2017

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Santa Fe County Community Services Department – Health Services Gap Analysis

10/10/2017

This report was prepared by ***Hyde & Associates – Policy and Practice Consulting, LLC***, under contract with the Santa Fe County Community Services Department. The Team for this project includes the following:

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SANTA FE COUNTY HEALTH SERVICES GAP ANALYSIS

October 10, 2017

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EXECUTIVE SUMMARY

Overview

The Santa Fe County Community Services Department (CSD) is leading efforts to create an Accountable Health Community (AHC) in Santa Fe County. An AHC is a healthy community with sufficient services and capacities to support the health and safety of its residents. Using leadership and aligning resources and efforts, CSD desires to implement an AHC model that creates a common vision, shares resources, recognizes everyone has a role in implementation, facilitates collaboration, and provides an experience where the whole community benefits.

One activity CSD has undertaken as part of the AHC initiative is an analysis of the County's population and needs along with identifying key gaps in existing services available to meet those needs. This report of the Health Services Gap Analysis project looks at:

- Demographics and population details of Santa Fe County residents;
- Individual health care risks and challenges faced by County residents; and
- Systemic and provider issues impacting access to health services and to the well-being of County residents.

The gap analysis team reviewed quantitative data from a variety of sources including the U.S. Census Bureau, the New Mexico Department of Health's Indicator Based Information System (NM – IBIS), University of New Mexico studies, the Share NM website, local and national foundation and organizational studies, and other state and federal data sources. The team also facilitated eight public town halls, conducted 22 key informant interviews, held five provider specific focus groups, and conducted a survey of local service providers. The goal of each of these qualitative opportunities was to engage with interested County residents to discuss barriers to care and good health, the cultural relevance of care, service capacity and unmet needs, as well as to gather recommendations for improving health and related human services and for promoting wellness and community health. The gap analysis report captures that quantitative data and qualitative input and summarizes themes and recommendations, as described below.

Population Data and Disparities – Highlights

1. The combination of age and sex with race, ethnicity, and poverty – along with housing costs, transportation challenges, the rate of uninsured, and food insecurity – creates a unique mix of social determinants that represent assets as well as challenges impacting health in Santa Fe County.

2. Santa Fe County is facing a "Silver Tsunami," with the largest concentration of the 147,108 population being adults 50 – 70 years of age. The proportion of adults 65 years and older is expected to increase by 62 percent by 2030, with the fastest growing group being the very old. This expected rate of growth is even higher than those of the state and the nation.

3. English is the primary language spoken in 62 percent of the County's households; Spanish is the primary language spoken in 33 percent of households. Neighborhoods with higher than average poverty rates have higher proportions of individuals who are Hispanic, immigrant, and individuals not born in the U.S. and not citizens. These areas also have the highest proportion of persons paying up to 50 percent of income or more for rent/housing.

4. Neighborhoods with the highest proportion of individuals and families with lower incomes have average to above average percentages of people in the workforce.

5. The LGBT population has higher rates of mental distress, suicide attempts, smoking, and individuals who have not visited a physician in the last year.

6. Areas of the County with the highest risk factors include Agua Fria Neighborhood & Downtown, North County/Pueblos Plus, Airport Road, and Agua Fria Village. The Opera Vicinity & North City and the East Foothills & Eldorado areas are the two areas with the lowest risk factors. The Bellamah/Stamm and South County areas have medium overall risk.

Health Behaviors and Risks – Highlights

1. Compared to the State and the nation as a whole, Santa Fe County is better off for some health factors but has worse rankings in the number of uninsured, the number of mental health providers, high school graduation rates, environmental issues, and severe housing problems. Compared to top-achieving counties nationwide, Santa Fe County has many health factors ranking the County lower in health or at greater risk.

2. The County's rates of alcohol and drug related deaths are higher than the State and are associated with areas with higher poverty rates. The County has high numbers of adults with mental illness, youth with depressive episodes, and individuals with substance use disorders. Less than half of all these individuals get the treatment they need.

3. Gaps in services; provider locations, hours, and staffing capacities; and uninsured rates impact access to care.

4. CSD Health Care Assistance Program provides critically needed healthcare assistance for people with no other payer source.

5. Medicaid is the single largest payer of mental health services and one of the largest for addiction services; therefore, Medicaid drives how services are structured and provided. Certain behavioral health services are not reimbursed, are heavily rationed or are reimbursed at such low rates providers have to limit or shift service activities. System disruptions and inadequate funding have resulted in insufficient service capacity.

6. Routine and preventive dental care is often not covered in most health plans – public or commercial – especially for adults.

7. Fear among immigrant communities inhibits their access to food, public benefits, transportation, and health care.

8. Prevention efforts hold promise. These include expanded early screening, home intervention, and intervention for youth at risk or experiencing first episode psychosis. The County's recent funding for a mobile crisis response team (MCRT) and the behavioral health crisis center have significant community support.

9. Although most aging adults want to remain at home as they age, Medicaid and Medicare provide limited in-home services. Existing in-home service providers in Santa Fe County have insufficient resources and capacity to meet current and future needs.

10. Senior centers are critical for providing meals, transportation, and social activities for older adults. The County's *Senior Services Strategic Plan* needs to be fully implemented.

Provider and System Issues – Highlights

1. Santa Fe County has significant Health Profession Shortage Areas in primary care, behavioral health, institutional and hospital care, dental care, and care for specific populations. The aging of the healthcare workforce, limited educational opportunities and the cost of health care education, along with lack of diversity, and funding and policy challenges create considerable concern for the future healthcare workforce.

2. Recent and proposed structural, payment, and policy shifts at the state and federal levels have left many providers struggling to keep up. Workforce and infrastructure needs are often deferred. Providers are cognizant of and try to address the strengths and challenges of cultural issues in their workforce and service recipients.

3. Collaborative efforts are significant, but are often experienced as unfocused with multiple activities drawing on limited provider capacities.

Provider Survey – Highlights

1. The 52 providers responding to the survey serve a wide range of age groups and population types. Provider funding is diversified, with non-profit providers generally having more revenue sources than commercial or government providers.

2. Most providers see people who are Medicaid and/or Medicare recipients, but less than half of these providers bill those sources due to the type of service provided not being reimbursable or the difficulty in being certified to be a provider who can bill such sources.

3. Community needs identified include expanded provider locations and hours of operation, streamlining of services, housing for low-income individuals and workforce, behavioral health services, transportation and basic needs, before and after school programs, and more preventive upstream services.

4. Provider challenges identified include services in certain geographic areas and population groups; housing, quality of care issues, the fast pace of change, and inadequate funding. While most providers reported having no waiting lists, many acknowledged long waits for appointment times.

5. Priorities recommended by providers include expansion of services, especially behavioral health services; addressing social determinants like housing, transportation, employment, and child care; shifting the service delivery system to focus on upstream targeted prevention activities; and using current services more efficiently by addressing high utilizers assisting with public benefits, more navigation, and better information and referral capacity.

Town Halls, Key Informants, and Provider Groups – Highlights

1. Participants identified many barriers to good health, including: a) high cost of housing, food, and other basic needs; b) lack of health and dental coverage; c) immigration status resulting in inability to obtain necessary employment, education, and health care; and d) untreated trauma and chronic stress.

2. The healthcare system is fragmented and thrives on illness rather than incentivizing health. Health promotion and public awareness; access to low or no-cost health activities and fresh and healthy foods; and home visitation for new parents are critical for the health of all County residents.

3. Healthcare organizations and leaders need to leverage existing resources and collaborate more to create administrative and operational efficiencies. Providers need help: a) recruiting and retaining staff; b) aligning resources, locations, and programs; and c) creating opportunities to discuss social determinants and to advocate for their common interests.

4. Priorities for services include: a) affordable housing for all residents, including those with low incomes, seniors, and non-profit staff as well as City and County first responders; b) behavioral health care of all kinds; c) services and supports for seniors, including use of volunteers and more in-home care; and d) information about and navigation of existing resources and supports.

5. Cultural competency, enhanced amounts and types of resources, and better public transportation were identified as additional community needs.

Themes and Recommendations – Highlights

Overriding themes emerging from this gap analysis include the need for clear and effective leadership and alignment of resources and efforts. CSD and even the Santa Fe County government cannot make or fund all the changes identified as needed. However, CSD can provide leadership and can work with community providers, funders, and advocates to help set goals, create momentum, and point the way. Providers, along with government entities and advocates can work to collaborate effectively, maximize resources, and advocate collectively to accomplish commonly agreed upon changes in funding and policy. Together, the County and community players need to agree on the priorities for action. This need for leadership and alignment is the overriding theme from all the input in this project.

From the quantitative and qualitative data analyzed for this report, priority populations, service needs, and provider issues emerged along with cross-cutting needs. Priority populations include seniors, persons with behavioral health needs, and persons at high risk due to income or circumstance. Priority service needs are housing, behavioral health, and navigation of the existing service system. Priorities for capacity building include workforce recruitment, retention, and support; and infrastructure. Cross-cutting needs include cultural issues, prevention/early intervention, and support to address social determinants such as transportation and food.

Highlights of these priorities are described below.

Housing

1. Embrace, prioritize, and work to support creation of expanded affordable housing units county-wide and housing subsidies for low-income households, critical practitioners, and first responders.

2. Expand shelter services to be year-round for men and women, and to meet the special needs of persons with disabilities and complex medical needs.

3. Work with Life Link and other providers to expand daytime drop-in center hours.

Behavioral Health

1. Develop a behavioral health strategic plan for a range of prevention, treatment, rehabilitative, and recovery services, including inpatient, residential, and outpatient services. Utilize peers and family-delivered services.

2. Create and open the planned behavioral health crisis center as soon as practicable. Include direct and co-located community services, training and support for caregivers and first responders, and navigation, with agreed upon protocols for client flow.

