Full Report

Policy Goals to Support the Healthcare Workforce in Healthy Aging Communities

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Center for Health Innovation, New Mexico's Public Health Institute

Acknowledgments

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EXECUTIVE SUMMARY

With funding from the New Mexico Department of Health, the Center for Health Innovation engaged five rural Southern New Mexico counties in research, analysis and discussion about their healthcare workforce development needs now and in the future. The five counties included Grant, Sierra, Socorro, Catron and Valencia. Project participants included representatives from NM Department of Health-Health Promotion, health councils, hospitals, Community Health Centers, schools, universities, community organizations, Council of Governments, county government, elected officials, and others.

The six month project spanned the period from January to June 2020. The project design included: (1) secondary data analysis; (2) surveys for primary data and analysis; and (3) group discussions for identifying provider and community needs; analyzing current and projected workforce challenges; and discussing and framing system alignment and policy issues that impact needs, services, and capacity to recruit and retain the healthcare workforce.

After being presented with evidence gathered through data collection and analysis, several deep group discussions led to the identification of two primary issues that have a significant impact on the current and future healthcare workforce: (1) the growing percentage of older adults, and (2) the need for a stronger behavioral health system. Participants also revealed two system issues that cut across both issue areas having a significant impacts on workforce development. First, there is lack of alignment between the needs of organizational providers; the training, licensing and certification requirements; what services are most needed verses services that are reimbursable by insurance; state departmental policies and procedures; and NM legislation. Second, there are challenges with developing a frontline team of paraprofessionals that provide comparable work across titles, but with different training and certification requirements. Additionally, services provided only by certain paraprofessionals are reimbursable by insurances even though other paraprofessionals may receive similar training and have a comparable scope of practice. In rural communities, these people often do very much the same type of work, with the primary distinction being that some are peers and other are not peers; and some have college degrees and others have high school or associate level educational credentials.

Project participants engaged in dialogue about the two primary issues (older adults and behavioral health) with the aim of agreeing on policy directions that would address the current and future healthcare workforce needs of their communities. Participants identified seven policy goals for each issue (14 total). Each policy goal was discussed further by examining what improvements would be achieved from the policy goal, examples of similar policy strategies in New Mexico or other states, and steps needed to implement the policy goal. Next, the group prioritized the top 2-3 policy goals for each issue. The top policy goals to support the healthcare workforce in healthy aging communities are:

- Providers work regionally, with Aging and Long Term Services Department (ALTSD), the Area Agency on Aging (AAA), the New Mexico Advisory Council on Aging with Senior Service Providers and Agencies (Advisory Council), NM HSD, NM DOH and other state

agencies and legislators to maintain, integrate and expand funding for local/regional older adult services.

- Integrate aging and healthcare into city, county and regional (i.e. Council of Governments) Comprehensive Plans for economic development.
- Expand Medicaid and Medicare reimbursable services for navigation, screening, and care coordination services to older adults at multiple sites (e.g. in Senior Centers, senior housing complexes, and in homes, telehealth), that can be delivered by frontline/ credentialed/ certified workers in addition to licensed professionals.

Implementation of the policy goals and strategies will be carried out by the Mid Rio Grande Economic Development Association and the Healthcare Task Force of Grant County's Community Workforce Alliance .

Policy Goals to Support the Healthcare Workforce in Healthy Aging Communities

Background

The Issue:

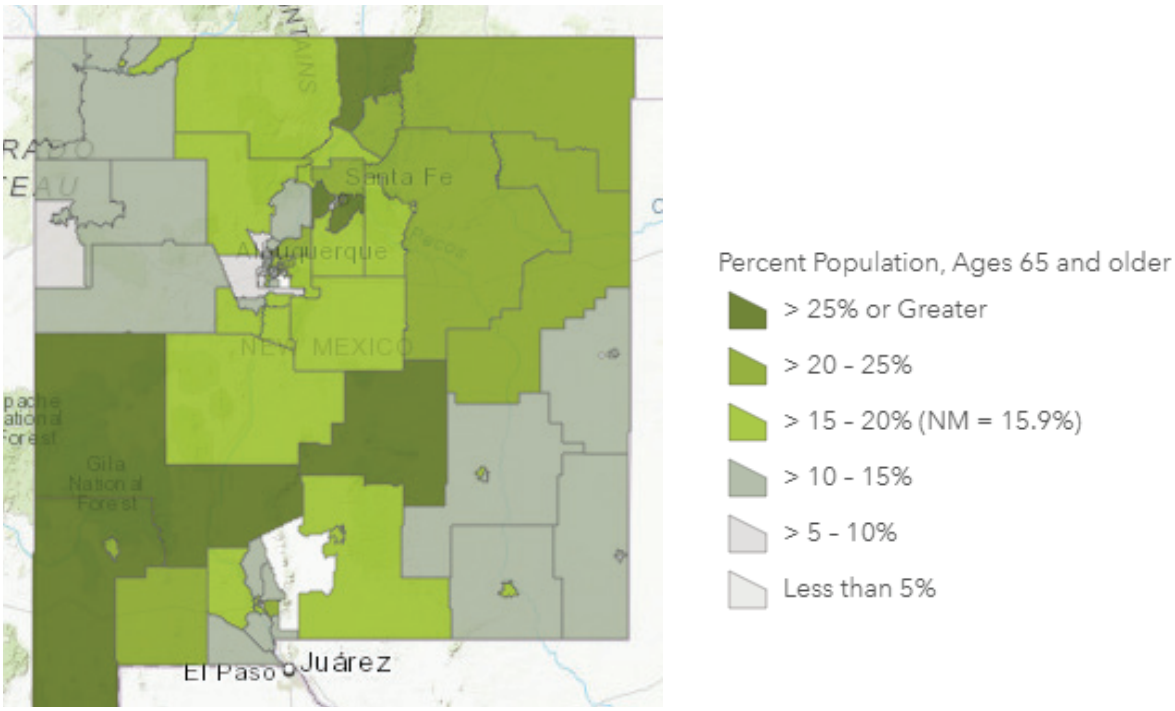
By 2030, New Mexico will have the fourth largest 65+ population percentage in the nation. Older adults contribute significantly to the economic health of rural communities. Policy changes are needed to promote healthy aging in communities and support a diverse healthcare workforce and services to ensure elders have the ability to age in place, live productively, with high quality lives.

