State of New Mexico Aging & Long-Term Services Department - Statewide Needs Assessment

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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. The Aging Network Division 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 go for a variety of services (i.e., meals and social/recreational activities), and healthy aging and prevention programs. The Adult Protective Services Division 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 includes 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.

The Institute for Social Research was contracted to complete a statewide needs assessment for the ALTSD focused on services provided by the Aging Network Division (AND). The scope of work included a number of tasks:

- A review of available literature related to needs assessment for similar type populations to provide a review of the current state of knowledge and best practices.
- A review of available data, including population statistics, health data, socio-economic data, and service data for New Mexico, by planning service area (PSA) and areas within PSAs to identify community needs, assets, and gaps in services.
- Review of administrative data, policies and procedures, contracts, reports, and any other written materials to describe how various programs operate, types and amounts of services, how services are delivered, costs of services, budgets, etc. that are funded using ALTSD funds or other funds if these data are available.
- Focus groups with service providers to study current processes and practices related to the ALTSD mission with a focus on the delivery of services, the size and composition of the target population, needs of the target population (i.e., general needs such as health, social issues, outreach, transportation, food insecurity, housing, etc.), gaps in services, resources, and supervision as well as any other identified area.
- Focus groups with service recipients to study top issues facing older adults, services received, satisfaction with services, gaps in services, as well as any other identified area.
- Surveys and/or stakeholder interviews to help identify needs and gaps in services.

- Field reconnaissance in targeted locations and the surrounding area to enhance and confirm data found online and from public sources.

This report is the final report documenting the results of the needs assessment. Importantly, this study was designed as a pilot to test a mixed-methods approach designed to more completely document the services provided to and received by New Mexico citizens and the needs of New Mexico citizens eligible for services. This is important for a number of reasons. First, in our review of the existing needs assessment, we could find no assessment that studied in detail and depth the needs of citizens and the services provided and received by citizens. Second, and related, this needs assessment can be used to comply with the requirements of the federal Older Americans Act that requires a needs assessment. Third, this review is designed as a pilot that, with the knowledge gained, can be refined in ensuing funding cycles so that a more thorough and complete needs assessment can be completed.

The State of New Mexico, via the federal Older Americans Act, 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, which enables the delivery of services to local areas. New Mexico includes two area agencies on aging.

The 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 community service employment for low-income older Americans; training, research, and demonstration activities in the field of aging; and vulnerable elder rights protection activities.

Fiscal Year 2018 funding totaling $2.038 billion was eight percent more than Fiscal Year 2017 levels and lower than every year since Fiscal Year 2009.

An Area Agency on Aging (AAA) is a public or private nonprofit agency designated by a state to address all older persons' needs and concerns at the regional and local levels.

AAAs are primarily responsible for geographic areas, typically known as a planning and service area (PSA), that is either a city, a single county, or a multi-county district. AAAs may be categorized as a county, city, regional planning council, or council of governments-- private or nonprofit.

AAAs coordinate and offer services that help older adults remain in their homes if that is their preference, aided by services such as home-delivered meals, homemaker assistance, and whatever else it may take to make independent living a viable option. By making a range of supports available, AAAs make it possible for older individuals to choose the services and living arrangements that are most beneficial.

New Mexico contains two AAAs and six 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 on Aging and includes the State's 19 pueblos, the Mescalero Apache Tribe, and Jicarilla Apache Tribe.

This pilot needs assessment ultimately focuses on assessing a sample of seven sites in New Mexico across five Planning and Service Areas (PSAs). Table 1 lists these seven sites and Figure 1 locates PSAs within New Mexico. Importantly, the original scope of work did not include PSA 5 or 6. These regions were excluded because of limited time to conduct focus groups and field observations, and the assumption that data was unavailable. However, in the course of obtaining data from the consumer data company WellSky, PSA 6 was unexpectedly captured. The scope of work for this assessment was eventually amended to include PSA 6 which provides services to 19 Native American pueblos, and the Jicarilla Apache and Mescalero Apache tribes. The 19 pueblos are located within PSAs 1 and 2, while the Jicarilla Apache tribe is located in PSA 2, and the Mescalero Apache tribe in PSA 4.

Our assessment does not include PSA 5 for a number of reasons. First, like PSA 6 the ALTSD does not directly oversee PSA 5; this would require us to negotiate separate agreements with the Navajo Area Agency on Aging in order to conduct focus groups and observations. We ultimately did not have time to include PSA 5 in this needs assessment which also encompasses a geographic region that crosses three state boundaries. Second, PSA 5 consumer data is not available. Had PSA 5 consumer data been captured as with PSA 6, we would have included them in our analyses. Future needs assessments could include PSA 5 with the appropriate agreements and time.

Table 1. Local Site Population

Local Site	PSA	Population
Bernalillo County	PSA 1	677,692
Las Cruces	PSA 4	101,742
19 Pueblos & Two Tribes	PSA 6	77,691
Gallup	PSA 2	22,105
Hobbs	PSA 3	38,052
Moriarty	PSA 2	2,223
Taos	PSA 2	6,021

U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Figure 1 is a map of the state of New Mexico outlining the 6 PSAs.

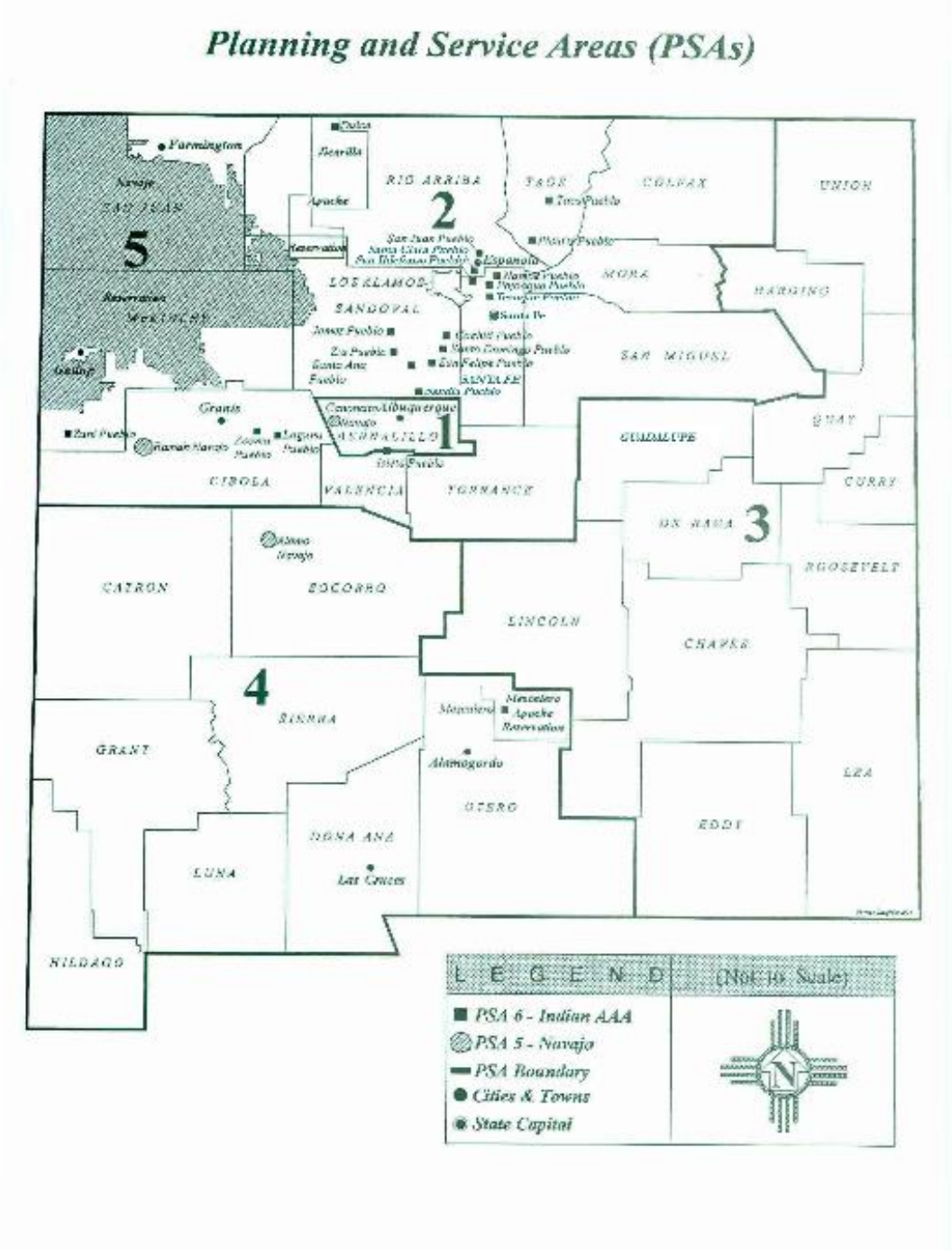

Figure 1

While statewide assessments are useful, they cannot tell us enough about local issues and how the needs of the elderly and their services vary within a state. Most statewide assessments have focused on statewide surveys and/or limited assessments of a few sites, typically larger population areas, and transferring these findings to the state. Our pilot is a proof-of-concept combining quantitative and qualitative research methods, focusing on a small set of purposefully selected sites in New Mexico. This needs assessment is designed to assess in more depth and detail the unique circumstances of local areas. It includes five research components:

(1) Census data to describe the general and aging population in the state, by PSA and local site.
(2) Analysis of consumer data focused on the number and type of services provided to residents.
(3) A review of the contract, budget, and expenditure data to better understand the budgeted services and expenditures.
(4) Field reconnaissance and visits to targeted sites.
(5) Focus groups and surveys of consumers to better understand from their perspective their use of available services and their needs and focus group and surveys of providers to gain a better understanding how providers view the services they provide, how they think about the services and consumers they serve, and how services could be enhanced or improved.

Our aim is to understand how needs vary by local areas and we believe this type of assessment, if done well, provides detailed information that is more useful for informed decision-making. We further believe we can prove this concept is viable and could be scaled-up in subsequent years to cover the state of New Mexico more completely.

This report contains a number of sections. Following this introduction, we describe the state of the state in New Mexico, followed by a review of relevant literature that concerns state assessments, plans, and other studies that have examined this population. The literature review is followed by a methodology section that describes how we completed the study, including our mixed methodology-- incorporating quantitative analysis of census data, consumer service data, and budgeting and contract data, as well as qualitative analysis of field reconnaissance, observations, and surveys and focus groups of consumers and providers. This mixed-method approach is a critical aspect of our design because a broad statewide assessment is not able to capture nuances at the local level.

Very importantly, we were not able to fully implement parts of this methodology. Specifically, we were not able to fully carry-out the qualitative portions of the assessment, including site reconnaissance and visits, surveys and focus groups of providers, and surveys and focus groups of consumers. The onset of the COVID-19 pandemic, the subsequent order in New Mexico declaring an emergency, and the memo suspending face-to-face research at the University of New Mexico occurred at the time we began to fully implement our site visits in mid-March 2020. While we are not able to fully implement the study methodology, we were able to conduct some activities including: one focus group, site-visits to three of six sites – Gallup, Moriarty, and several locations in Bernalillo County-- some initial and limited planning and recruitment for focus groups and surveys of consumers and providers, and fully completed a pilot web-based survey of service providers. These activities are described in detail later, including how these limitations impacted our research, but still provided useful information for this assessment.

NEW MEXICO

New Mexico is the fifth-largest state in the U.S. in terms of land area covering 121,298 square miles and a 2010 estimate of 17 persons per square mile. Santa Fe, the capital, is located in the north-central region of the state. The state's largest cities are Albuquerque, Las Cruces, and Rio Rancho. According to the July 2019 Census, the population estimate of New Mexico is 2,096,829, with 49.1% Hispanic or Latino, 37.1% White alone, 11.1% American Indian and Alaska Native alone, and 2.6% Black or African American alone. Almost 35% of the people in New Mexico speak a non-English language, and 94.4% are U.S. citizens.

New Mexico is home to nearly 341,515 older adults who represent just a fraction—about 0.7%— of all U.S. adults over the age of 65 and approximately 16.3% of the 2019 estimated New Mexico population. Compared to the total state population, New Mexico supports the 12th largest older adult community in the country. New Mexico's aging population ranks substantially higher nationally in many areas of public concern, including poverty, suicide, substance abuse, and mental illness. Indeed, New Mexico has the second-highest poverty rate in the country for adults over the age of 65. About 20% of all older adult New Mexicans live in poverty compared to the national average of approximately 13.1%. New Mexico similarly leads the nation with the highest suicide rate for those between the ages of 65 and 74. National Center for Health Statistics (NCHS) data on self-harm and mortality reveal that about 32.7 older adult New Mexicans per hundred-thousand older adults take their own lives. New Mexico also has roughly double the national rate of co-occurring substance abuse and mental illness. In terms of disability, New Mexico has the 11th highest rate of disability among older adults—both for those with any disability and for those with a cognitive disability. The CDC is able to capture mental distress among this population as well, indicating that New Mexico has the 4th highest mental distress rate for those with disabilities and who are 65 and over.

These statistics point out that New Mexico is home to many older adults who are at high risk and have high need. Services provided by entities like the ALTSD and other local and state organizations are necessary for supporting the health and welfare of New Mexico's aging adults. But social problems like poverty, mental illness, and disability have multifaceted effects and do not impact all people in the same way. It is vital then that we uncover the needs and supports of our aging community directly and from multiple sources, including census data; consumer or administrative data; contracts, budgets, and expenditures; and first-hand information from older adults and the providers who work with them. The OAA requires that state agencies conduct needs assessments which review the services they provide. As we will detail in the Literature Review, many needs assessments have been conducted across the country, but not all of them involve the same questions or population, or employ the same methods to discover the needs of older adults. Our study learns from these assessments and we propose a needs assessment using mixed social research methods.

A report published by the NM Department of Health (2018) noted with aging comes a higher risk of health problems, including chronic disease, disability, and death, and healthy lifestyles, along with early detection and management of chronic diseases are needed. Among the items the report noted needing to be done was the creation of a comprehensive and coordinated approach to using evidence-based healthy aging programs and services statewide. Our study recognizes these needs and our mixed-method study is designed to provide information that can be used to help fill this need.

LITERATURE REVIEW

Needs Assessments and Older Adult Needs

The Older Americans Act (OAA) requires that State Units on Aging (SUA) conduct Needs Assessments that "determin[e] the extent of need for supportive services, nutrition services, and multipurpose senior centers…[and] evaluat[es] the effectiveness of the use of resources in meeting [older adult] needs" (Older American Act of 1965 2020: 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)). Unfortunately, the OAA lacks a detailed procedure for 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 that AAAs can technically reuse their assessments for decades at a time (Thompson 2012).

The broadness in implementing needs assessments is documented (Cheung 1992) and is very likely responsible for the wide variation in how SUA's and AAA's have approached them. Such variation is of deep concern for SUAs and AAAs. Research by Lareau and Heumann (1982) who conducted a national survey of needs assessments, found that *more than half* of all needs assessments suffer from severe methodological shortcomings that undermine reliable policy planning. In fact, all of the government-sponsored needs assessments we reviewed reinforced those conclusions. 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, the literature captured a single broad imperative of assessments— to identify which existing service categories (e.g., meals, transportation, in-home services, etc.) older adults need or use most.

To establish structure for our review, we have organized our summary of needs assessments according to the methods they chose to implement—simplified here as either (1) mixed-method or (2) single-method assessments. We also briefly explore insights from the academic literature about how to explore specific service needs and then conclude our review with a short justification for the methods employed by our needs assessment. Importantly, our review of needs assessments is not exhaustive. To our knowledge only one study has reviewed needs assessment nationwide and is now nearly 40 years old (Lareau & Heumann 1982). Lareau & Heumann painstakingly solicited 252 older adult agencies that ultimately captured just *eight* SUAs. That review also required two months of solicitation and about two years of analysis. For reasons of practicality our literature is constrained to publications that populated in Google and Google Scholar searches. Documents we obtained span a decade and include needs assessments sponsored by SUAs, AAAs, and city governments. We argue that these documents provide reliable information about best (and at times, worst) practices, and inform our proposal of an effective needs assessment. We further argue that the documents we reviewed echoed Lareau & Heumann's findings and are therefore in agreement with the most recent academic research. Table 1 in Appendix B and Table 2 summarize key details about the government-sponsored needs assessments we reviewed.

Table 2. Government Sponsored Needs Assessments, 2012-2017

Location	Sponsoring Government Entity	Year	Institution Responsible for Report	Research Methods Used
Mixed Method Assessments				
Rapid City, SD	City Government	2012	Government Research Bureau, University of South Dakota	◦ Telephone Survey ◦ Focus Groups ◦ Community Resource Inventory
Montgomery County, MD	AAA	2015	Lisa Sturtevant & Associates, LLC- Center for Regional Analysis	◦ Secondary Data Analysis ◦ Community Resource Inventory ◦ Interviews with Community Housing Developers
Washington, D.C.	SUA & AAA	2016	Center for Aging Health and Humanities- George Washington University	◦ Community Survey ◦ Focus Groups ◦ Community Resource Inventory
Lane County, OR	AAA	2016	Lane Council of Governments- Senior & Disability Services (S&DS)	◦ Community Survey ◦ Focus Groups
Rockville, MD	City Government	2016	RTI International	◦ Online Survey ◦ Focus Groups ◦ In-Depth Interviews
Central Massachusetts	AAA	2017	Central Massachusetts Agency on Aging	◦ Community Survey ◦ Focus Groups ◦ Fact Finding Missions [Informal Conversations]
Single Method Assessments				
Idaho	SUA	2012	Boise State University	◦ Mailed Survey
Colorado	SUA	2018	National Research Center, Inc.	◦ Mailed & Online Survey

Mixed-Method Assessments

The government-sponsored needs assessments we reviewed often employed mixed methods to determine older adult needs in their communities. Six assessments over the past 8 years stood-out: (1) Rapid City, SD; (2) Montgomery County, MD; (3) Central Massachusetts; (4) Lane County, OR; (5) Rockville, MD; and (6) Washington, D.C. Critically, nearly all represent sub-geographies of each state (regions, cities, etc.)—with the exception of the District of Columbia. Only two of the needs assessments we reviewed investigated *all* of a state's Area Agencies on Aging (AAA)-- Idaho and Colorado (National Research Center, Inc. & Colorado Association of Area Agencies on Aging 2018; Fife and Hannah 2012). Both of those assessments were constrained to a single research method. In general, though, most

assessments were mixed-method. With one exception, mixed-method assessments reviewed U.S. Census data, and conducted surveys and focus groups. Assessments occasionally incorporated other methods as well: Stakeholder interviews, community resource inventories, reviews/summaries of government documents and procedures, and more rarely, 'fact-finding missions'.

In particular, The District of Columbia Office on Aging (DCOA) offers a fairly comprehensive example of an assessment measuring older adults' needs using mixed methods. The DCOA's previous needs assessment was conducted 34 years prior 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: 5). With an imperative to overhaul their needs assessments, the DCOA employed several methods to assess their community that 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. The DCOA also surveyed 14 areas of need—Quality of life, socialization, case management, home-delivered meals, and congregate meals, to name just a few.

But while DCOA's efforts were substantial, it sheds light on issues common to most needs assessments— (1) an inconsistent inclusion of minority older adult populations and (2) the absence of high-quality data from focus group research. In contrast to most assessments, the DCOA did afford special attention to some minority populations: persons with disabilities, senior caregivers, LGBT peoples, Hispanics and Latinos, and Asian and Pacific Islanders. Similarly, Lane County Oregon (Lane Council of Governments 2016) included LGBT, Veteran, and homeless older adults and was one of only two needs assessments to incorporate the perspectives of Native American elders. Despite their inclusion of minority perspectives, specifics about older adult need were scarce. For example, Lane County's LGBTQI focus groups identified that primary needs expressed included "*…concern[s] that end of life choices will not be honored or that a spouse will not be recognized*" and that "*lifestyle and life choices will not be honored or understood*" (79). DCOA similarly lacked depth in their analyses concluding that LGBT older adults expressed the need for "*safe place[s]*" and "*support systems*" (233).

In another emblematic example, the City of Rockville's (Pulliam & Triplett 2016) needs assessment conducted three focus groups with fairly unfocused target populations: African American older adults and "*Other*" older adults (anyone else who did not participate in senior services). Just 16 people were involved in all three focus groups. Perhaps due to the small sample size or other inherent limitations, Rockville's needs assessment concluded that all participants shared needs for generic categories like *awareness* of services, the *stigma* surrounding age, and limited *public transportation*. As a poignant contrast, the Central Massachusetts Agency on Aging (2017) supplied the richest details about perceived need among targeted older adults, holding dedicated focus groups with Vietnamese, Arabic, Chinese, Latino, and LGBT elders. Their focus groups identified *surprising needs* that were significantly unique and *unsupported* by existing services. Some of the needs they identified included a greater need for trauma support among older adult resettled refugees, English as a Second Language (ESL) services, and increased caregiver supports for overwhelmingly childless LGBT elders (6-7).