3. Work with community partners to create a step down unit for individuals ready to leave behavioral health inpatient units or the State hospital in Las Vegas.

4. Seek funding and advocate to implement specific prevention programs such as youth/young adults experiencing first episode psychosis (FEP), high risk youth experiencing prodromal syndrome symptoms, and Zero Suicide approaches in health systems; work with partners to support prevention programs addressing behavior management (for example, the Good Behavior Game), substance use, suicide, teen pregnancy, and violence prevention and conflict resolution training for youth.

5. Work with schools, health systems, and prevention advocates to implement a universal screening program for all at risk families, prioritizing home visiting and related services to meet identified needs for those at most risk.

Services for Seniors

1. Implement the *Senior Services Strategic Plan*, especially opening the new County senior center and increasing services at existing centers.

2. Enhance transportation options for non-medical purposes and work to link Medicaid recipients with medical-related transportation provided by Managed Care Organizations.

3. Enhance paid and volunteer mobile and in-home services for seniors living in isolation without other supports. Work with Santa Fe Community College to create a training program for in-home caregivers.

Navigating and Enhancing the Existing System

1. Create a comprehensive coordinated capacity for on-line and person-to-person real time up-to-date crisis assistance and information for law enforcement, providers, and the public.

2. Coordinate navigation resources to assure efficiency and effectiveness.

3. Work aggressively to increase enrollment of children and adults into available health insurance coverage.

4. Work with providers to locate or mobilize health and human services in or near areas where populations with the highest needs reside.

5. Work on increasing multi-cultural capacity, competency, and a welcoming environment.

6. Assist providers by: a) creating a consolidated or coordinated City and County planning and funding approach; b) creating a single provider forum or association to vet and consider joint strategies for funding, advocacy, training, and workforce development, recruitment, and support; and c) minimize the number of provider meetings and maximize their effectiveness.

Conclusion

These recommendations reflect clear needs and gaps, many of which are significant and longstanding. Creating a broad-based level of community, political, financial, and policy support for identified health priorities will help to create additional funding and activities to meet these needs. Working together, providing leadership, and aligning efforts and services will help to make Santa Fe County residents healthier and the community a safe and healthy place to live.

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SANTA FE COUNTY COMMUNITY SERVICES DEPARTMENT

HEALTH SERVICES GAP ANALYSIS

October 9, 2017

I. INTRODUCTION – CONTEXT AND DESCRIPTION OF PROJECT

A. Context

The Santa Fe County Community Services Department (CSD) believes in and is leading efforts to create a vision and plan for an Accountable Health Community (AHC). An AHC is a healthy community with the right services and capacities to support the health and safety of its residents. A healthy community as described by the U.S. Department of Health and Human Services *Healthy People 2010* report is "one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential."

During this time which brings some of the greatest change in health care in many generations, building a healthy community is a deeply held value for many, and a challenge to implement and develop. Building capacity at the community level, focusing on addressing needs and priorities, and addressing gaps with a system that is patient-centered and community-based will provide for focused and flexible movement forward with space for many different people at the table. The County has been actively engaged in identifying needs through the *Health Profile*; building and implementing strategies with the *Health Action Plan*, and in moving forward to address gaps and build a stronger, more responsive system with the gap analysis, information technology (IT), and Accountable Health Community (AHC) initiatives.

According to the Center for Medicare and Medicaid Services (CMS), "the Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization."[1] CMS also notes that AHC is "a model that addresses the unmet non-medical, social needs of individuals by linking clinical care and community services to improve community health, increase quality of care and reduce health care costs." According to CMS, this model will promote clinical-community collaboration through:

- Screening of community-dwelling beneficiaries to identify certain unmet health-related social needs;
- Referral of community-dwelling beneficiaries to increase awareness of community services;
- Provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services; and

[1] See https://innovation.cms.gov/initiatives/ahcm.

- Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries.

CSD has embraced the AHC model with a goal to improve the health and well-being of the community as a whole and of the people who live in Santa Fe County. CSD desires to create an AHC model that:

- Creates a common vision for stakeholders throughout the county;
- Shares resources in order to maximize impact and outcomes;
- Recognizes that everyone has a valuable role to play;
- Facilitates opportunities for collaboration among health and human service providers in order to optimize community health and well-being; and
- Provides an experience where the whole community benefits.

Utilizing leadership and alignment, CSD hopes to engage the whole community in the health of its residents by maximizing current resources, creating new capacities, and assuring residents are healthy and able to access services when they are needed.

Recognizing the many factors that play a role in a healthy community, CSD has launched an AHC initiative to build a system that helps residents navigate community services and offers providers and policymakers access to data and information to better serve residents, improve health, and reduce health care costs. CSD is working to align providers, resources, and decision-makers to address the social determinants of health (SDOH) that impact health and well-being of individuals, families, and communities. Some of these SDOH include poverty or income levels, education and literacy, age, ethnicity, immigration or other legal status, and access to good housing, transportation, nutritious food, and a safe environment. As the County's *Health Action Plan 2015 – 2017* states:

> The overarching issues that affect all aspects of health in Santa Fe County include demographic issues: poverty, ethnic and income disparities, and a growing aging population; and provider issues – the availability of adequate and appropriate manpower, the importance of prevention as well as treatment, and the need for greater coordination of services across agencies.

To implement this new AHC model, CSD invited providers and other leaders to a kick-off event in December 2016. In its first AHC newsletter in January 2017, CSD stated:

> How a person develops in early childhood, how much education a person obtains, the ability to get and keep a job, the type of job and how much money one earns, or where an individual lives, all influence a person's health. Improving the conditions of daily life can impact health and well-being of residents.

CSD along with its provider and community partners has undertaken to address some of the most critical needs that impede health and an overall healthy community. CSD has sought public input, is reviewing its current priorities, and is reconsidering the way it utilizes resources, including moving from a claims based approach to a contracting approach with its Health Care Assistance Program (HCAP). The Department has also established an AHC Advisory Committee and is partnering and providing leadership and direction on specific projects (for example, the development of a crisis center, enhancement of the social detoxification program,

and a cross-provider information technology project to gather and share data more easily for planning and individual care coordination efforts) as well as on more extensive community-wide health improvement efforts.

B. The Gap Analysis Project

One activity CSD has undertaken as part of the AHC initiative is an analysis of the County and the characteristics of its population along with the services available to serve the County's residents, to identify key gaps in those services. The overarching goal of the gap analysis was to gather, analyze, and provide information regarding issues impacting the health and well-being of Santa Fe County residents. This gap analysis project is intended to provide decision-makers and the public with information, data, ideas, and recommendations to assist in efforts to create a healthier community. The project is also intended to help the County and other public leaders identify priorities to tackle first among the many needs and challenges. These priorities include short and long term issues most directly affecting the health of the community and its residents, and issues County government, and particularly CSD, has some ability to impact, either through leadership, funding, collaboration with other governments and funders, regulation and decision-making, or advocacy.

The process of this gap analysis project consisted of significant data analysis of County and population characteristics from local and national sources; a series of eight public town halls throughout the County focusing on a variety of different geographic areas and demographic groups (including one conducted in Spanish); a set of five meetings with invited health and human services provider leaders and staff; a survey of 56 key service providers; and interviews of 22 representative key informants representing business and community leaders, faith communities, medical and human services providers, philanthropy organizations, service utilizers, and their families.

This gap analysis report addresses the County's most important demographics, health risks, challenges, and opportunities stemming from health disparities as well as health behaviors. The Kaiser Family Foundation's research on the relationship of social and behavioral factors to health shows that a combination of social, environmental, and behavioral factors represent 60 percent of the causative factors shaping overall health status during one's lifetime, as well as premature death.[2] This report describes those factors affecting the health of the community and its residents, building upon key County, State, foundation, and other health planning documents developed over the past few years, including but not limited to the *Community Health Needs Assessment, Community Health Profile,* and *Community Health Action Plan*.[3] The data in this report are focused on population-based issues and health disparities; health indicators, behaviors, and risks; and provider, systems, and structural issues that impact service availability and gaps in services.

Also described is the County's status as a designated Health Professional Shortage Area (HPSA), without enough health professionals in primary care, behavioral health, dental care, and specialty care, including current shortages of doctors, nurses, nurse practitioners, therapists, dentists, and other health practitioners. A number of experts indicate such shortages

[2] Harry J. Heiman and Samantha Artiga, *Beyond Healthcare: The Role of Social Determinants in Promoting Health and Health Equity,* 2015, Kaiser Family Foundation.

[3] *Transforming Health, Strengthening Our Community: CHRISTUS St. Vincent 2017-2019* and *Community Health Needs* Assessment, at http://www.christushealth.org/chna-chip*; Community Health Profile 2013,* at https://www.santafeCountynm.gov/userfiles/HealthStatusProfile6-2-2013.pdf*;* and *Santa Fe County Health Action Plan 2015-2017,* at https://www.santafeCountynm.gov/userfiles/HealthActionPlan2015-2017.pdf

will be greater in the coming years.[4] The issues described in this report have a disproportionately negative impact on low-income individuals and families and on those agencies that serve them. The County's health rankings as compiled by the Robert Wood Johnson Foundation is included as a method to compare Santa Fe County with the State as a whole as well as with top performing counties nationwide on key factors affecting community health and well-being.

The analyses and public input from this gap analysis process resulted in a set of recommendations stemming from the quantitative and qualitative information gained during the project and included in this report. This gap analysis is not meant to be a work plan or to represent decisions on behalf of Santa Fe County. Rather, it identifies needs and recommends possible approaches to meeting some of those needs. While much more data and analyses could be done, this project and this report represent a significant collection of information and ideas upon which CSD and its collaborators can build as they work to create an AHC and a healthier community for all Santa Fe County residents.