Background Information About the Issue:

► *Demographics:*

New Mexico has a fast-growing older adult population with increasing health and social needs. Over the next decade the 65 and older population will grow by over 30%. This makes New Mexico the state with the fourth highest percentage of people age 65 and older, with more people over age 65 than under age 18.[1]

1. Rinaldi, G. Aging in New Mexico. New Mexico Aging and Long Term Services Department. Retrieved 5/13/2020 from: www.nmaging.state.nm.us/uploads/FileLinks/bfde5e90da214f88a7211f760f5b9620/ALTSD_General_FY13_3_3_14.pdf



New Mexico Population by Small Areas Map
Source: *NEW MEXICO COMMUNITY DATA COLLABORATIVE; NM-IBIS, NMDOH VITAL RECORDS*
with
Source: Census.gov - Data from the 2010 United States Census. The Census counts every resident in the U.S. and is conducted once every 10 years.

The older adult population in New Mexico as a percent of past, current, and projected total state population is listed below:

Over 65	2015	2020	2025	2030
Population	343,622	419,690	497,357	555,184
Percent	16.8%	20.1%	23.6%	26.4%
National Percent	14.5%	16.3%	18.2%	19.7%

Most rural counties have even faster-growing aging trends combined with other challenges due to shrinking economies and working age populations moving to urban areas for school and education. In a pilot study of five rural counties (Grant, Catron, Sierra, Socorro and Valencia) those age 65 and older comprised up to 35.5% of the population in portions of the study area compared to a state average of 17.5%. (U.S. Census 2019). Over 15% of the U.S. population residing in rural areas have a disability, and the percent of those living with more or more disability increases with age.[2] Older adults in rural areas are more likely to live below the poverty level, have low access to healthy foods and have multiple chronic health conditions. (See Table 2)

2. Census.gov ACS

Select demographic characteristics of metro and non-metro New Mexico counties

Characteristic	Metro Counties	Non-Metro Counties
Poverty	17.3%	22.6%
Low access to healthy foods	50.1%	70.7%
2-3 chronic health conditions	18.9%	22.6%

Sources: U.S. Census Small Area Income and Poverty Estimates; National Center for Health Statistics Data Finder

► *Social Determinants of Health*

Research shows that when the elderly have access to nutritional food, exercise, medication reviews and health screenings, they are more likely to prevent injury and the onset of chronic disease. (NMIBIS) Transportation services are also critical to healthcare. Many individuals report that they miss or delay medical care because they lack appropriate transportation to their appointments.

- 13% of the population of New Mexico are age 65 or older
- 27% of older adults in New Mexico are living alone
- 47% of grandparents who live with their grandchildren in New Mexico are responsible for them
- 9% of New Mexico senior households have an annual income of less than $10,000 and 27% less than $20,000
- 24% of state residents aged 60 and over received food stamps in the last year
- The average Social Security Income in New Mexico is $15,929/year
- The median household income for an older adult in New Mexico is $35,779
- Compared to other states, New Mexico ranks 26th for Long Term Care and 33rd for America's Health Rankings
- There are 43,840 working older adults in New Mexico
- 25% of elderly in New Mexico are veterans

► *Healthcare Workforce Needs for Older Adults*

The following list captures key issues identified by the five counties working on this healthcare workforce development project, which have a significant impact on healthcare workforce planning and the pipeline. These include:

- Current and projected shortages in nursing and specialty care.
- The need for workers to assist older adults and their caregivers with home health care, navigation, medication management, care coordination and linkages to resources such as

transportation, food, etc.

- Parallel current and future projected workforce staffing needs, according to the small group of providers completing the survey. The secondary data indicates that there will be significant projected shortages in certain types of positions (i.e. nurses, and some specialists). There will also be shortages linked to the changing demography, especially in those counties with fast-growing older adult populations, which represent most of the counties in the region.
- Anticipated higher-than-current turnover levels among nurses, specialists and behavioral health workers.

About the Study/Project:

The Center for Health Innovation (CHI) has been able to engage five counties at a deep level in research, analysis and discussion about the healthcare workforce needs, challenges, pipeline, recruitment and retention issues, rating and ranking of priorities, and a group discussion to develop a set of recommendations for key areas for healthcare workforce development. These recommendations address both the two areas seen as the top priorities for healthcare workforce development by the five Southern NM Counties, as well as the two system issues that can either facilitate or impede healthcare workforce development.

► *Selection*

The counties selected included Grant, Sierra, Socorro, Catron and Valencia. These five were selected for the following reasons:

1. They are part of a CHI RCORP planning project, and multiple healthcare planning work, with PHS, New Ventures Community Building, BHSD, ALTSD, DOH, the regional Council of Governments, and economic and workforce development groups.
2. These counties have already engaged in this work, and, due to a short project turnaround time, are the counties most able to leverage their ongoing work to address the healthcare workforce development issues in a timely fashion.
3. Providers in the region have a history of working together in different configurations, and can leverage a broad base of cross-sector relationships.
4. There are some excellent healthcare-economic development-education cross-sector planning projects and relationships which provide a needed model for effective healthcare workforce development.

► *Project Leadership*

The project leader is Ms. Susan Wilger, Executive Director of CHI. Rev. Dr. Anne Hays Egan, Principal of New Ventures Community Building serves as the co-lead and project consultant. Other key project personnel include: Ms. Sharon Finarelli, Consultant; Thomas Scharman, NM Department of Health Community Epidemiologist; Dr. Joan Goldsworthy, NMCDC Consultant; Ms. Emily McRae, NMCDC Consultant; Ms. Bala Salgado, CHI FORWARD NM AHEC Director;

Ms. Paris Conerly, CHI Program Specialist; and Ms. Alexis Brandt, CHI Data Specialist.

► *Methodology*

The project lead and co-lead developed the methodology, informed by the other project staff. The design includes: (1) secondary data analysis; (2) surveys for primary data and analysis; (3) group discussions for (a) identifying provider and community needs; (b) analyzing current and projected workforce challenges; (c) discussing and framing system alignment and policy issues that impact needs, services, and capacity to recruit and retain the healthcare workforce.

There have been multiple meetings on a monthly basis, from February through April, where providers from the counties discussed the needs and key issues; completed surveys; analyzed and prioritized the topic and systems issues; and developed policy recommendations. During this time, the groups also participated in a CHI NMCDC Data-to-Action Training and a Policy Workshop Training and Discussion.