But mixed-method needs assessments incorporated yet other ways of understanding the perceived needs of older adults. With a single exception, assessments also explored older adult needs through surveys. In the majority of mixed-method assessments, surveys sampled adults 55 years and over and

compared the generalizability of each need category to the U.S. Census data. Each explored resoundingly similar topics and targeted 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. But communities approached these issues from widely different policy orientations. For *Central Massachusetts*, *DCOA*, *and Lane County,* their research primarily aimed to develop '*need profiles'* of their communities. On the other hand, Rapid City and Rockville focused on understanding older adult needs contributing to *community flight*. In sum, unmet need was acutely focused on services that might prevent older adults from migrating to other municipalities. These assessments were also more keenly interested in topics like *aging in place*.

As an outlier, Montgomery County's needs assessment conducted a meta-analysis of existing information (Sturtevant 2018). They reviewed U.S. Census data and other proprietary information—stakeholder interviews and an older adult program and resource inventory. This assessment was also the only mixed-method approach that didn't conduct focus groups or surveys. Their analysis of older adult needs was strictly limited to housing concerns and did not include the robust categories described earlier. As a whole, Montgomery County's needs assessment was less useful as a document to guide older adult services as it was for developing a comprehensive housing program. While Montgomery County's assessment may have adequately resolved that imperative, it remained a cogent example of when a needs assessment is too narrowly focused and ultimately subtracts older adult perspectives altogether. Still, many of the needs assessments we reviewed are instructive and Table 3 summarizes which assessments deployed surveys, conducted focus groups, or reviewed census data.

Table 3. List of Reviewed Needs Assessments & Methodologies, 2012-2018

Assessment Location	Level	Year	Survey	Census Data	Focus Groups
South Dakota	City	2012	Yes	Yes	Yes
Idaho	State	2012	Yes	No	No
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

Single Method Assessments

As we have described, only two needs assessments captured older adults and/or service providers for an entire SUA service area: the Idaho Commission on Aging (2012) and the Colorado Association of Area Agencies on Aging (2018). Both assessments implemented just one research method—surveys – to uncover older adult needs. Because of this, the Idaho and Colorado surveys were much longer, more robust, and comprehensive than their mixed method counterparts. For example, the Colorado survey expanded beyond just a single measure of socialization among older adults and instead assessed socialization across multiple contexts where it could occur: 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 more fully capture depth with these topics. 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*'" (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 which populations senior centers were most useful for. 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. Other approaches may involve understanding older adult satisfaction with life, community belonging, and developing context-dependent assessments of rural and underrepresented minority older adults. I general though, needs assessments lacked analytical depth and often neglected a critical resource for knowing more about older adult needs—older adult's themselves. As we have hopefully established, focus groups have been significantly underutilized in the development of needs assessments. Scholars like Cyr (2015), Barbour (2007), and Morgan (1996) underscore the importance of focus groups for obtaining rich details about perspectives. Cyr (2015) particularly emphasizes the need to move beyond an "Economy of Scales" design that needs assessments often use—deploying hard and fast focus groups to quickly and inexpensively obtain individual-level data. Focus groups are instead best utilized when they aim to reflect *"…diversity, not to achieve representativeness*" (Barbour 2007: 72). Expansive and rich descriptions like those from the Central Massachusetts' needs assessment demonstrate the effectiveness of that design. A key design recommendation for accomplishing that is to *"[develop] close-ended survey questions from focus groups, [so that] researchers can incorporate into the survey the difficult cognitive work needed to tap into perceptions on complex phenomena*" (Cyr 2015: 245). In this way, focus group data can more contextually describe population-level trends found in surveys and secondary data sources.

As Table 3 illustrates, most needs assessments utilized U.S. Census data to understand population-level trends among older adults. Needs assessments often used secondary data sources to tap into broader demographic dynamics like the prevalence of poverty, race and ethnicity, disability, health insurance status, etc. The greatest strength of most assessments was the use of U.S. Census data to describe need among older adults. Unfortunately, analyses rarely distinguish between population levels (City, State, region, etc.). As we argue in the methods section of this report, the benefit of our analysis is that it provides detailed information for the state of New Mexico, and Planning and Service Areas (PSAs), and more focused research sites. Our pilot needs assessment also moves beyond simple summarization of U.S. Census data and includes comparisons of older adult consumer data with budget and expenditure

information obtained from the New Mexico ALTSD. None of the needs assessments we reviewed evaluated consumer data. That data is vital for understanding how (under)utilized services really are. This direct comparison of services allows our needs assessments to better evaluate the use of older adult resources and services and also begin to understand the needs of New Mexico communities. As the next section will briefly discuss, the academic literature offers some insight into older adult need. It also reinforces the importance of analytical depth as we have described above.

Academic Insight

Two conclusions from our review of the academic literature were critical: (1) the need to refine research practices surrounding unique older adult populations and service categories, and (2) the importance of mixed methods for obtaining high-quality data.

Some of the literature we reviewed established the importance of nuance when conducting needs assessments. Research that has focused on unique populations of older adults—as with age cohort, disability, sexual orientation, Alzheimer's, and race and ethnicity—has found that unique service needs can exist. Research by Malonebeach & Langeland (2011) attempted to tease out needs among the newest older adult cohort—Baby Boomers. Born between 1946 and 1964, Baby Boomers have unique socio-economic characteristics compared to other age cohorts. They generally live longer, have higher levels of education, homeownership, and income (Pew Research Center 2020; Malonebeach & Langeland 2011; Crimmens et al. 2009; Manton, Gu & Lowrimore 2008). 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%) (122-23*). And more importantly, over two-thirds (68%) of boomers indicated that they *fully intended to utilize senior centers*, and ***half*** expect to either visit senior centers in order 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. echoed those sentiments about greater diversity in their study on LGB older adults—the largest and most nationally representative survey of LGB older adults in the U.S. They 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: 58). 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 greater caregiver assistance, counseling, etc.

Research by Yorkston and colleagues (2010) has also determined that the experience of aging is fundamentally different for those with disabilities. Particularly, the needs of older adults who have lived with 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: 1700). As one participant explained, 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 2010: 1700). To this point, respondents emphasized that support and assistance were central to their ability to cope with changing abilities. The authors explained that "*maintaining control was critical to [older adults'] emotional well-being*" (Yokston et al. 2010: 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: 226). Latinos too 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 significantly than others. Tucker-Seeley et al. (2016) concluded that 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*" (227). As we turn to next, our birds-eye view of the literature also suggests that surveying the needs of older adults necessitates multiple perspectives through multiple methods.

Mixed Methods are Vital

In line with our evaluations of the best SUA and AAA needs assessments, the academic literature also suggests that the most comprehensive needs assessments are mixed methods. Mixed method assessments are deeply informative because they can establish both "breadth" and "depth" about the topics they investigate. Some research methods like surveys can be implemented quickly and more broadly distributed to a target population. In contrast, focus groups can devote more energy to uncovering greater detail—the *why* and *how* people think and act—with fewer samples and more specific populations. In equal measure, surveys and focus groups together can complement the strengths and weaknesses of the other. As Chernesky and colleagues explain, "*information gathered through multiple methods results in a fuller and more accurate identification and description of individual needs and greater precision in setting priorities among [older adult] needs*" (2008: 116).

The needs assessment by Chernesky et al. (2008) collected extensive data from 304 in-person interviews with randomly selected older adults (ages 65-97), six focus groups with 53 service providers, surveys of 361 service provider organizations, and in-depth interviews with key informants. They focused on older

adult need for personal care, caregiving, and healthcare services (including mental healthcare). Chernesky et al. discovered that older adults tend to describe a very different set of needs than the providers who offer them social support services. While most older adults indicated that their greatest area of need was transportation assistance (21%), they also indicated that they received daily help for personal bathing and washing from *family caregivers* (2008:118-19). Capturing the older adult perspective therefore indicated that while yes, their needs were being met, they were being met by *unpaid family members*. Only capturing service providers would have indicated that the older adult needs actually included adult daycare, respite care, assisted living facilities, and caregiver assistance. The distinction made here between service providers and older adult responses is an important one—it underscores the importance of capturing multiple perspectives through multiple tools. Mixed methods assessments naturally accomplish this and can provide important information about need.

Overall, most academic needs assessments, regardless of methodology, did find similar concerns and needs among older adults— the need for (1) greater caregiver assistance and support, (2) greater transportation options, (3) expanded affordable housing options, (4) increased opportunities for socialization, and (5) better access to affordable medical care and long-term care services. While the *priority of needs* varied, the distribution of need is highly dependent on the community and population in question. Attributes that separate contexts like rural from urban, or poor from rich, fundamentally reorder what communities will identify as vital for aging well. For this reason, it's important for policy decision-makers to go beyond identifying services that are most used, and begin to ask what services are *most desired*. To answer that crucial question, multiple methods ensure that service priorities are triangulated and balanced among stakeholders, service recipients, and service providers. The research we have summarized here highlights the importance of need assessments to remain sensitive to unique older adult populations. One-size-fits-all service models are likely to neglect the critical needs of vulnerable older adults.

Lessons Learned

In light of the reviewed literature, we propose four best practices for conducting needs assessments: (1) that needs assessments follow a three-stage framework that includes pre-assessment community observations and fact-finding missions (field observations, informal interviews, etc.), (2) that needs assessments commit to mixed methods which integrate, at the very least, U.S. Census data, focus groups, and surveys, (3) that focus groups remain sensitive to unique subpopulation needs (disability, sexual orientation, race, income, urbanization, etc.), and lastly, (4) that focus groups avoid becoming extensions of survey data, and therefore inform survey design, or vice versa.

Informed by these best practices, the Institute for Social Research's Center for Applied Research and Analysis proposed to accomplish the following in this pilot needs assessment:

(1) Implement a mixed-methods needs assessment that integrates the following data sources: U.S. Census Bureau data, NM ALTSD program and policy records, WellSky consumer data, and community focus group and survey data.
(2) Conduct focus groups within multiple communities that capture diverse older adult and service provider perspectives.
(3) Informed by focus group data, design and implement community-wide surveys among older adults and service providers.
(4) Compare WellSky consumer data to the NM ALTSD program and policy records.

(5) Develop a needs assessment protocol that could be conducted every 3-4 years to guide Area Plans—with the possibility of following Central Massachusetts and Colorado's ability to develop historical data and region-specific trends.

METHODS

Our report assesses older adult need by collecting information from multiple sources. In total, we collected data from six separate sources: (1) the U.S. Census Bureau, (2) the WellSky consumer database, (3) NM ALTSD Budget and Expenditure information, (4) a service provider survey, (5) a focus group, and (6) field observations.

U.S. Census Data

The U.S. Census Bureau collects nationally representative data about the U.S. population and economy through the decennial census and other more frequently deployed surveys. Our report analyzes data specifically from the American Community Survey (ACS). The U.S. Census Bureau implements the ACS by sending mailout, telephone, and in-person surveys (along with non-response follow-up procedures) every month. At the end of each fiscal year, monthly data is aggregated into one-, three-, and five-year ACS survey estimates. ACS sampling frames are constructed from the Master Address File (MAF), which is maintained and continuously updated by the United States Postal Service (USPS) and U.S. Census Bureau. The ACS ultimately captures "*all 3,143 counties and county equivalents in the U.S., including the District of Columbia, as well as…the 78 municipalities in Puerto Rico*" (U.S. Census Bureau 2014:32).

However, the ACS does not always collect the same information from one year to the next, which has made it difficult to produce statistical analyses from the same ACS survey estimates. Our report adapts to this limitation by retrieving the most recent ACS 5-year estimate available for the topical area. Our needs assessment analyzes the most current 2014-18 ACS estimates for the older adult population and simple demographic details. More niche details like poverty variation and older adult living arrangements are alternatively captured by the second-most recent 2013-2017 ACS estimates. Table captions included in this report specify which ACS estimates are utilized. The authors would like to make a final note that in the course of our research, the U.S. Census Bureau migrated its data from the American Fact Finder website (AFF) to the new U.S. Census Data Explorer. All data in this report have been retrieved through the new U.S. Census web portal, except for one data point retrieved from New Mexico's Indicator-Based Information System, or NM-IBIS.

Consumer Data—WellSky (formerly SAMS database)

In addition to U.S. Census data, the New Mexico ALTSD provided UNM ISR's CARA with the official consumer service data they collect. This centralized data collection system is collectively termed WellSky—named after the private company which manages the software and server-side of this database. We coordinated with state officials from ALTSD to collect the Fiscal Year 2019 service data that included: Consumer ID, service categories and subcategories, service units, provider names, and Planning and Service Areas (PSA). State officials deposited the WellSky service data we ultimately obtained into a secure UNM server for analysis. Analyses were performed using IBM SPSS 26 statistical software.

NM ALTSD Policy/Budget Documents

Our needs assessment included a review of older adult service budgets and expenditures. Particularly, we sought to compare data on service providers' contractual obligations to the services they provided. That same data was the basis for developing an inventory of service costs throughout the state—that is, determining whether a service (e.g., congregate meals, respite care, etc.) costs more or less in Roswell compared to Albuquerque. The budget and expenditure documents we obtained were provided by the non-metro and Albuquerque/metro AAAs. We employed Microsoft Excel software to organize budgetary and policy data for simple comparisons, as well as a simple cost analysis.

Service Provider Survey

To better understand service provider perspectives, ISR staff—in collaboration with NM ALTSD administrators—conducted a three-week online survey with service providers throughout New Mexico. Our original research design included a series of focus groups that would have informed our design and implementation of surveys among older adults and service providers. But in light of COVID-19 social distancing rules and restrictions, our research team was unable to hold focus groups. Adapting to the changing context, we instead developed and implemented an entirely online survey among service providers. New Mexico's ALTSD provided the ISR with contact information for all service provider organizations' program directors. Our research team contacted 69 program directors through e-mail and asked for the contact information of any staff who has meaningful interactions with older adults and adults with disabilities. Sixteen (16) program directors responded with additional staff e-mails. In total, we invited 170 service providers to complete our survey.

The final survey is available in Appendix D. Our survey explored three issues: (1) the unmet needs of older adults and adults with disability, (2) gaps in services or service coverage among older adults and adults with disability, and (3) the impact of COVID-19 on service provision. The online survey consisted of 23 multiple choice and open-ended questions available through the Opinio e-survey software. Our online survey was restricted by e-mail invitation and was open to service providers from May 7th to May 28th, 2020. Reminder invitations were automatically sent out on May 11th, 14th, 18th, 22nd, and 26th. We further incentivized participation by offering one random participant, for every 10 submissions we received, a $25 Amazon gift card sent electronically to participants' self-reported e-mail addresses. Ultimately, we achieved a response rate of 61.2% (104/170 invitations).

Field Observations

In preparation for holding focus groups with older adults and service providers, our research team was able to conduct preliminary visits to three of six research sites: Moriarty, Gallup, and Taos. Our field visits served as 'fact finding missions' to establish contacts with senior center and service provider officials, recruit older adult participants, evaluate the best locations to hold focus groups and obtain information about the local older adult populations. Our research team developed a Field Observation protocol for recording details associated with each site, which can be found in Appendix E. We briefly discuss important findings from these field observations in our content analysis of the Tucumcari Data Center focus group.

Focus Groups

As noted earlier, our original research plan intended to capture the perspectives of service providers and older adults through 32 focus groups across six research sites: Bernalillo County, Moriarty, Gallup, Taos,

Hobbs, and Las Cruces. However, the COVID-19 health restrictions and social distancing guidelines prohibited us from completing this feature of our pilot need assessment. ISR staff managed to hold one focus group in February 2020 before restrictions went into effect. This focus group was held with the North Central New Mexico Economic Development District's (NCNMEDD) Tucumcari Data Center staff. We recruited 9 of 10 consumer coordinators to help us better understand WellSky data processes and quality as well as their daily work tasks and workload.

Participants completed pre-surveys (Appendix F), which included asking participants to provide the total number of years they had worked as consumer coordinators and the number of years they worked specifically with ALTSD or NCNMEDD. Our research team followed prescribed standards for semi-structured focus groups regarding the number of participants, structure, data analysis, and format (Uwe 2018; Rog and Bickman 2009; Barbour 2007; Morgan 1996). Four researchers were involved: a facilitator, co-facilitator, and two note-takers/observers. Our design attached specific responsibilities and duties to each of these 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, which elicited greater responses and details from our participants. Our co-facilitator monitored the focus group discussion to ensure that questions in our focus group guide were not neglected and also assisted the facilitator in encouraging participants' involvement. The two note-takers/observers served to more closely document group behaviors, outline the group discussion as it occurred in real-time, and take notes about the physical space and organization of participants and behaviors. Note-takers also ensured that participant consents and pre-surveys were completed. The Tucumcari Data Center focus group lasted a total of 87 minutes, was audio recorded and professionally transcribed.

To interpret the results of the Tucumcari Data Center focus group, the authors conducted a content analysis of the focus group transcription. Two researchers engaged in thematic coding of this 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. Both researchers collaborated to integrate, collapsing, and expand the coding categories for qualitative analysis.

FOCUS GROUP ANALYSIS

Because of the COVID-19 health crisis and social contact restrictions, the 32 older adult and service provider focus groups we had planned to conduct were not possible. However, as part of our pre-assessment plan to collect information on older adult service processes we coordinated a focus group with 9 consumer coordinators at the North Central New Mexico Economic Development District (NCNMEDD) Tucumcari Data Center. Our purpose in holding this focus group was to better understand WellSky (formerly SAMS) service data processes, collection, and quality. As the centralized hub for consumer data, the Tucumcari Data Center collects information from providers about services rendered. For a complete list of the questions, refer to our focus group guide in Appendix C.

Our primary purpose for conducting the Tucumcari Data Center focus group was to better understand WellSky data quality and service provider reporting requirements. We did not intend to perform content analyses on this data. However, in light of COVID-19, we have done so. Our report remains a pilot

demonstration of a scientifically-informed needs assessment. The following section should serve as a proof-of-concept for what our analysis might have looked like.

Our analysis of the Tucumcari focus group revealed three central themes: (1) Data validation processes and the prevalence of service data errors and corrections, (2) The effect of data ignorance and how to maintain reliable service data, and (3) Key recommendations for improving older adult services and data quality.

Data Errors and Issues

Like any data collection process, mistakes and errors are an inevitable challenge to overcome. In the Tucumcari Data Center case, data collection involves interacting on a monthly basis with service providers throughout the state of New Mexico. This requires managing consumer data from over 150 service provider sites. The sheer size of this network means that there are many avenues for mistakes and errors to be made. Our focus group with consumer coordinators suggests that while data errors may happen frequently, they tend to be manageable and resolved quickly. Data errors that consumer coordinators referred to most often centered around transmittal submissions, assessments/reassessments, and congregate or home delivered meals.

As we came to better understand the role of what kind of documents service providers report to the Tucumcari Data Center, participants explained that transmittals require significant validation. These documents—transmittals—contain a service count and roster of consumers. As transmittals are received, consumer coordinators ensure that adequate and accurate consumer information has been provided. That information is then reconciled with program eligibility requirements. One participant described this process in detail—

> So, the reassessment comes to be worked. It's been checked-in. It's in our reassessment folder. The validation will come in. I would open it up, and the consumer listed on the validation log, I would review it and make sure all of the information I need is there. I would make sure or see what services they are needing that either wasn't updated or it was an error. Maybe [the consumer] didn't request [the service] because we've had that happen. So, I would go review the file to see what's going on.

Participants described for us how data errors generally centered around consumer service units—for example, the actual number of congregate meals someone received—and reassessment deadlines, which are the recurring evaluations that quantify an older adults' need for support. Mistakes made in those two program areas (congregate meals and reassessment) ultimately prevent service providers from receiving their reimbursement through the WellSky system and must be corrected by data center personnel. In fact, *no* data regarding a consumer can be entered once an error appears. One focus group participant elaborated—

> Yeah, [they enter the units] into the WellSky database. ***If they are getting an error on that consumer…they are not able to do any of that data.***

Participants also explained why this error might occur—

> But the reason they can't enter their units is because maybe we didn't update an end date or we didn't update something…There's an end date on the services that way we kind of make sure that the providers stay in compliance with the state rules. That's when [other focus group participant] was talking about the reassessment dates.

