1 unmet social need***
> *Top needs: food insecurity, transportation*

Behavioral Health Needs Identified

Of the approximately 230 individuals who screened positive for depression or anxiety, 188 initiated psychotherapy — a conversion rate of approximately 82%.

Key limitations include:

924	25%	188
screened (18+)	positive screen (n≈230)	Initiated Psychotherapy (~82%)

> *"From positive screen to scheduled care, follow-through was strong: ~82% accepted services and initiated a first visit."*

This reflects strong follow-through from identification to service initiation.
The average depression score (PHQ-9) among Behavioral Health members was 10.3, indicating “moderate depression.” By comparison, the average score in the general population falls between 3-4, indicative of “mild depression.”[7]

The average anxiety score (GAD-7) among Behavioral Health members was 8.9, indicating “mild to moderate anxiety.” By comparison, the average score in the general population is 5-6, indicative of “mild anxiety.”[9]

Engagement & Retention

Among the 188 patients who initiated psychotherapy:

68.9%
attended two or more appointments

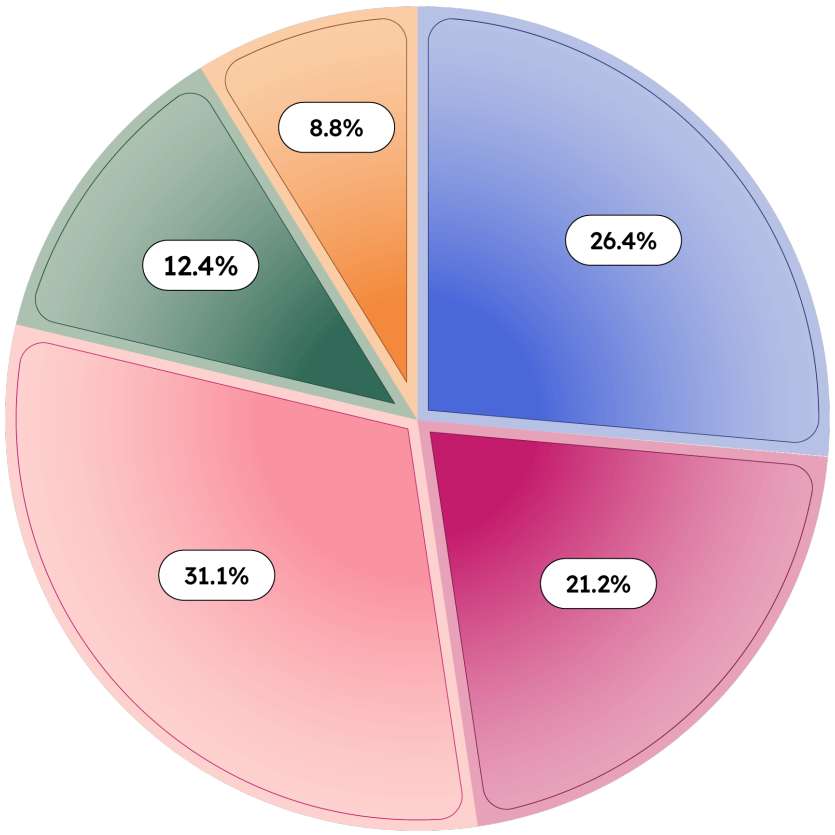
21.2%
completed 3–4 appointments

38.8%
completed 6 or more appointments

21.2% completed 3–4 appointments

38.8% completed 6 or more appointments

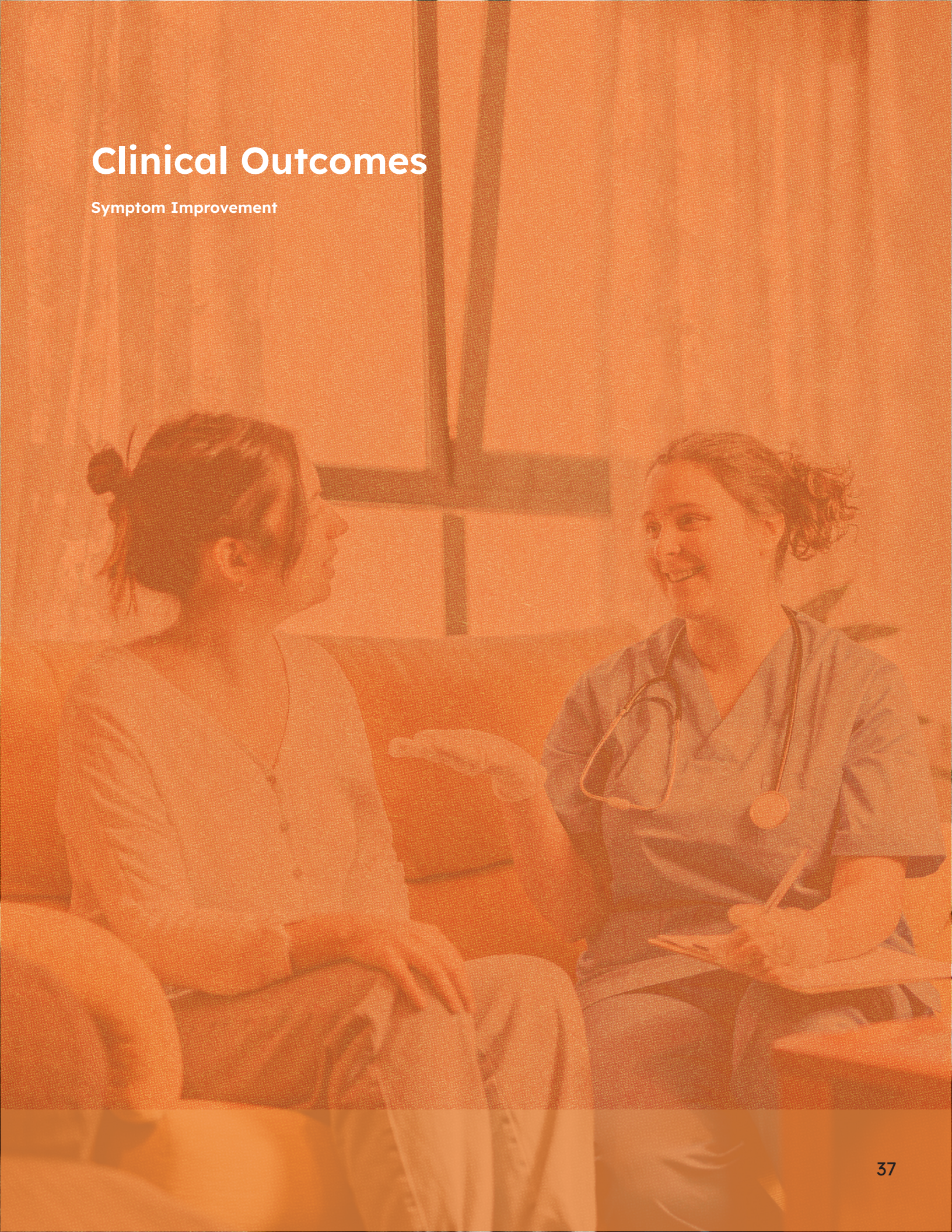
Count of Adherence Tier



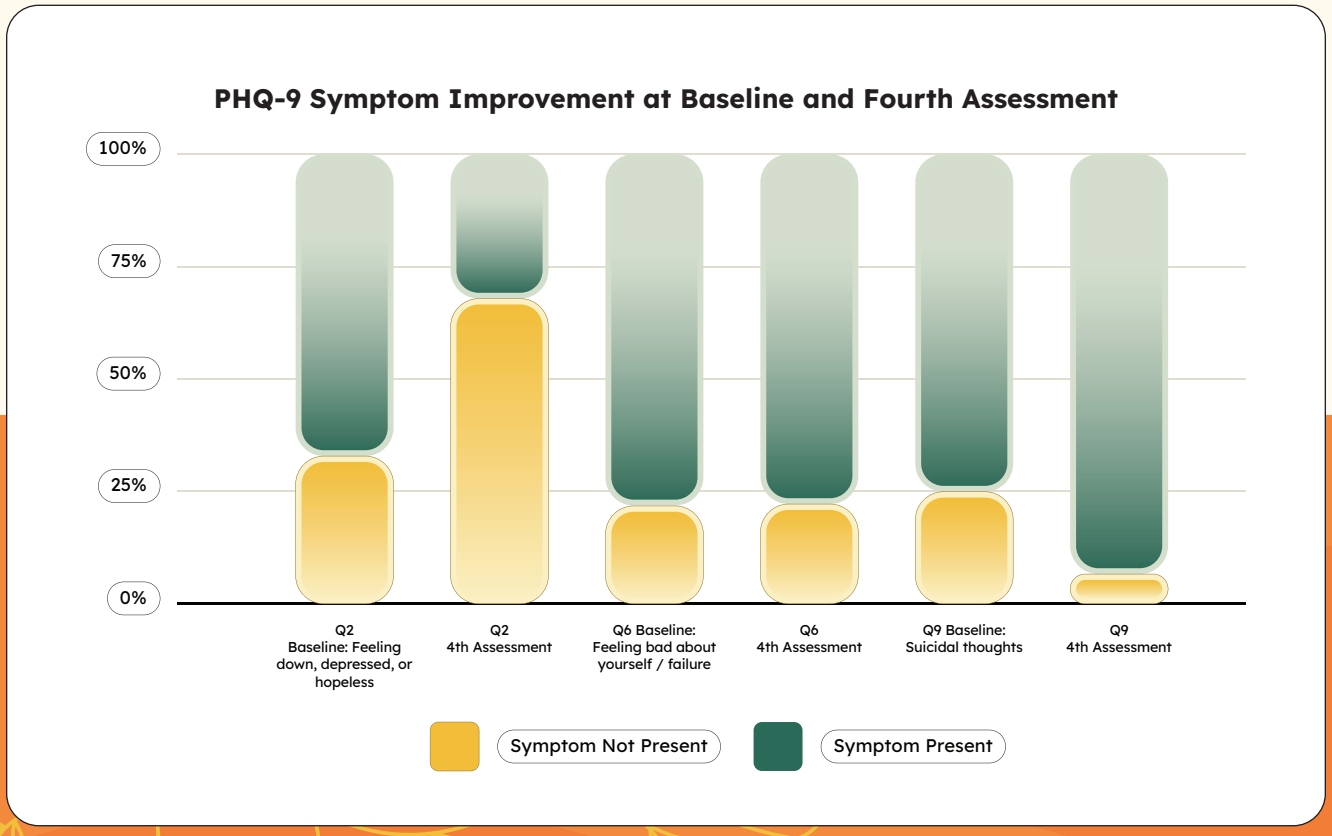
Spanish-speaking and Latino members demonstrated high early engagement (≥2 appointments) and sustained participation (≥6 appointments) —a reversal of national patterns in which these groups typically show lower treatment completion.