Because of the configuration of county working groups, these five counties divided into two primary groups which did some work separately: Grant County, and Sierra, Socorro, Catron and Valencia Counties (which form the Middle Rio Grande Economic Development Association (MRGEDA) and its Healthcare and Social Services Committee). All five counties met together for the policy work, and for the final plan development, utilizing a working group to go over the plan summary matrices and plan narrative in two working group meetings. The joint group held its final meeting on June 12th, to review and adopt the final plan draft.

Several direct healthcare service providers participated during the course of the planning process. The counties that were the most deeply engaged included Grant, Sierra and Socorro Counties. Some of the participation was impacted by the COVID-19 crisis, which took many of the core community healthcare leaders away from non-emergency work. However, even with these healthcare and economic challenges from COVID-19, a significant proportion of healthcare leaders from these counties did participate, including DOH frontline and management staff.

► *Plan*

The healthcare providers have been actively engaged in the following work to build the plan:

1. Identification of needs: through secondary data analysis work with CHI's NMCDC, surveys, and group discussions;
2. Discussion of goals and priorities: through using data for planning (Data-to-Action Workshop); surveys; group discussions; and prioritization process;
3. Analysis of key strategies and policies needed to address both provider healthcare

workforce needs, as well as systemic issues that need to be addressed which impact workforce development, and healthcare workforce recruitment and retention;
4. Review and development of final plan drafts.

► *Implementation and Ongoing Work*

The Policy Work Group, an integrated subgroup of the MRGEDA and Grant County groups, provided the recommendations for policy goals and strategies to the larger group, discussed on June 12, 2020. The implementation will be handled at multiple levels, by a diverse constituency of providers:

1. Local providers will work to implement specific areas of the plan, particularly those identified on the matrices as provider and/or county-related.
2. Local providers will continue to meet in regional groups to move the larger policy issues forward. Those issues that relate to state training, certification and licensing; policies and law; and Medicaid will have the following groups working collectively on the specific policy strategies which are identified in this report.

    a. MRGEDA's Healthcare and Social Services Committee;
    b. Grant County Community Workforce Alliance (County-COG-CHI partnership);
    c. Local Health Councils.

3. CHI will continue to work with its state partners, through New Mexico's Department of Health, Human Services Department, Behavioral Health Collaborative, Workforce Solutions Department, the New Mexico Public Health Association, the Area Health Education Centers, colleges/universities and others, to address the healthcare workforce development issues. Because CHI has multiple projects that address healthcare and healthcare workforce development, these represent ongoing groups and partnerships which can continue to move key policy and system development issues forward in a collaborative framework.

Additionally, CHI will commit resources to begin development of curricula which is common to three or more paraprofessions in an effort to help expand educational opportunities to local residents seeking careers in healthcare. Finally, CHI has applied for funding from the Health Resources Services Administration and if awarded, it will have resources to develop additional curricula and to work to expand clinical telesupervision, which will also help to expand the healthcare workforce. Award notices are scheduled for September 2020.

POLICY GOALS

The five counties in the project shared concerns about the lack of alignment that runs throughout the local, regional and state work in both the areas of behavioral health and aging. The five counties shared these concerns in multiple group meetings, through the survey, and in workgroups that discussed the issues and policy goals. This lack of alignment includes both horizontal and vertical lack of alignment. This happens as a natural result from (1) silos created between departments at local, regional and state levels; (2) ongoing additions and changes to policies and procedures at multiple levels; and (3) a lack of alignment within and across levels and types of care. Vertical alignment includes the different levels: local, regional, state and national/federal levels. Horizontal alignment refers to the intersection across different fields or areas of work.

The alignment challenges include the following:

- Community needs and adequate levels of quality services to meet needs;
- Local government procurement and contracting practices, and lack of alignment between these and services, as well as state contracting;
- Lack of alignment between healthcare staffing needs, training available, licensing and certification requirements, and supervision requirements;
- State policy issues, contracting procedures and requirements, and funding, with challenges caused by interagency and intra-agency lack of alignment between contracting departments, excessive contracting and reporting requirements;
- Medicaid requirements, provider challenges with managing Medicaid services and billing, and need to expand options for rural providers to expand with Medicaid services in multiple settings.

These alignment issues are woven throughout the policy descriptions, resources and next steps in the following section. The following policy goals focus on improving the system of care in communities serving older adults.

THE PURPOSE AND LONG RANGE IMPACT OF OUR POLICY EFFORTS

These policy efforts are developed in order to:

1) Keep older adults living more independently, with greater potential for civic engagement, aging in place, being more productive, with high quality lives. This contributes to the cultural, civic and social enrichment of communities. (beyond economic).

2) Improve local economies by creating a strong healthcare workforce for a range of services, which reduces the rate of older adult outmigration, the loss of these people to their

communities, loss of their proportion of the tax base, spending, and the related "economic leakage." It reduces the strain on the healthcare system (e.g. high cost services rather than preventative and early intervention)

3) Build a more equitable financing system for rural communities (e.g. healthcare services as well as funding for Senior Center congregate and home delivered meals and other services (based upon ratios set that incorporate the issue of rural and geographic distance challenges). Rural communities face greater challenges due to remoteness, larger proportions of older adults and fewer resources (e.g. broadband, food, healthcare providers, city/county revenue, etc.) than urban areas.

4) Develop comprehensive Economic Development Strategies, which are endorsed by the regional Council of Governments and other economic development groups, which support and prioritize healthcare- and older adult-related workforce development and economic development for counties.

WHAT CAN BE DONE AT AN ORANIZATIONAL LEVEL

[Local Organizations are defined as community organizations and local agencies that provide direct services for older adults, such as Community Health Centers, hospitals, Senior Centers, Public Health Offices, assisted living facilities, home health care, long-term care facilities, etc.]

Policy Goal 1: Social service aging and healthcare local providers work regionally, with Aging and Long Term Services Department (ALTSD), the Area Agency on Aging (AAA), the New Mexico Advisory Council on Aging with Senior Service Providers and Agencies (Advisory Council), and other state agencies and legislators to maintain and to expand funding for local/regional older adult services.

► *Improvements Achieved by This Policy Goal*

- Older adults living more independently, with high quality lives and engagement due to a greater number of services across the continuum of care.
- Greater integration between ALTSD-funded social service providers and Medicaid/ Medicare funded healthcare providers at local and state levels.