[4] *Adequacy of New Mexico's Healthcare Systems Workforce*, 2013, Department of Health and Allied Agencies, NM DOH.

II. SANTA FE COUNTY – POPULATION-BASED ISSUES AND HEALTH DISPARITIES

A. The County Geography and Population

Santa Fe County includes just over 1,900 square miles in north central New Mexico. It is the fifth smallest County geographically in New Mexico, but the third largest in population.[5] For reference, Figure 1 shows a map of the County as a whole. The people of Santa Fe County represent a diverse and multi-colored tapestry of races, ethnicities, and cultures reflecting a rich mix of people who have built a community and health system as complex as the land in which they live. The environment is filled with beautiful skies, mountain vistas, and an ecosystem both strong and fragile, as are the people and the systems that serve its residents.

Figure 1
Map of Santa Fe County

Race, ethnicity, immigration status, income, poverty status, age, sex, and sexual preference all shape the health of individuals, families, and communities. The County's health profile, although generally strong, contains some serious health risks very much related to these demographic characteristics. According to many health experts, it is these characteristics, and related social determinants of health (SDOH) that significantly shape health and health disparities. SDOHs and risk behaviors impact both access to and quality of care and can have a significant impact upon individual and community health. Understanding a community's SDOHs can also help decision-makers address and invest in services to impact those factors – services such as housing, transportation, access to nutritious food, health insurance or coverage, education, work readiness and supports, and health promotion and prevention of issues with disproportionately negative health outcomes such as substance use and addiction, suicidality, teen pregnancy, low birth weight babies, domestic violence, and chronic untreated health conditions. Altogether, understanding Santa Fe County's demographics will help identify needs, gaps, and priorities to improve health of residents and the community as a whole.

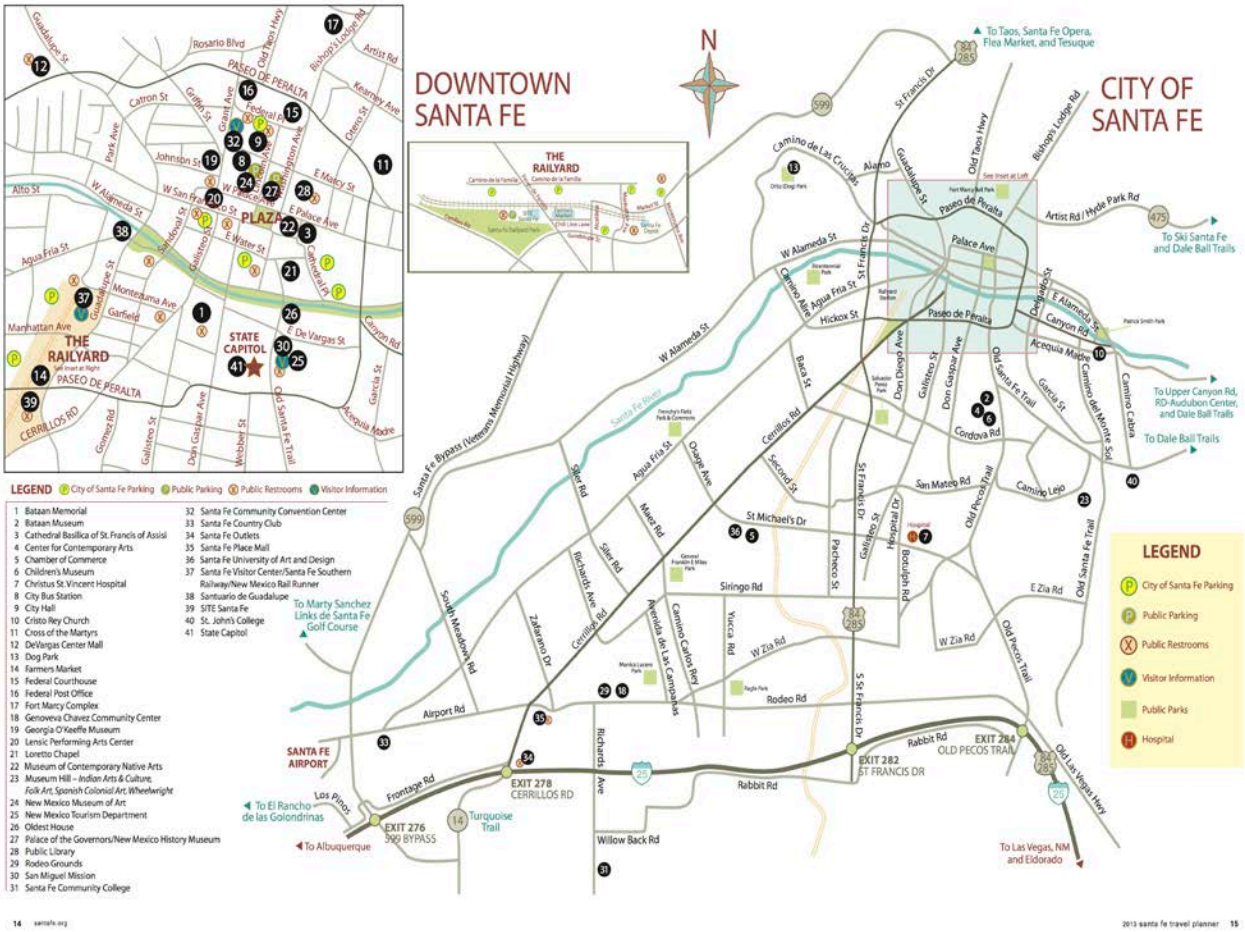
The City of Santa Fe is both the County seat and also the state's Capital City. The City of Santa Fe is home to one of the largest arts communities in the nation and is a location for many tourist and vacation destinations.[6] The largest City in the County is Santa Fe,

[5] See https://en.wikipedia.org/wiki/Santa_Fe_County,_New_Mexico
[6] See https://santafe.org/

representing over half of the County's population at approximately 80,822 in 2010, growing to 83,875 in July 2016.[7] Edgewood (population 3,805), Chimayo[8] (population 3,177), and Pojoaque (population 2,202) are much smaller. Some areas such as Eldorado (almost 6,000 population) are larger than the small towns within the County, but are not incorporated areas so are not cities or townships unto themselves. Similarly, Española is larger than these small towns (population over 10,000) but is located primarily in Rio Arriba County except for small portions of the southern and eastern parts of that City located in Santa Fe County.

For reference, Figure 2 shows a map of the City of Santa Fe where a significant portion of those at risk for health issues live.

Figure 2
Map of City of Santa Fe

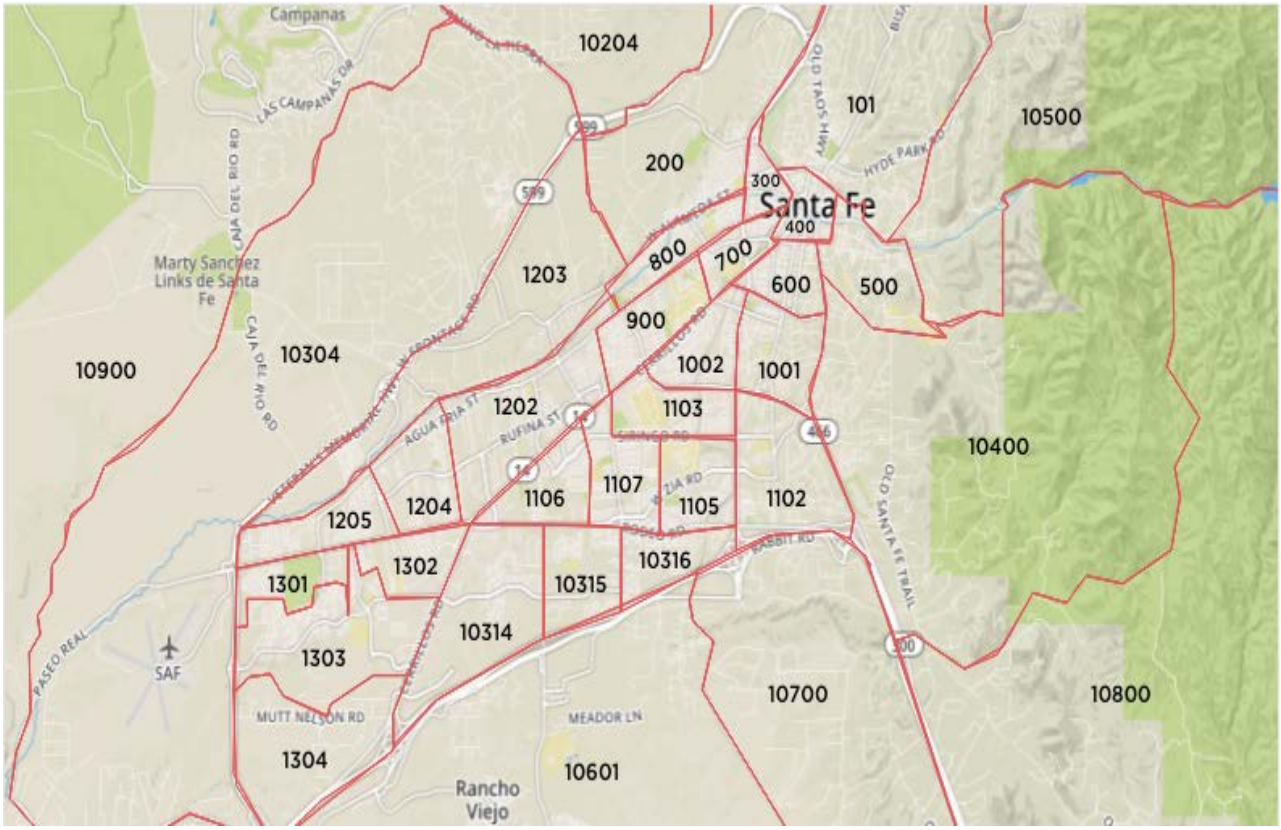


Source: www.santafe.org

[7] See https://www.census.gov/quickfacts/fact/dashboard/santafecitynewmexico,US/IPE120215
[8] Note: Chimayo is located partly in Santa Fe County and partly in Rio Arriba County to the north.