Consumer coordinators emphasized that their primary role in many data error situations was to safeguard compliance with state standards—in the case above, the reassessment of older adult need in 3, 6, or 12-month intervals. Participants explained that in these situations, service providers cannot receive reimbursement until compliance is met. Following this, we asked our participants whether there were ever cases in which data errors were simply never resolved. Our focus group members explained, rather definitively, that all data errors are invariably corrected—

> [Participant 1]: No. For the most part, they have to be corrected prior to assigning them because…
> [Participant 2]: That's how they get paid.
> [Participant 1]: That's how they get their reimbursement…

Error resolution is not without its causalities, though. Error corrections can cost service providers dearly. One participant detailed an emblematic case in which one service provider had *overestimated* nearly 400 units of services for a single month. They described for us how they were able to validate this—

> Typically, when we enter a service plan for a meal, we put 25 units. Now, that doesn't mean they can only get 25 units. They can get more. For instance, February is 28 days. Well, if it's a congregate lunch, which is only served Monday through Friday, they are not going to get 28 congregate lunches. You are only going to get Monday through Friday. So, say there's 20 weekdays on a congregate roster, they should not exceed 20 units for one.

According to our focus group, their ability to validate services is a relatively newer possibility. Data validation has been limited in the past because it did not require service providers to specify the services consumers received when seeking compensation. Participants detailed that standards had instead expected data center personnel "*just to know*" which services were provided.

Most consumer coordinators agreed though that the majority of data errors and mistakes were not attempts by providers to receive greater compensation. They explained that typically the same type of mistake occurs in which "1" unit has obviously been double-entered as "11" units. But with that said, participants did illustrate a cogent example of how one service provider attempted to receive greater compensation than allowable. They depicted for us how home-delivered meals had become a vehicle for reimbursement by designating some recipients as "unregistered guests." That is, while 10 people were registered to receive meals, 22 unregistered guests were sought for reimbursement—

> Yes. So, that's a recent finding because that lady quit…In talking to [service provider], she stated that yes…well, they hadn't had unregistered guests since last year sometime. And so, that's why she was actually going through and recording extra units for other consumers. So, they didn't actually receive that meal. ***She was just wanting to [get] reimbursement for it from another consumer because [reassessments] they weren't up to date.***

But the role of 'unregistered guests' has a similarly profound effect on the quality and interpretation of consumer data in the WellSky database. The prevalence of unregistered guests makes it nearly impossible to differentiate consumers from one another. For example, whether two people received 500 congregate meals over 12 months or whether 1,000 people received one congregate meal. And in light of dubious cases like the one quoted above, it can be difficult to determine whether services were

even received at all. As one participant put it, "*Yeah, we don't really know because we don't see their heart*."

Field observations from our research team's visit to Gallup's senior center revealed that making any assumption about current consumer data is fraught—even simply assuming that consumers are community residents or New Mexico residents. Informal conversations with older adults and staff indicated that Gallup's senior center serves older adults from many outlying communities like Arizona and other neighboring states, as well as many Navajo Nation and Indian Pueblo residents. While it is beyond the current assessment scope to determine how frequently services are provided to non-New Mexico or non-community residents, similar conversations with older adults in Moriarty reinforced this finding. According to older adults and staff at the Moriarty senior center, their facility was closed for an extended period of time in 2019. During that time, residents described traveling to several other nearby sites in Torrance county and even Bernalillo county to access older adult services. This 'community switching' has obvious implications for older adult facilities, which may be funded in proportion to older adults' official count within city limits or the PSA. As we turn to next, a major theme of our Tucumcari Focus Group was indeed the role of ignorance in consumer data estimates.

Data Ignorance

Despite the checks and balances that consumer coordinators have in place, in many cases, participants described needing to *trust* that the data they receive from service providers was accurate. This 'data ignorance' and their need to trust the data was much less about what participants *didn't know*—consumer coordinators were, in fact, very knowledgeable—rather, it captures what data center personnel simply *could not know*. Focus group participants detailed that it is often not possible to confirm whether data was factually correct because they do not observe its collection first-hand. This disjunction between data quality and trust was most clearly expressed in one participant's depiction—

> And that's another thing I was going to mention, things that we can't be sure of yet. ***When somebody sends in a reassessment, we don't know that they actually interviewed that person. There's no way for us to know that.*** *Because all we have to look for is to make sure there's two signatures. The person that's conducting the assessment and the [older adult], the consumer that's going to be receiving the services.*

Datacenter personnel reiterated that they could not 'see into service providers' hearts,' they must instead trust that data is legitimately and accurately collected. To that effect, participants explained that the quality of service data was dependent upon service providers, who handwrite many of their notes about older adults and the needs they might have. When we asked participants how they might verify the authenticity or accuracy of the assessment/reassessment notes, they elaborated that—

> …there's no actual way to compare. If it looks correct and if everything matches up, there's no actual way to confirm because we're not going to call and question everything. ***We kind of have to take their word for it.***

The fact that much of the data accuracy is left up to service providers indicated to our research team that exploring providers' work processes was vital to understanding how older adults even begin to gain access to broader support and assistance. It remains deeply unclear what aspects of older adult need providers are (or aren't) able to evaluate in their assessments/reassessments. In an emblematic example, consumer coordinators described for us how assessment/reassessment documents

occasionally leave out critical details that would make someone eligible for services. In these cases, the reality of an older adult's circumstances reveal a more complicated picture of older adult need—

> ***They might not qualify immediately based off what [service provider assessments] provided. But as [other participant] was saying, you call.*** And so, they might be…their notes might show that they drive. They can prepare a meal but maybe they are low on funds. They don't have the money. So, you ask them why they don't come to the center? For instance, they will say well, it's in the best benefit we've seen in the other consumers for them not to come eat because of hygiene. Maybe it's their own benefit because they drool. Maybe they have social anxiety. So, they can't…

It is important to note here that we are unable to determine at this point, with any degree of confidence, how often these situations occur or *why* they occur. But the rich conversation our team had with data center personnel left us with fundamental questions regarding the integrity of the service data that consumer coordinators receive, and what challenges providers may face that influence which details they do ultimately document. It is, however, evident that providers do sometimes fail to collect information that would otherwise demonstrate an older adult's eligibility to receive services. As our participants described—

> [Participant 1]: So, they would still qualify but they failed to tell us that [information]. So, then we would just update the assessment to give those details. And then, we would approve…
>
> [Participant 2]: But a lot of that stops before it ever gets to us. Like not qualifying because the providers know…
>
> [Participant 1]: ***We don't know how many people they send away.***

In conjunction with their uncertainty, our participants did reiterate many times that service providers, as a whole, still reflected a profoundly empathetic and caring class of support workers—

> I think for the most part, [service providers] try to be honest. It's not a retail industry or a sales industry. ***This is a service industry where they are providing a service for a needy population. I think a lot of the people, maybe not all of them, but a lot of the people that the provider is working with…the providers in this profession honestly want to take care of these people.*** They honestly want to do the very best they can for the aging population.

But a complicated picture of older adult needs remains that warrants further research— much of the service provider workflow remains elusive. The trust our participants exhibited for service providers appeared to be born out of necessity; as our participants described in an earlier quote, they can't call everyone to verify data accuracy. And as we have described throughout our report, our focus group with data center personnel was a prelude to holding further focus groups with service providers and older adults. Our analysis here reveals that need assessments should address how eligibility is actually determined by service providers and that critical limitations and caveats may exist with current consumer data. Although uncertainties persist regarding the reliability of service provider data, consumer coordinators seemed to be acutely aware of these issues. So much so, that they offered thoughtful recommendations about how administrators and policy-makers might resolve some of them.

Recommendations

Our focus group participants made two critical suggestions which they felt would improve older adult services. As a part of our discussion on errors and data ignorance, data center personnel suggested that hands-on training for providers could improve workflow and data accuracy—

> The trainings that we do for the providers are large groups most of the time. There's been a few small groups like Valencia county and the city of Santa Fe…It was all the same training and it was all within a couple of months. But those large group trainings, it's more taking notes and kind of trying to…***even though they understand to a point, a lot of it is not hands-on. So, we are not in there showing them through the database.***

Continuing this concept of hands-on support, participants described how recent updates to their workflow process now means that service providers are divided-up among consumer coordinators, who operate as a single point of contact with the data center. Their recommendation was to establish service provider trainings in the same fashion—

> I think it would be beneficial though for us on our end to go [train providers]. Because now, they have it where we all have point of contacts because there are a mass amount of providers that we service. So, now [our administrators] kind of broke it down to where you have four, you have five and like that and so on all the way down the line. ***These providers, we are their point of contact. So, if they have any in-depth questions on how to do something or enter something or whatever, now they are going to the direct person instead of just calling and whichever one of us answers the phone.*** Now, we are kind of trying to get a little more personal.

Other participants shared their agreement for this recommendation—

> [Participant 2]: I kind of think it would help if we got to go to each of the ones that we were [point of contact for]…
>
> [Participant 1]: If we got to meet them.
>
> [Participant 2]: Yeah. Or at least our own [group of providers], yeah.
>
> [Participant 3]: Yeah, our own [group of providers]. Instead of all of us going to every single one.

Consumer coordinators also pointed out that a prominent issue for providers is high rates of employee turn-over. A single individual working for a service provider may be the only employee trained in data center procedures, who may then later separate from that organization—

> [Participant 1]: Even if we got out there and trained every one of them, tomorrow there's going to be new people coming in.
>
> [Participant 2]: Yeah, there's a lot of turnover…

Participants offered a second recommendation that aimed to address this issue of employee turnover: visiting and meeting with service providers directly and training an entire site—

> [Participant 1]: Yeah. So, just visiting the sites to [get service providers to] better understand that.
>
> [Participant 2]: We never been there.
>
> [Participant 3]: We have never done that.
>
> [Several talking at once]
>
> [Researcher]: Would that be helpful?

[Participant 1]: I think so.

[Participant 2]: I think so too.

[Researcher]: How?

[Participant 3]: To show them and teach them.

[Participant 2]: Because the trainings that we do have sometimes, only a few get to go.

[Participant 1]: ***Yeah, only one person from this site and one person from this site. And then, they don't necessarily share back what they learn and tell everybody what they learned. They will just keep the knowledge for themselves.***

Altogether, our focus group with the Tucumcari Data Center consumer coordinators unveiled critically important details about older adult eligibility for services and the integrity of ALTSD consumer data. It is our conclusion that further research should be conducted to better understand three things: (1) How self-reported older adult need compares to the needs addressed by assessments/reassessments and WellSky consumer data, (2) How service providers appraise older adult need, and (3) What challenges providers experience in assessing need and providing services. In truth, our investigation was cut short by COVID-19 health restrictions and our conclusions are unfortunately limited and broad—conclusions that, under normal circumstances, would have led to a more sophisticated exploration of older adult need. This would have been achieved by conducting focus groups with service providers in various locations across the state to better understand the delivery of services. Another way is through conducting surveys or interviews with the stakeholders themselves to help identify needs and gaps in services. Overall, the authors intent for this section is to serve as an analysis of a single pilot focus group, which they hope provides readers with a glimpse into the level of detail our focus group research is capable of providing policymakers and, more generally, need assessments.

ISR SERVICE PROVIDER SURVEY

As described in detail in the methodology section, we conducted a three-week survey among 170 New Mexico older adult service providers. The following section details the three-week online survey results and the 104 service provider responses we received.

Respondents' Experience with Aging and Long-Term Services

Respondents were asked to reveal how much experience they had with aging and long-term services in order to better capture survey respondents' knowledge about ALTSD services and the target population. Respondents were specifically asked to indicate how long they have worked with older adults or adults with a disability. One-hundred (100) out of 104 respondents reported their years of experience, with most respondents (36%) having between 1 – 5 years of experience with older adults or adults with a disability. About 20% had 6 – 10 years of experience with this population, and another 24% between 11 – 20. Overall, the vast majority of respondents (80%) had between 1 – 20 years of experience, with the average respondent having nearly 13 years' worth of experience with older adults or adults with a disability. Roughly one-fifth (19%) of our surveyed providers had extensive experience— more than 20 years. Two of the respondents had less than one year of experience with the target population. Respondents were also asked about their experience with their current service provider organization. About 50% of surveyed providers indicated they had worked for the same agency for between 1 – 5

years. The other bulk of surveyed providers (49%) had between 6 – 39 years of experience at their current agency. And as with the previous question, only two respondents had less than one year of experience with their current agency. On average, surveyed respondents had nearly 9 years of experience with their current organization, and half of all respondents had more than 5 years of experience. A single respondent reported they had more than 50 years of experience.

Survey Respondent Services Profile

To capture more intricate details about service providers, we also asked several open-ended and free-response questions which providers could elaborate on. One question attempted to capture the services that respondents represented. Providers could select up to thirty-nine (39) separate services and were allowed to make multiple selections. Providers ranged from offering just a single service (e.g., transportation or health and disease prevention) to twenty-three (23), with ninety-97 of our 104 survey respondents (93%) selecting at least one service category. About 50% of survey respondents reported providing four or more different services, with the average provider offering about six. Out of the 97 older adult service providers who answered this survey question, none offered either loans of durable medical equipment or caregiver support, specifically through supplies or vouchers. Table 5 reflects the distribution of services our survey respondents identified with. Overwhelmingly, respondents generally reflected providers who offered congregate and home delivered meals (73), access services (57), in-home services (42), caregiver support (36), health promotion, and disease prevention services (23), and legal assistance (22).

Table 4. Service Provider Experience with Aging and Long-Term Services

	Experience with Older Adults or Adults with Disability		Experience with Current Agency	
Years	**Number**	**Percent**	**Number**	**Percent**
0	2	2%	2	2%
1 - 5	36	36%	48	48%
6 - 10	20	20%	22	22%
11 - 20	24	24%	20	20%
21 - 29	9	9%	6	6%
30 - 39	5	5%	1	1%
40-50	3	3%	0	0%
50+	1	1%	1	1%
Total	100	100%	100	100%
Mean	**12.78**		**8.63**	
Median	**10.00**		**5.50**	

Table 5. Older Adult Services Provided by ISR Survey Respondents

Service Category	Number	Percent*
Congregate & Home Delivered Meals	73	75%
Access Services	57	59%
In-Home Services	42	43%
Caregiver Services	36	37%
Health Promotion & Disease Prevention	23	24%
Legal Assistance Services	22	23%
All Service Categories	97	100%

*A single respondent could offer multiple services; therefore, percentages will not total 100%. Percentages reflect the number of unique respondents who offered that service category.

Service Provider Profile of Consumer Demographics Characteristics

In order to explore older adult need profiles, we asked survey respondents to describe the demographic characteristics of the population they work with most often. Table 6 provides an overview of those consumer characteristics, as identified by surveyed providers. Respondents were able to select characteristics from seven separate categories, which included: (1) Income, (2) Disability, (3) Race, (4) Age, (5) Living Arrangement, (6) Gender, and (7) English as a Second Language. Ninety-two of the 104 respondents (88%) selected at least one characteristic to describe their typical service recipients, with the average surveyed provider selecting five out of the seven demographic descriptors. The following consumer demographic profile emerged from survey responses: typically, consumers tend to have low incomes, live with a disability (or disabilities), are White or Hispanic, are between 61 – 80 years old, live alone or with a partner/spouse, are largely female, and primarily speak English. Table 6 reports the respondent's opinions about the consumers they serve. Readers should keep in mind two aspects of our service recipient profile— (1) this profile is compiled from providers' perspectives, and (2) our profile is not consistent *across* categories, meaning that it does not describe a *single* person with all seven characteristics.

Ranking Older Adult Need

Expanding our older adult need profile, we asked respondents to go beyond demographic characteristics and identify the specific needs of older adults or adults with disability in their community. Eighty-seven (87) of our 104 survey respondents (84%) described what they considered to be the top *three* older adult needs. Table 7 summarizes their answers. Overall, providers ranked nutrition (68%), transportation (59%), and social interaction (43%) as the greatest service needs of older adults. Responses that identified nutrition as a top need specifically depicted *food* and *meals*, *nutrition*, or *congregate* and *home delivered meals* as important resources.

Similarly, survey responses that identified transportation as a top older adult need explicitly described *transportation*, *errands*, *assisted transportation*, or *consistent transportation* in their depictions of this resource. And lastly, respondents overall ranked social interaction as the third greatest older adult need and did so through descriptions that emphasized older adult *isolation*, *companionship, comradery*, *socialization*, *social or personal contact, stimulation, and community inclusion* as vital supports for this vulnerable group. Beyond these top three needs, in-home services (30), health and medical assistance (20), physical fitness (10), and financial assistance (7) were all substantial categories of help that survey respondent identified.

Table 6. Service Provider Profile of Service Recipient Population

Service Recipient Characteristics	Demographic Categories	Number	Percent
Income	Low Income	61	82%
	Middle Income	9	12%
	High Income	4	5%
Disability	No Disability	8	12%
	Lives with a Disability	47	68%
	Lives with 2 or more Disabilities	14	20%
Race and Ethnicity	Hispanic	37	51%
	Native American	2	3%
	White (Non-Hispanic)	28	39%
	Other	5	7%
Age	50-60	2	2%
	61-70	29	35%
	71-80	43	52%
	81-90	8	10%
Living Arrangements	Lives Alone	52	74%
	Lives with Spouse or Partner	16	23%
	Lives with family	2	3%
Gender	Female	38	67%
	Male	11	19%
	Other	8	14%
English as Second Language	English	65	78%
	English as Second Language	18	22%

Table 7. Greatest Service Needs of Older Adults Identified by Service Providers

Service Category	Number	Percent*
Nutrition	59	68%
Transportation	51	59%
Social Interaction	37	43%
In-Home Services	30	34%
Health & Medical Assistance	20	23%
Physical Fitness/Exercise	10	11%
Financial Assistance	7	8%
All Services Categories	87	100%

*A single respondent could select up to three support services; therefore, percentages will not total 100%. Percentages reflect the number of unique respondents who identified a service category.

Meeting Older Adult Need & Adapting to COVID-19

In designing our survey, we wanted to capture whether service providers felt they are able to meet the needs of older adults or adults with a disability within their service area. We also wanted to better understand whether service providers felt that a significant number of older adults or adults with a disability could use greater support and services. It was also clear to us the COVID-19 pandemic has had an unexpected and intense effect on many industries, especially older adult services. For these reasons, we also aimed to capture the impact the current public health crisis has had on service provider business practices and older adult needs. In order to explore the first two topics, we asked survey respondents to indicate their level of agreement with the following two statements:

Statement 1: The service(s) my agency/organization currently provides are able to meet the needs of older adults or adults with a disability within my community.

Statement 2: More older adults or adults with a disability could use my agency/organization's help and/or services, but certain barriers prevent them.

Additionally, we asked respondents to indicate the degree to which the following two questions about COVID-19's negative impact was true:

Question 1: To what degree has the current pandemic (COVID-19) negatively affected your business practices for providing services to older adults and adults with a disability?

Question 2: To what degree has the current pandemic (COVID-19) negatively affected need among older adults and adults with a disability?

For the two statements, providers could select five Likert-scaled responses ranging from 'Strongly Disagree' (0) to 'Strongly Agree' (4), as well as 'Don't Know/No Response.' For the two questions above, respondents could choose five Likert-scaled descriptors ranging from 'Not at All' (0) to 'Extremely' (4), as well as 'Don't Know/No Response.' Refer to Appendix D to view the full range of responses and their code schemes.

Ninety-one (88%) providers responded to Statement 1, with over two-thirds of respondents (69%) agreeing or strongly agreeing that their agency/organization is meeting their populations' needs. On average, (2.64), participants were conflicted about the statement, neither agreeing nor disagreeing. To that effect, roughly one-fifth of participants (19%) disagreed or strongly disagreed, revealing that a significant minority of service providers believe that they are unable to meet the needs of older adults in their communities. Despite this, 82 (79%) service providers responded to Statement 2 and revealed that while most feel they are able to meet the needs of older adults in their communities, two-thirds of providers (66%) still believe that barriers exist for older adults or adults with a disability who need social support. Once again, the average participant remained conflicted—neither agreeing nor disagreeing—but notably, only 15% of respondents disagreed with Statement 2, with just a single respondent strongly disagreeing.