► *Examples of How New Mexico and Other States Have Successfully Implemented This Policy*

- Centers for Medicare and Medicaid Services have established past successes with pilot programs designed to improve the transition of beneficiaries from inpatient hospital settings. One such program, the Community-based Care Transitions Program (CCTP), worked with Community-Based Organizations (CBOs) to facilitate beneficiary transition from inpatient status to longer-term community placements3. In providing such care services, strong relationships were formed between participating CBOs and local service providers and participants experienced lower readmission rates4. Examining similar concept models for implementation in rural areas of New Mexico may prove fruitful.
- The Program for All-Inclusive Care for the Elderly (PACE) model has been developed throughout the U.S. over the past few decades, and provides an integrated model of care, similar to Accountable Health Communities. PACE systems include a wide range of integrated services and resources, focused on reaching elders "upstream," to help them address needs, healthcare issues, proactive management of chronic conditions, and strengthen their connections and supports. PACE is now a capitated system, with payments by CMS based on a per member/per month ratio, which creates challenges for small and rural providers, as capitation requires creating a sufficient sized pool of beneficiaries to manage risk. There is one PACE program in New Mexico, in Albuquerque, which is managed by InnovAge, out of Colorado. PACE options are available through CMS, with resources available by CMS.
- Other models to explore include The Village Model and Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs). The Village Model convenes local non-profit organizations to establish a web of support and health care services already present within a community. By organizing a network of accessible local service providers and resources, older adults are better enabled to remain in their communities as active participants5. There are Village Models in place and registered with the Village to Village Network across the U.S., including in Albuquerque and Santa Fe, New Mexico6. In a similar way, NORC-SSPs across New York State organize service networks of both public and private sectors to assist older residents with aging in their own homes. In doing so overall community health can be affected in a positive manner7. Examination of models including Villages and NORC-SSPs may also prove beneficial for maintenance and expansion of funding for older adult services.

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3. Community-based Care Transitions Program. Centers for Medicare & Medicaid Services. https://innovation.cms.gov/innovation-models/cctp. Published June 16, 2020. Accessed June 25, 2020.
4. Econometrica, Inc. & Mathematica Policy Research. Evaluation of the Community-based Care Transitions Program. Centers for Medicare & Medicaid Services. https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf. Published November 2017. Accessed June 27, 2020.
5. Accius J E. The Village: A Growing Option for Aging in Place. Washington, DC: AARP Public Policy Institute; 2010.
6. Village Map. Village to Village Network. https://www.vtvnetwork.org/content.aspx?page_id=1905&club_id=691012#search_results. Updated 2020. Accessed June 30, 2020.
7. Naturally Occurring Retirement Community (NORC). Office for the Aging. https://aging.ny.gov/naturally-occurring-retirement-community-norc. Updated 2020. Accessed June 30, 2020.

► *Steps Necessary To Accomplish This Goal*

- Identify and meet with the Advisory Board county representatives.
- Develop and implement local and regional Older Adult Services Plans, involving seniors and many community stakeholders in the planning process. 8
- Work with Non-Metro Area Agency on Aging to examine funding streams created by CMS Block Grants funneled through Aging and Long Term Care Services Department
- Identify Area Agency on Aging (AAA) contract providers for areas or counties of interest
- Develop a state collaborative plan to address interagency collaboration between ALTCSD, AAA, FQHCs, HSD (for Medicaid and Medicare funded services), contract providers, and state/local agencies to support regional services expansion and/or maintenance.
- Locate and disseminate funding resources for senior services, formulas for allocation, decision making points and decision makers. Find out when the next AAA contract funding cycle is.
- Assess senior service needs, gaps, and levels of funding needed to meet the need.
- Meet with the ALTSD Cabinet Secretary to discuss how the NM State Plan for Aging and Long Term Services and the AAA Four-Year Area Plan does or does not align with local need.
- Meet with the Governor, Lt. Governor or senior staff to understand the Governor's plan to address needs of older adults
- Identify potential federal funding resources not currently utilized that could be available to state agencies or local organizations.

WHAT CAN BE DONE AT LOCAL AND REGIONAL LEVELS

[Local and regional level efforts refer to city and county government, regional Council of Governments, etc.]

Policy Goal 2: Integrate aging and healthcare into city, county and regional (i.e. Council of Governments) Comprehensive Plans for economic development.

8. Grant County developed a model plan, called the *Grant County Collaborative Senior Services Plan*, which can be accessed at: http://uploads.documents.cimpress.io/v1/uploads/0970bead-c189-4c95-a150-7c92852ed431~110/original?tenant=vbu-digital

▶ *Improvements Achieved by This Policy Goal*

- Integrated job creation, retention and expansion and economic opportunities that are focused on healthcare and older adults can create more integrated plans and strategies, and bring more federal and state funding to the region.[9]
- [Why it is important to mention healthcare in the plans] Add multiplier impact for health care

▶ *Examples of How Communities in New Mexico Have Successfully Implemented This Policy*

- There are three Councils of Government (COGs) that represent the five target counties: the South Central COG, the Mid-Region COG, and the Southwestern COG. All three COGs address healthcare in their Comprehensive Economic Development Strategies. The South Central COG notes that investing in healthcare facilities and services for older adults is a key way to diversity the regional economy, and thus reduce reliance on government employment.[10] The Mid-regional COG outlines strategies to improve rural health and build resilience; these strategies include establishing new healthcare facilities in rural and remote areas, creating apprenticeships for the healthcare workforce in rural clinics, and leveraging clinics and university partnerships to expand health services.[11] The Southwest New Mexico COG lays out a plan to increase the number of healthcare workers through vocational and university training, increase telemedicine in frontier areas, and increase home healthcare for seniors and other target populations.[12]
- Four of the five target counties prioritize healthcare as part of their most recent comprehensive plans. Socorro,[13] Sierra,[14] and Valencia[15] counties outline steps to expand healthcare facilities and health services. Similarly, Grant County[16] plans to increase the