Clinical Outcomes

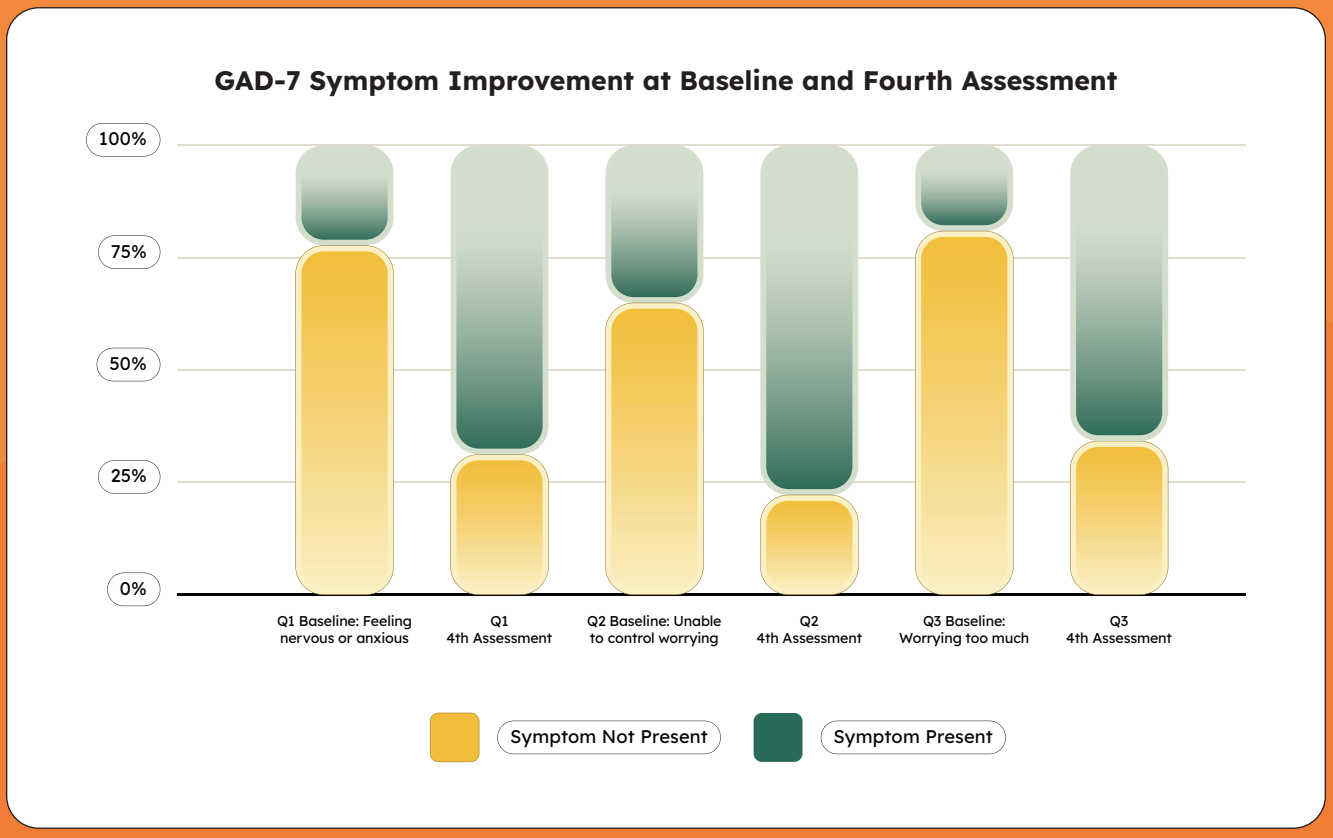
Symptom Improvement



Analyses revealed improvement in core symptoms of depression from the first through the fourth assessment, including low mood (PHQ-9 Item 2), feelings of failure (Item 6), and suicidal ideation.



Evidence also indicates improvement in anxiety symptoms from the first through the fourth assessment, including nervousness (GAD-7 Item 1), difficulty controlling worry (Item 2), and excessive worry (Item 3).



Overall Improvement

Members who sustained greater engagement experienced progressively greater symptom relief. Specifically, for every increase in adherence tier beyond the first visit:

1.23

Point decrease in PHQ-9 score (depressive symptoms)

0.91

Point decrease in GAD-7 score (anxiety symptoms)

Members who sustained engagement through six or more appointments showed clinically meaningful improvements in both depression and anxiety, with greater improvement observed among those with higher appointment counts.

“Treatment continuity mattered: higher engagement was associated with greater symptom improvement.”

Discussion

Implications for Equity,Quality, and Scalability

Behavioral health members entered treatment with moderate depression & mild-to-moderate anxiety, as measured by the PHQ-9 and GAD-7, respectively. The Community-Anchored Care Model yielded substantial case-finding, with over 80% of identified cases converting to active treatment. **The model also supported stronger retention of Latino members in psychotherapy, with over one-third completing a full course of treatment (six or more appointments).**

Item-level analyses demonstrated reductions in core depressive and anxiety symptoms over time, and regression models revealed a clear dose–response pattern: each step up in adherence tier corresponded to additional improvements in both depression and anxiety scores.

Equity Implications: Evidence of Gap Narrowing

The pilot data provide early evidence that culturally centered, bilingual, community-anchored care may effectively reduce long-standing disparities in behavioral health engagement and treatment completion for Latino populations. This finding is significant: national evidence consistently documents lower treatment initiation and completion for Latino and Black Americans.

Zócalo's early data suggest that system design—not population characteristics—may be the primary driver of these disparities.

Policy Alignment

The CMS Innovation in Behavioral Health (IBH) Model, the Rural Health Transformation initiative, and the broader federal emphasis on integrated, measurement-based, equitable behavioral health delivery align closely with Zócalo's approach. Health plans and integrated delivery systems that adopt similar models may be well positioned to meet evolving payment structures and regulatory expectations.

