Attachment F

CENTER FOR APPLIED RESEARCH & ANALYSIS

New Mexico Older Adult Needs Assessment

Prepared by:
Keith Wilkins, M.A.
Aaron Lenihan, Ph.D.
Paul Guerin, Ph.D.

Prepared for:
N.M. Aging & Long-Term Services Department

UNIVERSITY OF NEW MEXICO, CENTER FOR APPLIED RESEARCH & ANALYSIS
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EXECUTIVE SUMMARY

PURPOSE

The Center for Applied Research and Analysis (CARA) at the University of New Mexico's Institute for Social Research (ISR) was contracted from FY23 – 24 by the New Mexico Aging & Long-Term Services Department to conduct a statewide mixed methods needs assessment with attention to service gaps in rural and frontier communities.

METHODS

Our mixed methods needs assessment analyzed data from:

- Five focus groups (n = 45) with older adult participants in two urban and three rural New Mexico communities.
- Two statewide surveys of service providers which captured their perception of older adult need (n = 71) and their organizations' business and financial health (n = 64).
- U.S. Census American Community Survey (ACS) data for 2013 – 2017 and 2018 – 2022 5-year estimates to identify trends in New Mexico's older adult population.
- WellSky/SAMS consumer data to report on the distribution of Title III services across the state and by Planning & Service Area (PSA).
- Limited aggregate data on Adult Protective Services (APS), the Long-Term Care Ombudsman Program, and the Consumer and Elder Rights Division (CERD).

FINDINGS

1. New Mexico's older adult population has grown significantly and so have several metrics of vulnerability (Poverty, Disability, etc.)

Our comparison of U.S. Census American Community Survey (ACS) 5-year estimates for 2013 -2017 and 2018 – 2022 periods revealed that the 60 and older population in New Mexico has grown by an estimated 125,524 people, with significant increases in the total number of those: with any disability, with household incomes less than 200% of poverty, living alone, living alone and renting, dual Medicare & Medicaid recipients, SNAP recipients, and who are working. Overall, it will be necessary for the state to strategically plan for a significantly growing older adult population with increasing need for financial assistance and social supports.

2. Older adults in rural areas describe service deserts with high need for transportation assistance and access to medical supportive services like dental, vision, and hearing

Older adults in urban and rural areas who participated in our focus groups expressed similar types of supportive service needs (transportation, senior center activities, information support, etc.), but those from rural and frontier communities emphasized limited or non-existent supports, while those from urban areas highlighted the need to improve accessibility of resources. Both community types described need for services to recover from the COVID-19 pandemic – both in terms of resolving lingering public health fears and renewing opportunities to socialize and remain active at local senior centers. Future research should attempt to understand service needs among a representative sample of older adults to understand whether focus group thematic findings apply broadly.

3. Providers identified similar needs to older adult focus group participants

Most providers (84%) agreed that an important barrier to meeting older adult need is that providers do not offer enough services. They identified several services which overlapped neatly with services identified by focus group participants:

- Access to specialized medical and primary supportive care
- Mental health care
- After-hours public transportation options
- Transportation to store
- Assisted transportation
- Medicare/Medicaid information support
- Digital training/technology assistance
- Affordable senior housing options

4. Providers report funding, personnel, and training as critical barriers

Providers indicated in statewide surveys that the most significant barriers to expanding existing services or developing new ones was funding, available personnel, and training support. The majority of providers (78%) also reported challenges recruiting employees to provide direct services, emphasizing robust need to address workforce shortages and assist provider training to support obtaining available funding, providing customer service, and meeting the service demands of a growing population of older adults.

5. Consumer data highlight need for targeted service expansion to address service gaps

Consumer data show service needs vary by PSA considerably and that nearly all PSAs have service gaps relative to others. Policy decision-makers should consider local needs by service category when determining which to expand or develop. For example, PSA 6 – Tribes, Pueblos, and Nations – provides the highest number of services per average consumer for most services but have not offered *Health Promotion & Disease Prevention services* since FY19. Alternatively, despite the size of PSA 1 – Bernalillo County – in FY23 it provided the fewest total units of Access services as well as the fewest average units per 55+ consumer population.

6. Rural and urban vulnerabilities differ, but service gaps remain unclear

Our review of U.S. Census data show that urban areas account for most vulnerable older adults in the state for metrics we reviewed. The population of these older adults has also significantly grown for those in urban areas:

- With household incomes less than 200% of poverty
- Who receive SNAP benefits
- With any disability
- Who live alone
- Who live alone and rent their housing
- Who are dual coverage Medicare& Medicaid recipients

However, the proportion of older adults with vulnerabilities is higher in rural areas for older adult populations:

- With any disability
- Who live alone
- Who are dual Medicare & Medicaid recipients
- Who are grandparents responsible for raising grandchildren with household income below poverty

What remains to be seen is whether service provision and availability is different in rural and urban communities. Our analyses of consumer data were limited to PSA-level and county aggregates which limited our ability to identify what service gaps exist by community or provider. Future analyses might compile consumer-level WellSky data alongside a community-level inventory of services and costs to understand local needs.

RECOMMENDATIONS

1. Expand Services to Support Unmet Older Adult Needs: *Community Supports*, *Caregiver Support*, *In-Home Services*, *Health Promotion & Disease Prevention, Transportation,* and *Legal Services*

- Expand and/or develop services identified by older adults and providers as not currently meeting older adults' needs: community supports, caregiver support, in-home services, health promotion and disease prevention, transportation, and legal services.
- Prioritize services and resources that support a growing population of older adults in poverty, with physical disabilities, who live alone and/or rent, require nutritional support/benefits, and who also work into older adulthood.

2. Strategic Planning and Targeted Service Expansion

- Plan for a growing older adult population with increasing need for financial support/benefits, transportation assistance, nutritional support/benefits, and community supports to enhance socialization and social networking.
- Develop a service expansion strategy that considers each service category individually, focusing on local needs and deficits – e.g., rural/frontier community vs. urban area, vs. tribes, pueblos, and nations, and Navajo Nation.
- Prioritize communities with fewer total service units and lower service provision per 55+ population, avoiding a one-size-fits-all approach.

3. Improve Outreach and Centralized Information Supports

- Develop a more centralized and accessible non-digital information system that caters to older adults in both rural and urban areas.
- Emphasize local language resources and create "one-stop" information hubs at senior centers.

4. Address Workforce Shortages with Focused Recruitment and Training

- Implement recruitment initiatives for personnel in key services areas.
- Offer training programs to enhance service providers' skills in customer service, financial management, and health promotion.

5. Conduct Statewide Services Inventory

- Compile New Mexico ALTSD provider contracts and analyze the distribution of services by county to identify gaps.
- Compare service provision/availability to estimates of the consumer population.
- Consider cost-benefit of services in rural versus urban areas, factoring in service costs and geographic variations and need.

6. Implement Statewide Consumer Survey

- Develop and deploy a short (10 – 20 question) survey on ALTSD service use and needs among a representative sample of consumers, with a particular focus on those not accessing senior centers and adults with disabilities.

SUPPORTING DATA AND JUSTIFICATIONS

1. Expand Services to Support Unmet Older Adult Needs: *Community Supports*, *Caregiver Support*, *In-Home Services*, *Health Promotion & Disease Prevention, Transportation,* and *Legal Services*

Justification:

- **Provider Survey (Part A):**
  - Over 80% of providers indicated more services are needed to meet older adults' needs. Specific service gaps include health promotion and disease prevention (26%), in-home services (35%), caregiver support (37%), and legal services (51%). Providers also noted high need for meal, in-home, access, community, and caregiver support services, with over 80% agreeing that every service category reflected high demand.
- **Provider Survey (Part B):**
  - Providers strongly supported expanding transportation (96.7%), physical fitness programs and senior center activities (76.9%), meal (65.4%) and in-home (65.4%) services. Providers also expressed interest in expanding caregiver support (61.5%) and Health Promotion & Disease Prevention (61.5%), with Legal Assistance services identified as a lesser priority (57.7%).
- **WellSky/SAMS Consumer Data:**
  - Service provision declined during the COVID-19 pandemic, with Health Promotion & Disease Prevention services minimally provided in many PSAs and entirely absent in PSA 6 since FY19. Caregiver support is low in PSAs 3 and 6. In-Home support is least provided in PSAs 1 and 3, with PSAs 1, 2, and 3 providing the least amount of services per eligible 55+ population. However, congregate and home delivered meals, which account for 69% of all Title III services ALTSD provided in FY23, increased post-pandemic, with minimal unmet need in this service category as indicated by surveyed providers.
- **U.S. Census Data:**
  - In FY23 ALTSD provided services to 52,838 unique consumers, contrasting with the large population estimates for adults 65+ with any disability (144,779 people), with household incomes less than 200% of poverty (123,082), dual Medicare & Medicaid recipients (40,988) and who receive SNAP benefits (49,709). These figures have significantly increased from 2017 to 2022 5-year estimates.

2. Strategic Planning and Targeted Service Expansion

Justification:

- **U.S. Census Data:**
  - **Statewide Growth in 60+ Population and Economic Vulnerability:** U.S. Census data indicate the older adult (60+) population has grown by more than 125,000 people since 2012. Economic vulnerability among older adults has steadily increased across New Mexico too. The

percentage of older adults living below the poverty line and those reliant on SNAP benefits has grown. The statewide poverty rate for adults 65+ has increased to 12.2%, and the share of older adults receiving SNAP benefits now stands at an estimated 16.4%.
    - **Disability and Healthcare Needs:** Statewide data suggest substantial need for healthcare and disability-related services. Approximately 38% of adults 65+ live with a disability in New Mexico, with estimates higher for rural areas (44.2%). The population of dual Medicare and Medicaid recipients has also significantly risen to 40,988 older adults (65+) in 2022.
- **WellSky/SAMS Consumer Data:**
    - **PSA 6:** Despite high services levels per 55+ consumer, key services like Health Promotion & Disease Prevention have not been provided since FY19, highlighting the need for targeted service expansion.
    - **PSAs 3, 4, and 6:** These PSAs report low in-home support and community services both in terms of total volume and per 55+ consumer population; essential in rural areas for maintaining independence.
    - **PSA 1 (Bernalillo County):** Access services are the lowest in this urban PSA, which also has the lowest service provision per 55+ consumer population despite its large population base. This indicates need for urban-focused service expansion as well.

3. Address Workforce Shortages with Focused Recruitment and Training

Justification:

- **Statewide Provider Survey (Part A):** 78% of providers reported difficulty recruiting staff for direct services, which impacts ability to expand services like caregiving and in-home support.
- **Statewide Provider Survey (Part B):** 68.7% of providers highlighted the need for training programs, particularly in customer service, health programming, and financial management. This suggests workforce development should focus not only on recruitment but also improving skills to meet service demands.

4. Conduct Statewide Older Adult Services Inventory

Justification:

- **Focus Groups:** Rural area residents reported limited or eliminated services, while urban participants noted accessibility challenges. This discrepancy highlights a need for a comprehensive county-level inventory of services.
- **WellSky/SAMS Consumer Data:** Consumer data by PSA obscured service disparities between counties. A county-level inventory would allow a detailed understanding of service gaps and how resources can more effectively be distributed, particularly in rural PSAs where transportation and in-home services are of high-need.
- **U.S. Census Data:** Comparing vulnerable population estimates (poverty, disability) to registered recipients would reveal underserved older adults but requires consumer-level data by service provider.

5. Implement Statewide Older Adult Consumer Survey

Justification:

- **Focus Groups:** Existing focus group data are limited to older adults who participate in senior centers and may not reflect the broader older adult population, especially adults with disabilities. We therefore recommend specific attention to those populations in a representative survey of New Mexico's older adults.
- **Understanding Unmet Needs:** A statewide representative survey would help identify service gaps, particularly among homebound older adults and those with disabilities who are underrepresented in existing data.

INTRODUCTION

Created in 2004 by the New Mexico State Legislature, the mission of the Aging & Long-Term Services Department (ALTSD) is:

> To provide accessible, integrated services to older adults, adults with disabilities, and caregivers to help them maintain independence, dignity, autonomy, health, safety, and economic well-being, empowering them to live on their own terms in their own communities productively as possible.

The Aging & Long-Term Services Department is the primary department responsible for serving New Mexico's older adults, adults with disabilities, their families, and caregivers. To meet this mission, the ALTSD provides an assortment of services through the Aging Network Division, Adult Protective Services, the Consumer and Elder Rights Division, and Long-Term Care Ombudsman Program. The Aging Network Division (AND) provides a variety of services to seniors, including meals and nutrition, employment programs, transportation, help at home (i.e., respite and home-health care), senior centers where older adults can receive a variety of services (i.e., meals and social/recreational activities), and healthy aging and prevention programs. The Adult Protective Services Division (APS) provides protective services to individuals 18 years and older who are unable to protect themselves from abuse, neglect, or exploitation. Services include emergency protective placement, home care, adult daycare, attendant care, and filing of guardianship petitions in district courts. Through the Consumer and Elder Rights Division, the ALTSD provides disability resource services, counseling, a veteran directed home and community-based services program, the state health insurance program, the senior Medicare patrol, a care transitions program, and a prescription drug assistance program. And finally, the Long-Term Care Ombudsman Program advocates for older adults and adults with disabilities living in long-term care and nursing facilities by supporting individuals, their families, friends, and caregivers through the complaints processes and investigating complaints.

The Older Americans Act (OAA) is the primary federal program tasked with the organization and delivery of social and nutrition services to the elderly population and their caregivers. It authorizes a wide array of service programs through a national network of 56 state agencies on aging, 629 area agencies on aging, nearly 20,000 service providers, 244 Tribal organizations, and 2 Native Hawaiian organizations representing 400 Tribes. The OAA also includes support for community service employment for low-income older Americans; training, research, and demonstration activities in the field of aging; and vulnerable elder rights protection activities.

The State of New Mexico, via the federal OAA, receives funding provided by Congress for services based on a formula that considers the state's proportionate share of either the age 60 or older population or, in the case of caregiver support programs, the age 70 or older population. New Mexico, like all other states, has its own formula for allocating OAA funding to Area Agencies on Aging (AAAs), which enables the delivery of services to local areas.

New Mexico contains two AAAs and six Planning and Service Areas (PSAs). The Metro AAA is a joint powers agreement between Bernalillo County, the City of Albuquerque, and Los Ranchos de Albuquerque and oversees PSA 1, which is Bernalillo County. The non-Metro AAA includes the remainder of the state and encompasses PSA 2, PSA 3, and PSA 4. PSA 5 serves the Navajo Nation and is a tribal government-sponsored organization that includes areas in New Mexico, Arizona, and Utah. PSA 6 is the Indian Area Agency on Aging (IAAA) and includes the State’s 19 pueblos, the Mescalero Apache Tribe, and Jicarilla Apache Tribe.

Our Work

The Center for Applied Research and Analysis (CARA) located at the University of New Mexico's Institute for Social Research (ISR), previously completed a pilot needs assessment for ALTSD in June 2020. We initially reviewed the literature on needs assessments to determine best practices and assess feasibility of a full needs assessment for the following fiscal year. The COVID-19 pandemic interrupted planned focus groups with older adults, but we were able to review consumer WellSky data on senior services usage, conduct a statewide provider survey, and provide preliminary findings from limited observations and one focus group with providers. We ultimately concluded mixed method needs assessments were recommended by the literature and they tend to incorporate three primary data sources: (1) focus groups with targeted older adult populations, (2) surveys of provider input, and (3) analysis of U.S. Census data on the scope of older adult need, especially with attention to national comparisons.

CARA was subsequently contracted to collaborate with ALTSD to develop a biennial statewide needs assessment in Fiscal Year 2023 that prioritizes rural and frontier communities, and addresses services provided by the AND in New Mexico. This report documents our findings on New Mexico's older adult population. We report on the implementation of a mixed methods approach to assess services provided to and received by New Mexico older adults, and to understand the specific needs of older adults living in rural and frontier communities.

The scope of work included five tasks:

- Review available literature related to needs assessment for similar type populations to provide a review of the current state of knowledge and best practices.
- Organize and lead community focus groups with service providers and community members – to study current processes and practices related to the ALTSD mission, with an emphasis on service delivery, population demography, population needs (e.g., health, social issues, outreach, transportation, food insecurity, housing, etc.), gaps in services, resources, and supervision as well as any other identified area.
- Administer surveys and/or stakeholder interviews to receive feedback and identify needs and gaps in services.
- Analysis of WellSky/SAMS consumer data
- Analysis of U.S. Census Bureau data

This work is important for a few reasons. First, in our review of existing needs assessments, high quality assessments attempted to explore service gaps and needs through a variety of methods which included both older adults and service providers. Second, needs assessments are often used to comply with the OAA which requires State Units on Aging (SUAs) to conduct a needs assessment to guide state plans on aging. Third, this needs assessment is designed to explore the specific needs of seniors in rural and frontier communities – a focus which is unique and largely unexplored among needs assessments.

We specifically planned to conduct focus groups with older adults in two urban and five highly-rural New Mexico counties: (1) Bernalillo, (2) Santa Fe, (3) Catron, (4) De Baca, (5) McKinley, (6) Mora, and (7) Union County. Ultimately, we conducted focus groups in five of those counties. Two counties in particular – Catron and De Baca – were unable to accumulate enough local interest among older adults to achieve minimum participation. As we describe in our methods

Table 1

County population statistics for planned focus groups

County Site	PSA	Population	Percent Rural	Percent 65 or older living below poverty	Percent 65 or older living with a disability
Bernalillo	1	671,534	4.2%	11.0%	36.0%
Santa Fe	2	148,639	25.2%	9.0%	26.0%
McKinley	2	71,477	57.4%	24.0%	53.0%
Mora	2	4,500	100.0%	18.0%	40.0%
De Baca	3	1,974	100.0%	22.0%	57.0%
Union	3	3,475	100.0%	22.0%	41.0%
Catron	4	3,542	100.0%	13.0%	52.0%

Note. U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates.

section later in this report, we renewed interest in rural focus groups by incentivizing older adults in rural and frontier communities with cash payments. This shift in method was very successful, but due to time constraints, focus groups for Catron and De Baca counties were not completed. Others might consider a similar cash-incentive strategy to improve efforts to obtain rural and frontier community input.

We selected seven local New Mexico sites based on three factors: (1) percent rurality, (2) percent of older adults 65 and older who have incomes below poverty, and (3) percent of older adults 65 and older living with a disability. **Table 1** above summarizes U.S. Census data for selected focus group sites. Five of our selected sites are designated over 50% rural by the U.S. Census, and two of our sites are considered urban, with less than 30% rurality. Highly rural areas, unsurprisingly, contain the largest proportions of older adults (65 or older) who live below poverty and/or live with a disability. The average percentage of seniors who live below poverty for rural and urban areas is 19.8% and 10%, respectively. The average percentage of seniors who live with a disability for rural and urban sites is 48.6% and 31%, respectively.

While several studies and reviews of rural-urban divides exist, to our knowledge this needs assessment is the first of its kind to specifically explore the needs of rural and frontier communities. Our aim is to understand how needs vary across rural and frontier community contexts and we believe this type of assessment can provide vital details for informed decision-making. To achieve that aim, we have conducted a provider-based survey to review services offered, and to assess provider-level perceptions of older adult need and service improvements. Additionally, we analyze consumer data and statewide U.S. Census data by county (when possible) and present the aggregated results by PSA. Our review investigates the broader differences among rural and urban older adult New Mexicans and situates focus group and survey data within the broader statewide context.

This report contains several sections. Following our introduction, we review relevant literature that captures needs assessment methodologies and extant knowledge regarding older adult needs in rural and/or frontier communities. The literature review is followed by a methodology section where we describe how we completed our work. We also provide a brief description on the limitations of our findings and methodologies. The main body of this report is devoted to the results of our rural and urban focus groups, a statewide survey with Aging Network Division (AND) providers, U.S. Census data trends, WellSky/SAMS consumer data analysis, and a second statewide provider business health survey. We additionally include a limited review of internal performance summary and aggregated data for Adult Protective Services (APS), the Consumer and Elder Rights Division (CERD), and the Long-Term Care Ombudsman program. We conclude this report with a discussion on the take-away for each section, along with a conclusion that synthesizes a broader narrative on older adult need in the state. Our recommendations for addressing service gaps and planning future needs assessments are located at the beginning of this report following our Executive Summary.

LITERATURE REVIEW

Needs Assessments & Older Adult Needs

The Older Americans Act (OAA) requires that State Units on Aging (SUA) conduct Needs Assessments that "determine the extent of need for supportive services, nutrition services, and multipurpose senior centers…[and] evaluate the effectiveness of the use of resources in meeting needs" (Older Americans Act Of 1965, 2020, p. Sec. 306 No.1). In 2000, needs assessments were also expanded to address the need for caregiver services as well (Kietzman, Scharlack, & Santo 2004). Ideally, these assessments guide the regional and state administrative planning and funding of older adult services. OAA needs assessments are largely the responsibility of Area Agencies on Aging (AAAs) but should be coordinated with SUAs who are required to base their own state plans on AAA area plans (Older Americans Act of 1965: Sec 307(a)). However, the OAA lacks a detailed procedure about how need assessments should be carried out. Outside of instructions for SUAs and AAAs to submit area plans and state plans on two-, three-, or four-year cycles (determined by State Agencies), the OAA fails to provide a prescription for how frequently need assessments should be administered. This means AAAs can technically reuse their assessments for decades at a time (Thompson, 2012).

Current or recent literature on needs assessments is limited, especially with respect to any recent systematic reviews of how these official documents compare or contrast by SUA or local government sponsors. The most recent reviews are at this point are over 30 years old. However, broadness in methods and objectives among needs assessments is documented (Cheung, 1992) and indicates wide variation in how SUA's and AAA's have approached needs

Table 2

Reviewed Needs Assessments & Methodologies, 2012 – 2021

Location	Level	Year	Survey	Census Data	Focus Groups
South Dakota	City	2012	Yes	Yes	Yes
Idaho	State	2012	Yes	No	No
Colorado	City	2015	Yes	Yes	Yes
Maryland	County	2015	No	Yes	No
Washington, D.C.	State	2016	Yes	Yes	Yes
Oregon	County	2016	Yes	Yes	Yes
Maryland	City	2016	Yes	Yes	Yes
Massachusetts	County	2017	Yes	Yes	Yes
Colorado	State	2018	Yes	No	No
Maine	State	2019	Yes	Yes	Yes
Florida	State	2021	Yes	No	No
Illinois	Region	2021	Yes	No	Yes

assessments. Such variation is of deep concern for SUAs and AAAs. Lareau and Heumann (1982) conducted a national survey of needs assessments and found that more than half of all assessments suffer from severe methodological shortcomings that undermine reliable policy planning. Most assessments continue to remain largely unfocused about how to measure older adult need, and significant variation exists in the services they review, the methodologies they employ, and the people they sample. Generally, needs assessments and academic literature capture a single broad imperative — to identify which existing service categories (e.g., meals, transportation, in-home services, etc.) older adults need or use most.

We have organized our summary here according to two topical areas: (1) needs assessments methodologies and findings broadly, and (2) a specific attention to the rural-urban divide as it relates to older adult needs. We conclude our literature review with a short justification for the methods employed by our needs assessment. Importantly, our review of the literature is not exhaustive. For reasons of practicality our literature is constrained to publications that populated in Google, Google Scholar, and Web of Science searches for key terms, such as: needs assessments, older adult needs, rural seniors, and rural older adult needs assessments.

Mixed Method Needs Assessments

Needs assessments we reviewed often deployed mixed methods to determine older adult needs in their communities. **Table 2** summarizes key information about needs assessments we reviewed. Most needs assessments we reviewed were constrained to local contexts (regions, cities, counties, etc.).

Four of the needs assessments we reviewed captured all Area Agencies on Aging (AAA) in their state—Florida, Maine, Idaho, and Colorado (Department of Elder Affairs - State of Florida, 2021; Edris et al., 2020; Fife & Hannah, 2012; National Research Center, Inc. & Colorado Association of Area Agencies on Aging, 2018). With one exception, mixed method assessments we reviewed analyzed data pertaining to three kinds of sources: U.S. Census data, surveys, and focus groups. Assessments less commonly incorporated other methods as well, such as: stakeholder interviews, community resource inventories, reviews/summaries of government documents and procedures, and more rarely, 'fact-finding missions'.

A Maine 2020 needs assessment serves as a recent and comprehensive example of what a mixed method needs assessment can look like. The Maine Office of Aging and Disability Services employed the University of Southern Maine's Muskie School of Public Service to identify:

(1) Community assets and existing services valued by constituents
(2) Service and support needs and gaps in service delivery
(3) Barriers impacting access to services

To accomplish those objectives, evaluators reviewed six sources of data: U.S. Census data; a statewide survey of consumers through mail, online, and telephone formats; eight focus groups with older adults and caregivers; an online caregiver-specific survey; three group provider interviews; and three focus groups with minority specific populations – LGBT older adults, older adult refugees or immigrants, and older adults providing kinship care (Edris et al., 2020, p. 16). Altogether, each data source reinforced findings with in-depth qualitative data, and provided contextual insight to survey results and population trends.

In a cogent example, transportation was identified as a pressing need by all data sources in the Maine needs assessment. Statewide survey results found older adults were overwhelmingly driving on their own, despite citing transportation as a critical need in the face of limited-service availability. In combination with listening session results and caregiver surveys, evaluators found older adults broadly experience challenges accessing critical needs like "…food, medications, health care, and social activity" (2020, p. 81). Therefore, transportation needs were interrelated to other needs, and affected caregivers' wellbeing, who provide transportation for those they care for; physical health, because primary care is largely inaccessible for those who are unable to drive; and socialization, since access to social activities is severely limited without available transportation assistance. In sum, mixed methods needs assessments can reinforce findings and tell a vivid story about why needs occur, not just that they exist.

The District of Columbia Office on Aging (DCOA) similarly deployed a mixed method needs assessment to address significantly outdated information on older adult need. Prior to the Washington D.C. needs assessment in 2012, the only other comprehensive review of older adult needs completed by the locality had been conducted 34 years before in 1978. As they write in their report, "*Many of DCOA's present programs and services were developed as a result of that assessment. The senior population has changed since 1978, and today's seniors have a different level of engagement than seniors of the past*" (Thompson, 2012, p. 5). With an imperative to overhaul their needs assessments, the DCOA employed several methods to assess their community, which included, (1) Key informant interviews, (2) senior citizen focus groups, (3) long-form surveys at predetermined sites, (4) short-form surveys through telephone and mail, and (5) a comprehensive inventory of providers and services throughout D.C. Overall, the DCOA surveyed 14 areas of older adult need which included (but was not limited to): Quality of life, socialization, case management, home-delivered meals, and congregate meals. Ultimately, Maine and DCOA's assessments highlight how needs assessments should deploy multiple methods over time, with specific attention to: (1) consistent inclusion of minority older adult populations, and (2) implement high quality focus groups.

In contrast to most assessments, the Maine and DCOA reports afford special attention to vulnerable and underrepresented populations. However, not all needs assessments implement focus groups with underserved populations, or in ways that provide rich details about those populations. The needs assessment for Lane County Oregon (Lane Council of Governments 2016) serves as an example of how focus groups are not always implemented with fidelity. Specifically, focus group input was summarized by researchers without attention to the words and voice of participants. Focus groups were instead implemented more like surveys – a problem common to many studies. Focus group data also lacked details on the needs of the specific populations they were interested in (Cyr, 2015, p. 234). The Oregon needs assessment attempted to develop insight on traditionally underserved groups in their community: LGBT older adults, veterans, homeless older adults, and indigenous peoples. Notably, this assessment is also one of only three needs assessments we reviewed to incorporate the perspectives of Native American elders. But despite their inclusion of unique perspectives, details on older adult need were scarce. For example, Lane County's LGBTQI focus groups highlighted how the primary needs expressed by their participants were "…concern[s] that end-of-life choices will not be honored or that a spouse will not be recognized" and "lifestyle and life choices will not be honored or understood" at end of life (79). However, additional details and context about why this occurred, how it might vary, or what solutions older adults might have were largely missing.

Alternatively, a San Francisco Human Services Agency needs assessments offers an emblematic case for how focus groups can effectively address gaps in knowledge about minority older adult populations. The 2021 California needs assessment aimed "…to better understand the landscape of need and consumer experience among older and disabled [Black, Indigenous, and People of Color (BIPOC)] San Franciscans" (2021, p. i). They ultimately reached 70 consumers and 96 professionals through 26 focus groups and 41 individual interviews. Focus groups were held with five specific BIPOC groups: Asian, Latinx/Hispanic, Black/African American, LGBTQ+ People of Color, and Filipino and Pacific Islander. Findings were especially relevant for "…*recommendations regarding resource allocation, collaboration, outreach, and other actions that reinforce equity*" (2021, p. i). Focus groups identified a need for culturally appropriate mental health services, immigration support and legal services, language support and cultural resonance, and a need for expanded access to digital resources and technology training.

In sum, focus groups which provide rich details about older adult need also clearly target specific populations or advance specific service needs. Focus groups we reviewed which were used to broadly survey older adult needs in a community often lacked rich details and were ultimately less useful for understanding how services could be improved or how findings relate to a broader context.

For that reason, while rich details are a fundamental strength of focus groups and other qualitative methods, it is critical for policymakers to receive data that speaks to the population broadly. The benefit of mixed-methods needs assessments is the ability to combine rich details from qualitative methods like focus groups and interviews, with the big-picture utility of other methods like surveys and secondary data. Nearly all mixed method needs assessments explore older adult needs through survey research to develop need profiles of their communities. Needs assessments that deployed surveys also typically sampled adults 55 years and over and compared generalizability to national U.S. Census data. Needs assessment surveys also explore resoundingly similar topics and typically target seven areas of need: (1) Employment, (2) Health Status, (3) Health Insurance and Health Access, (4) Housing Affordability and Living Arrangements, (5) Nutrition and Home Delivered Meals, (6) Transportation Services, and (7) Veteran Status and Services.

Many of the needs assessments we reviewed are instructive and **Table 2** summarizes which assessments deployed surveys, conducted focus groups, or reviewed census data. U.S. Census data was always utilized to understand population-level trends among older adults. These data were used to specifically evaluate broad demographic dynamics like prevalence of poverty, race and ethnicity, disability, health insurance status, etc. The greatest strength of most assessments was their use of U.S. Census data to describe need among all older adults. Unfortunately, these analyses rarely distinguish between population levels (City, State, region, etc.). None of the needs assessments we reviewed evaluated consumer data to understand regional and local needs and services use or availability. That data is vital for understanding how (under)utilized services really are.

Single Method Needs Assessments

Four needs assessments captured older adults and/or service providers for an entire SUA service area: Florida's Department of Elder Affairs (2021), Maine's Office of Aging and Disability Services (2020), the Colorado Association of Area Agencies on Aging (2018) and the Idaho Commission on Aging (2012). Three of those assessments implemented a single research method—surveys – to uncover older adult needs. Except for Maine's assessment, the Florida, Idaho and Colorado surveys were longer, more robust, and comprehensive than most of their mixed method counterparts.

For example, Florida's State Plan on Aging (2021) incorporated three comprehensive surveys in their review: (1) an aging network provider survey, (2) a client satisfaction survey, and (3) an online public input survey. They primarily found AAAs and lead providers were concerned about the sustainability of services into the future, both in terms of funding and institutional support (2021, p. 12). Additionally, client satisfaction surveys revealed consumers desired "…additional types and quantities of services including additional times for respite (evening and weekends) and additional types of services (transportation and home repairs)" (2021, p. 13). Broader public input from Florida older adults also identified that critical improvements could include better communication and outreach, increased funding and service availability, expanded service provision, additional affordable housing, and greater transportation options.

Needs assessments that implemented statewide surveys also explored older adult issues with more robust measures. In this way, the Colorado needs assessment deployed an expanded survey that incorporated multiple socialization measures for older adults across multiple contexts: Senior centers, social clubs, everyday communications with friends and/or family, religious or spiritual activities, and everyday instances of help for friends or relatives. Idaho's survey similarly explored social participation (across 13 settings) and included additional measures of independent living that spanned an extensive range of 16 contexts. Indeed, Colorado and Idaho's assessments included many of the same measures in their surveys, exploring ten areas of older adult need related to: caregiving, community belonging, community satisfaction, healthcare and insurance, housing, independent living, physical activity/fitness, senior center interest, socialization, and transportation services.

One of the more surprising aspects about these two assessments was their interest in capturing community identity and satisfaction. Idaho and Colorado's assessments asked open-ended survey questions to collect more detailed information. Idaho's assessment found that stigma was key to older adults' sense of belonging at senior centers. The authors explained— "Senior centers, as one respondent put it, need to be 'cheerful and bright for active, intelligent people, not just [a place] to serve cheap meals and play Bingo'" (National Research Center, Inc. & Colorado Association of Area Agencies on Aging, 2018, p. 32). Idaho's survey also indicated that less than half of all older adult respondents expressed any level of interest in using services offered at senior centers. The bulk of these respondents were between 50 and 57, suggesting that age cohort was significant in explaining for which populations senior centers were most useful.

In sum, Idaho and Colorado's assessments illustrate that evaluating service needs among older adults (e.g., senior center use, interest in home-delivered meals, etc.) is only one dimension of support that assessments can capture. However, single method needs assessments can neglect a critical resource for knowing more about older adult needs—older adults themselves.

As such, the Maine and DCOA needs assessment offer a more comprehensive roadmap for needs assessments – that needs assessments accumulate a broad understanding of need from varied data sources and synthesize results. This can be accomplished by integrating secondary data on population trends and existing services with provider and consumer surveys, consumer focus groups, and stakeholder interviews.

Academic Insight

We also reviewed academic literature to understand older adult needs beyond needs assessments. Two conclusions from our review were made: (1) needs assessments should refine focuses to include unique older adult populations and service categories, and (2) mixed methods are critical for obtaining robust details on need.

Some of the literature we reviewed emphasized the importance of nuance for needs assessments. Research that focuses on unique populations of older adults—such as age cohort, disability, sexual orientation, Alzheimer's, and race and ethnicity—has found unique service needs do exist. Research by Malonebeach & Langeland (2011) describes how needs among the newest older adult cohort—Baby Boomers – are significantly different. Born between 1946 and 1964, Baby Boomers reflect unique socio-economic characteristics compared to other age cohorts. This generation typically lives longer, has higher levels of education, homeownership, and income (MaloneBeach & Langeland, 2011; Pew Research Center, 2020). Further, data from the Administration on Aging indicates that senior center and service use have decreased in recent years (Administration on Aging, 2020). Despite this, Malonebeach & Langeland found that baby boomers as a whole place special importance on spending time with family in retirement (88%), and nearly all anticipated increasing their civic participation through volunteer activities (96%) (2011, pp. 122–123). And more importantly, over two-thirds (68%) of boomers indicated they fully intended to utilize senior centers, and half expect to either visit senior centers to obtain information about older adult services and assistance, or to need caregiver assistance as they age (124). As a cluster of need, boomers reflect the largest aging cohort eligible for older adult services over the next thirty years (U.S. Census Bureau 2020).

Caregiver assistance was also critically important for other older adult populations. Older adults with Alzheimer's, as well as those who identified as Lesbian, Gay, or Bisexual (LGB), indicated a particular need for caregiver assistance. Eifert et al. (2012) reviewed research on increasing support for family caregivers, and found that 26 of 34 studies identified counseling and support services as vital for improving "care recipient's and caregiver's opportunities to adapt to the challenges of Alzheimer's disease and to maintain well-being…" (228). Eifert and colleagues' policy recommendations emphasized the importance of conducting individual caregiver needs assessments and of recognizing the inherent diversity of older adults and their caregivers (232). Orel et al. (2014) (Moone et al., 2022, p. 8) echoed those sentiments about greater diversity in their studies with LGBT older adults. Orel and colleagues concluded that fear of discrimination and bias can inhibit LGB use of older adult services and senior centers. LGB older adults revealed too that the HIV/AIDS epidemic has had a profound effect on the experience of aging. One emblematic participant in Orel et al.'s study described, "I don't want to be old and alone. When I lost all my gay friends to AIDS, I realized that my social sphere was pretty small. I can't just have gay friends" (2014, p. 58). Moone et al.'s survey echo the importance of those findings, which found that 40% of their LGBTQ survey respondents "..did not have enough close friends,"(2022, p. 16) and that "…gay men (42%) and bisexuals (37%) are most likely to be living alone, and it is the same group that do not have someone to act as a caregiver should

they require one" (Moone et al., 2022, p. 16). The needs assessment by Central Massachusetts similarly found that LGBT persons are disproportionately affected by the HIV/AIDS epidemic, and therefore have significantly different needs—especially with regards to greater caregiver assistance, counseling, etc.

Research by Yorkston and colleagues (2010) also notes how the experience of aging is fundamentally different for those with disabilities. The authors argue needs of older adults who have lived with a disability for much of their lives should be distinguished from those older adults who experience disability later in their lives. Older adults who experience disability early in their lives can develop resilience and coping mechanisms, which may be more difficult to achieve in older adulthood (Yorkston et al., 2010, p. 1700). As one participant in their study explains, when you're young and experience disability, "There's a certain resilience of view, you're…able to adapt, and you've got your whole life ahead of you…" (Yorkston et al., 2010, p. 1700). To this point, the authors emphasize how respondents found support and assistance were central to the ability to cope with changing abilities. Yorkston et al. write that "maintaining control was critical to [older adults'] emotional well-being" (2010, p. 1701) because making significant everyday choices while living with a disability can compensate for lack of control in other ways. The authors recommend that social services should therefore support programs that encourage psychosocial and emotional resilience among those living with disability.

Finally, research by Tucker-Seeley et al. (2016) has also demonstrated the significance of understanding the effect of race and ethnicity on the needs of older adults. Analyzing nationally representative longitudinal data from the Health and Retirement Study, Tucker-Seeley and colleagues assessed financial and economic hardship among older adults (50 and older). They found that "when compared to white respondents, black respondents were more likely to [indicate] financial dissatisfaction"; in fact, black respondents were twice as likely to indicate financial strain (Tucker-Seeley et al., 2016, p. 226). Latinos were 2.5 times more likely than their white counterparts to indicate that they experienced food insecurity. The results illustrated that financial hardship does impact some groups of older adults more than others. Tucker-Seeley et al. concluded their "recommended approach is to use multiple indicators of hardship across various domains such as food, housing, and medical care…along with traditional measures of socio-economic status" (2016, p. 227). Our review of the literature also suggests that surveying the needs of older adults necessitates multiple perspectives through multiple methods.

Rural vs. Urban Needs

In line with the extant literature which emphasizes the importance of capturing vulnerable populations in needs assessments, the unique needs of rural and frontier communities have been documented. Needs assessments for Maine and Northwest Colorado specifically note that rural older adult needs can be different from their urban counterparts (Edris et al., 2020; Northwest Colorado HEALTH & Aging Services Coalition of Northwest Colorado, 2021). Specifically, rural areas tend to identify the same needs and challenges as urban older adults, but for different reasons. As Edris et al explain, "In rural areas, public transportation options often do not exist, while in urban areas bus routes may not be located close enough to where older adults live making access impossible" (2020, p. 51). Limited and non-existent support in rural areas often extends beyond transportation to include other areas of support, such as caregiver assistance, healthcare, case management, food access, community activities, and communication and outreach resources. The Northwest Colorado needs assessment similarly emphasizes how mountain and rural communities in their sample revealed that transportation

services are especially important for these communities which primarily use access services for specialty health care, shopping, socialization and entertainment, dental care, and low cost health care (2021, p. 15).

The rural-urban distinction is particularly important for New Mexico where, according to a 2019 U.S. Census article, 25.6% of older adults live in a rural area (U.S. Census Bureau, 2019). Under the USDA definition of remote and frontier communities, 23.5% of New Mexico's population also lives in frontier and remote communities. The U.S. Department of Agriculture explains how frontier and remote communities are characterized by "…low population levels that affect access to different types of goods and services" (U.S. Department of Agriculture, 2019). Compared to other states, New Mexico ranks 8th for the total number of people who live in a frontier or remote community. This feature of New Mexico's aging population is critical, since research finds that rural and frontier older adults struggle with accessing food resources (National Council on Aging 2022) and healthcare (USGAO 2023). Older adults living in rural areas are also more dependent on support from others for everyday and emergency transportation (Mattson 2011), have worse social functioning and quality of life, (Baernholdt et al 2012; Henning-Smith 2020) and have greater social isolation (Henning-Smith et al 2022).

Older adults living in rural areas are therefore more reliant on services that supplement limited infrastructures in their communities. Despite this, senior support and services provided by AAAs in rural areas can be significantly limited. To that point, a data brief for a 2020 National Survey of Area Agencies on Aging compared 485 rural and non-rural AAAs and the services they offer. They found that in comparison to their non-rural counterparts, rural AAAs had significantly smaller median budgets – roughly half that of non-rural AAAs (46%) – and substantially less median number of staff – exactly half (National Association of Area Agencies on Aging, 2019, p. 10). Further, research by Rhubart et all (2021) highlights how rural AAAs "…are less likely to provide vital services like adult day care, care transition services, money management counseling, and integrated care" and seniors living within rural AAAs often "…face long waitlist(s) or learn that certain services are unavailable in rural parts of a service area" (Mabli et al., 2015; Rhubart et al., 2021, p. 25; The Lewin Group, 2016). The authors conclude that special attention should be given to differences within rural communities, and especially with respect to minority populations and unique sub-populations living within rural contexts.

In sum, older adults who live in rural areas represent people with unique challenges due to their geographical isolation, which likely affects their needs. These needs are also generally unexplored by needs assessments which do not typically distinguish between rural and urban populations. However, research suggests senior service differences do exist between rural and urban communities and that attempts to understand these contexts should distinguish between types of rural areas and the unique sub-populations who live within them.

Lessons Learned

Two important lessons from our review of needs assessments are: (1) needs assessments should commit to mixed methods that integrate, at the very least, U.S. Census data, focus groups, and surveys, and (2) focus groups should remain sensitive to unique geographic contexts and subpopulations, including level of rurality, race and ethnicity, income, disability, and sexual orientation.

Incorporating these lessons into the needs assessment we completed the following in the first phase of a two-year needs assessment:

(1) Focus groups within rural and urban communities with attention to unique needs of older adults in these contexts
(2) A statewide survey with Aging Network Division (AND) service providers with respect to their perspectives on older adult needs broadly

The second phase of the two-year needs assessment included two additional research activities:

(3) An analysis of the state of older adults throughout New Mexico using U.S. Census data, with specific attention to rural and frontier community features
(4) An analysis of consumer Wellsky data with respect to rural and frontier communities, and service disparities or continuities that occur in these contexts

The present report describes the results of our mixed method study of older adult need in the state of New Mexico incorporating data from: (1) focus groups in rural, frontier, and urban communities, (2) a statewide survey of AND service providers, (3) U.S. Census data about trends and differences in New Mexico's aging population in rural and urban communities, and finally, (4) an analysis of consumer data on senior support and services with specific attention to rural and urban contexts. To our knowledge, this report represents the second needs assessment to date that affords specific attention to rural and urban divides. It is also the only needs assessment to include an analysis of consumer service provision to that effect. In the next section, we detail the methodology of our needs assessment.

STUDY DESIGN & METHODOLOGY

Our report assesses older adult need by collecting information from multiple sources. In total, we collected data over two years from six separate sources: (1) a statewide service provider survey, (2) a second statewide provider survey on financial and business health, (3) consumer focus groups, (3) statewide WellSky consumer service data, (4) the U.S. Census Bureau's American Community Survey (ACS), and (5) Adult Protective Services (APS), Consumer and Elder Rights Division (CERD), and Long-Term Care Ombudsman data.

Service Provider Survey – Part A

CARA developed a 30-question online survey which was distributed through Microsoft Qualtrics. Surveys were incentivized with a random drawing for $25 Amazon gift cards. One out of every ten survey recipients were randomly selected to win a gift card. At the end of the provider survey, respondents were directed to a second gift card survey where they could provide contact information to be entered into the gift card drawing – this allowed surveys to be completed anonymously and separated contact info from survey data. Ultimately, 46 survey respondents entered the gift card drawing and five people were randomly selected at survey close for $25 gift cards.

Participant recruitment occurred over two-months. Participants were first notified of the option to participate by senior ALTSD staff who spoke with service providers in January 2023. Senior ALTSD staff also subsequently sent an introductory e-mail to personnel describing the effort on 12/30/2022. ALTSD then provided CARA with an initial list of 133 unique contacts, with 22 missing email addresses. CARA staff contacted personnel with missing information to obtain their e-mails for the survey, which resolved 11 instances of missing information. This left 122 contacts with an email address. Upon first delivery of survey introduction e-mails on 2/6/2023, 23 contact e-mails were undeliverable. A total of 99 ALTSD personnel were successfully sent invitations to participate in the online provider survey on 2/8/2023. The survey was initially expected to close on 3/8/2023 – one month later.

On 3/2/2023 CARA notified ALTSD only 19 providers completed the statewide survey and requested their outreach to increase turnout. ALTSD sent a reminder e-mail to ALTSD staff on 3/6/2023 explaining personnel still had time to respond and that the survey would provide critical information for the 2023 needs assessment. On 3/7/2023 the Aging Network Division Director requested CARA expand the provider list to include volunteer providers and APS contract providers. CARA sent survey invitations to an additional 197 providers on 3/7/2023 and 3/8/2023 and extended the survey window to 3/16/2023.

CARA closed the provider survey on 3/16/2023. A total of 71 survey responses were received. These included only instances where respondents both consented and responded to at least one question. The survey response rate was therefore 24.0% (71/296). Of the seventy-one respondents, sixty-three (88.7%) completed the survey and eight (11.3%) started but did not finish. Sixty-four (90.1%) respondents answered more than half of all survey questions.

Service Provider Survey – Part B

At the direction of ALTSD administrators, CARA was asked to support and deploy a second survey in Spring 2024 that would assess the business and financial health of providers throughout the states. The Part B survey contained 41 questions in addition to 24 questions CARA included from Part A. We were asked by ALTSD to re-deploy the Part A survey from the

previous year in order to increase the response rate. This combined Part A & B survey ultimately include 65 total questions and was distributed to an ALTSD-approved contact list of 159 providers on March 25th, 2024. Surveyed providers were composed of administrators at senior centers, as well as on-the-ground service providers. Our survey contact list included 30 providers and administrators serving PSAs 5 & 6. As part of recruitment, ALTSD sent initial introductory e-mails and roughly a month prior to survey open, notified providers at a statewide provider meeting to expect a survey from CARA in March. CARA staff subsequently sent introductory e-mails one-week prior to survey open and described the incentive structure for survey participation. Providers were incentivized with $100 gift cards, distributed to a random respondent for every 10 survey responses. Four respondents were ultimately distributed gift cards via e-mail.

Surveys were initially set to close 1-month after distribution (April 25th), but response rates were exceptionally low and ALTSD expressed interest in extending the survey through at least May 1st. The survey was extended a third and final time to allow providers from PSA 5 & 6 additional time to submit responses. The survey closed at 11:59 PM on June 1st, 2024. Despite survey extensions, response rates remained low and culminated in 64 completed surveys (39.6% response rate); 5 from PSA 5 & 6 contacts (16.7%; 5/30). We ultimately report PSA 5 & 6 as a combination of PSA 5 & 6 provider contacts and two additional contacts who reported they provide services to Tribes, Nations, & Pueblos. PSA 5 & 6 responses reflect this combined reporting for seven respondents.

Part of the intention with re-deploying the original Part A survey was to increase response rates. Because response rates in Spring 2024 are lower than in Spring 2023, data collected for Part A in 2024 are not analyzed. Survey responses are anonymized to elicit confidential responses and cannot be combined with 2023 data. Further, there are methodological issues with combining data from more than one year prior and which elicited fewer responses. We have, however, analyzed data from the Part B survey questions collected in 2024. As noted, Part B questions were designed by ALTSD administrators and as such, do not reveal much about the vulnerabilities of older adults and adults with disability in New Mexico. They do, however, describe potential vulnerabilities in the service infrastructure for older adult services and are therefore useful to broader business needs.

Focus Groups

Eight focus groups were held in February and April 2023 which aimed to solicit input on older adult needs across five New Mexico counites: (1) Bernalillo, (2) McKinley, (3) Mora, (4) Santa Fe, and (5) Union. Focus group sites were selected based on three characteristics: (1) rurality, (2) percent of adults 65 and older living below poverty, and (3) percent of adults 65 and older with a disability. The largest senior centers residing in counties with the greatest vulnerability across all three measures were selected as focus group sites. People were eligible to participate in focus groups if they were 60 years or older and lived within county lines. Focus groups were limited to a maximum of 14 participants and required a minimum of three participants to be held. We reached out to senior center directors in January and March 2023 and distributed recruitment materials which included flyers and newsletter advertisements. We also physically visited senior centers 1-2 weeks prior to planned focus groups to recruit participants. We set-up tables with flyers and offered free food during 3-hour visits. At these table sessions, we spoke with older adults at senior centers about the purpose of our work and their potential role in the state's needs assessment. In two cases – McKinley County and Mora

County – participants were solely recruited by senior center or ALTSD staff, who were able to serve as trusted contacts within these communities. In these cases, focus groups achieved the maximum number of participants and were socioeconomically diverse. We extend our gratitude to both Kimberly Ross-Toledo, Rebecca Baca, and Gloria Martinez for their support.

While recruitment strategies were largely successful in urban areas, they were typically unsuccessful in rural communities. We initially incentivized focus groups with a variety of breakfast food items, snacks and refreshments. However, we cancelled or rescheduled four of five planned focus groups in rural areas in February because of low interest and participation. We adapted to low turn-out by subsequently incentivizing rural areas with $35 cash, in addition to food refreshments. The monetary incentive was successful, and we held focus groups in all but one of the originally planned rural locations. Overall, we held focus groups with 63 older adults.

Participants also completed pre-surveys (Appendix A) which provided limited demographic information about participants. We followed prescribed standards for semi-structured focus groups regarding the number of participants, structure, data analysis, and format (Barbour, 2007; Morgan, 1996; Rog & Bickman, 2009). Except for one focus group – Mora - two researchers were involved in every group discussion, which included a facilitator and co-facilitator. Our design attached specific responsibilities and duties to both roles. In alignment with standard focus group techniques, our facilitator followed the predetermined focus group protocol and questions while simultaneously guiding the conversation toward topics and questions. This elicited better responses and rich details from our participants. Alternatively, the co-facilitator monitored focus group discussion to ensure questions in the focus group guide were not neglected and otherwise assisted the facilitator in encouraging participants' involvement. The co-facilitator also closely documented group behaviors and outlined the group discussion as it occurred in real-time. Over eight hours of focus group audio was recorded and professionally transcribed by the *TranscribeMe!* company.

To interpret the results of the focus groups, we conducted a content analysis of the focus group transcriptions. This included thematic coding of content, which followed the analytical frameworks described by Timmermans and Tavory (2012) and Erlingsson and Brysiewicz (2017). In this way, themes and codes develop as an informed response to the text. In the interest of privacy, all participant names referred to in our analysis are randomly selected pseudonyms which do not reflect the characteristics of actual participants. We have also opted to remove references to specific senior center or ALTSD staff that participants referred to.

Consumer Service Data

A key aspect of defining future needs is to understand what services are currently being provided to meet those needs and what gaps in service provisioning may exist. To understand current service provisioning, ISR requested consumer data for all services provided by ALTSD in the previous five years. ALTSD consumer data is maintained within a centralized data collection system referred to as WellSky (after the name of the private company that owns and manages the software and server). ALTSD administrators generated reports (i.e., datasets) from WellSky based on our request criteria and transferred the data to ISR via a secure data transfer site: Revver. We received the first round of WellSky consumer data on February 28, 2024.

WellSky data was divided into separate spreadsheets for each county and for each fiscal year from 2019 to 2022 (FY19 – FY23). After cleaning and analyzing these data, we found that the number of services and unique clients did not perfectly match the official figures reported for those years. The reason for this is likely due to unregistered users being absent from the reports we were provided, which only included individuals with complete names and addresses. After the governor of New Mexico declared a state of emergency in March 2020, service provisioning was modified based on public health guidance to accommodate social distancing, which also affected data collection practices, leading to more unregistered consumers.

To ensure consistency in reporting and to account for these unregistered users, we requested WellSky reports that included all users (registered and unregistered) for the same five-year period. This second round of data collection occurred in May and June of 2024. Unfortunately, these data could only be provided in aggregated form (i.e., not services by individual consumer). The aggregated data reported the number of unique users and total units of service for each service type over the five-year period at three levels of aggregation: the county, the PSA, and statewide.

U.S. Census Data

To understand the statewide needs of older adults we collected and analyzed the most recent 2017 and 2022 5-year U.S. Census American Community Survey (ACS) population estimates for 18 topical areas relating to older adult need:

1. Older Adult Population
2. Race & Ethnicity
3. Educational Attainment
4. Marital Status
5. Disability Status
6. Employment Status
7. Health Insurance & Poverty
8. Household Type
9. Dual Coverage Medicare & Medicaid
10. Poverty Status
11. SNAP Benefit Status
12. Veteran Status
13. Grandparent Responsible for Grandchildren: Older Adult Grandparents
14. Grandparent Responsible for Grandchildren: Race & Ethnicity
15. Grandparent Responsible for Grandchildren: Employment Status
16. Grandparent Responsible for Grandchildren: Poverty Status
17. Grandparent Responsible for Grandchildren: Disability Status
18. Grandparent Responsible for Grandchildren: English as Second Language

When possible, we have analyzed these topical areas by Planning and Service Area (PSA) and over time – change between 2017 and 2022 5-year survey estimates. Note, survey years are the combined estimates for 2013 – 2017 and 2018 – 2022. The one exception here is for aging cohort, where we look at change by age range for older adults (60+) between the 2008 – 2012 and 2018 – 2022 ACS estimates. Some questions, such as Race & Ethnicity and Educational attainment are not analyzed over time. Race & Ethnicity survey questions have changed significantly over time, and therefore ACS does not recommend comparing estimates for this

question since wording is expected to significantly affect how people report. Additionally, comparing educational attainment over time is not expected to clearly affect the development of services and need, except as a data point for understanding the current demographic make-up of the older adult population.

Lastly, we report results primarily based on significant changes over time and/or significant differences between PSAs. To accomplish this, we identify significance based on z-score formulas recommended by the U.S. Census for analyzing ACS data using a 90% confidence interval (U.S. Census, 2020). Readers should also be mindful that U.S. Census data we reviewed are for the American Community Survey, and as such, is ultimately a very educated and typically reliable estimate of the population. There are times, however, where that estimate is worse because less of a population was sampled. As such, the U.S. Census recommends keeping track of a calculation called the coefficient of variation (CV). Simply put, the CV is a measure of the range of error, as a percent of the total estimate. For example, the number of older adults with Medicare only coverage is estimated to have increased in PSA 5 (Tribes, Nations, & Pueblos) by 5.0% (±4.8%) between the 2013 – 2017 and 2018 – 2022 periods. Because the margin of error is so high (±4.8%) relative to the estimated change (5.0%), the CV is 59.2%. The U.S. Census recommends that CVs greater than 30% are to be used with extreme caution, because of the extreme variability relative to the estimate. In our example, the true change could very well be 0.0%. We therefore do not report estimates where the CV is greater than 30% and we note when this occurs.

APS, Long-Term Care Ombudsman Program, and CERD

We received limited and aggregate data on three other departments within the ALTSD:

1. Adult Protective Services (APS)
2. Long-Term Care Ombudsman Program
3. Consumer and Elder Rights Division (CERD)

Data we received for APS included 2022 Key Indicators, FY19 – 22 Performance Data, and summary information from a FY22 – 23 Overview report. Data included summary counts and percentages by fiscal year on APS investigations and clients who were found to be victims, as well as summary performance metrics regarding case investigations per case worker, reports received, reviewed, substantiated, and referred to additional supportive services.

Long-Term Care Ombudsman Program data pertained to official reporting for Federal Fiscal Years (FFY) 20 – 23 and which identified case and complaint summaries, type of complaint by facility type, facility number and bed capacities, and funds expended.

Lastly, we also received data from CERD for SAMS Call Profiler reports for FY21 – 23, which detailed the types of calls received by the 1-800-ADRC line as it pertained to New Mexico older adult calls. We subsequently developed 20 collapsed categories for the 255 unique call codes. Collapsed categories were reviewed and approved as accurate by the director of CERD. As noted, these three data sources were reviewed with attention to identifying other work the department oversees. In-depth review of all three departments was beyond the scope of this report but does deserve greater attention with regard to older adult needs.

LIMITATIONS

The present report reflects the results of reliable and accurate data collection. However, as with all research designs, certain limitations apply. Firstly, signficant limitations exist with interpreting focus group results and applying those conclusions writ-large. Rather, focus group results should be interpreted with caution and serve as a starting point for more in-depth investigations of older adult need throughout the state. Our inclusion of U.S. Census data and WellSky/SAMS consumer data attempt to verify some of the trends and/or needs emphasized by focus group participants. With that said, focus group themes and feedback were salient regardless of site, and we present only the most prominent themes expressed by multiple or most participants.

Secondly, with respect to the statewide surveys we conducted, it remains unclear whether the results are representative of the experiences and perceptions of the total population of service providers across the state of New Mexico. To enhance the representativeness of the survey results, we sought to administer the survey to as large a sample as possible and requested contact information for as many providers as possible. The final list of 296 service providers for the first survey and 159 contacted in the second round of surveys, are unlikely to represent the complete pool of older adult service providers in New Mexico. Moreover, only 71 self-selected to take the first survey and 64 for the second one. We therefore cannot know in what ways these survey participants differ from the broad pool of service providers statewide. For this reason, we recommend caution in generalizing our survey findings. Despite these reservations, the survey sample represents nearly a quarter (24%) of identified statewide providers for the first survey, and about 40% of statewide providers in our second survey. And respondents of both surveys encompasses a broad range of locations and experience levels. We believe this suggests survey results provide an outline of the range of provider experiences and perceptions from across the state.