Table 8. Descriptive Statistics for Likert Survey

Survey Item	Mean	Median	Mode	N
The service(s) my agency/organization currently provides are able to meet the needs of older adults or adults with disability within my community.	2.6	3	3	91
More older adults or adults with disability could use my agency/organization's help and/or services, but certain barriers prevent them.	2.7	3	3	82
To what degree has the current pandemic (COVID-19) negatively affected your business practices for providing services to older adults and adults with disability?	2.6	3	4	83
To what degree has the current pandemic (COVID-19) negatively affected need among older adults and adults with disability?	2.8	3	3	83

Table 9. UNM Service Provider Survey Responses

Survey Item	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Don't Know/ Didn't Answer
The service(s) my agency/organization currently provides are able to meet the needs of older adults or adults with disability within my community.	0	1	2	3	4	N/A
More older adults or adults with disability could use my agency/organization's help and/or services, but certain barriers prevent them.	0	1	2	3	4	N/A
	Not at All	**Slightly**	**Moderately**	**Very**	**Extremely**	**Don't Know/ Didn't Answer**
To what degree has the current pandemic (COVID-19) negatively affected your business practices for providing services to older adults and adults with disability?	0	1	2	3	4	N/A
To what degree has the current pandemic (COVID-19) negatively affected need among older adults and adults with disability?	0	1	2	3	4	N/A
	No	**Yes**	**Don't Know/ Didn't Answer**			
Does your agency collaborate with other state agencies to ensure that senior needs are met?	0	1	N/A			

COVID-19 Impact on Service Providers

Considering COVID-19's effect on aging and long-term services, 83 respondents (80%) answered Question 1 above, with more than half (60%) indicating that the current public health crisis has very negatively or extremely negatively impacted service provider business practices. Indeed, the most common survey response for Question 1 was that service provider operations had been extremely affected (33%). The average respondent further indicated that business practices had been moderately

affected (2.61), with roughly one-quarter (23%) of all surveyed providers suggesting that COVID-19 has either only slightly impacted business practices or not affected them at all.

Providers were able to elaborate on their selections, briefly describing how COVID-19 has affected the way they operate. Overall, sixty-four respondents (77%) affirmed COVID-19 has impacted their business practices. According to respondents, the COVID-19 pandemic has shut down or canceled many of the services they provide— an unsurprising finding. About 53% (40) of respondents revealed that they had stopped providing any number of older adult services, up to and including closing down entirely. Because of this, respondents explained that profound shifts in their business models have been necessary. For many of our respondents, this transition in service design was not without pronounced strain on their personnel and financial resources. Eighteen respondents (24%) described how necessary shifts in their business operations—especially in the case of drive-thru and home delivery models—have largely undermined their workforce and their ability to employ staff. And 21% (16) of respondents described financial instability or significant challenges with solvency as a result of COVID-19.

Table 10. COVID-19 Impact on Service Provider Business Practices

Business Practice Affected	Number	Percent*
Canceled Services and Operations	40	53%
Shift in Business Practices and Models	30	40%
Personnel and Staffing Concerns	18	24%
Financial Resources and Instability	16	21%
All Business Practices	75	100%

*A single respondent could identify multiple impacts on their business practices; therefore, percentages will not total 100%. Percentages reflect the number of unique respondents per category.

COVID-19 Impact on Older Adult Need

COVID-19's impact on older adult needs has been more pronounced, according to our respondents. Eighty-three providers (80%) answered Question 2, revealing that the global pandemic on older adults or adults with a disability has been substantial. Seventy percent of respondents (58) depicted the effect of COVID-19 as very negatively or extremely negatively impacting need among older adults or adults with a disability. The average respondent indicated a moderate impact on older adult need, and just 12% of surveyed providers described older adult need as slightly impacted or not at all affected.

Again, we asked respondents to further describe the specific effects COVID-19 has had on older adult needs. Seventy-three respondents (88%) indicated that need among older adults was moderately, very, or extremely affected by the current pandemic. As we might expect, service providers largely identified socialization (52%) as the most concerning older adult need impacted by COVID-19. Respondents also generally suggested (29%) that older adult need has increased for several service categories, including meal services, and disability assistance, among others. Additionally, many service providers emphasized that social isolation has had other consequences on older adult needs. In particular, many respondents (28%) described significant effects on older adults' quality of life—all the more important, considering that 22% of surveyed providers described limited availability of crucial older adults' services, including healthcare access services and nutrition programs.

Table 11. COVID-19 Impact on Older Adult Needs

Service Category	Number	Percent*
Social Isolation	36	52%
Increased Older Adult Need	20	29%
Quality of Life	19	28%
Limited Services	15	22%
Miscellaneous	6	9%
All Service Categories	69	100%

*A single respondent could identify multiple impacts on older adult needs; therefore, percentages will not total 100%. Percentages reflect the number of unique respondents per category.

Service Provider Inter-Agency Collaboration

To better understand how service providers network with other organizations to provide services, we asked survey respondents about the interagency collaborations they have engaged in, specifically for meeting older adult needs. Respondents could answer 'Yes' or 'No,' with zero (0) indicating 'No' and one (1) reflecting 'Yes'. Of the 83 respondents, most providers (84%) revealed that they *had* engaged in collaborative efforts with state agencies. In contrast, 16% of respondents had *not* engaged in collaborative efforts. Respondents could then specifically name the agency (or agencies) they have collaborated with— Fifty-seven (57) of the sixty-eight (69) respondents (84%) who answered 'yes', also went on to list the specific agency (or agencies) they collaborated with. Responses at times varied substantially, and many providers listed collaborations with non-state entities like local non-profits, including food banks, city governments, or even federal agencies like the Federal Communications Commission (FCC). Still, respondents identified collaborations with thirty-one (31) separate New Mexico state agencies. In particular, the Aging and Long-Term Services Department (ALTSD) was the most commonly identified state agency providers collaborated with, listed for about 49% (28) of all respondents. As Table 12 illustrates, collaborations with Adult Protective Services (23), Area Agencies on Aging (20), the Department of Health (12), and various subdivisions of the Human Services Department (12) accounted for the most substantial categories of state agencies listed by providers. UNM ISR can provide a full list of agencies upon request.

Table 12. Agencies That Service Providers Have Collaborated With

Agency	Number	Percent*
Aging and Long-Term Services (ALTSD)	28	49%
Non-State Agencies	28	49%
Adult Protective Services (APS)	23	40%
Area Agency on Aging (AAA)	20	35%
Department of Health (DOH)	12	21%
Human Services Department (HSD)	12	21%
All Agencies	57	100%

*A single respondent could identify multiple agencies; therefore, percentages will not total 100%. Percentages reflect the number of unique respondents who identified an agency category.

The Future of Older Adult Need

Lastly, we tasked survey respondents with identifying future services that ALTSD should support in order to meet older adult need through 2030—the time at which New Mexico's older adult population is estimated to rank 4th highest in the U.S. Responses are summarized in Table 13. Twenty-nine respondents (39%) indicated that expanded transportation options were most vital for meeting older adult need by 2030. Additionally, twenty-five respondents (34%) identified in-home services such as assistance with chores, home cleanliness, and personal care as equally important for meeting older adults' needs as New Mexico's aging population grows. And finally, roughly one-fifth (18%) of respondents suggested that caregiver services—Adult day care, assistance for grandparents raising grandchildren, respite care, and caregiver services—would broadly reflect one of the most important support services ALTSD aims to meet older adult need through 2030.

Table 13. Future Services Providers Should Offer to Meet Older Adult Need by 2030

Service Category	Number	Percent*
Expanded Transportation Options	29	39%
Increased Availability of In-Home Services	25	34%
Increased Availability of Caregiver Services	13	18%
Increased Nutrition/Meal Funding	9	12%
Increased Support for Physical Fitness Services	8	11%
All Service Categories	74	100%

*A single respondent could be coded in multiple categories; therefore, percentages will not total 100%. Percentages reflect how many unique respondents were coded for a single category.

CENSUS DATA

To better understand the composition of the older adult population of New Mexico, various data sources were reviewed in an attempt to collect details about this population. Census data was the most readily available at the state, county, and city levels. Although additional information on topics such as food insecurity, physical activity, and transportation needs would have been ideal additions, this data was typically not available at the city or county level.

Data were compiled on the elderly population of New Mexico, the four PSAs, and the six local sites (when possible). These variables included the total population, the population 60 and older, gender, race, marital status, educational attainment, labor force participation, veteran status, poverty rates, income categories, living arrangements, receipt of food stamps or SNAP, disabilities, and leading causes of death. With the exception of the leading causes of death, the data was gathered from the American Community Survey (ACS). Most of the ACS data was from the 5-year estimates ranging from 2014 to 2018, although in some instances when data for specific locations were unavailable, the 2013 to 2017 data was used. While eligibility for ALTSD services is age 60, data were not available in a separate category for people 60 to 64 as part of higher age categories. Some data are for New Mexican's 60 and older, and some are for those 65 and older. The counts were gathered for the local sites and counties, then aggregated to the PSA level. The data on leading causes of death were compiled from New Mexico's Indicator-Based Information system (NM-IBIS). This data was aggregated to the PSA level but was not available at the local site level.

Overall Population

Based on estimates from the U.S. Census Bureau, NM's population in 2018 was just under 2.1 million people (see Table 14). The most populated PSA was PSA 2, with 744,020 people. PSA 1 was the next most populated, with an estimated population of 677,692 people. PSA 3, 4, and 6 have smaller populations, with an estimated 301,269 in PSA 3, 369,453 in PSA 4, and 77,691 across PSA 6. The largest site was Bernalillo County, (PSA 1) with 677,692 people, followed by Las Cruces, with 101,742 people, and Hobbs with 38,052 people. Gallup was the next largest at 22,015, followed by Taos (6,021) and Moriarty (2,223).

Table 14. Population by Location, 2018

Location	Population
New Mexico	2,092,434
Bernalillo County (PSA 1)	677,692
PSA 2	744,020
PSA 3	301,269
PSA 4	369,453
PSA 6	77,691
Las Cruces	101,742
Gallup	22,105
Taos	6,021
Hobbs	38,052
Moriarty	2,223

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Age

Of the 2.1 million people living in New Mexico in 2018, approximately 22.7% were 60 and older (see Table 15). The portion of the population that was 60 and older varied across the local sites. Among the five PSAs, the proportion of this age group ranged from 20.5% in PSA 3 to 24.3% in PSA 2. In the six selected sites, this age cohort comprised between 14.2% of the population (Hobbs) and 32.9% of the population (Taos).

Table 15. Population 60 and Older by Location, 2018

Location	% 60 and Older	Count 60 and Older
New Mexico	22.7%	474,147
Bernalillo County (PSA 1)	21.5%	145,554
PSA 2	24.3%	181,036
PSA 3	20.5%	61,627
PSA 4	23.3%	85,930
PSA 6	21.1%	16,400
Las Cruces	20.2%	20,546
Gallup	18.9%	4,177
Taos	32.9%	1,981
Hobbs	14.2%	5,419
Moriarty	19.3%	429

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Of the 2.1 million people living in New Mexico in 2018, approximately 16.3% were 65 and older (see Table 16). Among the six sites, Taos had the highest portion of the population who were 65 and older at 25.0%; and among PSAs, PSA 6, with those 65 and older comprising 18.1% of the total population.

Table 16. Population 65 and Older by Location, 2018

Location	% 65 and Older	Count 65 and Older
New Mexico	16.3%	341,515
Bernalillo County (PSA 1)	15.2%	103,210
PSA 2	17.4%	129,488
PSA 3	14.7%	44,285
PSA 4	17.5%	64,532
PSA 6	18.1%	14,092
Las Cruces	15.1%	15,353
Gallup	12.9%	2,843
Taos	25.0%	1,506
Hobbs	10.2%	3,878
Moriarty	14.9%	332

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Gender

For those aged 60 and older, all PSAs and local sites had a greater proportion of females than males, with the exception of Moriarty (see Table 17). In all other areas, the older adult female population was between 5.2% and 12.8% greater than that of males. Among PSAs, PSA 6 had the greatest proportion of older adult women compared to men (56.4%), while PSA 3 had the least (52.6%). And as we noted, Moriarty was the only site where this trend was reversed (43.6%), while Las Cruces had the highest proportion of older adult females (55.7%).

Table 17. Population 60 and Older by Gender and Location, 2018

Location	% Male, 60 and Older	% Female, 60 and Older
New Mexico	46.2%	53.8%
Bernalillo County (PSA 1	44.9%	55.1%
PSA 2	46.3%	53.7%
PSA 3	47.4%	52.6%
PSA 4	47.1%	52.9%
PSA 6	43.6%	56.4%
Las Cruces	44.3%	55.7%
Gallup	46.9%	53.1%
Taos	46.9%	53.1%
Hobbs	46.9%	53.1%
Moriarty	56.4%	43.6%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Race/Ethnicity

Table 18 reports race/ethnicity. In New Mexico, the population 60 and older is composed primarily of White, non-Hispanic individuals (59.6%) and Hispanic individuals (33.1%). American Indian persons

account for 5.8% of the population, 60 and older and Black persons account for 1.6%. Among the six sites, this pattern is generally consistent. However, PSA 6 has the lowest portion of Whites (20.0%) and the highest proportion of American Indian individuals (41.7%) than all other sites. PSA 6 also includes the highest proportion of Hispanic persons. Racial and ethnic variation across the six sites is substantial, with White individuals accounting for 29.5% of the Gallup population, but 61.0% in Taos. American Indian individuals accounted for 25.9% of the Gallup population and less than 1.0% in Las Cruces, Hobbs, and Moriarty. In Hobbs, Black individuals accounted for 9.0% of the population and less than 1% in Taos and Moriarty. Moriarty's population aged 60 and older was 50.7% Hispanic, while the remaining sites ranged from 30.6% in Hobbs to 37.1% in Las Cruces. Although the census data was available for all cities and counties, the categories available for calculating race are not exhaustive or exclusive and there may be some categories which are not represented, such as Asian / Pacific Islander. There may also be overlap between the American Indian and Black race category, as well as with those who identify as Hispanic.

Table 18. Population 60 and Older by Race/Ethnicity and Location, 2018

Location	% White, Non-Hispanic, Total	% American Indian Alone, Total	% Black Alone, Total	% Hispanic Alone, Total
New Mexico	59.6%	5.8%	1.6%	33.1%
Bernalillo County (PSA 1)	61.3%	2.6%	2.1%	34.0%
PSA 2	55.7%	12.2%	0.9%	31.2%
PSA 3	67.3%	1.0%	2.3%	29.3%
PSA 4	59.2%	1.3%	1.3%	38.2%
PSA 6	20.0%	41.7%	0.3%	37.9%
Las Cruces	59.6%	0.8%	2.5%	37.1%
Gallup	39.5%	25.9%	1.7%	32.9%
Taos	61.0%	2.6%	0.7%	35.7%
Hobbs	59.9%	0.5%	9.0%	30.6%
Moriarty	48.4%	0.9%	0.0%	50.7%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Marital Status

As shown in Table 19, among those 65 and older males were more likely to be married than females. Across New Mexico, nearly two-thirds (66.1%) of males over 65 were married, while only 43.3% of females were married. The higher percentage of married males compared to females is consistent across the six selected sites as well. Statewide, females were nearly three times as likely to be widowed (31.6% compared to 11.9%) as males. This higher percent of widowed females in comparison to widowed males was also consistent across the sites. Females were also more often divorced or separated (19.0% compared to 15.6%), although both males and females were never married at nearly the same rate (6.2% and 6.3%, respectively). As with married and widowed individuals, divorce and separation were higher among males across nearly all sites. This was consistent with the rate of individuals never married. As a notable exception once again, PSA 6 was the only site where the number of divorced or separated men outnumbered women—19.8% compared to 17.9%. Similarly, three locations had higher proportions of females who have never married—PSA 6, 2, and the city of Hobbs.

Table 19. Population 65 and Older by Marital Status and Location, 2018

Location	% Male Married	% Male Widowed	% Male Divorced or Separated	% Male Never Married	% Female Married	% Female Widowed	% Female Divorced or Separated	% Female Never Married
New Mexico	66.1%	11.9%	15.6%	6.3%	43.3%	31.6%	19.0%	6.2%
PSA 1	64.7%	11.3%	17.1%	6.9%	39.6%	32.6%	22.2%	5.7%
PSA 2	65.5%	11.5%	16.4%	6.6%	44.3%	29.4%	18.1%	8.2%
PSA 3	67.4%	14.9%	12.2%	5.5%	43.5%	36.7%	15.5%	4.3%
PSA 4	68.6%	11.7%	14.5%	5.2%	47.2%	30.7%	17.8%	4.2%
PSA 6	56.6%	14.0%	19.8%	9.6%	35.0%	35.9%	17.9%	11.3%
Las Cruces	71.3%	11.1%	12.9%	4.7%	45.2%	30.4%	20.0%	4.3%
Gallup	63.7%	15.0%	10.2%	11.1%	38.2%	38.6%	17.8%	5.4%
Taos	43.9%	5.0%	38.7%	12.4%	26.9%	22.6%	44.5%	6.0%
Hobbs	77.9%	11.4%	9.1%	1.6%	37.5%	48.4%	11.1%	3.0%
Moriarty	55.2%	18.6%	13.7%	12.6%	42.3%	36.9%	16.1%	4.7%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Educational Attainment

In New Mexico, 82.5% of the population 65 and older had at least a high school diploma and 30.3% had a Bachelor's degree or higher. Across the six sites, the percent of the population 65 and older with a high school diploma or higher ranged from 75.8% in PSA 4 up to 87.6% in PSA 1. The variation was even more significant in the local sites, ranging from 63.7% of the population 65 and up having a higher diploma in Hobbs, up to 93.5% in Taos. The portion of the population with a Bachelor's degree or higher was 20.2% in PSA 3 and 36.0% in PSA 1. At the local sites, the variation was even greater in the percent of the aged population with a Bachelor's degree or higher, at 8.7% in Moriarty and 46.0% in Taos.

Table 20. Population 65 and Older by Educational Attainment and Location, 2018

Location	% High School or Higher	% Bachelor's or Higher
New Mexico	82.5%	30.3%
Bernalillo County (PSA 1)	87.6%	36.0%
PSA 2	83.9%	31.3%
PSA 3	76.4%	20.2%
PSA 4	75.8%	26.1%
PSA 6	76.3%	21.4%
Las Cruces	81.4%	35.8%
Gallup	72.7%	16.8%
Taos	93.5%	46.0%
Hobbs	63.7%	19.2%
Moriarty	71.1%	8.7%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Labor Force Participation

Table 21 reports labor force participation. Among New Mexicans 60 and older, just over 1 in 4 (26.2%) were estimated to be participating in the labor force. By PSA, the percent of this age group participating in the labor force varied from 22.5% in PSA 4 up to 28.0% in PSA 1. The proportion of those 60 and older participating in the labor force varied from 20.2% in Moriarty up to 38.0% in Gallup in the local sites.

Table 21. Population 60 and Older by Labor Force Participation and Location, 2017

Location	% Labor Force Participation
New Mexico	26.2%
PSA 1	28.0%
PSA 2	26.8%
PSA 3	25.7%
PSA 4	22.5%
PSA 6	24.9%
Las Cruces	23.6%
Gallup	38.0%
Taos	32.7%
Hobbs	29.5%
Moriarty	20.2%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Veterans

Just over 1 in 5 (21.4%) New Mexicans 65 and older were veterans (see Table 22). The veteran portion of the population varied by a few percent in the six sites, from 19.5% in PSA 6 to 23.3% in PSA 4. There was greater variation across the sites. In Taos, 9.6% of the population age 65 and older were veterans, and 25.3% of those in Moriarty were veterans.

Table 22. Population 65 and Older by Veteran Status and Location, 2018

Location	% 65+ Vet
New Mexico	21.4%
Bernalillo County (PSA 1)	22.2%
PSA 2	20.4%
PSA 3	19.9%
PSA 4	23.3%
PSA 6	19.5%
Las Cruces	23.1%
Gallup	23.6%
Taos	9.6%
Hobbs	16.3%
Moriarty	25.3%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Poverty

Based on U.S. Census ACS estimates, 12.8% of individuals 60 and up in New Mexico lived in poverty – that is, with incomes lower than the poverty threshold – in 2017 (see Table 23). While the percent of individuals living below poverty varied to a smaller degree across the six sites ranging from 10.8% in PSA 1 and 14.2% in PSA 2, the variation is much higher across the local sites. The percent of those living below poverty was lowest in Hobbs (9.2%) and Las Cruces (9.5%) and highest in Moriarty (28.1%). Data for those 60 and older was not available for PSA 6, and therefore reflects the portion of those 65 and older livening below the poverty level. If the trend held true for those between 60 and 65, PSA 6 would have the highest proportion of older adults living below poverty out of the five PSAs.

Table 23. Population 60 and Older Below Poverty by Location, 2017

Location	% Below Poverty, 60 and Up
New Mexico	12.8%
PSA 1	10.8%
PSA 2	14.2%
PSA 3	11.8%
PSA 4	13.8%
PSA 6	19.7%*
Las Cruces	9.5%
Gallup	16.5%
Taos	17.0%
Hobbs	9.2%
Moriarty	28.1%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.

*PSA 6 data was not available for those 60 and up, and instead reflects those 65 and up.