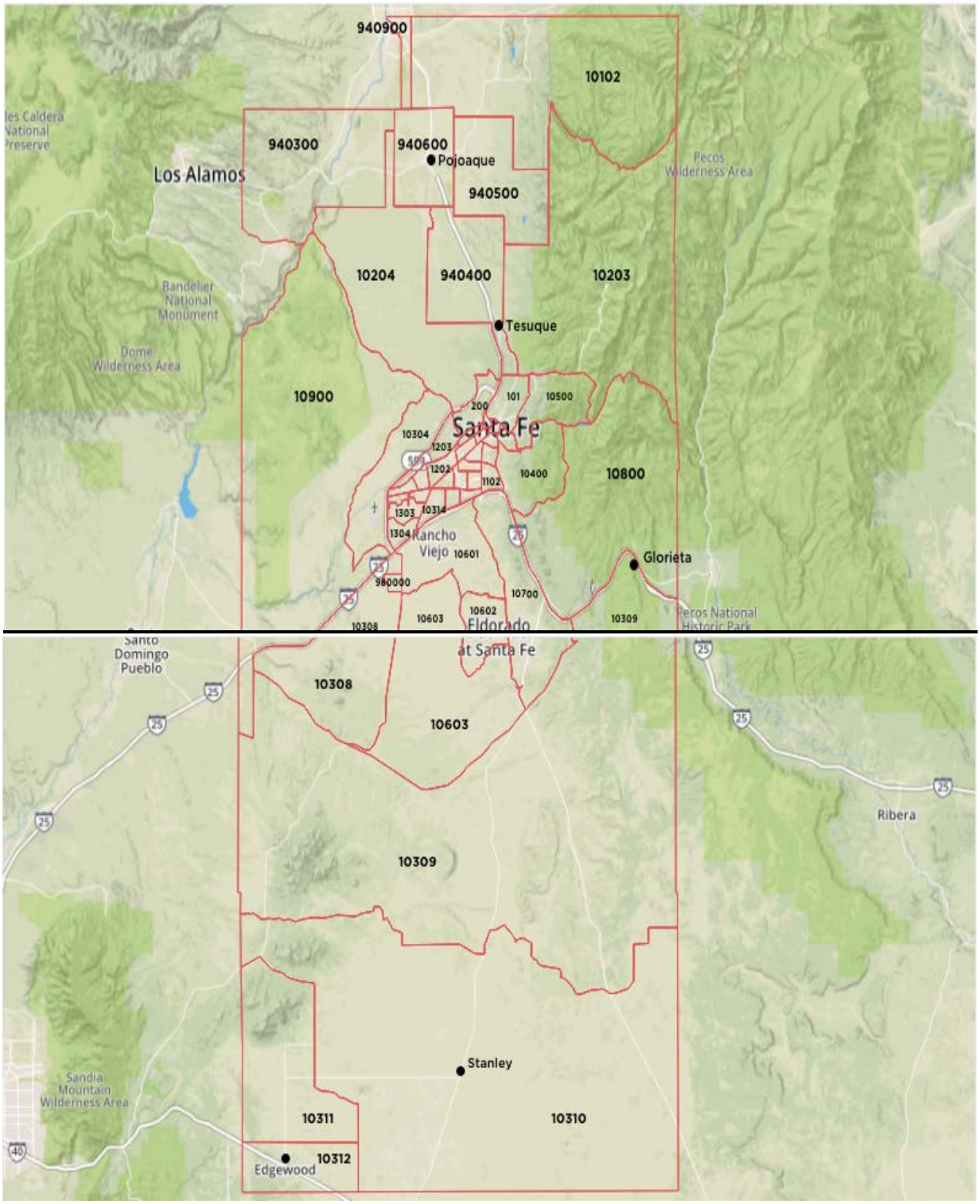
Santa Fe County's population has continued to grow over the past few decades and stands at 147,108 for the period 2011-2015.[9] The County has slightly more women than men. The largest concentrations of people are from ages 50-70, and the smallest between ages 20 and 35. This has an impact upon needs, projected challenges, and gaps. The combination of age and sex with race, ethnicity, and poverty creates a unique mix of social determinants that represent assets as well as challenges. Women face unique health challenges often related to male-oriented research that existed for many decades, skewing health care data and indicators toward the male profile. A growing emphasis on women's health is addressing this gap.[10] Many parents find it increasingly challenging to locate affordable child care, after-school activities, and summer programs for their children. Youth and young adults face an increasing number of behavioral health challenges, including isolation, disconnection, significant high school dropout rates, lower than average employment rates, depression, injury, and suicide.[11] Data about these issues are often depicted by census tract, shown for reference in Figures 3a and b below.[12]

Figure 3a
Santa Fe County Census Track Boundaries – City of Santa Fe



[9] For most of the data analysis, the consulting team looked at 2011-2015 multi-year data because it offers a solid picture of numbers over time; the team also looked at single years as needed to check for trends within these time periods.
[10] Sections on women's health in *Transforming Health, Strengthening Our Community: CHRISTUS St. Vincent 2017-2019 Community Health Needs Assessment;* women's health specialty services in County Community Health Centers and CHRISTUS St. Vincent.
[11] NM DOH IBIS reports; NM *YRRS*; SFC *Health Action Plan, 2014*; Youth Shelters and Family Services reports.
[12] See https://www2.census.gov/geo/maps/dc10map/tract/st35_nm/c35049_santa_fe/ for a comprehensive look at census tracts in Santa Fe County.

Figure 3b
Santa Fe County Census Tract Boundaries – North and South County

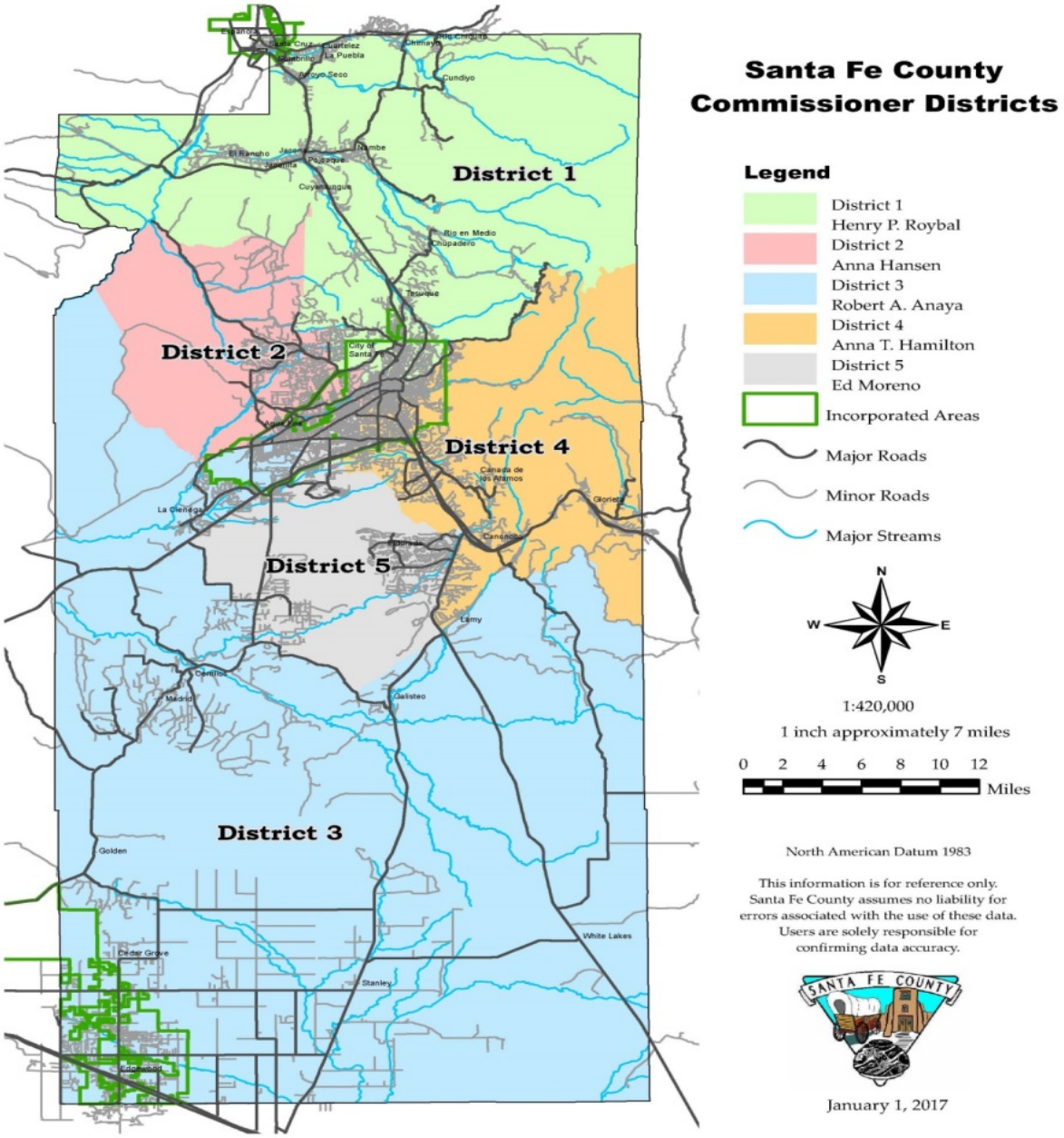


Data in this report are sometimes described by neighborhoods or small areas corresponding to multiple census tracts, shown in Figure 4 below. Figure 5 shows County Commission district boundaries as of January 2017.