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9. The NM Department of Workforce Solutions has projected healthcare to be one of the areas for largest projected job growth by 2026. See https://www.dws.state.nm.us/en-us/Researchers/Publications/Reports-Special-Analysis
10. South Central Council of Governments. Comprehensive Economic Development Strategy. https://8c42eee4-23d8-4c0e-8b51-464a018c35c0.filesusr.com/ugd/3c44a3_dc5e792edf47473a9e056d4944c7c8aa.pdf. Published June 30, 2017. Accessed June 2020.
11. Mid-Region Council of Governments. Leveraging Strengths in the MRCOG Region: The 2020 Comprehensive Economic Development Strategy (CEDS). http://www.mrcog-nm.gov/DocumentCenter/View/3976/2020-CEDS-PDF. Published 2020. Accessed June 2020.
12. Southwestern Council of Governments. Comprehensive Economic Development Strategy. Published 2020. Accessed June 2020.
13. Sites Southwest LLC. Socorro County Comprehensive Plan. Published June 2003. Accessed June 2020.
14. Draker Cody, Wilson & Company. Comprehensive Plan Update for Sierra County, New Mexico 2017. Sierra County website. https://www.sierraco.org/wp-content/uploads/2018/06/sierra-county-comprehensive-plan-2017.pdf. Published July 2017. Accessed June 2020.
15. Valencia County. Comprehensive Land Use Plan. Valencia County website. https://www.co.valencia.nm.us/DocumentCenter/View/2120/2005-Valencia-County-Comprehensive--Plan-PDF. Published October 2005. Accessed June 2020.
16. Bohannan Huston, Inc. Grant County Comprehensive Plan. Grant County website. https://grantcountynm.gov/wp-content/uploads/2017/12/Grant-County-Comprehensive-Plan.pdf. Published June 2017. Accessed June 2020.

capacity of its healthcare facilities by exploring shared staffing models between the County and the Town of Silver City. Both Grant and Sierra counties note that healthcare is a significant economic driver in their region. Sierra and Socorro County Plans explicitly commit to investing in services for older adults.

- The Grant County Collaborative Senior Services Plan comprehensively addresses the needs of older adults, service strategies, policies, and financing, with strong Grant County involvement. This plan is recognized as a model for other counties and municipalities.
- Of the five County seats in the target region, Silver City, Truth or Consequences (TorC),[17] Los Lunas,[18] and Silver City[19] have comprehensive plans in effect. All four plans recognize the importance of healthcare as an economic driver. All three plans also commit to building new healthcare facilities or expanding existing healthcare services. Los Lunas' and TorC's comprehensive plans call for partnerships with local schools and universities as a way to increase healthcare workforce development. TorC was the only county seat to prioritize health services for older adults in their comprehensive plan.[8]

► *Steps Necessary To Accomplish This Goal*

- Investigate how much progress has been made towards achieving County and Municipal Plan healthcare workforce development goals, especially for Counties that had Comprehensive Plans drafted before 2015.
- Check with Executive Director at South Central Council of Governments to find out which cities or counties identify healthcare as a current priority and if healthcare is listed as a priority in the COG's Comprehensive Economic Development Strategy (CEDS). Priscilla Lucero, Executive Director for Southwest Council of Governments is the contact for Grant, Luna, Hidalgo and Catron Counties.
- Support/develop local efforts to get older adults involved in planning meetings, needs assessments and other economic development efforts.
- Continue efforts to develop a Healthcare Task Force as part of the Grant County Community Workforce Alliance, building upon the planning work already accomplished by the *Grant County Collaborative Senior Services Plan* and coordinating with that plan's implementation work to build a Senior Services Integrated Network.
- Check with Municipal League and County Associations about how current funding streams and taxes are being spent for health-related services and where healthcare is a priority.
- Develop a plan to disseminate information about healthcare workforce development as an

17. Consensus Planning Inc. City of Truth or Consequences Comprehensive Plan 2014. http://cms5.revize.com/revize/truthorconsequences/Comprehensive%20Plan/Final%20Comprehensive%20Plan%20-%20October%202014.pdf. Published October 2014. Accessed June 2020.
18. Sites Southwest LLC. Village of Los Lunas 2013 Comprehensive Plan. Village of Los Lunas website. https://www.loslunasnm.gov/DocumentCenter/View/6525/2035-Comprehensive-Plan_10_10_13_email?bidId=. Published October 2013. Accessed June 2020.
19. Town of Silver City. Comprehensive Plan. Town of Silver City website. https://www.townofsilvercity.org/DocumentCenter/View/159/Town-of-Silver-City-Comprehensive-Plan-PDF. Published September 2017. Accessed June 2020.

economic driver and funding opportunities to groups working to build healthcare services and the workforce.
- Gather and disseminate data to compare the economic cost of keeping certain services for older adults (senior centers, senior meals, transportation, etc.) versus short, intermediate and long term costs of not having those services.
- Gather and disseminate information about the economic leakage and tax base reduction costs created by ~~of~~ older adults leaving communities.

Policy Goal 3: Expand Medicaid and Medicare reimbursable services for navigation, screening, and care coordination services to older adults at multiple sites (e.g. in Senior Centers, senior housing complexes, in homes, and through telehealth), that can be delivered by frontline/credentialed/ certified workers in addition to licensed professionals.

► *Improvements Achieved by This Policy Goal*

- Greater and more diversified mix of funding for a wide range of social/behavioral, prevention and early intervention, annual wellness, chronic disease management, and other healthcare services.
- Cost savings resulting in early identification and treatment of health issues and factors that impact health issues.
- Better integration of services between the social-medical models at state and local levels.
- More independent living options for older adults as they age, productively and with high quality lives, staying in the community.
- Numbers and types of healthcare workforce jobs increases for local communities and providers, improving the percentage of living wage jobs in rural communities, and strengthening the local economies.

► *Examples of How New Mexico and Other States Have Successfully Implemented This Policy*

- HMS has integrated social services at Senior Centers (funded by ALTSD), with FQHC-based medical services, with HMS-based navigation and care coordination, along with a new Senior Services Integrated Network which can serve as a model to be replicated in other communities.
- New Mexico Human Services Department (HSD) has allowed for Medicaid reimbursement for care coordination for over six years. Care Coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information

among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning. Managed care organizations (MCOs) may delegate care coordination functions through a full delegation model or a shared functions model, while retaining oversight of all care coordination activities. Full delegation model allows the MCO to delegate the full set of care coordination functions to a provider/health system through a value-based purchasing (VBP) arrangement.[20] [Susan to ask where services can be delivered]

- A substantial body of research suggests that payment reforms, such as those employed in an Accountable Care Organization (ACO) system, may improve quality of care and reduce costs. In 2011, HB35 was introduced in the NM Legislature to establish a demonstration project and task force. Although the bill was endorsed by the Legislative Health and Human Services Committee and passed the legislature, it was vetoed by the Governor. HB35 requested HSD to establish an ACO demonstration project task force whose purpose was to develop a strategic plan with recommendations on several items, including the following:
- The utilization of specific care and case management models and strategies.
- Promotion of a "health commons" model of integrated primary care, specialty, behavioral and dental health care services, including telehealth services.
- Incentives for encouraging longer hours for primary care services, including weekend and evening hours.
- Recommendations for designing and implementing a comprehensive incentive and risk system whereby providers of care in an ACO demonstration site [Hidalgo County] receive financial incentives for measurable improvements in the health of their patients, including recommendations for quality evaluation and measurement protocols and for increasing community support for improving health care outcomes while addressing the social determinants of health.