Income

In order to determine income levels, we created a ratio between income and the poverty threshold and assigned income categories based on this. A score of less than 100% indicated incomes below the poverty level. Between 100% and 199% were designated low income. Middle income reflects between 200% and 399%, and high income indicates 400% or more of the poverty threshold. Throughout New Mexico, 11.9% of the population 65 and older lived in poverty. An additional 22.1% were classified as low income, with an additional 30.8% falling into the middle-income category. Of this portion of the population, 35.1% were classified as high income. Across PSAs, the percent living in poverty was lowest in PSA 1 (10.0%) and highest in PSA 6 at 19.7%. Similarly, those with low income among the population comprised 18.9% of the population in PSA 1, and 29.5% in PSA 6. There was less variation for those classified as middle income, ranging from 29.5% in PSA 6 to 32.1% in PSA 4. Those in the high-income category ranged from 21.3% in PSA 6 to 39.9% in PSA 1. It is critical to note here that PSA 6 reflected the PSA with both the highest percentage of impoverished to low income individuals, while simultaneously having the lowest percent of high-income earners.

By site, the variation was larger in certain categories. For those 65 and older, 7.9% were living in poverty in Las Cruces, while as many as 32.5% lived in poverty in Moriarty. In Las Cruces, 20.1% of older adults were low income and 29.6% in Taos were low income. Those 65 and older in the middle-income

category accounted for as low as 17.1% of the older adult cohort in Gallup and as much as 34.0% in Moriarty. Finally, the percent of the population 65 and older in the high-income category ranged from 6.9% in Moriarty to 41.8% in Las Cruces.

Table 24. Population 65 and Older by Income Category by Location, 2017

Location	Poverty	Low Income	Middle Income	High Income
New Mexico	11.9%	22.1%	30.8%	35.1%
Bernalillo County (PSA 1)	10.0%	18.9%	31.2%	39.9%
PSA 2	13.5%	21.3%	29.7%	35.6%
PSA 3	11.5%	28.6%	31.4%	28.6%
PSA 4	12.3%	24.3%	32.1%	31.2%
PSA 6	19.7%	29.5%	29.5%	21.3%
Las Cruces	7.9%	20.1%	30.2%	41.8%
Gallup	15.3%	27.3%	17.1%	40.3%
Taos	16.2%	29.6%	27.2%	27.1%
Hobbs	9.7%	25.0%	31.6%	33.7%
Moriarty	32.5%	26.6%	34.0%	6.9%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.

Living Arrangements

In New Mexico, those 65 and older s lived in various circumstances (see Table 25). Nearly 1 in 4 (24%) New Mexicans 65 and older live with a spouse. While the portion living with a spouse doesn't vary significantly across PSAs (from 22.6% in PSA 1 up to 30.8% in PSA 6), there is more variation by site, with as few as 12.9% living with a spouse in Taos and as many as 26.6% living with a spouse in Las Cruces. The majority of people 65 and older in New Mexico reside with a relative (41.9%). Across the sites however, those in this group residing with a relative comprised between 22.4% and 42.5% of the population 65 and older—PSA 6 once again representing the region with the lowest proportion. The variation was similarly large across the selected sites, with 35.4% in Taos and 45.4% in Hobbs living with relatives. A smaller percentage of people in New Mexico age 65 and older live with a non-relative (4.4%). Across PSAs, those living with non-relatives accounted for between 3.3% and 6.6% of the population that was 65 and older, while those in selected sites ranged from 0.0% in Moriarty up to 5.8% in Taos. Statewide, 27.6% of seniors aged 65 and older lived alone. There was slight variation in the percent of persons living alone--26.0% in PSA 4 and 37.5% in PSA 6-- and equally as varied across sites, with 25.1% in Hobbs living alone and 35.6% in Taos living alone. A small percent of individuals 65 and older in New Mexico live in group quarters (2.1%). Across the five PSAs, the percent of this age group living in group quarters ranged from 2.0% in PSA 2 to 2.5% in PSA 6; with the percent 65 and older living in group quarters ranging from 0.0% in Moriarty to 10.3% in Taos in the selected sites.

Table 25. Population 65 and Older by Living Arrangement and by Location, 2017

Location	Spouse	Relative	Non-Relative	Alone	Group Quarters
New Mexico	24.0%	41.9%	4.4%	27.6%	2.1%
Bernalillo County (PSA 1	22.6%	40.6%	5.1%	29.6%	2.1%
PSA 2	23.9%	42.4%	4.9%	26.8%	2.0%
PSA 3	24.6%	42.1%	3.3%	27.9%	2.1%
PSA 4	25.9%	42.5%	3.3%	26.0%	2.3%
PSA 6	30.8%	22.4%	6.8%	37.5%	2.5%
Las Cruces	26.6%	40.7%	3.0%	27.8%	1.8%
Gallup	20.7%	38.1%	2.7%	32.6%	5.8%
Taos	12.9%	35.4%	5.8%	35.6%	10.3%
Hobbs	23.5%	45.4%	3.0%	25.1%	3.0%
Moriarty	19.8%	41.9%	0.0%	38.3%	0.0%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.

SNAP / Food Stamps

In New Mexico, 12.0% of households with at least one member aged 60 or older received food stamps or SNAP in the year prior to the U.S. Census survey. Across PSAs, use of this social support ranged from as low as 10.8% in PSA 1 to as high as 20.7% in PSA 6. The percent of households receiving food stamps or SNAP in this group was higher in the sites than in New Mexico overall. In Gallup, 12.5% of the households with at least one member 60 or older received food stamps or SNAP and in Taos, 13.9% of households.

Table 26. Population 60 and Older in Household Receiving Food Stamps by Location, 2018

Location	Food Stamps or SNAP in Prior 12 Months
New Mexico	12.0%
Bernalillo County (PSA 1)	10.8%
PSA 2	11.7%
PSA 3	11.8%
PSA 4	14.7%
PSA 6	20.7%
Las Cruces	13.5%
Gallup	12.5%
Taos	16.3%
Hobbs	14.1%
Moriarty	13.9%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates

Functional Limitations/Disability

In New Mexico, 39.9% of people 65 or older have one or more of several types of disabilities, including hearing, vision, cognitive, or ambulatory difficulties and/or difficulties with self-care or independent living. Adults 65 or older with one or more of these disabilities ranged from as low as 35.9% in PSA 1 to

46.4% in PSA 6. Across the sites, the range was broader, from as low as 31.1% in Taos to as high as 51.2% in Hobbs. By category, the most common disability among New Mexicans 65 and older was ambulatory disabilities (24.8%), followed by hearing disabilities (19.3%). This pattern was consistent across all sites. In New Mexico, 9.0% of adults 65 or older had difficulties with self-care (bathing or dressing), and 16.2% have difficulties with independent living (such as difficulties running errands and such along). Self-care difficulties in the sites ranged from 8.4% in PSA 1 and 11.6% in PSA 6. Once again, PSA 6 had the highest concentration of disadvantage among all the PSA, consistently representing the highest proportion of older adults with disabilities out of any region. Among local sites, the percent of older adults with these difficulties ranged from as low as 5.1% in Taos and 14.0% in Hobbs. Rates of independent living difficulties were lowest in PSA 2 (15.5%) and highest in PSA 6 (20.5%). In the local sites, rates of independent living difficulties were lowest in Taos (8.3%) and highest in Hobbs (25.8%).

Table 27. Population 65 and Older with Disabilities by Location, 2018

Location	Hearing	Vision	Cognitive	Ambulatory	Self-Care	Independent Living	Total Disability
New Mexico	19.3%	8.7%	11.0%	24.8%	9.0%	16.2%	39.9%
Bernalillo County (PSA 1)	15.8%	6.5%	10.0%	22.9%	8.4%	15.7%	35.9%
PSA 2	20.9%	9.4%	11.9%	24.2%	8.9%	15.5%	40.3%
PSA 3	20.2%	9.6%	10.7%	29.1%	10.0%	19.1%	44.7%
PSA 4	21.0%	10.2%	10.8%	26.1%	9.3%	16.4%	42.0%
PSA 6	24.9%	13.8%	15.0%	30.4%	11.6%	20.5%	46.4%
Las Cruces	17.7%	10.5%	9.0%	24.4%	8.7%	15.5%	40.2%
Gallup	15.4%	7.2%	12.8%	29.8%	10.9%	14.5%	43.1%
Taos	13.6%	5.8%	4.6%	19.4%	5.1%	8.3%	31.1%
Hobbs	15.6%	14.2%	15.0%	35.0%	14.0%	25.8%	51.2%
Moriarty	12.3%	2.7%	8.4%	19.0%	9.9%	12.7%	31.9%

Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates.

Leading Cause of Death

According to the NM-IBIS, the top five causes of death in New Mexico in 2018 were heart disease, cancer, unintentional injuries, chronic lower respiratory diseases, and stroke. While site data was not available, state and county-level data were available and aggregated by PSA (with the exception of PSAs 5 & 6). In 2018, among those 65 and older, there were 3,211 deaths from heart disease, with the bulk of these occurring in PSA 1 (1,046) and PSA 2 (842). Of the five top causes of death, the second most common among adults 65 and over was cancer, with approximately 2,712 deaths in New Mexico, primarily in PSA 1 (273) and PSA 2 (371). Among those 65 and older, chronic lower respiratory diseases were the third most frequent of the top five causes of death, with approximately 1,025 deaths in New Mexico in 2018. There was an additional 718 from a stroke and 527 from unintentional injuries.

Table 28. Population 65 and Older and New Mexico's Top Ten Leading Causes of Death, 2018

Location	Heart Disease	Cancer	Chronic Lower Respiratory Diseases	Stroke	Unintentional Injuries
New Mexico	3,211	2,712	1,025	718	527
Bernalillo County (PSA 1)	1,046	842	273	258	207
PSA 2	961	956	371	229	176
PSA 3	592	374	165	72	52
PSA 4	611	539	203	146	83

Source: NM-IBIS, 15 Leading Causes of Death in New Mexico and 15 Leading Causes of Death in New Mexico, Decedent's County of Resident, 2018

Census Data Summary

The adult population of New Mexico consists of approximately 1 in 5 (22.7% or 474,147) who are 60 and over. In New Mexico, those 65 and older comprise a higher portion of females (53.8%) than males. Those 60 and older are primarily white, non-Hispanic (59.6%), Hispanic (33.1%), or American Indian (5.8%). Males 65 and older in New Mexico were more likely than females in this age group to be married (66.1% compared to 43.3%), and females were more likely to be widowed than males (43.3% compared to 11.9%). Of those 65 and older, 82.5% in New Mexico had a high school diploma or higher, and 30.3% had a bachelor's degree or higher. Approximately 1 in 4 (26.2%) of those 60 and older in New Mexico participated in the labor force in 2017, and approximately 1 in 5 (21.4%) of those in New Mexico was a veteran. Of those 65 and older, 11.9% had income below the poverty rate, and 22.1% were low-income, 30.8% were middle-income, and the remaining 35.1% were classified as high-income. Of New Mexico households with a resident 60 and older, 12.0% received food stamps or SNAP in 2018. The majority of individuals 65 and older lived with a relative (41.9%), a spouse (24.0%), or lived alone (27,6%). Of those 65 and older in New Mexico, 39.9% had some form of disability, including hearing, vision, cognitive, ambulatory, self-care, or independent living.

While nearly half a million New Mexico residents meet the age requirement for services from ALTSD, the needs vary by PSA and local site. The portion of adults 60 and older was slightly lower in PSAs 1 and 3 and higher in PSA 6. Most notably, Taos had a higher portion of adults 60 and older compared to New Mexico (32.9%), and Hobbs had a lower portion (14.2%). Moriarty was the only site with a higher portion of males 60 and older (56.4%). Gallup had more than twice the percentage of people 60 and older who were American Indian (25.9%), and Moriarty had a higher percentage of people 60 and older who were Hispanic (50.7%). Hobbs had a higher percentage of individuals who were 60 and older and Black compared to all other sites (9.0%). In Taos, both males and females 65 and older were less likely to be married, and females were more likely than males to be widowed in Taos. In Hobbs, men were more likely to be married than the state average. The percent of the population 65 and older with a higher diploma was highest in Taos (93.5%) and lowest in Hobbs (63.7%) and Moriarty (71.1%). In Taos, the percent of those with a bachelor's was higher than the state average (46.0% compared to 30.3%) and much lower than the state average in Hobbs (19.2%) and Moriarty (8.7%). Labor force participation among those 60 and older was nearly twice as high in Gallup as in Moriarty (38.0% compared to 20.2%). Compared to the state, Taos had a much smaller portion of veterans 65 and older (9.6%). Poverty among those 65 and older was highest in Moriarty at nearly 3 times the state average (. While Gallup and Taos

are slightly above the state average for poverty, Hobbs and Las Cruces are lower (9.7% and 7.9%, respectively). Las Cruces had a slightly lower percentage of low-income adults 65 and over (20.1%), but all other sites were higher than the average. Taos had the highest portion of the population who were low income (29.6%). The households that consisted of individuals 60 and older and who received SNAP were highest in Taos (16.3%) and lowest in Gallup (12.5%). The highest percentage of people 65 and older living alone was in Moriarty (38.3%), followed by Taos (35.6%), and Hobbs had the smallest percent at (25.1%). The population 65 and older with one or more disabilities was much higher in Hobbs than the state average (51.2%) but lowest in Taos (31.1%) and Moriarty (31.9%). Difficulties with self-care were lowest in Taos (5.1%) and nearly three times higher (14.0% in Hobbs). Independent living issues were lowest in Taos (8.3%) and also three times higher in Hobbs (25.8%).

Circumstances at specific sites would indicate there is likely a greater need for services at these sites. High rates of living and self-care issues in Hobbs as well the higher portion of people living alone in Hobbs, may indicate a greater need for assistance with chores and transportation. Higher rates of food stamp/SNAP use, as well as higher rates of poverty and low-income older adults, indicate a possible need for assistance with home-delivered or congregate meals. While it is difficult to fully estimate need in these communities, it is clear the need is community-driven rather than a one-size-fits-all scenario.

BUDGETS AND EXPENDITURES

This section reports budgets and expenditures for the state of New Mexico, the four PSAs, and six selected sites. When available, we also report the number of consumers included in the budget to be served by type of service. The total budget for New Mexico was $32,500,104.67. This includes PSA 1 Bernalillo County's total and the totals reported for PSA 2, PSA 3, and PSA 4. PSA 4, with a population of 85,930 60 years and older, had the largest budget, followed by PSA 2 (181,036 and $9,308.918.51), PSA 1, or Bernalillo County (145,554 and $7,690,882.64), and PSA 3 with a population of 61,627 and budget of $4,256,357.44. Because the budget for PSA 1 is separate from PSA 2, PSA 3, and PSA 4, the budgets in Table 29 do not match completely. The budget for PSA 1 is entirely reported in Table 32. It is clear the budgets are not apportioned based on the size of the elderly population. It would be useful to understand the specific method for determining budgets and categories.

Table 30 reports the FY 2019 budget and the count of services for the six sites. The Bernalillo County budget was almost 8 times larger than the site with the next largest budget, Las Cruces. Moriarty, with the smallest population, also had the smallest budget. It is important to recall Bernalillo County is also PSA 1 and has the third-largest budget in the state among the four PSAs we analyzed.

The budgeted services by type and budget are reported in Table 31, highlighting the budgeted cost per unit, the units budgeted, and the expended units by site. Table 31 excludes Bernalillo County, which is reported separately in Table 32. We report this site separately because of the size of the budget and the number of services budgeted.

Table 29. PSA Budgets by Service Type

Services	PSA 1	PSA 2	PSA 3	PSA 4
Congregate Meals	$1,189,607.07	$2,477,297.86	$1,109,626.01	$3,264,874.80
Home-Delivered Meals	$864,465.93	$3,160,504.88	$1,740,013.64	$4,042,039.52
Transportation	$873,048.45	$1,664,633.54	$618,711.31	$1,756,517.62
Assisted Transportation		$0.00	$19,932.00	$53,518.00
Case Mgmt.	$445,861.00	$55,361.20	$0.00	$5,680.20
Adult Day Care	$363,137.00	$218,637.46	$283,766.92	$143,748.22
Chore	$241,868.71	$76,447.71	$21,533.85	$40,000.00
Homemaker	$152,889.25	$562,746.73	$225,821.50	$1,114,790.76
Physical Fitness/ Exercise/Health Screening	$618,060.09	$3,840.00	$22,965.64	$69,488.82
EB-Health Education Training	$79,781.09	$58,688.04	$43,717.66	$76,668.54
Elder Respite - In Home	$134,045.00	$512,690.45	$170,268.91	$646,515.20
Elder Respite - Adult Day Care	$185,836.70	$404,154.82	$0.00	$0.00
Elder Respite Care – Vouchers		$37,778.12	$0.00	$0.00
GRGC Respite Vouchers		$10,000.00	$0.00	$30,104.40
GRGC Respite In-Home		$56,044.20	$0.00	$0.00
GP Counselling		$10,093.50	$0.00	$0.00
Elder Respite Care -Counseling		$0.00	$0.00	$0.00
Respite - Information Services		$0.00	$0.00	$0.00
Respite -- Supplemental Services		$0.00	$0.00	$0.00
Total	**$7,690,882.64**	**$9,308,918.51**	**$4,256,357.44**	**$11,243,946.08**

Table 30. Local Sites Budget, Services, and Population

	Total Budget	Count of Services	Population 60 and older
Bernalillo County	$7,690,882.64	22	145,554
Gallup	$378,445.64	3	4,177
Hobbs	$127,229.00	2	5,419
Las Cruces	$914,777.60	5	20,546
Moriarty	$326,280.37	3	429
Taos	$707,115.96	3	1,981

Each of the six sites were budgeted to provide congregate meals and home-delivered meals. These two services constituted the majority of each site's budget, accounting for an average of 83.7% and ranging from 100% (Hobbs) to 33.4% (Albuquerque). Three of the five sites were also budgeted to provide transportation, and these three sites only provided these three services – Gallup, Moriarty, and Taos.

Table 31. Budgeted Service for Five Sites

Site	Service Type	Services Budgeted	Rate	Units Budgeted	Units Expended
Gallup	Congregate Meals	$200,170.53	3.51948	56,875	43,874
	Home-Delivered Meals	$84,438.98	3.54042	23,850	14,342
	Transportation	$93,836.13	5.89794	16,910	12,588
	Total	$378,445.64			
Hobbs	Congregate Meals	$77,101.00	3.64899	20,923	21,976
	Home-Delivered Meals	$50,128.00	2.09504	23,927	23,780
	Total	$127,229.00			
Las Cruces	Congregate Meals	$311,876.23	2.38903	130,545	100,905
	Home-Delivered Meals	$423,417.70	1.89789	223,100	213,769
	Home Maker	$74,356.92	12.69973	5,855	4,948
	Respite	$90,074.55	15.01243	6,000	4,019
	Grand Parents Raising Grand Children	$15,052.20	57.89308	260	292
	Total	$914,777.60			
Moriarty	Congregate Meals	$84,895.13	5.03082	16,875	13,253
	Home-Delivered Meals	$195,847.74	8.99209	21,870	21,144
	Transportation	$45,537.50	13.01071	3,500	2,045
	Total	$326,280.37			
Taos	Congregate Meals	$147,692.80	4.25306	34,726.25	31,433
	Home-Delivered Meals	$395,396.93	6.07065	65,132.55	51,642
	Transportation	$164,026.23	10.27412	15,965	10,274
	Total	**$707,115.96**			

Table 32. Services for Bernalillo County

Service Type Detail	Expenditures	Cost per Service Expenditures	Unduplicated Persons Budgeted
Supportive Services			
Case Management	$445,861.00	$80.96	1,700
Information & Assistance	$175,564.00	$76.30	2,750
Transportation	$873,048.45	$15.59	1,750
Outreach/Client Finding	$0.00	$0.00	0
Housekeeping	$152,889.25	$12.25	92
Chore	$241,868.71	$48.26	565
Legal Direct Services	$471,499.99	$152.39	2,045
Legal Workshops, Clinics, etc.	$0.00	$0.00	460
Adult Day Care	$363,137.00	$8.50	78
Senior Center Activities	$322,326.44	$2.73	1,500
Physical Fitness/Exercise	$295,733.65	$2.08	5,970
Administration	$224,815.64		-
Total	$3,566,744.13	$9.14	16,910
Congregate Meals			
Congregate Meals	$1,106,081.81	$5.91	3,250
Administration	$83,525.26		-
Total	$1,189,607.07	$6.35	3,250
Home Delivered Meals			
Home Delivered Meals	$794,892.88	$6.17	900
Administration	$69,573.05		-
Total	$864,465.93	$6.71	900
Health Promotion and Disease Prevention			
Health Promotion and Disease Prevention	$24,811.80	$25.27	50
Total	$24,811.80	$25.27	50
Caregiver Support			
Adult Day Care Respite	$185,836.70	$11.81	37
In-Home Respite	$134,045.00	$10.29	37
Education/Training	$79,781.09	$105.39	120
Respite Care (Supp./Vouchers)	$0.00		-
Access Assistance	$0.00	$0.00	500
Administration	$136,102.18		-
Total	$535,764.97	$17.78	694
All State Other			
Senior Hunger Initiative	$85,000.00	$0.50	295
Screening	$59,960.51	$249.84	650
Medication Management	$22,343.37	$62.76	80
Home Repair/Retrofit	$392,570.39	$50.56	1,500
Bernalillo County	$94,994.50		-
Tijeras	$95,000.00		-
Total	**$749,868.77**	**$4.20**	**2525**

CONSUMER DATA

A variety of services are available to New Mexico's older adults, adults with disabilities, and their caregivers. The New Mexico Aging & Long-Term Services Department (ALTSD) provided UNM ISR with WellSky consumer service data for the fiscal year 2019. That data altogether captures 40 different services provided by 90 different providers, across 180 sites in New Mexico. Older adult services are organized into six categories: (1) Support Services, (2) Congregate Meals, (3) Home Delivered Meals, (4) Health Promotion and Disease Prevention, (5) Caregiver Support, and (6) All other services. Support Services, Health Promotion and Disease Prevention, Caregiver Support, and Other services are subdivided into increasingly specific categories. The Table 56 in Appendix G displays detailed service categories and their associated unit(s) of measure.