Figure 4
Census Tracts Included in Small Areas within Santa Fe County

Small Area Description	Census Tracts Included
92 – East Foothills & Eldorado (to Lamy)	10400, 10500, 10601, 10602, 10603, 10700, 10800
93 – Opera Vicinity & North City (northern Santa Fe City limits & area just north)	101, 200, 10304, 10900
94 – North County/Pueblos Plus	10102, 10203, 10204, 940300, 940400, 940500, 940600, 940900
95 – Agua Fria Neighborhood & Downtown	300, 400, 500, 600, 700, 800, 900, 1001, 1002, 1102
96 – Agua Fria Village	1202, 1203, 1204
97 – Bellamah/Stamm (Cerrillos Rd, Camino Carlos Rey east side, Osage)	1103, 1105, 1106, 1107, 10314, 10315, 10316
98 – Airport Road (both sides)	1205, 1301, 1302, 1303, 1304
99 – South County (south of Airport Rd)	10308, 10309, 10310, 10311, 10312

Figure 5
Santa Fe County Commission District Boundaries as of January 2017[13]



The rest of this section describes the characteristics of the Santa Fe County population, with an emphasis on critical areas where poverty and demographics combine to create high risk residents and areas of the County.

[13] This information along with information about each Santa Fe County Commissioner and the County Commission as a whole can be found at https://www.santafeCountynm.gov/County_commissioners.

B. Older Adults

The population of older adults in Santa Fe County is growing rapidly with an anticipated increase of 62 percent by 2030.[14] This is a significant concern as the current infrastructure will not support this huge increase. The County's aging population currently experiences higher rates of unintended, fall-related injury deaths[15] and lower rates of immunization against the flu[16] as compared to state and national averages. Individuals who are elderly have a wide range of needs and capacities. Older adults fall into three primary categories: young old (ages 55-69); middle old (70-84); and old old (85 and older).[17] Health issues and disabilities often increase as older adults move from being active healthy young seniors in their 60s, to becoming frailer in their 80s and 90s. An age-related bell curve leans disproportionately toward older age groups, meaning that the increases in the older population for the County will be faster and larger than national and state norms, which will stress many County resources from housing and transportation to health care.[18] There are smaller proportions of young adults when compared to national averages, which can have an impact upon the healthcare workforce.

New Mexico is projected to experience a rapid growth in the proportion of older adults ages 65 and older living in the state. The state is anticipated to move from being 39th in the U.S. in proportion of older adults to the total population to being fourth (4th) in 2030. Santa Fe (SF) County is expected to have slightly higher proportions of older adults than the state as a whole, with very old individuals the fastest growing group. This population shift has enormous implications for community health[19] and health service needs.

One of the national experts on aging coined the term "The Age Wave."[20] Other experts have called the aging of our population and the shifting of Baby Boomers into retirement the "Silver Tsunami." Whatever the terms used, it is clear that we have a growing population of older adults at national, State, and County levels. The trend is significant at the national level, greater at the State level, and extremely pronounced at the County level. When one compares Santa Fe County's population distribution to the state and national distribution in the charts below, it is clear that (1) the County's population distribution will place enormous stresses on the entire healthcare, housing, social service, and broader community infrastructures; and (2) there are proportionately fewer younger generations to support the expanding group of aging individuals in the County.

Older individuals are most heavily concentrated in a number of areas of the County highlighted in Figure 6 below. These small areas include multiple census tracts as shown in Figure 4 above.

[14] U.S. Census Bureau, Projected Population Distribution by Age, and Con Alma Health Foundation's materials..
[15] NM Department of Health: Bureau of Vital Records and Health Statistics
[16] Centers for Disease Control and Prevention
[17] Some have euphemistically called these groups the "go-goers," the "slow-goers," and the "no-goers."
[18] U.S. Census statistics on demographic trends, the "Age Wave," and reported by the Con Alma Health Foundation in EngAGE New Mexico, 2013.
[19] Emily Kaltenbach, *EngAGE New Mexico: Promoting and Strengthening Grantmaking in New Mexico to support an Aging Population,* 2012, Con Alma Health Foundation.
[20] Ken Dychtwald with Joe Flower, 1990, *Age Wave: How the Most Important Trend of Our Time Will Change Your Future*, Bantam Books.

Figure 6
Percentage of Individuals Who are Elderly Living in Areas of the County[21]

Small Area #	Small Area Description	Percent 65+
93	Opera Vicinity & North City	44.40%
92	East Foothills & Eldorado	38.10%
95	Agua Fria Neighborhood & Downtown	35.70%
97	Bellamah/Stamm	33.80%
99	South County	30.20%
94	North County/Pueblos Plus	30.00%
96	Agua Fria Village	17.40%
98	Airport Road	15.60%

In addition to concerns of the quickly aging population, people with physical and developmental disabilities also face significant challenges accessing care. The areas of the County that have the greatest percentage of people with disabilities are shown in Figure 7 below.

Figure 7
Percentage of Persons with Disabilities Living in Areas of the County

Small Area #	Small Area Description	Percentage of People With Disabilities
94	North County/Pueblos Plus	14.2%
93	Opera Vicinity & North City	14.0%
95	Agua Fria Neighborhood & Downtown	14.0%
96	Agua Fria Village	14.0%
97	Bellamah/Stamm	12.4%
92	East Foothills & Eldorado	12.2%
99	South County	12.0%
98	Airport Road	11.0%

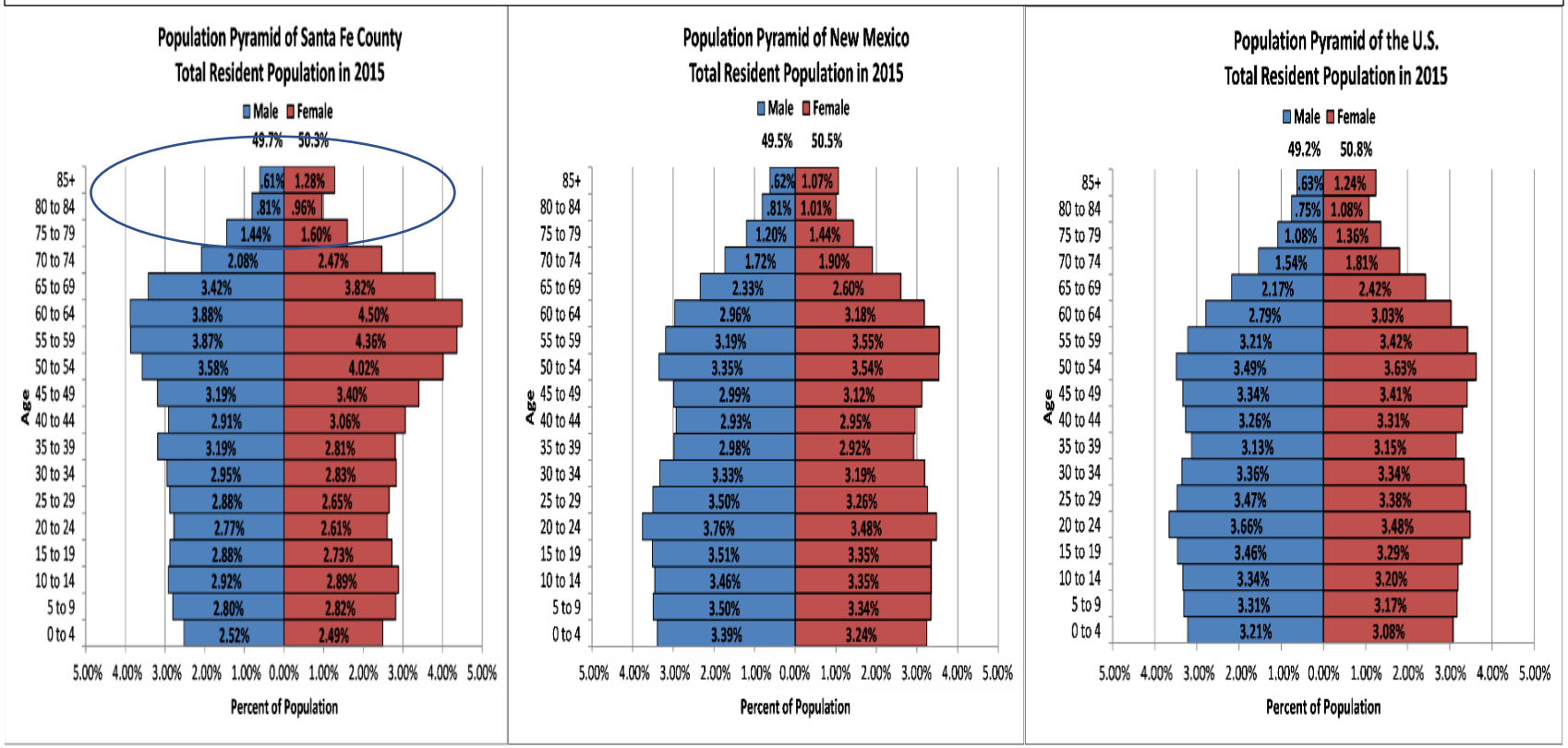
Even with the graying of the U.S. population, the national demographic chart in Figure 8 represents the more traditional picture seen over the past decades, with the majority of the population in their middle years; a large group of children and young adults; a smaller cohort of older adults. The state's picture in Figure 8 shows a large group of people over age 50; as they age, the group of older adults will be quite large. Santa Fe County's demographic shift is more pronounced, and about 10 years ahead of the state's trend with a much larger percentage of people over 50 moving into the older adult age group. This means that the size, scope and pace of the "Age Wave" or "Silver Tsunami" will be greater in Santa Fe County than in NM or the U.S.