Thirdly, WellSky consumer data was ultimately provided to us in aggregate form and limited the analyses we could perform. For example, we could not know the number of unique users for superordinate service categories that we grouped various service types into, nor could we analyze the variability in quantity of services received across recipients (e.g., the maximum, minimum, and median number of services received by clients in each category). Critical limitations also exist with respect to Legal Assistance support which reduce our ability to speak to service provision. Nonetheless, because the data are aggregated to several useful levels (county, PSA, state), we found this data sufficient to conduct the most critical analyses we set out to accomplish.

Finally, the ALTSD encompasses the work of more than just the Aging Network Division (AND) and includes myriad supports offered by Adult Protective Services (APS), the Consumer and Elder Rights Division (CERD), and the Long-Term Care Ombudsman Program. We received aggregated and performance summary data to report on the rough outline of all the work these divisions do. However, our goal was not to fully assess the Department’s support of older adults, but rather, to understand older adult need and vulnerabilities throughout the state. As such, we remind readers our report does not consider the totality of supports available, nor how successful the department is in addressing older adult needs. These are important caveats to bear in mind as you read through our findings.

CONSUMER FOCUS GROUPS

We selected focus group sites by identifying vulnerable rural New Mexico counties within Planning and Service Areas (PSAs). We supplemented those rural areas by choosing two urban sites to compare needs to. Prior to focus group sessions, we collected self-reported demographic and other social characteristics data from participants. **Table 13** in Appendix A summarizes that self-report focus group data.

In general, we recruited a diverse set of older adults. Participants were ethnically diverse, with 71.4 % (45) of participants identifying as Hispanic or Latino. While most participants identified as White (75.0%), one-quarter identified as a race other than White. In these cases, participants identified as Native American or Alaskan Native, Black or African American, East Indian, Native Hawaiaan or Pacific Islander, or multiracial. Only 8% of participants chose not to answer this question and 16% chose “Other” as their race and identified as Hispanic or Latino.

Most of our focus group participants were also women (66.7%; 42). The average annual household income of our participants was $35,528 and the average age was 75.8, with 88.9% of participants between the ages of 60 and 89. Two partipants were between 50 – 59 and five were between 90 – 99. While most focus group members did not work (85.5%; 53), several were actively working or looking for work (14.5%; 9). About 10% of our participants were also caregivers for an elderly person, with one participant caring for a child between 5 – 11 years old. In sum, participants reflected a diverse cross-section of older adults in New Mexico. Our sample of older adults who were mostly low- to middle-income, lived in a rural community, were White and/or Hispanic or Latino, were between 60 and 89 years of age, primarily female, and were living alone.

Focus group participants in rural and urban areas identified a range of needs specific to their communities. Salient themes from our discussions with older adults centered on five prominent senior service need areas: (1) Senior center support, (2) Information support, (3) Improved service accessibility and availability, (4) Health support, and (5) Transportation support. We conclude our analysis of focus group data with a brief discussion about what ideal senior service programs older adults expressed desire for.

Senior Center Support

One of the most prominent themes described by all focus group participants, and particularly among urban sites, was the desire for greater friendliness and intimacy at senior centers. Many participants directly compared the senior center focus groups were held at to other *less* friendly senior centers they used to go to. Older adults explained what they enjoy most about certain senior centers was a welcoming atmosphere, and friendly and personable staff who acknowledged their existence. Descriptions in these cases identified how helpful staff could be at preferred senior centers. Ideal senior centers are places where staff know them personally and where older adults can build social networks and socialize with each other.

Sally: We know their names. We call them by their names. ***They [Senior Center Staff] call us by our names. And, so, you do feel welcome here.***

- Manzano Mesa Multigenerational Center

Maria: Well, I was surprised because when I walked in, the people, I didn't even know, ***they came over and say, "Welcome," and walked by. I go, "Oh that's wonderful." And that hadn't happened to me before.*** They're more human. They're more courteous. They are more courteous.

- Los Volcanes Senior Center

Geraldine: But when we started coming here, we liked it even better. ***I mean, way better because of the socialization aspect of it.*** And we have a regular group at our table, includes [senior center staff] was there.

- Tijeras Senior Center

Older adults living in urban areas appeared to sample a wide range of available senior center facilities, evident by frequent descriptions of their experiences at other locations. One participant claimed to have visited every senior center in the city of Albuquerque before settling on Manzano Mesa as their favorite. Another explained the center they attend most often was tens of miles away from where they lived. In this way, participants discriminated between senior centers and described precisely what constituted less-desirable facilities.

Stephanie: I used to live over in the northeast and I went to Palo Duro. And I said, "This is so much better than Palo Duro." You walk in and it's like you've been in a desert. ***Nobody's at the window... And you'd walk the halls around, you'd hear footsteps more than anything else. [laughter]*** There's a lot more activity here. People are friendlier here. I'll take the northwest over the northeast anytime. [laughter]

- Los Volcanes Senior Center

Mike: ***When I first came here, I went to Bear Canyon. And I thought they were more standoffish too.*** Because I used to live over there. When I came here [Manzano Mesa], here this morning, this is the first time I'm here. It was like coming to a family house because they were so-- I said, "Wow, this is really, really quite nice," the way everybody was so friendly and everything.…I mean, I was sitting down and the woman-- she was busy with someone else, somebody at the desk…So she came over and asked me, "Is everything okay?" I said, "Oh, yes." And I said, "Wow." ***It made me feel so different, and that's the way it should be because …To me, it doesn't make sense to be unfriendly.*** It does not.

- Manzano Mesa Multigenerational Center

Sally: And there's just one other little thing. And I introduced myself to [Andrea] ***because seniors want to be acknowledged***. That was my perception of seniors. ***They want to be acknowledged and they must think that they're worthwhile that people want to be around them and so it's important.*** Wherever I go, I introduce myself to people, and I try, like with [Researcher]. I said, I'm going to remember his name, and that's what we have to do. I don't care how old you are. Just reach out. Seniors sometimes just go in, in inside. Reach out.

- Manzano Mesa Multigenerational Center

Participants offered their insight as to why some centers failed to cultivate welcoming atmospheres. Explanations generally fell within two broad camps: (1) that senior centers physically appeared neglected and created uncomfortable environments, and (2) inattentive staff make older adults feel disrespected and unwanted.

Pam: I think I've been to the Pasatiempo site once. But I used to walk-in and the books were arranged nicely. This [center], it looks like somebody hasn't gone in there and refreshed anything. ***The same plants are there and they're dusty, and it's like they think that we're going to accept this look. I mean, they need to be refreshed. They need to be up-to-date.*** I mean, some people come to this place to socialize and to feel good about themselves.

And walking in that front door does not make you feel good. And especially now they move the meal. If you want to come and pick up a meal, they have this little tiny place where it's almost like they don't want you here. So you just get in there, grab it and go. They don't even let you walk through the lobby to go pick-up the meal. So, since I haven't been to the other [senior centers], but this one in particular, we need to pay more attention to the senior citizens and update it because it's a psychological thing, I think.

- Mary Esther Gonzales Senior Center

Sally: I'm so grateful for [senior center staff member] here. ***I have seen people at this center who don't like seniors. They don't like seniors***. At least that was my perception. But now we have people who, honest to God, I think they like us. Because seniors, I have to tell you, some of them focus on their health and they're crabby.

- Manzano Mesa Multigenerational Center

In comparison to urban sites, all rural areas we held focus groups at had access to one senior center. Perhaps due to limited options, feedback about senior centers at rural sites was uncommon. Still, two of our rural focus groups generally supported the centers they attended and anecdotally praised the diligence and support of local site administrators and staff. Our Clayton focus group is a noteworthy contrast, because participants were overwhelmingly dissatisfied with the state of their senior center. They cited a broad lack of available services, an inability to socialize with others, and limited opportunities to provide feedback about their senior center to senior administrators.

Pam: I think the attitude behind the director right now says, "You're not welcome."

- Clayton Memorial Library

Sally: Well, this is a drum I beat all the time. I belong to two different senior centers. In Springer, which is half the size of Clayton, they have these services. They have people that come and clean your house. They have people that mow your grass and take care of your property. They take you wherever you need to go. I've mentioned this to [senior center administrator]. He just blows me off and, "Well, we can't do that. We

don't." ***Well, I think if Springer can do it, they should be able to do it over here.***
- Clayton Memorial Library

Flora: And they [Springer senior center] have all these extra services for seniors. ***And I think that would be a great idea if we could even join their corporation or make one of our own so we're able to use the money the state gives the town, which we have no way to see if we're getting all the money that their town is given for the senior center.*** They may be spending it on something else. But I think it would be great if we had some way to know what--
- Clayton Memorial Library

Pam: ***I would like to see an information center set up so that anybody that had a question or wanted to know about a service-- that they could go to the information center and find out what service are available or what they'd have to do to get help.*** And then anybody that was-- you set up and-- we set that up. So if you were willing to do two hours' worth of volunteer service or three hours of volunteer service a week or a month, then that center would have that information if somebody came in.
- Clayton Memorial Library

Sally: ***One of the things on-- and talking about youth and senior, I have gone to the city, and I have talked to them specifically about creating a program that puts the young people and the old people together and pets coming in to see older people.*** We have a plethora of knowledge. And we know how to play games. We know how to live in this small town. And the attitude of, "There's nothing to do," has got to end because there's plenty to do, is we have to learn how to utilize the time. And we can be great teachers, but we can also learn from the young people. And I have begged for them to-- I'd like to sit on an advisory board and help somebody coordinate a service like that.
- Clayton Memorial Library

There were pervasive feelings among Clayton participants that the senior center was no longer a place that welcomed them or could help. When older adults were asked what program or service they would desire if they had a magic wand, participants overwhelmingly agreed they would like to see a central location for seniors, services, and information – i.e., a senior center. Participants in Clayton expressed preference for a senior center in the model of a multigenerational facility, where youth and older adults could access services together and learn from one another.

Information Support

Another key theme was a clear desire among participants to know more about available services and supports. Urban participants frequently initiated conversations with each other about how to access help or services following questions from researchers or other participants about services. Participants frequently expressed surprise upon learning that so many senior services and supports are available, or in some cases, that loved ones might qualify for additional support.

Guadalupe: And what do they call that? I mean, because I'm looking for it in other centers near me.

Connie: I can't remember what it's called, but the fire department regularly comes here, and brings mats and all kinds of stuff and show you how to fall. It's really--

Guadalupe: How to fall?

Connie: Yeah. Without breaking everything. Instead of breaking 10 bones, you only break 3.

- Manzano Mesa Multigenerational Center

Shirley: Do they still have home delivery though?

All participants: Yeah.

Alice: Yeah. But you have to qualify.

Elma: But you have to get it every day.

Martina: Yeah, you have to make it every day, and you have to be homebound.

Vaughn: And you have to make sure you have a doctor's thing saying you can't come to the center

Martina: I don't know about that.

Alfonzo: What are they now, $6 a meal? Are they still 6?

Reyes: Yeah. You have to have the doctor thingy.

- Clayton Memorial Public Library

Diane: No. I'd like to be a companion. How do you get to be a companion? You have to have someone else be a companion?

Lonnie: You got to have your license.

Alvaro: You apply for that program if you want to be the volunteer for it.

Luna: Oh. And then if we need volunteers to come in, it's the same number?

Lonnie: Yes, you would call that access line and say, "Oh, I'm interested in this kind of help. Do I qualify?" Because there's qualifications for it.

- Tijeras Senior Center

This kind of information sharing among participants also spurred conversations in focus group sessions about which sources of information older adults seek-out to learn about senior services and supports. Most participants from both rural and urban areas expressed greater desire for non-digital information, but preferences for non-digital mediums were different. Individuals from urban focus groups preferred non-digital mediums that could be accessed at their local senior center, including service catalogs, bulletin boards, and brochures. In contrast to rural counterparts, urban older adults also described preferences for some digital sources such as Googling or accessing city or senior center websites for information.

Denise: ***I get a lot of my information from the Senior Scene Newsletter, but I do it online***. They always have a pile at the grab-and-go.
-Santa Fe Senior Center

Marcos: They have these papers, these little newspapers that you put out, and sometimes they're at restaurants or different things. That's where I get mine.
- Manzano Mesa Multigenerational Center

Michele: They have stuff posted too. And that's another thing. ***Most people will see me at least once a week in front of the place, on the board with what is available***. And actually, that's how I found out about you guys and the thing because there was this little thing and I go, "Oh, yeah. Let me call and sign up for this."
- Los Volcanes Senior Center

Elena: I've used 311, and I get the bulletin from here, ***but I can go online----to the Albuquerque website and then find whatever I'm looking for***, if it's seasonal events, or what's happening today in Albuquerque.
- Monzano Mesa Multigenerational Center

Researcher: Yeah. So the next thing we wanted to find out from you all was, where do you or other older adults go to get information about senior services--

Mae: From the computer.
- Santa Fe Senior Center

In contrast to urban areas, rural sites strongly emphasized the importance of non-digital and traditional information sources in the context of unreliable internet or challenges with understanding how to use digital mediums. Preferences for sources like newspapers, radio stations, senior center staff, and word-of-mouth were cited often. Gallup focus group participants highlighted the need to distribute marketing, information, and support materials in the native languages of communities. Participants in Gallup stressed the importance of specific radio stations and newspapers for reaching indigenous older adults who primarily access those resources in their native languages.

Gina: ***Most of it comes verbally here, and I think word of mouth is just channeled through people because if you're catching a radio announcement, sometimes it just flies by or it goes in in one ear and out the other.*** You might find a flyer set up somewhere. Here at the senior center, you get some individuals where they're sharing information. They'll give you stuff. And that's how we found out about your meeting now. It was conveyed by [Senior Center Administrator] who runs here and a couple other people to show up for this meeting on Friday.
- Mora Senior Center

Kelley: The radio, yeah, usually is the only one. That's done in the native language too, so they are able to get it. A lot of them, I think, hear their news based on that.

Chandra: ***KGNN. It's for natives really***.
- Gallup Senior Center

Elena: ***Our greatest resource are our newspapers.***

Mae: --seniors, seniors

Elena: Our greatest resource is our newspapers for people of our generation that might not be using the internet. Our greatest resource is the public radio station and all of the private, for-profit radio stations and the newspapers. We have a weekly newspaper, The Sun, and then we have the newspaper, The Gallup Independent. It used to be daily but it had to be cut back, okay? We have a monthly magazine which is The Journey.

- Gallup Senior Center

Lynnette: Whenever you're calling for medical help or whatever and you call a number, they just say, "Look it up in the computer," like “soandso.com”. But I don't have a computer.

Researcher: Okay. So what did you do then?

Lynette: ***I just let it go. Or I'll ask around to see if somebody's heard about it or something like that.***

- Clayton Memorial Public Library

As the final quote above suggests, participants in rural areas were also the only kinds of focus group participants describing instances where information-seeking for senior services and support sometimes ceased altogether after failed attempts. Participants suggested this might occur for two reasons – (1) a general distrust of certain information sources and (2) a broad absence of information which, for participants, meant information-seeking was a waste of time.

Researcher: Where do you all get information about services from?

Carmine: Nowhere, I guess.

Guadalupe: [In agreement with Carmine] I'm sorry. That's what it is.

Audrey: ***We can't really rely on anything because I don't even listen to the radio.***

- Clayton Memorial Public Library.

Mariana: We hate all of it because everybody wants something different.

Aida: ***It's lack, lack of information***.

Edwin: [In agreement with others] Right.

Researcher: So you think that the information is not getting out well-enough now?

All participants: Yeah.

- Gallup Senior Center

Rural participants were also more insistent than urban counterparts that coordination of information and support was urgently needed. A conversation with participants in our Clayton focus group was representative of this broader sentiment.

Carmine: Coordination of information is huge right now. I mean, none of us know-- I mean, if it's available to one, it should be available to all of us. And so somebody over here [crosstalk]

Guadalupe: Poor public information.

Audrey: ***It's just we're scattered.***

Mariana: The coalition has transportation, and I'm not sure how it works. The way it was explained to me, and [Maribel] may know more about it than I do--

Maribel: No, not really.

Edwin: I'd just learned this recently, that some people qualify for free transportation, and Ruby knows.

Audrey*:* And I mean, that's something that is great information if it's true and if everybody knew it. ***I think communication in this town-- if somebody knows something, it's not like they don't want to share it, but it doesn't get shared***.

- Clayton Memorial Public Library

COVID-19 Impacts

A critical theme among focus groups from both rural and urban sites was the profound impact COVID-19 has had within older adult communities. Respondents from all areas were quick to describe how attendance at senior centers has not returned to pre-pandemic levels. When asked why this has continued to occur, participants explained a general fear of COVID still exists. The effect of this fear on older adults was situated differently depending on urban and rural focus group sites. Urban participants broadly suggested the most tangible effect of COVID has been social isolation and decreased participation. One participant from Tijeras told us it feels "…like we're starting over again."

Vicky: I think it's fear-driven. Fear-driven. Because everybody's been so brainwashed. I call it brainwashed. About COVID. ***So they're afraid of close contact.***

- Manzano Mesa Multigenerational Center

Rosa: People are still scared of COVID. I go to Trader Joe's sometimes...I study that all the time when I'm in Trader Joe's and it's just--

Researcher: *So still a fear, a general fear of infection?*

Rosa ***Yeah. A fear factor there.***

- Santa Fe Senior Center

Viola: And we had a lot of things going on and a lot of prospects ready to go. And since COVID, now we're back to 0-1 almost. Well, maybe a little bit, we got going. ***I feel like we're just starting over again. And we have the arts and crafts, but there's a lot of people that used to come that haven't come or they died.***

- Tijeras Senior Center

Rural participants similarly identified pervasive fears among older adults due to COVID but instead highlighted the role of political schisms within their communities which impacted desire for socialization. This split was described by many participants as a social tension, but also seemed to reflect a generalized fear of infection from new variants, especially from those who remained unvaccinated because of their political ideologies.

Delores: We used to have 30 - 40 people go down to eat. ***Now there's hardly nobody since COVID opened back up, I mean. I think they're still afraid.*** I think a lot of people are just still afraid. I know some never got any of the shots. So now they're afraid to get out and get in between people because they never got any shots. And they don't want to get sick, so they just don't go down any. And then, of course, since there's nobody down there, we can't play cards or anything because there's nobody going down there.

- Clayton Memorial Public Library

Sofia: Flu didn't affect them in that regard. Some would just get the flu shot or something like that. But COVID scared the crap out of people. I think it just-- where there's a lot of people just remaining more sheltered within home, just afraid that they're going to get it because they do hear it on the radio, "Hey, we got another virus coming out,"

- Mora Senior Center

Oscar: And I noticed that when the center opened, I don't know the exact date, but it's pretty recently, for everybody, so we didn't have to have four to a seat-- to a table. So that the six feet distance was-- and you don't have to wear a mask anymore. Those two restrictions were removed and you don't have to have your temperature taken anymore. ***That's when I noticed a lot more people came back because I don't think they could mentally navigate we can do some things, but not other things.*** They didn't want to chance [it], because they didn't want to do the wrong things. Somebody would say, "Oh, you're not wearing a mask at all." I think that might have been-- they were waiting for the older, kind of what they're used to, to come back.

Researcher: Since COVID, from before COVID to now, do you think there's people who still aren't coming for other reasons?

Oscar: ***Oh, yeah. A lot of them were scared to death. They're still scared.***

- Gallup Senior Center

Participants from rural areas also described COVID's impact beyond personal fears. They explained how COVID has significantly affected the *provision* of services that used to exist pre-pandemic. Rural participants suspected service limitations stemmed from the COVID shutdown. As they perceive it, older adults socialize less because senior centers have yet to restart many services that closed during the pandemic, thus linking a permanent reduction in senior services and supports after pandemic closures.

Patrice: We used to play cards at the center, but…

Allen: …since COVID, nothing.

Patrice: Since COVID, nothing.

Allen: ***Yes, since COVID, nobody does anything…***

- Clayton Memorial Public Library

Tomas: We used to go to [cooking] class. That class we used to go to, we have it no more. They quit that class.

Francesca: We have volunteers. We have our membership here. Mr. [Jim] right there, and his wife, provide leather classes here, but this facility relies on volunteers that are members. Whereas, before, we had aerobic classes in the gym.

Valerie: No more.

Researcher: *No more?*

Francesca: ***When it was is when COVID came in, it wiped everything out. It closed this place. So I think…this is the deal.***
- Gallup Senior Center

Regina: They used to have more programs, but right after the COVID, it stopped.

Loyd: Yeah. We had bingo, and then they would take us to the casino and they take us to different places.

Researcher: *So you've all used it at some point, but maybe since COVID, it's been slow to return?*

Rose: Before COVID, we used to have an awful lot more stuff going on here. We used to have the -

Rosalie: Crocheting, sewing.

Researcher: *So why has it--?*

Leona: Everything went down.

Rose: Yeah, everything went down. We didn't come to the center for quite a while.

Researcher: *And are some people still not coming?*

Rose: Yes, there's an awful lot of people.

John: ***There's probably still some people that are afraid to be exposed to around a lot of people. You still have flus and things that are affecting. And I think COVID really scared the crap out of a lot of people, even though they don't want to leave.***
- Mora Senior Center

All participants detailed their sense that COVID has led to lasting social isolation among many seniors. For some, this was described as the result of limited services and fewer social supports. With fewer social activities and community services at senior centers, older adults explained few reasons existed to get-up and socialize with others. One participant succinctly pointed out how "*Yeah, we don't have nothing to [do] – just go home and watch TV*." Another noted that fear of COVID continues to be so salient that some older adults only receive meals at home and that lack of engagement has made such habits comfortable.

Alta: I think some of them are definitely kind of isolated. And I call a couple of people and check on them to see how they're doing. So they're not people who are going to reach out and say, "I need someone."
-Clayton Memorial Public Library

Myrna: Oh yeah, but a lot of people are dying. So they used to come, and now, they don't come because they're ready just to--

Researcher: *But it sounds like some people still are choosing not to come, out of fear?*

Myrna	Yeah.
Maribel	And some don't have vehicles to come. They used to go pick them up---- in their bus. ***The seniors used to go pick them up at their home because some don't drive or don't have nobody to bring them.***
Monty:	No, and got used to getting the Meals on Wheels. [inaudible]. And so now they can just go with that.
Researcher:	*Okay. And so they don't interact as much?*
Monty:	No. ***They just got used to having the meal delivered right to their home. And I don't remember having-- and [senior center staff] said Meals on Wheels are being delivered way, way more than ever***. *- Mora Senior Center*

Service Accessibility

Flowing from conversations about COVID, urban and rural focus group participants frequently described how senior centers "used to have" services or programs. This theme ultimately reflected a broad desire to regain or expand access to a range of services and supports. For urban participants, services seem to be slowly resuming and descriptions of service accessibility and availability were characterized by a broad need to improve older adult participation and convince seniors that socialization opportunities are worthwhile and safe. As one of the quotes above indicates, some participants felt services were 'starting from scratch' as older adults navigated fear of COVID and attempted to reintegrate social activities back into their lives.

But while urban participants identified the difficulties returning to pre-pandemic levels of participation, rural participants described a broadly limited array of services and supports that started to decline pre-pandemic and which post-pandemic have begun to disappear altogether. Rural participants indicated broad needs for developing new services that re-engage older adults in socialization and physical activity, and which also support older adults who don't traditionally qualify for in-home assistance, but who require such supports regardless.

Tania:	I came in late. I'm not sure if it was mentioned, but I was talking to several people, and they said that there aren't that many people that did pool [billiards]. ***They would like to have other activities to get people out of their chairs like shuffleboard or ping-pong or some other—*** *- Gallup Senior Center*
Researcher:	*Has anyone ever used in-home services like housekeeping, chore help, home healthcare, that sort of thing in Mora? Or they may not exist, that's fine.*
Nadine:	It doesn't exist.
Donna:	They did.
Carlos:	They did.
Donna:	Yes, they did. But for some reason, it just collapsed. Yeah. But we did have it.
Researcher:	*Before COVID, it was ended?*
Donna:	Well, before COVID, it had already collapsed.

Marisol: [Eddie] here talked earlier about us being at one time the poorest county, and now we're probably the third poorest. But we're still far, far from below any kind of a median income, where there's any kind of utility assistance. Yeah, you've got people that came, they found New Mexico or this area to be a place to retire after they sold their place in California or got a retirement somewhere else, and they're living pretty decent on their income. ***But the people that were from here and stuck it out and stayed here, their property just passed on generation to generation. And because they own that property doesn't mean they're banking money in the pocket.***

- Mora Senior Center

A clear need for access to disability and health services and support was identified by several rural participants, who identified medical transportation assistance as crucial for rural communities to access help they needed. A dialogue with Clayton focus group participants was emblematic.

Researcher: Or how often do you have to travel to Amarillo or Santa Fe or Albuquerque to get things?

Elnora: Too often. Too often for a medical. And I mean, we have gone as often as every week for a while. And it's too hard, too hard, so. ***Access to medical. That's the only thing that—That's the only thing I have any issue with.***

Carmen: When you're having medical body repairs that requires a specialist, then there is definitely a transportation issue. ***And my concern is for the people who are between services. In other words, neither one of the services helped them with the transportation. And they don't qualify for Medicare to help them go through Medicaid help. And there's a blank area.*** And if you'd like-- or if you have to go to Raton for a kidney treatment three times a week and you don't qualify for any kind of gasoline assistance, it gets really pricey because you're just right on the edge. You're in the middle. It's a dead zone. And that is a serious issue.

- Clayton Memorial Public Library

While infrequent, some rural participants also noted a critical need for caregiver support, given their own disabilities and, therefore, limited ability to care for loved ones. One participant – again from Clayton – summarized participants' need in this capacity.

Rosio: And in this community, it's hard to get VA and this hospital to work together, or this rest home. I need to put my husband in a home, but he is on VA medication. That's his insurance. Okay? When he was 65, no one told him, "You need Part B in case." Okay? So he has no Part B because VA said they would take care of it. And now VA is saying, "We're not going to take care of you because you don't have a certain percentage of whatever." ***And so there's all of this stuff that is just piling up on me because I'm the one who deals with it, not my husband. He's absent. And I am myself disabled, so it's difficult.*** And I'm not alone. That's what's bad. This summer, I tore a pectoral muscle

lifting the lid on the dumpster and had to have them replace the dumpsters. ***We need more disabled services available to us.*** We have to find a way to modify the way we put our trash out. I'm just 4'9". I can't lift those things up. And now I can't lift them up at all. So there has to be a different way. I called the city, and they brought an inferior broken dumpster to replace the one we had. And then they finally came back and brought us a decent one.

- Clayton Memorial Public Library

Health Supports and Services

Alongside discussions on the importance of accessible health supports and services, participants identified a broader need for expanded availability of medical supports and services. The character of health support varied by urban and rural focus groups. Urban sites tended to identify the importance of disability assistance vis-à-vis facility and equipment support and ADA compliant senior transportation – a feature already available for most participants in urban areas. For that reason, urban participants tended to identify the importance of existing health services and expressed a desire for wider availability and expansion.

Alternatively, rural participants readily identified a deficit of services in their communities and broadly described three kinds of health improvements that would support healthy aging in their rural communities: (1) greater access to medical services beyond emergency medical care, and (2) support for existing local medical services to keep local health supports available.

Firstly, individuals from rural focus groups described a general need for older adult healthcare beyond surgical and emergency services, including a range of supportive medical assistances like dental, hearing, and vision. According to participants, these services are critical. Participants explained how medical services are entirely absent or severely limited with respect to geriatric-specific medical services like cataract surgeries. This means that for many participants, travel to and from cities around a hundred miles away is a routine part of obtaining healthcare.

Mary: Oh no, it's pricey, yeah, for your dentist care. ***We do have chiropractic, and we do have vision, but we don't have cataract services.*** So if you're going to have cataracts replacements, then you do have to get assistance in Amarillo or a larger city that provides that medical facility. And that is a disadvantage if you have to have somebody take you and bring you back. But I don't think that's going to change in a rural area.

- Clayton Memorial Public Library

Selena: We don't have doctors. We don't have nurses. So we're constantly driving to Albuquerque to get services.

Valeria: I agree with these ladies but a lot of times, we need to get to Albuquerque. And if my spouse can't go, then we have to adjust. ***Because if you go for an eye appointment, they dilate your eyes. You better have somebody to bring you home.***

Selena: To drive you back. Oh, they won't do any-- the Eye Associates in Albuquerque will not operate on you unless you do have a driver to take you home.

- Gallup Senior Center

Eva: Springer has El Centro. Roy, Wagon Mound has El Centro. Las Vegas has the dental clinic. I go there. I know Jerry Padilla goes there. If your income is a certain income, it's basically free. You can get anything.

Jordan: They don't have it here.

Vicente: They don't have it here.

Trisha: Do you have a number for that?

Jordan: Yeah, but Las Vegas is 154 miles.

Eva: Yep. Yeah, I know. I'm saying-- -- ***Las Vegas is a long way to go, but have you tried to get a bridge fixed or something? It costs a lot more than a trip to Las Vegas.***

Patricia: Yeah. I went to Rio Rancho [for dental services]. Went there because I wanted to see my son, so.

- Clayton Memorial Public Library

Secondly, limited health services and supports were commonly described by rural participants as practical issues of access and availability. They emphasized the need for medical transportation assistance to access services in larger cities nearest to them. Likely because of limited medical support and services within rural areas, participants were acutely concerned with the loss of existing services and described a general need to find ways to retain limited services, clinics, or hospitals. Participants were widely concerned with how to financially support existing services and facilities and retain medical professionals. Participants explained these challenges frequently meant medical services were sporadic and inconsistently provided in their communities. One conversation with focus group participants in Mora was representative of the broadly identified need for improved availability of health supports and services.

Maura: We need a clinic for people here in Mora. ***We had one, but the doctors are always going away now. That is they don't pay them enough or something. They're just leaving.*** And we need something like that. For an emergency, you got to go all the way to Vegas.

Lucio: We're lucky that we have an [ambulance] service.

Beverly: Before, we didn't have. Now, it's back but I don't even know if they even have a place for them to stay to live in or not.

Researcher: What service is that?

Beverly: The ambulance service.

Researcher: So if there's an emergency they can take you to Vegas?

Maura: Yeah. They can take you to Vegas.

Beverly: Now we have that service. Before, we didn't have it.

- Mora Senior Center

Transportation Support

Needs assessments broadly find that transportation is a key issue for older adults of all kinds and from all places. It is therefore unsurprising that all sites – urban and rural – described need for transportation assistance. Participants from urban areas described needing more

transportation options as they aged to sustain access to senior centers and grocery stores, to accommodate disability, and attend social activities that enhanced their quality of life.

Gwendolyn: And actually, if you're a veteran-- I'm a veteran. And so I have found-- I have an appointment on Thursday. I found that they provide transportation…If you're a veteran, you can call and they will provide transportation services for you, so a lot of people don't know that. They know about ABQ RIDE or this wonderful service that I get to the center. It's perfect.

- Manzano Mesa Multigenerational Center

Ana: …when my husband died, all my kids moved in because they couldn't afford anything. So they are all moved in. So now everybody has to use my car, so I have to make an appointment for my car. Luckily, school's out this week, yes. But there was one thing-- they were good, but because it is county [transportation services], it's kind of questionable right now whether they can pick me up or not.

- Santa Fe Senior Center

Noah: I've got a question. What if you have a vehicle, and you're a senior, and you can't really drive like you used to, or you don't own a vehicle, you can't have a license no more, like persons with visual disorders or something rather in that nature, is there assistance where I can have my own vehicle and have someone in Albuquerque kind of transport me and get paid for it but use my vehicle?

- Los Volcanes Senior Center

In comparison to urban focus groups who desired expansion of senior bus systems and improved accessibility, rural participants explained how transportation services were extremely limited or non-existent. That is, although all focus group participants identified transportation as essential rural areas were more likely to identify need for transportation as a fundamental challenge of survival. As mentioned previously, medical transportation was overwhelmingly identified as a top need, but other types of transportation for accessing services and stores were also desired. Because rural areas often lacked health services, amenities, and affordable groceries, transportation out-of-town was cited as a top priority.

Gwendolyn: We do have a transportation service that there's a charge for. But if the charge is very minimum-- but the charge is very minimum if you have money. I meant, it's like-- I want to qualify that because, for me, I had enough money that the charge was minimum

- Clayton Memorial Public Library

Therese: ***This is because we don't have transportation to transport people out of town. We only have one vehicle, and this one vehicle only takes three people.*** So that's why we're not doing casinos or shopping. And we're supposed to get a van, but this has been going on for a year or longer. So it's not here, so I can't take people to the casino as I would like to, those who want to sign up. But there's no transportation vehicle that we can do that.

Ernie: ***Another thing that we don't have no stores. We had a Russell's and they closed it. And we don't got big stores, so we've got to go to Vegas or to Santa Fe or to somewhere else.***

Claudia: Yes, we need transportation. I try to get help from here because I got a bad knee, a bad hip. I tried to get help and see if they could take me. ***The only people that took me was the center here to Santa Fe, which I appreciated. They were very good. I tried to get help from a clinic down here in [inaudible]. They said they couldn't take me because I didn't have a doctor here in Mora because I've got a doctor in Las Vegas.*** And they said they couldn't take me because I had to be registered here at the clinic.

- Mora Senior Center

Selma: ***So I would go to Costco to get groceries. We'd go to Albuquerque with my sister once a week and we buy stuff from [inaudible] do some shopping***, and then me and my sister go to a different place to eat, and then we go to Costco to have groceries and we drive back.

Researcher: *Once a month. So are groceries a lot more expensive [in Gallup]?*

Rey: Oh, yeah. Gallup is--

Petra: ***Yeah. Because you get no Walmarts here.***

Researcher: *So it's worth it to drive and pay the gas and everything?*

Selma: Yeah. ***And get what you need. They load up for a month.*** Yeah.

- Gallup Senior Center

Magic Wand

We posed the same final question to all participants: *if you could design a program that would help older adults in your community, what would that program look like?* In their responses, many of the needs we identify above – transportation, socialization, service access, etc. - were invoked as problems worth fixing. But urban focus groups frequently focused on expanding services, especially classes, socialization opportunities, trips for cultural enrichment, and activities to enhance physical health.

Researcher: *Well, that leads kind of nicely into our last question, which is if you had a magic wand and you could design a program that would help older adults in Albuquerque, what would it look like?*

Ruth: ***Like I say, I like hands-on. I like to meet people, but I find that-- I don't know. I moved and we moved here just about a year or so before COVID hit. And then once COVID hit, everybody, of course, just stopped communicating in person with everybody.*** So I could understand that. And now, I don't have that communication with people, and when my husband died, forget about it. It's a lonely type of a thing…

- Manzano Mesa Multigenerational Center

Lela: ***Seniors like to do things. They like to socialize. They like to talk with each other. They like to see each other frequently. They like to know that everybody is still okay. Nobody has dropped dead and nobody***

knows about it. Seniors are gregarious. We like to talk. We like to share and sit outside, have a picnic, whatever.

Elias: ***I think she hit the nail on the head when she said we like to learn. And we like to learn from each other. And I can see bringing people in like an author. I can see having a book club.*** I can see having this place filled with art. How many senior citizens are artists? Well, why can't we have some of that work on there?

- Santa Fe Senior Center

Chris: There is one thing that I wanted to say. The centennial for Zozobra is this year. It's 100 years old. And they're wanting people to contribute stuff. I knew a guy who photographed - I'm trying not to say names - the first Zozobra being loaded into the pickup truck. And they want information. They want some of these stories. It's Richard Eads, on his radio show can connect you with these people. I think the guy is Ray Lovato who's running the centennial. And… ***There's a lot of people that know different stories about history here. They have stuff like that. Maybe there could be a group that just kept those stories going on.***

- Santa Fe Senior Center

Participants from rural areas generally identified three types of ideal programs for older adults in their communities:

(1) A centralized information and resource program
(2) An older adult housing program
(3) Improved transportation programs

Older adults from Clayton and Gallup described a critical need for programs that would consolidate information and/or accessible formats for senior services and supports.

Sandy ***The other, something we haven't touched on, was housing. And just the other day, I was going through a Gallup Housing Authority in the Sun. It was amazing. They had everything listed for senior***-- I mean, it's in the phonebook too kind of. But I was really glad that the Gallup Sun had a whole full page of housing, subsidized HUD housing and just all the housing. Because sometimes we transition very quickly. Right now I'm living in my own home. But who knows? Next year, I may have to move.

- Clayton Memorial Library

Truman: One of the things on-- and talking about youth and senior, ***I have gone to the city, and I have talked to them specifically about creating a program that puts the young people and the old people together and pets coming in to see older people.*** We have a plethora of knowledge.

- Clayton Memorial Public Library

Edwina: Just information.

Albert: And when they type it, use big letters. [laughter]

- Gallup Senior Center

Housing was also described as an important need within rural communities. Specifically, comprehensive information about housing options for seniors. Participants were quick to describe “beehive alley” and “assisted living alley” as unaffordable options and openly joked about these resources with one another. One participant explained how senior apartments without assisted living supports were not options they could rely on, and therefore were not “…feasible for residents”.

Dee: Beehive. [laughter]

Cecilia:: ***I can't afford Beehive. Are you kidding me? [laughter] I'd be out in the alley of Beehive, maybe.*** But I mean, it was just really nice.
- Gallup Senior Center

Glen: ***But if I had a magic wand, I would get a nursing home going in Mora in conjunction with the senior citizens because a nursing home in Vegas is somewhat full of residents from Mora.*** So if we had it here in Mora--the money would generate around the community much better than in Vegas.

Audrey: No, excuse me. Now they're working on a nursing home for Mora County. Some legislators will be talking about it, to establish a nursing home here in Mora. So they're working on acquiring the land for it. So it should've been in the stars already.
- Mora Senior Center

In sum, while several categories of need were evident across all focus group sites, needs were unsurprisingly characterized by the contexts of their communities. Urban communities expressed an overwhelming desire to re-engage older adults in services and increase senior participation to pre-pandemic levels, as well as enhance existing services and supports to improve quality of life. Rural areas were alternatively characterized by a need for creating or retaining access to services and support broadly. Participants in rural areas frequently described limited or non-existent service availability and therefore, that older adults needed assistance traveling to nearby communities with access to critical services and supports. Rural participants were quick to understand the limitations of their communities to provide the same services available in larger communities, and that a decision to live in a rural community was in many ways a de facto choice to eschew an urban lifestyle and its concomitant privileges. Still, it was clear from focus groups that older adults in rural areas desire greater information support about existing services, and in comparison to urban areas, rural older adults desire greater assistance with basic supports targeting more fundamental needs related to survival, namely, access to healthcare and affordable food.

STATEWIDE PROVIDER SURVEY – PART A

We conducted a survey in Spring 2023 which targeted 296 New Mexico older adult service providers. Of the 296 service providers who were sent the survey, 71 responded. The following section details the results of this survey.

Respondent Profiles

Our first task in the statewide provider survey was to assess which kinds of providers ultimately responded. Survey respondents identified the amount of experience they have with ALTSD services and ALTSD's target populations. Respondents also reported where in New Meixco they provide services and for how long. Overall, we captured at least one provider from every New Mexico county, with the exception of one: Bernalillo County. We subsequently discovered City of Albuquerque blocks external e-mails and survey invitations were not received by them. However, this does not explain why other providers in Bernallillo County did not respond. Regardless, we advise readers to consider the results of our survey with careful attention to this particular geographic blindspot. Despite this limitation, survey respondents in our sample are experienced with older adult services. Respondents indicated that on average they have provided services to older adults or adults with disability for nearly 13 years (12.72). Half of all surveyed providers reported having 11.5 years or more of experience in their field. Overall, our sample captures a wide swath of providers with professional experiences ranging from *less than one year* to a maximum of *30 years or more*.

We also asked respondents to indicate how much experience they have with their present agency or organization. Our average survey respondent has worked for their current organization for around a decade (9.87 years), with 50% of all surveyed providers working for 9 years or more with their current employer. Once again, these providers reflect a diverse set of experience levels, with providers having anywhere between *less than one year* of experience with their current organization, all the way to a maximum of *30 years or more*. These results taken altogether means that respondents represent a diverse set of experience levels – from the most to the least experienced providers across the State of New Mexico, but with the one exception we noted (Bernalillo County).

Services Inventory

To better understand the range of services providers offer, we asked respondents to compelte a self-report inventory of ALTSD services they have experience with. We separated services into seven categories according to the OAA budget model: Meal services, Access services, In-Home services, Legal Assistance services, Other Community services, Health Promotion and Disease Prevention services, and Caregiver Support services.

Across all seven service categories, it is evident that *Access services*, *Other Community services*, and *Meal services* are the most common types of services offered by providers in our sample (**Table 3**). More respondents provided senior center activities than any other service activity (77%; 55), followed by congregate meals (70%; 50), transportation (70%; 50), home-delivered meals (469%; 9), information assistance (62%; 44), and physical fitness/exercise services (58%; 41). Service categories offered infrequently by providers in our sample include caregiver support services (56%; 40), followed by legal assistance (59%; 42), in-home services (69%; 49) and health promotion and disease prevention (59%; 49). As these numbers indicate,

Table 3

*Number of respondents that reported providing each type of **Access services***

Service Type	Count
Transportation	50
Information Assistance	45
Outreach/Client Finding	32
Case Management	24
Other	21
Assisted Transportation	18

Note. n=71.

most services are captured by our sample. Even for the least common service categories, 56% or more of our sample had experience providing services in those categories.

Other Community services encompass the largest category of services provided by our respondents, with the top activity being Senior Center Activities (**Table 4**). The next most common response was for physical fitness/exercise (57%; 41), followed by loan of durable medical equipment (25%; 18), and "other" services (18%; 13). For other unspecified services, respondents listed 16 unique activities, including: social gatherings, community gardening, crafts, bingo, tax preparation, computer lab, artistic expression, piano lessons, senior olympics, end of life planning classes, food pantries, library book delivery for homebound seniors, Rx and Grocery delivery, out-of-town events, prescription pick-ups, and volunteer opportunities.

The most common meal service offered by providers in our sample are congregate meals (70%; 50) (**Table 5**). Nearly as many providers offer home-delivered meals (69%; 49). The next most common response was for "other" services, reflecting a broad range of meal services, such as:

Table 4

*Number of respondents that reported providing each type of **Other Community services***

Service Type	Count
Senior Center Activities	55
Physical fitness/Exercise	41
Loan of durable medical equipment	18
Other	13

Note. n=71.

Table 5

*Number of survey respondents that reported providing each type of **Meal services**.*

Service Type	Number of respondents
Congregate Meals	50
Home Delivered Meals	49
Other	22

Note. n=71

grab-and-go meals, emergency meals, meals delivered to sheltered homeless seniors, medically-tailored meals, and rural food boxes.

The fourth most common service offered by providers – *Health Promotion and Disease Prevention* services – captured three types of service activities: (1) staff training, (2) evidence-based programming, and (3) other unspecified activities. The most common activity within this service category was staff training (30%; 21), followed by evidence-based health programming (17; 24%), and "other" services (13; 18%) (**Table 6**). Under "other," respondents listed services such as: blood pressure checks, diabetes education, educational presentations, health fairs/events, shot clinics for flu and COVID, Tai Chi, Walk With Ease, and Matter of Balance training.

In-Home service providers were also widely sampled, with 68% (48) offering some activity within this broad category (**Table 7**). The most common service activity was for telephoning support (37%; 26), followed by home visiting (25%; 18) and housekeeping services (23%; 16). Personal care and other unspecified activities were the least commonly reported (13%; 9). Unspecified in-home services included: general check-ups, homemaker services, meal delivery, respite and wellness calls, and general in-home services for grandparents raising grandchildren.

One of the most uncommon service categories offered by our sample – *Legal Assistance* – captured five activity types: (1) education distribution, (2) legal clinics, (3) interactive workshops, (4) direct services, and (5) other unspecified services. The most common legal service activity

Table 6

*Number of providing each type of **Health Promotion and Disease Prevention services***

Service Type	Count
Staff training in evidenced-based programming	21
Evidence-based health programming	17
Other	13

Note. n=71.

Table 7

*Number of survey respondents that reported providing each type of **In-Home services***

Service Type	Count
Telephoning	26
Home Visiting	18
Housekeeping	16
Chore	13
Other	9
Personal Care	9

Note. n=71.

was for education distribution (35%; 25), followed by legal clinics (11%; 8), other unspecified activities (10%; 7), interactive workshops (8%; 6), and direct services (1%; 1) (**Table 8**). Under "other," respondents listed services such as: Online trainings, referrals to legal assistance program for the elderly, referrals to NM Legal Aid, and promotion of free online events.

The most uncommon service category offered by providers in our sample was therefore *Caregiver Support* services. When asked which *Caregiver Support* services providers have experience with, the most common responses were for two activities: in-home respite care for caregivers serving elderly (20%; 14) and information services pertaining to caregivers serving elderly (20%; 14) (**Table 9**). The next most common activity offered by providers was for Caregivers serving Elderly: Education/Training (14%; 10). Under "Other", 8% of respondents listed services such as: Dementia and grief support groups, Information distribution resources, and senior companions programs for companionship and assistance with activities of daily living and chores.

Table 8

*Number of respondents that reported providing each type of **Legal Assistance services***

Service Type	Count
Education Distribution	25
Legal Clinic	8
Other	7
Interactive Workshop	6
Direct Service	1

Note. n=71.

Table 9

Number of survey respondents that reported providing each type of Caregiver Support service

Service Type	Count
Caregivers serving Elderly: Respite Care (In-Home)	14
Caregivers serving Elderly: Information Services	14
Caregivers serving Elderly: Education/Training	10
Caregivers serving Elderly: Respite Care (Adult Day Care)	9
Caregivers serving Elderly: Access Assistance	8
Grandparents/Elderly Caregivers: Information Services	7
Other	6
Grandparents/Elderly Caregivers: Access Assistance	5
Caregivers serving Elderly: Supplemental Services	5
Grandparents/Elderly Caregivers: Education/Training	4
Grandparents/Elderly Caregivers: Respite Care (In-Home)	3
Caregivers serving Elderly: Counseling	2
Grandparents/Elderly Caregivers: Respite Care (Adult Day Care)	2
Grandparents/Elderly Caregivers: Respite Care (Supp./Vouchers)	1
Grandparents/Elderly Caregivers: Counseling	1
Caregivers serving Elderly: Respite Care (Supp./Vouchers)	1
Grandparents/Elderly Caregivers: Supplemental Services	1

Note. n=71.

Older Adult Profile

We also tasked providers with constructing a portrait of the most common kinds of older adults supported, describging seven attributes typical of older adult clients they serve (**Table 10**). While considerable variability existed, most respondents reported their typical client is low income (47; 66%), Hispanic (36; 51%), female (42; 59%), lives alone (41; 58%), lives with a disability (37; 52%), and speaks English as a primary language (44; 62%). A plurality of respondents (31; 44%) said their typical client is between the ages of 71-80. We highlight these attributes in **Table 10.** Please not that typical attributes were not conditional, and so do not describe *one* single client with all seven attributes.

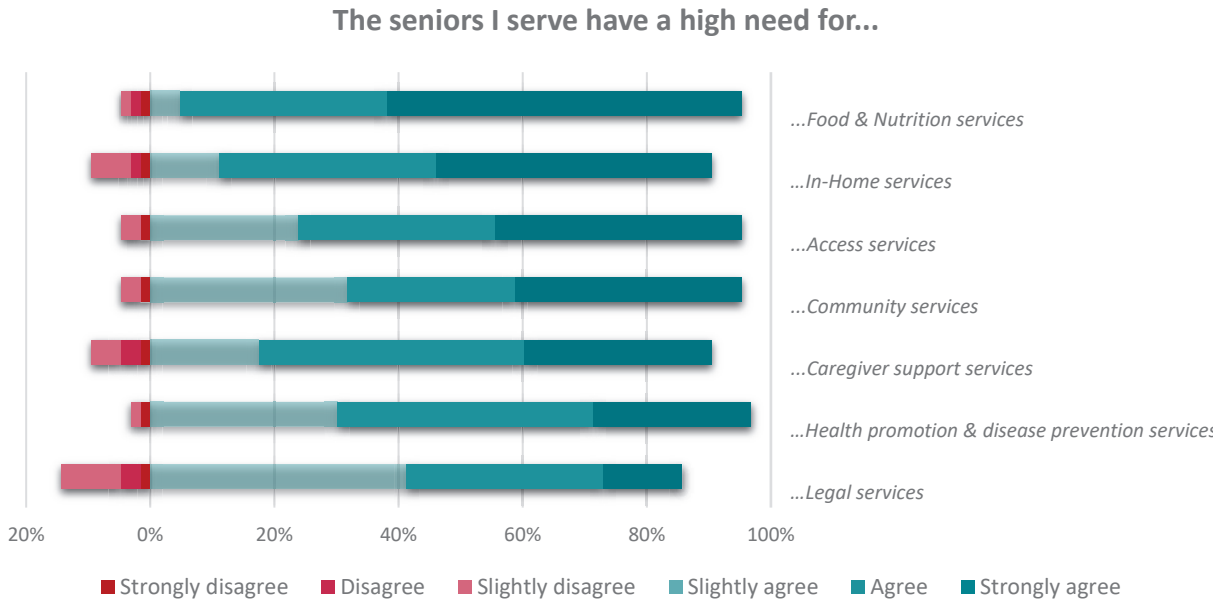
Older Adult Need

Our survey also aimed to produce a broad picture of older adult need throughout New Mexico, according to those who work most closely with older adult clients – providers. According to the service provider inventory (page 45), providers we surveyed have broad service experience to assess which service categories are most needed. Surveyed providers rated older adult need with respect to the seven service categories we inventoried: Meal services, access services, in-home services, legal assistance services, other community services, health promotion and disease prevention services, and caregiver support services. Specifically, we asked how much providers agree with statements about older adults with a high need for each service type. Responses were restricted to a 6-point likert-scale where 1 corresponded to "strongly disagree" and 6 corresponded to "strongly agree".

Results indicate providers perceive older adult need is high across all service types. **Figure 1** details how greatest agreement occurs on high need for *meal* services, with the average provider response between "Agree" and "Strongly agree" (average = 5.38). This is followed by agreement on high need for *in-home* services (average = 5.10) and *access* services (average = 5.03), which also have an average response slightly above "Agree." Lowest agreement among providers occurs for *other community* services (average = 4.92), *caregiver support* services (average=4.87), *health promotion and disease prevention* services (average = 4.86), and *legal assistance* services (average = 4.37). However, average agreement on high need for these services remained positive – between "Slightly Agree" and "Agree."

Figure 1

Provider agreement that given service category is highly needed by seniors



Note. n=71.

Table 10

Summary of physical attributes respondents indicated was most typical of the average client

Attribute	Count	Percent
Income Category		
Low Income	**47**	**66.2%**
Middle Income	15	21.1%
High Income	0	0.0%
Don't know or Not Applicable	9	12.7%
Age		
Younger than 50	1	1.4%
50 - 60	1	1.4%
61 - 70	23	32%
71 - 80	**31**	**44%**
81 – 90	7	10.0%
91 or older	0	0.0%
Don’t know or Not Applicable	8	11.2%
Racial Identity		
White (Non-Hispanic)	11	15.5%
Hispanic	**36**	**50.7%**
Native American	12	16.9%
African American	0	0.0%
Other	1	1.4%
Don't know or Not Applicable	11	15.5%
Gender		
Male	10	14.1%
Female	**42**	**59.2%**
Other	5	7.0%
Don't know or Not Applicable	14	19.7%
Living Arrangement		
Lives alone	**41**	**57.7%**
Lives with spouse or partner	10	14.1%
Lives with friend	1	1.4%
Lives with family	9	12.7%
Don't know or Not Applicable	10	14.1%
Language Spoken		
English	**44**	**62.0%**
English as second language	17	23.9%
Does not speak English	2	2.8%
Don't know or Not Applicable	8	11.3%
Disability Status		
Lives without a disability	5	7.0%
Lives with a disability	**37**	**52.1%**
Lives with 2+ disabilities	10	14.1%
Don't know or Not Applicable	19	26.8%

Note. n = 71

Table 11

Unmet needs among seniors, according to provider survey respondents

Medical Needs	In-Home Needs
Access to a primary care provider	Housekeeping
End of life opportunities	Assistance for home renovations/maintenance
Specialized medical care	Yard work (mowing lawn, chopping wood, etc.)
Medication management	Pest control
In-Home mental health therapy	Chore services
Behavior health services	Pet assistance
Chronic pain management	
Disease prevention	**Meal Needs**
	Food pantries
Transportation Needs	Food assistance
After hours public transportation options	Daily nutrition needs (e.g., fresh fruits/veg.)
Affordable out-of-town medical transportation	
Night-time transport from Hospital	**Caregiver Needs**
Transportation to store	Companionship
Assisted transportation	Affordable Adult Day Care Centers
Adequate roads	
	Legal and Financial Needs
Housing Assistance Needs	Middle income elders in need of financial help
Affordable housing	Protection from predatory lending
Housing assistance	Living wills
Low-income housing	Legal assistance
	Tax services
Information Needs	
Medicare information	**Utility Needs**
Understanding Medicare/Medicaid	Utility assistance (water, electricity, solid waste)
Explanation of health care systems	Heating (firewood, propane)
Health education by licensed professionals	
Digital technology training/assistance	
Financial education/literacy	
Financial elder abuse education	
Language translation/interpretation	
Programs in other languages	

Providers also identified *unmet* service needs for older adults. Responses were open-ended and varied. We grouped these identified unmet needs into nine categories: (1) Medical, (2) Transportation, (3) Housing Assistance, (4) Information, (5) In-Home, (6) Meal, (7) Caregiver, (8) Legal and Financial, and (9) Utility Assistance. **Table 11** (above) summarizes the range of needs providers identified. Many of these unmet needs are described by older adults who participated in our focus group sessions. We highlight in blue which needs were described by both older adult focus group participants and surveyed providers.

Service Gaps & Barriers

Surveyed providers also described gaps in services and barriers to effectively providing services. Critically, a majority of respondents said their current organization does ***not*** adequately meet the legal service needs of their clients (51%; 36) (**Table 12**). A little over one third of respondents also clearly identified improvement for meeting need in *caregiver support* (37%; 26) and *in-home* services (35%; 25). Lastly, about one-quarter of respondents identified gaps in meeting need with respect to h*ealth promotion and disease prevention* services (27%; 19), and one-fifth of surveyed providers identified unmet need for *access* services (20%; 14). Only eight surveyed providers said their organization meets all needs adequately.

To better understand why needs are unmet, providers rated the extent to which they believed the following factors are important barriers to satisfying older adult needs:

1) Service providers often don't know what those needs are
2) Service providers don't provide enough services
3) Older adults don't know what services are available

Respondents rated their level of agreement with each statement along a 6-point scale, from "Strongly disagree" (point value = 1), to "Strongly agree" (point value = 6). The average respondent indicated every barrier significantly affects how providers meet older adult needs, although respondents emphasized certain barriers more than others. **Figure 2** summarizes how providers overwhelmingly agree the most significant barrier is that ***providers do not offer enough services***. Agreement on this factor was high, with an average response between "Slightly agree" and "Agree" (average = 4.71) and 84% of respondents indicating some level of agreement. Providers reported, on average, that older adult knowledge of services was similarly

Table 12

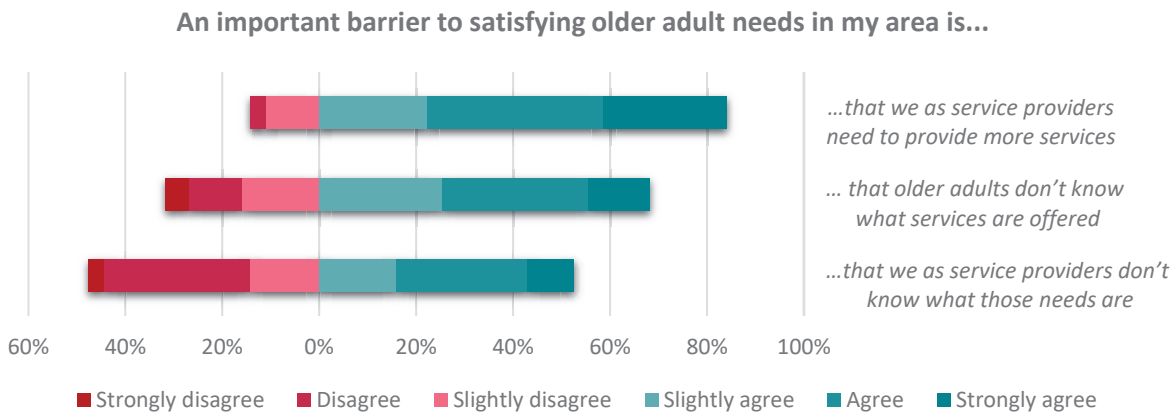
Number of respondents indicating their organization does NOT adequately meet senior need

Need Category	Count
Legal services	36
Caregiver Support services	26
In-home services	25
Health Promotion & Disease Prevention services	19
Access services	14
Other Community services	10
All needs are met adequately	8
Food & Nutrition services	5
Other	4

Note. n=71.

Figure 2

Provider agreement that given category represents a barrier to meeting older adult needs



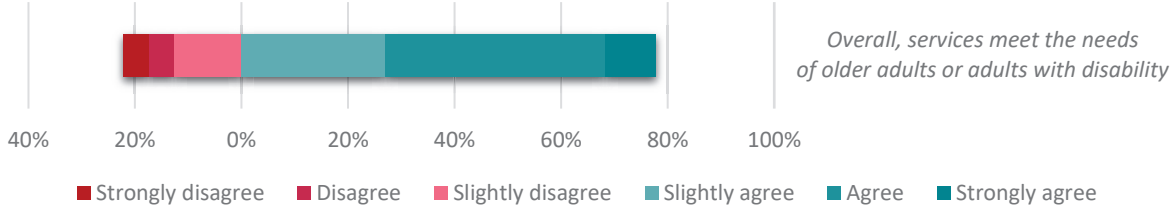
Note. n=71.

a significant barrier (average = 4.03), with 68% of all surveyed providers finding it an important challenge. The final statement, that ***an important barrier was lack of knowledge among older adults about services***, received mixed responses. The average response was between "Slightly disagree" and "Slightly agree" (average = 3.62), with roughly half of all respondents (52%) indicating agreement.