Individuals who register for ALTSD services are assigned a unique ID. We have used that ID to report the number of unique consumers in New Mexico and count the total number of units per service category. Importantly, unregistered consumers have no unique ID and cannot be tracked—we have excluded these consumers from some of our analyses and note when this occurs.

In the following sections, we report three critical values: (1) the total number of consumers per service category, (2) the number of registered and unregistered units of services, and (3) the number of unique consumers. Alongside those values, we report the average and median number of services or units per consumer. We include both average and median calculations, because the average is not always the best indicator if data contain extreme values or outliers. For example, if a few consumers receive a disproportionately large number of services, the average can be inflated. Including the median alongside the average is useful in that case, because it reports a value where half of consumers are above and half of consumers are below. When the median is smaller than the average it indicates that there are consumers with disproportionately higher service usage; oppositely, when the median is larger than the average it indicates that there are consumers with disproportionately lower service usage.

New Mexico

Statewide data reflects service usage for PSA 1 through PSA 4. As stated earlier, PSA 5 is not reported in this assessment. PSA 6 is reported at the end of this section. Because PSA 6 services are not funded by ASLTD we do not include PSA 6 services in combined counts for Tables 33 - 43.

Table 33 reports the number of service units by category for registered and unregistered consumers in the New Mexico. Recreational Services, Physical Fitness, and Nutrition Education services were excluded since none of their service units could be linked to a consumer ID. Assessment and Reassessment services were also excluded from the table because they only identify whether an individual qualifies to receive services. Details for those services are reported separately as a result.

Based on WellSky data for the 2019 Fiscal Year, 44,022 unique consumers in New Mexico used at least one service funded by the ALTSD. Approximately 21% of consumers used two services and 13.9% used three or more services. Overall, 34.7% or 15,256 individuals used more than one service throughout the state. The maximum number of services used by a consumer was 16.

The total number of service units consumed statewide was 3,779,143. On average, each consumer used 1.6 different services and 72.5 service units for the fiscal year. However, half of all consumers use 18

service units or less. The average number of units is significantly higher than the median, indicating that some consumers used services much more frequently than others. For example, Caregiver Support services were used by 793 unique individuals with an average of 150 units per consumer. A single consumer though used 1,836 service units of caregiver support—substantially higher than the median of 54.5 units per consumer. Cases like these highlight the importance of exploring in-depth why some consumers use more units of a particular service compared to others. It remains unclear whether barriers or demographic disparities exist in these contexts.

Returning to Table 33, Home Delivered Meals reflect the most used service, with 1,741,866 meals consumed-- 46.1% of all service units provided in New Mexico. On average, each consumer was provided 183.7 meals a year. Interestingly, Home Delivered Meals were the only service where the average and the median were similar, indicating that the service usage was evenly distributed above and below the average. Consumers typically consumed 46.1 Congregate Meals annually—with a combined 1,310,266 meals for the 2019 fiscal year.

Table 33 further indicates that 98,730 units of service were not associated with a registered consumer, and could not be tracked. As we show, 57,248 units (9.8%) of Supportive Services were used by unregistered consumers.

Table 33. New Mexico Statewide Services by Category – FY19

Registered Consumers with an ID						***Unregistered***	***Total Units***
Services by Category	**Number of Consumers**	**Units**	**% Units**	**Mean units per consumer**	**Median units per consumer**	**Units Not linked to a Consumer**	
Supportive Services	12,724	582,097	15.4%	45.7	5.0	57,248	639,345
Congregate Meals	28,432	1,310,266	34.7%	46.1	14.0	33,978	1,344,244
Home Delivered Meals	9,480	1,741,866	46.1%	183.7	180.0	7,123	1,748,989
Health Promotion	700	25,045	0.7%	35.8	20.0	0	25,045
Caregiver Support	793	118,944	3.1%	150.0	54.5	377	119,321
All State Other	33	925	0.0%	28.0	20.0	4	929
Total		**3,779,143**	**100.0%**	**72.5**	**18**	**98,730**	**3,954,519**
Unique Consumers	***44,022***						
Consumers that used two or more Services	*15,256*						

Recreational Services, Physical Fitness, Nutrition Education, and Assessment and Reassessment services are reported in Table 34, which displays services that could not be linked to a consumer and accounted for 682,830 units of services. ALTSD service providers offered 35,974 hours of Assessment and/or Reassessment (not shown), 347,772 units of Recreation Services, 222,438 units of Physical Fitness, and 76,646 units of Nutrition Education.

Table 34. Additional Services in NM – FY19

Services Not Associated with a Consumer ID	
Services	**Units Not linked to any Consumer**
Nutrition Education	76,646
Physical Fitness	222,438
Recreational Services	347,772
Total	**646,856**

Overall, registered and unregistered individuals accounted for 4,637,349 service units throughout New Mexico.

Planning and Service Areas

In this section we report data for 5 out of 6 New Mexico PSAs. PSA 1 encompasses Bernalillo County, while PSAs 2,3, and 4 capture the remainder of New Mexico's ALTSD-funded counties. PSA 6, reported at the end of this section, captures the state's 19 Native American Pueblos, and the Jicarilla Apache and Mescalero Apache tribes. As we noted at the beginning of our report, this assessment does not include PSA 5 because consumer data is not available for this region. Once again, Figure 1 at the beginning of this report maps PSA boundaries in New Mexico.

Table 35 (below) summarizes by PSA: (1) the unique services offered, (2) the number of providers, (3) the number of sites, and (4) the number of unique consumers. We would like to note that readers should not assume that consumers necessarily live within the geographic boundaries of the PSA they receive services in. For example, individuals who live in Moriarty (PSA 2) may choose to have a congregate meal in Tijeras, located in PSA 1. Members of PSA 5 and PSA 6 may also receive services in a PSA located in the county where they live and not necessarily from a provider who offers services for PSA 5 or PSA 6. While it is conceivable that most consumers who live within a PSA access services there, initial investigations have revealed that individuals do cross boundaries fairly often and future needs assessments should explore this finding further.

Table 35. Services, Providers, Sites, and Consumers

PSA	Number of Services offered	Number of Providers	Number of Sites	Unique Consumers
PSA 1	24	11	41	9,062
PSA 2	20	20	68	18,226
PSA 3	14	28	33	7,971
PSA 4	15	11	34	9,290
PSA 6	28	20	4	3,471
Total				48,020

Planning and Service Area 1 (PSA 1)

PSA 1 includes Bernalillo, Albuquerque, and Los Ranchos de Albuquerque, and generally encompasses Bernalillo County. In FY19, 24 services were offered by 11 providers from 41 different locations across PSA 1. This area provided services to 9,602 unique consumers. Overall, 38.2% or 3,459 unique consumers used more than one service in PSA 1, with approximately 18% of them using just two services, and 20.3% of them using three or more services. PSA 1 was also the region with the highest proportion of consumers who use three or more services. At most, consumers accessed 11 separate services. But on average, consumers accessed 1.7 services, with 50% of consumers using one or more services.

Registered consumers in PSA 1 accounted for 380,607 service units, with the average consumer accessing 36.1 units of services, and half of all consumers using 4.0 or more units of services (shown in Table 36)—suggesting some consumers are accessing services disproportionately higher than most. Congregate meals were the most used service in PSA 1(157,624 meals), reflecting 41.4% of all units consumed in this area. The average number of congregate meals per consumer was 46, which was also similar to the statewide average (46.1 meals per consumer). Compared to all other PSAs, PSA 1 was the only region where Congregate Meals were the most accessed service. Programs like Supportive Services and Home Delivered Meals were the second-most used services in PSA 1, representing approximately 23% of total service units in the area. In terms of untraceable consumers, a total of 12,709 service units were linked to unregistered persons.

Table 36. PSA 1 - Services by Category – FY19

Registered Consumers with an ID						***Unregistered***	***Total Units***
Services by Category	**Number of Consumers**	**Units**	**% Units**	**Mean units per consumer**	**Median units per consumer**	**Units Not linked to a Consumer**	
Supportive Services	5,728	91,102	23.9%	15.9	2.0	6,416	97,518
Congregate Meals	3,584	157,624	41.4%	44.0	11.0	6,293	163,917
Home Delivered Meals	701	90,281	23.7%	128.8	94.0	0	90,281
Health Promotion	151	1,783	0.5%	11.8	12.5	0	1,783
Caregiver Support	365	39,566	10.4%	108.4	27.0	0	39,566
All State Other	18	251	0.1%	13.9	12.0	0	251
Total		**380,607**	**100.0%**	**36.1**	**4.0**	**12,709**	**393,316**
Unique Consumers	***9,062***						
Consumers that used two or more Services	*3,459*						

Table 37 identifies which services were never attached to registered consumers. Recreational Services, Physical Fitness, and Nutrition Education could never be linked to unique consumers and were responsible for an additional 505,751 units across PSA 1. Consumers participated in 326,924 units of Recreational Services, 173,047 Physical Fitness units, and 5,780 units of Nutrition Education. Compared to all other PSAs, PSA 1 used the most 'additional services'. Overall though, registered and unregistered consumers accessed a total of 899,067 service units; 19.4% of all units used within New Mexico.

Table 37. Additional Services in PSA 1 - FY19

Services Not Associated with a Consumer ID	
Services	**Units Not linked to a Consumer**
Nutrition Education	5,780
Physical Fitness	173,047
Recreational Services	326,924
Total	**505,751**

Planning and Service Area 2 (PSA 2)

PSA 2 captures Cibola, Colfax, Los Alamos, McKinley, Mora, Rio Arriba, Sandoval, San Miguel, San Juan, Santa Fe, Taos, Torrance and Valencia Counties. In this region, 20 providers from 68 sites offered services to 18,226 unique consumers. In sum, 35.4% of consumers used more than one service, 21.2% used two services, and 14.2% used three or more services. The average consumer in PSA 2 received 1.6 services, with half receiving one or more services. The maximum number of services used by a consumer was 16.

Home Delivered Meals were the most frequently used service in PSA 2. Registered individuals consumed 772,354 meals, which accounted for 48% of all service units in the area. PSA 2 provided nearly 9 times the number of meals when compared to PSA 1, despite the fact that PSA 2's population is 2 times larger. Congregate meals were the second-most used service reflecting 542,455 units and 33.9% of all units. Together, meals accounted for 82.2% of all services provided. Across all categories, consumers used an average 73.3 service units, while half of all consumers accessed 20 service units or less. A total of 1,600,024 service units were used by registered consumers, meaning that PSA 2 consumed the most service units out of all PSAs.

As shown in Table 38, Caregiver Support was the most used service by any one consumer, with an average consumer needing nearly 221 hours of support. Specifically, Respite Care accounted for the exceptionally high use of Caregiver Support. Consumers in that category used at least 1.5 hours of support, with one consumer using 1,836.3 hours. In total, 51,912 hours of Respite Care were needed, accounting for ***91.4%*** of all Caregiver Support provided.

Table 38. PSA 2 - Services by Category

Registered Consumers with an ID						*Unregistered*	*Total Units*
Services by Category	**Number of Consumers**	**Units**	**% Units**	**Mean units per consumer**	**Median units per consumer**	**Units Not linked to a Consumer**	
Supportive Services	3,945	225,298	14.1%	57.1	11.0	50,319	275,617
Congregate Meals	13,427	542,455	33.9%	40.4	12.0	21,279	563,734
Home Delivered Meals	4047	772,354	48.3%	190.8	199.0	5,872	778,226
Health Promotion	131	2,436	0.2%	18.6	13.0	0	2,436
Caregiver Support	257	56,806	3.6%	221.0	88.5	368	57,174
All State Other	15	674	0.0%	44.9	34.0	4	678
Total		**1,600,024**	**100.0%**	**73.3**	**20.0**	**77,842**	**1,677,865**
Unique Consumers	***18,226***						
Consumers that used two or more Services	*6,451*						

Individuals in PSA 2 also accessed 23,135 units of Physical Fitness, 29,283 units of Nutrition Education, and 8,679 units of Recreation Service units. As described earlier, these services never include registered consumers and are therefore untraceable. Additional services reflect a combined total of 61,097 service units.

Table 39. Additional Services in PSA 2 - FY19

Services Not Associated with a Consumer ID	
Services	**Units Not linked to a Consumer**
Nutrition Education	29,283
Physical Fitness	23,135
Recreational Services	8,679
Total	**61,097**

Overall, registered and unregistered consumers within PSA 2 accessed 1,756,676 units of services; 37.9% of all service units in New Mexico.

Planning and Service Area 3 (PSA 3)

PSA 3 captures De Baca, Chaves, Curry, Guadalupe, Eddy, Harding, Lea, Lincoln, Quay, Roosevelt and Union Counties. In FY19, PSA 3 provided 14 different services, which were offered by 28 providers at 33 different sites. A total of 7,971 unique consumers used 831,657 service units across this region. In terms of service usage, approximately 27.0% of consumers used more than one service; 17.9% used two services, and 8.9% used three or more services. The maximum number of services used by any one person was 10.

As with PSA 1 and 2, Home Delivered Meals were the most used service, with 366,803 total meals provided which reflected 44.1% of all units in the PSA. The typical consumer accessed 170 meals, with a median of 171 meals per consumer—indicating again, that service usage was not clustered around extreme consumption. PSA 3 further supplied 278,688 Congregate Meals (33.5% of all units), with an average of 53.9 meals per consumer. Beyond meals, consumers were provided 20,316 units of service

for Health Promotion and Disease Prevention (2.4% of all units), and 7,553 units of Caregiver Support (0.9% of all units). Interestingly, as a percent of all services Caregiver Support was used *the least* in PSA 3 compared to all other PSAs. In terms of unregistered consumers, around 6,000 service units could not be tracked in PSA 3. Most of these untraceable units (74%) were Congregate Meals.

Table 40. PSA 3 - Services by Category- FY19

Registered Consumers with an ID						***Unregistered***	***Total Units***
Services by Category	**Number of Consumers**	**Units**	**% Units**	**Mean units per consumer**	**Median units per consumer**	**Units Not linked to a Consumer**	
Supportive Services	1,738	158,297	19.0%	91.1	23.0	514	158,811
Congregate Meals	5,166	278,688	33.5%	53.9	18.0	4,495	283,183
Home Delivered Meals	2,161	366,803	44.1%	169.7	171.0	1,060	367,863
Health Promotion	381	20,316	2.4%	53.3	49.0	0	20,316
Caregiver Support	68	7,553	0.9%	111.1	83.5	9	7,562
Total		**831,657**	**100.0%**	**87.4**	**38**	**6,078**	**837,734**
Unique Consumers	***7,971***						
Consumers that used two or more Services	*2,137*						

A total of 7,731 Assessments and/or Reassessments were conducted in PSA 3. The table below summarizes additional services (never traceable). Unregistered consumers accessed 5,629 units of Physical Fitness, 19,931 units of Nutrition Education, and 12,169 units of Recreation Services. Overall, PSA 3 accounted for 19.4% (883,194 units) of all service units provided in New Mexico.

Table 41. Additional Services in PSA 3 - FY19

Services Not Associated with a Consumer ID	
Services	**Units Not linked to a Consumer**
Nutrition Education	19,931
Physical Fitness	5,629
Recreational Services	12,169
Total	37,729

Planning and Service Area 4 (PSA 4)

PSA 4 captures Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra and Socorro Counties. In FY19, PSA 4 providers offered 15 distinct services at 34 sites, for over 9,000 unique consumers. Out of unique consumers, 32.1% used more than one service annually, 23.6% used two services, and 9% used three or more services. The typical consumer on average used 1.5 different services and about half of all consumers accessed one service. The maximum number of services used by any one consumer was 9.

Registered consumers used 966,857 service units, distributed across five categories, as shown in Table 42. Like most PSAs, the most used service was Home Delivered Meals. A combined 512,428 meals were provided, with an average of 198.6 meals per consumer. PSA 4 reflects the only region where more than 50% of *all units* were captured by a single service. The second-most used service was Congregate Meals, with 331,499 meals distributed across the region. On average, individuals accessed Congregate Meals

3.9 times ***less*** than Home Delivered Meals. Compared to all other PSAs, PSA 4 had the highest average service usage per consumer, overall-- with the average consumer accessing 198.6 meals in the 2019 fiscal year.

As we show in Table 42, 2,102 service units could not be linked to a registered consumer—the lowest of any PSA. Like with PSA 3, Congregate Meals also represented the bulk of untraceable consumers. A total of 968,959 units were provided to registered and unregistered consumers.

Table 42. PSA 4 - Services by Category - FY19

Registered Consumers with an ID						***Unregistered***	***Total Units***
Services by Category	**Number of Consumers**	**Units**	**% Units**	**Mean units per consumer**	**Median units per consumer**	***Units Not linked to a Consumer***	
Supportive Services	1,343	107,400	11.1%	80	27.0	0	107,400
Congregate Meals	6,559	331,499	34.3%	50.5	17.0	1,911	333,410
Home Delivered Meals	2,580	512,428	53.0%	198.6	179.0	191	512,619
Health Promotion	37	510	0.1%	13.8	8.0	0	510
Caregiver Support	103	15,020	1.6%	145.8	136.3	0	15,020
Total		**966,857**	**100.0%**	**91.0**	**35.0**	**2,102**	**968,959**
Unique Consumers	***9,290***						
Consumers that used two or more Services	*3,028*						

Table 43 illustrates 'additional service' usage. Interestingly, PSA 4 was also the only region in which all Physical Fitness units were linked to a consumer ID which allowed us to track unique consumers. In total, 20,627 Physical Fitness units were used by 473 persons, with the average consumer using 43.6 units. Unregistered consumers attended 21,655 units of Nutrition Education. No consumers in PSA 4 accessed Recreational Services.

Table 43. Additional Services in PSA 4 – FY19

Services Not Associated with a Consumer ID			
Services	**Units Not linked to a Consumer**	**Units linked to a Consumer**	**Total Units**
Nutrition Education	21,655	0	21,655
Physical Fitness	0	20,627	20,627
Recreational Services	0	0	0
Total	**21,655**	**20,627**	**42,282**

Overall, 1,021,770 service units were provided throughout PSA 4, reflecting 22.0% of all units used in New Mexico.

Planning Service Area 6 (PSA 6)

PSA 6 includes 19 pueblos, the Mescalero Apache Tribe, and Jicarilla Apache Tribe. Twenty providers offered 28 different services in this region. Consumer data for PSA 6 was limited, with most service provider site information 'unknown.' Exceptions included data from the Eight Northern Pueblos Senior Centers that provided services at: Nambe, San Ildefonso, Pojoaque, and Picuris Senior Centers.

In sum, PSA 6 provided services to 3,471 unique persons—21% of all older adults in the area. About 72% of PSA 6 consumers used two or more services, indicating PSA 6 had the highest proportion of consumers who received multiple services. Specifically, we found 20.2% of PSA 6 consumers used 2 services, while **51.5% used 3 or more services**. PSA 6 similarly had the highest average service use compared to all other PSAs. The average consumer in PSA 6 used 3.8 services, compared to the next highest average of 1.7 services per consumer in PSA 1. The maximum number of services used by any consumer in PSA 6 was 18 (the highest maximum).