[21] Much of the data provided in this report is provided by census tract areas. The geography of these census tracts are generally described in Figures 3a and b and Figure 4 in this report. For a comprehensive look at census tracts in Santa Fe County, see https://www2.census.gov/geo/maps/dc10map/tract/st35_nm/c35049_santa_fe/.

Figure 8
Population Compared by Age – County, State and National Profiles

Population Pyramids - 2011-2015 - U.S. Census Data

Santa Fe County | New Mexico | United States



C. Poverty and Its Impact on Health

Over many decades, researchers in health have determined income, income inequality, and poverty are some of the greatest shapers of individual, family, and community health. People with high-incomes tend to manage their health and health care very proactively. They have higher salaries, savings, and investments. They have more discretionary time which allows them to finance, schedule, and access more effectively different services needed. They engage in more preventive care and their health status is better, on average, than people with lower incomes and fewer resources.[22]

Those who have limited incomes or who live in poverty are in circumstances where they need to stretch the scarce funds available to pay for food, housing, utilities, and health care, the latter often being deferred. Lower income adults are usually in a situation where they cannot easily take time off from work for health care appointments, and if they do, they are less likely to have paid leave for this time off. Many parents tend to the care of their children first, and postpone attending to their own health care needs. Most limited income families struggle to pay premiums or co-pays on even the most highly subsidized health care. The combination of limited available funds, covering co-pays, and scheduling care often create insurmountable barriers. This means that those who live in poverty or have limited incomes are very much at risk, and the impact of their poverty provides one of the greatest barriers to accessing care.

The federal poverty level (FPL) guidelines for 2017 are shown in Figure 9 below.[23]

Figure 9
U.S. Poverty Guidelines by Number in Household – 2017 and 2015

# in Household	Poverty Guideline Annual Income 2017	Poverty Guideline Annual Income 2015
1	$12,060	$11,770
2	$16,240	$15,930
3	$20,420	$20,090
4	$24,600	$24,250
5	$28,780	$28,410
6	$32,960	$32,570
7	$37,140	$36,730
8	$41,320	$40,890
More than 8	Add $4,810 per person over 8	Add $4,160 per person over 8

[22] Los Alamos County, NM is considered to be the healthiest County in the state by Robert Wood Johnson's *County Health Rankings and Roadmaps*. It is correspondingly one of the wealthiest counties in the nation. Anne Hays Egan, *LACHC 2015-2016 Los Alamos County Community Health Needs Assessment & Call to Action*, Los Alamos County Health Council.
[23] Poverty Guidelines, for U.S. and 48 contiguous states and D.C.; U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation.

Despite the existence of substantial wealth among many living in Santa Fe County, which puts the County as a whole above the economic status of most other counties within the state, certain areas within the County (especially in North County and in specific parts of the City of Santa Fe) include individuals, families, and whole communities living in significant poverty. Essentially, there is a "tale of two cities" within Santa Fe County where the residents of specific neighborhoods have much higher risk factors, including higher poverty rates, than others.

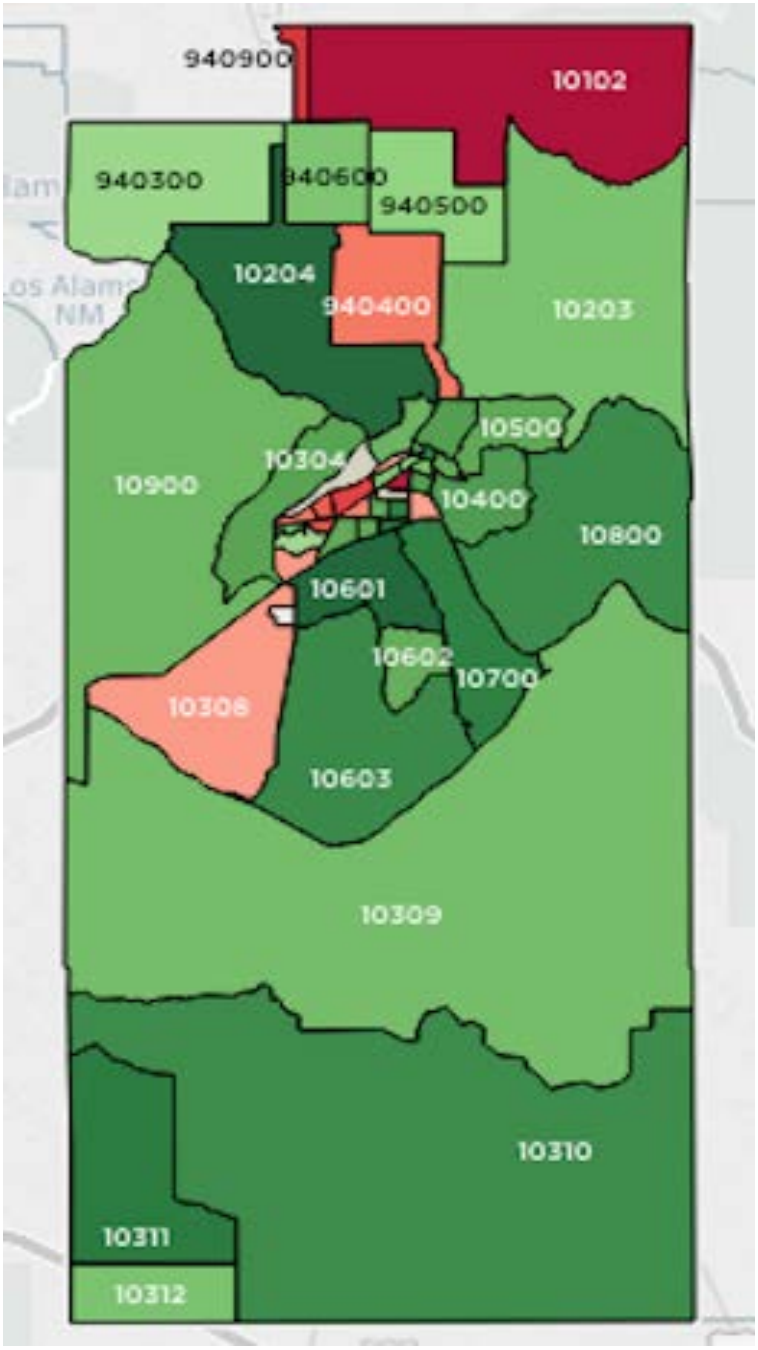
The County's overall poverty rate was 15.6 percent during 2011-2015, higher than the national average of 14.7 percent and lower than the statewide rate of 21 percent. Almost seven percent (6.6 percent) of the population in Santa Fe County lived under 50 percent of poverty; and almost 30 percent (29.1 percent) of the population lived at 200 percent of the federal poverty level or less. The poverty rate of children under age 18 was 23 percent during this same time period.[24] The household poverty rate in Santa Fe County is 13.5 percent. In some neighborhoods, the household poverty rate is more than double the County's average (as high as 29.5 percent), while in wealthier communities the household poverty rate is 0 percent.[25]

A statewide study has shown a high correlation between those who self-report fair to poor health and their level of poverty.[26] It is extremely difficult for a family of four to live on $24,600 per year in Santa Fe County. This poverty level represents a low threshold for poverty. Many federal and state benefit benchmarks are set at different percentages of the poverty level, including 138 percent, 185 percent, 200 percent, and a few up to 400 percent. Poverty is one of the most important SDOH because it impacts all areas of individual, family, and community life. Poverty is literally woven into the fabric of life, and thus heavily impacts health. In communities where there is a high concentration of poverty, the community's own health is impacted by the aggregation of hundreds of poor families. The commitment of many of the community providers to bring services to neighborhoods where individuals and families live in poverty reflects an understanding of this important reality.[27] However, significant needs remain.

Areas with higher than average poverty rates, including parts of the North County/Pueblos Plus area (94), Agua Fria Village (96), Agua Fria Neighborhood & Downtown (95), Bellamah/Stamm (97), Airport Road (98), and the areas just south of the Airport Road neighborhood,[28] also have a high proportion of individuals who are Hispanic, immigrant, or Native American. Neighborhoods with the highest proportion of households living in poverty are represented in Figures 10a – c.

[24] Data from U.S. Census, reformulated by NM DOH IBIS, at https://ibis.health.state.nm.us/query/result/acs/ACSEconomic/Pov18.html.
[25] Data from U.S. Census ACS Factfinder and NM DOH IBIS dataset query.
[26] U.S. Census data, 2011-2015 on poverty levels; *NM Health Status 2016*, Behavioral Risk Factors Surveillance System, NM DOH, data from 2015.
[27] Examples of provider commitment to neighborhoods include: La Familia's Community Health Center locations, the many outreach locations of Presbyterian Medical Services, Presbyterian Healthcare Services' development in the County's south side, CHRISTUS St. Vincent's Care Connection, the United Way of Santa Fe's Agua Fria Children's Zone, CSD's mobile van, cross training of first responders, and other services and activities not listed all reflect that understanding of the aggregate impact of health disparities at the community level, and the need to be in the community whenever possible.
[28] A set of census tract maps with drawn boundaries can be found in Figures 3a and b, earlier in this report.

Figure 10a
Santa Fe County Households Below Poverty by Census Tract



Rank	Census Tract	Percent HH Under FPL
1	10102	29.52%
2	1002	28.20%
3	1202	24.93%
4	1302	23.55%
5	1204	23.06%
6	1205	20.89%
7	1106	20.64%
8	1304	18.72%
9	10308	18.69%
10	1102	18.18%
11	800	17.87%
12	1103	16.40%
13	1203	16.33%
14	1303	15.20%
15	700	14.25%

(U.S. Census reports, 2011 – 2015 data)

Highest poverty rate areas are mapped in darker shades of red/purple. Lower poverty rate areas are mapped in green with the darker green showing less poverty.