Finally, to gain an overview of providers' perception of their organization's capacity to meet senior needs, we asked survey respondents to rate their level of agreement that: "***The service(s) my organization currently provides meet the needs of older adults in my community.***" The majority (78%) of providers agreed with the statement (**Figure 3**). The average response was between "Slightly agree" and "Agree" (average = 4.24).

Figure 3

Provider agreement that provider's service(s) meet needs of older adults in their community



Note. n=71.

U.S. CENSUS DATA

To assess vulnerability across New Mexico's older adult population, we review American Community Survey (ACS) 5-year estimates for 2013 – 2017 and 2018 – 2022. For nearly all ACS topical areas data are restricted to these two most recent 5-year estimates because changes in survey question wording make comparisons with older estimates inappropriate, with one exception – age. In this case, we compare 5-year estimates for 2008 – 2012 and 2018 – 2022 for a wider ten-year analysis of change. Analysis of race and ethnicity are also limited due to changes in survey question wording which occur more recently, so comparisons are not possible with any previous 5-year data. Our analysis of "older adults" are also limited to either adults 60+ or 65+, depending on how public data are restricted by the U.S. Census for each topical area.

Additionally, while the ACS is an extensive and typically highly accurate estimate, it ultimately reflects samples of the population and is generally not a total population count. As a result, estimates from the ACS should be considered alongside margins of error (MOE). Margins of error reflect a 90% confidence interval above and below the estimate provided, where the true population count lies. For example, approximately 521,739 adults 60 and over live in New Mexico. The margin of error for this estimate is ±5,107 people. Therefore, the true count of older adult New Mexicans likely lies somewhere between 392,875 and 399,555 people. Estimates therefore represent the midpoint of the confidence interval. We frequently show margin of error with estimates and indicate when differences over time are significantly different (at 90% Confidence Interval (CI)). We also make note and/or do not report estimates which are highly uncertain. In these cases, the coefficient of variation (CV) for an estimate is greater than 30% and should only be considered with extreme caution. Being extremely cautious, we do not consider or report these estimates.

In this section we use ACS data to review 18 demographic and topical areas relating to older adult needs:

19. Older Adult Population
20. Race & Ethnicity
21. Educational Attainment
22. Marital Status
23. Disability Status
24. Employment Status
25. Health Insurance & Poverty
26. Household Type
27. Dual Coverage Medicare & Medicaid
28. Poverty Status
29. SNAP Benefit Status
30. Veteran Status
31. Grandparent Responsible for Grandchildren: Older Adult Grandparents
32. Grandparent Responsible for Grandchildren: Race & Ethnicity
33. Grandparent Responsible for Grandchildren: Employment Status
34. Grandparent Responsible for Grandchildren: Poverty Status
35. Grandparent Responsible for Grandchildren: Disability Status
36. Grandparent Responsible for Grandchildren: English as Second Language

Older Adult Population

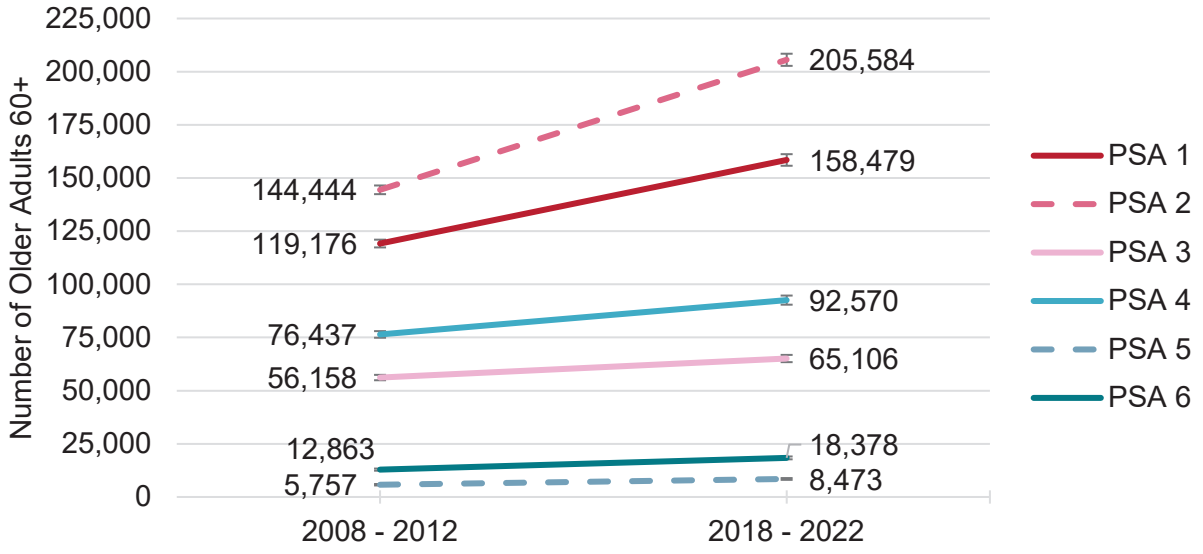
As of 2022 5-year estimates, New Mexico's older adult population (60+) has grown significantly across the state. Unlike other survey questions from the American Community Survey (ACS), the survey question for age has not changed significantly over time allowing comparison of more distant 5-year estimates for 2008 – 2012 with the most recent 2018 – 2022 estimates (**Table 13**). New Mexico's older adult population has increased significantly (90% confidence interval (CI)) over time, with some areas and age cohorts experiencing more change than others. **Figure 4** breaks down change in the 60+ population over time by PSA.

Key Insights

- Approximately **521,739 (±5,107)** older adults aged 60 and older live in New Mexico as of the 2022 5-year estimates.
- The older adult population (60+) increased by **125,524 (±6,103)** people between 2012 and 2022 estimates.
- **PSA 1** & **PSA 2** have the largest older adult populations, with over 100,000 residents each.
- **PSA 2** and **PSA 5** saw the largest percentage increases in older adult populations:
  - **PSA 2** grew by **42.9% (±2.8%)**.
  - **PSA 5** experienced a **47.2% (±11.3%)** increase.

Figure 4

New Mexico's older adult (60+) population over time, statewide & by PSA



Note. Data source: ACS 5-year estimates for 2008 – 2012 and 2018 – 2022.

Table 13

Change in New Mexico's older adult population (60+) from 2012 to 2022, by region

	2008 – 2012		2018 – 2022		Change*	
Region	Estimate	MOE	Estimate	MOE	Estimate	MOE
Statewide	396,215	±3,340	521,739	±5,107	125,524	±6,103
PSA 1	119,176	±1,825	158,479	±2,726	39,303	±3,280
PSA 2	144,444	±2,042	205,584	±2,852	61,140	±3,508
PSA 3	56,158	±1,267	65,106	±1,705	8,948	±2,124
PSA 4	76,437	±1,556	92,570	±2,146	16,133	±2,651
PSA 5	5,757	±339	8,473	±417	2,716	±537
PSA 6	12,863	±500	18,378	±672	5,515	±838
Rural Counties	63,721	±1,402	80,224	±1,790	16,503	±2,274
Urban Counties	332,494	±3,091	441,515	±4,458	109,021	±5,425

Note. *Change for all regions reflects significant difference at 90% confidence level. PSA stands for Planning and Service Area. MOE – Margins of Error at 90% CI.

- **PSA 3** & **PSA 4** had the smallest population increases, growing by **15.9% (±4.0%)** and **21.1% (±3.7%)**, respectively.
- Older adults in rural counties grew by **16,503 (±2,274)** people over this period.
- **Urban** counties accounted for most growth over time, adding **109,021 (±5,425)** older adults from 2012 to 2022 estimates.

Changes Over Time (2017 and 2022 5-year estimates)

- The **older adult population** (**60+**) increased significantly in all PSAs from 2012 to 2022 estimates.
- **PSA 2** saw the largest absolute increase, with **61,140 (±3,508)** more older adults, followed by **PSA 1**, with an increase of **39,303 (±3,280)**.
- **Urban counties** accounted for most of the growth in the 60 and older population, increasing by **109,021** (**±5,425**) residents, a growth of **32.8%** (**±1.8%**).
- **Rural counties** grew by **16,503** (±**2,274**) older adults, representing a **25.9%** (**±3.9%**) increase.

Age Cohort Changes (60 and older)

- The **65+ cohort** experienced the largest growth, adding **107,569 (±5,111)** older adults, representing a **41.0%** (**±3.8%**) increase from 2012 to 2022 estimates (**Figure 50**, Appendix C).
- In contrast, the **45 – 54 age cohort** saw a **14.9%** (**±0.1%**) decrease, equivalent to **49,335** (**±1,122**) fewer people (**Figure 50**, Appendix C).

Key Observations

- Growth in the **60+ population** is most pronounced in urban counties overall, and particularly within **PSA 2** which had that largest absolute increase.
- Rural counties also experienced a notable increase in their older adult population, though the total numbers remain smaller compared to urban areas.
- The shift in age cohort dynamics, with an increase in **65+ age cohort** and a decline in the **45 – 54 age cohort**, signals potential challenges for future planning regarding services for older adults (**Figure 50**, Appendix C).

Race & Ethnicity

The ACS assesses racial identity within seven categories: (1) White, (2) Black or African American, (3) American Indian or Alaskan Native, (4) Asian, (5) Native Hawaiian Islander, (6) Other Race, and (7) Two or More Races. Each category is mutually exclusive. Ethnicity is considered within two categories: White Non-Hispanic, or Hispanic or Latino. Data are available for older adults 65 and older. We find PSAs 1 – 4 have similar distributions to the statewide pattern of racial identity; rural and urban counties are also reported in Appendix C. Change over time is not considered since recent ACS question changes make comparison inappropriate.

- **Figure 5** summarizes the statewide racial and ethnic distribution of older adults (65+) in 2022.
- **Table 52** in Appendix C reports racial and ethnic identity for each PSA in 2022.

Statewide Race & Ethnicity

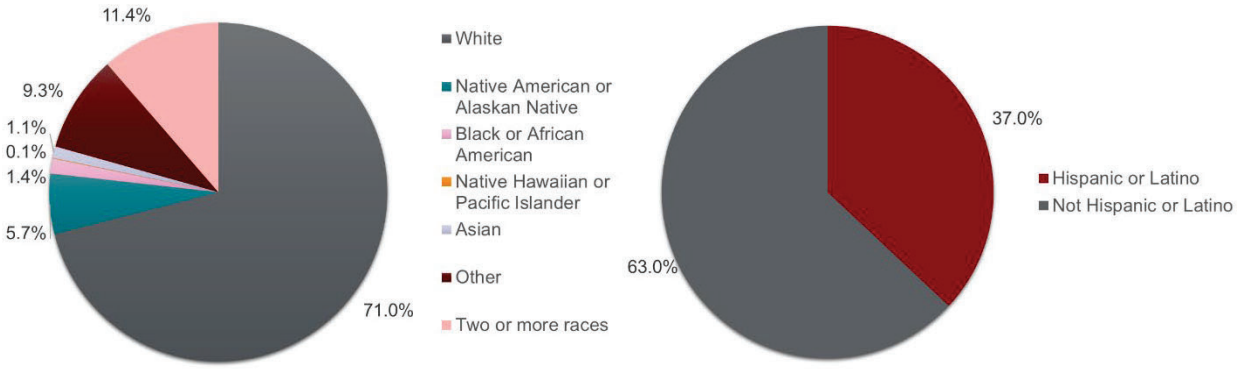
- **71%** (**±0.1%**) of New Mexicans aged 65 and older identify as **White**.
- The second largest racial group is **Two or More Races**, representing **11.4% (±0.4%)** of the older adult population.
- **5.7%** (**±0.1%**) identity is for **Native American or Alaskan Native**.
- **37.0%** (**±0.4%**) of older adults identify as **Hispanic or Latino**.

Race & Ethnicity by PSA

1. **PSA 1 – 4 (Bernalillo County and Non-Metro Areas):**
    - **67.5% to 76.6%** of older adults identify as **White**.
    - **33.4% to 37.0%** identify as Hispanic or Latino, similar to the statewide proportion.
    - Native American or Alaskan Native representation is comparatively low, except for **PSA 2**, where **11.8%** of older adults identify as such.
2. **PSA 5 (Navajo Nation):**

Figure 5

Race & Ethnicity for New Mexico older adults (65+), 2022



Note. Data from ACS 2018 – 2022 5-year estimates

- The overwhelming majority (**96.7% (±2.3%)**) of older adults identify as **Native American or Alaskan Native**
- **2.1% (±1.3%)** identify as **White**; a notable **40.9% (±0.8%)** identify as **Hispanic or Latino**.

3. **PSA 6 (Tribes, Pueblos, Nations):**
   - **36.8% (±1.9%)** identify as **Native American or Alaskan Native.**
   - **34.6% (±1.8%)** identify as **White.**
   - **11.3% (±1.4%)** identify as **Two or More Races**, and **16.8% (±2.1%)** identify as some **other** race.

Urban vs. Rural Demographics

1. **Urban Counties:**
   - **73.0% (±0.2%)** of older adults identify as **White**, similar to statewide proportion.
   - Less than half (**43.4%** (**±1.0%**)) identify as **Hispanic or Latino**.
   - A Relatively small proportion (**3.8%** (**±.0.1%**)) identify as **Native American or Alaskan Native.**
2. **Rural Counties:**
   - Relatively fewer older adults in rural areas identify as **White** – **60.1%** (**±0.4%**).
   - **16.1%** (**±0.5%**) identify as **Native American or Alaskan Native**; significantly higher than in urban areas.
   - **69.4% (±1.3%)** identify as **Hispanic or Latino**.

Key Observations

- **PSA 5** stands out with its predominantly **Native American or Alaskan Native** older adult population **(96.7%).**
- **PSA 6** shows significant racial diversity, with notable proportions identifying as **Native American or Alaskan Native**, **White**, and **Hispanic or Latino**.
- **Rural** counties show a higher concentration of **Hispanic or Latino** and **Native American or Alaskan Native** older adults, while urban areas are more aligned with the statewide distribution of **White** older adults.

Educational Attainment

Data for educational attainment are available on older adults 65 and older. Educational attainment is summarized within three categories: (1) Less than a high school diploma, (2) High School Graduate/GED, and (3) Bachelor's degree or higher.

- **Figure 6.1** summarizes educational attainment statewide and by PSA in 2022.
- **Figure 6.1** summarizes educational attainment for rural and urban New Mexico counties in 2022.

Statewide Older Adult (65+) Educational Attainment:

According to 2022 American Community Survey (ACS) estimates:

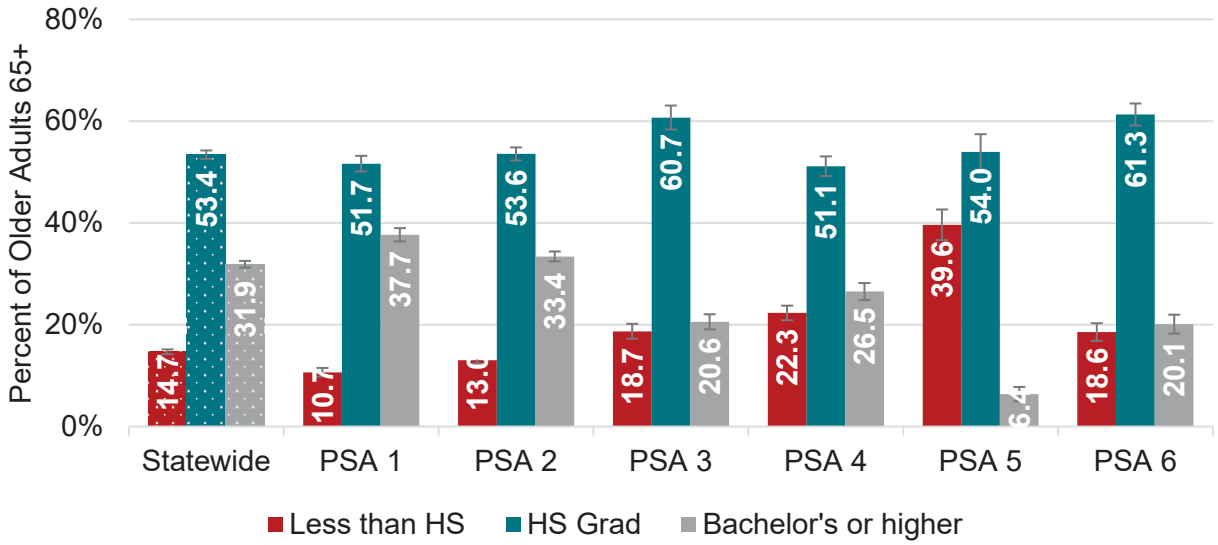
- **14.7%** (**±0.5%**) of New Mexico's older adults have not completed high school.
- **53.4%** (**±0.8%**) have obtained a high school diploma or equivalent.
- **31.9%** (**±0.7%**) hold a bachelor's degree or higher.

Educational Attainment by PSA

1. **PSA 1 (Bernalillo County)**
    - **10.7%** (**± 0.9%**) of older adults have not completed high school, the lowest proportion among all PSAs.
    - A higher proportion of older adults in PSA 1 hold a bachelor's degree or higher (**37.7%** (**±1.3%**)).
2. **PSA 4**
    - **22.3%** (**±1.4%**) of adults 65 and older in PSA 4 have not obtained a high school diploma, the highest proportion among PSAs 1 – 4.
3. **PSA 5 (Navajo Nation):**
    - **39.6%** (**±3.0%**) of older adults in PSA 5 have not completed high school, the highest proportion of any PSA.
    - PSA 5 also has the lowest proportion of older adults with a bachelor's degree or higher at 6.4% (±1.4%).
4. **PSA 6 (Tribes, Pueblos, Nations):**
    - Similar to PSA 5, PSA 6 has a low proportion of older adults with a bachelor's degree or higher at **9.8%** (**±1.6%**).
    - **26.3%** (**±1.9%**) of older adults in PSA 6 have not completed high school.

Figure 6.1

Educational attainment for New Mexico older adults (65+) in 2022, statewide and by PSA



Note. Data from American Community Survey (ACS) for 5-Year 2018 – 2022 estimates.

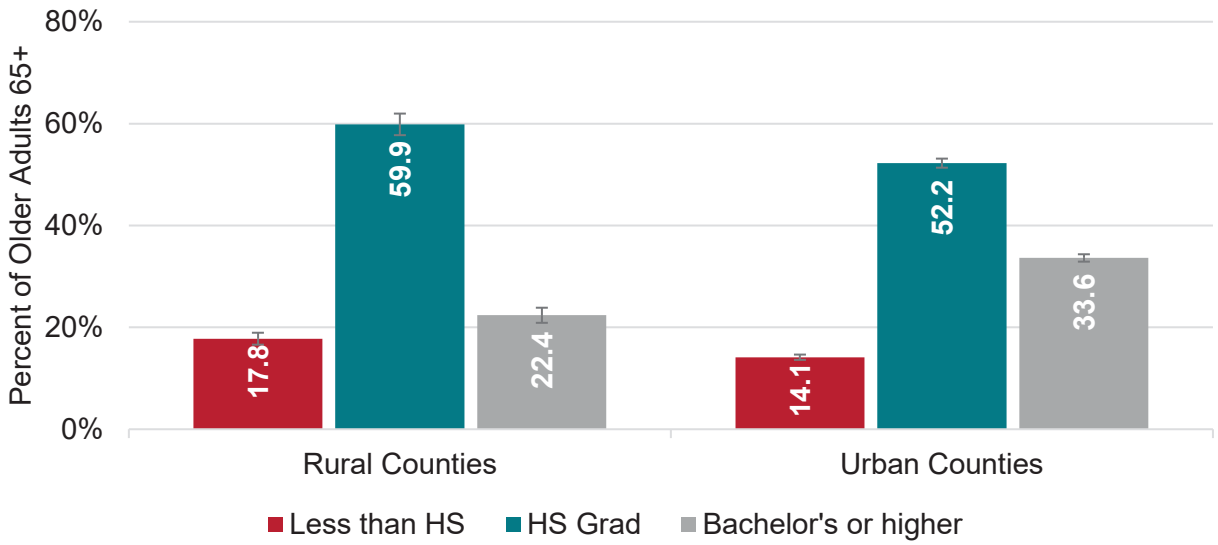
Urban vs. Rural Educational Attainment:

There is a significant but modest divide between rural and urban areas in terms of educational attainment among older adults (**Table 70** in Appendix F):

1. **Rural Counties**
   - **17.8%** (**±1.2%**) of older adults in rural counties have not completed high school, higher than the urban proportion.
   - **22.4%**, (**±1.5%**) of older adults in rural areas have a bachelor's degree or higher.
   - **59.9%** (**±2.1%**) of rural older adults have completed high school, a higher proportion than in urban counties.
2. **Urban Counties:**
   - **14.1%** (**±0.5%**) of older adults in urban counties have not completed high school.
   - A larger share of urban older adults, **33.6%** (**±0.7%**), hold a bachelor's degree or higher, more than for rural areas.
   - **52.2%** (**±0.9%**) of older adults in urban areas have obtained their high school diplomas.

Figure 6.2

Educational attainment for New Mexico older adults (65+) in 2022, rural and urban counties



Note. Data from American Community Survey (ACS) for 5-Year 2018 – 2022 estimates.

Key Observations

- **PSA 5** stands out with the lowest educational attainment levels, where **almost 40%** of older adults have **not completed high school**.
- **PSA 1 (Bernalillo County)** has the highest proportion of older adults with higher education (bachelor's degree or above).
- Older adults in **rural counties** are more likely to hold only a high school diploma but are less likely to have completed higher education compared to their urban counterparts.
- Educational disparities are particularly pronounced between **rural and urban areas**, with a significantly lower proportion of older adults in rural areas holding bachelor's degrees.

Marital Status

The marital status of older adults 60 and older in New Mexico, as of 2022 5-year estimates, shows a largely married population. Trends over time indicate changes in the proportions of never married, widowed, and divorced older adults.

- **Figure 7.1** reports the marital status of older adults statewide over time, from 2017 to 2022 5-year estimates.
- **Figure 7.2** further reports the percent of older adults (60+) for each marital status for 2022 estimates, statewide and by PSA.

- **Figure 51** in Appendix C summarizes change over time in unmarried populations.

Statewide Older Adult (60+) Marital Status:

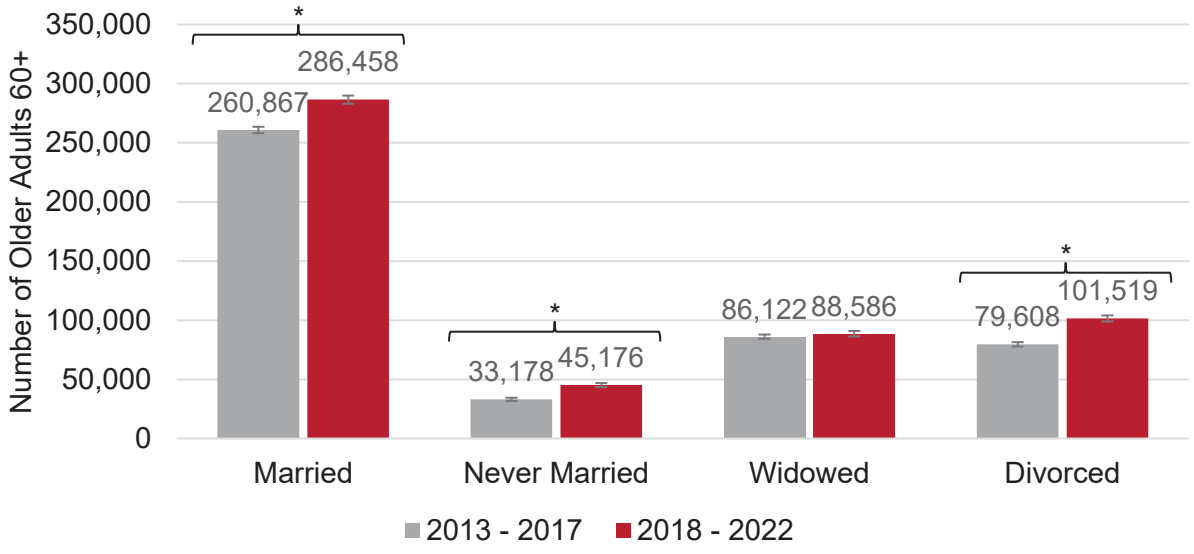
- **54.9%** (**±0.4%**) of New Mexico's older adults are married or partnered, representing **286,458** (**±3,447**) people (**Figure 58** in Appendix F).
- **8.7% (±0.3%)** of all older adults have **never been married**.
- **17.0% (±0.4%)** of the population are **widowed**.
- **19.5% (±0.5%)** are **divorced**.
- **Unmarried** (never been married, widowed, and divorced) older adults (60+) account for **135,281 (±3,883)** people statewide.

Changes Over Time Statewide (2017 vs. 2022 Estimates)

- The total number of **married older adults** increased by **25,591 (±4,371)** people from 2017 to 2022 estimates.
- The number of **never married** older adults grew by **11,998 (±2,136)** people, while the number of **divorced** older adults increased by **21,911 (±3,158)**.
- Despite the increase in absolute numbers, the **proportion of married older adults decreased** by **1.8% (±0.5%)**.
- Conversely, the proportion of **never married** older adults increased by **1.4% (±0.4%)**, and the proportion of **divorced** older adults increased by **2.1% (±0.6%)**.

Figure 7.1

Marital status of older adults (60+) over time in New Mexico



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

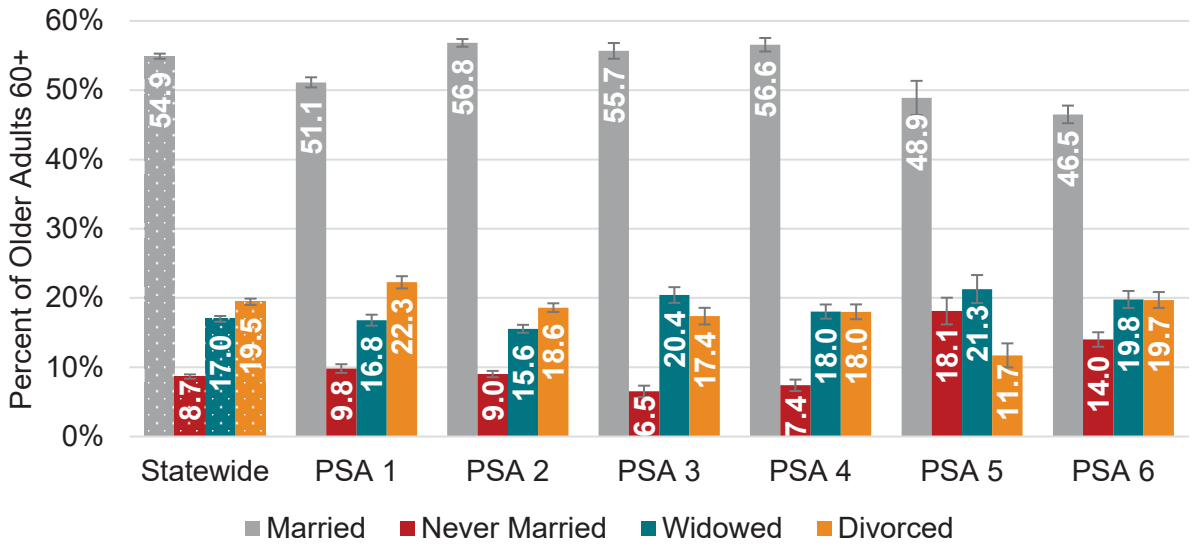
- Estimates for change over time in **widowed** older adults are uncertain, though individual estimates in 2017 and 2022 are reliable.

Marital Status by PSA

1. **PSAs 1 – 4:**
    - The number of **unmarried** older adults significantly increases for all PSAs over time, potentially reflecting broader changes of an increasingly older cohort.
    - **51.1% (±0.7%)** – **56.8% (±0.6%)** of older adults in these PSAs are **married** and less than **10%** of these populations are **never married**.
    - The proportions of **widowed** and **divorced** older adults are close to statewide averages.
2. **PSAs 5 & 6 (Navajo Nation & Tribes, Pueblos, Nations)**
    - A **majority (53.5%)** of older adults are **unmarried** in **PSA 5**, which is also the highest proportion of any PSA.
    - **PSA 5** has the highest proportion of **never married** older adults: **18.1% (±1.9%)**.
    - **PSA 6** follows closely, with **14.0% (±1.0%)** of older adults having never married.
    - These PSAs also have higher proportions of **widowed** and **divorced** older adults compared to PSAs 1 – 4, indicating a largely unpaired older adult population.

Figure 7.2

Marital status of older adults (60+) in 2022, statewide and by PSA



Note. Data reflects 2018 – 2022 ACS 5-year estimates.

Urban vs. Rural Marital Status:

1. **Urban Counties:**
    - The number of **unmarried** older adults increased by **39,019 (±4,343)** people between 2017 and 2022 5-year estimates, while the number of **married** older adults increased by **23,048 (±4,004)**.
    - Over time, the proportion of **married** older adults increased slightly by **3.5% (±1.1%)** (**Figure 57** in Appendix F**)**.
2. **Rural Counties:**
    - The number of **unmarried** older adults increased by **5,354 (±1,911)** people during the same period, with uncertain estimates for growth in **married** older adults (coefficient of variation > 30%).
    - Rural areas saw a **2.9% (±0.9%)** increase in the proportion of **never married** older adults and a **1.2% (±1.1%)** increase in the proportion of **widowed** older adults.

Key Observations:

- **PSA 5 & 6** are characterized by a majority of **unmarried** older adults, a trend not observed in other PSAs.
- The overall number of **married** older adults has grown, but the proportion is declining statewide as the population ages.
- Both **urban and rural areas** have seen increases in the number of **unmarried** older adults, but growth is more pronounced in urban counties.
- **Urban counties** show a slight increase in the proportion of **married** older adults.
- In contrast, **rural areas** demonstrate a growing share of **never married** and **widowed** older adults, potentially reflecting social and demographic differences in aging populations across urban and rural counties.

Disability Status

The American Community Survey (ACS) assesses disability status among older adults (65+) based on six self-reported functional limitations:

1. Hearing difficulties
2. Vision difficulties
3. Cognitive difficulties
4. Ambulation difficulties
5. Self-care difficulties
6. Independent living difficulties.

Items 5 & 6 – self-care difficulty and independent living difficulty – are based upon Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) measures used by health care providers. These measures assess limitations relating to physical, mental, or emotional conditions that interfere with "*dressing, bathing, or getting around inside the home*" and "*doing errands alone such as visiting a doctor's office or shopping*" (ACS 2022). Disability status is reported as having *any one* of the six types of limitations named above.

- **Figure 8.1** illustrates the number of older adults (65+) with any disability, both statewide and by PSA, highlighting changes over time between ACS 5-year estimates for 2017 and 2022
- **Figure 8.2** compares trends in disability status between rural and urban counties, showing both the number of older adults with any disability in these areas during the same period.

Statewide Older Adult (65+) Disability Status

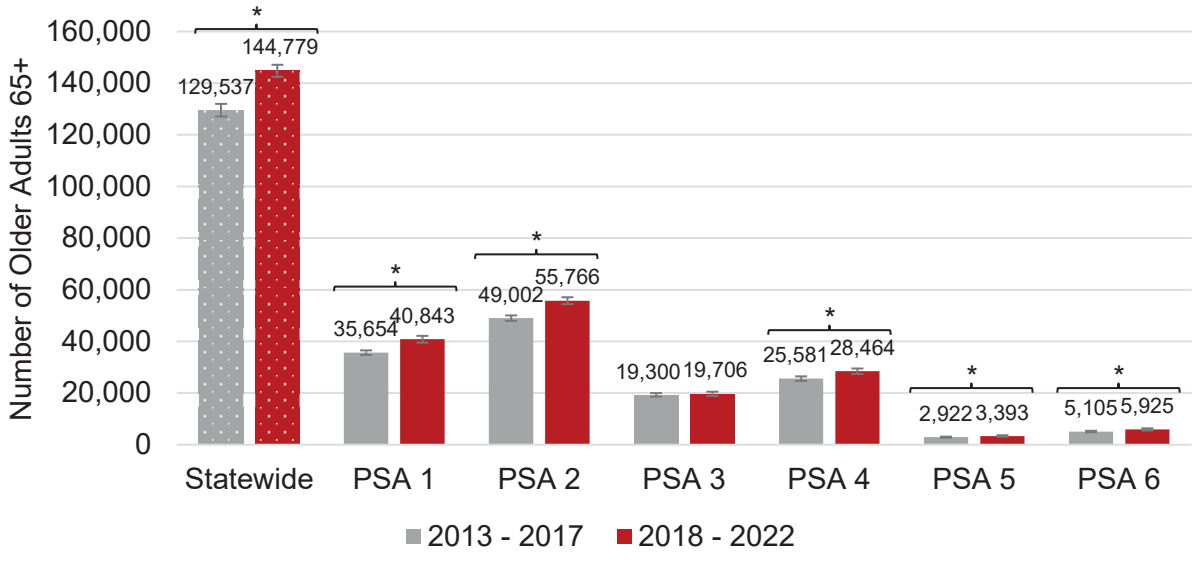
- As of 2022, approximately **144,779 (±3,340)** older adults 65 and older in New Mexico reported having any disability.
- This reflects an **11.8% (±2.8%)** increase from 2017 estimates, with approximately **15,242 (±3,378)** more older adults reporting a disability in the 2022 period.
- All PSAs, except for PSA 3, experienced significant increases (at 90% confidence interval) in the number of older adults with any disability between 2017 and 2022 estimates.

Change Over Time by PSA (2017 vs. 2022 Estimates)

- **PSA 1:** Increase of **5,189 (±1,580)** older adults (65+) with disabilities
- **PSA 2:** Increase of **6,764 (±1,707)** older adults (65+) with disabilities
- **PSA 4:** Increase of **2,883 (±1,372)** older adults (65+) with disabilities

Figure 8.1

Older adults (65+) with any disability over time, statewide and by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

- **PSA 3:** No significant change in number of older adults with disabilities over this period.
- **PSA 5 & PSA 6:** While there is an increase in the number of older adults with disabilities, the precise count is mot reported due to high uncertainty (coefficient of variation > 30%).

Proportion With Any Disability by PSA (2022 Estimates)

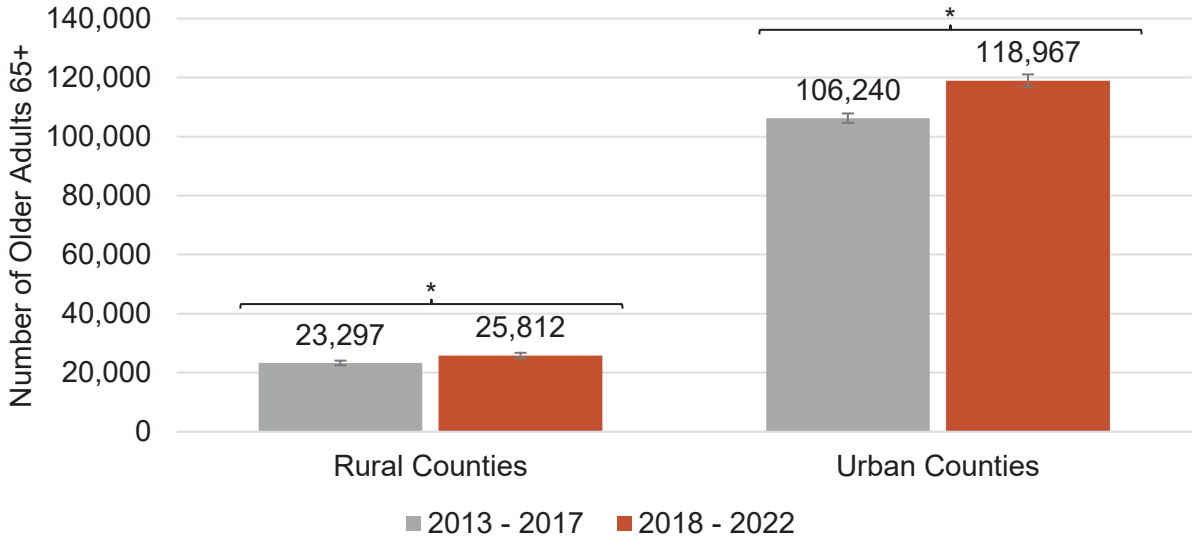
- The proportion of older adults with disabilities varies by PSA, with **PSA 5** (Navajo Nation) reporting the highest proportion of any PSA (**Figure 59** in Appendix F):
  - **61.0% (±3.1%)** of older adults in **PSA 5** report having a disability.
- For other PSAs, the proportion of adults reporting any disability ranges from:
  - **35.8% (±1.1%)** in **PSA 1**.
  - **44.1% (±2.4%)** in **PSA 6**.
- **PSA 2** experienced a significant decline in the proportion of older adults with disabilities, decreasing from **40.2% (±0.9%)** in 2017 to **37.4% (±0.9%)** in 2022.

Rural vs. Urban Disability Status (2022 Estimates)

1. **Rural Counties**
   - The number of older adults (65+) reporting disability significantly increased from **23,297 (±792)** in 2017, to **25,812 (±928)** in 2022.

Figure 8.2

Older adults (65+) with any disability over time, rural and urban counties



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

- Older adults with disabilities comprised **44.2% (±1.5%)** of all older adults in rural counties, with no significant change in the proportion over time (**Figure 60** in Appendix F).

2. **Urban Counties**
   - The number of older adults with disabilities rose from **106,240 (±1,589)** in 2017, to **188,967 (±2,102)** in 2022.
   - In 2022, **37.3% (±0.7%)** of older adults in urban counties reported a disability, a significant decrease from **39.0% (±0.6%)** by 2017 estimates.

Key Observations

- **PSA 5** stands out with the highest proportion of older adults reporting any disability, where nearly two-thirds of older adults are affected.
- **PSA 2** is the only PSA where the proportion of older adults with disabilities significantly increased over time.
- While **urban areas** saw a modest but significant reduction in the proportion of older adults reporting disabilities between 2017 and 2022 5-year estimates, **rural areas** did not significantly change over the same period.
- The overall number of older adults with disabilities has grown statewide, particularly in **PSA 1** and **PSA 2**.

Employment Status

Employment status among older adults (60+) is categorized by ACS as either **employed, unemployed,** or **not in the labor** force (e.g., retired or not seeking work). Unemployed individuals are those who are actively seeking work but do not have a job. The most recent ACS 2022 5-year estimates indicate that approximately **24.5% (±0.5%)** of New Mexico's older adults are employed, while another **1.1% (±0.1%)** are unemployed and actively looking for work.

- **Figure 9.1** presents the change in the number of employed older adults (60+) across the state and within each PSA between the 2017 and 2022 periods. The data shows that, except for PSA 4, all PSAs experienced significant increases in the number of working older adults.
- **Figure 9.2** compares the number of employed older adults between rural and urban counties over the same time period. Estimates indicate that most working older adults reside in urban counties, with significant increases observed in urban areas over time.

Statewide Older Adult (60+) Employment (2022 Estimates)

- Approximately **127,881 (±2,771)** older adults (60+) in New Mexico are actively employed, while another **5,791 (±708)** are unemployed and seeking work.
- As a proportion of the total older adult population, **24.5% (±0.5%)** of all older adults are employed, and **1.1% (±0.1%)** are unemployed (**Figure 61** in Appendix F).

Changes Over Time by PSA (2017 vs. 2022 Estimates)

1. **PSA 1 – 3:**

   The number of employed older adults significantly increased from 2017 to 2022, but precise estimate of change is highly uncertain (coefficient of variation > 30%).

2. **PSA 5 & 6:**
    - The number of **employed** older adults **significantly increased**, but estimates for change have high variability (coefficient of variation > 30%).
3. **PSA 4:**
    - No significant change in the number of employed older adults between 2017 and 2022 estimates.

Overall, the total number of employed older adults (60+) across New Mexico increased by **12,551 (±3,531)** people between 2017 and 2022.

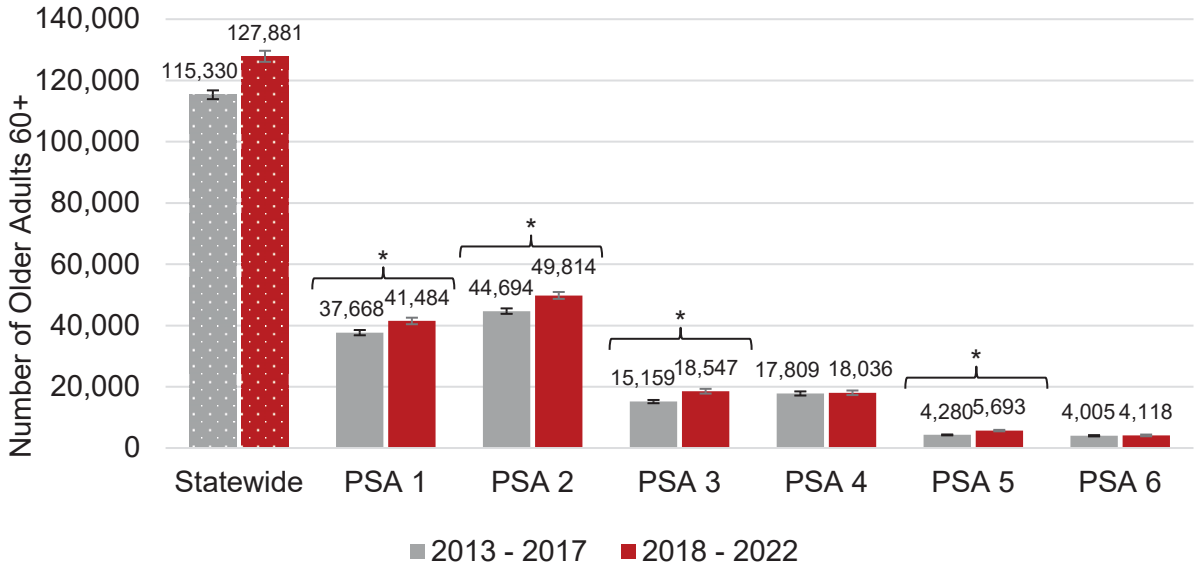
Unemployment Trends by PSA (2022 Estimates)

Unemployment estimates for older adults in PSAs 3 – 6 are uncertain due to high variability (coefficients of variation >30%). However, estimates for PSAs 1 and 2 are moderately reliable:

1. **PSA 1:**
    - Approximately **2,157 (±444)** older adults are **unemployed** and seeking work, accounting for **1.4% (±0.3%)** of all older adults in the PSA (**Figure 63** in Appendix F).
2. **PSA 2:**
    - An estimated **1,838 (±372)** older adults are **unemployed**, about **0.9% (±0.2%)** of the population.

Figure 9.1

Number of employed older adults (60+) over time, statewide and by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Rural and Urban Employment Trends (2022 Estimates)

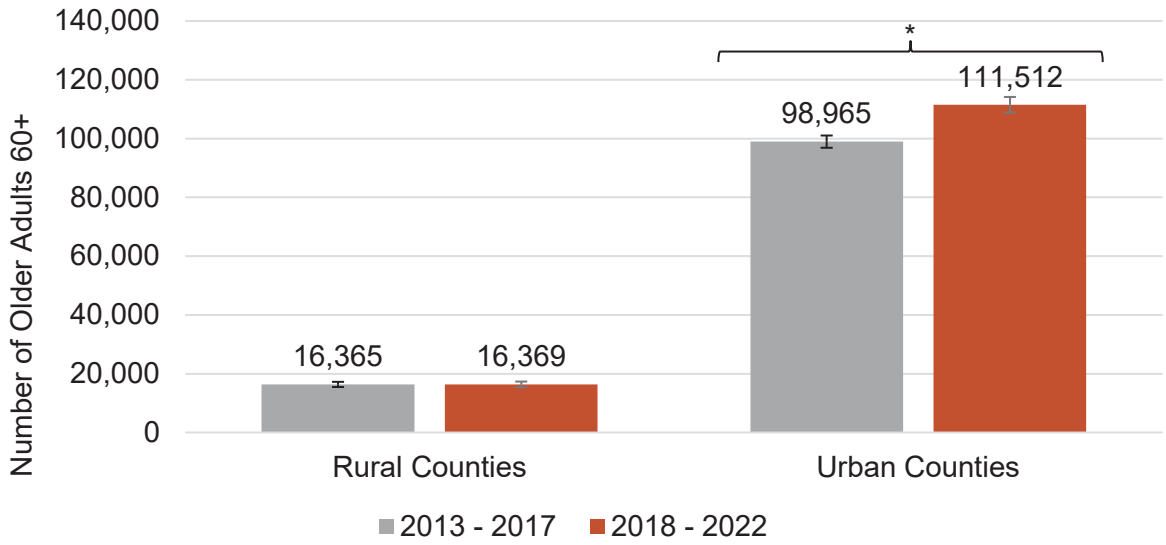
1. **Urban Counties:**
    - Approximately **111,512 (±2,660)** older adults are **employed** in **urban areas**. The number of working older adults increased significantly between 2017 and 2022 – about **12,547** more people.
2. **Rural Counties:**
    - A total of **16,369 (±973)** older adults are **employed** in **rural areas**. While the overall number of employed older adults did not change significantly, rural areas account for a smaller share of the employed population compared to urban areas (**Figure 62** in Appendix F).

Unemployment Trends in Rural and Urban Counties

Unemployment data for older adults in rural and urban counties indicate urban counties account for most unemployed older adults **(5,164 (±701)**) compared to rural ones **(627 (±286))**(**Figure 64** in Appendix F). Count estimates for unemployment in rural and urban areas have not significantly changed over time. Available estimates also show:

Figure 9.2

Number of employed older adults (60+) over time in rural and urban New Mexico counties



Note. * Significant difference between 2017 and 2022 5-Year Estimates at 90% CI. Rural & urban counties reflect aggregate estimates for “majority rural” or “majority urban” New Mexico counties.

1. **Urban Counties**
    - Approximately **1.2% (±0.2%)** of older adults in urban counties are unemployed.
2. **Rural Counties**
    - **0.8% (±0.4%)** of older adults in rural counties are unemployed.

Key Observations

- **Employment Growth:** Significant growth in employment among older adults is observed statewide, particularly in **PSA 1** and **PSA 2**, although the precision of these estimates varies.
- **Urban vs. Rural Employment:** The majority of employed older adults live in urban counties, and employment growth over time is most notable in these areas. In contrast, rural areas saw little change in the number of employed older adults (**Figure 66** in Appendix F).
- **Unemployment Uncertainty:** While some reliable data exists for **PSA 1** and **PSA 2**, unemployment estimates for **PSAs 3 – 6** and rural counties are highly uncertain due to high variability in the data.

Health Insurance & Poverty

The American Community Survey (ACS) provides estimates on health insurance coverage among older adults aged 65 and older in New Mexico, including breakdowns by household income as a percent of the poverty threshold. This section examines the number of older adults without health insurance, as well as those with incomes below 200% of the poverty threshold. The analysis also compares health insurance coverage across PSA, rural and urban counties, and change over time.

- **Table 14** summarizes health insurance coverage by region for 2022 estimates, showing the number of older adults with and without coverage.
- **Figure 10.1** visualizes the number of older adults without health insurance and with incomes less than 200% of the poverty threshold across PSAs.
- **Figure 10.2** presents the proportion of older adults without health insurance, broken down by PSA and income, over time.
- **Figure 10.3** presents number of older adults without health insurance, by rural and urban counties, over time.

Statewide Health Insurance Coverage (2022 Estimates)

- Approximately **3,866 (±1,036)** older adults in New Mexico have no health insurance, representing **1.0% (±0.3%)** of the older adult (65+) population (**Table 14**)(**Figure 67** and **Figure 71** in Appendix F).
- The vast majority of older adults have health insurance coverage, with **373,760 (±5,108)** older adults covered.
- Most older adults without coverage are located in **PSAs 1, 4, and 6.**

Significant Differences Between PSAs

- **PSA 5** has a significantly lower number of uninsured older adults compared to other PSAs.

Table 14

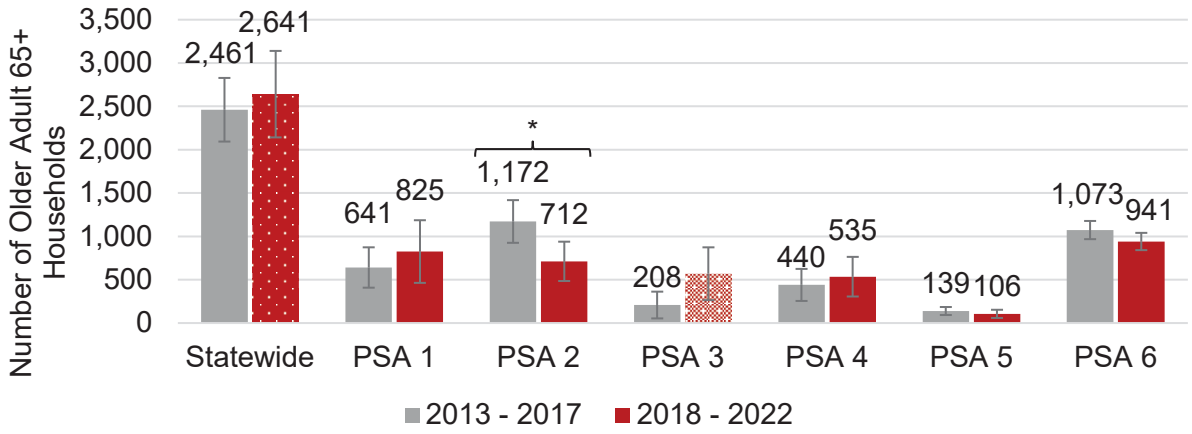
Health insurance coverage for older adults (65+) in 2022, statewide and by PSA

Region	Coverage	MOE	No Coverage	MOE
Statewide	373,760	±5,108	3,866	±1,036
PSA 1	112,721	±2,678	1,444	±576
PSA 2	147,883	±2,836	1,137	±390
PSA 3	45,140	±1,669	614	±308
PSA 4	68,016	±2,118	671	±252
PSA 5	5,354	±399	208	±88
PSA 6	18,664	±660	1,658	±517
Rural Counties	57,825	±1,896	556	±260
Urban Counties	315,935	±4,347	3,310	±908

Note. Data reflect 2018 – 2022 ACS 5-year estimates. MOE – Margins of Error at 90% CI.

Figure 10.1

Number of older adult (65+) households without health insurance and income less than 200% of poverty over time, statewide & by PSA

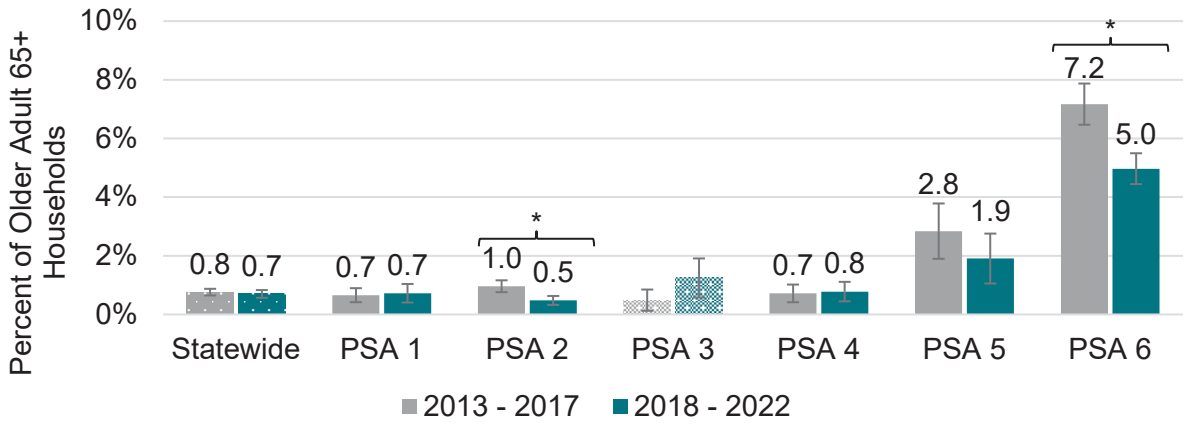


Note. * Significant difference between 2017 and 2022 ACS 5-year estimates at 90% CI.

PSA 3 estimates highly uncertain and not reported (CV > 30%).

Figure 10.2

Proportion of older adult (65+) households without health insurance and income less than 200% of poverty over time, statewide & by PSA



Note. * Significant difference between 2017 and 2022 ACS 5-year estimates at 90% CI.

PSA 3 estimates highly uncertain and not reported (CV > 30%).

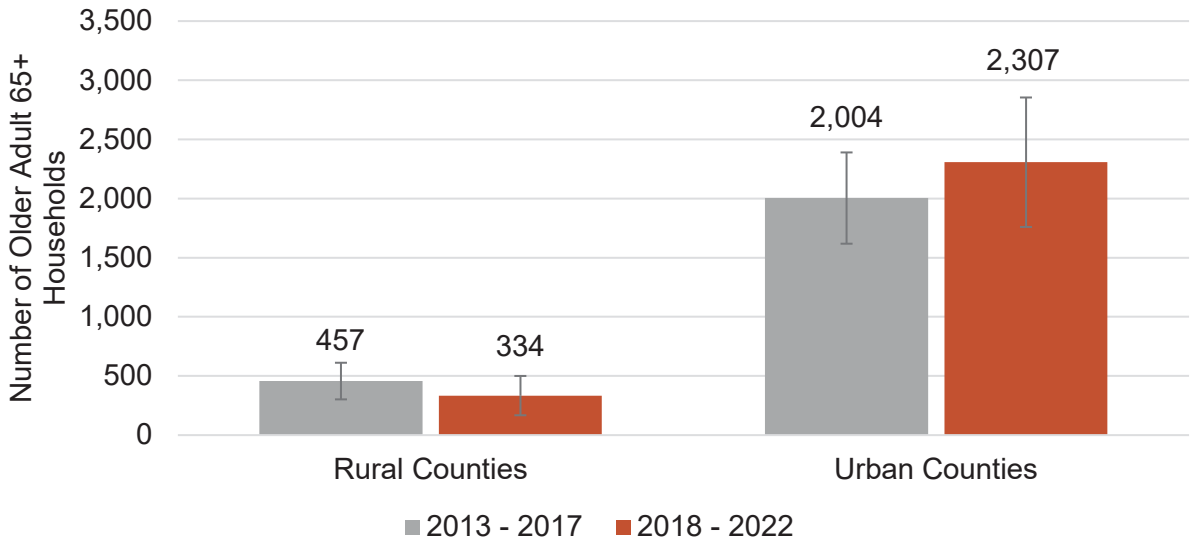
- **PSAs 1,2 ,4, and 6** have similar estimates, and while individual values may differ, they are not significantly different from one another.
- Over time, **PSA 2** and **PSA 6** experienced significant decreases in the number of uninsured older adults:
    - **PSA 2:** The number of uninsured older adults dropped from **1,172 (±246)** in 2017 to **712 (±227)** in 2022.
    - **PSA 6:** Despite a significant decrease, it still has the highest proportion of uninsured older adults, with **5.0% (±0.5%)** lacking coverage in 2022, as shown in **Figure 10.2**

Rural and Urban Differences in Health Insurance Coverage

- In **urban counties**, **2,307 (±547)** older adults without health insurance have incomes below 200% of the poverty level, compared to **334 (±166)** in **rural counties**.
- The proportion of uninsured older adults is similar between rural and urban areas, although estimates for rural areas are highly uncertain (coefficient of variation > 30%) and not reported for some cases (**Figure 68** in Appendix F).
- Neither rural nor urban areas show significant changes over time in the proportion of uninsured older adults with incomes below 200% of poverty (**Figure 70** in Appendix F).

Figure 10.3

Number of older adult (65+) households without health insurance and income less than 200% of poverty over time, rural and urban counties



Note. No significant differences over time; urban areas significantly higher than rural. Rural & urban counties reflect aggregate estimates for "majority rural" or "majority urban" New Mexico counties.

Key Observations

- **PSA 6** has the highest proportion of uninsured older adults, even though the share has decreased from 2017 to 2022 5-year estimates.
- **PSA 5** consistently reports the lowest number of uninsured older adults, significantly lower than in other PSAs.
- **PSA 2** has seen the most notable improvement, with a significant decrease in the number of uninsured older adults.
- More uninsured older adults with incomes below 200% of poverty reside in **urban counties** compared to rural ones, but the proportions are not significantly different between the two areas.

Household Type

The American Community Survey (ACS) provides data on the living arrangements of older adults (65+), including whether they live alone or with someone else and whether they own or

rent their dwelling. The 2022 ACS 5-year estimates reveal important insights into how these arrangements differ by PSA, rural and urban counties, and over time.

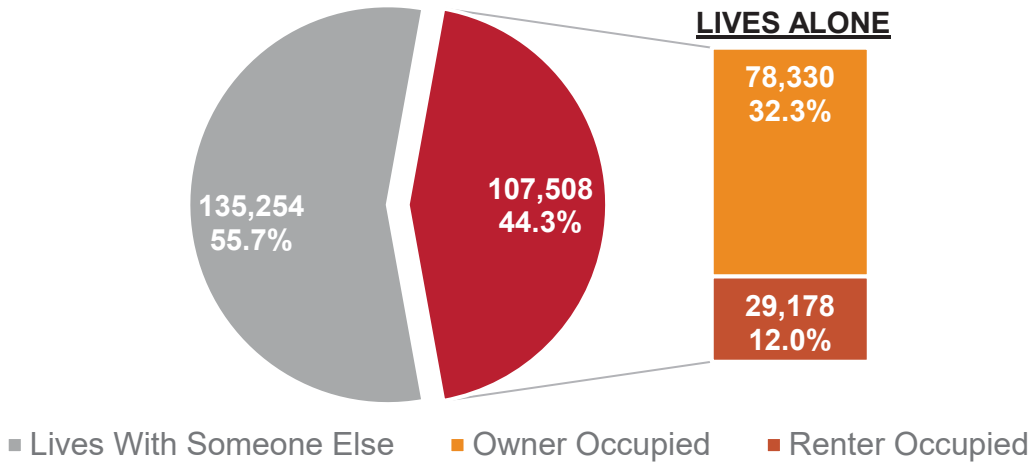
- **Figure 11.1** summarizes the number of older adults living alone in New Mexico according to 2022 5-year estimates.
- **Figure 11.2** shows the change over time in the number of older adults living alone, broken down by PSA.
- **Figure 11.3** presents the proportion of older adults who live alone by household type (owning vs. renting) in 2022.
- **Figure 11.4** shows the percentage of older adults who live alone and rent their housing, broken down by PSA, over time.
- **Figure 11.5** and **Figure 11.6** compare rural and urban counties regarding older adults living alone, and those who live alone and rent.
- **Table 52** in Appendix C summarizes 2022 5-year estimates for the number of older adult (65+) households living alone or with someone else.