- PACE Models (Programs of All-Inclusive Care for the Elderly) emphasize provision of comprehensive and continuous care and services to assist elderly populations with aging in place and remaining in their communities. PACE Programs are currently operational in 31 states, including New Mexico. Successful PACE Programs have demonstrated blending of sponsor organizations at state and local levels to provide quality care for older adults within their service areas.

  PACE programs implemented by Senior CommUnity Care PACE in Montrose, Colorado and Cherokee Elder Care in Tahlequah, Oklahoma serve an annual 337 and 194 rural elderly residents, respectively, with high-quality medical and social care services. Such programs reflect some of the successes which could be attained by implementation of PACE in rural areas of New Mexico.

  PACE is a Medicare/Medicaid program designed to provide nursing home level of care

20. New Mexico Human Services Department. New Mexico Administrative Code. Retrieved 6/10/2020 at: https://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx

to older adults living in the community. The program relies on interdisciplinary teams of healthcare providers, who develop a comprehensive care plan for each enrollee. Participants are then able to receive holistic healthcare support services through the PACE program. In this way, PACE is both a health provider and a health plan.

InnovAge New Mexico PACE has been the state's designated PACE provider since 1998. Today, InnovAge NM serves approximately 400 older adults in Bernalillo County, as well as parts of Sandoval and Valencia counties. Unfortunately, most of the state's older adults live outside of InnovAge's service area, making them ineligible to receive PACE services.

In order to be eligible for PACE care coordination, participants must require the level of care typically provided in nursing homes, and must also be able to live safely in the community. Participants can receive services at home, at the PACE center in Albuquerque, or in a healthcare facility.

Financing for the PACE program is capped, so PACE providers are given a set fee per patient regardless of services required. This allows providers to deliver all the services participants need, rather than only those reimbursable under Medicare and Medicaid fee-for-service plans. In New Mexico, PACE operates under an annual census cap established by the New Mexico Human Services Department. New enrollment into PACE is done through attrition; there is a waitlist of approximately 250 individuals awaiting PACE services. New Mexico's PACE services are supported by federal Medicare funds, as well as federal and state Medicaid funds (69% federal funds and 31% state funds).

- Medicaid Funded Care in Senior Center Models

► *Steps Necessary To Accomplish This Goal*

- Further explore barriers to providing and getting reimbursed for essential services for older adults.

HOW ACHIEVING THE POLICY GOALS CONTRIBUTE TO BUILDING THE COMMUNITY'S SENSE OF POWER.

- Healthier communities, such as those considered "Age-Friendly Communities" by AARP, build community health and wellness, power, and resiliency. These communities:
- Involve more older adults, and all community members in greater levels of community engagement, contributes to healthier communities.
- Strengthen socio-cultural assets and community connections.
- Build greater ownership of assets and resources of the community
- Integrate, a stronger community voice.
- Value diversity and mitigate reduce age discrimination, which promotes equity.
- Have reduced disproportionate and unfair burdens on rural communities, enabling them to provide essential services for older adults.

NON-POLICY GOALS THAT CAN BE AIDED BY THIS EFFORT:

- Additional data gathering:
  - Conduct program-based budgeting related to types and levels of care possible with current funding sources, and advise all funders of real costs as well as limits on services. Is budget appropriate for services that is needed?
  - Conduct an analysis of what services are most needed but not currently reimbursed by current grants, contracts, Medicaid, Medicare of other insurance.
  - Unfunded mandates
- Attend local and regional economic development planning meetings to be sure that healthcare workforce development is included as a priority issue.
- Ensure that older adults are involved in planning which impacts them.
- Restructure and reintegrate senior centers, BH providers, medical providers, home health care providers, and economic development

OTHER POLICIES FOR CONSIDERATION

During the course of the project there were a total of seven policy strategies identified with the top priorities listed above. An addition four policy strategies, listed below, were discussed at length and although not ranked as a top priority, they deserve mentioning.

Policy Goal: Investigate with municipalities and county leadership and COGs and any potential funding/financing opportunities that may exist, along with pros and cons, and potential unintended consequences.

► *Improvements Achieved by This Policy Goal*

- Local governments can expand and diversify funding sources that will allow for the level of investment needed to build, maintain, and sustain a diverse continuum of services of programs and services that benefit older adults.

► *Examples of How New Mexico and Other States Have Successfully Implemented This Policy*

- HMS has partnered with Grant County to provide a wide range of meals and social services in Senior Centers, funded by ALTSD; navigation and case management, funded through Medicare, Medicaid and other sources; and healthcare services funded by Medicare,

Medicaid, grants and contracts. These services represent a highly diversified network of navigation, social/human services, and healthcare.

- Rio Arriba County has developed a partnership with three local FQHCs, especially with El Centro Family Health, co-located in the Rio Arriba Health Commons, to provide a range of meals and social services in Senior Centers, navigation and case management, advocacy, and healthcare. Rio Arriba County (RAC) is also the first county to bill Medicaid for its services, and is expanding Medicaid billing through the RAC Health and Human Services Department, for people of all ages, with some Medicaid-funded services delivered to older adults in senior centers.
- The New Mexico Indigent Hospital and County Health Care Act. The Act authorizes counties to pay health-care claims for the medically indigent by dedicating revenue from a second 1/8th increment to the gross receipts tax (GRT). This is an optional tax and all New Mexico counties, except DeBaca, Harding, and Socorro, have created county health-care assistance funds, which are not matched by federal dollars.

  Each county makes independent decisions about how to manage their fund, including eligibility and covered services and administration. They commonly cover services that are not Medicaid-reimbursable such as preventive care clinics, detox and sobering centers, and county inmate health care.[21] The County Health Care Act limits how counties can use their health-care assistance funds, including prohibiting them from assisting residents with out-of-pocket costs. Counties are also required to contribute to the County-Supported Medicaid Fund and/or the Safety Net Care Pool. The County-Supported Medicaid Fund is a mandatory program in which counties provide funding to the state to support their share of Medicaid expenditures. Nineteen counties, have elected to impose a separate 1/16th GRT increment for this purpose; the other counties transfer the equivalent amount from their existing community indigent fund.[22]

► *Steps Necessary To Accomplish This Goal*

- Check with Municipal League, NM Association of Counties, COGs, Health Councils, and economic development groups to see how different counties are expanding their funding opportunities, how taxes are being spent, and if healthcare spending is a priority.
- Explore opportunities for counties to develop local initiatives and/or partner with the state for shared management and distribution of funds such as the alcohol tax; upcoming marijuana CBD tax revenues, junk food taxes, etc.