Figure 10b
Santa Fe City Households Below Poverty by Census Tract (with City Boundaries)

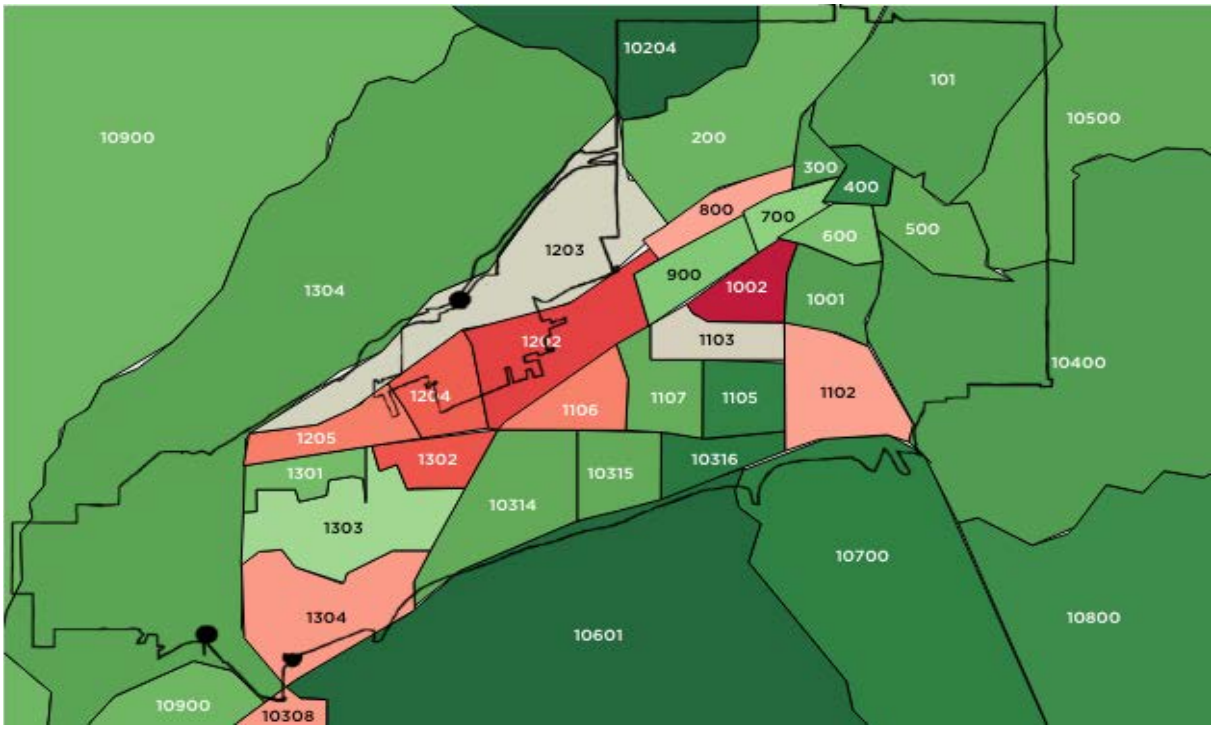
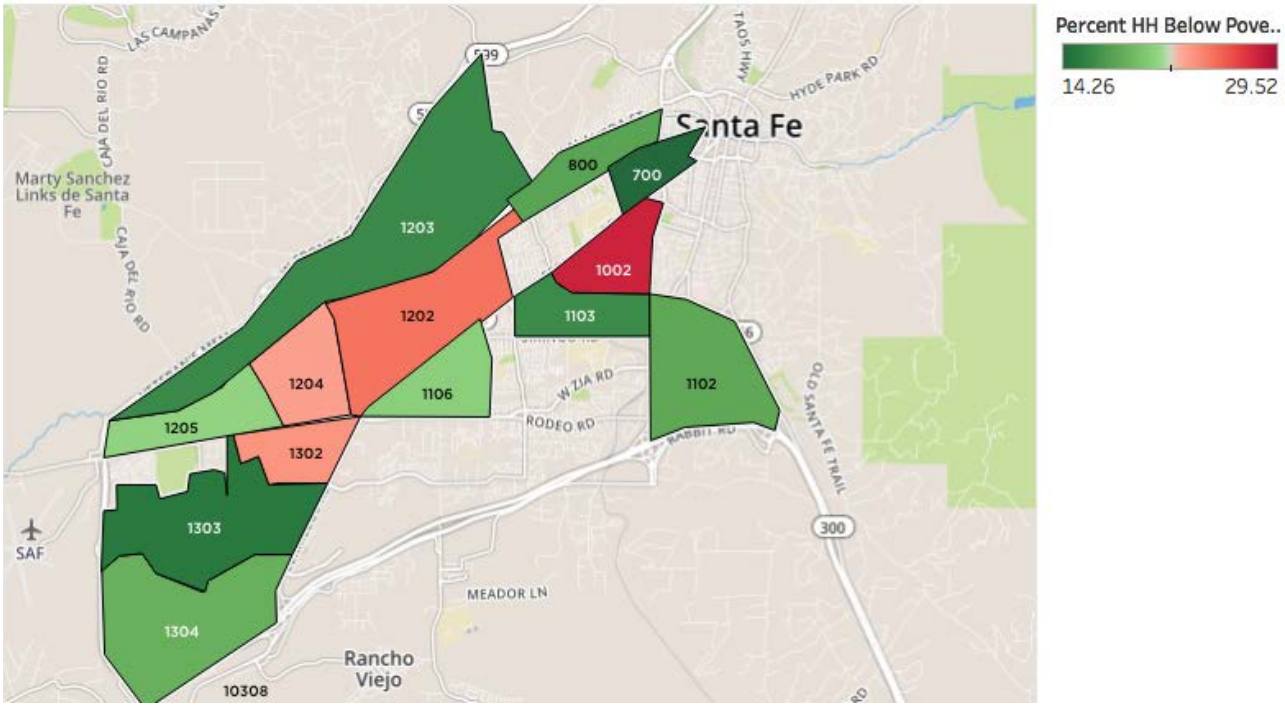


Figure 10c
City of Santa Fe's 15 Census Tracts with Highest Poverty Levels



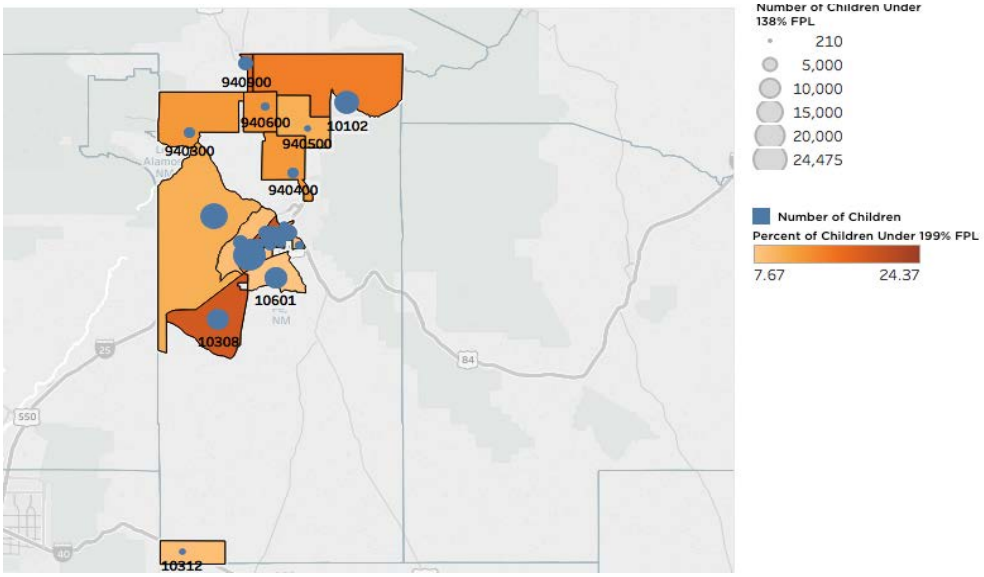
In SF County, about 20 percent more women live in poverty than men.[29] During 2011 – 2015, 12,104 females compared to 10,373 males were living below poverty level in Santa Fe County. The poverty level of women affects the poverty of their children. Poverty stresses children, families, communities, and institutions serving them. Areas of SF County with the highest concentrations of children in poverty are listed in rank order in Figure 11 below.

Figure 11
Areas with Highest Concentrations of Children in Poverty

Small Area # and Description	# Children in Poverty	Total Area Population	Percentage
96 – Agua Fria Village	1,091	2,673	40.80%
95 – Agua Fria Neighborhood & Downtown	808	2,496	32.40%
98 – Airport Road	1,114	3,955	28.20%
94 – North County/Pueblos Plus	800	3,163	25.30%
97 – Bellamah/Stamm	426	2,407	17.70%
93 – Opera Vicinity & North City	247	1,713	14.40%
99 – South County	237	2,434	9.80%
92 – East Foothills & Eldorado	140	2.916	4.80%

Figures 12a and b show the proportion of children under 199 percent of FPL who live in poverty, focusing upon the 15 census tracts with the highest overall percentage of poverty (as outlined in Figures 10c). The highest rates of overall poverty and child poverty are in the far north (census tracts 940900 and 10102), the southern part of the City of Santa Fe (census tract 10308), and just south of the City. Census tracts with higher rates (percentages) of persons in poverty are highlighted in shades of brown; the darker the coloring, the poorer the region. The number of children in poverty within each of these poorest census tracts is indicated with blue bubbles – the larger the circle, the more children in poverty.