Statewide Household Type (2018 – 2022)

- **107,508 (±2,599)** older adults (65+) live alone in New Mexico, accounting for **44.3% (±0.9%)** of the state's older adult population.
- Most older adults who live alone also **own their homes** – this situation represents **32.3% (±0.7%)** of all older adults or **78,330 (±2,099)** people.

Figure 11.1

New Mexico older adult (65+) households where householder lives alone in 2022



Note. Data reflect 2018 – 2022 ACS 5-year estimates.

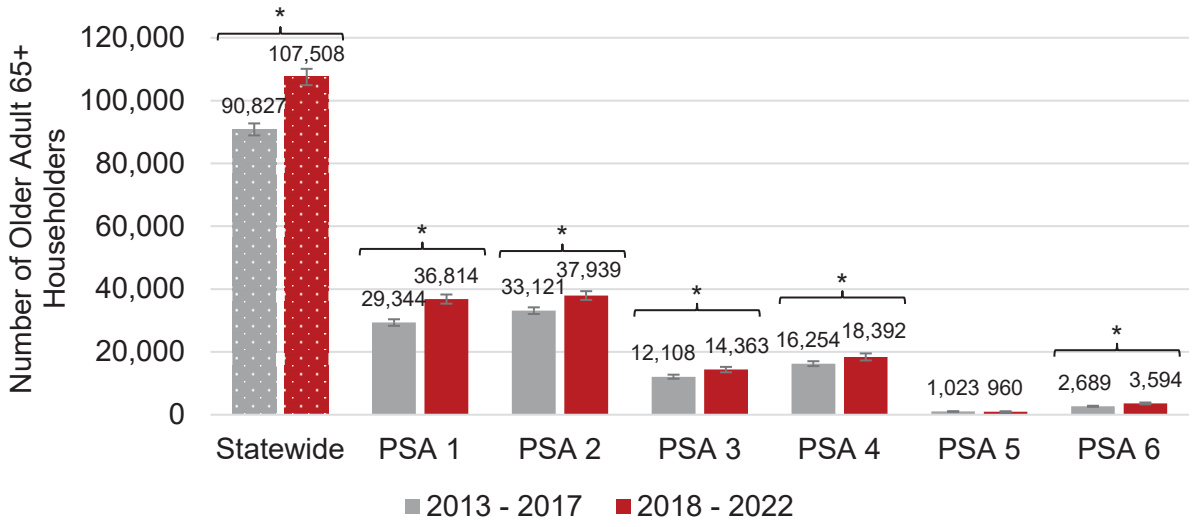
- **12.0% (±0.6%)** of older adults live alone and **rent their homes**, which translates to **29,178 (±1,533)** people.
- The total number of older adults living alone increased by **16,681 (±3,222)** between 2017 and 2022. Most of this increase occurred among homeowners (**10,830 (±2,650)**), while renters accounted for the remainder (**5,851 (±1,833)**), as show in **Figure 11.1**.

Changes Over Time in Living Alone by PSA (2017 vs. 2022 Estimates)

- **PSA 1** and **PSA 2** account for most older adults living alone, representing **69.5%** of all older adults who live alone in the state (**75,753 (±2,013**) people) (**Figure 11.2**).
- **PSA 5** has the smallest estimate, with **960 (±147)** older adults living alone.
- **PSA 1** and **PSA 3** have the highest proportions of older adults living alone, at **48.9% (±105%)** and **47.3% (±2.2%)**, respectively.
- **PSA 2** and **PSA 5** are the only areas where the proportion of older adults **living alone** significantly changes over time.
  - **PSA 5** decreased significantly from **32.2% (±2.7%)** in 2017 to **26.1% (±3.3%)** in 2022. Precise estimates of change are highly uncertain (CV > 30%).
  - **PSA 2** decreased significantly from **42.7% (±1.1%)** in 2017 to **40.3% (±1.2%)** in 2022. Precise estimates of change are highly uncertain (CV > 30%).

Figure 11.2

Older adult (65+) householders living alone over time, statewide & by PSA

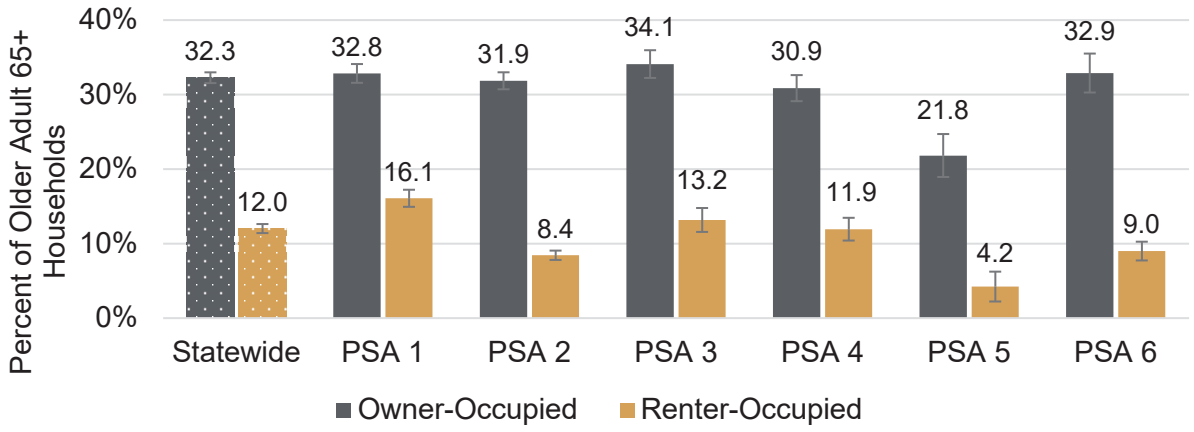


Note. * Significant difference between 2017 and 2022 ACS 5-year estimates at 90% CI.

Householders includes individuals who own or rent their housing.

Figure 11.3

Percent of older adult (65+) householders living alone by household type in 2022, statewide & by PSA



Note. Data reflect 2018 – 2022 ACS 5-year estimates.

Living Alone and Renting by PSA

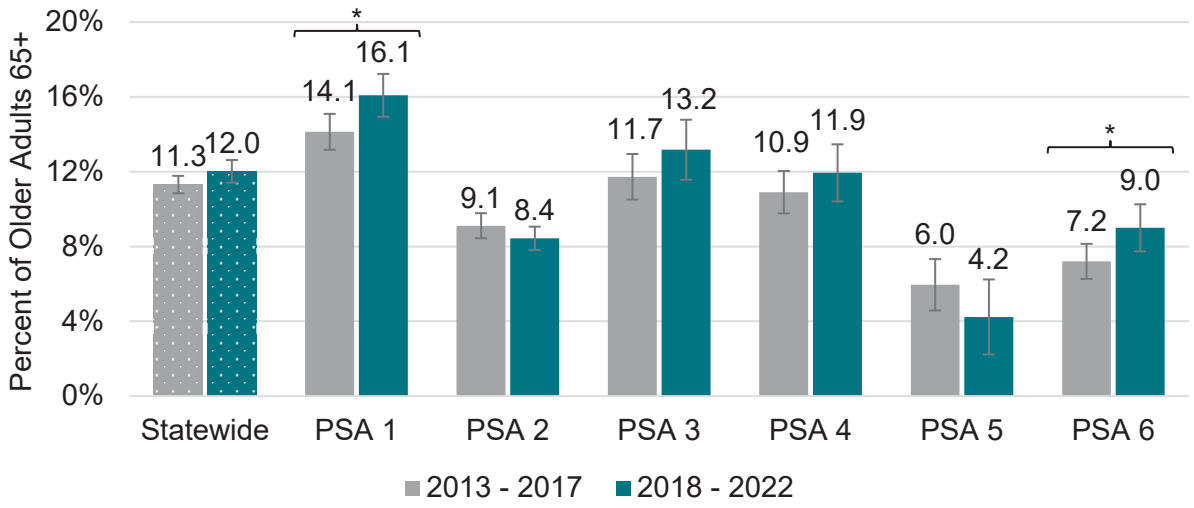
- The proportion of older adults who live alone and rent their housing varies significantly by PSA. In **PSA 1**, **16.1% (±1.1%)** of older adults live alone and rent, the highest proportion of any PSA. By contrast only **4.2% (±2.0%)** of older adults in **PSA 5** live alone and rent, as show in **Figure 11.4**.
- Over time, the proportion of older adults living alone and renting has increased in **PSA 1** (from **14.1% (±1.0%)** in 2017 to **16.1% (±1.1%)** in 2022) and in **PSA 6** (from **7.2% (±0.9%)** to **9.0% (±1.3%)**), as illustrated in **Figure 11.4**.

Rural vs. Urban Older Adults Living Alone

- **Urban counties** have significantly more older adults living alone than rural ones – **92,081 (±2,282)** older adults in urban areas live alone, compared to **15,427 (±926)** in rural areas, as seen in **Figure 11.5**.
- The number of older adults living alone increased significantly in **urban counties** over time, with **15,446 (±2,819)** more older adults living alone in 2022 compared to 2017.
- **Rural counties** saw a significant increase in the number of older adults living alone over the same period, but the precise estimate of change was highly uncertain (CV > 30%).

Figure 11.4

Percent of older adult (65+) householders live alone and rent housing over time, statewide & by PSA



Note. Data reflect 2018 – 2022 ACS 5-year estimates.

Urban vs. Rural Counties Living Alone and Renting (2022 Estimates)

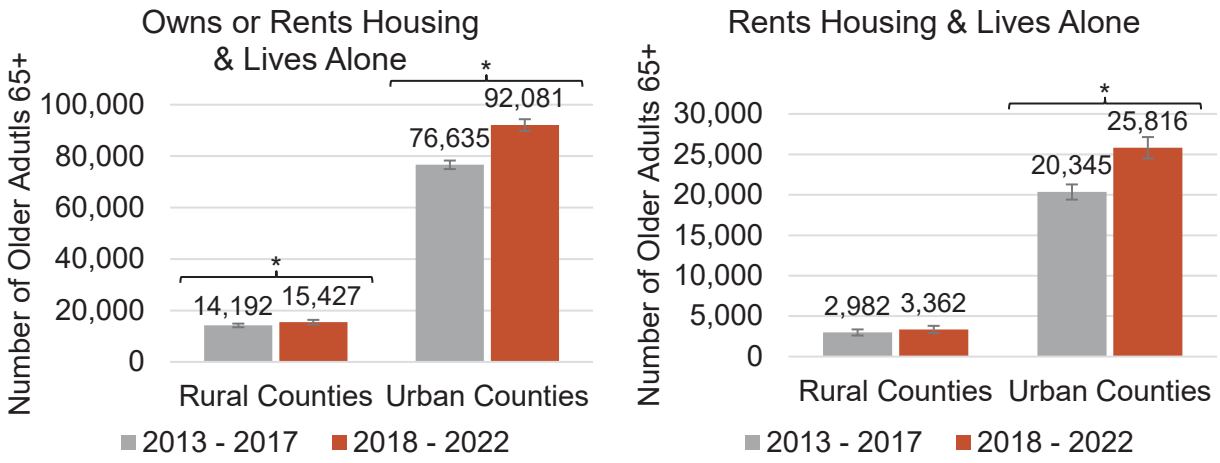
- A significantly higher number of older adults in urban counties live alone and rent their homes – **25,816 (±1,321)** households—compared to **3,362 (±441)** in rural areas, as shown in **Figure 11.5**.
- In **urban counties**, **12.5% (±0.6%)** of older adults live alone and rent, while in **rural counties**, **9.3% (±1.2%)** of older adults live alone and rent, as shown in **Figure 11.6**.
- Over time, urban areas have experienced significant increases in the number of older adults who live alone and rent. Rural areas, however, have not experienced significant changes.

Key Observations:

- **Urban areas** have a higher total number of older adults living alone compared to rural areas, with **92,081 (±2,282)** older adults in urban counties versus **15,427 (±926)** in rural counties.
- **Rural areas**, however, have a significantly higher proportion of older adults living alone – **44.6% (±0.9%)** of the rural older adult population lives alone, compared to **32.1% (±0.8%)** in urban areas.
- **PSAs 1** and **PSA 3** have the highest proportions of older adults living alone, while **PSA 5** has the lowest.

Figure 11.5

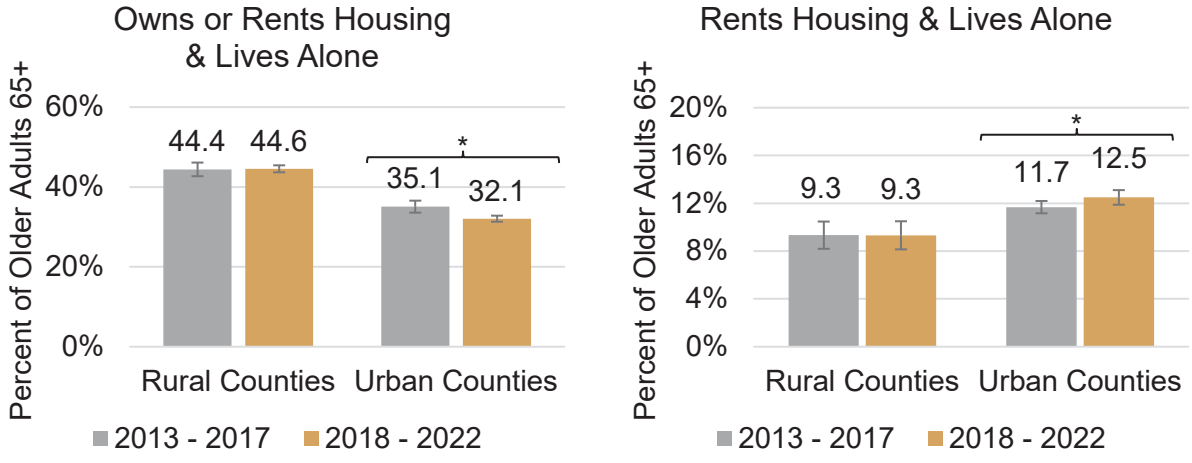
Number of older adults (65+) who live alone by household type over time, rural and urban counties



Note. * Significant difference between 2017 and 2022 ACS 5-year estimates at 90% CI.

Figure 11.6

Percent of older adults (65+) who live alone by household type over time, rural and urban counties



Note. * Significant difference between 2017 and 2022 ACS 5-year estimates at 90% CI.

- The number of older adults living alone has significantly increased across the state, particularly among those who own their homes.
- **Urban areas** have seen significant increases in the number of older adults living alone and renting, while rural areas have remained relatively stable over time.

Medicare & Medicaid

The American Community Survey (ACS) provides data only health insurance coverage type for adults 65 and older, categorized into four types:

1. **Medicare Only**
2. **Dual Coverage** Medicare & Medicaid)
3. **All Other Insurance** (includes employer-based insurance, TRICARE, VA healthcare, or any combination not involving dual Medicare and Medicaid)
4. **No Insurance**

Our analysis examines the distribution of these insurance types among older adults across PSA, as well as for rural and urban counties.

- **Figure 12.1** presents the percent of older adults (65+) in New Mexico with each type of health insurance for 2022 5-year estimates.
- **Figure 12.2** compares the percentage of older adults with each insurance type statewide and across PSAs, excluding the "All Other Insurance" category.
- **Figure 12.3** illustrates changes over time in the number of older adults with dual Medicare and Medicaid coverage, statewide and by PSA.
- **Figure 12.4** presents changes over time in the proportion of older adults with dual Medicare and Medicaid coverage, statewide and by PSA.
- **Table 15** provides a detailed count of older adults with each type of health insurance by PSA in 2022.

Statewide Health Insurance Coverage (2022 Estimates)

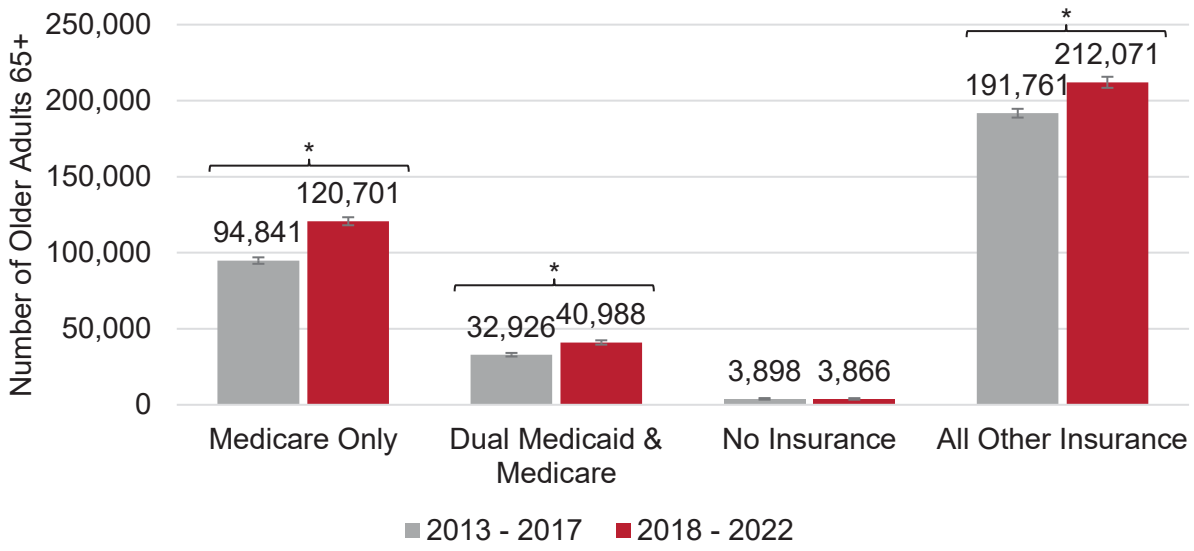
- **88.1% (±0.9%)** of older adults, or **332,772 (±4,483)** people, have any single-source health insurance coverage (Medicare, Medicaid, employer-based, or VA healthcare).
- **10.9% (±0.4%)**, or **40,988 (±1,418)** older adults, have **dual coverage** (Medicare and Medicaid).
- **1.0% (±0.1%)**, or **3,866 (±508)** older adults, have **no health insurance**.

The most reliable statewide estimates, visualized in **Figure 12.1**, show significant increases in the number of older adults with health insurance from 2017 to 2022. This includes:

- **8,062 (±1,848)** additional people with **dual Medicare and Medicaid** coverage.
- **25,860 (±3,380)** additional older adults with **Medicare Only** coverage.
- **20,310 (±4,464)** more older adults with **All Other Insurance** coverage.

Figure 12.1

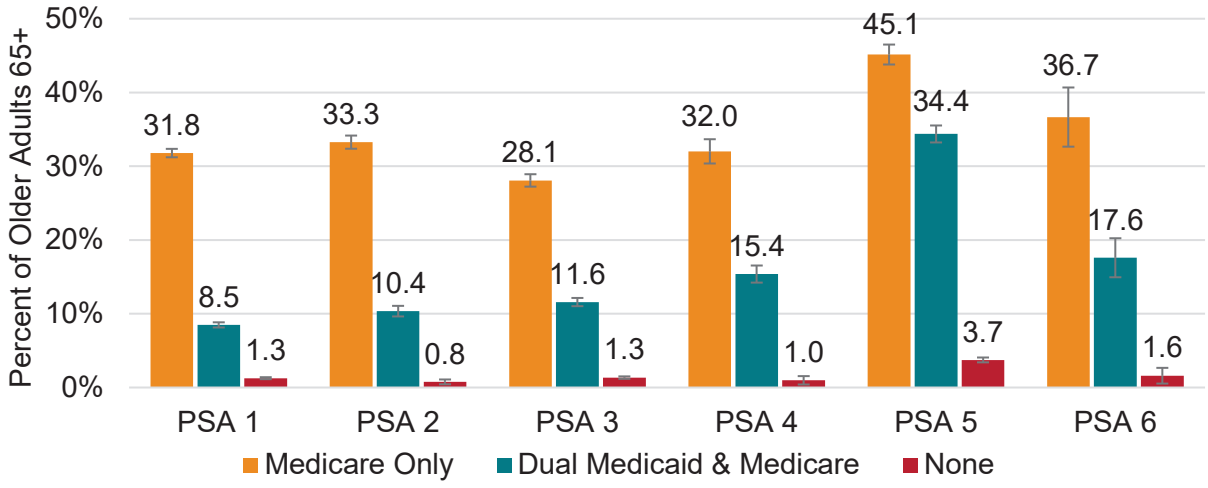
Percent of older adult (65+) New Mexicans with health insurance type in 2022



Note. Data reflects 2018-2022 American Community Survey (ACS) 5-year estimate.

Figure 12.2

Percent of older adults (65+) with health insurance type in 2022, by PSA



Note. Data reflects 2018-2022 American Community Survey (ACS) 5-year estimate. Excludes *All Other Insurance* category.

Table 15

Number of older adults (65+) with health insurance type in 2022, by PSA

	Medicare Only		Dual Medicaid & Medicare		All Other Insurance		No Insurance	
	Count	MOE	Count	MOE	Count	MOE	Count	MOE
Statewide	120,701	±2,632	40,988	±1,418	212,071	±3,629	3,866	±508
PSA 1	36,289	±1,291	9,692	±846	66,740	±1,926	1,444	±375
PSA 2	49,574	±1,578	15,430	±883	82,879	±2,228	1,137	±249
PSA 3	12,846	±891	5,301	±566	26,993	±1,306	614	±261
PSA 4	21,992	±1,159	10,565	±858	35,459	±1,601	671	±226
PSA 5	2,511	±283	1,912	±198	931	±160	208	±61
PSA 6	4,929	±361	2,365	±309	5,934	±419	215	±82
Rural counties	19,213	±990	8,831	±683	29,781	±1,371	556	±168
Urban counties	101,488	±2,305	32,157	±1,444	182,290	±3,326	3,310	±542

Note. Data reflect 2018 – 2022 ACS 5-year estimates; MOE – Margins of Error at 90% CI.

Health Insurance Coverage by PSA (2022 Estimates)

- **PSA 1: 36,289 (±1,291)** older adults have Medicare Only coverage, while **1,444 (±375)** have no insurance.
- **PSA 2: 49,574 (±1,578)** older adults have Medicare Only, and **1,137 (±249)** have no insurance.
- **PSA 5: 2,511 (±283)** older adults have Medicare Only, and **208 (±61)** are uninsured, representing the highest proportion of uninsured older adults at **3.7% (±1.1%)**.

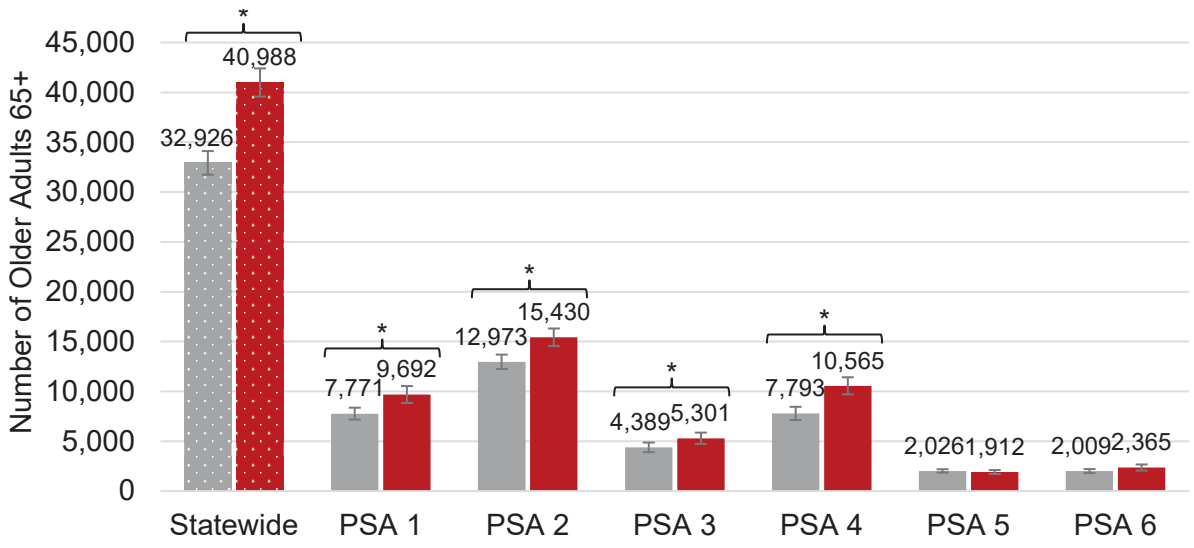
The breakdown by PSA, shown in **Figure 12.2**, reveals that **PSA 5** and **PSA 6** have the highest proportions of older adults with **Medicare Only** coverage, at **45.1% (±4.0%)** and **36.7% (±2.0%)** respectively. **Figure 12.2** further highlights that **PSA 5** and **PSA 6** have significantly higher rates of Medicare Only coverage compared to other PSAs.

Changes Over Time in Dual Coverage (2017 vs 2022 Estimates)

- The number of older adults with **dual Medicare and Medicaid coverage** increased significantly statewide from 2017 to 2022, as shown in **Figure 12.3**.
- The number of older adults in **PSAs 1, 2, 3, and 4** significantly increase over time. However, only **PSA 2** and **PSA 4** have moderately certain estimates of change:
  - **PSA 2** has the highest number of older adults with dual coverage **(15,430 (±883))**; significantly increasing by **2,457 (±1,140)** people during this period.

Figure 12.3

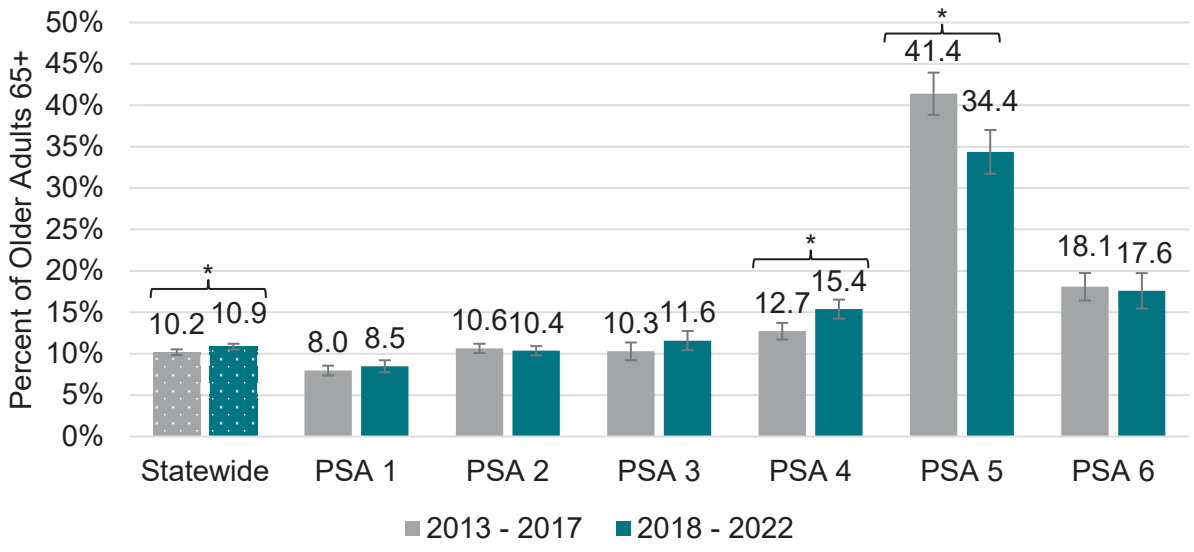
Number of older adults (65+) with dual coverage over time, statewide and by PSA



Note. Data reflects 2018-2022 American Community Survey (ACS) 5-year estimate.

Figure 12.4

Percent of older adults (65+) with dual coverage over time, statewide & by PSA



Note. Data reflects 2018-2022 American Community Survey (ACS) 5-year estimate.

- **PSA 4** has the second-highest population of dual coverage older adults – significantly increasing by **2,772 (±1,084)** older adults from 2017 to 2022.
- In contrast, **PSA 5** has the lowest number of older adults with dual coverage (**1,912 (±198)**), but the highest proportion at **34.4% (±2.6%)** of the PSA's older adult population (**Figure 12.3** vs. **Figure 12.4**).

Rural vs. Urban Health Insurance Coverage (2022 Estimates)

- **Urban counties: 101,488 (±2,305)** older adults have Medicare Only coverage, while **32,157 (±1,444)** have dual coverage. The number of older adults with dual coverage in urban areas increased significantly between 2017 and 2022 by **7,467 (±1,799)** people (**Figure 69** in Appendix F).
- **Rural counties: 19,213 (±990)** older adults have Medicare Only coverage, while **8,831 (±683)** have dual coverage. The proportion of older adults with dual coverage in rural areas is significantly higher than in urban areas – **15.1% (±1.1%)** vs. **10.1% (±0.4%)**(**Figure 70** in Appendix F).

Despite the higher proportion of dual coverage in rural areas, the number of older adults with dual coverage in rural areas did not significantly change between 2017 and 2022. **Urban areas**, by contrast, saw a significant increase in the number of older adults with **dual coverage**, from **9.1% (0.4.%)** of older adults in 2017 to **10.1% (±0.4%)** in 2022 (.

Key Observations:

- **Dual coverage** increased significantly from 2017 to 2022, particularly in **urban counties**, which account for most of the growth in older adults with both Medicare and Medicaid.
- **PSA 5** stands out with the highest proportion of older adults without any health insurance (**3.7% (±1.1%))** and the highest proportion of dual Medicare and Medicaid coverage (**34.4% (±2.6%))**, despite having the lowest total number of older adults with dual coverage.
- The proportion of older adults with **Medicare Only** coverage is significantly higher in **PSAs 5 and 6** compared to other regions, with **45.1% (±4.0%)** and **36.7% (±2.0%)**, respectively.
- **Rural areas** have a higher proportion of older adults with dual Medicare and Medicaid coverage compared to urban areas, but the number of older adults with dual coverage in rural areas has not significantly changed over time.

Poverty Status

The American Community Survey (ACS) provides detailed data on the income levels of households for adults aged 65 and older. This section focuses on older adult households with annual incomes below 200% of the poverty threshold. It highlights changes in poverty levels between 2017 and 2022, statewide and by PSA, as well as rural and urban counties.

- **Figure 13.1** illustrates changes in the proportion of older adult (65+) households with incomes below 200% of the poverty threshold between 2017 and 2022, categorized by income level.
- **Figure 13.2** shows the total number of older adult households with incomes less than 200% of poverty over time, statewide and by PSA.

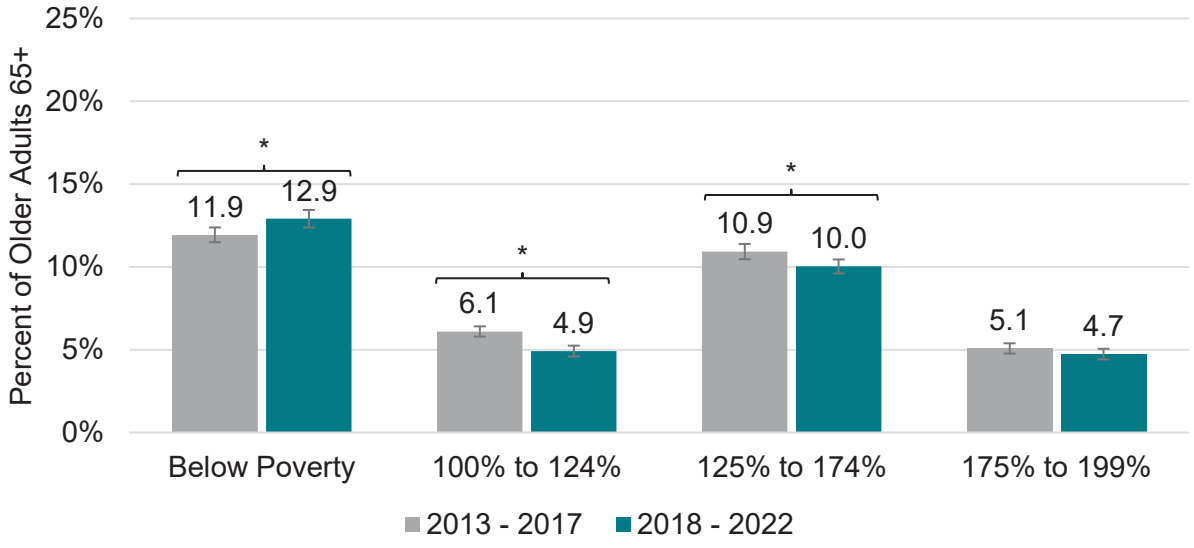
- **Figure 13.3** presents the proportion of older adult households with incomes below 200% of the poverty threshold from 2017 to 2022, statewide and by PSA.
- **Table 53** in Appendix C reports number of older adult households by poverty level as a ratio of income to poverty threshold for New Mexico, by PSA, and rural and urban counties.

Statewide Older Adult Poverty (2022 Estimates)

- **123,082 (±3,086)** older adult (65+) households in New Mexico have annual incomes below 200% of the poverty threshold (**Figure 71** in Appendix F).
- This represents about **32.6% (±0.8%)** of all older adult households in the state.
- From 2017 to 2022, the number of older adult households with incomes below 200% of poverty increased significantly by **12,983 (±3,978)** households.
- Most of this increase occurred among households with incomes below poverty, accounting for **10,148 (±2,468)** additional households.
- **Figure 13.1** illustrates that while the number of households with incomes below poverty has increased, the proportion of households below 200% of poverty has slightly decreased from **34.0%** in 2017 to **32.6%** in 2022. This indicates that the number of households above 200% of poverty has grown more rapidly.

Figure 13.1

Percent of older adult (65+) households with incomes less than 200% of poverty over time in New Mexico



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Changes Over Time in Poverty Level (2017 vs. 2022 Estimates)

- The share of older adult households with incomes **below poverty** significantly increased from **11.9% (±0.4%)** in 2017 to **12.9% (±0.5%)** in 2022.
- **Households just above poverty** (income at 100% to 124% of poverty) significantly decreased from **6.1%** to **4.9%** over the same period.
- **Households with incomes between 125% and 174% of poverty** also decreased, from **10.9%** to **10.0%**.
- There was **no significant change** in households with incomes between 175% and 199% of poverty.

Income and Poverty by PSA (2022 Estimates)

- **PSA 1** experienced the largest increase in older adult (65+) households with incomes below 200% of poverty, with an increase of **7,061 (±2,215)** households (**Figure 13.1).**
- While the precise estimate for change in **PSAs 2, 4, 5, and 6** is uncertain due to high variability (CV > 30%), significant increases in the total number of households below 200% of poverty occurred across these regions.
- **PSA 1** accounted for **4,863 (±1,450)** more households below poverty, out of the statewide increase of **10,148 (±2,468)** households. Significant increases occur across **PSAs 2, 3, and 4**.
- No significant changes were observed in **PSAs 5 and 6** in the number of households below poverty between 2017 and 2022 5-year estimates.

Proportion of Households Below 200% of Poverty by PSA

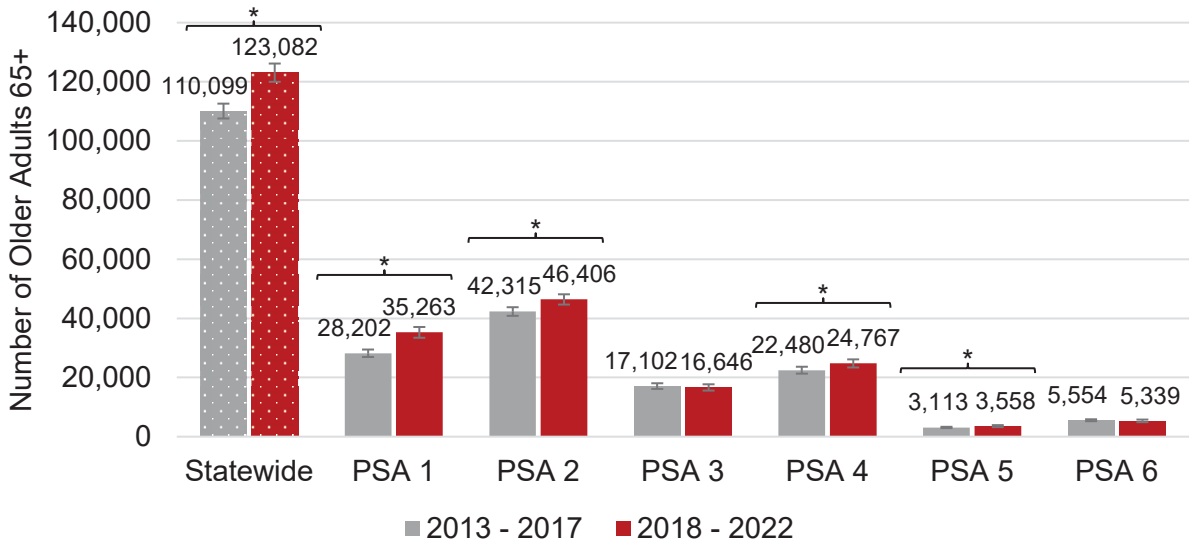
- **PSA 5** has the highest proportion of older adult households with incomes less than 200% of poverty, at **64.0% (±4.4%)** (**Figure 13.3**).
- **PSA 6** follows with **39.7% (±2.7%)** of households falling below the 200% poverty line.
- Conversely, **PSA 1** has the lowest proportion, with **30.9% (±1.6%)** of older adult households having incomes below 200% of poverty.
- Over time, **PSAs 2, 3, and 6** have seen significant decreases in the proportion of households below 200% of poverty, with **PSA 6** experiencing the largest decline – from **50.0% (±2.2%)** in 2017 to **39.7% (±2.7%)** in 2022, as illustrated in **Figure 13.3**.

Rural vs. Urban Poverty Levels

- **Urban counties** account for a much larger total number of households with incomes below 200% of poverty – **99,764 (±2,794)** older adult (65+) households, representing **31.2%** of all older adult households in urban areas (**Figure 73** in Appendix F).
- However, the proportion of older adult households below 200% of poverty in urban areas did not significantly change over time (**Figure 74** in Appendix F).

Figure 13.2

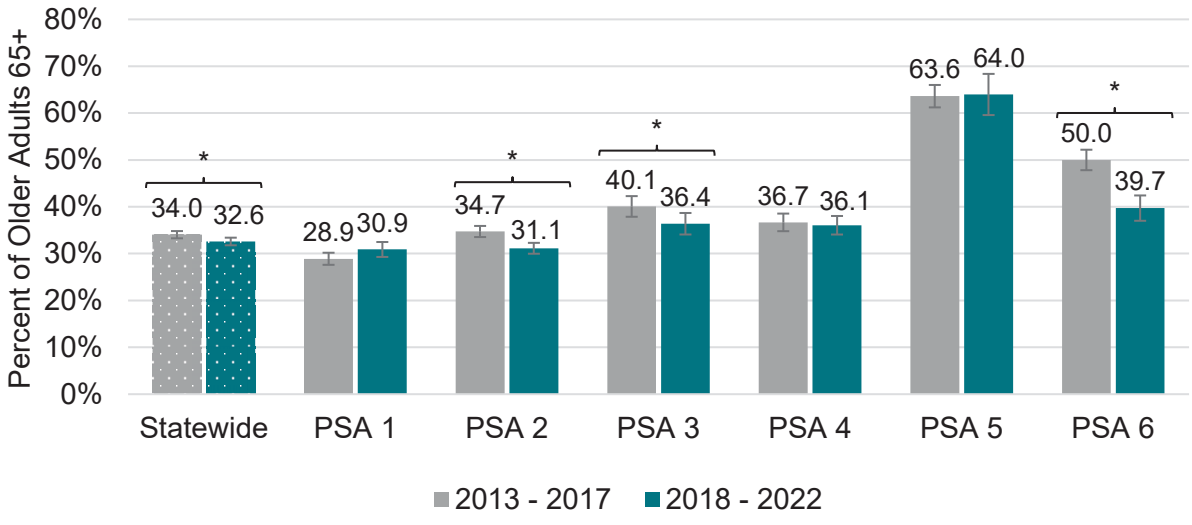
Older adult (65+) households with income less than 200% of poverty over time, by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Figure 13.3

Percent of older adult (65+) households with incomes <200% of poverty over time, by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

- In **rural counties**, the proportion of older adult (65+) households with incomes less than 200% of poverty significantly decreased from **43.1% (±2.1%)** in 2017 to **39.9% (±2.1%)** in 2022. By 2022 estimates, **23,318 (±1,235)** older adult households in rural counties live below 200% of poverty.
- No significant changes occur over time in the number of older adult households below 200% of poverty in rural areas.

Key Observations:

- The number of older adult households with incomes below 200% of poverty increased significantly from 2017 to 2022 **(10,148 (±2,468))**, but the proportion of such households has slightly decreased, indicating that households with incomes above 200% of poverty are growing at a faster rate.
- **PSA 5** has the highest proportion of households with incomes below 200% of poverty, while **PSA 1** and **PSA 2** have the lowest.
- The proportion of older adult households living below poverty has modestly increased, now representing about **12.9% (±0.5%)** of all older adult households statewide.
- **Urban counties** account for most of the statewide increase from 2017 to 2022 in older adult households with incomes below 200% of poverty – **9,294 (±2,170)** more households. **Rural counties** have not seen significant changes during the same period.
- **Rural counties** experienced a significant decrease in the proportion of older adult households below 200% of poverty over time, while urban areas have not.
- **PSAs 2, 3, and 6** have seen significant decreases in the proportion of older adult households below 200% of poverty over time.

Supplemental Nutrition Assistance Program (SNAP)

The American Community Survey (ACS) provides data on Supplemental Nutrition Assistance Program (SNAP) participation for older adult (60+) households in New Mexico. The following analysis examines both the total number and proportion of older adult households receiving SNAP benefits from 2017 to 2022, broken down by PSA and by rural and urban counties.

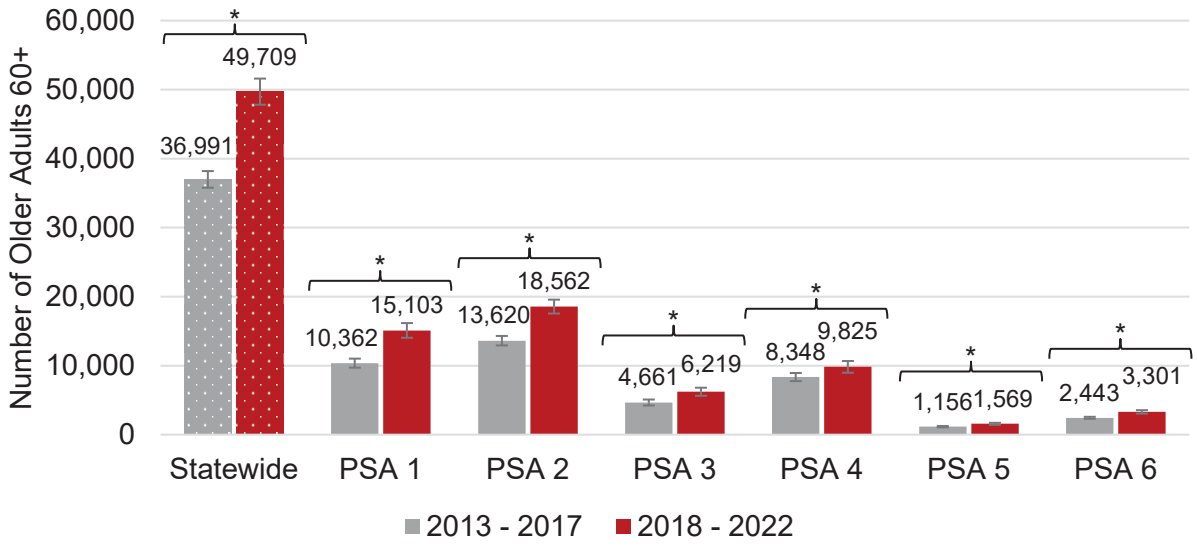
- **Figure 14.1** shows the total number of SNAP-receiving older adult households statewide and by PSA from 2017 to 2022.
- **Figure 14.2** visualizes the proportion of older adult households receiving SNAP statewide and in each PSA over time.

Statewide Older Adult SNAP Recipients (2017 vs. 2022 Estimates)

- As of 2022, approximately **49,709 (±1,894)** older adult households (60+) receive SNAP benefits, representing **13.8% (±0.5%)** of all older adult households in New Mexico.
- From 2017 to 2022, the number of older adult households receiving SNAP increased significantly by **12,718 (±2,246)** households.
- The proportion of all older adult households receiving SNAP benefits increased by **2.0% (±0.6%)** over the same period, as shown in **Figure 14.2**.

Figure 14.1

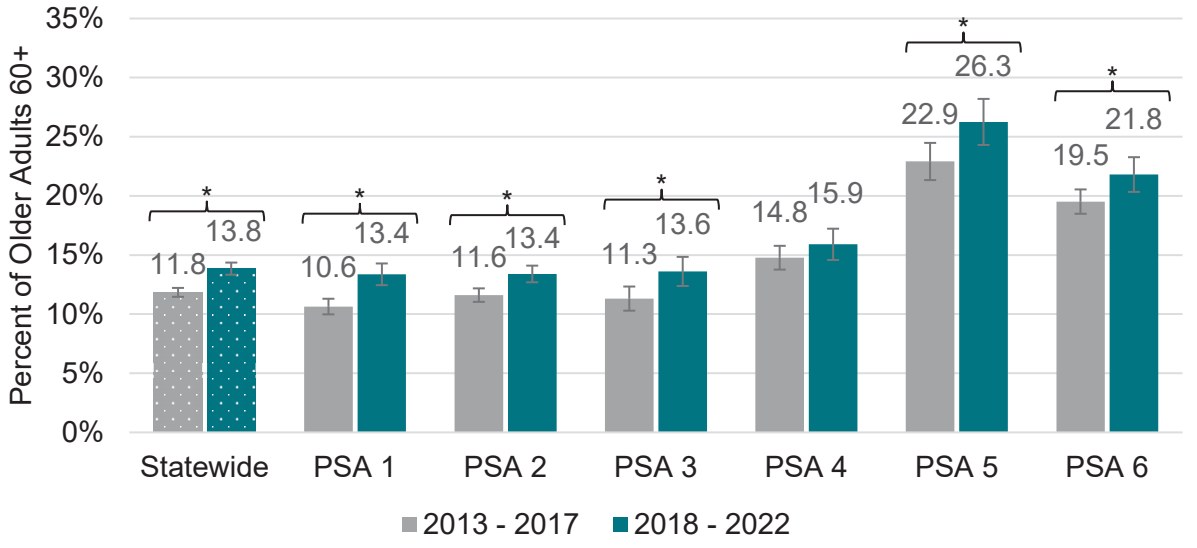
Number of SNAP-receiving older adult (60+) households over time, statewide & by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Figure 14.2

Proportion of older adult (60+) households receiving SNAP over time, statewide & by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

SNAP Recipients by PSA (2022 Estimates)

- **PSA 1** and **PSA 2** have the highest total number of SNAP-receiving older adult households:
  - **PSA 1: 15,103 (±1,066)** households receive SNAP.
  - **PSA 2: 18,562 (±1,005)** households receive SNAP.
- **PSA 5** and **PSA 6** have the lowest total number of SNAP-receiving households, but they also have the **highest proportion** of older adult households receiving SNAP:
  - **PSA 5: 26.3% (±1.9%)** of older adult households receive SNAP.
  - **PSA 6**: **21.8% (±1.5%)** of older adult households receive SNAP.

In contrast, **PSAs 1, 2, and 3** have the lowest proportions of SNAP-receiving households, with between **13.4% (±0.7%)** and **13.6% (±1.2%)** of older adult households receiving benefits, as visualized in **Figure 14.2**.

Change Over Time in SNAP Recipients by PSA (2017 vs. 2022 Estimates)

- **PSA 1:** The number of SNAP-receiving older adult households increased by **4,942 (±1,217)** between 2017 and 2022.
- **PSA 2**: The number of SNAP households increased by **4,741 (±1,251)** over the same period.
- **PSA 5** saw the smallest increase in the total number of SNAP-receiving households, with **413 (±173)** more households by 2022.
- **PSA 5** also experienced the greatest increase in the proportion of households receiving SNAP, rising from **22.9% (±1.6%)** in 2017 to **26.3% (±1.9%)** in 2022.
- **PSA 2** had the smallest increase in the proportion of SNAP-receiving households, from **11.6% (±0.6%)** in 2017 to **13.4% (±0.7%)** in 2022.
- **PSA 4** saw no significant change in the proportion of older adult households receiving SNAP, although the total number of households receiving benefits did increase significantly over time.

Rural vs. Urban SNAP Recipients (2022 Estimates)

- **Urban counties** experienced the greatest increase in both the total number and proportion of SNAP-receiving older adult households:
  - The number of SNAP households in urban areas increased by **10,988 (±1,975)** between 2017 and 2022 (**Figure 77** in Appendix F).
  - The proportion of older adult households receiving SNAP in urban areas rose from **11.2% (±0.4%)** to **13.3% (±0.5%)** over the same period (**Figure 78** in Appendix F).
- Rural counties saw a smaller increase in SNAP participation:
  - The proportion of older adult households receiving SNAP in rural areas increased from **15.3% (±1.0%)** to **17.1% (±1.2%)**.
  - Estimates for the precise change in the number of rural SNAP-receiving households are unreliable due to a high coefficient of variation (CV > 30%).

Key Observations:

- **SNAP participation** among older adult households has increased significantly both in total numbers and as a proportion of households across New Mexico.
- **PSA 5** and **PSA 6** stand out for having the highest proportion of older adult households receiving SNAP, while **PSAs 1, 2, and 3** have the lowest proportions.
- The **greatest increases** in the number of SNAP-receiving households occurred in **PSA 1** and **PSA 2**, though **PSA 5** saw the largest proportional increase.
- **Urban counties** experienced the largest growth in both the number and proportion of SNAP-receiving older adult households, while **rural counties** also saw significant increases in the proportion of households receiving SNAP benefits.

Veteran Status

The American Community Survey (ACS) provides estimates on the veteran status of older adults aged 65 and older in New Mexico. This section focuses on the total number and proportion of older adult veterans, highlighting changes from 2017 to 2022 by Planning and Service Area (PSA) and by rural and urban counties.

- **Figure 15.1** shows the total number of older adult veterans (65+) over time, broken down by PSA.
- **Figure 15.2** visualizes the change in the proportion of older adults (65+) who are veterans, from 2017 to 2022, by PSA.

Statewide Veteran Population Overview (2017 vs. 2022 Estimates)

- As of 2022, there are approximately **68,924 (±1,199)** veterans aged 65 and older in New Mexico, representing **18.0% (±0.3%)** of all older adults.
- Between 2017 and 2022, the number of older adult veterans decreased significantly by **4,126 (±1,649)** people.
- The proportion of all older adults who are veterans also decreased significantly, dropping by **4.2% (±0.5%)** over the same period.
- Both the total count and proportional decrease in the veteran population are significant at the 90% confidence interval, as illustrated in **Figure 15.1** and **Figure 15.2**.

Veteran Status by PSA (2022 Estimates)

- **PSA 2** has the highest number of older adult veterans, with **25,802 (±929)** veterans, which is significantly higher than any other PSA.
- **PSA 5** has the smallest veteran population, with only **587 (±133)** veterans, a significantly lower number than all other PSAs.
- Most PSAs experienced significant decreases in the number and proportion of veterans between 2017 and 2022, except for **PSA 2** and **PSA 5**, where changes were not statistically significant.
- In **PSA 6**, the percentage of veterans decreased by **6.9% (±1.5%)**, the largest decline among all PSAs.

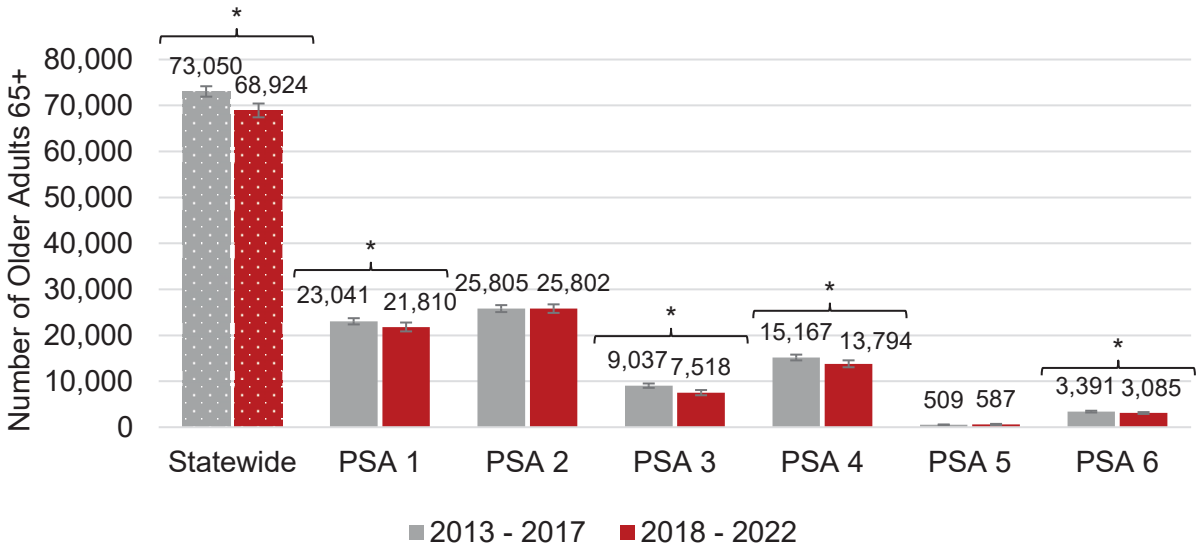
- **PSA 5** has the smallest proportion of older adults who are veterans (**10.6% (±2.3%)**), while all other PSAs range from **17.1% (±0.6%)** to **19.7% (±1.1%)**, shown in **Figure 15.2**.

Rural vs. Urban Veteran Status (2022 Estimates)

- The majority of older adult (65+) veterans live in **urban counties**, with **57,793 (±1,510)** older adult veterans in urban areas compared to **11,131 (±633)** in **rural counties**.
- The number of veterans in **rural counties** did not significantly change over time, while urban areas saw a significant decline, from **61,325 (±1,166)** in 2017 to **57,793 (±1,510)** in 2022 (**Figure 79** in Appendix F).
- Both rural and urban areas have similar proportions of older adult veterans:
  - **Rural counties**: **18.8% (±1.1%)** of older adults are veterans.
  - **Urban counties**: **17.9% (±0.5%)** of older adults are veterans.
- From 2017 to 2022, the percentage of older adult veterans decreased by **3.8% (±1.5%)** in rural areas and by **4.3% (±0.6%)** in urban areas. These changes are significant at the 90% confidence interval (**Figure 80** in Appendix F).

Figure 15.1

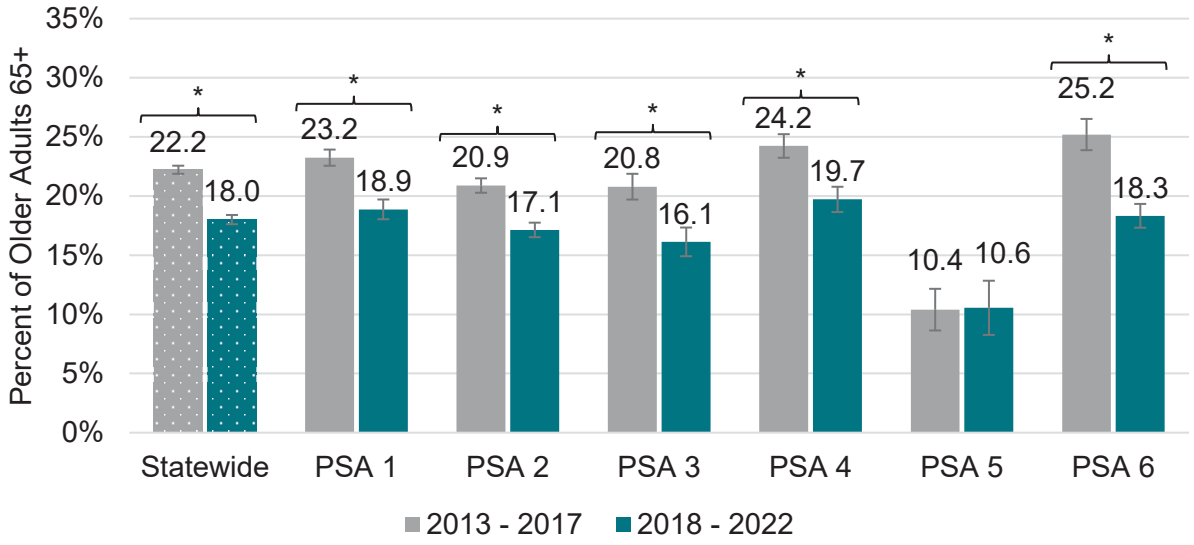
Number of older adult (65+) veterans over time, statewide & by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Figure 15.2

Proportion of adults 65 and older who are veteran over time, statewide & by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Key Observations:

- The total number and proportion of older adult veterans in New Mexico significantly decreased between 2017 and 2022.
- **PSA 2** has the largest veteran population, while **PSA 5** has the smallest, both in total number and as a proportion of the older adult population.
- **PSA 6** experienced the largest decline in the proportion of veterans, with a **6.9% (±1.7%)** decrease from 2017 to 2022.
- Both **rural and urban counties** saw significant declines in the proportion of veterans, but the majority of older veterans reside in **urban areas**.
- The proportion of older adults who are veterans in rural and urban areas are similar and not significantly different.