21. Program Evaluation Unit Legislative Finance Committee. Uncompensated care in New Mexico after the affordable care act. October 27, 2015.
22. Ibid

Policy Goal: Develop multiple and flexible sources of revenue (including Medicaid and Medicare) for older adult services, across the systems of care and across agencies (ALTSD, HSD and HSD/BHSD, DWS). Reduce areas where there is a lack of alignment in policies, procedures, and requirements for providers. Support social, medical and hybrid social-medical services through these multiple funding sources.

► *Improvements Achieved by This Policy Goal*

- More flexible funding that can be used to address local needs of older adults and gaps in services which would result in quality of life for the seniors.

► *Examples of How New Mexico and Other States Have Successfully Implemented This Policy*

- A 2017 study of state public health and Medicaid policymakers looked at federal proposals to blend, braid or block-grant funds for public health and prevention to maximize resources across programs.[23] An ad hoc group of state officials identified key policy considerations, which included piloting large-scale cross-agency federal demonstration waiver projects that braid, blend, and align public health and Medicaid funding beyond what is permitted under current law. Such waiver projects could include funding from agencies such as CMS, CDC, HUD, HRSA, SAMHSA, and the USDA, in order to efficiently address health-related needs for food, shelter, and other supports. They could also spur greater alignment between federal agencies. To maximize the waivers' effectiveness, policymakers could:
  - Set a five-year time frame for cross-agency waivers, and establish goals that can be achieved within that time period.
  - Require waiver applications to contain a core set of measures agreed upon by the state Medicaid and public health agencies.
  - Permit states that have accountable care entities to fold public health and other agencies into those entities, and/or expand them to include investment from Medicare.
  - States might use such waiver authority to address the needs of special populations or combat addiction. Currently, federal funds to prevent and treat drug addiction flow to states from CDC, SAMHSHA, HRSA, and other federal agencies. Medicaid also makes substantial investments in addiction treatment services. The flexibility to align funding across agencies and reduce re-porting burden could help states meet the challenge of addiction in their communities.
  - Align eligibility requirements across programs. Medicaid and safety net programs have

23. The National Academy For State Health Policy, Blending, Braiding, and Block-Granting Funds for Public Health And Prevention: Implications for States.

different eligibility thresholds. Some states are already working to align these programs to maximize their impact, such as Louisiana's enrollment of residents into expanded Medicaid using SNAP eligibility data.
    - Help states strategically invest their time in applying for grants by aligning funding cycles and application requirements.
- Add California model (braided funding)

► *Steps Necessary To Accomplish This Goal*

- Further explore examples of braided and blended funding options and actual applications at the state and federal levels.
- Create a cross-agency task force at the state level to guide the integration of the systems, policies, and funding, to include aging providers (both ALTSD funded and Medicaid/Medicare funded FQHCs), as well as COGs and other economic development leaders.

Policy Goal: Apply innovative financing models to other public and private service lines. (e.g. CMS cost-based reimbursement for Critical Access Hospitals, PACE model, Accountable Health Community Model, CCSS-related high-reimbursement behavioral health models, and other value-based and budget-based payment models not dependent on volume, etc.)

► *Improvements Achieved by This Policy Goal*

- Reduced financial burden on rural communities by promoting a fair rate that can cover actual expense.

► *Examples of How New Mexico and Other States Have Successfully Implemented This Policy*

- HMS Integrated Care, and their Senior Services Advisory Network (described earlier).
- Rio Arriba's System of care (described earlier).
- A substantial body of research suggests that payment reforms, such as those employed in an Accountable Care Organization (ACO) system, may improve quality of care and reduce costs. In 2011, HB35 was introduced in the NM Legislature to establish a demonstration project and task force. Although the bill was endorsed by the Legislative Health and Human Services Committee and passed the legislature, it was vetoed by the Governor. HB35 requested HSD to establish an ACO demonstration project task force whose purpose was to develop a strategic plan with recommendations on several items, including the following:

- The utilization of specific care and case management models and strategies.
- Promotion of a "health commons" model of integrated primary care, specialty, behavioral and dental health care services, including telehealth services.
- Incentives for encouraging longer hours for primary care services, including weekend and evening hours.
- Recommendations for designing and implementing a comprehensive incentive and risk system whereby providers of care in an ACO demonstration site [Hidalgo County] receive financial incentives for measurable improvements in the health of their patients, including recommendations for quality evaluation and measurement protocols and for increasing community support for improving health care outcomes while addressing the social determinants of health.

► *Steps Necessary To Accomplish This Goal*

- Develop workgroup to review current financing system and options to cover actual costs

Policy Goal: Redesign state contracting system to focus on streamlining and aligning requirements (including data/reporting), programs and systems within departments, and between departments (like ALTSD and HSD), vertically and horizontally, resulting in greater efficiencies and reduction in unfunded mandates.

► *Improvements Achieved by This Policy Goal*

- Lower costs due to greater coordination and efficiency at the state and organizational levels. Reduce duplication of effort and unfunded mandates.

► *Examples of How NM and Other States Successfully Implemented this Policy*

- New Mexico is not alone in calling for contract reform. A 2010 national study of government contracting with nonprofit organizations found that over half of the nonprofits surveyed had experienced problems with their contracts and grants. These included late payments, changes to contracts, complex applications and reporting requirements, and insufficient payments to cover mandates and expenses.[24] This study found that in New Mexico, well over half of nonprofits reported that government contract payments

24. ET Boris, E de Leon, K Roeger, M Nikolova. National Study of Nonprofit Government Contracting: State Profiles. The Urban Institute. https://www.urban.org/research/publication/national-study-nonprofit-government-contracting-state-profiles/view/full_report. Published October 7, 2010. Accessed June 2020.

did not cover the full cost of contracted services, and that these unfunded mandates were a problem for the organization.[25] New Mexican nonprofits have also reported delays in reimbursements, inefficiency in receiving signed state contracts, challenges due to cumbersome reporting requirements, and unfunded mandates.[26] Since the state government makes up 84% of all government contracts in New Mexico, there is a significant need for state policy reform.