Registered consumers used 487,508 service units, with an average of 71.7 units per consumer. Interestingly, PSA 6 was the only region where Supportive Services were the most used service category. Importantly, Physical Fitness and Recreation Service units were included under Supportive Services—PSA 6 was the only region where this occurred. Supportive Services accounted for 196,773 units, 40.4% of all service units in the region. The second-most used service, Home Delivered Meals, accounted for 37.1% (180,733 units) of all service units in PSA 6, with the average consumer receiving 134 meals annually. Additionally, 23,727 units could not be linked to a consumer ID. Registered and unregistered consumers accessed a combined 511,235 service units throughout PSA 6.

Table 44. PSA 6 Services by Category – FY19

Registered Consumers with an ID						***Unregistered***	***Total Units***
Services by Category	**Number of Consumers**	**Units**	**% Units**	**Mean units per consumer**	**Median units per consumer**	***Units Not linked to a Consumer***	
Supportive Services	2,367	196,773	40.4%	83.1	10.0	534	197,307
Congregate Meals	2,020	89,810	18.4%	44.5	18.0	23,193	113,003
Home Delivered Meals	1,345	180,733	37.1%	134.4	144.0	0	180,733
Caregiver Support	685	18,515	3.8%	27	4.0	0	18,515
All State Other	387	1,677	0.3%	4.3	3.0	0	1,677
Total		**487,508**	**100.0%**	**71.7**	**15.0**	**23,727**	**511,235**
Unique Consumers	***3,471***						
Consumers that used two or more Services	*2,757*						

Local Sites

As described earlier, local sites were ultimately chosen for this pilot needs assessment because state-wide assessments cannot capture local issues or describe how the needs of older adults and older adult services vary by community. Our needs assessment remains a proof-of-concept combining quantitative and qualitative methods, and focusing on a small subset of purposefully selected sites in New Mexico. We intended to assess in more depth and detail the unique circumstances of local areas using a range of

data from a variety of sources. This included census data; the analysis of consumer data; a review of the contract, budget, and expenditure data to better understand the budgeted services and expenditures; the use of field reconnaissance and visits to targeted sites; focus groups and surveys of consumers, and focus group and surveys of providers. Despite the challenges of the public health crisis, we were able to identify our six selected sites within the WellSky consumer data. Table 45 shows in detail our selected sites and several consumer and service provider characteristics for each. Bernalillo County was also one of our selected sites, but it also happens to represent PSA 1. Because of this, we do not include or describe that site here again. Our five other sites—Gallup, Hobbs, Las Cruces, Moriarty, and Taos—are discussed below.

Table 45. Local Site Consumer Data

Local Sites	Number of Services offered	Number of Providers	Number of Sites	Unique Consumers
Gallup	5	2	1	1,355
Hobbs	6	1	Unknown	838
Las Cruces	6	1	6	2,651
Moriarty	4	1	1	145
Taos	7	2	2	777
Total Consumers				**5,766**

Gallup

Five services were offered in Gallup, which provided support to 1,355 unique consumers. Approximately 195 of those consumers (14%) used more than one service. A total of 76,271 units were linked to registered consumers; 57% of all these units were attributed to Congregate Meals. Approximately 93% of unique consumers had at least one Congregate Meal in FY19, with the average person receiving 34.8 meals annually. Gallup also supplied 14,333 Home Delivered Meals to 99 unique consumers (7%), averaging 144.8 meals per registered consumer. Transportation Services were utilized by 10.3% of consumers, translating to 12,577 one-way trips. Only 10 people received Respite Care through Caregivers Serving Elderly. However, this service category reflected a combined 5,593 hours of support, which averaged to 559.3 hours per consumer. Most services in Gallup could be linked to consumers, with the exception of Nutrition Education. Over 500 service units of Nutrition Education were provided to unregistered consumers.

Table 46. Gallup Services by Type - FY19

Registered Consumers with an ID					*Units Not linked to a Consumer*	*Total Units*
Services by Category	**Number of Consumers**	**Units**	**Mean units per consumer**	**Mean units per consumer**		
Transportation	139	12,577	90.5	13.0	11	12,588
Congregate Meals	1,257	43,768	34.8	11.0	133	43,901
Home Delivered Meals	99	14,333	144.8	128.0	9	14,342
Respite Care -CG	10	5,593	559.3	143.6	0	5,593
Nutrition Education	0	0	0.0	0.0	512	512
Total Units		**76,271**	**50.7**	**13.0**	**1,817**	**78,088**
Unique Consumers	*1,355*					
Number of Unique Consumers that used 2 or more services	*195*					

Hobbs

The City of Hobbs offered a total of six services to 838 unique consumers, reflecting a combined service provision of 67,608 units for FY19. Interestingly, 72.6% of these consumers used more than one service. As we have commonly found in the previous section on PSAs, Congregate Meals and Home Delivered Meals were the most frequently used services—reflecting 21,795 and 23,780 meals, respectively. On average, consumers accessed 44.0 Congregate Meals and 133.6 Home Delivered Meals. The least-used service in Hobbs was Transportation Services, with 89 (10.6%) unique consumers using an average of 53.2 one-way trips and accounting for 4,736 service units. It is worth pointing out that a single person needed 443 one-way trips. Recreation Services were the second-most utilized service in Hobbs, needed by 40% of all consumers. The average consumer used 36.1 units of Recreation Services. An unknown number of consumers used a total of 795 units of Nutrition Education.

Table 47. Hobbs Services by Type - FY19

Registered Consumers with an ID					*Units Not linked to a Consumer*	*Total Units*
Services by Category	**Number of Consumers**	**Units**	**Mean units per consumer**	**Mean units per consumer**		
Multipurpose Senior Services	142	5,128	36.1	15.5	0	5,128
Recreation Services	336	12,169	36.2	6.0	0	12,169
Transportation	89	4,736	53.2	3.0	0	4,736
Congregate Meals	495	21,795	44.0	10.0	2	21,797
Home Delivery Meals	178	23,780	133.6	133.5	0	23,780
Nutrition Education	0	0	0.0	0.0	795	795
Total Units		**67,608**	**54.5**	**14.5**	**797**	**68,405**
Unique Consumers	*838*					
Number of Unique Consumers that used 2 or more services	*608*					

Moriarty

The PMS Torrance County Senior Program offered just four services to 145 unique consumers. About 63% of consumers used more than one service. Surprisingly, only 11% or 16 individuals needed Transportation Services. The average number of one-way trips per consumer was about 71, with half of all consumers using Transportation Services 18 times. A total of 3,255 Congregate Meals and 6,249 Home Delivered Meals were offered to registered consumers, with an average of 31.6 and 53.0 meals (respectively) per consumer. Compared to the two previous sites, Moriarty had more service units that could not be linked to a consumer. In sum, 43 one way-trips, 85 Congregate Meals, 78 Home Delivered Meals, and 360 units of Nutrition Education were used by an unknown number of people.

Table 48. Moriarty Services by Type - FY19

Registered Consumers with an ID						
Services by Category	**Number of Consumers**	**Units**	**Mean units per consumer**	**Mean units per consumer**	***Units Not linked to a Consumer***	***Total Units***
Transportation	16	1,128	70.5	18.0	43	1,171
Congregate Meals	103	3,255	31.6	12.0	85	3,340
Home Delivered Meals	51	6,249	122.5	69.0	78	6,327
Nutrition Education	0	0	0.0	0.0	360	360
Total Units		**10,632**	**62.5**	**25.5**	**566**	**11,198**
Unique Consumers	*145*					
Number of Unique Consumers that used 2 or more services	*92*					

Las Cruces

The City of Las Cruces offered a total of seven services to 2,651 unique consumers. Approximately 59% of those individuals used more than one service in FY19. As expected, Home Delivered Meals were the most utilized service in terms of units consumed, with 213,531 meals provided throughout Las Cruces and an average of 269.3 meals per consumer. The second-most used service was Congregate Meals with 99,569 meals and an average of 53.0 meals per consumer. Interestingly, Homemaker services were the third-most used service, with an average of 55.6 units of service used per consumer. And only 28, or 1.1%, of consumers accessed Respite Care services in Las Cruces. Consumers needed a total of 4,019 hours of support, but with the average person needing 143.5 hours of services. Nutrition Education services, once again, could not be linked to registered consumers and account for 14,508 units.

Table 49. Las Cruces Services by Type - FY19

Registered Consumers with an ID						
Services by Category	**Number of Consumers**	**Units**	**Mean units per consumer**	**Mean units per consumer**	***Units Not linked to a Consumer***	***Total Units***
Homemaker	89	4,948	55.6	52.3	0	4,948
Congregate Meals	1,879	99,569	53.0	17.0	281	99,850
Home Delivered Meals	793	213,531	269.3	252.0	0	213,531
Respite Care - CG*	28	4,019	143.5	154.0	0	4,019
Respite Care - CG- GPRG*	13	292	22.5	22.0	0	292
Nutrition Education	0	0	0.0	0.0	14,227	14,227
Total Units		**322,359**	**115.0**	**44.0**	**14,508**	**336,867**
Unique Consumers	2,651					
Number of Unique Consumers that used 2 or more services	*1,557*					

Taos

Out of all our selected sites, Taos had the lowest number of individuals who used more than one service. Taos offered seven services to 777 unique consumers. Only 23% of consumers used more than one service. As expected, Congregate Meals and Home Delivered Meals were the most used services. The average consumer needed 31.8 Congregate Meals and 178.4 Home Delivered Meals. Approximately 19% of consumers also used 6,810 one-way trips--an average of 47.3 trips per consumer. Compared to the other four sites, Taos' had the highest total service units that could not be linked to a consumer—2,280 units of Nutrition Education, 636 Home Delivered Meals, 308 Congregate Meals, and 122 one-way trips.

Table 50. Taos Services by Type - FY19

Registered Consumers with an ID					***Units Not linked to a Consumer***	***Total Units***
Services by Category	**Number of Consumers**	**Units**	**Mean units per consumer**	**Mean units per consumer**		
Case Management	14	259	18.5	14.9	0	259
Transportation	144	6,810	47.3	9.0	122	6,932
Congregate Meals	570	18,103	31.8	6.0	308	18,411
Home Delivered Meals	172	30,688	178.4	200.0	636	31,324
Counseling/Training - GPRG	8	23	2.9	2.5	0	23
Respite Care - GPRG	8	46	5.8	4.6	0	46
Nutrition Education	0	0	0.0	0.0	2,280	2,280
Total Units		**55,929**	**61.1**	**11.0**	**3,346**	**59,275**
Unique Consumers	*777*					
Number of Unique Consumers that used 2 or more services	*186*					

DISCUSSION AND CONCLUSION

We now turn to synthesizing and summarizing the various sections of this report. First, we discuss the implications of the census, consumer, and budget data. Second, we discuss the results of our focus groups, and provider and consumer surveys-- which we were not able to fully implement due to the COVID-19 pandemic. Nevertheless, we provide some insights from the work we completed. Third and finally, we include a section that compiles the census, consumer, and budgetary data with special focus on the six local sites. This final section concludes our pilot Needs Assessment.

Census, Consumers, and Budgets

New Mexico is geographically large and diverse, servicing 6 PSAs, four of which are directly supported by the ALTSD and are the focus of this assessment. According to census data, approximately 22.7% of New Mexico's population is 60 years of age or older, or about 474,147 people. In FY 2019, ALTSD provided services to 44,022 unique individuals or about 9.3% of the eligible population. This calculation does not capture three populations: (1) the number of consumers who are younger than 60 years of age, (2) the number of disabled individuals in New Mexico who may be eligible for services, or (3) the number of people who are served in PSAs 5 and 6. Despite this, we believe the Department should try to better understand consumers with a disability who fall under the ALTSD's target population. The consumer data maintained in WellSky unfortunately does not differentiate between elderly users, disabled users, or users who are both elderly and disabled-- and so it is not currently possible to make this differentiation. Regardless, this review shows that a large portion of the elderly population does not receive services. We do not know why more of the eligible population does not receive services. Our full assessment was designed to better understand the eligible population, and ALTSD should consider implementing the full needs assessment when this is possible. The ongoing pandemic does not currently make this practical. Still, research could be conducted to understand how the pandemic has impacted the populations served by ALTSD and how the ALTSD may have to adapt to public health crises.

Table 45 reports several features of the eligible population, considering the number of individuals 60 years of age or older, the number of consumers served in the site, and the percent of the eligible population served. It is important to note that this value is only an estimate because consumers served in a single site do not necessarily live within that site's boundaries. For example, as we reported earlier, we know some consumers served in Gallup were residents of Arizona. Our complete assessment would have explored this issue in enough depth to report on the extent this occurs. For example, in Moriarty our research would have involved studying the number of consumers who use services in Moriarty, but who are not residents within city boundaries. This would have allowed us to expand the parameters we used for generating the population served by Moriarty, thereby understanding where exactly consumers lived. This would have been completed for all the study sites. We hope to complete this research in the future.

Keeping in mind the limitations of our estimates, less than 10% of the eligible elderly population received services in FY 2019 in New Mexico. The number served varied by PSA from 6.2% in PSA 1 (Bernalillo County) to 21.2% in PSA 6. The numbered served by local sites varied from 6.2% in Bernalillo County (PSA 1) to 39.2% in Taos. These large differences may partly be a result of the population served within a site not being well-represented by the census population estimates. Based on our preliminary work, we know that sites draw consumers from outside the census area covered by the site, and this may be more pronounced for smaller geographical areas. Again, our complete assessment was designed

to explore this issue. Other factors include the specific needs of consumers within the PSAs and sites, as well as socioeconomic factors. This is explored further next.

Table 51. Population and Consumers

Site	Population	Percent	Consumers	Percent Served
New Mexico	474,147	22.7	44,022	9.3
PSA 1	145,554	21.5	9,062	6.2
PSA 2	181,036	24.3	18,226	10.1
PSA 3	61,627	20.5	7,971	**12.9**
PSA 4	85,930	23.3	9,290	10.8
PSA 6	16,400	21.1	3,471	**21.2**
Gallup	5,419	18.9	1,355	25.0
Hobbs	4,177	14.2	838	20.0
Las Cruces	20,546	20.2	2,651	12.9
Moriarty	429	19.3	145	**33.8**
Taos	1,981	32.9	777	**39.2**

Table 52 (below) summarizes service usage among Planning and Service Areas (PSAs). Without exception, as a percentage of unique consumers PSA 6 had the highest service usage out of all PSAs. Despite this fact, PSA 6 also has the smallest population of older adults of all PSAs. Further, the mean service usage per consumer was at least 2 times that of all PSAs; median service usage per consumer was 3 times higher. The next highest service usage was by PSA 1, where 38% of consumers use 2 more services; followed by PSA 2 with 35% of consumers using 2 or more services.

Table 52. Summary of Services and Consumers by PSA

PSA	Unique Consumers	Mean services per consumer	Median Services per Consumer	Max # Service per Consumer	Consumers that used 2 or more Services	% of consumers that used 2 or more Services
PSA 1	9,062	1.7	1.0	11	3,459	38.2%
PSA 2	18,226	1.6	1.0	16	6,451	35.4%
PSA 3	7,971	1.4	1.0	10	2,161	27.1%
PSA 4	9,290	1.5	1.0	9	3,028	32.6%
PSA 6	*3,471*	***3.8***	***3.0***	*18*	*2,487*	***71.7%***

Table 53 reports selected census data for New Mexico, PSA, and local sites. The reported census data provides a description of the sites providing indications of poverty, living situations, and disability. A number of cells have been highlighted and indicate PSAs and sites with higher percentages of the particular factors. For example, Gallup, N.M. had higher percentages of low income, percent below poverty, percent living alone, and percent with a total disability compared to other sites. Similarly, Taos had a higher percentage of low income, below poverty, living alone, and using food stamps in the prior 12-months. Taos also had the highest percentage of 60 years of age or older residents in their census population. Interestingly, Bernalillo County (shown as PSA 1) and Las Cruces, in comparison, did not have any of the highest values of disadvantage, but did have the largest number of eligible consumers. This contrasted with PSA 6 which had the smallest eligible population, but retained the highest total disadvantage of all PSAs. Despite this, Table 51 also indicates PSA 6 is the best at serving its eligible

consumers—reaching nearly twice as many eligible persons. As we have explained though, Table 51 and all our analyses rely on census data to describe populations by site, and we know that consumers from outside the immediate census areas access services provided by other sites. To this point, the census population is only an approximation and more research should be completed to understand who uses services and why. Once again, our full assessment would have provided context, insight, and greater depth to older adult need and desire for services by site.

Table 53. Population and Census Data

Site	Population	Percent 60 years or older	Low Income	Below Poverty	Alone	Food Stamps or SNAP in Prior 12 Months	Total Disability
New Mexico	474,147	22.7	22.1	12.8	27.6	12.0	39.9
PSA 1	145,554	21.5	18.9	10.8	29.6	10.8	35.9
PSA 2	181,036	**24.3**	21.3	14.2	26.8	11.7	40.3
PSA 3	61,627	20.5	**28.6**	11.8	27.9	11.8	**44.7**
PSA 4	85,930	**23.3**	24.3	13.8	26.0	**14.7**	42.0
PSA 6	77,691	21.1	**29.5**	**19.7**	**37.5**	**20.7**	**46.4**
Gallup	5,419	18.9	27.3	**16.5**	**32.6**	12.5	**43.1**
Hobbs	4,177	14.2	25.0	9.2	25.1	**14.1**	**51.2**
Las Cruces	20,546	20.2	20.1	9.5	27.8	13.5	40.2
Moriarty	429	19.3	26.6	**28.1**	**38.3**	13.9	31.9
Taos	1,981	**32.9**	**29.6**	**17.0**	**35.6**	**16.3**	31.1

Focus Group and Field Observations

As we have reiterated throughout this report, we could not completely implement our research methodology which would have included field observations, site visits, focus groups, and surveys designed to collect information at the local site level. These data would have helped describe the circumstances of the local sites and provide context to the census data and consumer data.

Based on our single focus group, ALTSD has established a fairly comprehensive and reliable data system focused on documenting the number and type of services provided. However, there is currently no method for examining older adult service processes or need, or for determining the most *needed* older adult services, *desired alternative* services, or the proportion of *unmet* need. The work proposed in this assessment was purposefully designed to explore these topics by holding focus groups with older adults and service providers directly.

Our single focus group with consumer coordinators, who are responsible for the client level data collected in PSA 2, PSA 3, and PSA 4, revealed the robust and detailed information achievable through this research method—information vital for the creation of long-term planning. Our focus group analysis, along with our literature review, emphasized the critical importance of eliciting and incorporating the perspective of consumers into short- and long-term area plans. Our research plan ultimately included six key research questions (figure below), three of which focused on consumers and service providers.

Older Adult Focus Group Research Questions	Service Provider Focus Group Research Questions
How do current ALTSD services address the needs of older adults?	In what way(s) do providers interact with older adults?
In what way(s) do existing older adult services contain gaps in coverage, delivery, etc.?	In what way(s) do providers identify the needs of older adults and attempt to address those needs?
How can existing services be improved to address the needs of older adults?	How would resources or services not currently available allow providers to meet older adults' needs?

Our team was able to complete three site visits prior to the COVID-19 pandemic, which shut-down in-person research at the University of New Mexico. These preliminary visits occurred in Bernalillo County, Moriarty, and Gallup. Site visits to the senior centers in Gallup and Moriarty suggested that older adults may live in the broader surrounding areas outside of site boundaries. Because PSAs receive funding based on the size of the older adult populations they support, budgets may currently fail to account for the effects of this PSA boundary movement. Service need where this occurs could be substantially higher than local older adult population sizes suggest. In one cogent example, senior center administrative staff in Gallup anecdotally described that they do often receive older adults from Arizona and Utah, as well as from nearby reservations. Additionally, older adults from Moriarty described rotating between senior centers, which included centers as far away as Albuquerque. Beyond this, our informal conversations with administrative staff in the Albuquerque/metro area further revealed that the most popular older adult services tend to be programs that support socialization and physical activity.

In sum, the results of our focus group and field observations provided preliminary insight into who receives services at local sites, and further study is needed to better understand *who* receives services, which services are preferred by consumers, the reasons why consumers receive services, and the types of services older adults receive.

Budget and Expenditures and Consumer Data

Our analysis of budget, expenditure, and consumer data indicated some surprising findings. In total, the FY 2019 budget for New Mexico was $32,500,104.67. Table 54 combines information from earlier tables in this report, and includes the totals for PSA 1 (Bernalillo County) as well as the totals reported for PSA 2, 3, 4, and 6. PSA 4, with a population of 85,930 60 years and older, had the largest budget, followed by PSA 2 (population 181,036), PSA 1 (population 145,147), and PSA 3 (population 61,627). Table 54 also includes the percent of services which were either Home Delivered Meals or Congregate Meals. Meals in general accounted for the vast majority of services provided in FY 2019 in New Mexico and across the PSAs, with the exception of PSA 1 (65.1%) and 6 (55.5%). In PSA 6 Support Services accounted for roughly half (40.4%) of all provided services in the region.