Grandparents Responsible for Grandchildren (GRGC)

The American Community Survey (ACS) provides estimates for older adult (60+) grandparents responsible for their grandchildren (GRGC), including situations where the child's parent is or is not present. This section reviews the prevalence of GRGC households in New Mexico, changes over time, and differences by PSA, rural and urban counties, and demographic characteristics.

- **Figure 16.1** illustrates the number of GRGC households (60+) where the child's parents are not present, over time.

- **Figure 16.2** shows the proportion of older adult GRGCs (60+) as a percentage of all GRGCs (30+) over time, statewide and by PSA.
- **Figure 16.3** presents the percentage of GRGC households where older adults (60+) are responsible, and the child's parents are not present, over time by PSA.
- **Figure 17.1** reports statewide self-reported racial identity of older adult GRGC households in 2022.
- **Figure 17.2** presents statewide self-reported ethnic identities for older adult GRGC householders in 2022.
- **Figure 18.1** summarizes the number of older adult GRGC householders in the labor force in 2022, by PSA.
- **Figure 18.2** shows the percentage of older adult GRGC householders in the labor force over time, statewide and by PSA.
- **Figure 19.1** presents the number of older adult GRGC households below the poverty line, over time, statewide and by PSA.
- **Figure 19.2** highlights the percentage of GRGC households (60+) below the poverty line, by PSA, in 2022.
- **Figure 20.1** shows the number of GRGC householders with disabilities in 2022, statewide and by PSA.
- **Figure 20.2** presents the percentage of older adult GRGC households (60+) with any disability in 2022, by PSA.
- **Figure 21.1** illustrates the number of ESL (English as a Second Language) older adult GRGC householders over time, statewide and by PSA.
- **Figure 21.2** shows the percentage of ESL older adult (60+) GRGC householders over time, statewide and by PSA.

Statewide GRGC Overview (2022 Estimates)

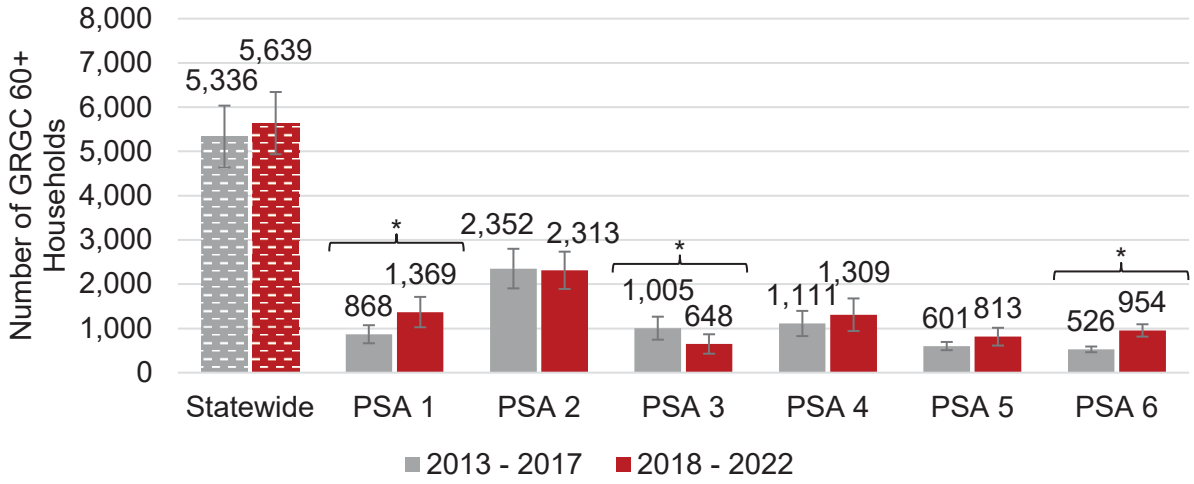
- In 2022, about **21,747 (±1,380)** grandparents in New Mexico, aged 30 and older, were responsible for their grandchildren. Of these, **11,060 (±897)** are older adults (60+).
- About **51.0% (±4.1%)**, or **5,639 (±703)** of older adult GRGC households are responsible for their grandchildren without the parents being present.
- From 2017 to 2022, no significant change occurred in the total number of older adult GRGC households, either with or without a parent present, as shown in **Figure 16.1**.

Change Over Time in GRGC Households by PSA (2017 vs 2022 Estimates)

- **PSAs 1, 2, and 4** collectively account for **87.5% (±7.6%)** of all older adult GRGC households in New Mexico.
- Significant increases in the number of GRGC households were seen in **PSA 1** and **PSA 6**, while **PSA 3** experienced a significant decrease in the number of GRGC households over time, as shown in **Figure 16.1**.
- **PSA 6** had the greatest increase in both the total number of GRGC households and the proportion of GRGCs where no parent is present.

Figure 16.1

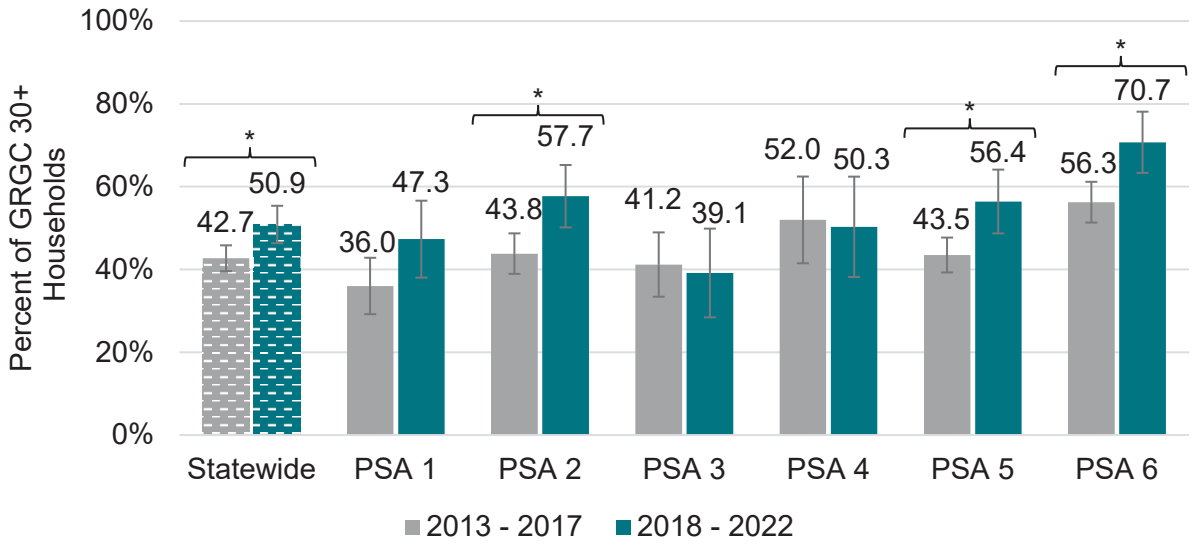
Number of older adult (60+) GRGC households where child's parents not present, over time



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Figure 16.2

Percent of GRGC (30+) households that are older adults (60+) over time, statewide & by PSA



Note. * Significant difference between 2017 and 2022 5-year ACS estimates at 90% CI.

Older adult (60+) GRGCs reflect both situations where parent is or is *not* present

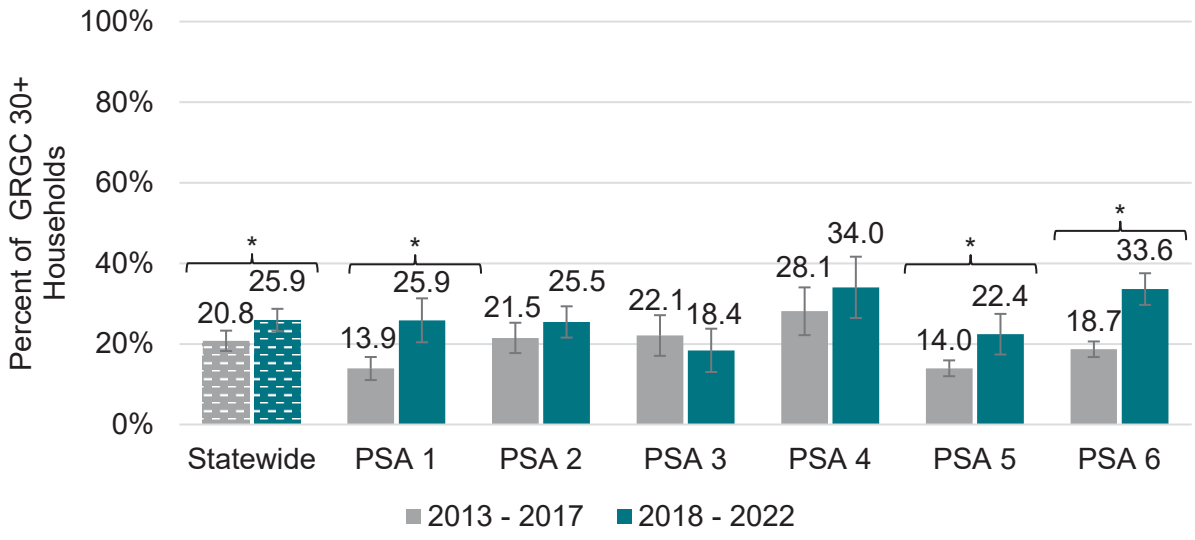
- By contrast, **PSA 3** saw a significant decline in the number of GRGCs, with other PSAs remaining stable or showing only minor changes.

Proportion of Older Adults as GRGCs (60+)

- The proportion of older adult GRGCs significantly increased over time, rising from **42.7% (±3.1%)** of all GRGC households (30+) in 2017 to **50.9% (±4.5%)** in 2022, as illustrated in **Figure 16.2**.
- **PSAs 2, 5, and 6** saw the most significant increases in the proportion of older adult GRGCs:
  - **PSA 2:** From **43.8% (±4.9%)** in 2017 to **57.7% (±7.5%)** in 2022.
  - **PSA 5:** From **43.5% (±4.2%)** to **56.4% (±7.7%)**.
  - **PSA 6** experienced the largest increase, from **56.3% (±4.9%)** to **70.7% (±7.4%)** of all GRGCs (30+).
- This shift indicates that while the total number of GRGCs is steady, older adults are increasingly responsible for grandchildren, especially in areas like **PSA 6**.

Figure 16.3

Percent of GRGC (30+) households that are older adults (60+) and parents are not present over time, statewide & by PSA



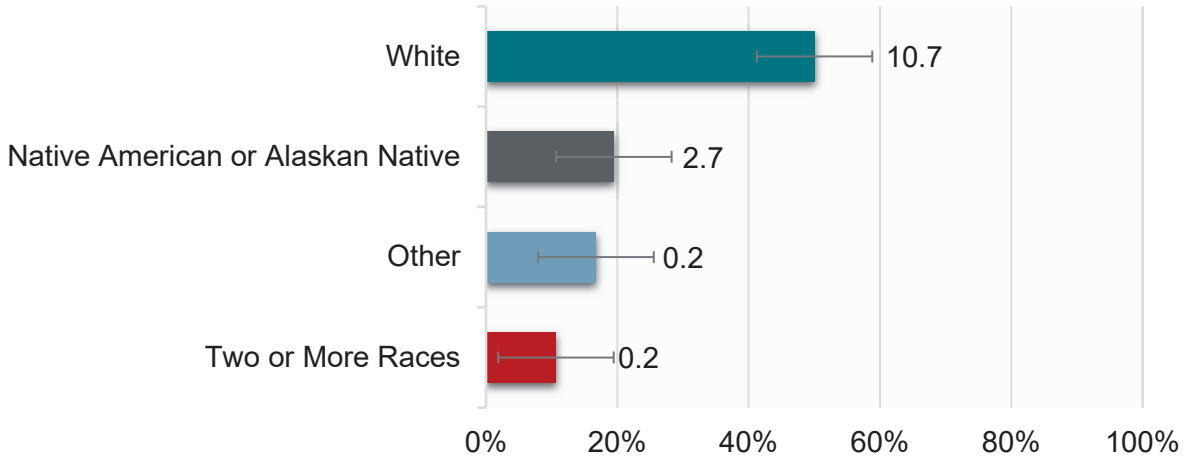
Note. * Significant difference between 2017 and 2022 5-Year Estimates at 90% CI.

GRGC Households Where No Parent is Present (2022 Estimates)

- In 2022, about **25.9% (±2.8%)** of all GRGC households (30+) in New Mexico were led by older adults (60+) where no parent was present. This reflects a significant increase from **20.8% (±2.5%)** in 2017, as shown in **Figure 16.3**.
- **PSAs 1, 4, and 6** had the highest percentages of older adult GRGCs where no parent was present, ranging from **25.5% (±3.9%)** to **34.0% (±7.6%)**.
- **PSAs 1, 5, and 6** saw significant increases in the proportion of GRGCs where no parent was present:
  - **PSA 6** had the largest increase, from **18.7% (±2.2%)** in 2017 to **33.6% (±3.9%)** in 2022.
- **Urban counties** show a higher number of GRGC households where no parent is present, with **4,274 (±614)** households in urban areas compared to **1,365 (±319)** in rural areas.

Figure 17.1

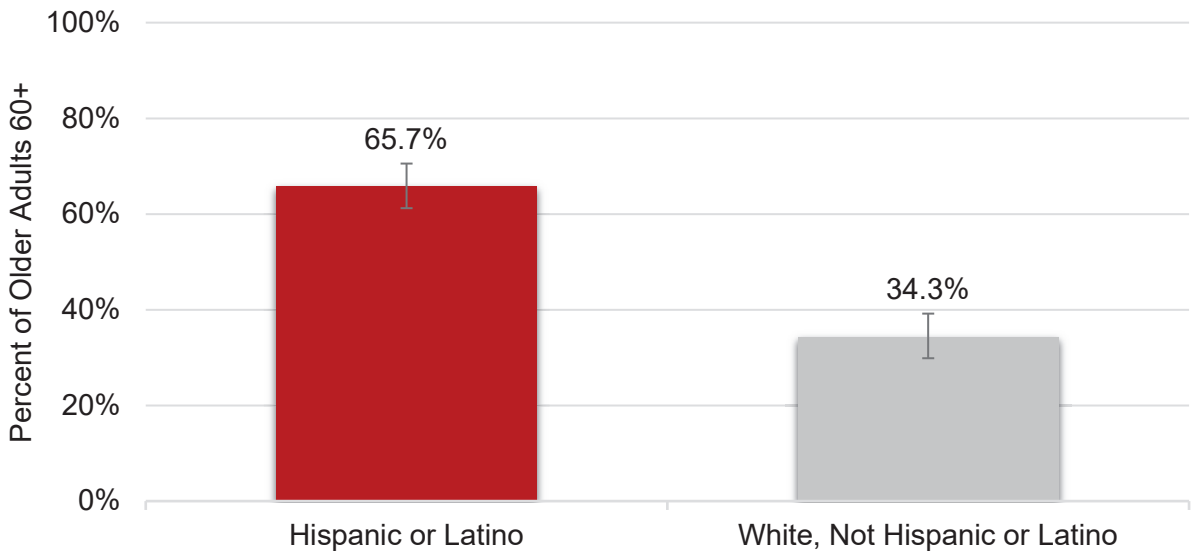
Statewide self-reported racial identities for older adult (60+) GRGCs in 2022, New Mexico



Note. Data reflect 2018 – 2022 American Community Survey (ACS) 5-Year Estimates. Estimates for Asian, Black or African American, and Native Hawaiian or Pacific Islander highly uncertain (CV > 30%) and are not reported; about 96.6% (±16.3%) and 97.0% (±9.4%) of racial identities accounted for without inclusion of categories with highly uncertain estimates.

Figure 17.2

Statewide self-reported ethnic identities for older adult (60+) GRGCs in 2022, New Mexico



Note. Data reflect 2018-2022 American Community Survey (ACS) 5-Year Estimates.

Demographic Characteristics of Older Adult GRGCs (2022 Estimates)

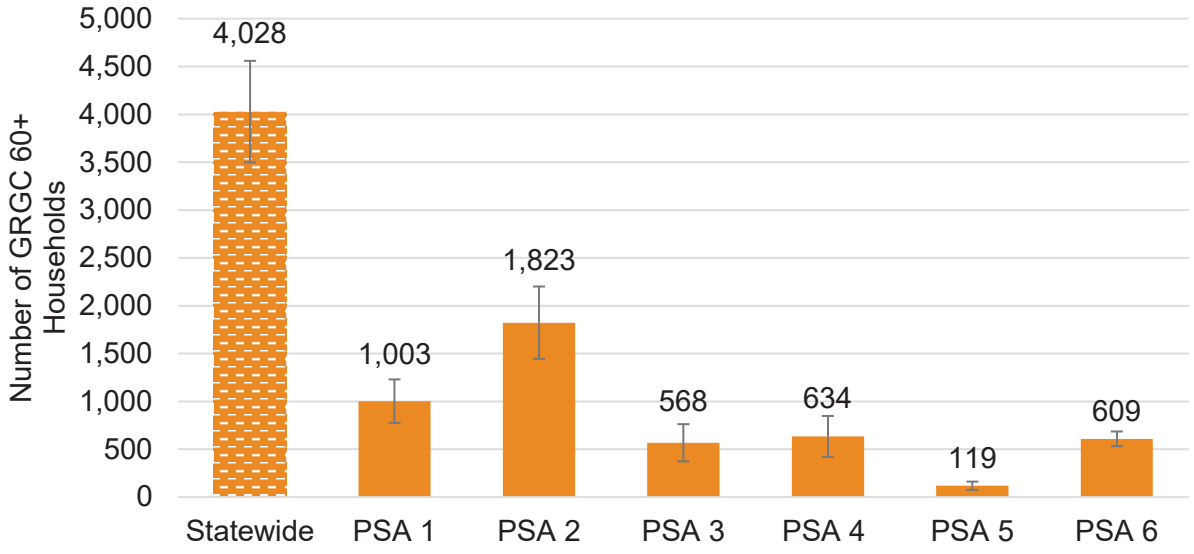
- **Race:** The largest share of older adult GRGCs (60+) self-identify as **White (50.0% (±6.3%)**, about **5,534 (±700)** householders (**Figure 17.1**).
  - **19.5% (±2.6%)** identify as **Native American or Alaskan Native**.
  - **16.8% (±4.1%)** identify as some **Other** race.
  - About **10.7% (±2.8%)** of older adult GRGCs identify as **Two or More Races**.
  - The most infrequently self-reported racial identities (Asian, Black, or Native Hawaiian/Pacific Islander) are not reported due to high uncertainty.
- **Ethnicity:** The majority of older adult GRGCs **(65.7% (±4.9%)**) identify as **Hispanic or Latino**, while **34.3% (±4.5%)** identify as White, Not Hispanic or Latino **(Figure 17.2)**.
  - **Rural areas** show higher proportions of **Native American or Alaskan Native** GRGCs **(46.7% (±9.1%))** compared to urban areas (**12.1% (±2.6%)**).

Older Adult GRGCs in the Labor Force (2022 Estimates)

- About **36.4% (±3.9%)** of older adult GRGCs (60+) are in the labor force, representing an estimated **4,028 (±531)** households, as shown in **Figure 18.1**.

Figure 18.1

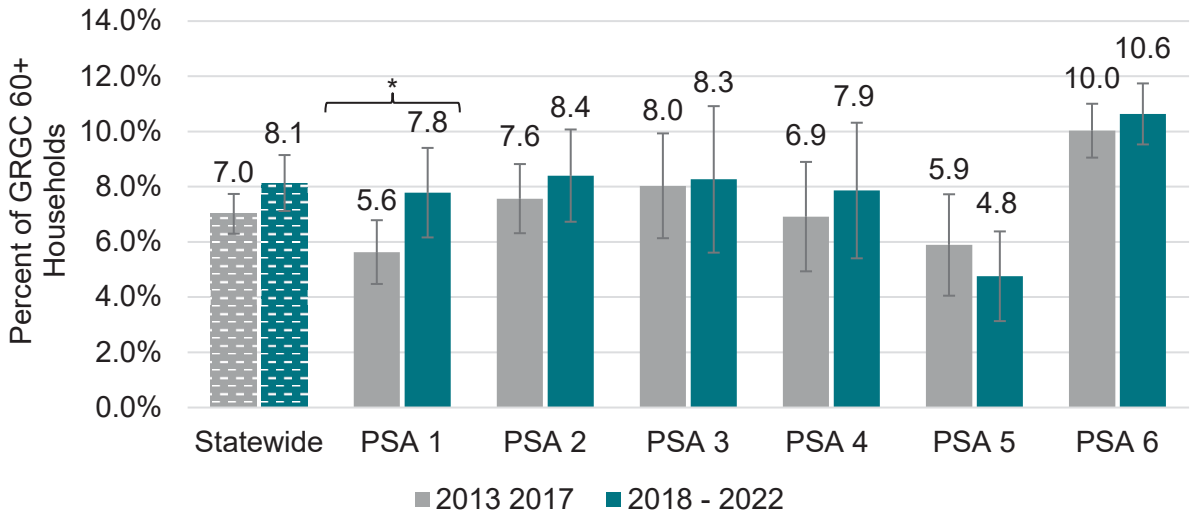
Number of older adult (60+) GRGC householders in labor force in 2022, statewide & by PSA



Note. Data reflect 2018 – 2022 5-Year ACS estimates.

Figure 18.2

Percent of older adult (60+) GRGC households in labor force over time, statewide & by PSA



Note. * Significant difference for 2017 & 2022 5-year ACS estimates at 90% CI.

- **PSA 1** and **PSA 2** account for about **70.2% (±5.9%)** of all older adult GRGCs in the labor force, reflecting about **1,003 (±227)** and **1,823 (±378)** households, respectively (**Figure 85** in Appendix F).
- **Urban counties** have the highest number of working GRGC households (**3,362 (±493))** compared to **666 (±187)** in **rural areas**.

Changes Over Time in Older Adult GRGCs in the Labor Force

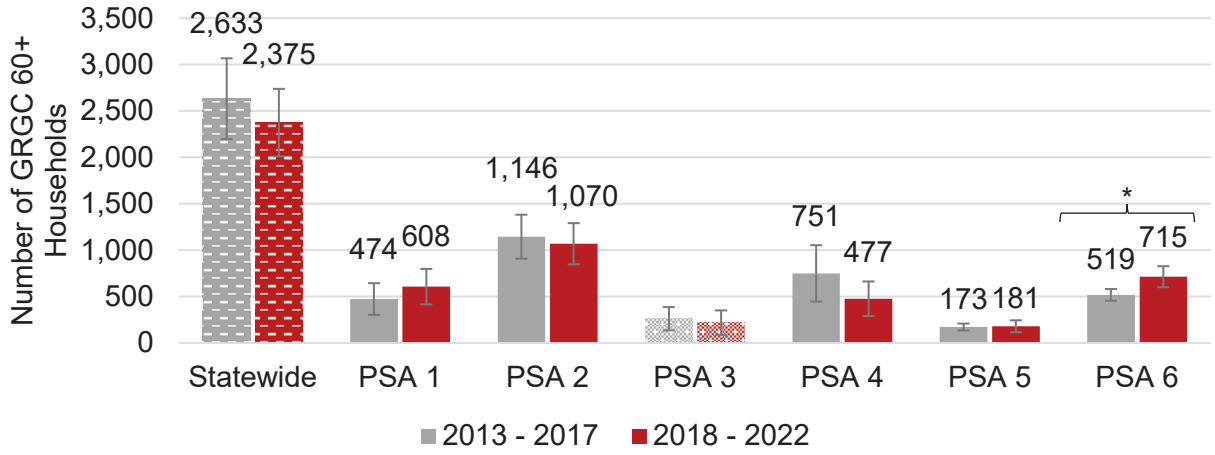
- **Figure 18.2** shows that over time, the proportion of working GRGC households in most PSAs does not significantly change from 2017 to 2022 estimates. However, in **PSA 1** the percent of older adult GRGC households in the labor force significantly but modestly increased from **5.6% (±1.2%)** in 2017 to 7.8% **(±1.6%)** in 2022.
- The proportion of working older adult GRGC households increased in **urban counties** from **6.8% (±0.8%)** in 2017 to **8.5% (±1.2%)** in 2022, while rural areas remained relatively stable over the same period **Figure 86** in Appendix F).

Poverty Status of Older Adult GRGCs (2022 Estimates)

- About **21.5% (±2.8%)**, or **2,375 (±364)** older adult GRGC households, have incomes **below the poverty threshold**, as shown in **Figure 19.1**.
  - **PSA 2** and **PSA 6** account for approximately **75.2% (±4.8%)** of GRGC households below poverty.

Figure 19.1

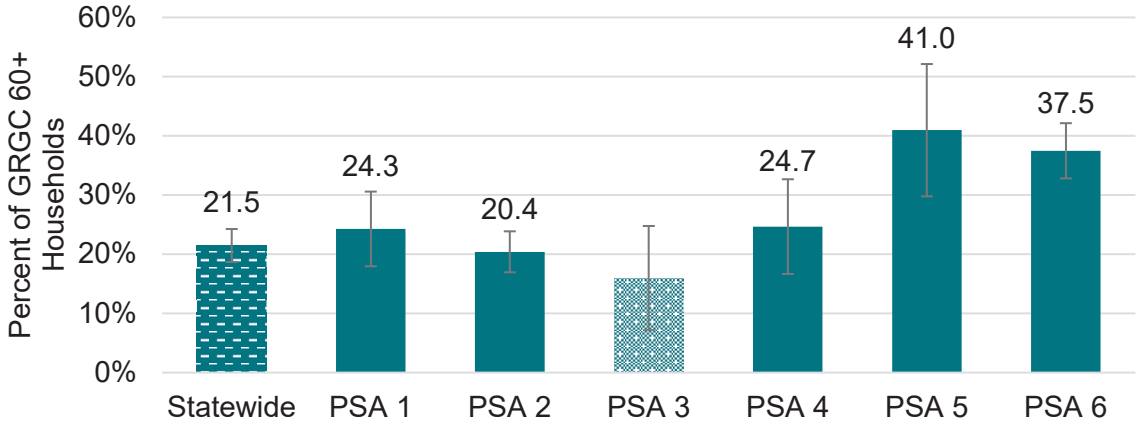
Number of older adult (60+) GRGC households below poverty over time, statewide & by PSA



Note. *Significant difference for 2017 & 2022 5-year ACS estimates at 90% CI. PSA 3 data highly uncertain (CV > 30%).

Figure 19.2

Percent of older adult (60+) GRGC households below poverty in 2022, statewide & by PSA



Note. Data reflect 2018 – 2022 ACS estimates. PSA 3 data highly uncertain (CV > 30%).

  - **PSA 2** has the highest number of GRGC households below poverty **(1,070 (±222))**, while **PSA 5** has the lowest **(181 (±64))**.

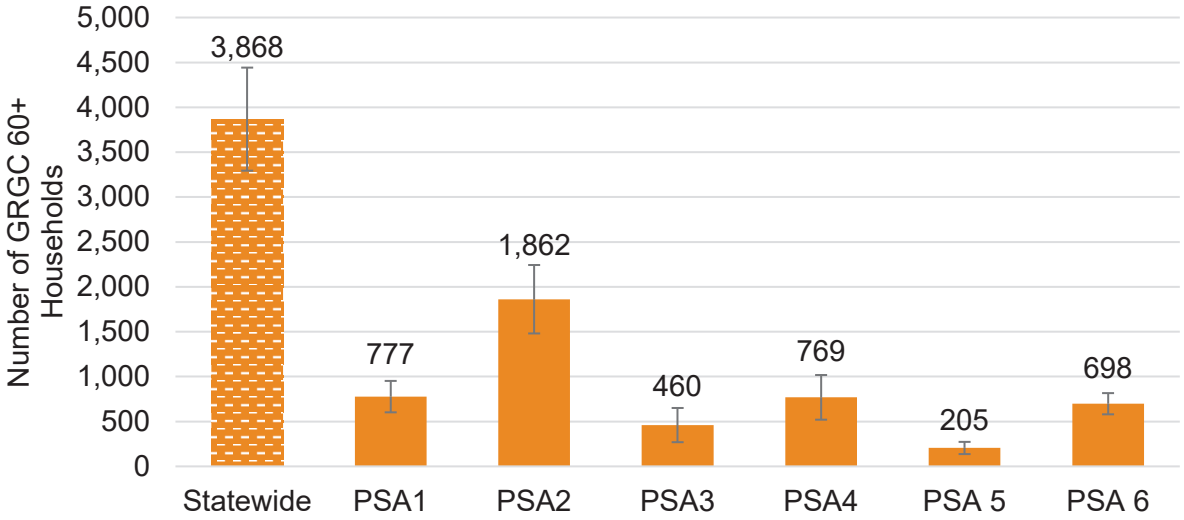
- **Urban counties** have **1,617 (±309)** older adult GRGC households below poverty, compared to **758 (±206)** in rural counties (**Figure 87** in Appendix F).
- **Rural Counties** have a significantly higher percentage of GRGC households below poverty (**32.7%**) compared to urban ones (18.5%), as shown in **Figure 19.2**.

Disability Status of Older Adult GRGCs (2022 Estimates)

- Roughly **35.0% (±4.3%)** of older adult GRGC householders have at least one disability, translating to **3,868 (±574)** households, as shown in **Figure 20.1**.
- **PSA 1** and **PSA 2** account for **68.2% (±3.9%)** of all GRGC households with any disability, with **PSA 2** having the highest count of such households **(1,862 (±381))**.
- **PSA 5** has a significantly lower number of GRGC householders with any disability **(205 (±68))** compared to all other PSAs.
- **Figure 20.2** shows that the proportion of GRGC households with any disability in 2022 is not significantly different for **PSAs 1, 2, 3, 4, and 6**.
- The proportion of older adult GRGC households with any disability in **PSA 5 (46.4% (±11.9%)** is significantly higher than PSA 1, but not any other PSA.

Figure 20.1

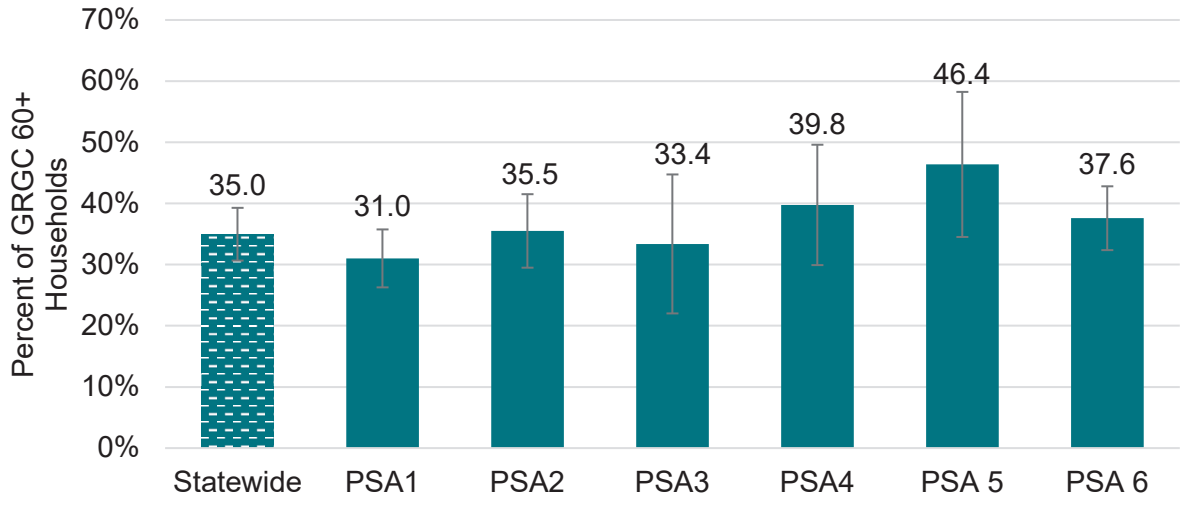
Number of older adult (60+) GRGC householders with any disability in 2022, statewide & by PSA



Note. Data reflect 2018 – 2022 ACS 5-year estimates.

Figure 20.2

Percent of older adult (60+) GRGC households with any disability in 2022, statewide & by PSA



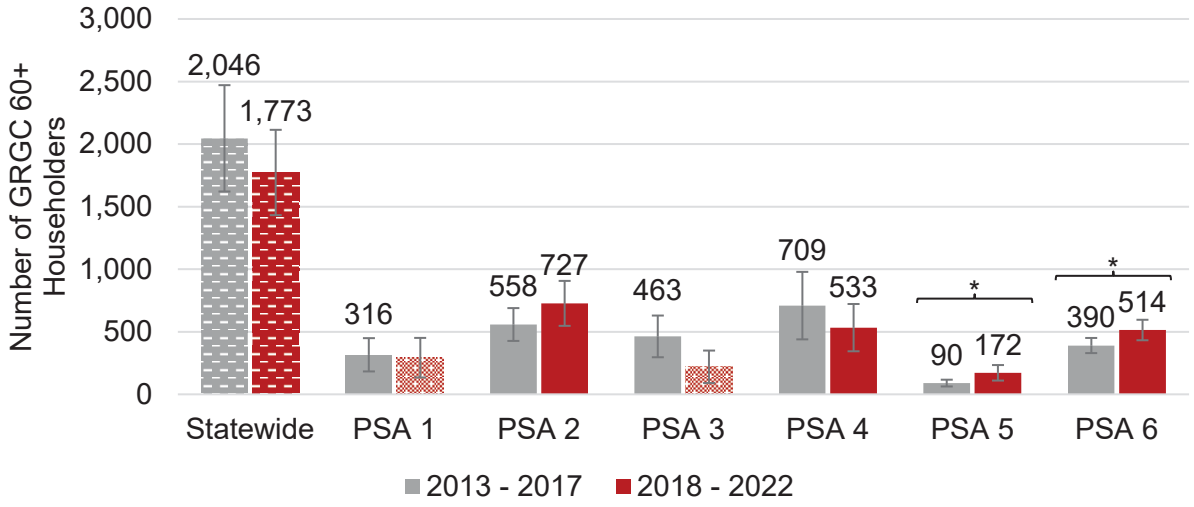
Note. Data reflect 2018 – 2022 ACS 5-year estimates.

English as a Second Language (ESL) for Older Adult GRGCs (2022 Estimates)

- About **16.0% (±2.8%)** of older adult GRGC households in New Mexico speak English less than "very well," accounting for **1,773 (±341)** households, shown in (**Figure 21.1**).
  - **PSA 2** and **PSA 4** have the highest number of ESL households, while **PSA 5** has the lowest **(90 (±27))**.
  - **Rural counties** have a significantly higher proportion of ESL households **19.6% (±6.4%)** compared to urban ones **(15.1% (±2.9%))**(**Figure 92** in Appendix F).
- **Figure 21.2** shows that while the number of ESL households did not significantly change over time for most PSAs over time, the proportion of ESL households grew significantly in **PSA 5**.
  - **PSA 5** estimates significantly increased from **14.8% (±4.5%)** in 2017 to **38.9% (±11.7%)** in 2022. The precise estimate of change is highly uncertain and not reported (CV > 30%).

Figure 21.1

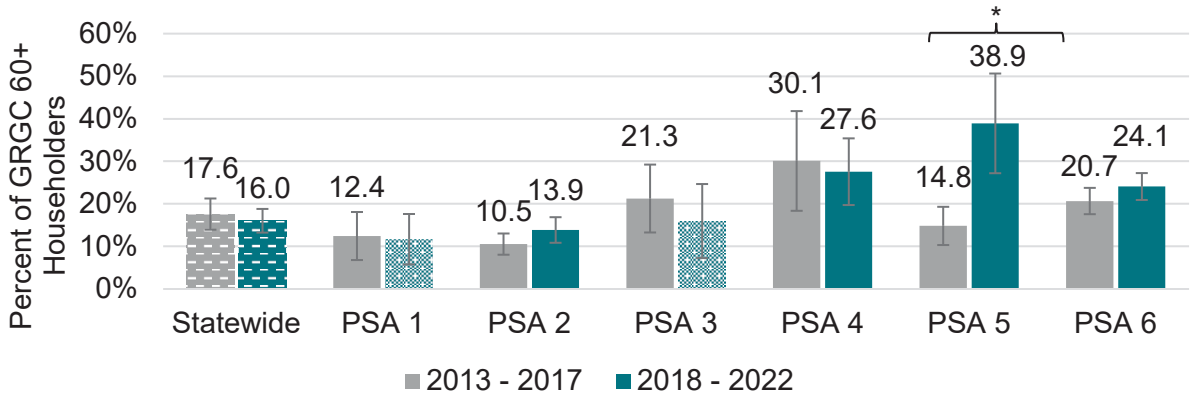
Number of ESL older adult (60+) GRGC householders over time, statewide & by PSA



Note. PSA 1 & 3 2018 – 2022 ACS estimates are highly uncertain (CV > 30%). ESL defined as speaking English less than "Very Well". * Significant difference between 2017 and 2022 5-year estimates at 90% CI.

Figure 21.2

Percent of ESL older adult (60+) GRGC householders over time, statewide & by PSA



Note. PSA 1 & 3 2018 – 2022 ACS estimates are highly uncertain (CV > 30%). ESL defined as speaking English less than "Very Well". * Significant difference between 2017 and 2022 5-year estimates at 90% CI.

Key Observations:

1. **Stable Statewide Total but Increasing Proportion of Older Adult GRGCs:**
   - The total number of older adult GRGC households (60+) in New Mexico remained stable from 2017 to 2022 5-year estimate, but the proportion of GRGC households led by older adults increased significantly, from **42.7%** to **50.9%** of all GRGCs (30+). This suggests grandparents responsible for their grandchildren are an increasingly older population, despite the overall number of older adult GRGC households not significantly changing over time.

2. **PSA-Specific Increases and Decreases:**
   - **PSA 6** stands out with the largest increases in both the number and proportion of older adult GRGC households where no parent is present. The proportion increased from **18.7%** in 2017 to **33.6%** in 2022, representing a significant shift.
   - **PSA 3** experienced a notable decline in the number of older adult GRGC households over time, but the proportion of GRGC households which are older adult (60+) has remained stable.

3. **Urban vs. Rural Patterns:**
   - **Urban counties** account for a much higher number of older adult GRGC households where no parent is present **(4,274 households)**, compared to **1,365 households** in rural areas. The proportion of older adult GRGC households where no parent is present is not significantly different between rural and urban counties.

4. **Racial and Ethnic Composition of Older Adult GRGCs:**
    - The largest share of older adult GRGCs (60+) identify as **White (50.0%)**, followed by **Native American or Alaskan Native (19.5%)** and **Other** races **(16.8%)**. The proportion of Native American or Alaskan Native and Other races are not significantly different.
    - The proportion of racial identities differ significantly between rural and urban counties, with rural GRGCs predominantly identifying as Native American or Alaskan Native (46.7%), while urban GRGCs are primarily White (54.7%). The majority of urban and rural counties identify as Hispanic or Latino (65%), and proportions are not significantly different (**Figure 53** and **Figure 54**, Appendix C).
    - **Hispanic or Latino** older adults make up the majority of GRGC households in New Mexico **(65.7%)**, reflecting the broader ethnic composition of the state.
5. **Labor Force Participation:**
    - About **36.4%** of older adult GRGC households are in the labor force, with the highest numbers in **PSA 1** and **PSA 2**, which account for about **70.2%** of working older adult GRGC households.
    - The proportion of working GRGCs increased significantly but modestly across **urban counties**, from **6.8%** to **8.5%** between 2017 and 2022 5-year estimates.
6. **Poverty Status of GRGCs:**
    - Approximately **21.5%** of older adult GRGC households are living **below the poverty threshold**, with the majority located in **PSA 2** and **PSA 6**.
    - The poverty rate is much higher for older adult (60+) GRGC households in **rural counties (32.7%)** compared to urban ones **(18.5%),** indicating a significant disparity between these areas.
    - **PSA 2** has the highest number of GRGC households **below poverty**, while **PSA 5** has the fewest.
7. **Disability Among GRGCs:**
    - Roughly one-third **(35.0%)** of older adult GRGC householders report having at least one disability. Most of these households are concentrated in **PSA 1** and **PSA 2**, with **PSA 2** having the highest total number of GRGCs with a disability.
    - No significant changes occurred over time in the proportion of GRGCs with disabilities.
8. **English as a Second Language (ESL) Households:**
    - **16.0%** of older adult GRGC households are classified as ESL, with **PSA 2** and **PSA 4** accounting for the highest numbers.
    - **Rural counties** have a significantly higher proportion of ESL older adult GRGC households **(19.6%)** compared to urban counties **(15.1%)**.
    - The proportion of ESL households grew significantly in **PSA 5**, from **14.8%** in 2017 to **24.1%** in 2022.

CONSUMER SERVICE DATA

We received consumer data from ALTSD for state fiscal years 2019 – 2023 (FY19 – FY23). These data include total units and number of unique consumers by service type which have been aggregated to PSA level for PSAs 1 – 4, and PSA 6. Data for PSA 5 (Navajo Nation) was not available for review and therefore not included in our analyses. A second consumer service dataset was also provided aggregated at the county level for FY23 only.

We analyze these consumer service data to provide insights on the number of services provided and variation in service types available. We further compare the number of active consumers to the estimated population of older adults aged 55 and older for each PSA over time. This information should inform stakeholders about how service needs vary across time and place, as well as where potential service gaps may occur.

Services Overview

In FY23 a total of 4,423,603 units of service were provided to 52,838 unique consumers throughout New Mexico. **Table 16** summarizes consumer data for the five most recent fiscal years and indicates moderate variability over time. Total units of services provided and the number of unique clients served have fluctuated over time, most notably occurring in FY21 when average units of service per consumer decline from 87.2 in FY19 to 79.2 in FY20. This figure increases significantly in FY21 and drops once more through FY22. In FY23, about 83.7 units are provided per consumer, the lowest for all four years of service data. This fluctuation is likely attributable to the COVID-19 pandemic period. New Mexico officially declared a public health emergency due to COVID-19 on March 11th, 2020, which also officially ended on March 31st, 2023 (Office of the Governor, 2023).

Figure 22 illustrates data for total service units and number of unique clients over time. In terms of total units, FY19 has the lowest level of service provision for all four years, at 4,384,904 units. Total units increase in FY20 and peak in FY21 to 4,984,814 units. Beyond FY 21, total units drop steadily until FY23, where service provision is marginally higher than FY19 – roughly 38,000 units higher. The number of unique clients shares a similar trajectory, with the lowest number of unique consumers also occurring in FY19 (50,261). However, the following year, FY 20 evidences the highest level of unique consumers (56,948) and then drops to roughly pre-pandemic levels in FY22. In contrast to total service provision, the number of unique consumers

Table 16

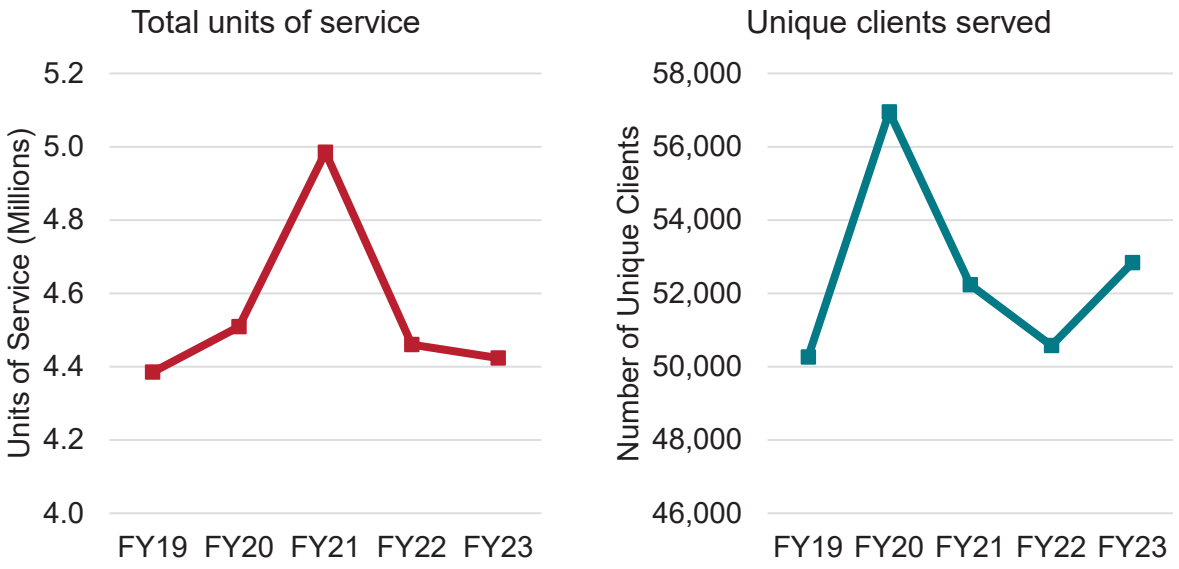
Overview of NM ALTSD service provision for all service types, FY19 - 23

Statistic	FY19	FY20	FY21	FY22	FY23
Total units of service	4,384,904	4,509,274	4,984,814	4,460,303	4,423,603
Unique clients served	50,261	56,948	52,230	50,575	52,838
Average units per client	87.2	79.2	95.4	88.2	83.7

Note: Excludes Legal Assistance service data, which were analyzed separately below.

Figure 22

New Mexico ALTSD total service provision and number of unique clients served, FY19 – 23



Note. Service provision includes Older Americans Act (OAA) Title III and state-funded programs and services.

has significantly risen in FY23 to its second-highest level in four years – 52,838 unique consumers. As noted, in considering total service provision per consumer we find the average units per client in FY23 have decreased below FY19 rates, following surges in FY21 in overall service provision and number of unique clients. It is interesting to find that surges in FY21 during the COVID-19 pandemic also correlate with more services per consumer. Further, despite providing more services in FY23 than in FY19, the New Mexico ALTSD is serving more unique consumers, but providing fewer overall resources on average to clients than for any other time in the four years we received data for.

County-Level Service Provision

Our analysis of FY 2023 consumer data indicate considerable variation occurs at the county-level for service provision. **Table 56** in Appendix D is illustrative. Data on services and unique clients by county for FY23 provide a snapshot of variation across geographic jurisdictions. Data show Bernalillo County is a significant outlier in comparison to all other counties in New Mexico. Firstly, Bernalillo County provides the highest total amount of services – 530,214 units – to more clients – 13,122 unique consumers. This is unsurprising since Bernalillo County has the largest senior population in the state, with an estimated 201,872 older adult residents 55 and older (U.S. Census, 2022). However, when we divide total units provided in FY 2023 by the number of unique consumers served for the same year, Bernalillo County has the *lowest* average units

provided per client for any county (40.4 units per consumer). In comparison, the next lowest average is for Otero County, with 62.7 units per consumer – more than 20 units per consumer higher than Bernalillo County.

Further, in considering the total potential population of older adult consumers, we divided the by the number of unique clients served by U.S. Census estimates for the 55+ population. The result estimates what proportion of the total 55+ year old population is being served in each county. While this metric is an underestimate (does not consider older adults with disability) it is standardized and considers most real-world consumers who are older adults. By this metric, Bernalillo County has the 3rd lowest proportion served, at 6.5%. This is only slightly above Grant County (5.4%) and Santa Fe County (6.1%).

At the other end of this scale is Harding County with the highest average services per client (159.8) and the second highest proportion of 55+ year old population served (29.2%). It is important to note Harding County serves the fewest total clients (73) out of all counties. It is striking that Harding is also one of the most rural counties – 100% of its population lives in areas designated as rural by the U.S. Census (2020), and yet provides the highest average services per client. In contrast, Bernalillo is designated highly urban with 96.0% of its population residing in urban areas.

We explore this rural-urban divide in service provision by grouping New Mexico counties into one of two categories: (1) urban counties where more than 50% of population lives in designated urban areas, and (2) rural counties where more than 50% of the population lives in rural areas. No county had exactly 50% of its residents living in rural areas and urban areas. **Table 17** summarizes each PSA based on this grouping and reports what percent of each PSA's residents live in rural areas. Our analysis of broad PSA rural-urban differences finds that rural areas serve a much larger proportion of the total older adult population compared to urban areas (13.7% vs. 7.9%, respectively). The average units per client in rural areas is also 36% higher than in urban areas (97.4 units/client vs. 71.5 units/client, respectively). By this metric, service coverage is generally *higher* in rural areas compared to urban ones.

Table 17

Statewide overview of service provision within rural and urban counties

	Rural Counties	Urban Counties
Total units of service	1,338,069	3,115,148
Number unique clients	13,740	43,570
Average units per client	97.4	71.5
Percent of 55+ population served	13.7	7.9

Note. Excludes Legal Assistance services, analyzed separately. Rural and Urban counties reflect counties where more than 50% of county deemed rural or urban by U.S. Census.

PSA-Level Service Provision

Most of our analyses focus on Planning and Service Areas (PSA) – the smallest units responsible for planning long-term care needs. PSAs 1 – 4 are aggregations of contiguous county geographies, except for PSA 1 which reflects one county – Bernalillo County. **Table 18.1** summarizes total population and the percent of the population living in rural areas for PSAs 1 – 4. We find that in terms of total population, PSA 2 has the largest population (754,690) and PSA 3 has the smallest (309,448). In terms of percent of the population living in rural areas, PSA 2 has the highest percent rurality (39.1%) and PSA 1 (Bernalillo County) has the lowest (4.0%). Importantly, PSA 5 and PSA 6 pertain to Navajo Nation and Tribes, Nations, and Pueblos, which cut across county geographies and make reconstruction of these regions challenging. However, PSA 6 data could be reported and is included in our analyses. As we note in our limitations, PSA 5 consumer data could not be reported to us and are therefore absent in this section.

According to the most recent FY23 consumer data, PSA 2 provides the greatest units of service – 1,709,584 total units – and PSA 6 provides the fewest – 429,411 total units (**Table 18.2**). Accounting for the number of unique clients served, we find PSA 6 provides the most units *per client* (118.8). PSAs 2, 3, & 4 all provide between 88.9 and 98.3 units per client on average. PSA 1 provides the lowest number of units per client on average, at 40.9. We observe a similar pattern considering the number of clients served as a proportion of the estimated total 55+ population. In this case, PSA 6 again serves the largest proportion of their 55+ population (15.5%) and PSA 1 serves (again) the smallest proportion (5.9%). The remaining PSAs 2, 3 & 4 range between serving 7.5% to 9.6% of their 55+ populations.

Readers should bear in mind consumer data were provided to us by PSA, and ultimately reflects where a service was *provided*. Where a service was provided may be different than the PSA a recipient of that service lives within. This is significant because consumers can and do travel to receive services outside the PSA boundaries they may reside in. To generate a picture of how frequently this occurs, we use county-level data provided by the New Mexico ALTSD which reports by PSA how many service units were provided to consumers living in each New Mexico

Table 18.1

Total population percent rural by PSA, 2020

	Total Population	Percent of Population Residing in Rural Areas
Statewide	2,117,522	25.5
PSA 1	676,444	4.0
PSA 2	754,690	39.1
PSA 3	309,448	28.5
PSA 4	376,940	34.1

Note: Population counts are based on the 2020 Decennial Census.

Table 18.2

Service provision overview by PSA, FY23

Location	Total units	Unique clients	Avg. units per client	Percent of total 55+ population served
Statewide	4,423,603	52,838	83.7	8.1
PSA 1	483,402	11,816	40.9	5.9
PSA 2	1,709,584	19,225	88.9	7.5
PSA 3	777,549	7,908	98.3	9.6
PSA 4	1,023,658	10,818	94.6	9.5
PSA 6	429,411	3,616	118.8	15.5

Note: The 55+ population estimates are based on 2022 5-year American Community Survey (ACS) estimates.

county (e.g., PSA 1 services to Bernalillo County residents, to Sandoval County residents, etc.). To assess consumer movement between PSAs we combined data for counties where recipients live and assigned respective PSA boundaries. We then calculated the proportion of all services provided by a PSA received by residents from a different PSA (i.e., “out-of-PSA consumers”). **Table 18.3** reports results of this analysis and shows that PSA 1 provides the greatest proportion of services to out-of-PSA consumers (5%) and PSA 4 provides the smallest proportion (0.5%).

Table 18.3

Comparison of service location and consumer residence, by PSA

Service Location	Consumer Residence				Percent of units provided to out-of-PSA consumers
	PSA 1	PSA 2	PSA 3	PSA 4	
PSA 1	474,790	24,414	77	328	5.0
PSA 2	21,880	1,674,510	1,071	2,441	1.5
PSA 3	1,523	7,607	760,337	2,916	1.6
PSA 4	827	3,339	1,222	1,013,481	0.5

Note.

Table 18.4

Services consumers accessed outside the PSA they reside within, FY23

Consumer Residence	Services *within* PSA	Services outside of consumer's PSA	Percent of services received outside consumer's PSA
Statewide	3,990,761.2	67,643.7	1.67
PSA 1	499,020.1	24,229.8	4.86
PSA 2	1,709,869.5	35,360.0	2.07
PSA 3	762,706.0	2,369.5	0.31
PSA 4	1,019,165.7	5,684.4	0.56

Note: PSA 6 services were excluded.

We subsequently calculated the proportion of services received by consumers in each PSA which they traveled out of the PSA they live within to obtain (**Table 18.4)**. We find that PSA 1 residents left their PSA boundaries the most to obtain services. About 4.86% of all services received by PSA 1 consumers were provided by other PSAs. Conversely, consumers in PSA 3 received the least amount of their services in other PSAs, meaning they traveled the least outside of their PSA to obtain support.

Why consumers leave their PSAs for services remains unclear. Potentially, New Mexicans living in urban centers may maintain social ties with family and friends in rural areas and vice versa. This may lead some to travel outside their locality. Alternatively, it may be there are specific services offered within either urban or rural areas, and seniors travel from one to the other for service-specific needs they may have. Travel could also be spurred by service-quality issues or consumer preferences related to service providers. However, it is important to keep in perspective that consumer movement between PSAs reflects, overall, 1.67% of all services provided in FY23. Data provided to us could not offer resolution on the number of unique consumers this reflects, but the small percent of services suggest a marginal amount.

PSA 6 is excluded from our analyses of consumer movement because data provided could only be assigned for PSAs 1 – 4. PSA 6 irregularly cuts across county boundaries and makes an analysis impossible with county-based data. PSA 6 consumers were therefore not included in our analysis of out-of-PSA consumer service provision altogether. Removing PSA 6 services introduces some error and likely undercounts estimated movement of consumers, potentially inflating the true rate of PSA service provision to out-of-PSA consumers. Given the small population across PSA 6, we expect any error in the true rate to be small, since estimates without PSA 6 indicate less than 5% of services by PSA are provided to out-of-PSA consumers.

Service Provision by Type

We reviewed 73 types of services documented in the WellSky database, which were ultimately collapsed into 10 broad categories:

- Home-Delivered Meals
- Congregate Nutrition
- Access Services
- Caregiver Support
- Older Relative Caregiver Support
- Public Health Emergency Support
- Health Promotion & Disease Prevention
- In-Home Support
- Other Community Support
- Other Services

Eight of these are based on the ALTSD budget categories outlined in a document we received in 2023 (AAA Administration Summary By Service 2a-2b Budget Forms FY23). In consultation with ALTSD administrators we added two additional categories not outlined in their budget document: *Public Health Emergency Support* and *Older Relative Caregivers Support*. Legal Assistance consumer data was provided to us in a different data format specific to federal reporting guidelines and is reviewed separately at the end of this section.

We discuss in this section insights gleaned from consumer data and what they reveal about the number of services provided for each service category by PSA from state fiscal year 2019 – 2023 (FY19 – FY23). Consumer data were provided to us already aggregated by client services, meaning we cannot report the number of unique clients provided services. To extend our analysis of service provision we report two measures by PSA:

(1) Average service units provided to an estimated 55+ consumer population
(2) Percent of all services provided in FY23 that each service category reflects

Within each service category, the average units provided per 55+ consumer is calculated by dividing total units of service by the estimated 55+ population residing within a given PSA. Population estimates are based on the 2022 American Communities Survey (ACS) 5-year estimates. This statistic provides a reasonable standardized measure for the number of services provided, adjusting for the estimated size of the 55+ consumer population. While this statistic does not include the estimated size of adults younger than 55 with a disability, it does account for most of the potential eligible consumer population served. Finally, our statistic for the percent of all services provided is calculated by simply dividing the number of units provided for a service category by the total service units for all categories in a given year. Again, this provides a standardized measure of the relative quantity of services provided within a service category for each PSA.

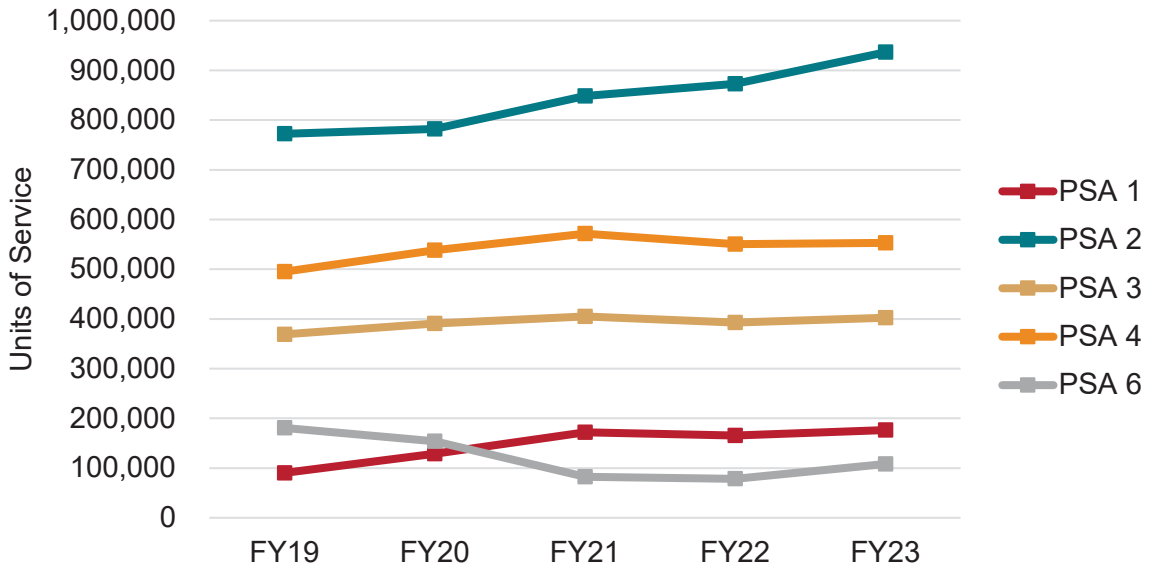
Home-Delivered Meals

Home-Delivered Meals refer to one service type in WellSky data: home-delivered meals. Rates of this service are relatively consistent over time and across all PSAs. Every PSA, save one, evidence increases over time in service provision from FY19 – 23 (**Figure 23**).