Business Implications: ROI Pathways

These findings support several plausible pathways to return on investment in Medicaid value-based arrangements, to be tested directly in the next evaluation phase:

Crisis Prevention

Proactive engagement and social needs support can reduce crisis escalation and avoidable acute utilization.

Lower Total Cost of Care

Sustained engagement in behavioral health care is associated with lower total cost of care over time.

Care Coordination Efficiency

Integrated care coordination can reduce fragmented care and duplicative services, such as repeated workups for somatic complaints.

Symptom Improvement & Chronic Disease Management

Improved depression and anxiety outcomes can support better medication adherence and self-management, potentially reducing emergency department visits and hospitalizations.

Replicability & Scale

The model uses structured, scalable components: Promotora de Salud teams, standardized measurement, integrated workflows, and a blend of virtual and in-person care. It can be deployed across Medicaid populations in rural and semi-urban areas — particularly those designated as Health Professional Shortage Areas — and in regions with significant Spanish-speaking, low-income, high-need populations.

Looking Ahead: Evaluation Roadmap

Our pilot results are promising, but it is too early to declare victory. Instead, they represent a disciplined starting point for building an evidence base that health plans, regulators, and investors can rely on. The next phase of work is designed to advance two goals in parallel: strengthening confidence in the Community-Anchored Care Model effectiveness and clarifying downstream outcomes that matter to payers and members, including utilization, disease control, and productivity.

Phase 1: Peer-Reviewed Validation

The first phase of this roadmap is a peer-reviewed academic publication that parallels this outcomes paper. This work will elaborate on the theoretical and evidentiary rationale underlying the Community-Anchored Care Model and present a more rigorous analysis of the pilot cohort, examining patterns of engagement, retention, and symptom improvement.

Academic publication provides a high-signal form of validation by ensuring clarity around definitions, methods, and interpretation, while offering independent credibility for payers and partners, distinguishing narrative results from generalizable evidence. Importantly, this process also supports continuous improvement by identifying where engagement or outcomes weaken along the care pathway, enabling earlier and more targeted refinement.

Phase 2: Prospective Evaluation of Downstream Health and Cost Outcomes

The second phase is a one-year prospective evaluation that extends beyond symptom change to assess outcomes relevant to value-based care. Building on the pilot, this evaluation will examine whether sustained engagement, combined with psychotherapy and services addressing social drivers of health, is associated with improvements in chronic disease management, reductions in avoidable hospital utilization, and related functional outcomes.

Prior research suggests that effective psychological interventions for individuals with common mental disorders and chronic conditions are associated with reduced hospital use, supporting the importance of testing these relationships directly in Medicaid populations.[9] This phase is essential for translating clinical engagement gains into outcomes that inform payer decision-making and return-on-investment assessments.

Phase 3: Comparative Effectiveness Across Geographic Contexts

The third phase will assess model performance across rural, suburban, and urban settings to determine where operational adaptations are needed to achieve consistent engagement and outcomes. Analyses will focus on workforce configuration, outreach strategies, modality balance, and community partnerships.

This work is timely given the substantial federal investment in rural health delivery infrastructure. CMS has directed significant resources toward rural health transformation, emphasizing models that improve access, reduce fragmentation, and support continuity in resource-limited settings. Pilot findings suggest the Community-Anchored Care Model may be particularly well suited to these environments by reducing the navigation burden and supporting retention despite the scarcity of specialty providers. Demonstrating effectiveness across diverse contexts will strengthen the case for responsible expansion and partnership with states, health plans, and rural delivery systems.

Conclusion

Latino communities carry high burdens of depression and anxiety yet remain systematically underidentified and undertreated due to persistent language, cultural, geographic, and structural barriers. Fragmented healthcare delivery and standard clinical processes alone are insufficient to overcome these challenges.

Zócalo Health's Community-Anchored Care Model — grounded in community partnership, cultural competence, integrated care coordination, and measurement-based practice — demonstrates early evidence of meaningful engagement gains and symptom improvement that run counter to national disparities.

For health plans and healthcare systems committed to behavioral health equity, improved population health, and economic efficiency in high-need populations, this model offers a replicable, evidence-informed approach.

The opportunity is clear: investing in culturally designed, integrated behavioral health care is not only an equity imperative but an economically sound strategy aligned with federal policy direction.

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