- The New Mexico Legislature has acknowledged the need to support nonprofits through contracting reform. In 2015, the state passed House Memorial 129, calling for an Interim Legislative Nonprofit and Public Sector Collaboration Work Group to help New Mexico improve the effectiveness and efficiency of its collaborations with nonprofits.[27] The work group was charged with studying opportunities to improve contracts, contracting processes, capacity to meet state programmatic needs, and methods to build relationships between government and nonprofits. Unfortunately, there were no appropriations or other funding resources for the study so it was never carried out.
- States have been working to take advantage of the Office of Management and Budget's 2015 OMB Uniform Guidance rules, which streamline cost allocation rules and allow nonprofits to be reimbursed for more of their direct costs.[28] Under the new rules nonprofits can use up to 10% of federal funds (it may be lower with certain types of grants) to cover indirect costs if they do not have a federal negotiated indirect cost rate. This rule applies to federal block grant or other federal funding that is granted or contracted out to not-for-profit organizations.

  The California Association of Nonprofits' Overhead Project is working to increase available funding for overhead costs, by educating both the public sector and the nonprofit community about how to better adhere to the new OMB Uniform Guidance rules.[29]
- Nonprofit associations in multiple states, including Washington, Arizona, and North Carolina, support state legislation that ensures the full cost of nonprofit services is covered by public funds dedicated to the service. These associations provide policy guidance and educational materials to member nonprofits as a way to increase civic engagement.[30,31,32]
- Approximately a dozen different State Nonprofit Associations partnered with the National

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25. Ibid.
26. S Wilger. HM 129: Nonprofit and Public Sector Collaboration. Center for Health Innovation. Published 2015. Accessed June 2020.
27. Nonprofit and Public Sector Collaboration Group, House Memorial 129 (2015). https://www.legiscan.com/NM/bill/HM129/2015. Accessed June 2020.
28. National Council of Nonprofits. Government Grants and Contracting. CouncilofNonprofits.org. https://www.councilofnonprofits.org/trends-policy-issues/government-grants-contracting. Accessed June 2020.
29. California Association of Nonprofits. Nonprofit Overhead Project. Calnonprofits.org. https://calnonprofits.org/programs/overhead/about-the-nonprofit-overhead-project. Accessed June 2020.
30. Washington Nonprofits. Policy agenda and action. Washingtonnonprofits.org. https://washingtonnonprofits.org/public-policy/policy-agenda-action/. Published 2019. Accessed June 2020.
31. Alliance of Arizona. 2020 Public Policy Agenda. Arizonanonprofits.org. https://cdn.ymaws.com/arizonanonprofits.org/resource/resmgr/files/advocacy_files/2020_alliance_legislative_ag.pdf. Published 2019. Accessed June 2020.
32. North Carolina Center for Nonprofits. 2019 Public Policy Agenda for North Carolina's Nonprofit Sector. Nc-nonprofits.org. https://www.ncnonprofits.org/sites/default/files/2019%20Public%20Policy%20Agenda.pdf. Published February 14, 2019. Accessed June 2020.

Council of Nonprofits in a multi-year pilot to test out contracting reform. The strategies differed by state, from small changes to intensive system re-redesign. Illinois, which engaged in intensive system re-design, saved at least 1% of the state budget in the first year they collected outcome data, more savings projected for the future. See https://www.councilofnonprofits.org/trends-policy-issues/government-nonprofit-contracting-reform

► *Steps Necessary To Accomplish This Goal*

- Explore the development of a State Contracting Reform Task Force. This can be done in partnership with the NM State Nonprofit Association, NM Thrives, CHI and New Ventures Community Building, which have all been working on this issue.
- Identify specific unfunded mandates required of behavioral health providers and the related costs.
- Assess the intended and unintended consequences if these mandates are not provided. Assess what the consequences of unfunded mandates have been and address with state and/or providers in community.

Older Adult Policy Summary At-a-Glance Matrix

This Policy Matrix represents a summary of the policy goals to offer a framework for the different policies that are presented in detail in the full policy report. Across the top of the matrix, there are the different levels at which each of the priority areas can be addressed, from the local provider to local government; training, licensing and certification; and state policies and procedures. There are also federal regulations promulgated by the Centers for Medicare and Medicaid (CMS) and other federal entities as well as national certification bodies for specific fields, which are not included in this matrix, but which do shape policies and procedures, and require a significant amount of time to address and modify.

GREEN = Top Priority	Provider or Agency	County Government	NM State Policy	Medicaid
Older Adults Fast-growing older adult population, with increasing needs. NM is moving from 39th in the US in proportion of older adults (2010) to 4th (2030). Many Southern Counties have even faster growing aging trends.	**Social service, aging and healthcare local providers work regionally, with Aging and Long Term Services Department (ALTSD), the Area Agency on Aging (AAA), the New Mexico Advisory Council on Aging with Senior Service Providers and Agencies (Advisory Council), and other state agencies and legislators to maintain and to expand funding for local/regional older adult services.**	**Integrate aging and healthcare into the city, county and regional (i.e. Council of Governments) Comprehensive Plans.** Investigate with municipalities and county leadership and COGs and any potential funding/financing opportunities that may exist, along with pros and cons, and potential unintended consequences.	Develop multiple and flexible sources of revenue (including Medicaid and Medicare) for older adult services, across the systems of care and across agencies (ALTSD, HSD and HSD/BHSD, DWS). Reduce areas where there is a lack of alignment in policies, procedures, and requirements for providers. Support social, medical and hybrid social-medical services through these multiple funding sources. Apply innovative financing models to other public and private service lines. (e.g. CMS cost-based reimbursement for Critical Access Hospitals, PACE model, Accountable Health Community Model, CCSS-related high-reimbursement behavioral health models, and other value-based and budget-based payment models not dependent on volume, etc.) Redesign state contracting system to focus on streamlining and aligning requirements (including data/reporting), programs and systems within departments)ALTSD and HSD), vertically and horizontally, resulting in greater efficiencies and reduction in unfunded mandates.	**Expand Medicaid and Medicare reimbursable services for navigation, screening, and care coordination services to older adults at multiple sites (e.g. in Senior Centers, senior housing complexes, in homes, and through telehealth), that can be delivered by frontline/credentialed/certified workers in addition to licensed professionals.**