PSA 1 experiences a 95% increase in services, from 90,281 units in FY19 to 176,432 in FY23. This increase iss by far the largest of any PSA. The next largest increase occurs in PSA 2 (21.2%), followed by PSA 4 (11.8%) and PSA 3 (9.1%). Increases in *Home-Delivered Meals* over time makes sense given increased need among vulnerable older adults during the COVID-19 pandemic. The only area where *Home-Delivered Meals* decrease is for PSA 6, which decreases by 40.1% from 180,733 units in FY19 to 108,204 units in FY23. This trend for PSA 6

Figure 23

Annual Home Delivered Meals provided over time, FY19 – 23



Note.

Table 19

Home-Delivered Meals per consumer and out of all services by PSA, FY23

Location	Units	Avg. units per 55+ consumer	Percent of all services provided
Statewide	2,176,635	3.3	49.2
PSA 1	176,432	0.9	36.5
PSA 2	936,318	3.7	54.8
PSA 3	402,417	4.9	51.8
PSA 4	553,264	4.9	54.0
PSA 6	108,204	4.6	25.2

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

is surprising, given that tribal communities were some of the worst impacted by COVID-19 (Manson & Buchwald, 2021).

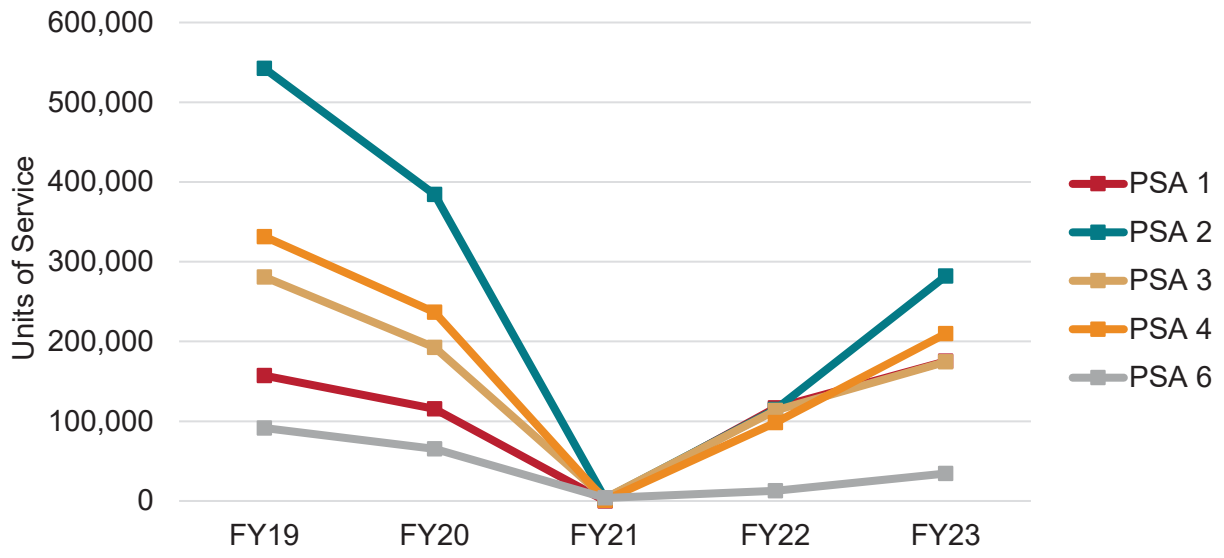
Critically, *Home-Delivered Meals* service provision in FY23 looks different when we adjust for PSA population size (**Table 19**). Considering the average units of service provided per 55+ consumer indicates provision is lowest for PSA 1 (0.9 units per 55+ consumer). And in contrast to the overall decrease in total units of services provided in PSA 6, in FY 23 this area averages 4.6 units per 55+ consumer; more than the state average of 3.3 units per person. The highest rate of service provision is 4.9 units per 55+ consumer in PSA 3 and PSA 4. Interestingly, *Home-Delivered Meals* account for the smallest proportion of all services provided in PSA 6 (25.2%), whereas it accounts for over half of all services in PSAs 2, 3, & 4.

Congregate Nutrition

Congregate Nutrition includes two distinct service types in the WellSky database: *Congregate Meals* and *Nutrition Education*. In contrast to the overall pattern for *Home-Delivered Meals* where service provision increases over time, *Congregate Nutrition* decreases from one of the most prevalent services across all PSAs in FY19, to close to zero in FY21 (**Figure 24**). This trend makes sense in the context of public health mandates implemented during COVID-19 to mitigate health vulnerabilities in the older adult population. After FY21 *Congregate Nutrition* services rebound, but do not return to pre-pandemic levels for any PSA, except PSA 1. Over time, PSA 1 *Congregate Nutrition* increases by 11.3%, from 157,277 units in FY19 to 175,103 in FY23. In contrast, all other PSAs significantly decrease by at least 36% from FY 19 – 23. PSA 6

Figure 24

Annual Congregate Meals provided over time by PSA, FY19 – 23



Note.

Table 20

Congregate Meals by PSA per consumer and out of all services, FY23

Location	Units	Avg. units per 55+ consumer	Percent of all services provided
Statewide	875,660	1.3	19.8
PSA 1	175,103	0.9	36.2
PSA 2	281,948	1.1	16.5
PSA 3	174,399	2.1	22.4
PSA 4	209,813	1.8	20.5
PSA 6	34,397	1.5	8.0

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

evidences the greatest decrease in this period of 62.4%, from 91,487 units provided in FY19 to 34,397 in FY23.

As we adjust FY23 service provision with respect to the 55+ consumer population (**Table 20**), we find PSA 3 provides the most units of service per 55+ consumer on average (2.1), followed by PSA 4 (1.8 units/consumer), PSA 6 (1.5 units/consumer), and PSA 2 (1.1 units/consumer). While PSA 1 provides the fewest average units of service per 55+ consumer (0.9 units/consumer), the highest proportion of PSA 1 services are for *Congregate Nutrition* – 36.2% of all PSA 1 services*,* which are also the highest proportion out of all PSAs. In comparison, the next highest proportion is for PSA 3 where 22.4% of all services are *Congregate Nutrition*. We find it surprising that *Congregate Nutrition* represents a higher proportion of all services in an urban area (PSA 1) compared to more rural PSAs. We might expect demand for social opportunities to be higher in rural areas, but data suggest the reverse, that a highly urban PSA has higher demand for this service than other services. Over a third of all PSA 1 (Bernalillo County) services are for Congregate Nutrition, in comparison to one-fifth or less of all services in other more rural PSAs.

Access Support

Access Support refers to services designed to improve access to resources or existing services. This includes the following WellSky services:

- Assessment/reassessment
- Assisted transportation
- Transportation
- Case management
- Information and assistance
- Information and referral
- Outreach/client finding

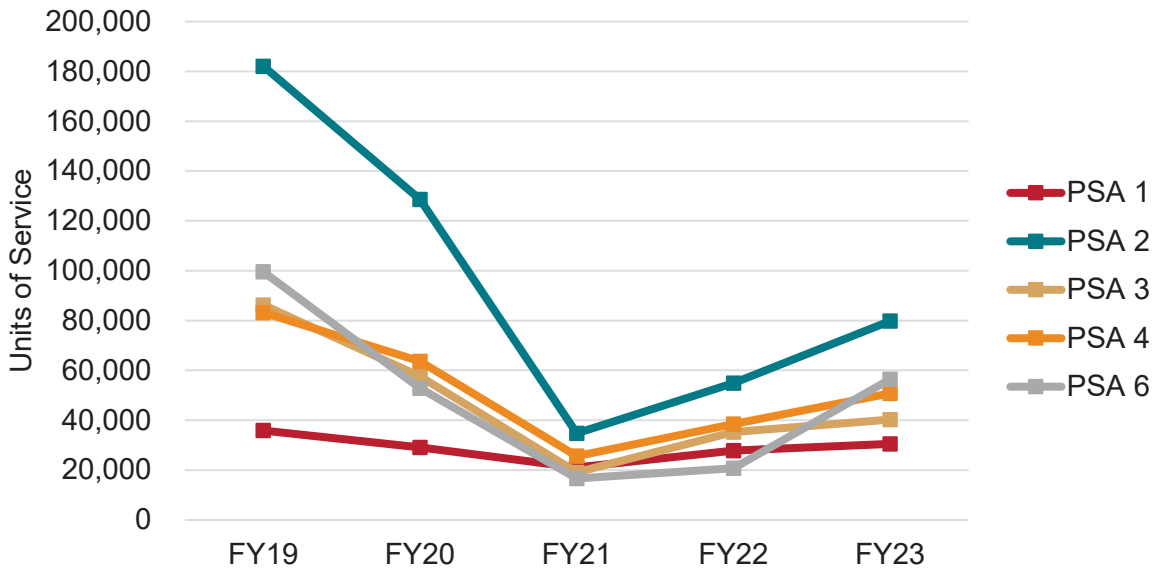
Access Support follows a similar trend to *Congregate Nutrition*. *Access Support* service provision decreases significantly from FY19 – 21 and rises steadily afterward from FY21 – 23. Like *Congregate Nutrition*, increases in recent fiscal years for *Access Support* have not returned to pre-pandemic levels (**Figure 25**). Out of all PSAs, PSA 2 decreases *Access Support* the most over time, decreasing by 56.2% from 182,089 units in FY19 to 79,809 in FY23. Oppositely, PSA 1 shows the smallest decrease in service provision (14.7%), dropping from 35,872 units in FY19 to 30,586 in FY23. It is important to note while PSA 1 *Access Support* decreases least, this area also provides the fewest total units of *Access Support* most years.

When accounting for population size for services in FY23, PSA 1 also provides the fewest average units of *Access Support* per 55+ consumer (**Table 21**). PSA 6, by contrast, offers the most average units of service per 55+ consumer (2.4 units/consumer); nearly five times higher than the second-highest rate in PSA 3 (0.5 units per consumer). Four of the five PSAs we obtained consumer data for provide *Access Support* at a rate of between 0.2 – 0.5 units per consumer.

As a proportion of all services in FY23, *Access Support* accounts for between 4.7% – 6.3% in four of five PSAs. This service accounts for the smallest proportion of all PSA 2 services. PSA 6 was a significant outlier, where 13.2% of all services offered are for *Access Support.* This was more than double the second-highest proportion of 6.3% in PSA 1.

Figure 25

Annual Access Services provided over time by PSA, FY19 – 23



Note.

Table 21

Access Services per consumer and out of all services by PSA, FY23

Location	Units	Avg. units per 55+ consumer	Percent of all services provided
Statewide	257,978	0.4	5.8
PSA 1	30,586	0.2	6.3
PSA 2	79,809	0.3	4.7
PSA 3	40,345	0.5	5.2
PSA 4	50,754	0.4	5.0
PSA 6	56,485	2.4	13.2

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

Caregiver Support

Caregiver Support refers to services supporting those who care for the elderly or those with disabilities. WellSky data services captured by this category include:

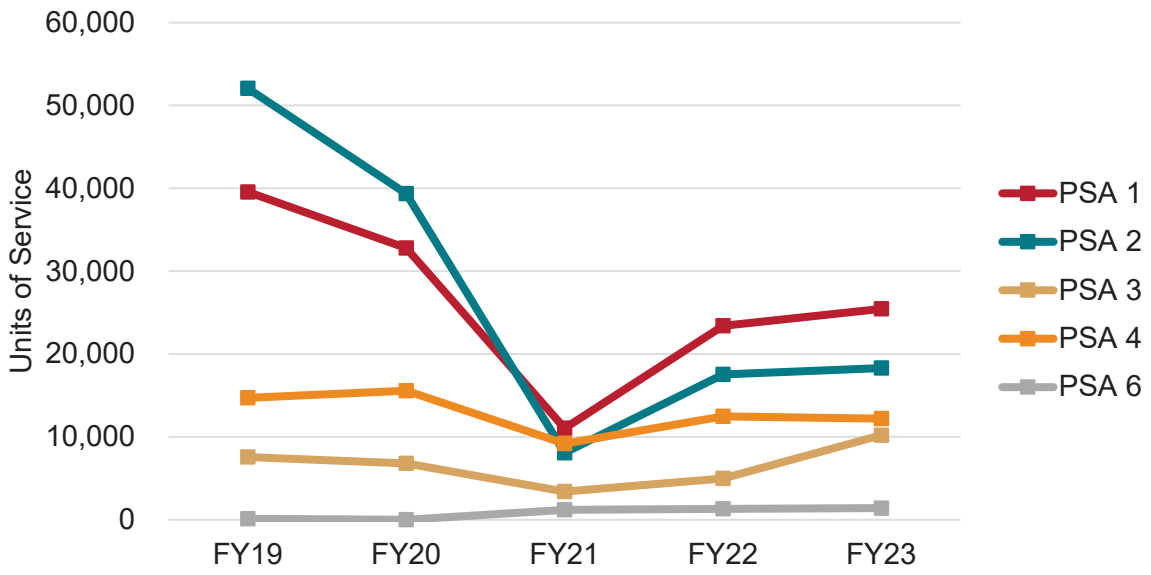
- Access assistance
- Counseling/support groups/training
- Information services
- Respite care
- Supplemental services

Caregiver Support service provisioning decreases over time throughout New Mexico from FY19 – 21, before rising again in FY21 – 23 (**Figure 26**). Statewide, *Caregiver Support* decreases by 40.8% over the five-year period from 114,023 units in FY19 to 67,555 in FY23. Only two PSAs show a net increase in *Caregiver Support* in the same period – PSA 3 and PSA 6. PSA 3 increases service provision by 35.2%, from 7,553 units in FY19 to 10,214 in FY 23. PSA 6 increases Caregiver Support by 1,126.1%. The increase for PSA 6 is in part a reflection of very low initial service provision in FY19, when only 115 units of *Caregiver Support* were offered. In FY23 this increases to 1,410 units which remains the lowest service provision for this category in any PSA.

Relative to all other service categories, *Caregiver Support* represents one of the least frequently offered service types, reflecting just 1.5% of all services in FY23. By PSA, Caregiver Support accounts for the highest proportion in PSA 1 where 5.7% of all services are accounted for by this service; PSA 6 has the lowest proportion where *Caregiver Support* reflects 0.3% of all services in FY23. In all other PSAs *Caregiver Support* accounts for between 1.1% - 1.3% of all services.

Figure 26

Annual Caregiver Support provided over time by PSA, FY19 – 23



Note.

Table 22

Caregiver Support provided per consumer and out of all services by PSA, FY23

	Units	Avg. units per 55+ year old consumer	Proportion of all services provided
Statewide	67,555	0.1	1.5
PSA 1	25,446	0.1	5.3
PSA 2	18,294	0.1	1.1
PSA 3	10,214	0.1	1.3
PSA 4	12,190	0.1	1.2
PSA 6	1,410	0.1	0.3

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

Adjusting for the estimated 55+ consumer population in each PSA, we find *Caregiver Support* service provisioning is equal across all areas. Considering total units of this service are low, rates of provision per 55+ consumer are also low. All PSAs provide on average 0.1 units of *Caregiver Support* per 55+ consumer in FY23 (**Table 22**).

Public Health Emergency Support

Public Health Emergency Support refers to services related COVID-19 aid, and therefore all contain COVID-19 prefixes to services in the WellSky database. There are 20 individual services within this category which include:

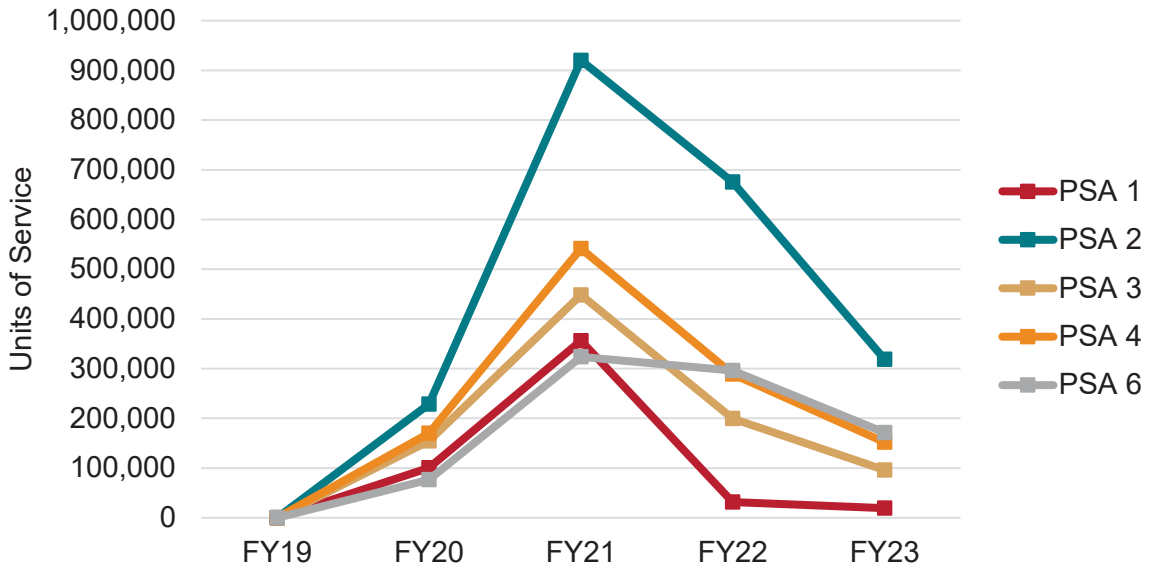
- COVID-19-CG-Home Delivered Meals
- COVID-19-CG-Homemaker Delivery
- COVID-19-Food Box Assembly
- COVID-19-Food Box Delivery
- COVID-19-Home Delivered Meals
- COVID-19-Senior Center
- COVID-19-Well Check Call
- COVID-19-CG-Consumable Supplies
- COVID-19-VAC Call
- COVID-19-Assistive Technology/ Durable Equipment/
- COVID-19-Congregate Meals
- COVID-19-Consumable Supplies
- COVID-19-Homemaker
- COVID-19-Individual Socialization
- COVID-19-Nutrition Education
- COVID-19-Other Fitness/Health Promotion
- COVID-19-Public Information
- COVID-19-Group Socialization
- COVID-19-VAC Information
- COVID-19-CG-Assistive Technology/ Durable Equipment

Public Health Emergency Support service provision corresponds with the intensity of the COVID-19 pandemic over time. Support of this kind rises steeply from zero in FY19 to its peak in FY21. From FY19 – 23, over 7.5 million units of *Public Health Emergency Support* are provided throughout New Mexico. As COVID-19 infections become less of a public health emergency over time, this support drops steadily (**Figure 27**). From FY 21 – 23 net service provision of *Public Health Emergency Support* declines by 70.8%. However, decline in this service varies by PSA.

As **Figure 27** visualizes, PSA 1 shows significant decline in FY21 compared to other PSAs. PSA 1 by FY23 nearly returns to zero service provision whereas other areas provide at least 100,000 annual service units of *Public Health Emergency Support*. PSA 1 service provision ultimately drops 94.6% from its peak in FY21 of 356,114 units to a modest 19,217 in FY23. Other PSAs in FY 23 decline by between 65.4% to 78.5%. The smallest decrease occurs in PSA 6, where over the same period service provision drops 47.0%, which amounts to slightly fewer total units of service compared to FY20. Conversations with providers serving tribal areas indicate the COVID-19 pandemic had a more significant and lasting impact on services in these communities. For example, senior centers remained closed longer in these areas. We therefore might expect that *Public Health Emergency Support* service provision reflects this reality and that support has been higher and more sustained for these areas.

Figure 27

Public Health Emergency Services provided over time by PSA, FY19 – 23



Note.

Table 23

Public Health Emergency services per consumer and out of all services by PSA, FY23

Location	Units	Avg. units per 55+ consumer	Percent of all services provided
Statewide	757,011	1.2	17.1
PSA 1	19,217	0.1	4.0
PSA 2	318,447	1.2	18.6
PSA 3	96,239	1.2	12.4
PSA 4	151,696	1.3	14.8
PSA 6	171,412	7.3	39.9

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

Buttressing that expectation, *Public Health Emergency Support* accounts for more of PSA 6 totals services in FY23 than for other PSAs. Services of this type account for 39.9% of all services provided in PSA 6 (**Table 24**). This is more than double the next highest proportion in PSA 2, where 18.6% of all services are accounted for by *Public Health Emergency Support*. PSA 1 service provision for this type decreases more rapidly than for other PSAs and reflects only 4.0% of all services PSA 1 provided in FY23.

Adjusting for the potential consumer population, PSA 6 provides *Public Health Emergency Support* at higher rates relative to its estimated 55+ consumer population. As **Table 23** reports, in FY 23 PSA 6 provided about 7.3 units of *Public Health Emergency Support* per 55+ consumer. By comparison, PSAs 2, 3, & 4 all provide between 1.2 and 1.3 units of support per 55+ consumer. PSA 1 provides the lowest rate of support at 0.1 units per 55+ consumer.

Health Promotion & Disease Prevention Services

Health Promotion and Disease Prevention services refers to fitness and education programs aimed at keeping older adults healthy. This category captures the following WellSky services:

- EB-A Matter of Balance MOB
- EB-Diabetes Self-Management Program DSMP
- EB–Enhanced Fitness
- EB-My CD
- EB-Tai Chi for Arthritis
- EB-Tai Chi Quan Moving for Better Balance TJQMBB
- EB-Chronic Disease Self-Management Program CDSMP

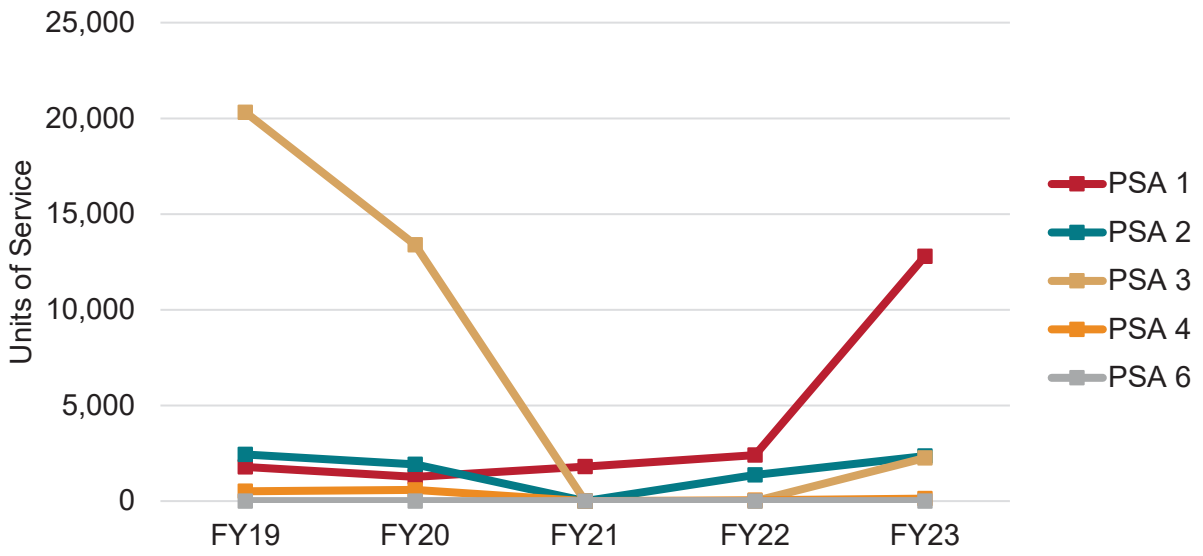
As with most other service categories up to this point, *Health Promotion & Disease Prevention* services drop between FY19 – 21 and rise from FY22 – 23 (**Figure 28**). PSA 3 is an interesting outlier, where in FY19 it provides by far the most *Health Promotion & Disease Prevention* services, at 20,316 units – all other PSAs (except PSA 1) provide fewer than 5,000 annual units. In FY19, PSA 2 provides the second highest level of support – 2,436 units. Over time, all PSAs, except for PSA 1, maintain fewer than 5,000 annual units of this service type. PSA 3 also ultimately experiences the greatest decrease in *Health Promotion & Disease Prevention*, with provision falling 88.9% to 2,247 service units in FY23 – similar total units to most other PSAs at this timepoint.

PSA 1 is also an interesting outlier, as it shows the opposite trend to PSA 3, and is the only PSA where *Health Promotion & Disease Prevention* services increase over the 5-year period. PSA 1 services increase by 617.6%, from 1,783 units in FY19 to 12,794 units in FY23. PSA 1 is also the only PSA to provide any *Health Promotion & Disease Prevention* services in FY21 at the height of the COVID-19 pandemic. In contrast to all other PSAs, PSA 6 provides no *Health Promotion and Disease Prevention services* from FY19 – 23.

As a proportion of all services provided, *Health Promotion & Disease Prevention* accounts for a fraction of services in each PSA. In FY23, PSA 1 has the highest proportion of services accounted for by *Health Promotion & Disease Prevention*, reflecting about 2.6% of all services provided (**Table 24**). In all other PSAs, *Health Promotion & Disease Prevention* accounts for less than 1.0% of all services provided in FY23.

Figure 28

Health Promotion& Disease Prevention services provided over time by PSA, FY19 – 23



Note.

Table 24

Health Promotion & Disease Prevention per consumer and out of all services by PSA, FY23

Location	Units	Avg. units per 55+ consumer	Percent of all services provided
Statewide	17,536	0.0	0.4
PSA 1	12,794	0.1	2.6
PSA 2	2,359	0.0	0.1
PSA 3	2,247	0.0	0.3
PSA 4	136	0.0	0.0
PSA 6	--	--	0.0

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

Adjusting for population size we find service provision for this category is extremely low, 0.0 units of service per 55+ consumer are provided statewide in FY23. Only one PSA has provided this service at greater than 0.0 units per 55+ consumer – PSA 1 with a rate of 0.1 units per 55+ consumer. A rate could not be calculated for PSA 6 since no services of this kind are provided over the 5-year period we received data for.

In-Home Support

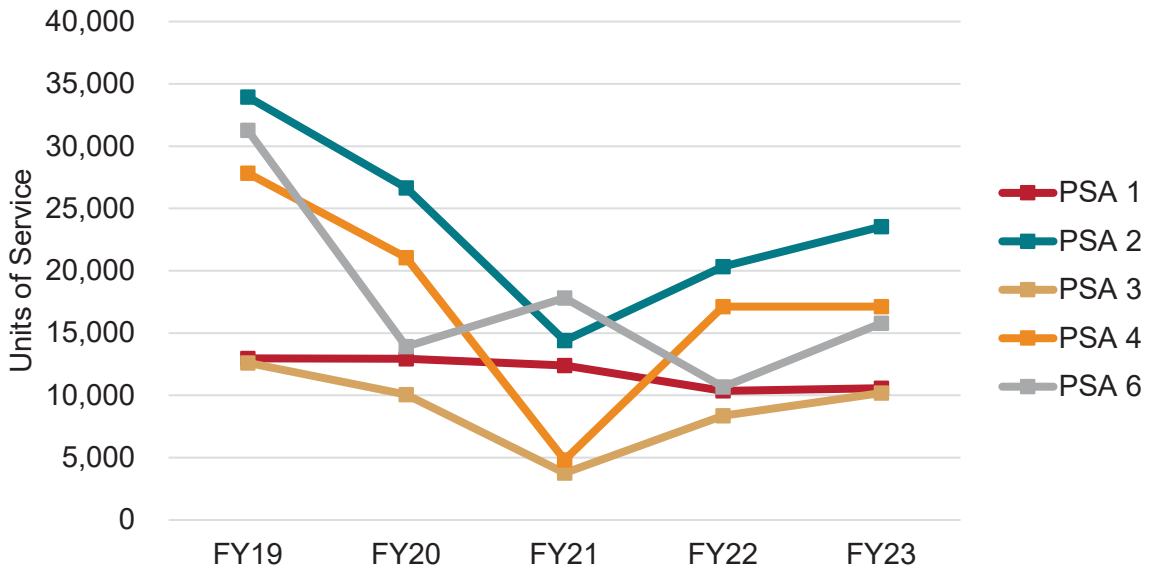
In-Home Support refers to services helping elderly and those with disability to remain in their homes and maintain quality of life. The following services in WellSky data are captured under this category:

Chore	Personal Care
Home Visiting	Respite Care
Homemaker/Housekeeping	Telephoning(r)

Like other services, *In-Home Support* service provision decreases from FY19 – 21 and increases from FY21 – 23 (**Figure 29**). PSA 1 and PSA 6 modestly deviate from this overall trend, where service provision takes slightly longer to reaches its lowest point. Relative to the lowest point in other PSAs which occurs in FY21, the lowest service provisioning for PSA 1 and PSA 6 occurs roughly one year later in FY22. All PSAs experience a net decrease for *In-Home*

Figure 29

In-Home support provided over time by PSA, FY19 – 23



Note.

Table 25

In-Home support provided per consumer and out of all services by PSA, FY23

Location	Units	Avg. units per 55+ consumer	Proportion of all services provided
Statewide	77,210	0.1	1.7
PSA 1	10,570	0.1	2.2
PSA 2	23,542	0.1	1.4
PSA 3	10,196	0.1	1.3
PSA 4	17,114	0.2	1.7
PSA 6	15,789	0.7	3.7

Note. Avg. units per 55+ consumer calculated using 2022 ACS 5-year estimate of 55+ population for each locality.

Support from FY19 – 23, with PSA 6 experiencing the largest decrease in services (49.5%) and PSA 1 seeing the smallest decrease (18.5%).

Despite showing the largest decrease of all PSAs, in FY23 PSA 6 offers the highest average units of *In-Home Support* per 55+ consumer (**Table 25**). PSA 6 provides 0.7 units of service per 55+ consumer in FY23, which is more than three times the next highest rate in PSA 2, providing on average 0.2 units of *In-Home Support* per 55+ consumer. The rate for all other PSAs is 0.1 units per 55+ consumer on average. As a proportion of all services provided, *In-Home Support* reflects just 1.7% of all services offered in FY23. In PSA 6, *In-Home Support* accounts for 3.7% of all services offered in FY23, the highest of any PSA. The next highest proportion occurs in PSA 1, where 2.2% of all services provided are *In-Home Support*. These services comprise less than 2.0% of services in all other PSAs.

Other Services

The *Other Services* category mostly reflects state-funded nutrition services, many of which are connected to COVID-19 relief. Eight services in WellSky are captured by this category and include:

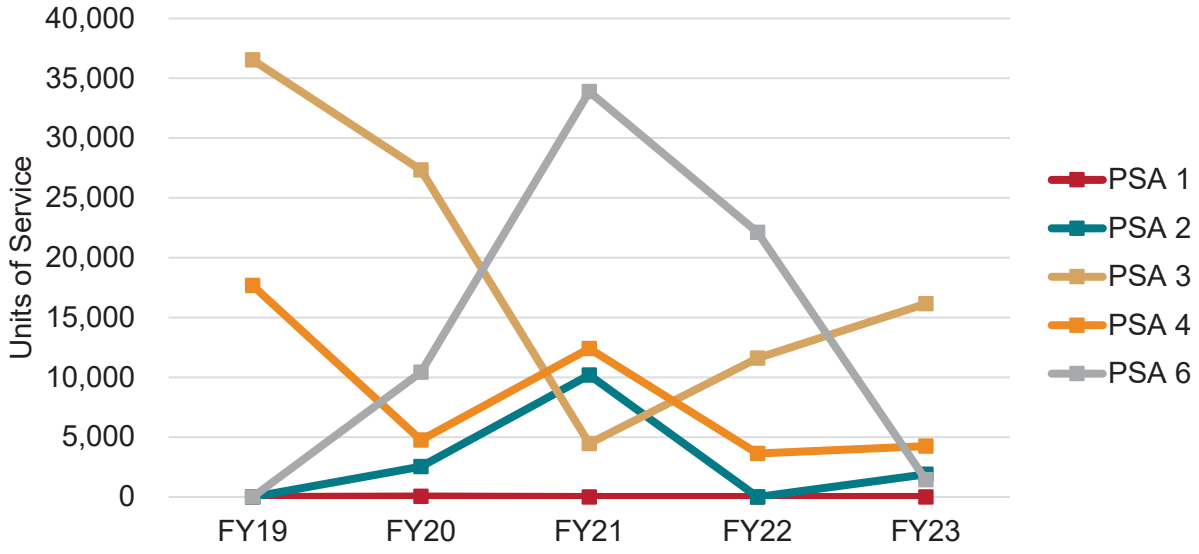
- Multipurpose Senior Services
- Non-Title III home delivered meals
- COVID-19-Adult under 60 Meals-State Funded
- COVID-19-Children Meals-State Funded
- COVID-19-Adult 50 to 59 Meals-State Funded
- Children Meals-Congregate-State Funded
- Children Meals-Home Delivered-State Funded
- Rural Senior Food Box Delivery

In FY19, most PSAs do not provide *Other Services* – PSAs 1, 2, & 6. Beginning in FY20 though, *Other Services* rises in these PSAs, peaking in FY21 before dropping in FY22, and then rising slightly once more in FY23 (**Figure 30**) The number of unique clients shares a similar trajectory, with the fewest unique consumers in FY19 (50,261 consumers). In the following year, this service is provided to the most unique consumers (56,948 consumers) and then drops to nearly pre-pandemic levels in FY22. In contrast to total service provision though, the number of unique consumers significantly rises in FY23 to its second-highest level in four years – 52,838 unique consumers. In PSA 1, *Other Services* are minimally provided (38 units) and in all other years are not provided. These highly varied trends by PSA make sense given the combination of services captured by this category, three of which are for COVID-19 relief. In PSA 2 and PSA 6, COVID-19 services account for the steady increases in service provisioning from FY19 – 21, and steadily decline afterward. PSAs 3 and 4 follow a different trend, seeing their highest provision of *Other Services* in FY19, which then drop and rise irregularly over time. We expect in PSA 3 & 4 this is attributable to provision of non-COVID-19 services captured by *Other Services*.

In general, *Other Services* account for extremely small proportions of all services PSAs provide. About 0.5% of all statewide services in FY23 are for *Other Services.* And for most PSAs, *Other Services* comprise between 0.0% and 0.4% of all services in FY23. PSA 6 has the highest proportion in FY23, where 2.1% of all services are for *Other Services.* Unsurprisingly, this category reflects one of the lowest rates of provision per our estimates of the 55+ consumer population. On average, 0.0 units of service are provided per 55+ consumer statewide. PSA 3 provides *Other Services* at the highest rate, where in FY 23 they provide 0.2 average units of

Figure 30

Other Services provided over time by PSA, FY19 – 23



Note.

Table 26

Other Services provided per consumer and out of all services by PSA, FY23

Location	Units	Avg. units per 55+ consumer	Percent of all services provided
Statewide	23,744	0.0	0.5
PSA 1	--	--	0.0
PSA 2	1,907	0.0	0.1
PSA 3	16,147	0.2	2.1
PSA 4	4,256	0.0	0.4
PSA 6	1,434	0.1	0.3

Note.

Other Services per 55+ consumer. *Other Services* account for less than 0.5% of all services in all other PSAs. PSA 6 provides 0.1 units per 55+ consumer in FY23, and PSA 2 & 4 provide 0.0 units per 55+ consumer in the same fiscal year. PSA 1 does not provide any *Other Services* in FY23 and a rate could not be calculated.

Other Community Support

Other Community Support refers to 12 services documented in WellSky:

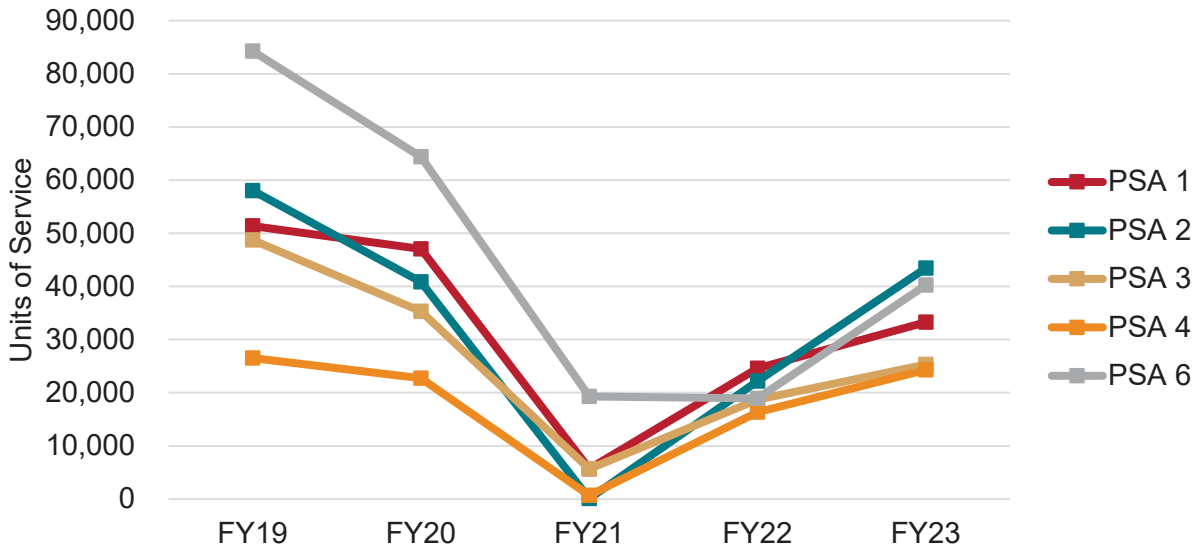
- Adult Day Care/Adult Day Health Care
- Adult Dar Care/Health
- Advocacy/Representation(r)
- Education/Training
- Health Screening
- Home Repair/renovation/maintenance
- Home Safety/Accident Prevention(r)
- Interpreting/Translating
- Loan of durable medical equipment
- Medication Management
- Physical Fitness
- Recreation

Like most other supports and services, *Other Community Support* decreases in the first two fiscal years that overlap with the COVID-19 pandemic, reaching its lowest point for all PSAs in FY21 (**Figure 31**). We expect this is the result of senior centers closing and the curtailing of in-person services during this period to comply with public health recommendations. Most *Other Community Support* services – such as Adult Day Care, Education/Training, Physical Fitness, and Recreation – are provided by local senior centers, and services like *Home Repair / Renovation/ Maintenance* are provided at consumers' homes and necessarily in-person.

As with other service types, *Other Community Support* also increases in FY22 – 23 but has not returned to pre-pandemic service levels in FY23. As service provision in this category decreases from FY19 – 23, PSA 4 shows the *smallest* decrease in services (8.3%) and PSA 6

Figure 31

Other Community services provided over time by PSA, FY19 – 23



Note.

Table 27

Other Community services provided per consumer and out of all services by PSA, FY 2023

Location	Units	Avg. units per 55+ year old consumer	Percent of all services provided
Statewide	166,645	0.3	3.8
PSA 1	33,253	0.2	6.9
PSA 2	43,443	0.2	2.5
PSA 3	25,345	0.3	3.3
PSA 4	24,323	0.2	2.4
PSA 6	40,281	1.7	9.4

Note.

shows the *largest* decrease (52.2%). No other remarkable trends in the total amount of *Other Community Support* services are observed.

However, adjusting for the estimated 55+ consumer population evidences two noteworthy patterns. Firstly, despite experiencing the greatest percent decrease in *Other Community Support* over the the 5-year period, PSA 6 in FY23 provides by far the highest average units of *Other Community Support* per 55+ consumer – 1.7 average units of these services per 55+ consumer (**Table 27**). For comparison, the next highest rate of service provision occurs in PSA 3 where 0.3 units of *Other Community Support* are provided per 55+ consumer in FY23. All other PSAs provide 0.2 units per consumer. As a proportion of all services provided statewide in FY23, 3.8% are for *Other Community Support*. PSA 6 provides the highest proportion of *Other Community Support* (9.4%) and PSA 1 provides the second highest (6.9%). For all remaining PSAs, *Other Community Support* comprises between 2.4% and 3.3% of all services provided.

Older Relative Caregiver Support

Older Relative Caregiver Support refers to services aimed at supporting older New Mexicans who care for other family members (e.g., grandchildren). This category was formerly called *Grandparents Raising Grandchildren (GPRG)*. For the 5-year period we received WellSKy data, only two services are captured by this category:

(1) Counseling/Support Groups/Training
(2) Respite Care

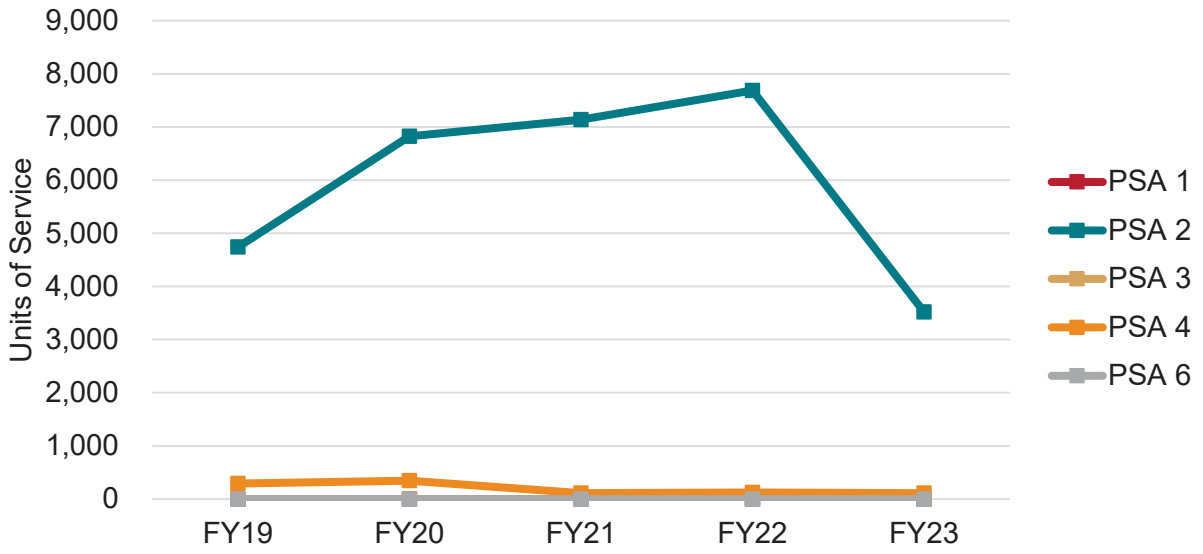
Older Relative Caregiver Support is only provided in two PSAs for the entire five-year period we reviewed – PSA 2 and PSA 4. In contrast to nearly all other service types, *Older Relative Caregiver Support* increases modestly during the COVID-19 pandemic period and is provided at its highest levels between FY20 – 22. Service provision decreases steeply for PSA 2 in FY23, while the minimal level of provision in PSA 4 occurs much earlier in FY21 (**Figure 32**). From FY19 – 23 *Older Relative Caregiver Support* decreases by 61.6% in PSA 4 and 25.9% in PSA 2. It is unclear to us why this service category is only provided in two PSAs from FY 19 – 23, or why services drop steeply in FY21 and FY23.

Given limited provision of *Older Relative Caregiver Support* it is unsurprising this service category reflects a small fraction of services in New Mexico – about 0.1% of all services in FY23. In PSA 2 *Older Relative Caregiver Support* accounts for 0.2% of all services they provide (**Table 28.1**). The exceedingly small amount of *Older Relative Caregiver Support* in PSA 4 means this category accounts for 0.0% of all services provided in FY23. Adjusting for population size, average *Older Relative Caregiver Support* per 55+ consumer is less than 0.0 in both PSA 2 and PSA 4.

To better understand gaps in *Older Relative Caregiver Support* ALTSD provided us with additional county- and provider-level service data for this service type, including an FY23 Older Americans Acts Performance System (OAAPS) report the Department submitted to the Administration for Community Living (ACL). Provider-level data show only three providers in New Mexico offer *Older Relative Caregiver Support*: Las Cumbres Community Services in Rio Arriba County (PSA 2), the City of Santa Fe (PSA 2), and the City of Las Cruces (PSA 4). Las Cumbres provides 96.1% of all *Older Relative Caregiver Support* in the state. Las Cumbres provided 3,488 units of service to 63 unique consumers in FY23. Most services (83.6%) are

Figure 32

Older Relative Caregiver support provided over time by PSA, FY19 – 23



Note.

Table 28.1

Older Relative Caregiver support per consumer and out of all services, FY 2023

Location	Units	Avg. units per 55+ year old consumer	Percent of all services provided
Statewide	3,630	0.0	0.1
PSA 1	--	--	0.0
PSA 2	3,518	0.0	0.2
PSA 3	--	--	0.0
PSA 4	112	0.0	0.0
PSA 6	--	--	0.0

Note.

Table 28.2

Older relative caregivers service recipient characteristics, FY 2023

	Count	Percent
Age		
55-59	15	14.9
60-64	27	26.7
65-74	42	41.6
75-84	12	11.9
85 and Above	5	5.0
Missing	0	0.0
Gender		
Female	79	78.2
Male	22	21.8
Rurality		
Rural	14	13.9
Non-Rural	87	86.1
Poverty Status		
At or Below Poverty	30	29.7
Above Poverty	71	70.3
Ethnicity		
Hispanic or Latino	86	85.1
Not Hispanic or Latino	14	13.9
Missing	1	1.0
Care Recipient of Older Relative Caregivers		
Children	98	97.0
Adults with disabilities	3	3.0
Number of unique consumers	101	100.0

Note.

for *Respite Care*. Additionally, in the same year the City of Las Cruces provided 112 units to 22 unique consumers and the City of Santa Fe provided 30 units to 16 unique consumers.

The OAAPS report further summarized consumer-level characteristics for *Older Relative Caregiver Support* recipients. **Table 28.2** reports these features. We find that recipients of *Older Relative Caregiver Support* services are disproportionately female (78.2%), live in urban areas (86.1%), have annual household incomes above the poverty threshold (70.3%), and are predominantly Hispanic (85.1%), and White (96%). In terms of who recipients are caring for, 97% of older relative caregivers care for children and 3% care for adults with disabilities.

Legal Assistance

Legal Assistance service data were provided to us in different data files and formats than for all other service types. This was because *Legal Assistance* service providers are under a separate contract and have unique reporting requirements determined by the Administration for Community Living (ACL). Analyzing these data was challenging. Firstly, reports we received from the New Mexico ALTSD capture a different reporting period than all other consumer data, aligned instead to federal fiscal years rather than state fiscal years. Secondly, Federal Fiscal Years 2019 – 2021 (FFY19 to FFY21) were provided in a different format and included different variables than reports for FFY22 and FFY23. This is because the reporting system for *Legal Assistance* changed in FFY22 when it transitioned from a previous State Program Reports (SPR) system to the current Older Americans Act Performance System (OAAPS).

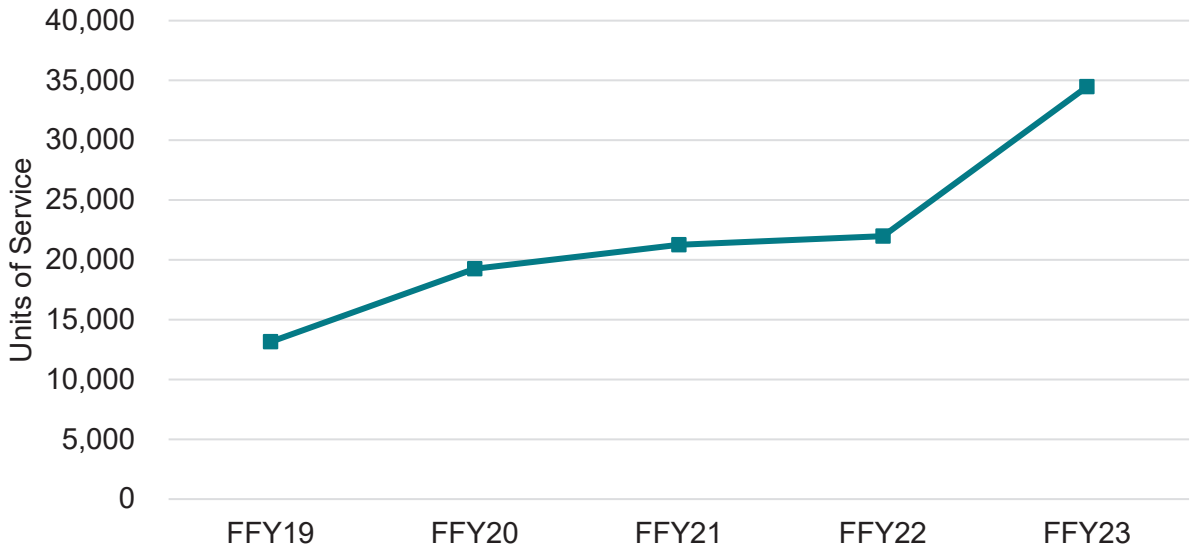
The key difference between reports for FFY19 – 21 and FFY22 – 23 is that FFY22 – 23 reports include *types* of legal services (i.e., case types), number of unique consumers, and consumer demographics. In contrast, FFY19 – 21 reports contain total number of units of service provided, the number of providers, and total program costs. Our analysis adapts to these reporting differences by combining similar data where possible, and when not, data are analyzed separately. We note in tables and charts the specific time frames data are restricted to and encourage readers to remain aware of them.

Figure 33 illustrates the statewide provision of *Legal Assistance* from FFY 19 – 23. In the 5-year period, total units of *Legal Assistance* services increase by 162.2%, with the largest increase occurring between FFY22 and FFY23. Available consumer data for FFY22 and FFY23 suggest the number of unique clients receiving services also increases in this period in tandem with total service units provided; from 5,512 service recipients in FFY22 to 5,577 in FFY23 (**Table 29.1**). Importantly, despite these increases the number of closed cases *decreases* from 5,592 cases to 5,394 cases.

We also were able to review limited case type data, which revealed some of the kinds of legal issues consumers accessed services for. This analysis was only possible for FFY22 – 23. Based on these data, the most prevalent case type is for *Other/Miscellaneous* – 2,547 and 2,547 cases, respectively. The second-most common case type is for issues related to *Housing* (1,163 cases in FFY23), followed by *Defense of guardianship or protective services* (538 cases in FFY23), *Heath Care* (432 cases in FFY23), and *Income* (260 cases in FFY23). Case type ranking outlined above is consistent across FFY22 and FFY23. All other case types represent fewer than 100 cases, with one exception, *Age discrimination* cases. This category increases from 39 cases in FFY22 to131 cases in FFY23.

Figure 33

Legal Assistance provided over time by PSA, FFY19 – 23



Note.

Since FFY20 *Legal Assistance* services have been offered by just three providers: Legal Resources for the Elderly Program (LREP), Senior Citizens Law Office, and Pegasus Legal Services for Children. OAAPS reports we received for FFY22 and FFY23 breakdown provider services received by older adults and detail the number of unique clients served (**Table 29.2**). From FFY22 – FFY23, LREP provided most *Legal Assistance* offered in New Mexico and served the most clients – 3,924 closed cases and 3,499 unique clients in FFY23. The Senior Citizens Law Office provided the second-highest total services – 1,249 closed cases and 1,563 unique clients – followed by Pegasus – 221 closed cases and 515 unique consumers. Virtually all cases for LREP (99.6%) are classified as "advice". Advice is also the most frequent *Legal Assistance* service provided by Pegasus (65.2% of all services). All remaining services provided by Pegasus in FFY23 are for "representation" (29.9% of all services) or "limited representation" (5.0%). Most services provided by the Senior Citizens Law Office are for representation (46.0% of all services), followed by *Advice* (31.9%) and *limited representation* (22.0%). We expect that *Representation* services are more intensive than *Advice*, which readers should consider as they evaluate overall rates of *Legal Assistance* by each provider.

Limited data were available on the demographic characteristics of Legal Assistance recipients. These are reported in **Table 29.3**. Demographic data indicate the LREP serves the highest proportion of rural consumers (23.9% living in rural areas) and compared to other *Legal Assistance* providers (836 unique consumers). About 15.0% of Pegasus service recipients live in rural areas, and 9.8% of Senior Citizens Law Office recipients. We also find that Pegasus serves more clients below poverty (100%), than Senior Citizens Law Office (79.7% in poverty), and LREP which served the fewest below poverty (34.4%).

Table 29.1

Legal Assistance types provided and number of unique consumers, FFY19 – 23

	FFY22	FFY23
Case types (closed cases)		
Income	279	260
Health care	437	432
Long-term care	39	66
Nutrition	--	2
Housing	1,218	1,163
Utilities	23	28
Abuse/neglect	79	53
Defense of guardianship/protective services	931	538
Age discrimination	39	131
Other/miscellaneous	2,547	2,721
Number of unique consumers	5,512	5,577
Number of closed cases	5,592	5,394

Note: These data were only provided from FFY22 onward, due to changes in the reporting system from SPR to OAAPS.

Table 29.2

Legal Assistance by provider in FFY 2023

	Senior Citizens Law Office		LREP		Pegasus	
	Count	Percent	Count	Percent	Count	Percent
Levels of service						
Advice	399	31.9	3,909	99.6	144	65.2
Limited representation	275	22.0	15	0.4	11	5.0
Representation	575	46.0	--	0.0	66	29.9
Closed cases	1,249		3,924		221	

Note.

For all providers, most clients served are female. More of Pegasus recipients are also Hispanic/Latino, while most clients served by LREP and Senior Citizens Law Office are non-Hispanic Latino clients (60.6% and 57.4% respectively). It is important to note while Pegasus serves a higher proportion of Hispanic/Latino consumers, the total count of Hispanic/Latino *Legal Assistance* recipients is significantly higher for the LREP and Senior Citizens Law Office.

Based on these data, we expect rural areas in general may be underserved by *Legal Assistance* services. At most, 23.9% of provider services are received by rural consumers. Moreover, the provider serving most rural residents also renders, almost exclusively, legal advice services. As noted, we expect *Advice* services are less intensive than those for *Representation*. While *Legal Assistance* data overall are interesting, we remind readers they are also significantly limited. Specifically, current data reporting does not allow us to identify which areas of New Mexico may lack *Legal Assistance* services. County-level data are not currently available and may be of interest to the New Mexico ALTSD. It may also be of interest to collect additional metrics from *Legal Assistance* providers in the future, which identify service gaps of interest.

Table 29.3

Legal Assistance support recipient characteristics by provider, FFY23

	Senior Citizens Law Office		LREP		Pegasus	
Characteristic	Count	Percent	Count	Percent	Count	Percent
Gender						
Female	1,053	67.4	2,127	60.8	373	72.4
Male	496	31.7	1,372	39.2	142	27.6
Rurality						
Rural	153	9.8	836	23.9	77	15.0
Non-Rural	1,410	90.2	2,663	76.1	438	85.0
Poverty status						
At or Below Poverty	1,246	79.7	1,205	34.4	515	100.0
Above Poverty	205	13.1	1,950	55.7	--	0.0
Missing	112	7.2	344	9.8	--	0.0
Ethnicity						
Hispanic or Latino	616	39.4	1343	38.4	288	55.9
Not Hispanic or Latino	947	60.6	2007	57.4	227	44.1
Missing	0	0.0	149	4.3	0	0.0
Unique consumers	1,563		3,499		515	

Note.

STATEWIDE PROVIDER SURVEY PART B – BUSINESS HEALTH

At the request of the Aging & Long-Term Services Department (ALTSD), we deployed a second survey in the Spring of 2024 to collect additional data from providers on the business and financial health of older adult service providers across New Mexico. The survey was open from 3/25/2024 through 5/31/2024. Sixty-three (63) providers ultimately finished at least 50% of the survey. Out of 30 contacts we received for providers in PSAs 5 & 6 – Navajo Nation, and Tribes, Pueblos, and Nations – five participated in the survey. Our total response rate was 39.6%; 16.7% for PSA 5 &6 contacts. Approximately 4.4% of all respondents in our sample provide services in Tribes, Nations, or Pueblos.

The survey consists of seven sections:

(1) Business Organization
(2) Business Volume
(3) Business Strength
(4) Business Growth
(5) Service Expansion
(6) Workforce Growth
(7) Capital Improvement

Our analysis focuses on understanding responses between PSAs1 -4 and PSAs 5 & 6. PSAs 5 & 6 reflect responses for contacts from PSA 5 & 6 as well as respondents who reported providing services to Tribes, Nations, or Pueblos. Ultimately, seven of 159 total contacts reported they service Tribes, Nations, or Pueblos.

Business Organization

Respondents were first asked to report the kind of entity their agency/organization is owned by, which we summarize in **Table 30**. The majority (67.7%; 42) of surveyed providers indicate their agency or organization is owned by a city or non-profit. Respondents from PSAs 5 & 6 were

Table 30

Entity category surveyed providers reported their agency/organization is owned by

	PSA 1 – 4		PSA 5 & 6		All Responses	
Response	Count	Percent	Count	Percent	Count	Percent
Tribe, Nation, or Pueblo	0	0.0	4	57.2	4	6.4
County	11	20.0	0	0.0	11	17.7
City	23	41.8	1	14.3	24	38.7
Non-Profit	17	30.9	1	14.3	18	29.0
Private entity	1	1.8	0	0.0	1	1.6
Other	3	5.5	1	14.3	4	6.5
Total	55	100.0	7	100.0	62	100.0

Note. Three “Other” responses included (1) ENIPC, (2) Not sure, and (3) Village.

notably different from all other PSAs, where most of surveyed providers report their agency/organizations are owned by Tribes Nations, or Pueblos (57.2%). Three other respondents indicated their agency or organization is owned by either a city, non-profit, or the Eight Northern Indian Pueblos Council (ENIPC). In comparison to respondents from, PSAs 5 & 6 most indicated they were owned either by Cities (41.8%; 23), Non-Profits (30.9%; 17) or Counties (20.0%; 11).