Table 55 reports similar information as Table 54, but for the six selected sites. Compared to the PSAs, there was more variability in sites regarding the proportion of services accounted for by meals, but the

general trend remained the same. Meals accounted for the lowest percentage of all services in Bernalillo County and Hobbs and accounted for the large majority of services in Moriarty and Taos and almost all the services in Las Cruces. It would be useful to better understand why meals accounted for the vast majority of all New Mexico services and why this varies by PSA and site.

Table 54. PSA Budget, Population, Consumers, and Services

Site	Budget	Population	Consumers	Budgeted Services	Meals
New Mexico	$32,500,104.67	474,147	44,022		80.8%
PSA 1 (Bernalillo County)	$7,690,882.64	145,554	9,062	22	65.1%
PSA 2	$9,308,918.51	181,036	18,226	15	82.2%
PSA 3	$4,256,357.44	61,627	7,971	10	77.6%
PSA 4	$11,243,946.08	85,930	9,290	12	87.3%
PSA 6	N/A	77,691	3,471	N/A	55.5%

Table 55. Local Sites, Budget, Population, Consumers, and Services

Site	Budget	Population	Consumers	Services	Budgeted Services	
Bernalillo County	$7,690,882.64	145,554	9,062	24	22	65.1%
Gallup	$378,445.64	4,177	1,355	5	3	76.2%
Hobbs	$127,229.00	5,419	838	6	2	67.4%
Las Cruces	$914,777.60	20,546	2,651	6	5	97.1%
Moriarty	$326,280.37	429	145	4	3	89.4%
Taos	$707,115.96	1,981	777	7	3	87.2%

Services by PSA and local site varied overall, but Congregate Meals and Home Delivered Meals always accounted for a majority of services. Currently, it is not clear why meals constitute between 56% and 97% of all services by PSA and local sites, and 80.8% of all services in New Mexico. It is unclear if meals are the primary service desired by eligible residents, or whether this service is considered the most needed and desired. It is possible to that meal services are the most cost effective and reach the largest number of eligible residents.

By focusing on a limited number of sites, our full assessment was designed to explore in detail the use of services by consumers and better understand at a more local level how consumers and providers view services. As we established in our review of previous needs assessments, state-wide assessments cannot tell us enough about local issues and how the needs of the elderly and the services available to them vary within a state. Our needs assessment is a proof-of-concept combining quantitative and qualitative methods, and focusing on a small subset of purposefully selected sites in New Mexico. Our work was intended to assess in greater depth and detail the unique circumstances of local areas using a range of data from a variety of sources. This included census data; the analysis of consumer data; a review of the contract, budget, and expenditure data to better understand the budgeted services and expenditures; the use of field reconnaissance and visits to targeted sites; focus groups and surveys of consumers, and focus group and surveys of providers. In combination, these sources provide more insight than any single source on its own.

Reviewing the services used by consumers is important and useful, but also limited. The reliance on administrative data tells us what services are being provided, but it cannot tell us what is important to consumers and what consumers think about the available services, and what services that would be of the most assistance or most desirable. It also does not provide insight from service providers' viewpoint regarding, among other things, the provision of services, how consumers use the services, and the quality of services.

The full assessment would have similarly provided insight into the disabled population served by the Department. Currently, very little is known about whether and how this population, which is not elderly, accesses services and what portion of the elderly population live with disability. Service type sheds some light on consumers with disabilities but is significantly limited.

ALTSD should consider implementing the full needs assessment when this is feasible. The ongoing pandemic does not make this practical. Some research could examine how the pandemic has impacted the populations served by ALTSD, how the ALTSD has adapted to the pandemic, and the impact on consumers and target populations.

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APPENDIX C

FOCUS GROUP GUIDE TUCUMCARI DATA CENTER

Focus Group Topics and Questions

● OPENING

◦ Remind participants about using restroom, answering phone calls, speaking one at a time, getting food, etc.

● PROCESSES

◦ **What does a typical work day look like for you?**

[PROBE: details about □ the variety of tasks in a day, □ who do you normally interact with, □ what *kinds* of data do you receive and enter, □ are there divisions of roles and responsibilities among consumer coordinators in the office, and □ common challenges]

◦ **Is any portion of your work/job not related to data entry?**

[PROBE: details about □ examples of what these non-data-entry tasks look like, □ what portion of their work includes these non-data entry tasks]

◦ **In what ways do you work with service providers?**

[PROBE: details about □ specific examples of these interactions, □ specify situations with "sponsors" of service providers, □ what does it look like if service providers make mistakes]

● QUALITY

◦ **When information/data you receive doesn't look right or you know is incorrect/problematic, what do you do?**

[PROBE: details about □ how these get resolved, □ do some cases never get resolved]

◦ **What do you think about the *quality* of the data you gather and enter?**

[PROBE: □ What kinds of data would you consider "Poor or Low Quality" □ What kinds of data would you consider "Average" □ What kinds of data would you consider "High/Excellent Quality"□ How you know when you have high/excellent quality data, □ how you know when you have poor/low quality data]

◦ **Thinking about the types of data you receive: How would you rank that data from Very Poor, to Average, to Excellent?**

[PROBE: details about □ how these get resolved, □ do some cases never get resolved]

◦ **What kinds of changes do you think would improve the quality of the data?**

[PROBE: details about □ why, □ changes that could improve quality of data *collection* □ changes that could improve quality of data *entry*]

● CLOSING

◦ **Are there any comments or thoughts that haven't come up that you would like to share?**

APPDENDIX D

Survey Questions for Service Providers

Introduction: This survey is being conducted by the University of New Mexico's Institute for Social Research (ISR). We have been contracted by the Aging & Long-Term Services Department (ALTSD) to perform a Need Assessment of older adults and adults with disability. You provide services to this group of people within one of our selected research sites and we would like your insight on their needs. This information will guide ALTSD in implementing policy to support older adults and adults with disability in our communities. Your survey responses will be entirely anonymous and any identifying information kept strictly confidential by ISR.

As a thank you for your participation and time, for every ten people who complete this survey, ISR will randomly select one of those ten respondents to receive a $25 Amazon gift card. Participants must complete at least 50% of the survey to be eligible. In light of the current public health emergency we will be e-mailing selected participants a digital Amazon gift card which they can redeem. At the end of this survey, you will be asked whether you'd like to be entered into this sweepstakes. If you choose to be entered, you will be asked for your contact information. This information will not be associated with your survey responses and ISR will keep it strictly confidential.

SPECIAL NOTE: COVID-19 has widely transformed the availability and delivery of services, and may have affected need among older adults and adults with disability. But as you consider the questions in this survey, please limit your responses to older adult services and need prior to COVID-19's impact. In light of the public health crisis, we have created a dedicated section in this survey to specifically explore the impact of COVID-19.

CONTACT US: If you have any questions or concerns about this survey, please feel free to call Keith and leave a message at (505) 389-8393. Voicemails are checked every two days. Alternatively, you can also e-mail ISR at CARAproject@unm.edu.

CONSENT TO PARTICIPATE

(1) [THIS IS THE ONLY REQUIRED QUESTION IN THE SURVEY]
You are being asked to participate in a survey conducted by the Institute for Social Research (ISR) with the University of New Mexico (UNM). In selecting "I Do Consent" below, you agree to allow ISR researchers to use your survey responses as data in our final report for the Aging Network Division's Need Assessment. You also acknowledge by consenting, that you understand

your participation is entirely voluntary and that you have the right to decline to participate in this survey at any point, for any reason.

(1) I Do NOT Consent (2) I Do Consent
--MULTIPLE CHOICE QUESTION—

BACKGROUND & EXPERIENCE

(2) Which city do you provide services within: (Ex. Albuquerque (PSA 1), Gallup (PSA 2), Moriarty (PSA 2), Taos (PSA 2), Hobbs (PSA 3), Las Cruces (PSA 4))
--OPEN ENDED—

(3) How many years have you worked with older adults or adults with disability? NOTE: Please round down to the nearest year.
--NUMERICAL VALUE

(4) How many Years have you worked for the agency/organization you are currently at? NOTE: Please round down to the nearest year.
--NUMERICAL VALUE--

PROVIDER SERVICES INVENTORY

(5) Please select which service(s) you provide to older adults. If your service(s) is not listed, please select Other and specify the service(s).

Access

- Case Management
- Information Assistance
- Outreach/Client Finding
- Transportation
- Assisted Transportation

In-Home

- Housekeeping
- Chore
- Personal Care
- Home Health Care
- Home Visiting
- Telephoning

Legal Assistance

- Direct Service
- Interactive Workshop
- Legal Clinic
- Education Distribution

Other Community

- Loan of Durable Medical Equipment
- Senior Center Activities
- Physical Fitness/Exercise

Congregate Meals

Home Delivered Meals

Health Promotion & Disease Prevention

- Evidence Based Health Programming
- Staff Training in Evidence-Based Programming

Caregiver Support

Caregivers serving Elderly

- Respite Care (Adult Day Care)
- Respite Care (In-Home)
- Respite Care (Supp./Vouchers)
- Counseling
- Education/Training
- Supplemental Services
- Access Assistance
- Information Services

Grandparents/Elderly Caregivers

- Respite Care (Adult Day Care)
- Respite Care (In-Home)
- Respite Care (Supp./Vouchers)
- Counseling
- Education/Training
- Supplemental Services
- Access Assistance
- Information Services

Services Not Listed

Other:

--MATRIX QUESTION WITH CHECKBOXES. PARTICIPANTS CAN CHOOSE ALL THAT APPLY—

OTHER OPTION FOR PROVIDER SERVICES INVENTORY

(6) [CONDITIONAL UPON SELECTING "OTHER" IN QUESTION 5]
Please specify the service(s) you provide which wasn't listed:
--OPEN ENDED--

PROFILE OF SERVICE RECIPIENTS

(7) Thinking about the people you provide services too most often, please select the descriptors from each category which ***best*** describe the population you work with:

INCOME

Low Income	Middle Income	High Income	Don't Know

DISABILITY

Lives w/o a Disability	Lives w/ a Disability	Lives w/ 2+ Disabilities	Don't Know

Race & Ethnicity

White (Non-Hispanic)	Hispanic	Native American	African American	Other:	Don't Know

LIVING ARRANGEMENTS

Lives Alone	Lives with Spouse or Partner	Lives with Friend	Lives with Family	Don't Know

AGE

<50	50-60	61-70	71-80	81-90	91+	Don't Know

PRIMARY LANGUAGE

English	English as Second Language	Does not Speak English	Don't Know

GENDER

Male	Female	Other:	Don't Know

--DROP DOWN SELECTIONS—DEFAULT RESPONSE SET TO "CHOOSE NOT TO RESPOND"—

OLDER ADULT NEED

(8) How much do you agree or disagree with the following statement:
The service(s) my agency/organization currently provides are able to meet the needs of older adults or adults with disability within my community.
(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree
(6) Don't know
--RATING QUESTION WITH LIKERT CHOICES ABOVE--

(9) Please briefly explain why you chose your response for Question 8:
--OPEN ENDED--

(10) Please list up to five tangible resources (potential services, administrative support, technology, types of funding, etc.) that would ***best*** support your agency/organization in meeting the needs of those you provide services to:
1._____ 2. _____ 3. _____ 4. _____
5. _____

--MATRIX WITH OPEN ENDED TEXT BOXES--

---

(11) How much do you agree or disagree with the following statement:
More older adults or adults with disability could use my agency/organization's help and/or services, but certain barriers prevent them.
(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree
(6) Don't know

--RATING QUESTION WITH LIKERT CHOICES ABOVE--

SERVICE BARRIERS & PROVIDER SUPPORT

(12) Thinking about question 8, please describe a real-world case or example of someone who could use services, but isn't or wasn't able to. Be sure to explain what primarily prevented them from using your service(s):
--OPEN ENDED--

(13) In terms of services and social support generally, please list what you think are the top 3 ***greatest*** needs of older adults or adults with disability:
1._____ 2. _____ 3. _____

--MATRIX WITH OPEN ENDED TEXT BOXES--

(14) Continuing question 10, for each area of need you identified please briefly explain ***why*** you think it exists:
1._____ 2. _____ 3. _____

--MATRIX WITH OPEN ENDED TEXT BOXES--

THE FUTURE OF OLDER ADULT SERVICES & INTER-AGENCY COLLABORATION

(15) New Mexico's senior population is growing and predications indicate that the state's senior population will be the 4th highest in the country by 2030. Anticipating this future, please briefly describe what additional senior supportive services would be needed in your service area:
--OPEN ENDED--

(16) Does your agency collaborate with other state agencies to ensure that senior needs are met?

Yes No

--MULTIPLE CHOICE QUESTION—

INTER-AGENCY COLLABORATION OPEN ENDED

(17) [CONDITIONAL UPON 'YES' SELECTION IN QUESTION 16]:
If so, please list the state agencies you have collaborated with:
---OPEN ENDED---

COVID-19 BUSINESS PRACTICES

(18) To what degree has the current pandemic (COVID-19) negatively affected your business practices for providing services to older adults and adults with disability?
(1) Not At All (2) Slightly (3) Moderately (4) Very (5) Extremely
--RATING QUESTION WITH LIKERT CHOICES ABOVE--

OPEN ENDED COVID-19 BUSINESS PRACTICES

(19) [CONDITIONAL UPON SELECTING OPTIONS 2-5 IN QUESTION 18]
Please briefly describe how COVID-19 has negatively affected your business practices:
--OPEN ENDED—

COVID-19 OLDER ADULT NEED

(20) To what degree has the current pandemic (COVID-19) negatively affected need among older adults and adults with disability?
(1) Not At All (2) Slightly (3) Moderately (4) Very (5) Extremely

--RATING QUESTION WITH LIKERT CHOICES ABOVE--

OPEN ENDED COVID-19 OLDER ADULT NEED

(21) [CONDITIONAL UPON SELECTING OPTIONS 2-4 IN QUESTION 20]
Please briefly describe how COVID-19 has negatively affected need among older adults and adults with disability:
--OPEN ENDED—

ADDITIONAL COMMENTS

(22) Is there anything else related to older adults and support services that you would like to tell us?
--OPEN ENDED—

INCENTIVE PARTICIPATION

(23) **NOTE:** Your responses have not been submitted yet.

If you would you like the chance to be selected for a $25 Amazon gift card, please select YES below and provide ISR with your contact information.

If you decline to be selected for a $25 Amazon gift card, please select NO and your survey responses will be submitted.

Yes No

--MULTIPLE CHOICE QUESTION—

INCENTIVE CONTACT INFO

(24) [CONDITIONAL UPON SELECTING YES IN QUESTION 23]
To be included in ISR's sweepstakes, please provide your contact information below:

NOTE: Your contact information will be kept strictly confidential by ISR and will NOT be associated with your survey responses.

FIRST NAME:

LAST NAME:

E-MAIL ADDRESS:

--MATRIX WITH OPEN ENDED TEXT BOXES —

CLOSING

Thank you for participating!

APPENDIX E

A Needs Assessment of older adults in New Mexico
Consumer Coordinator Focus Group Survey

Please complete the following questions about your job or affiliation with North Central New Mexico Economic Development District (NCNMEDD).

1. **How many *years* have you worked in your current job as a Consumer Coordinator?**
   _____ years

(Please round up or down for partial years – 6 months or more equals 1 year)

2. **Including your time as a Consumer Coordinator, how many years have you worked for NCNMEDD or Aging and Long-Term Services (ALTSD)?** _____ years

(Please round up or down for partial years – 6 months or more equals 1 year)

APPENDIX F

Name of Observer:_____ Date:_____

Name of Site: _____

Site Recon Task	Completed?	Notes/Details
Field Observations: Administration	☐	
Field Observations: General Impressions	☐	
Field Observations: Recipients	☐	
Field Observations: Service Providers	☐	
Field Observations: Volunteers (if applicable)	☐	
Field Observations: Organizations of Materials (tables, chairs, stage, etc.)	☐	
Field Observations: Organization of People	☐	
Field Observations: Visible Services	☐	
Location(s) for Focus Group Available?	☐	
Extra Considerations to Note	☐	
Rough Sketch of Site	☐	
Collect schedule for site (Lunch when, what services when, etc.)	☐	
Establish Contacts with Admin	☐	

Rough Sketch

[**Hand Drawn**]

Script

If someone asks what you're doing, say something like the following:
"I was just curious about what's available here (services, activities, etc.). I'm a student/work at UNM and am involved in a project related to seniors (or older adults) and wanted some more information about services they can get (or are available). Do you mind if I look around?"

Key Aspects for Observations

[Field Observations] Administration- Record important details about the number of staff, where they're at, what they're doing.

[Field Observations] Recipients- Observe the number of people who are at the site- are they relatively young, old, etc. Are there only a few in groups next to each other, far from each other, crowded and very limited room for anyone?

[Field Observations] General Impressions- What is your sense of the site in general? Is it crowded or empty, noisy or quiet, do you think the site is comfortable or uncomfortable and why?

[Field Observations] Service Providers- Record observations related to those providing food (if a meal site) or others providing services (Zumba instructors, nurses, etc.).

[Field Observations] Volunteers- This may be difficult to observe if a volunteer is not obvious. Only record if there is some certainty about whether someone is a volunteer (and detail why there is certainty).

[Field Observations] Organization of Materials- Record/Observe the design and layout of the spaces. Are there enough chairs? Is there room for nearly a hundred people, or less than fifty? Are certain spaces dedicated to activities, or are they multifunctional?

[Field Observations] Organization of People- Record/Observe factors related to how people are sitting, working or moving in relation to one another. For example, is there much separation between people eating and people working? Are people engaged in activities close to those eating/working? Consider where people are in relation to others and how they're arranged.

[Field Observations] Visible Services- What activities are people engaged in that you can clearly observe?

[Field Observations] Focus Group Locations- Are there rooms or spaces which could be isolated so that a focus group could be held without interruption/noise?

[Field Observations] Extra Considerations- Anything else that you have observed or would like to note that doesn't fit within other categories.

[Field Observations] Rough Sketch- Draw a rough sketch/map of the site for future reference (Page 2)

[Field Observations] Collect Site Information- This may consider with the last item (Admin Contacts). If there are pamphlets, flyers or other advertising material related to the site itself, collect them and bring back with this checklist.
[Field Observations] Admin Contacts- Obtain contact information (business card, phone number) of director/administrator/scheduler in case that site selected for a focus group.

APPENDIX G

Table 56. Consumer Data Unit Measure by Services

Services	Unit Measure
SUPPORTIVE SERVICES	
Access	
Assessment/Reassessment	1 Hour
Assisted Transportation	1 One-way Trip
Case Management	1 Hour
Information and Assistance	1 Contact
Information and Referral	1 Contact
Outreach/client finding	1 Contact
Transportation	1 One-way Trip
In-Home	
Chore	1 Hour
Homemaker	1 Hour
Home Visiting	1 Visit
Personal Care	1 Hour
Telephoning	1 Call
Legal Assistance	
Advocacy/Representation	1 Contact
Legal Assistance	1 Hour
Other Community	
Adult Day Care/Health	1 Hour
Health Screening	1 Hour
Home Repair/Renovation/Maintenance	1 Hour
Interpreting/Translating	1 Hour
Loan of durable Medical Equipment	1 Distribution
Multipurpose Senior Services	1 Contact
Physical Fitness	1 Participant/Session
Recreation	1 Participant/Session
CONGREGATE MEALS	1 Meal
HOME DELIVERED MEALS	1 Meal
HEALTH PROMOTION & DISEASE PREVENTION	
A Matter of Balance MOB	1 Participant/Hour
Diabetes Self-Management Program	1 Participant/Hour
Enhanced Fitness	1 Participant/Hour
My CD	1 Participant/Hour
Tai Chi for Arthritis	1 Participant/Hour
Tai Chi Quan Moving for Better Balance	1 Participant/Hour
CAREGIVER SUPPORT	
Caregivers Serving Elderly	
Access Assistance	1 Contact
Education/Training	1 Participant/Hour
Counseling/support groups/training	1 Session/Participant

Information Services	1 Activity
Respite Care	1 Hour
Supplemental Services	1 Distribution
Grandparents Raising Grandchildren	
Counseling/Support Groups/Training	1 Session/Participant
Respite Care	1 Hour
ALL-STATE OTHER	
Medication Management	1 Contact
Nutrition Education	1 Session/Participant