Most respondents were also not affiliated with a parent company (87.1%; 54); and none of the surveyed providers from PSAs 5 & 6. Only eight of 62 respondents (12.9%) who answered this question indicated they were affiliated with a parent company, which included: PMSCSS, Mora Valley Health Services, Adelente Development Center, Inc., Presbyterian Medical Services, NMAAA, Hidalgo Medical Services, and Adalante Development Center, Inc.

Business Volume

Table 31 summarizes reported total business volume conducted by surveyed providers in the 2023 calendar year. About half of all respondents (60.8%; 34) indicate that total business volume was at either extreme of their available responses: either less than $50,000 (30.4%; 17) or more than $1,000,000 (30.4%; 17). Alternatively, about 50% of all respondents indicate their business volume was less than (51.8%; 29) *or* more than (48.2%;27) $250,000 in 2023. Respondents from PSAs 5 & 6 mostly report business volume totaling less than $499,000 in 2023 (71.4%; 5), with two respondents indicating volume at $1,000,000 or more. Respondents from PSAs 1 – 4 followed the overall trend, where most reported volume at either extreme ends: less than $50,000 (32.7%;16) in 2023, or at $1,000,000 or more (30.6%; 15).

To better understand funding streams, respondents were also asked to note all current funding sources from available responses. The overwhelming majority of respondents (95.2%; 59)

Table 31

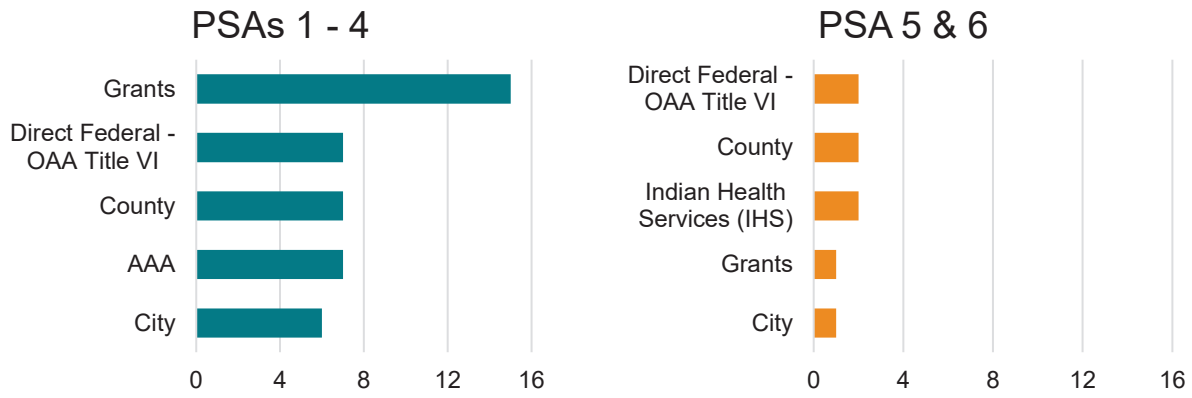
Respondent agency/organization volume of business in 2023 calendar year

	PSA 1 – 4		PSA 5 & 6		All Responses	
Response	Count	Percent	Count	Percent	Count	Percent
Less than $50,000	16	32.7	1	14.3	17	30.4
$50,000 - $99,999	5	10.2	1	14.3	6	10.7
$100,000 - $249,999	4	8.2	2	28.6	6	10.7
$250,000 - $499,999	5	10.2	1	14.3	6	10.7
$500,000 - $999,999	4	8.2	0	0.0	4	7.1
$1,000,000 or more	15	30.6	2	28.6	17	30.4
Total	49	100.0	7	100.0	56	100.0

Note.

Figure 34

Top five funding sources respondents are interested in contracting with in the future



Note. Providers could select multiple responses; counts across categories do not reflect unique respondents.

report funds from an Area Agency on Aging (AAA), followed by funding from cities (40.3%; 25) and counties (40.3%; 25). A little less than a third of all respondents (30.6%;19) reported grants as a funding source and about 1/5 reported other funding sources. Other sources included donations, Bingo fundraiser, AmeriCorps, ALTSD NM Grown & Volunteer programs, legislative appropriations, Veterans Administration funding, and Navajo Nation General Funds and funds from the State of Arizona and Utah regarding Title III funding. All other funding sources capture less than 10% of respondents.

Respondents from PSA 5 & 6 report similar funding sources to surveyed providers writ-large, primarily identifying funding from AAAs (100.0%; 7), grants (28.6%; 2), and other sources (18.6%; 2). However, respondents from PSA 5 & 6 are differentiated by the fact that most report receiving direct federal OAA Title III funds – 71.4% of PSA 5 & 6 respondents, compared to 1.8% in PSAs 1 – 4.

Surveyed providers were further tasked with identifying which funding sources they are interested in contracting with in the future. Most report desire to contract with grants (50.0%), counties (28.1%) and with direct federal funds through the OAA Title VI (28.1%). Beyond this, many surveyed providers also desire to contract with cities (21.9%), AAAs (21.9%) and Medicaid (15.6%). All other sources individually account for fewer than 10.0% of all respondents.

Figure 34 filters the top 5 funding sources for respondents from PSAs 1 -4 and PSAs 5 & 6. Most providers within PSAs 1 -4 report interest in contracting with grants, direct federal funds from OAA Title VI, counties, AAAs, and cities. Alternatively, the top five funds of interest for respondents in PSA 5 & 6 were Direct Federal Funds through the OAA Title VI, counties, Indian Health Services (IHS), grants, and then cities.

Business Strength

Five questions assess providers sense of business strength as it relates to providing services. Firstly, surveyed providers were asked to rate their level of agreement with each of the following:

(1) The part of my organization that maintains contracts for services and provides services is financially healthy

(2) My agency/organization is health in the workforce and operations area

(3) My agency /organization provides the best services possible

Finally, surveyed providers were also asked to identify specific resources necessary for their organizations to "be financially healthy", as well as resources necessary to "provide the best services possible".

Figure 35 summarizes provider agreement by PSA for each of the three statements we asked respondents to report their level of agreement with. Respondents first rated agreement with: *The part of my organization that maintains contracts for services and provides services is financially healthy.* Responses varied, with a slight majority indicating agreement (53.3%; 32), and 26.7% (16) neither agreeing nor disagreeing. Nearly half of respondents from PSA 1 (44.4%, 4 respondents) neither agreed nor disagreed that contracting for services was financially healthy for their organizations. A significant minority of all providers in our survey – 20%, 12 respondents – expressed disagreement that contracting for services was financially healthy.

Respondents who disagreed that their organization's contracting for services and providing services was healthy, serve counties within PSAs 1 – 4; most (11 out of 12) operate in PSA 2, 3, & 4. All respondents in our survey from PSA 5 & 6 agreed their organizations contracting for services are financially healthy.

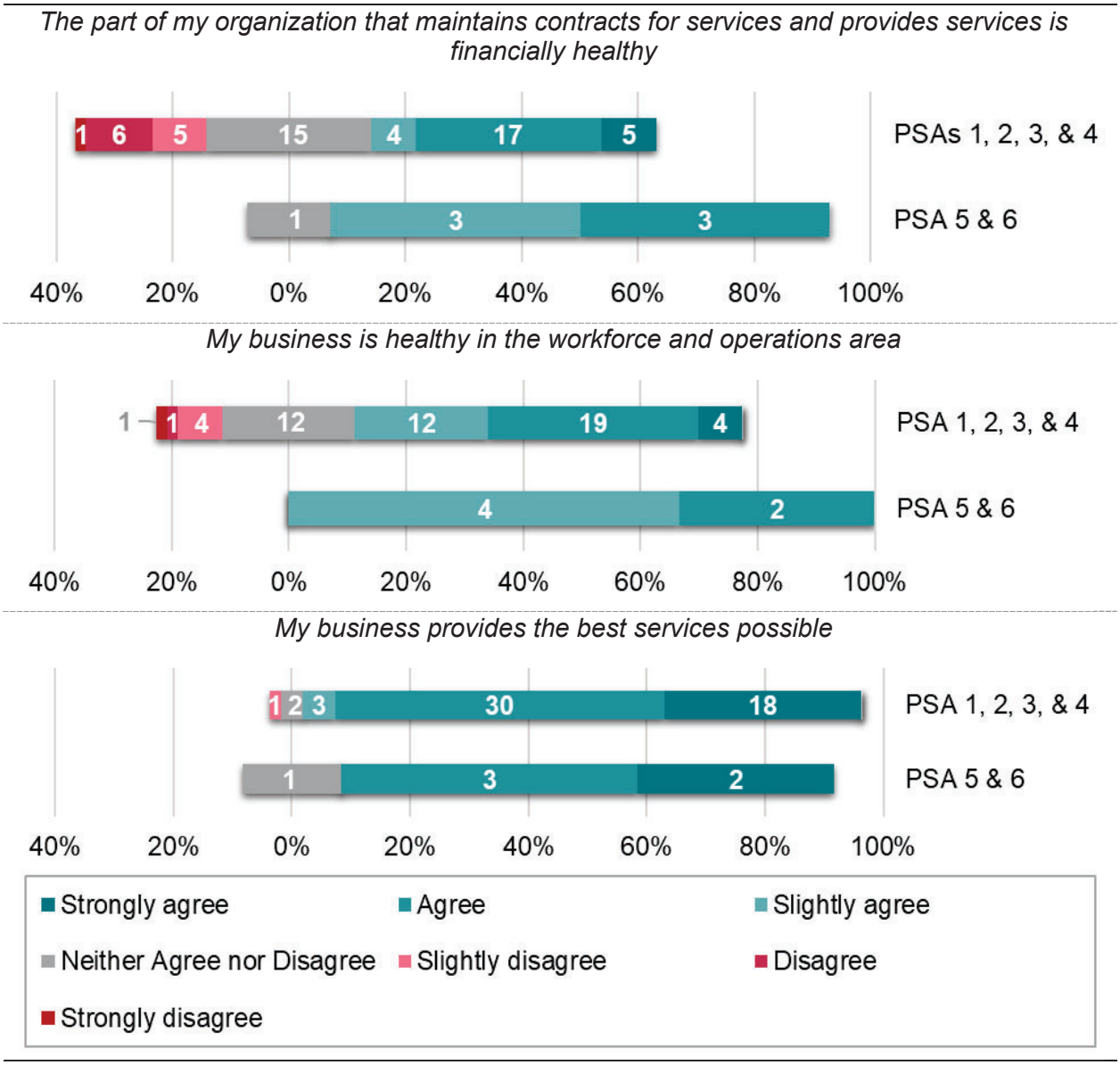
Providers also reported their level of agreement with the following: *My business is healthy in the workforce and operations area*. Nearly 70% (41) of all surveyed providers agreed their businesses were healthy in the workforce and operations area. About 10% (6) of providers disagreed that their businesses were healthy and 20% (12) neither agreed nor disagreed. Three providers in PSA 2 indicated they thought their businesses are not healthy in the workforce and operations area, and one provider in PSA 1, 3, & 4 reported the same. All providers (6 respondents) from PSAs 5 & 6 agreed or strongly agreed with the statement.

Providers responded to a third and final statement on business strength: *My business provides the best services possible*. The overwhelming majority of providers in our survey agreed with the statement – 93.3%, 56 respondents. Three providers neither agreed nor disagreed (5.0%, 3 respondents), and one provider from PSA 1 slightly disagreed that their business provides the best services possible. As with the overall trend, providers from PSA 5 & 6 also overwhelmingly agreed (83.3%, 5 respondents) their business provides the best services possible. Only one provider in PSA 5 & 6 neither agreed nor disagreed. And none of the providers from these regions disagreed with the statement.

Respondents were additionally tasked with identifying specific resources that are necessary for their organizations to provide the best services possible. **Table 32.1** presents 11 collapsed

Figure 35

Rate your level of agreement with each statement…



Note. Respondents could indicate multiple counties they provide services within. Therefore, respondents may be duplicated across PSA.

Table 32.1

Resources necessary to provide the best services possible

Resource	Count	Percent
Additional Funding	18	64.3
Personnel-Related	11	39.3
Training-Related	7	25.0
Collaboration w/ Agencies & Health Services	1	3.6
Marketing & Outreach	2	7.1
Caregivers	1	3.6
Community Support	1	3.6
Office Equipment	1	3.6
Better Menus for Seniors	1	3.6
Chore Services	1	3.6
Increase Availability of Transportation Services	1	3.6

Note. n = 28. Respondents could list multiple resources; counts and percents reflect the number of unique respondents identifying each resource and do not add to 100%.

general categories which resources fell into. Nearly two-thirds of providers (64.3%, 18 respondents) identify additional funding as necessary. Several providers (5) elaborated that additional funding for increasing personnel pay was important. Two respondents noted more funding was essential for maintaining services, outreach, and for providing legal services to constituents. Personnel-related resources were the second most-common resource (39.3%, 11 respondents). Many respondents identified the importance of tapping into a qualified and reliable workforce, as well as improving recruitment and retention of personnel. Finally, a quarter of respondents (25.0%, 7 respondents) emphasized training resources as critical to providing the best services. Training was frequently connected to billing and operations, and better training for both clients and staff generally.

Finally, providers were asked to list vital resources for their businesses to be financially healthy. **Table 32.2** reports the collapsed categories of responses. Respondents generally identified the same resources as those noted necessary for providing the best services possible, namely: additional funding (80.0%, 20 respondents) and personnel-related resources (28.0%, 7 respondents). In this case, additional funding for improving financial health centers around sustaining existing operations (e.g., adequate for operations, inflation-related meal and Home-Delivered Meal fuel costs), or supporting services (e.g., transportation, legal services, creating routes between cities in San Juan County). Several providers also identified additional general funding from specific entities like state and federal agencies, city and county governments, and the non-metro AAA.

Personnel-related resources were the second most-common resource which was frequently connected to higher pay for staff and in-home personnel, and improved recruitment within

Table 32.2

Resources necessary for provider businesses to be financially healthy

Resource	Count	Percent
Additional Funding	20	80.0
Personnel-Related	7	28.0
More Donations	3	12.0
Increased Access to Service Providers	2	8.0
Outreach & Marketing	1	4.0
Additional Services	1	4.0
Caregivers	1	4.0
New Equipment & Repairs	1	4.0
Cooking Meals Education for Seniors	1	4.0
Government Contracts	1	4.0
Grants	1	4.0
Retirement & Insurance for Staff	1	4.0
Staff for Data Collection & Documentation	1	4.0
Training	1	4.0
Better Transportation Vehicles	1	4.0

Note. n = 25. Respondents could list multiple resources; counts and percents reflect the number of unique respondents identifying each resource and do not add to 100%.

served communities. Lastly, three respondents noted “more donations” and specifically having more seniors provide requested donations, as essential resources for financial health of their businesses. All other response categories (12) captured fewer than 3 respondents.

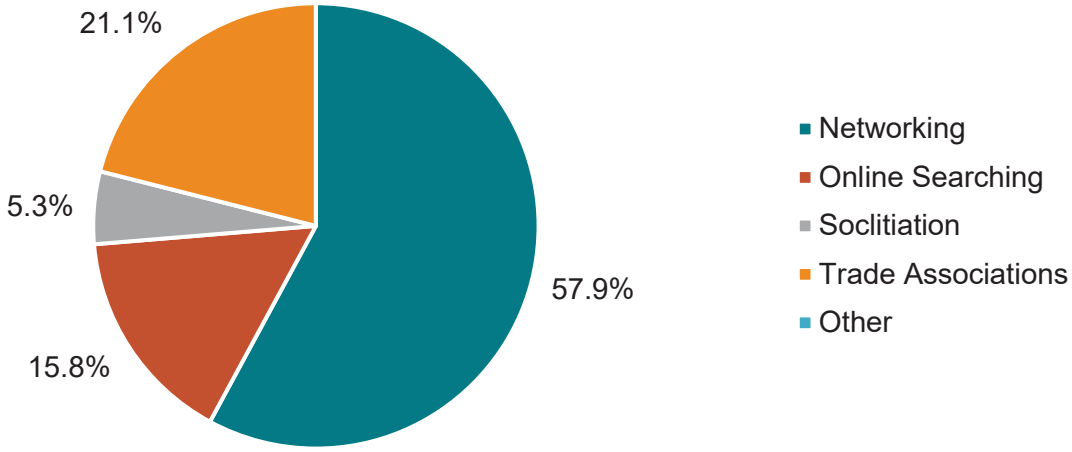
Business Growth

ALTSD developed 21 questions to understand business growth needs among surveyed providers. Providers indicated *Yes* or *No* about whether their agency/organization is aware of additional business opportunities. Over two-thirds (68.3%; 41) answered *Yes*, with 19 respondents (21.7%) indicating *No.* Seventy-one percent (71.4%, 5 respondents) of respondents serving PSAs 5 & 6 indicated they were aware of business opportunities.

Providers who indicated their agency/organization was not aware of additional business opportunities, further elaborated on the mediums they would prefer to learn more about them. **Figure 36** summarizes the range of responses. Most of the 19 providers who elaborated on their preferences indicated networking (57.9%, 11) was the top medium for receiving news about additional business opportunities, followed by trade associations (21.1%, 4), and online searching (15.8%, 2). One provider reported solicitation as their preferred venue. Two providers

Figure 36

Provider preferences for accessing information about business opportunities



Note. n = 19.

from PSAs 5 & 6 identified Networking (1 respondent) and Online Searching (1 respondent) as their preferred medium.

Providers were subsequently tasked with reporting on whether their agency/organization is interested in expanding existing Title III services they provide, and if so, identify which PSA and category of services (e.g., meals, caregiver support, etc.) they would like to expand provision within. Forty-three percent of providers (43.3%; 26) reported they are interested in expanding services.

Expanding Existing Services

Table 33 summarizes kinds of services surveyed providers want to expand and where they want to expand them. Providers could report multiple areas and services for expansion. **Table 33** should be read by column, which reports the number of unique providers that want to expand a service by PSA. The *All PSAs* row indicates overall number of unique providers who want to expand any service, as well as the percent out of all respondents who answered the question. PSAs 1 – 4 are aggregated from specific counties providers identified to expand services within. Because specific Tribes, Pueblos, and Nations could not be reported as areas for expansion, we have combined responses for providers based on Question 3 of the survey, which asked whether providers primarily serve any of the 23 Tribes, Pueblos, or Nations in New Mexico. For clarity, if a provider identified McKinley County as an area to expand services within, they have been separated out from PSA 2, and into PSA 5 or 6 (whichever was appropriate) if they answered affirmatively to Question 3.

Table 33

Provider interest in expanding service types they currently offer, by PSA

	Meal		Access		In-Home		Legal Assistance		Community		Disease Prevention & Health Promotion		Caregiver Support	
Location	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
All PSAs	17	65.4	25	96.2	17	65.4	15	57.7	20	76.9	16	61.5	16	61.5
PSA 1	0	0.0	1	4.0	0	0.0	1	6.7	0	0.0	0	0.0	0	0.0
PSA 2	5	29.4	7	**28.0**	7	**41.2**	3	20.0	5	25.0	6	**37.5**	6	**37.5**
PSA 3	2	11.8	7	**28.0**	4	23.5	5	33.3	6	**30.0**	3	18.8	2	12.5
PSA 4	6	**35.3**	7	**28.0**	2	11.8	6	**40.0**	6	**30.0**	4	25.0	4	25.0
PSA 5	1	5.9	2	8.0	1	5.9	1	6.7	1	5.0	1	6.3	1	6.3
PSA 6	2	11.8	2	8.0	2	11.8	1	6.7	2	10.0	1	6.3	1	6.3

Note. Respondents could select multiple responses and areas to expand services within; column percents are out of unique providers that want to expand service type within PSA counties (e.g., 23.5% of respondents that want to expand meal services want to do so within PSA 2 counties). *All PSAs* row reflects number and percent of unique providers interested in expanding services (e.g., 65.4% of respondents that want to expand existing services, identified Meal services for expansion). **Bold** percents indicate top supported PSA identified for expanding existing services, for each type.

While data were collected at the county level, we report results at the PSA-level for clarity, rather than list all applicable counties identified for services. However, **Tables 55 – 68** in the Appendix E report interest in expanding or developing specific services by county, and are grouped by PSA. At least half of all respondents supported all seven service categories for expansion: Meal, Access, -In-Home, Legal Assistance, Community, Disease Prevention & Health Promotion, and Caregiver Support. Respondents identified *Access* services (96.5%, 25) and *Community* services (76.9%; 20) for expansion the most. Legal Assistance services had the fewest supporters for expansion but was still cited by 57.7% (15) of providers.

Providers wanting to expand Access services identified counties within PSAs 1– 4 equally – seven respondents in support for each PSA. *Transportation* and *Case Management* had the most support from providers – 70.8% and 41.6% of providers under Access services. All respondents serving PSAs 5 – 6 (2 respondents in each area) identified Access services for expansion. PSA 5 & 6 providers reported interest in expanding *Transportation* (3), *Assisted Transportation* (3), and *Outreach* (2) Access services most.

While 76.9% of all providers identified existing Community services for expansion, support was concentrated in counties within two PSAs. Thirty percent (30.4%; 6) of all providers reported Community services should be expanded within PSAs 3 & 4, and 25.0% (5 respondents) within PSA 2. No provider reported PSA 1 as an area to expand existing Community services. Most reported support for expanding *senior center activities* (75.0%, 15) and *physical fitness/exercise* Community services (70.0%, 14). Providers within PSAs 5 – 6 exclusively supported expanding *senior center activities* and *physical fitness/exercise Community* services.

Meal and In-Home services were the third-most cited service types, with 65.4% of all providers in our sample wanting to expand these services. Providers who wanted to expand Meal services primarily identified counties within PSAs 2 and 4 (23.5% and 35.3%, respectively), with two respondents (11.8%) identifying counties in PSA 3. No provider identified PSA 1 for Meal service expansion. Greatest support was for expanding *Home Delivered Meals* (75.0%, 12), and *Congregate Meals* (62.5%, 10). Most providers serving PSAs 5 and 6 also identified *Home Delivered Meals* (75.0%, 3) and *Congregate Meals* (50.0%, 2). Finally, providers wanting to expand *In-Home* services mostly identified counties within PSAs 2 and 3 for expansion (35.3% and 29.4%, respectively). Two respondents identified counties within PSA 4. No provider identified PSA 1 for expanding In-Home services. Most providers specifically noted *Caregiver Respite Care* (56.3%, 9), *Chore* (56.3%, 9), and H*omemaker* (56.3%, 9) services in this category. Three of four PSA 5 & 6 providers from supported expanding In-Home services. Providers serving these areas specifically supported expanding existing *Chore*, *Homemaker*, and *Caregiver Respite* In-Home services.

Develop New Services

Providers in our sample were also asked to identify which new services (if any) they would like to offer and where to develop them. Seventeen (28.3%) providers reported they would like to develop new services not currently offered. No provider from PSA 5 reported interest in developing new services. One provider from PSA 6 reported interest in new services. **Table 34** summarizes responses for each service category by PSA.

Like the trend for provider interest in expanding existing services, all service categories had support for new development. Providers overwhelmingly reported interest to offer new *In-Home*

Table 34

Provider interest in offering a new service type they do not currently provide, by PSA

	Meal		Access		In-Home		Legal Assistance		Community		Disease Prevention & Health Promotion		Caregiver Support	
Location	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
All PSAs	5	29.4	12	70.6	14	82.4	11	64.7	12	70.6	12	70.6	11	64.7
PSA 1	0	0.0	1	8.3	1	7.1	1	9.1	1	8.3	1	8.3	1	9.1
PSA 2	1	20.0	5	**41.7**	5	**35.7**	1	9.1	5	**41.7**	5	**41.7**	3	**27.3**
PSA 3	2	**40.0**	2	16.7	3	21.4	3	27.3	2	16.7	2	16.7	3	**27.3**
PSA 4	1	20.0	4	33.3	3	21.4	4	**36.4**	4	33.3	4	33.3	3	**27.3**
PSA 5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
PSA 6	1	20.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

Note. Respondents could select multiple responses and areas to expand services within; column percents are out of unique providers that want to expand service type within PSA counties (e.g., 40.0% of respondents that want to offer new meal services want to do so within PSA 3 counties). *All PSAs* row reflects number and percent of unique providers interested in expanding services (e.g., 29.4% of respondents that want to offer new services not currently deployed, identified *Meal* services for development). **Bold** percents indicate top supported PSA identified for deploying new services for each type.

services (82.4%, 14). The second-most cited service categories were equally distributed across *Access*, *Community*, and *Disease Prevention & Health Promotion* services (70.6%, 12). New *Meal* services had the least support with 29.4% of providers expressing interest. Importantly, no surveyed provider serving PSA 5 reported interest in offering any new services.

Providers wanting to develop new In-Home services mostly identified counties within PSA 2 (35.7%, 5), followed by PSA 3 (21.4%, 3) and PSA 4 (21.4%, 3), One respondent in PSA 1 also wanted to offer new In-Home services. No provider from PSA 5 or 6 expressed interest in deploying new In-Home services. Most specifically supported developing new *Caregiver Respite* (53.8%, 7), *Chore* (53.8%, 7), and *Homemaker* (53.8%, 7) In-Home services. And roughly 40% of respondents (38.5%, 5) wanted to offer new *Adult Day Care* services.

The second-most cited service types – *Access*, *Community*, and *Disease Prevention & Health Promotion* services – all followed the same pattern of support. Providers wanted to deploy all three service types in counties within PSA 2 (41.7%, 5), followed by PSA 4 (33.3%, 4), and then PSA 3 (16.7%, 3). A single respondent advocated for each service type within PSA 1 (not necessarily the same respondent for each). No surveyed provider from PSAs 5 or 6 expressed interest in deploying any new *Access*, *Community*, or *Disease Prevention & Health Promotion* services.

Most providers wanting to deploy new *Access* services cited *Case Management* (66.6%, 8) services, followed by *Transportation* (58.3%, 7) and *Assisted Transportation* (58.3%, 7). A sizeable minority identified *Outreach* (41.7%, 5) and *Information Assistance* (41.7%, 5) services as well. Support for Community services was concentrated on new *Physical Fitness/Exercise* services (83.3%, 10), *Senior Center Activities* (66.7%, 8), and *Loan of Medical Equipment* (33.3%, 4). Provider support for new *Disease Prevention & Health Promotion* activities centered around *Staff Training of Evidence-Based Heath Programming* (75.0%, 9) and *Evidence-Based Health Programming* (66.7%, 8). A minority of providers expressed support for *Other Disease Prevention & Health Promotion* services (33.3%, 4), with just one respondent elaborating on desire to offer “health clinics”. Many providers also reported desire for new *Legal Assistance* (64.7%, 11) and *Caregiver Support* (64.7%, 11) services. Providers emphasized need in counties within PSA 4 (36.4%, 4) and PSA 3 (27.3%, 3). Most wanted to offer *Legal Clinics* (70.0%, 7) and *Legal Workshops* (50.0%, 5), with some interest to develop *Legal Education Support* (40.0%, 4) and *Direct Legal Services* (40.0%, 4).

Providers interested in offering Caregiver Support wanted to expand these services in counties equally distributed across PSAs 2, 3, and 4 – 27.3% of respondents (3) for each PSA. One provider reported interest in PSA 1. Support for new Caregiver Support services was concentrated on caregivers serving elderly: *Respite In-Home Care* (45.5%, 5), *Information Services* (36.3%, 4), *Education/Training* (36.3%, 4), and *Access Assistance* (36.4%, 4).

Lastly, five respondents reported interest in offering new *Meal* services in counties within PSA 3 (40.0%; 2), PSA 2 (20.0%, 1), PSA 4 (20.0%; 1) and PSA 6 (20.0%, 1). Most emphasized their support for *Other* meal service types (80.0%, 4), specifically reporting desire to offer: additional locations for meals; breakfast meals; breakfast home delivered meals; and Grab-N-Go. Remaining support was for offering new *Home Delivered Meals* (40.0%, 2) and *Congregate Meals* (40.0%,2). The only provider from PSA 6 with interest in developing new services supported offering new Meal services, specifically *Home Delivered Meals*.

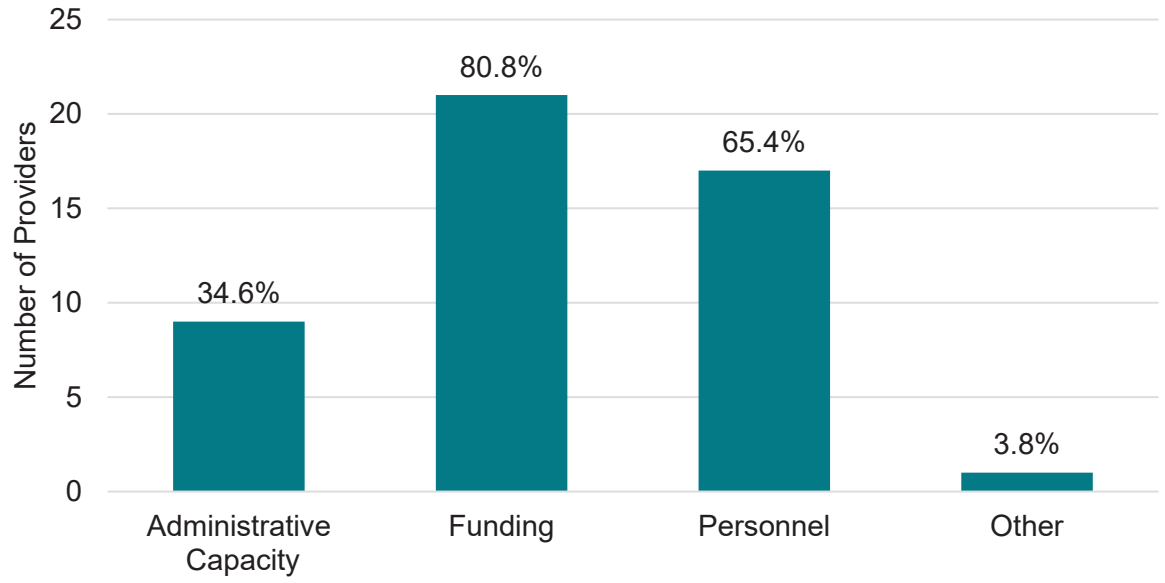
Service Expansion

Providers in our sample who were interested in expanding existing services were also asked to elaborate on what barriers might interfere with expansion. **Figure 37** summarizes provider responses, who were able to select all four barriers that apply. About 80% of providers (21) report that funding is a significant barrier to expanding existing services and 65.4% (17) identified available personnel in their communities as another barrier. A little over a third (34.6%, 9) of surveyed providers reported administrative capacity, and one respondent chose O*ther.* The respondent who chose *Other* explained that availability of partnerships was a significant barrier to expanding congregate meals at a new senior center.

Providers interested in expanding existing services were also tasked with naming up to five of their own resources most necessary for expansion. Resources were ranked by providers as 1st tier – most needed – to 5th tier – least needed. Seventeen providers reported their own resources which we summarize in **Table 35**. Once again, providers overwhelmingly report funding as the resource most needed to expand existing services. Most ranked funding as a 1st tier (70.6%, 12) or 2nd tier (27.3%, 3) resource. Funding was described generally (10), for personnel (4), transportation (2) or programming (1). Staff as a resource were frequently cited as well (12) and account for 17.6% of 1st tier resources (3) and 45.5% (5) of 2nd tier resources. Personnel resources were reported generally (7), or as specific types of supportive staff, such as caregivers (2), personal care staff (1), community personnel (1), and health promotion staff (1). Two respondents listed Transportation resources, generally, as a 1st tier resource.

Figure 37

Summary of what providers identify as barriers to expanding existing services



Note. n = 26. Providers could select multiple barriers; percents do not add to 100%.

Table 35

Provider-ranked resources necessary for expanding existing services

Resource	Count
Funding	17
Personnel	12
Training Support	4
Marketing Support	3
Equipment	2
Outreach	2
Transportation	2

Note. n = 17.

Less frequently cited 2nd tier resources were for equipment, marketing support, and staff training. All three resources were described broadly by providers as necessary, and when specific, providers reported needing “fitness equipment”, “billing training”, or “marketing materials”. Outreach, contractor support, and “resources” broadly were always noted as 3rd to 5th tier resources.

Providers with interest in either expanding existing services *or* developing new services were asked to identify which of five predetermined resources were most and least needed: (1) Financial, (2) Business Operation (Accounting Human Resources), (3) Leadership, (4) Resources to get new business, or (5) Outreach). **Figure 38** visualizes the number of times providers ranked each resource 1 – 5 and color codes more providers (red) to fewer providers (green). The graph is easily reviewed by column and identifying the cell with the most counts for each rank. Coincidentally, resources are listed from 1st ranked resource (Financial) to lowest ranked resource (Outreach).

Most (83.3%, 15) providers ranked financial resources as most needed to expand services or develop new services not currently offered. The second critical resource was identified by 61.1% (11) of providers as business operational (accounting human resources). The most frequently 3rd ranked resource was for leadership resources (55.6%), followed by resources for new business (50.0%) and outreach (50.0%). While leadership resources were overwhelmingly identified as the third-most important resource, one third reported leadership resources as the least critical resource. Additionally, it may appear that resources for new business and resources for outreach are equally ranked, however, more providers more favorably ranked resources for new business (more 2nd and 3rd rankings) than they did outreach resources (more 3rd and 4th rankings).

Figure 38

Heat map of ranked resources most needed for expansion or development of services

Resource	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Financial	15	2	0	1	0
Business Operation (Accounting Human Resources)	1	11	2	3	1
Leadership	0	1	10	1	6
Resources to get new business	1	3	3	9	2
Outreach	1	1	3	4	9

Note. n = 18. Red – Yellow – Green color scale applied. Rank 1 identifies resource as most needed, and Rank 5 denotes resource as least needed by providers.

Workforce Growth

Four survey questions assessed workforce growth. Providers were first asked to rate their agreement with two statements about whether they face challenges recruiting employees and if their organization could benefit from training support. We then also tasked providers with identifying types of training their agency/organization might benefit from. Lastly, providers were asked to identify training *mediums* which might be most effective for their agency/organization.

Providers first rated their agreement to the following statement: *I have challenges recruiting employees who provide direct services (***Figure 39.1**). Most providers (78.0%, 47) agree that recruiting employees to provide direct services is challenging. About 17% of providers (10) indicate they feel neutral, and 5.1% (3) reported that recruiting employees for direct services is not a challenge. Notably, all providers in our sample who serve PSAs 5 & 6 report recruitment is challenging. Providers subsequently rated their agreement with a second statement: *My agency/organization could benefit from training support.* Most providers (68.7%, 48) agree that training support would benefit their agencies/organizations. About 16% (10) of providers feel neutral, and 4.9% (3) do not feel their agency/organization would benefit from training support. All surveyed providers who for PSAs 5 & 6 report their agency/organization would benefit from training support.

Providers offered many training types their agency/organization could benefit from, about 48 different topics from 35 unique respondents. We report the top 10 topical areas respondents supported (**Table 36**). The top training topic was for *Customer Service* broadly, with 25.7% (9) of respondents supporting. Roughly 1/5th (22.9%, 8) also supported *Financial* topics, which included budget training, overviews of funding, billing, and finances broadly. Several providers

Figure 39.1

Provider agreement on statements assessing recruitment challenges and training support

Note. n = 60.

also indicated they would benefit from training on Available Resources Services (17.1%, 6), including social services for vulnerable seniors, supportive service requirements, and available senior services and resources broadly. Programming (14.3%, 5), Health & Safety (14.3%, 5), and Management topics (14.3%, 5) were also reported. Programming training was focused on understanding senior program & activity requirements, offering homemaking services, and on providing exercise trainings for elderly. Health & Safety was centered on first aid, healthcare, health promotion, and the topic broadly. Management training was cited in relation to management and administration techniques trainings, and the topic broadly.

Some support existed for training on Driving, Marketing & Outreach, Nutrition, and Reports. Driving topics related to defensive driving courses, passenger loading, and general safety. Reports were broadly identified, with some specific attention to financial reports, and "paperwork" appropriate to the provider reporting. Nutrition was broadly indicated, and in one instance focused on nutrition education trainings. Marketing & Outreach was also broadly identified, with no specific topics noted by providers.

Nine additional topics had minimal support – 2 or 3 providers per training topic – and 29 of the remaining were especially niche – individual provider support. Our elaborated table with all 48 training topics listed and elaborated topical areas is available in Appendix F (**Table 69**).

Table 36

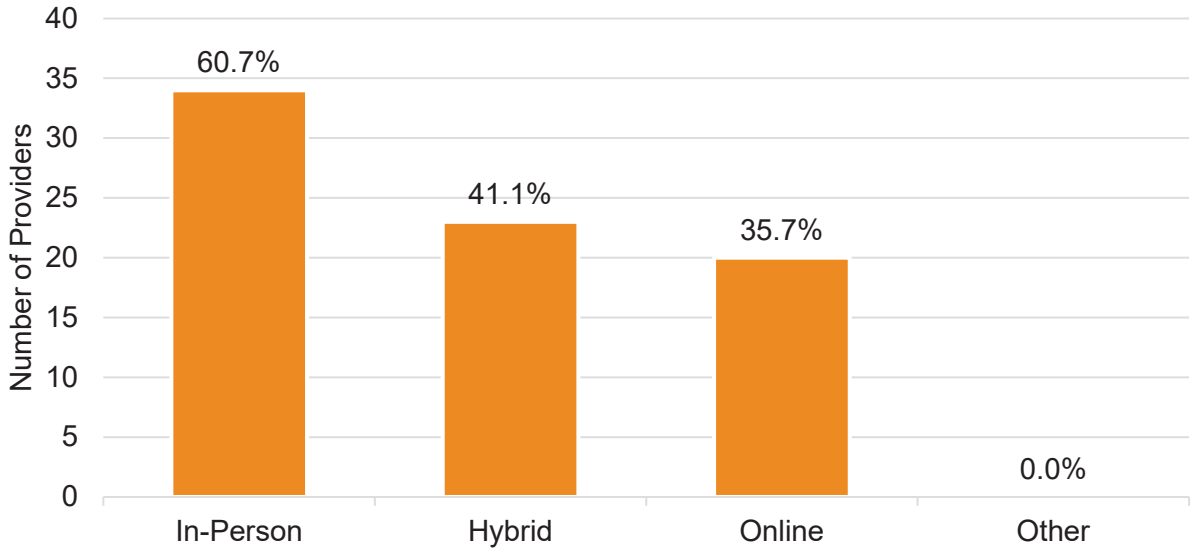
Training topics providers generated and felt would be beneficial for their agency/organization

Topic	Count	Percent
Customer Service	9	25.7
Financial	8	22.9
Resource & Service Inventory	6	17.1
Programming	5	14.3
Health & Safety	5	14.3
Management	5	14.3
Driving	4	11.4
Marketing & Outreach	4	11.4
Nutrition	4	11.4
Reports	4	11.4

Note. n = 35.

Figure 39.2

Summary of provider opinion on most effective training mediums for their agency/organization



Note. n = 56. Providers could select multiple options; counts & percents do not add to 100%.

Lastly, providers reported their opinions about which mediums are most effective for trainings. **Figure 39.2** summarizes their responses. More than half of all surveyed providers (60.7%, 34) reported in-person trainings are most effective. A little over a third of providers also felt hybrid (41.1, 23) and online (35.7%, 20) were also effective. All providers in our sample who serve PSA 5 & 6 reported they thought in-person trainings were effective, with one-third of the same providers feeling that hybrid (33.3%, 2) and online (33.3%, 2) mediums were also effective.

Capital Investment

The last section of ALTSD's survey assessed Capital Investment among providers by determining whether providers participate in the capital outlay process for improvements to senior centers, and if applicable, interrogating which explanations best describe non-participation and what improvements would make participation easier.

However, surveyed providers overwhelmingly participate in this process and no significant insights were gleaned from two respondents who reported they do not participate. Out of 60 surveyed providers, 96.7% (57) participate in the capital outlay process, with just two reporting they do not participate. Respondents who do not participate could select from six explanations for why, including *Other*. **Table 37** summarizes their responses. All applicable respondents (2) selected the *Other* response, but did not elaborate. The only text response was "NA". However, it might be assumed that the alternative explanations – that ignorance of the process, not having enough administrative capacity, lack of time to engage in capital outlay, being ineligible, or being too challenging a process – were all unsatisfactory or inappropriate explanations. Both providers serve counties within PSA 2.

Table 37

Provider responses for why agency/organization does not participate in Capital Outlay

	All PSAs	
My Agency/Organization…	Count	Percent
…is unaware of the capital outlay process	0	0.0
…has insufficient administrative capacity to apply	0	0.0
…does not have enough time in the process to apply	0	0.0
…did not know it was eligible to apply	0	0.0
…finds the capital outlay process is too challenging to complete	0	0.0
Other	2	100.0
Total	2	100.0

Note. n =2. Only two respondents reported not participating in the Capital Outlay Process.

Neither respondent that chose *Other* offered textual elaboration beyond "NA".

APS, CERD, & OMBUDSMAN SERVICES

ALTSD provides myriad services to support older adults in New Mexico, which includes work by Adult Protective Services, the Consumer and Elderly Rights Division (CERD), and Long-Term Care Ombudsman Program. The following section reviews select data the Department provided and which capture important metrics for each department and program as they strive to meet increasing older adult need across the state.

CERD Call Data

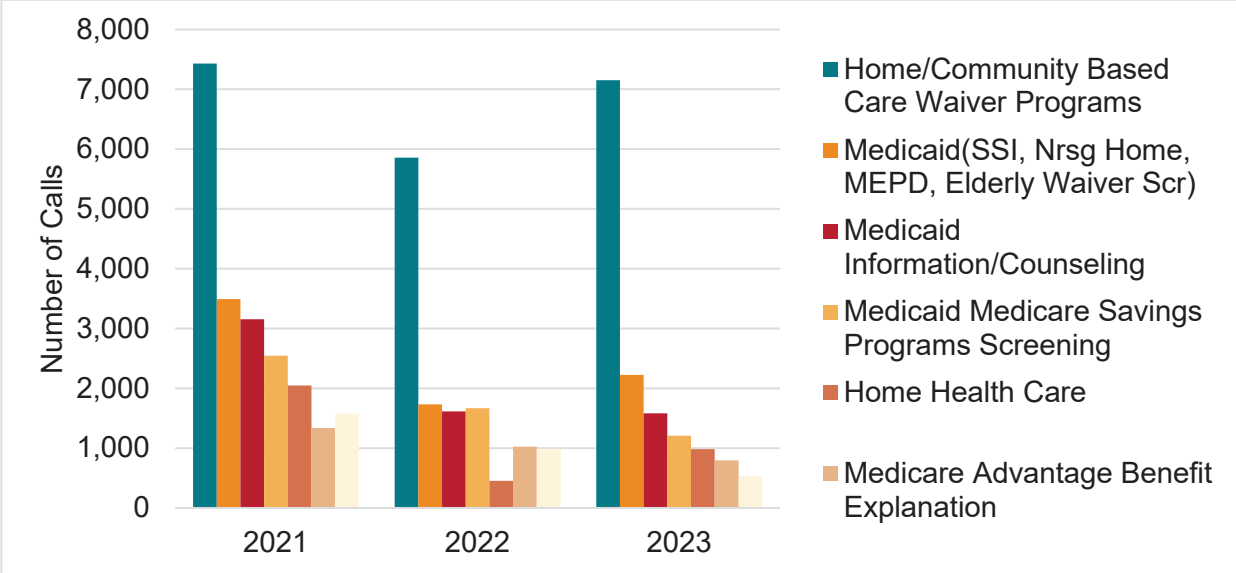
CERD receives calls from a 1-800 ADRC line, where older adults and adults with disability can be directed to available services and supports. We received call data for senior-specific topics from 2021 through 2023 calendar years. We subsequently compiled all calls and collapsed data into simplified categories. **Figure 40.1** summarizes all calls for services (using CERDs call labels) from 2021 to 2023, where call topics received 1,000 or more calls each year.

For each year, CERD has received the most calls for the *Home/Community-Based Care Waiver Program*. This program provides vulnerable individuals access to a caregiver in their home through Centennial Care Medicaid benefits. The program intends to help those who might otherwise be forced to enter Long Term Nursing Facilities, to remain in their own homes or Assisted Living Facilities (CERD). Based on data we received, CERD has received more than 20,000 calls over three years regarding this program.

Medicaid-type calls were also the second-, third, and fourth-highest call categories received each year. The first category of calls – Medicaid as it relates to SSI, Nursing Homes, MEPD,

Figure 40.1

CERD calls for services where topic received 1,000 or more calls annually, FY21 – 23



Note.

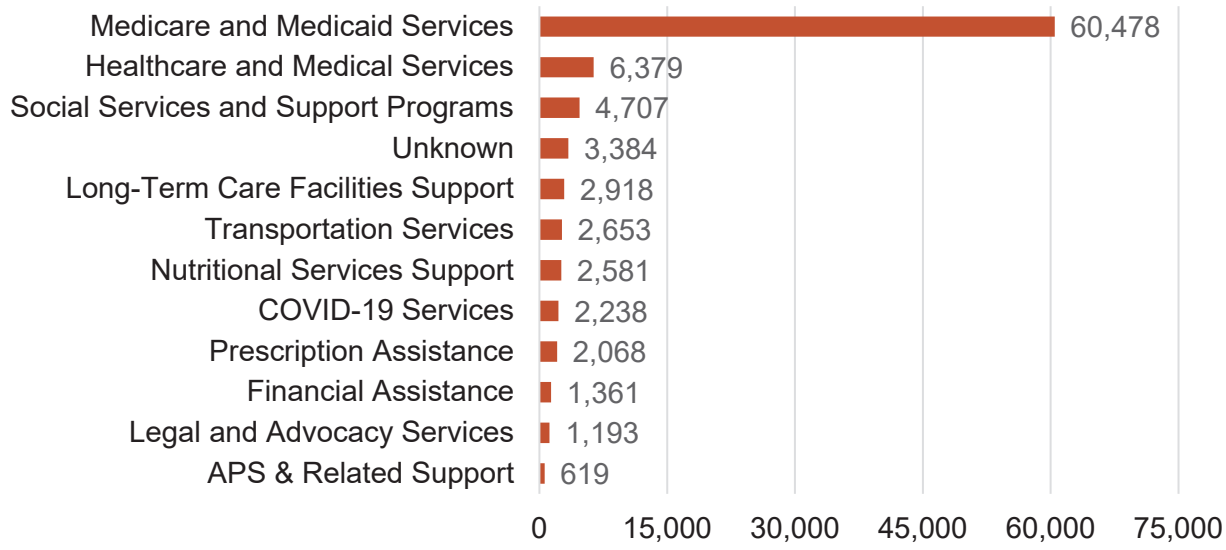
and Elderly Waiver Screening – received 7,452 total calls. The second category of Medicaid calls are for Medicaid information/counseling (6,355 total calls), and then finally Medicaid Savings Programs Screenings calls (5,422).

The fifth category of calls with more than 1,000 calls per year was for *Home Health Care* which, despite receiving more than 2,000 calls for in 2021, dropped to 453 calls in FY22, and increased in the 2023 calendar year. The sixth and seventh call categories with high call volume over three years has been for Medicare related services, particularly, *Advantage Benefit Explanation*, and *Parts A & B Benefit Explanation*. Importantly, many of the original call labels really capture the same program types (i.e., Medicaid, Medicare, Social Services, etc.). We therefore collapsed calls into 20 simplified categories which we confirmed were appropriate with the ALTSD Bureau Chief at ADRC. Data are visualized in **Figure 40.2**.

Overall, CERD receives most service calls for Medicaid and Medicare programs or questions, which account for 65.9% of senior-specific call data from FY21 – 23. Healthcare and Medical Service calls account for 6,379 calls for service, and Social Services and Support Program related calls account for 4,707. All other categories received fewer than 4,000 calls from 2021 through 2023. We note that calls regarding long-term care facilities total fewer than 3,000 total calls from FY 21 – 23, and senior-center and Title III service-related calls amount to 181 calls over the same period.

Figure 40.2

Cumulative number of calls for service to CERD (simplified topical areas), FY21 – 23



Note. Unknown calls capture calls supporting older adults, but for which no topical area was included with call data.

Adult Protective Services (APS)

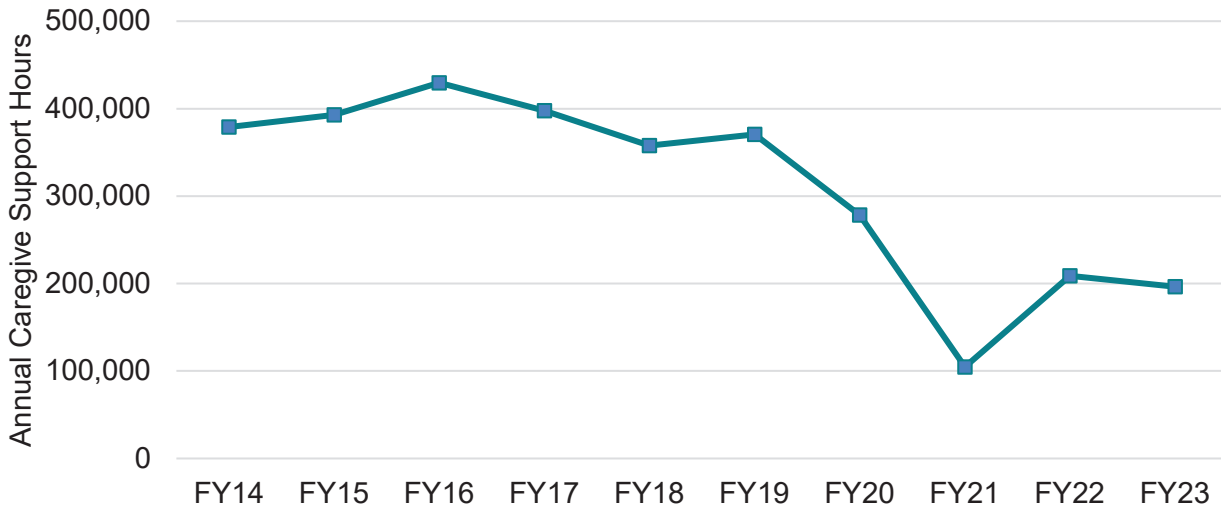
ALTSD provided us with select data on Adult Protective Services (APS) investigations, caregiver support, and victims and perpetrators of substantiated allegations of maltreatment. These data reflect summary performance measures and key indicators from the National Adult Maltreatment Reporting System (NAMRS).

We received summary performance metrics state fiscal years 2023 and 2022. Data indicate APS received 47,952 reports of maltreatment in FY23, and 20,736 in FY22. Based on this data, over 70% of reports received are through Critical Incident Reports (CIRs), and over 20% of reports are received through the ALTSD WellSky system for each year. Of 12,560 reports that were received in WellSky in FY 23, 54.6% (6,863 reports) were screened-in and accepted for investigation. This screen-in percentage for investigations was similar to the FY22 rate of 55.9%. Ultimately, summary metrics report APS conducted 6,863 investigations in FY23, finding 10.0% (690) of cases were substantiated. The substantiation rate was, again, very similar to the FY 2022 figure of 11.0%.

Data we received for FY14 – 23 also show that APS has historically provided hundreds of thousands of hours of caregiver support each year. As we summarize in **Figure 41.1**, from FY14 – 19 APS provided more than 300,000 annual hours of caregiver support, despite a downward trend beginning in FY16. Annual caregiver support hours steadily decrease from FY16 – 21, dropping at its lowest point to 104, 730 hours. According to most recent FY 23 data, APS has increased annual caregiver support to 196,246 hours which is marginally lower than the annual caregiver support provided in FY22 of 208,898 hours.

Figure 41.1

Annual Caregiver Support hours provided by Adult Protective Services, FY14 – 23



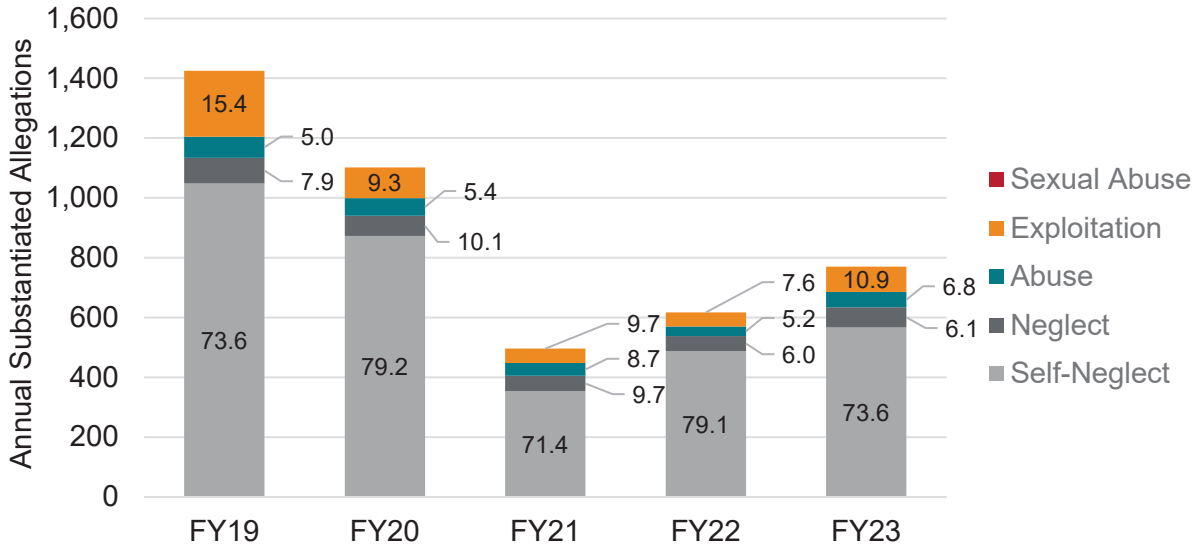
APS also investigates thousands of allegations each year and determines whether they are substantiated. We received data for this work between FY16 and FY23. **Figure 41.2** illustrates, restricted to the most recent five years. From FY16 – 23, APS substantiates, on average, 998 cases per year with the highest number of substantiated allegations occurring in FY19 (1,425) and fewest in FY21 (496). Most allegations are substantiated for Self-Neglect cases, making up at least 70% of allegations for all years we received data on. All other allegation types on average comprise fewer than 1/8th of substantiated cases per annum: Abuse, 7.1%; Neglect, 8.3%, Exploitation, 11.1%; and Sexual Abuse, 0.0%. Data we received report just one substantiated case of sexual abuse for across all 10 years.

Figure 41.3 further summarizes, by region, the average number of annual investigations per APS case worker. The statewide average has fluctuated between 61 and 115 cases per case worker, per year. The Northwest, Northeast, and Southeast regions consistently average fewer investigations than the statewide average. In contrast, average annual investigations in the Metro and Southwest regions are consistently above the statewide average for FY19 – 23.

Limited demographic and case data were available for victims and perpetrators of substantiated maltreatment cases for federal FY21 – 23. We have chosen not to report race and ethnicity data since in most cases this information was unknown (77.6% and 85.2% of all cases, respectively). Therefore, data may be biased in unknown ways toward those victims most likely to report their race and ethnicity. Data are more consistently available for age, gender, and maltreatment type – note, these data were provided by Federal Fiscal Year (FFY).

Figure 41.2

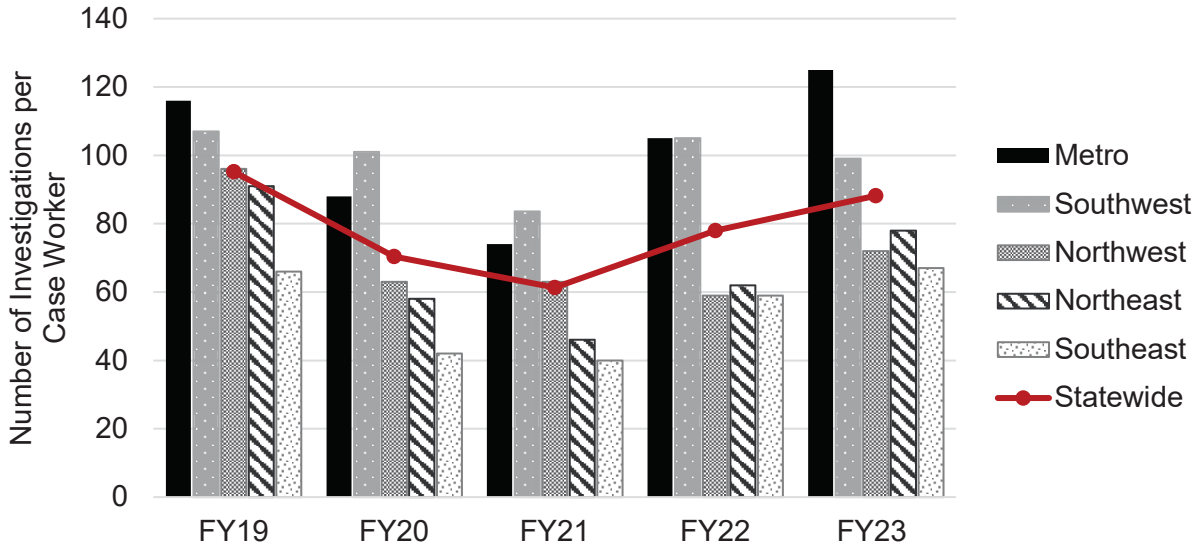
Annual substantiated allegations investigated by APS by type, FY19 – 23



Note. Labels reflect percent of allegations: allegation type divided by total annual allegations.

Figure 41.3

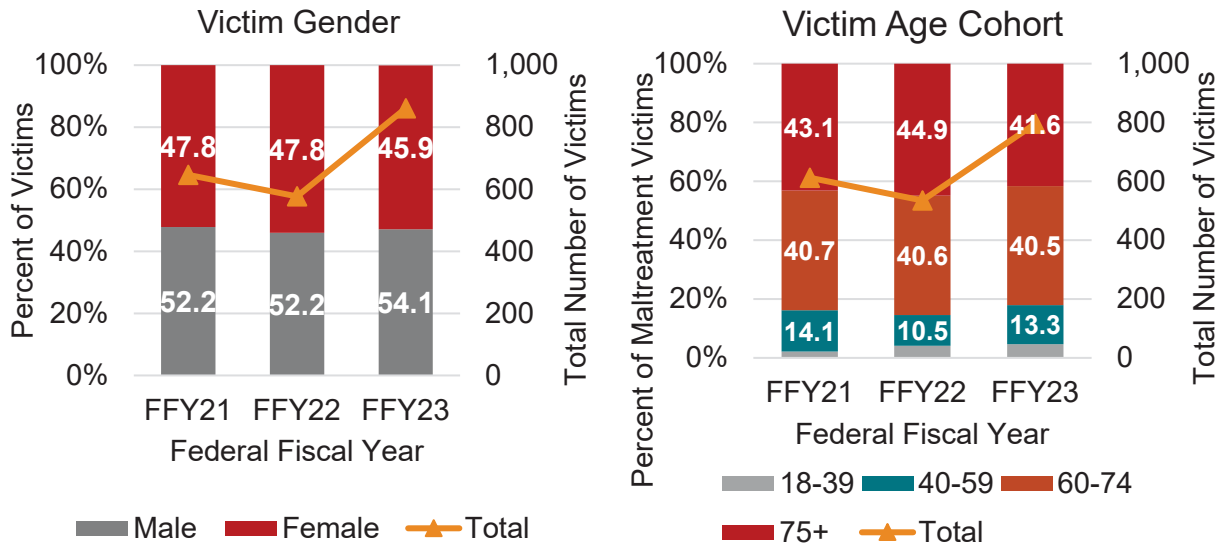
Average annual investigations per case worker by region, FY19 – 23



Note.

Figure 41.4

Age & gender identity of victims in cases investigated by APS, FFY21 – 23



Note. Data are by Federal Fiscal Years (FFY).

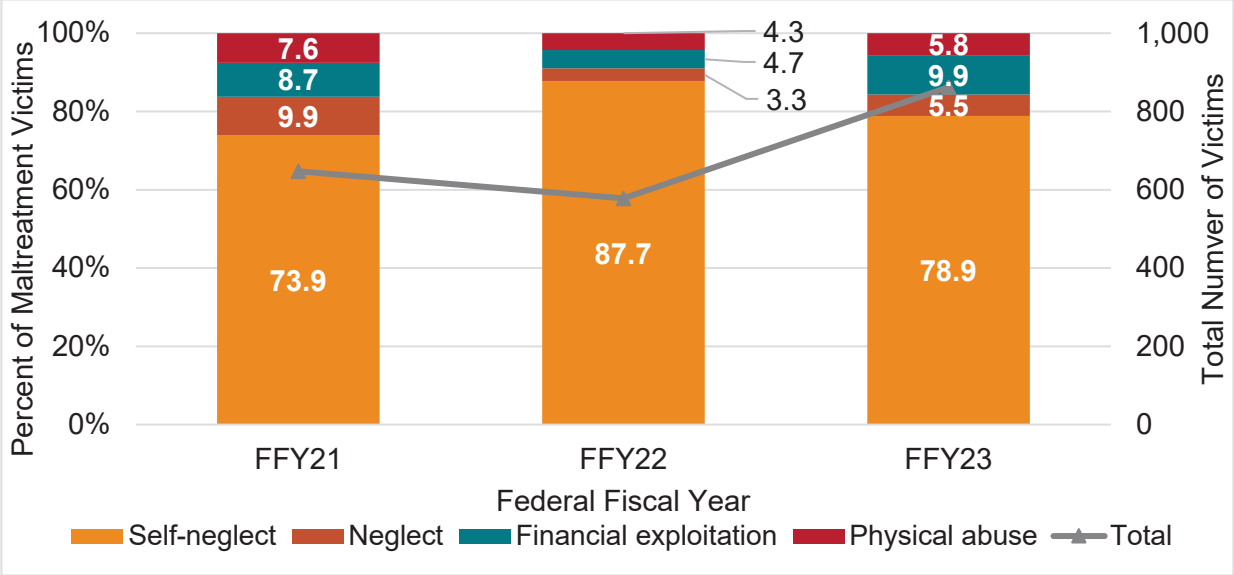
The age distribution and gender identity of victims remains consistent over time, fluctuating within just a few percentage points over the three federal fiscal years we reviewed data for. **Figure 41.4** summarizes age and gender identity over time, illustrating that most victims over FFY21 – 23 have been women, and that proportions by gender have remained constant. Data for victims who are transgender indicate this group consistently reflect about 0.0% of all victims, with one transgender victim from FFY21 – 23. Age data for victims shows that from FFY21 – 23 most victims are 60 or older, with the largest cohort being for those 75 and older. The smallest cohorts for victims were those 40-59, and 18-39, together accounting for between 16.2% and 18.0% of all victims.

Figure 41.5 further breaks-down maltreatment type for victims in cases investigated by APS. Data we received contained 11 categories of maltreatment type, but four maltreatment types captured all cases: Self-neglect, Neglect, Financial exploitation, and Physical Abuse. The overwhelming majority of cases in the past three federal fiscal years (79.7%, 1665) concern victims of self-neglect, followed by financial exploitation (8.0%,168) and neglect (6.2%, 130). Physical abuse accounts for the fewest number of substantiated maltreatment cases (5.9%, 124).

Data we received about perpetrators of maltreatment is limited and captures three features: age, gender, and total number of perpetrators with a kinship relationship to the victim. Age and gender were both significantly missing – 97.0% and 75.4%, respectively. **Table 38** summarizes data we received on the number of perpetrators per year who were identified by APS to have a kinship relationship to the victim. Few perpetrators of maltreatment have a kinship connection to victims and the total number and proportion of perpetrators with a kinship connection has

Figure 41.5

Victim maltreatment type for cases investigated by APS, FFY21 – 23



Note. Data are by Federal Fiscal Years (FFY).

Table 38

Perpetrators with kinship tie to victim in cases investigated by APS, FFY21 – 23

	FFY21		FFY22		FFY23	
	Count	Percent	Count	Percent	Count	Percent
Has Kinship relation	137	21.2	99	17.1	68	7.9
No kinship relation	510	78.8	479	82.9	794	92.1
Total Cases	647	100.0	578	100.0	862	100.0

Note. Data are by Federal Fiscal Years (FFY).

steadily decreased over federal fiscal years 2021 to 2023. The average annual number of perpetrators with a kinship relation is 101 cases per year, and the proportion of cases where the perpetrator of maltreatment has a kinship tie has decreased from 21.0% in FFY21, to 7.9% in 2023.

Comments from APS on this data suggest the decrease may be the result of "*…reporting practices or enhanced efforts to accurately document kinship relationship between perpetrators and victims,*" but may "*…signify a more focused approach in identifying and addressing cases of maltreatment involving family members or individuals with close familial ties*". Critically, better detection and identification practices would conceivably translate to *more* cases of kinship relationship, rather than fewer. Alternative explanations in the comments relating to changes in perpetrators *identification* as family may be more explanatory if data rely chiefly on interviews with perpetrators to self-identify. Whether perpetrators are less likely or less willing to self-identify as kin to victims would be an interesting theory to verify.

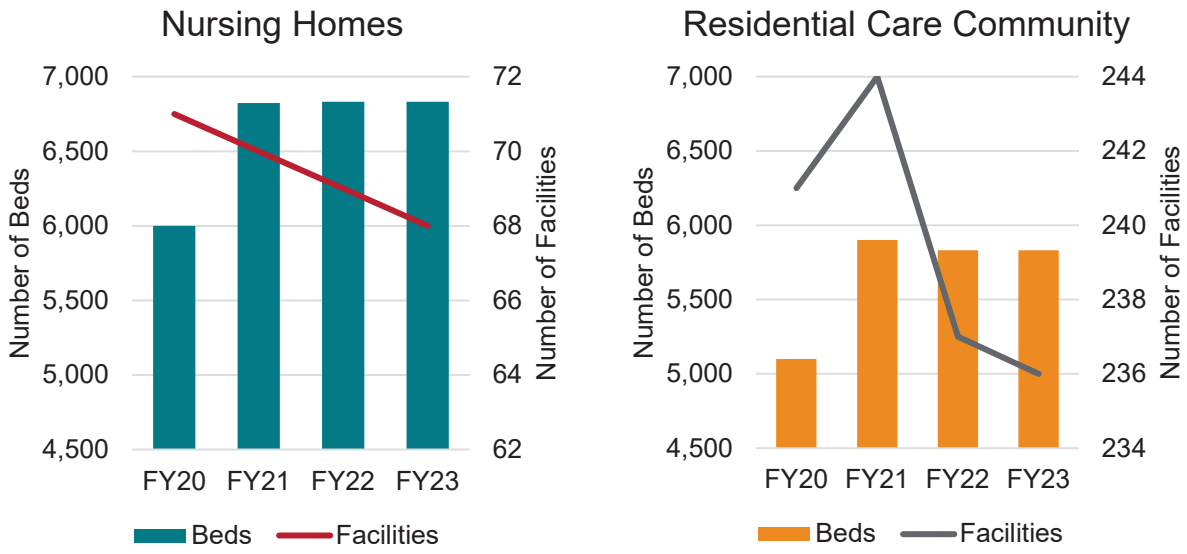
Long Term Care Ombudsman Program

ALTSD supports Ombudsman for long-term care facilities throughout New Mexico, which support constituents with complaints and issues they may have with long-term care facilities. We received some data on this work, including longitudinal data on number of facilities and beds, Ombudsman cases, constituent complaints, complaint verification status, and final disposition of Ombudsman cases handled.

According to data we received, there are more than 300 long-term care facilities throughout New Mexico. The total number of long-term care facilities has decreased in the past three years, from 312 facilities in 2020 to 304 in 2023. In contrast to total facilities, bed capacity *increased* in 2021, then decreased slightly the following year and stabilized in 2023. Overall, bed capacity has increased from 11,100 beds in 2020 to 12,664 in 2023. **Figure 42.1** presents data for Nursing Facilities and Residential Care Communities, which both evidence the same pattern of fewer facilities and higher bed capacity over time. In contrast to Nursing Facilities which have experienced a consisted downward trend in number of facilities, the number of Residential Care Communities and beds increased briefly in 2021 and decreased each year thereafter. Despite

Figure 42.1

Number of Long-Term Care facilities and bed capacity in New Mexico, FY20 – 23



Note. Right-hand axes for both charts have different scales; significantly more Residential Care Communities than Nursing Facilities.

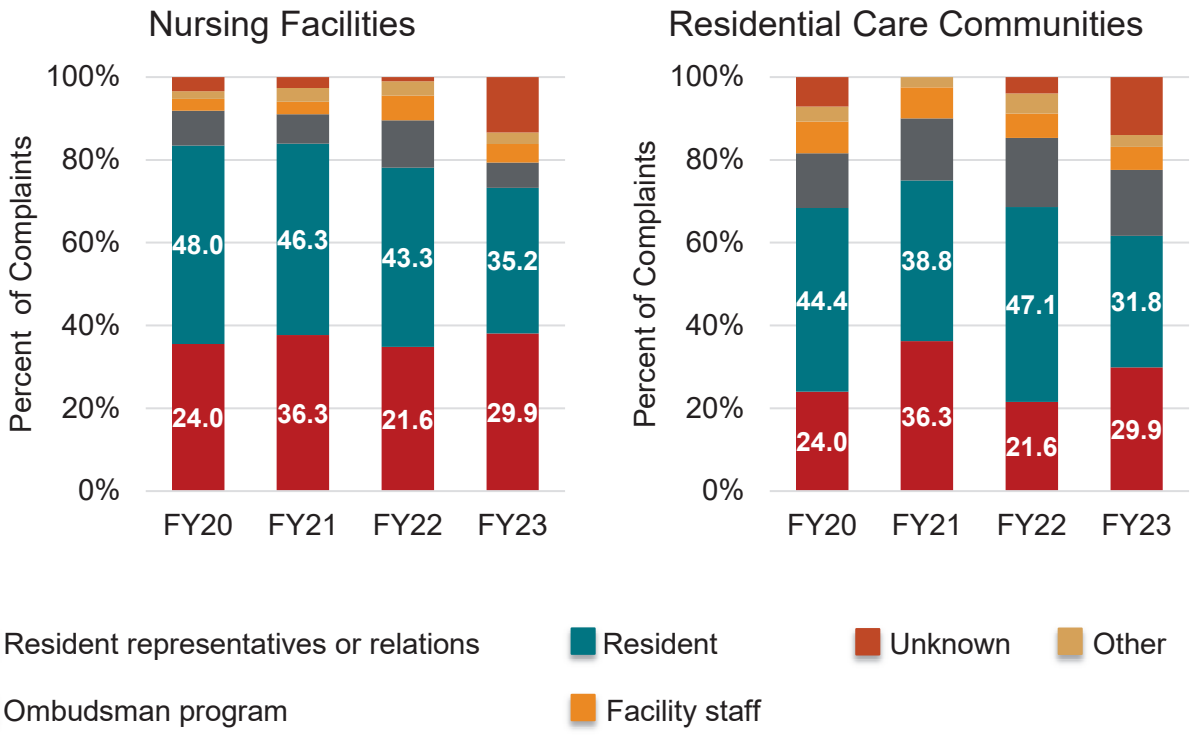
the decreasing numbers of facilities in the past three years, total bed capacity is still higher than the 2020 estimate.

Ombudsman chiefly respond to support complaints on behalf of long-term care residents. We received data for complainant type, as well as the kinds of complaints that were submitted from 2020 to 2023. **Figure 42.2** summarizes complainant type by facility type. For all long-term care facilities, more than 300 complaints are made each year. The lowest number of complaints occurred in 2022 (303) and most complaints in 2020 (549). Long-term care residents themselves, as well as their representatives and relations account for the majority (76.2%) of all complainants from 2020 to 2023. As **Figure 42.2** illustrates, while individual categories of complainants naturally fluctuate year to year, at minimum 60% of complainants each year in Residential Care Communities and Nursing Facilities are long-term care residents or their representatives and relations. The next highest category of complainants are for Ombudsman program staff, which make up 10.3% of all complainants in the past four years. All other types comprise less than 14% of all complainants.

Information on the kinds of complaints brought forth to the Long-Term Care Ombudsman program are illustrated by **Figure 42.3** for each type of facility. Over half of all complaints (53.8%) from 2020 to 2023 are related to facility: Care (27.7%, 672); Autonomy, choice, and rights (14.7%, 358), and Admission, transfer, discharge, and eviction (11.4%, 278). Ombudsman investigated at minimum 500 complaints each year from 2020 to 2023. The lowest

Figure 42.2

Long-term care facility Ombudsman program complainant types, FY20 – 23



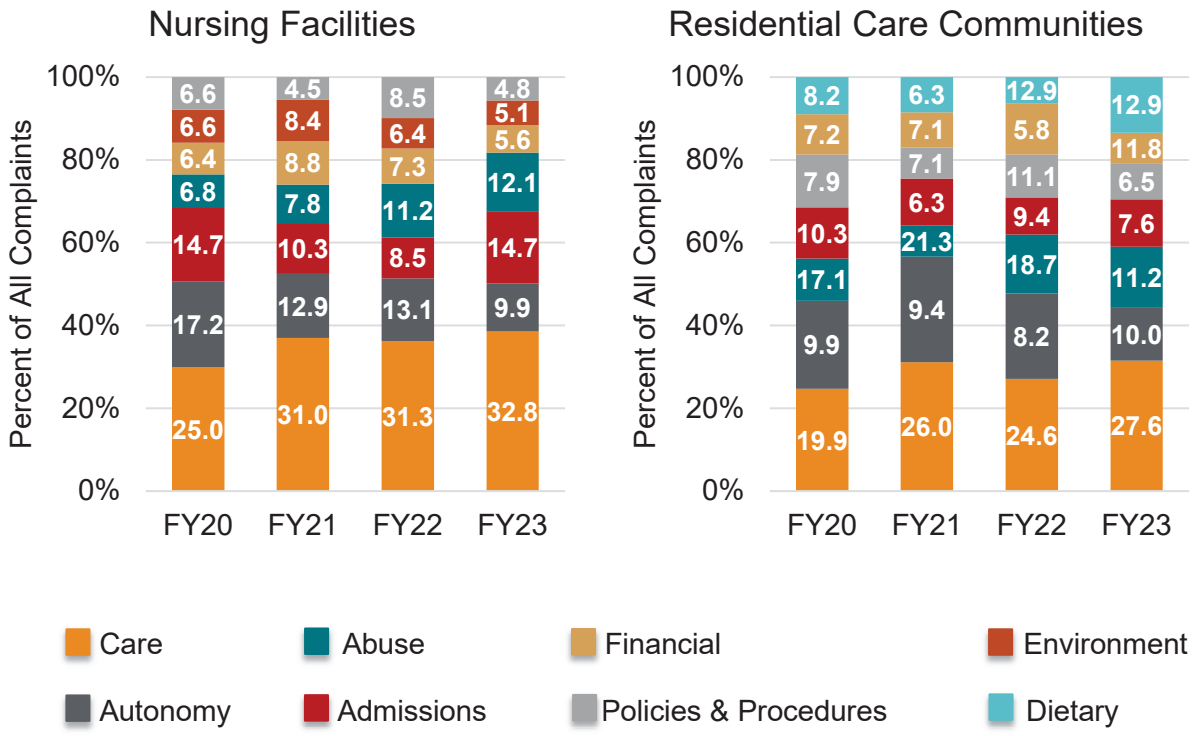
Note. Percentage values less than 20% not shown.

number of complaints occurred in 2022 (500), and the highest in 2020 (814). Types of complaints are similar for Nursing Facilities and Residential Care Communities, where out of 12 categories of complaints, the same six types make-up 78.4% and 77.0% of all complaints: (1) Care, (2) *Autonomy* (3) *Admissions* (4) *Abuse* (5) *Financial*, and (6) P*olicies & Procedures*. For both facility types, the largest categories of complaint type are related to *care*, and *autonomy, choice, rights.* Both these categories account for 43.2% and 40.5% of all complaints in Nursing Facilities and Residential Care Communities, respectively. The only significant difference between complaint types at nursing facilities and residential care communities is for the 7th most frequent complaint, which at Nursing Facilities is for *dietary* concerns and issues, while at residential care communities it is for *environment* related concerns and issues.

Over time, some significant changes occur from 2020 to 2023. Firstly, complaints at Nursing Facilities related to *autonomy, choice, and rights* has *decreased* by 7.4% as a proportion of all types. And complaints related to *care*, or *abuse, gross neglect, and exploitation* have *increased* by 7.8% and 5.4%, respectively. Secondly, for the same period complaints at Residential Care Communities related to *autonomy, choice, and rights*, and *access to information* have

Figure 42.3

Complaint types for Long-Term Care Ombudsman investigations by facility type, FY20 – 23



Note. Complaint labels are shortened descriptions of types.

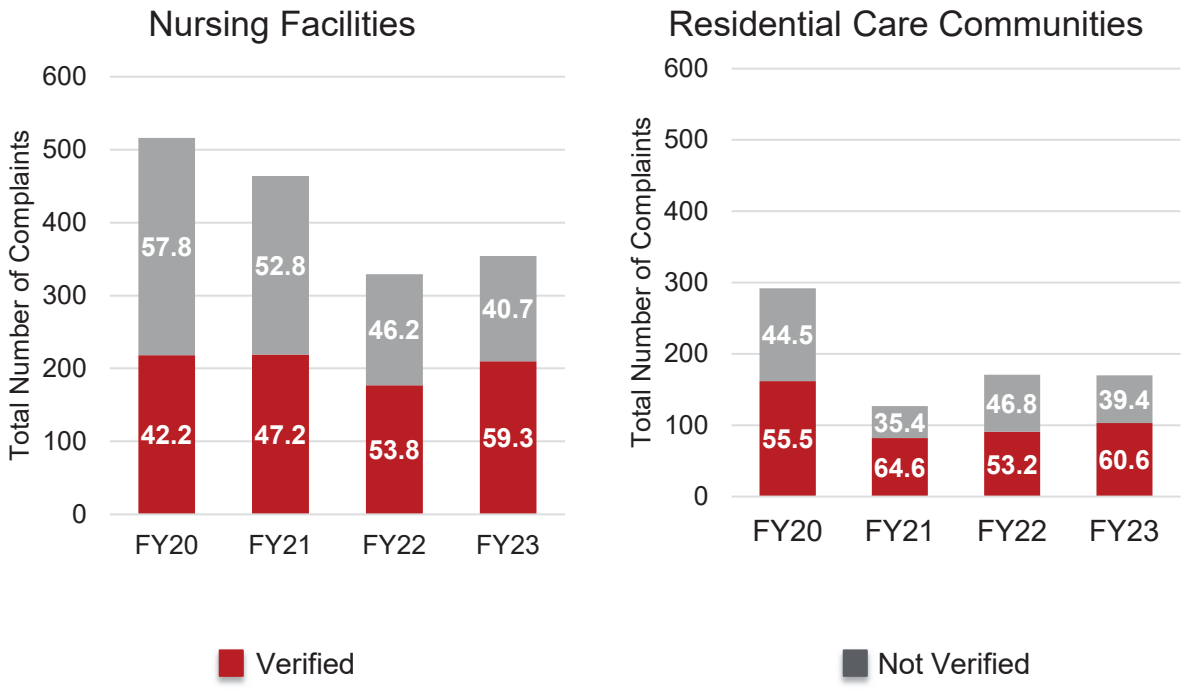
decreased by 5.9% and 3.2%. Complaints related to care, or admission, transfer, discharge, eviction, or dietary, have all increased by 7.8%, 4.7%, and 4.6%.

Review of complaints ultimately involves verification of whether the complaint is substantiated. Ombudsman staff indicate whether complaints are "verified," meaning that part or all of the complaint is determined to be factual. Data suggest that for three of four years, slightly more complaints have been verified than not. Roughly 60% of all complaints from 2020 – 2023 were verified, with the lowest verification rate occurring in 2020 (46.9%). **Figure 42.4** visualizes verification rates among Nursing Facilities and Residential Care Communities. Overall, verification rates are higher for Residential Care Communities than for Nursing Facilities. Importantly, fewer complaints originate each year at Residential Care Communities than at Nursing Facilities. For the 2020 – 2023 period, 67.6% (354) of all complaints occur for Nursing Facilities, compared to 32.4% (170) at Residential Care Communities.

Finally, Ombudsman document the final disposition of complaints – whether the complaint is satisfactorily resolved for the resident at the center of a concern or issue. Depending on the health and ability of the resident, disposition may be determined by someone other than the resident, but who is nevertheless interested in a resident's health and welfare and may in fact

Figure 42.4

Verification status of Long-Term Care Ombudsman investigations, FY20 – 23



Note. Percentages reflect proportion of all complaints verified or not verified.

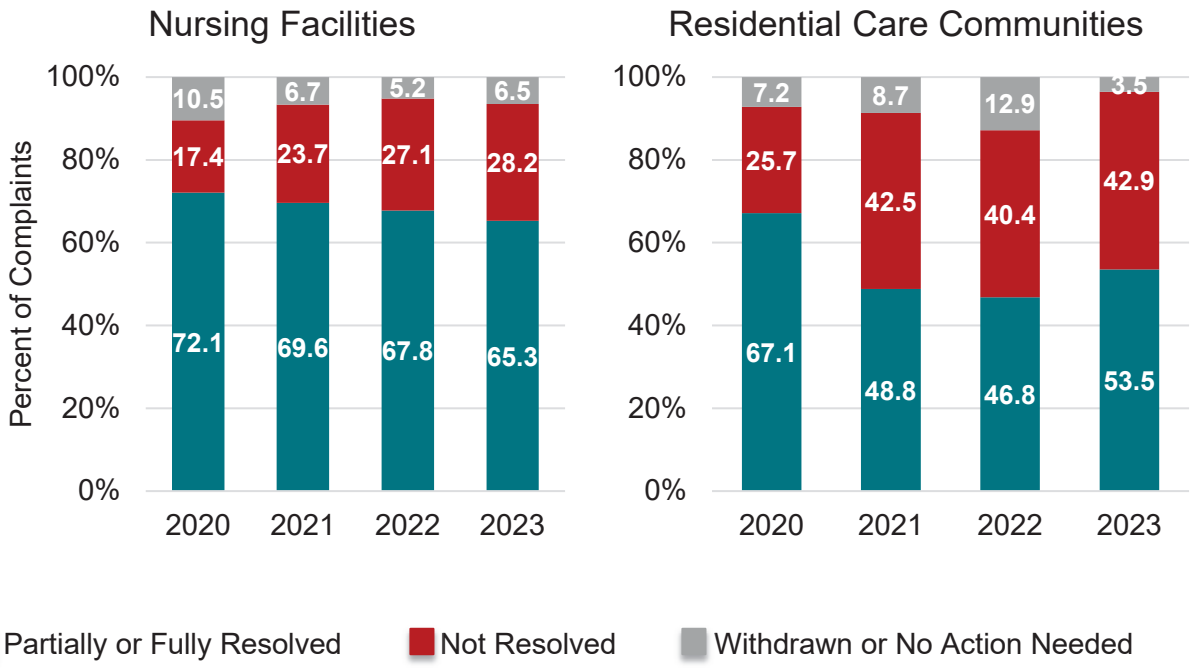
be the original complainant. Between 2020 and 2023, over half of all complaints (65.1%) across all long-term care facilities resolve partially or fully. About 27.2% of complaints do not resolve, and another 7.6% are either withdrawn or no action is needed.

Figure 42.5 summarizes the proportion of complaints by disposition status for Nursing Facilities and Residential Care Communities from 2020 to 2023. Nursing Facilities in general have higher proportions of complaints resolving partially or fully, compared to Residential Care Communities. For all four years, 69.1% of Nursing Facility complaints resolve partially or fully, compared to 56.4% for Residential Care Communities. Overall, both facility types have relatively similar rates of dispositions where complaints are withdrawn or no action is needed – 7.5% compared to 7.9%.

Over time, Nursing Facilities and Residential Care Communities have both experienced increases in the proportions of unresolved complaints, and which have increased more significantly among complaints for Residential Care Communities. The increase in unresolved complaints from 2020 to 2023 has increased by 17.3%, from 25.7% of all complaints in 2020, to 42.9% in 2023. Compare that to Nursing facilities where unresolved complaints have increased by 10.3% - 17.4% of complaints in 2020, to 28.2% in 2023. This feature is interesting when

Figure 42.5

Disposition of complaints investigated by Long-Term Care Ombudsman, FY20 – 23



Note.

considering that fewer complaints are submitted each year involving Residential Care Communities. Despite more complaints in Nursing Facilities, complaints are consistently determined by advocates and residents to resolve more favorably than for those in Residential Care Communities.

DISCUSSION

Statewide Service Provider Survey – Part A

There was a general consensus among providers that their organizations are effective in satisfying older adult needs in the communities they serve. However, there was also general agreement that room for improvement exists in the face of some important barriers. Most providers reported they know what older adult needs are and the critical challenge is providing *more* existing services. Providers also identified *Legal* services, *Caregiver Support* services, *In-Home* services, and *Health Promotion & Disease Prevention* services are not adequately meeting older adult needs. These perceived unmet needs correspond exactly with the four service categories providers reported offering least in communities they serve. These findings suggest, at least from the perspective of providers, that these services are ideal areas to focus on to meet older adult needs in New Mexico. Importantly, providers also felt the totality of services available meet the needs of older adults or adults with disability.

While most providers in our sample reported offering *Access* services like *Transportation* and *Information Assistance*, they also frequently cite the same services as overlooked older adult sneeds. It was unclear whether this indicated more services are needed , or if some nuance existed with respect to gaps in these services. However, our second survey in the Spring of 2023 (Part B) revealed that providers report interest in both expansion of existing services and development of new service types. We discuss this further in the next section.

A strength of our first survey is its alignment with some of our focus group findings. In particular, provider repsonses about unmet older adult needs suggest general alignment between providers perceptions of older adult needs and what older adults themselves identify. Specifically, alignment regarding unmet needs occurred for 10 services we highlight in **Table 11**. This includes:

- Access to specialized medical and primary supportive care
- Mental health care
- Afterhours public transportation options
- Transportation to store
- Assisted transportation
- Medicare/Medicaid information support
- Digital training/technology assistance
- Affordable senior housing option

Some provider perceptions in our sample were contradicted by participants in focus group discussions. This occurred particularly for older adult awareness of available services. Although half of surveyed providers did not believe older adult awareness of available services was a significant barrier to meeting older adult need, many of our focus group participants described difficulties understanding what services were availalble and frequently cited centralized information and information support as unmet needs. Lack of service awareness and client resource sharing were prominent themes in six of the seven focus groups we held.

Statewide Service Provider Survey – Part B

In a second survey in the Spring of 2023, we asked providers to respond to a business health survey designed by senior ALTSD administrative staff. Providers responding to this second survey were diverse, but primarily worked for agencies/organizations owned by city and county governments. Seven providers in our sample served tribes, pueblos, or nations, and over half of those providers worked for organizations owned directly by tribes, pueblos, or nations.

Much of the Part B survey focused on financial and business health, and the resources providers feel are critical for maintaining or achieving economic sustainability. On this topic, providers in our sample were incredibly consistent, reporting that funding, recruitment of personnel, and training support are resources most useful to ensure their businesses thrive. Providers agreed their businesses offer the best services possible (93.3%), and for the most part, are healthy in the workforce and operations area (69.5%). Nearly a third (30.0%) felt neutral or disagreed on the latter question. And while most agreed their agencies/organizations are financially health in contracting and providing services (53.3%), nearly half felt neutral or disagreed (20.0%) on the same point. Many providers explained the top resources needed to provide the best services possible and maintain financial health are more (1) funding, (2) available personnel, and (3) training support.

Most providers also reported support for expanding existing services and offering new ones. In fact, providers generally support expanding all seven service types asked about in the survey. Providers serving counties across PSAs 1 – 4 mostly desire to expand currently available Access services like *Transportation, Assisted Transportation*, and *Case Management* supports. Providers serving PSAs 5 & 6 also specifically support expansion of the same services. Significant provider interest also exists for expanding Community service types like *Physical fitness/exercise services*, and *senior center activities*. Support for Community service types is especially concentrated among providers serving counties in PSAs 3 and 4.

Providers want to develop new services too, particularly In-Home services like *Caregiver Respite*, *Chore,* and *Homemaker* supportive services. Greatest interest for developing these services was found for providers serving counties in PSA 2, followed by those in PSAs 3 and 4. Development of new Access, Community, and Disease Prevention & Health promotion service types also have support, particularly for: *Case Management*, *Transportation*, and *Assisted Transportation*; *Physical fitness/exercise services*, and *Senior Center Activities*; and staff training of and programming for evidence-based health services.

Providers are clear that despite these desires to build services out, the critical barriers for expanding services are financial (80.8%) and available personnel within communities (65.4%). Providers echoed this when asked to report which resources are most critical for expansion and their responses once again favored: funding (100.0%) and personnel (70.6%). Indeed, providers overwhelmingly agreed they experience challenges recruiting employees to provide direct

services (78.0%) and that their agencies/organizations would benefit from training support (68.7%). Providers report that training on customer service broadly, budgeting and billing, and available funding would be most beneficial. In sum, funding and how to use funds more efficiently. Providers report both in-person and hybrid training platforms are the most effective mediums for deploying training support.

While the Department was interested in understanding why providers do not participate in the capital outlay process, virtually all providers in our sample reported participating. Only two providers indicated they did not, neither of whom elaborated on why they did not; both served counties within PSA 2.

Overall, provider responses paint a straightforward picture that service provision across the state is largely dependent on funding and available personnel in communities to provide direct services. Providers also identified need for adequate training support. Should these critical resources be met and provided, service providers report they are motivated to expand and develop services to meet older adult needs.

Focus Groups

Focus groups helped to gain deeper insight into older adult needs from older adults themselves. We selected focus group sites based on level of rurality and two other vulnerability measures – disability and poverty. We aimed to compare people in these areas with urban older adults and identify rural-specific older adult needs. Readers should exercise caution in viewing focus group discussions as broadly representative of statewide older adult needs. Focus group findings should instead be interpreted as indications worthy of further investigation – especially through future representative surveys of older adult need throughout the state.

With that said, focus group themes varied between rural and urban areas. Focus group discussions with older adults higlighted five commonly occuring service need categories: (1) Senior center support, (2) Information support, (3) Improved service accessibility and availability, (4) Health support, and (5) Transportation support. Three of the five need categories coincide with providers perspectives on need as well. Specifically, providers also agree on high need for senior center services as well – e.g., food and nutrition services and access services like transportation and assisted transportation. Older adults, like providers, also identify the need for expanding already existing services, and to improve accessibility of services to seniors with disability and/or who are also caregivers. Finally, transportation was a common topic of discussion across all focus group sites. Older adults frequently cited a desire for expanding transportation routes, availability of transportation options over the weekend or outside business hours, and for assisted or medical transportation support.

In contrast to many surveyed providers, older adults in our focus groups emphasized the need for improved information awareness and support, and solutions that consider the preferences and limitations of the current senior population, especially with regards to digital information sources that many have difficulty accessing. This need for information support cannot be overstated – every focus groups involved some degree of older adult participants sharing resources and information with each other amidst confusion about service qualifications and availability. In some cases, seniors attended focus groups with a specific hope of learning more about senior services. Participants from all areas desired more information and clarification about existing services, and mostly wanted support to be readily available at senior centers and information provided by non-digital sources like radio, newspapers, and trusted individuals.

Focus group discussion also suggest that rural areas significantly differ from their urban counterparts. While older adults from all areas often shared similar broad need for the same senior services and supports, the reasons for those needs could vary tremendously. In many cases, urban older adults who participated in our focus groups were experienced consumers of services and supports, and described needs in three ways:

(1) Expanded availability and accessibility of existing services
(2) Improved intimacy of senior centers and friendliness of staff
(3) Reengage older adults in existing services

In contrast, participants living in rural communities described how need primarily stems from limited-service provision and senior supports. Older adults in our rural focus groups were most insistent on the need for:

(1) Improved information centralization, with respect to local languages and trusted sources
(2) Availability of, and access to out-of-town transportation options – for medical and affordable food access
(3) Greater access to primary health support services like dental, vision, and hearing
(4) More socialization and community support services

Additionally, while urban and rural communities pointed out that COVID-19 adversely affected services, *urban* participants highlighted how fear of COVID among older adults has meant *participation* has lagged behind service provision. Rural participants more frequently described how COVID-19 resulted in the curtailment of services which have yet to resume. Older adults in rural communities therefore described how services that existed before COVID lockdowns remain unavailable to them despite their desire to participate.

Surveys and focus group corroborate some of the same narratives about older adult need in the state of New Mexico – particularly that existing services could meet need, if services were expanded and available to more older adults and in more areas. In contrast to surveyed providers though, focus groups strongly emphasize need for information support, especially through comprehensive non-digital resources older adults can readily access within their specific communities. Information support should proactively describe existing services and the ways in which they restrict eligibility, so general confusion about who does or does not qualify can be ameliorated. We specify this and two other recommendations in the last section of this report, which we believe would further enhance ALTSD's understanding of the breadth of older adult need throughout the state.

With that said, providers and participants alike emphasize their appreciation to ALTSD staff and existing services and supports. Providers overwhelmingly agree (78%) that ALTSD is, overall, meeting the needs of older adults throughout the state. Older adults who participated in focus groups also noted that many ALTSD services are helpful and supportive, and that they simply want greater accessibility or availability to those services. Senior centers, congregate meals, and community services were all highly valued and noted as *important* supports in focus group discussions. As one participant explained: *"Well, personally, I haven't enjoyed growing older, but [laughter] I like Albuquerque because everything's convenient and the senior centers are nice. They are nice…And I guess growing older here has made me realize that there's a lot more to do."*

Consumer Service Data

We analyzed 10 consumer service types offered throughout New Mexico from FY19 – 23, and, when possible, reviewed distribution of these services by PSA. Overall, services evidence the profound effect of the COVID-19 pandemic which disrupted services across the globe. We find ALTSD services were also affected. Nearly all service categories significantly decreased around 2020 and began to increase around 2022. Only four services present a different pattern during the COVID-19 pandemic and subsequent recovery period – *Home-Delivered Meals*, *Older Relative Caregiver Support*, *Other Services*, and *Public Health Emergency Support*. *Home-Delivered Meals* service provision increased during the pandemic and sustained relatively higher service provision when compared to FY19. *Public Health Emergency Support* was specific to aid provided during the pandemic and services steeply increased in FY20 and tapered off into FY23. According to consumer data, *Public Health Emergency Support* and *Home-Delivered Meals* account for 93.7% of all services provided in FY21 at the height of the COVID-19 pandemic. *Public Health Emergency Support* has not returned to zero in FY23, suggesting services of this kind may still be provided in FY24.

Despite the effect of COVID-19 on service provision, WellSky consumer data show ALTSD ultimately increased total units of services to consumers in FY21 and provided more total services in FY23 than in FY19. However, this is true because over 1.8 million units of *Public Health Emergency Support* services are provided in FY21 alone and are still provided in FY23 despite significant decreases in this service category. We ultimately expect that should *Public Health Emergency Support* run-out, ALTSD will provide fewer services than pre-pandemic (FY19). To this point, subtracting *Public Health Emergency Support* from FY23 total service units results in 3,66,592.5 units of service – 718,311.8 units less than FY19 total service provision, the lowest in four years. We find the total number of unique consumers evidence the same pattern as for total service provision, increasing substantially in FY20 and decreasing in FY22, before rising again in FY23. Data indicate in FY23 the ALTSD serves the second-highest number of unique consumers than any other time in four years. Notably, increasing consumer demand occurs in tandem with less total service provision across most service types.

Adjusting for the size of each PSA's potential 55+ consumer population, we also find most services provide fewer than 1 unit of service per potential consumer. The only two exceptions are for *Congregate Meals* and *Home-Delivered Meals*, which provide 1.3 and 3.3 units statewide on average per potential 55+ consumer. We expect this reflects the fact that most services the Aging Network provides are for *Congregate Meals* and *Home-Delivered Meals*. Of the nearly 4.5 million total units of services provided in FY23, roughly 3 million units are for *Congregate Meals* and *Home-Delivered Meals*.

Some concerning patterns emerge in our review of consumer data. Over time many services, especially key services like *Congregate Meals* and *Access Services*, have increased since FY21 but provision in most places has not returned to pre-pandemic levels in FY23. *Health Promotion & Disease Prevention Services* also decreased during the COVID-19 pandemic rather than increased – services that ostensibly should be offered more during a public health emergency. Especially surprising, we found consumers in PSA 6 have not received any *Health Promotion & Disease Prevention Services* since at least FY19. These trends are concerning since health comorbidities can be major contributing factors to illness severity, as was the case with COVID-19 ((Bigdelou et al., 2022). In terms of policy planning and health emergency preparedness, it may be sensible to explore options for expanding supportive and health

education services, especially during public health emergencies. It may also be useful to investigate how PSA 1 managed to increase *Health Promotion and Disease Prevention Services* over the course of the COVID-19 pandemic to develop and/or apply similar strategies within other areas.

Limited data were available on *Legal Assistance* services provided to older adults and adults with disabilities. In contrast to other consumer data, *Legal Assistance* is only reported for Federal Fiscal Years (FFY), and detailed consumer and case characteristics are only available for FFY22 – 23. As these challenges suggest, we identify significant gaps in data collection for *Legal Assistance* services. It remains unclear what kinds of cases are ultimately helped, which service types are most useful to consumers, and *who* is ultimately served. In FFY22 and FFY23 45.5% and 50.4% of all cases are designated *Other/Miscellaneous*. These are substantial proportions and may indicate inadequate existing categories, or possibly some other issue with data entry procedures. Additionally, county-level data are not available for *Legal Assistance* service provision, and therefore *where* gaps occur cannot be brought into focus.

Data collection gaps are especially salient given we find that the most productive *Legal Assistance* provider primarily offers services designated as *Advice,* rather than for *Representation.* We expect the former is a less intensive service than the latter. The same provider also serves the most rural consumers out of all providers. Because rural consumers comprise at most 29% of provider cases, we expect most rural consumer cases are likely provided *Advice* rather than *Representation.* We therefore wonder if rural consumers are underserved in this category. Existing data reporting cannot identify whether this gap exists. Improving data collection by reporting county of service, consumer demographics, and connecting these to general *Legal Assistance* case categories would help future attempts to understand gaps in service provision. For example, the second- and third-most common *Legal Assistance* case types were for issues related to *Housing* and *Defense of guardianship/protective services*. Do these cases serve mostly rural or mostly urban contexts, mostly women or men, etc.? Additionally, are some cases more frequently closed or left open for some individuals? Improved data collection and reporting would help to elucidate such questions.

Aging Network Division consumer services over time show significant recovery from disruptions during the COVID-19 pandemic, especially for *Home-Delivered Meals* which increased during the pandemic and are provided at higher levels than before the pandemic. Still, service provisioning has not fully returned to pre-pandemic levels for most services and most places. Preparing for future public health emergencies by developing contingencies for service provisioning during such events would be useful. We find this is especially critical considering *Health Promotion & Disease Prevention Services* decreased during the COVID-19 pandemic rather than increased. And in PSA 6 – Tribes, Nations, & Pueblos – *Health Promotion & Disease Prevention Services* have not been offered since at least FY19. Lastly, we also found that *Legal Assistance* service data collection is minimal. We recommend improving collection of metrics on these services to better understand gaps and, at the very least, to know *who* is being helped, *what* kinds of help they are provided with, and *where*.

APS, CERD, & Long-Term Care Ombudsman Data

ALTSD provides a variety of services and supports for older adults and adults with disabilities. We reviewed three data sources documenting that support from: the Consumer and Elderly Rights Division (CERD), Adult Protective Services (APS), and the Long-Term Care Ombudsman program. While data we received were limited, they provide insight into work ALTSD does in addition to services offered through the Aging Network Division.

The CERD provides a centralized support system to direct individuals to appropriate services and provide information about how to access and use those supports. Data we reviewed suggest CERD answered over 20,000 calls related to senior topics in FY23 and almost 40,000 calls in FY21. They primarily support New Mexicans with requests for support related to Medicare and Medicaid, as well as home healthcare and social service support topics. While CERD has received fewer calls each year related to senior topics, total calls per annum are more than 20,000. We note, however, that calls related to long-term care facilities and senior center services and supports reflected 2,918 and 181 calls from FY21 – 23, respectively. This is interesting considering our focus group findings regarding need for centralized information support and help with finding available services at senior centers. This may ultimately reflect a need to improve outreach and public service messaging to make resources like the 1-800 ADRC number more widely known so older adults can be linked to services they qualify for.

APS supports older adults and adults with disabilities by investigating serious allegations of neglect, self-neglect, physical abuse, exploitation, and sexual abuse. APS reviews tens of thousands of cases each year. In the 2023 Federal Fiscal Year (FFY), 54.6% of cases were referred through ALTSD's WellSky system and investigated. Roughly 10.0% of those cases were determined to be substantiated. Most substantiated cases between FFY16 – 23 involve self-neglect and exploitation (84.5%), averaging 845 cases for either type each year. APS can refer victims to services to prevent further maltreatment and improve quality of life following a substantiated allegation. Data we received report that since FFY21, more victims each year are ultimately referred to supportive services. Out of 862 substantiated allegations in FFY23, 126 victims were referred to services, compared to 58 out of 647 cases in FFY21. It is unclear from data we reviewed why only a small percentage of substantiated allegations result in referrals. This topic is worthy of further research to understand who may be underserved.

Lastly, the Long-Term Care Ombudsman program aids residents in long-term care facilities by supporting them in the complaints process, verifying complaints made, and monitoring their resolution. Ombudsman records we received for FY20 – 23 indicate the number of long-term care facilities has declined overall while bed capacity has increased. Complaints overall from FY20 – 22 decreased, and then increased slightly in FY23. Most complaints originate from either residents (33.5%) or their representatives and relations (42.7%). Seven out of twelve complaint types account for over 80% of all complaints made from FY20 – 23. The largest share of complaint types are for those related to *care* (27.7%) and *autonomy, choice, rights* (14.7%). Most complaints at facilities for all years are verified (52.0%), and most complaints resolve partially or fully (69.1%). Nearly one-quarter of all complaints are not resolved (23.4%). About 7.5% of all complaints are ultimately withdrawn or no action is needed to resolve them.

Myriad supports are offered by ALTSD personnel. In the past three to four years, CERD calls for service related to senior topics, complaints on behalf of residents at long-term care facilities,

and allegations referred to APS have all decreased over time, with recent upticks occurring for each type in FY23.

U.S. Census Data

We reviewed 18 topical areas available from the U.S. Census American Community Survey (ACS) for two 5-year estimates: 2013 – 2017 and 2018 – 2022. We aimed to understand how vulnerabilities have changed over time (if at all) for New Mexico statewide, for individual PSAs, and by rural and urban counties. We found that at the statewide level population estimates for six topical areas significantly increased (at 90% confidence interval) from 2017 to 2022:

1. Older adults 60+ population
2. Adults 65+ with any disability
3. Adults 65+ with annual household incomes less than 200% poverty
4. Adults 65+ who live alone and/or rent their housing
5. Adults 65+ with dual Medicare & Medicaid
6. Adult households (60+) receiving SNAP
7. Adults 60+ in the labor force

In some cases, statewide estimates did not significantly change while PSA-level estimates did. This occurred for three topical areas, all of which occurred for the population of Grandparents Responsible for Grandchildren (GRGC) and its intersection with other vulnerabilities:

- GRGC: Older adult (60+) population
- GRGC: Adults 60+ where English is spoken less than “Very Well” (ESL)
- GRGC: Adults 60+ with household incomes below poverty

And for a single topical area, statewide estimates did not change over time, but they did for rural areas – GRGC: Adults 60+ where English is spoken less than “Very Well” (ESL).

Our focus on rural and urban counties intended to understand whether the distribution of vulnerabilities differs between these types of areas. We found evidence from ACS estimates that they do. Specifically, ACS estimates over time for rural counties significantly increased for the proportion of older adults raising grandchildren where English is a Second Language, as well as the number and proportion of SNAP recipients. In contrast with urban New Mexico counties, rural areas also evidence a significantly higher proportion of vulnerable older adults:

- With disability
  - 44.2% vs. 37.3%
- Living alone
  - 44.6% vs. 32.1%
- Who are dual Medicare & Medicaid recipients
  - 15.1% vs. 10.1%
- GRGCs with household incomes less than 200% of the poverty threshold
  - 32.7% vs. 18.5%

However, it is critical for readers to note that greater disparities exist for some estimates within urban areas compared to rural ones. ACS data indicate significant increases in the number of older adults living alone and who rent, and the number of older adult dual Medicare & Medicaid

recipients within urban counties. Additionally, significant increases have occurred over time in the size of vulnerable populations in urban areas than for rural ones, namely, for older adults:

- With household incomes less than 200% of poverty
- Who receive SNAP benefits
- With any disability
- Living alone
- Living alone and renting
- Who are dual Medicare & Medicaid recipients

In sum, urban areas account for the most substantial populations of vulnerability we examined, and the size of those populations has significantly and primarily grown within urban counties. With that said, for four metrics we highlighted (disability, living alone, dual coverage, and GRGCs less than 200% of poverty) a greater proportion of older adults in rural areas show vulnerability compared to urban areas.

Overall, U.S. Census data reveal New Mexico's older adult (60+) population has significantly grown over time, increasing by 125,524 people from 2012 to 2022 5-year estimates. New Mexico's older adult population also evidences significantly increasing vulnerability within 12 of the 18 topical areas we reviewed. This includes more older adults in poverty and at or near poverty, who are working, receiving SNAP, with any functional disability or disability that affects daily living, and who are grandparents responsible for grandchildren where no parent is present. While these conclusions may not apply to all communities, estimates suggest a confident trend exists and some unique health and socioeconomic disparities are expected among older adults living within rural or urban New Mexico counties. U.S. Census data emphasize that multiple surveys of New Mexico's older adult population indicate it is significantly growing and that they exhibit increasing need relating to physical health, economic stability, and social support.

CONCLUSION

This report is the culmination of two-years' worth of mixed-method research aiming to understand older adult needs across New Mexico. To accomplish this, we reviewed appropriate literature on Needs Assessments, conducted focus groups in urban and rural communities, and analyzed U.S. Census American Community Survey (ACS) data, WellSky consumer service data, two statewide provider surveys, Adult Protect Services (APS) data, Consumer & Elder Rights Division (CERD) data, and Long-Term Care Ombudsman data. Our research was completed in two-phases, where Phase 1 involved the deployment of focus groups in rural and urban communities to understand differences in older adult needs, and a statewide survey to understand needs from service provider perspectives. Phase 2 involved the collection and analysis of all remaining secondary data and the deployment of a second statewide survey on service providers' financial and business health.

Focus groups we conducted with older adults in the Spring of 2023 suggest that urban and rural communities share many of the same needs and desire for supports: (1) Senior center support, (2) Information support, (3) Improved service accessibility and availability, (4) Health support, and (5) Transportation support. These coincide with service providers' perspectives on need, who reported in our statewide survey that high need exists for senior center-specific services, food and nutrition services, and access services like transportation and assisted transportation. Older adults, like providers, also identified the need for expanding already existing services and to improve accessibility of services to seniors with disability and/or who are also caregivers.

However, providers responding to our second statewide survey in the Spring of 2024 were equally adamant that such expansion of services is dependent on key resources, training, and available personnel within their communities to provide such services. While nearly all providers report they provide the best services possible, one-fifth (20.0%) of the providers also felt their agencies/organizations are *not* financially healthy when it comes to contracting for or providing services. Providers also overwhelmingly agree that recruiting employees to provide direct services remains a significant challenge. Funding, available personnel, and training support were identified as critical resources for meeting older adult needs.

Despite challenges, providers generally support expanding services. Providers serving counties across PSAs 1 – 4 mostly desire to expand currently available Access services like *Transportation, Assisted Transportation*, and *Case Management* supports. Providers serving PSAs 5 & 6 support expansion of the same services. Service providers would also like to expand Community services like *Physical fitness/exercise services*, and *senior center activities*. Support for Community service types is especially concentrated among providers serving counties in PSAs 3 & 4.

Older adults who participated in our focus groups emphasized in both rural and urban areas that Community services, especially socialization activities and opportunities, were heavily reduced during and after the COVID-19 pandemic. Focus group participants in urban areas described a slow return of some services, while rural participants felt that some services all but disappeared. Our review of WellSky consumer service data does lend evidence to a significant disruption in service provision which began around the COVID-19 pandemic. We found that nearly all service categories significantly decreased around FY20 and began to increase around FY22. Only four services present a different pattern during the COVID-19 pandemic and subsequent recovery

period – *Home-Delivered Meals*, *Older Relative Caregiver Support*, *Other Services*, and *Public Health Emergency Support*.

ALTSD has significantly increased service provision for most service types in most areas, but it is clear from WellSky data that service provision for most services has not returned to pre-pandemic levels. Perhaps more concerning is that should one service type end – *Public Health Emergency Support* – and FY23 service provisioning remain stable, ALTSD would be on track to provide the fewest total units of services since FY19. While it is beyond the scope of the current needs assessment to determine why recovery from the COVID-19 disruption in service provision has not occurred, the intuition focus group participants had about decreased service provisioning is supported by WellSky consumer data.

This disruption and subsequent drop in older adult services occurs at a time when New Mexico's older adult population is substantially growing, and by all indications, will continue to grow over the next 20 years (UNM, 2024). Our review of U.S. Census estimates on older adult topical areas related to vulnerabilities suggests that more of New Mexico's older adults have disabilities, household incomes less than 200% of poverty, live alone, rent their housing, receive SNAP benefits, are in the labor force, and are dual coverage Medicare and Medicaid recipients. And while statewide estimates did not significantly increase over time for grandparents responsible for grandchildren when no parent is present (GRGCs), some PSAs do show significant increases in this population (PSA 1 and PSA 6), GRGCs who have household incomes below, at, or near poverty (PSA 6) and GRGCs where English is a Second Language (PSA 5 and PSA 6). In sum, U.S. Census data suggest needs have increased and more older adults are accessing financial assistance resources like SNAP and Medicaid. Further, we emphasize that the estimated population of older adults with high need does not necessarily need to grow over time to remain substantial or underserved.

Estimates for rural areas evidence significant increases in the number of SNAP-receiving older adult households, and the proportion of ESL older adult GRGC households. And contrary to our expectation, urban areas evidence significantly higher need by ACS estimates, relative to rural areas. Six of the 18 categories of vulnerability we reviewed significantly increase over the past decade for urban areas – the older adult population generally, households below poverty, receiving SNAP, with any disability, living alone, renting, and with dual Medicare and Medicaid coverage. Five categories also make-up significantly larger shares of the older adult population in urban areas over time – SNAP-receiving households, dual Medicare and Medicaid coverage recipients, working older adults, as well as the number of GRGCs broadly, and who are working.

We also find PSA 5 & 6 – Navajo Nation, and Tribes, Pueblos, and Nations – frequently evidence high need. In our review of Census data for these areas, we find significant increases over the past decade in the number of older adults (60+) writ-large, the number of older adults with disabilities, without health insurance coverage, who are working, receiving SNAP, and with household incomes below poverty. What is more, a significantly greater share of these older adult populations are also working, receiving SNAP, below poverty, and without health insurance coverage. We are not the first to identify such high needs among this population, which are also found in assessments completed by the National Resource Center on Native American Aging (2023). They shared limited data with us for the most recent survey cycle (Cycle 8) for New Mexico's Native American elders. Infographics we received suggest surveyed Native American elders in New Mexico report high rates of health vulnerabilities such as high blood pressure (52.1%), disability (23.7%), and obesity (38.2%). About 10.8% report skipping

meals due to money concerns, 47.7% report not socializing at all in the past month or socializing infrequently (1 – 2 times in the past month), and about a third report taking care of their grandchildren (33.6%).

However, we find consumer WellSky data reveal that PSA 6 frequently provides more services to unique consumers, and to a greater proportion of their potential 55+ consumer population than any other PSA. We also found that PSA 6 provides little or no caregiver support and/or older relative caregiver support, some of the lowest provisioning of Access services, and have not provided *Health Promotion & Disease Prevention* services since FY19. More concerning is that close to half (39.9%) of all PSA 6 services in FY23 are also accounted for by *Public Health Emergency Support* funding (COVID-19 relief), which is expected to end by FY24. Their reliance on this funding stream is especially higher than any other PSA. Considering the varied service types supported by this funding source (e.g., Caregiver – Home Delivered Meals, Senior Center services, individual socialization, fitness health/promotion, group socialization, Well Check Call, Consumable Supplies, etc.), we might expect that existing service provisioning for similar Title III services are not sufficient to meet existing older adult need in these areas. Indeed, surveyed providers in PSAs 5 & 6 clearly identify interest in expanding services for all available service categories, but particularly *Access*, *Case Management*, *Other Community* services, and *Caregiver* services.

Given the expansive needs of New Mexico's older adults, it is important to emphasize that ALTSD provides services undocumented by the WellSky database which we also reviewed: Adult Protective Services (APS), Consumer & Elder Rights Division (CERD), and Long-Term Care Ombudsman data. APS data reveal that tens of thousands of cases of neglect, self-neglect, physical abuse, exploitation, and sexual abuse are reviewed annually. APS ultimately supports victims and refers them to appropriate social services. Additionally, thousands of complaints are received each year by the Long-Term Care Ombudsman program, which primarily supports residents of long-term care facilities with complaints relating to autonomy, choice, and rights. Data we received indicate 69.1% of all verified complaints resolving fully or partially – however, what precisely that means is unknown and uncategorized. What's more, a slim minority of cases are ultimately referred to appropriate services – a feature that warrants deeper understanding and study.

Lastly, CERD data we received shed light on a significant need identified by focus group participants: the need for centralized information support. CERD receives calls for support through a centralized information service provided through the Aging and Disability Resource Center. We reviewed and analyzed call type data to CERD and found that in FY23 alone, they received more than 20,000 calls for service. Call types varied significantly, with most calls for service regarding Medicare and Medicaid services – an area of information support clearly identified by providers in our 2023 statewide survey an unmet need. Calls relating to inquiries about long-term care facilities and senior center services and support accounted for a small portion of all CERD calls – around 3,000 calls out of the 60,000 received from FY21 – 23. This was interesting, because most focus group participants emphasized feeling lost or unaware about what services are available and how to find help. It may be that our participants were biased toward new senior center users or some other feature (i.e., seeking information) and are not reflective of most older adults. It may also be the case that such accessibility resource services are not widely advertised or are not advertised in the right places. Understanding how

to improve awareness of the significant assistance and resources CERD provides, may be useful.

On balance, ALTSD supports a wide infrastructure of resources and services to a dispersed and diverse older adult population, largely supported by state funds which, from FY19 – 25, support Title III services at 2.5 – 3.5 times the monetary amount provided by the federal government. However, the constellation of data we reviewed show that significant challenges arose during the COVID-19 pandemic, which older adult participants in our focus groups throughout New Mexico described and consumer WellSky data overwhelmingly evidenced. Our review also identifies significant needs and challenges facing New Mexico's older adults based on trends in U.S. Census older adult population estimates for New Mexico, as well as the business and financial supports required to address older adult needs as reported by on-the-ground service providers. We hope this document will guide policy decision-making. To this point, we offer several recommendations based on our findings to address existing older adult needs and guide future needs assessments – they can be found at the beginning of this report following our Executive Summary.

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