Figure 12a
Proportion of Children Under 199% FPL by Census Tracts



[29] Data from U.S. Census ACS Factfinder, op.cit.

Figure 12b
Proportion of Children Under 199% FPL by Census Tract (Enlarged)

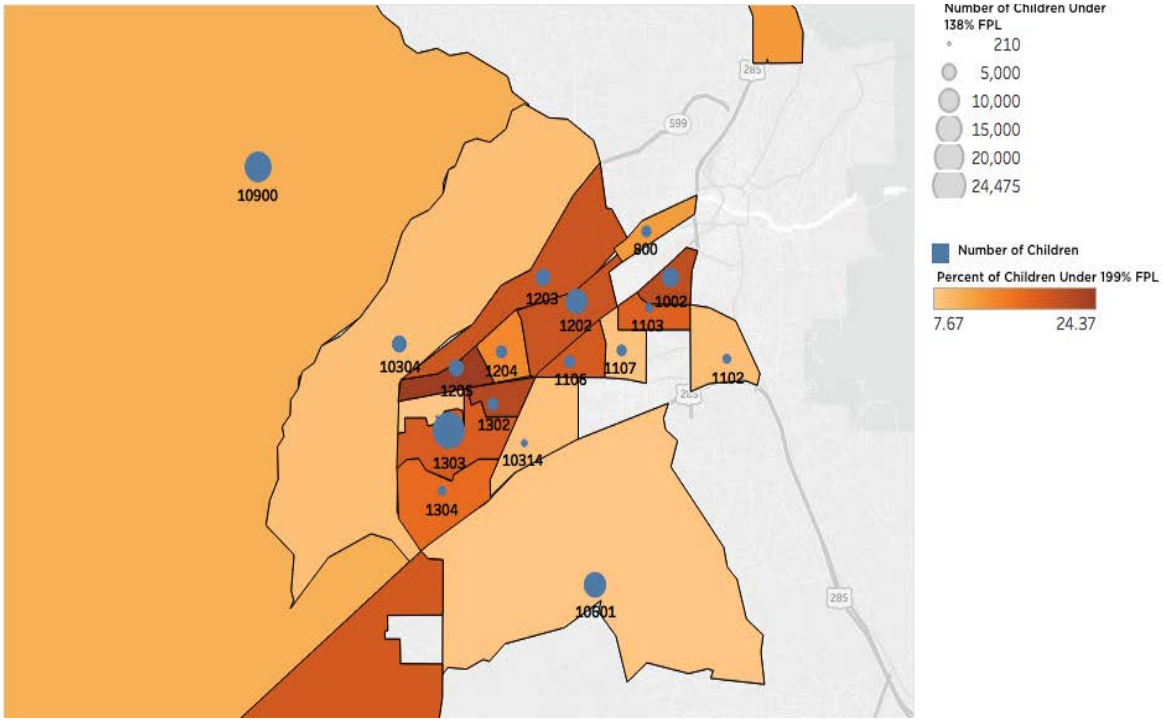


Figure 12b above shows that neighborhoods in the central County area with the highest proportion of children living in poverty are not necessarily within the City limits, but are in census tracts 10900 (in the Opera Vicinity & North City), 1303 (along Airport Road), and 10601 (Rancho Viejo area in the East Foothills & Eldorado neighborhood).

Like children, the County has significant numbers of older adults living in poverty, especially in the southern and eastern parts of the County and in North County. A significant number of poor and limited income older adults live in some of the same areas of the County where the poverty rates are highest as seen in Figures 13a and b below. The orange circles on the map represent number of older adults – the larger the circle the more persons who are elderly live in that area. The shaded areas on the map represent percentages – the darker the area, the higher the percentage of older adults living in poverty in that area.

Figure 13a
Proportion of Older Adults Living in Poverty in Santa Fe County

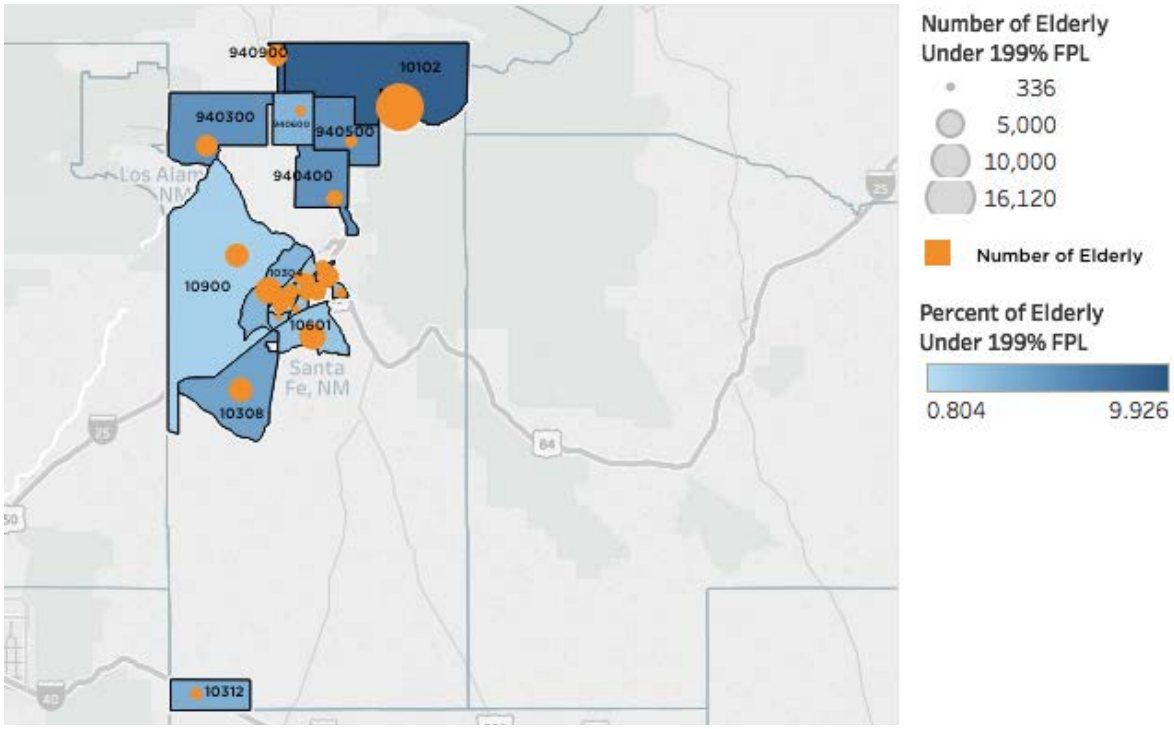
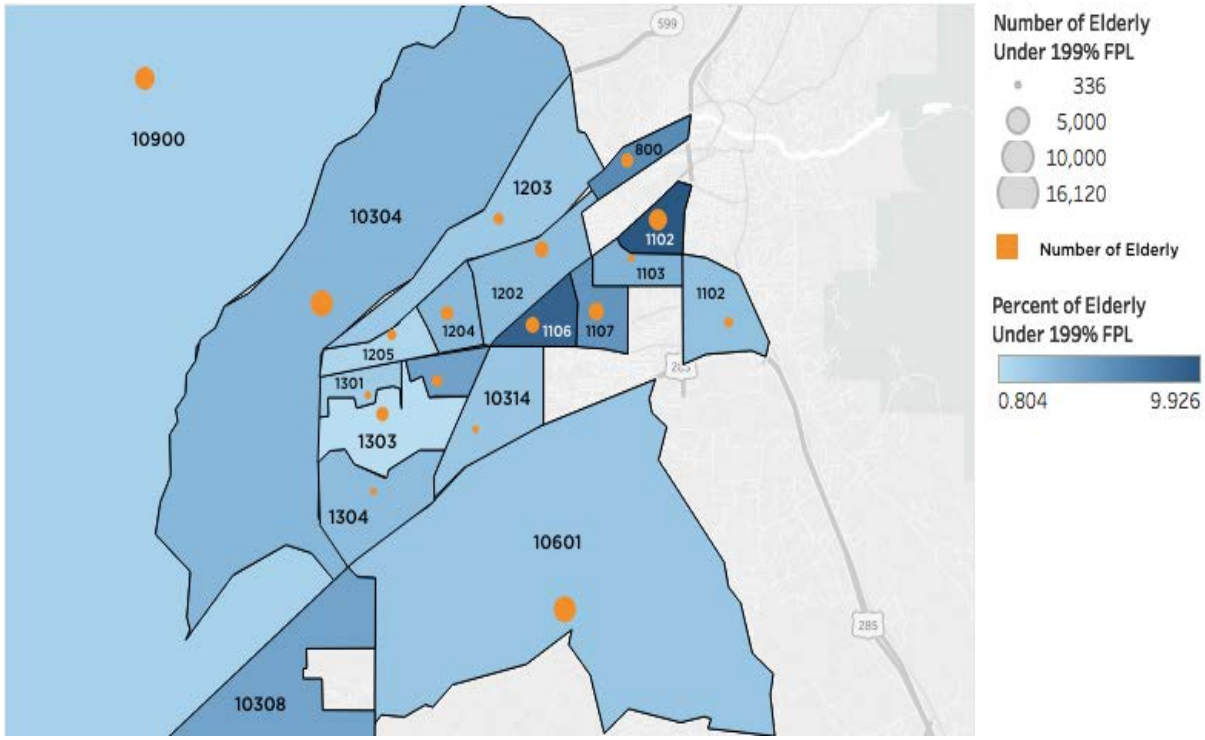


Figure 13b
Proportion of Older Adults Living in Poverty in Central Santa Fe County



An analysis of the census data shows a growing trend of people with limited incomes under 400 percent of the federal poverty level. Women aged 65 and older are twice as likely to live in poverty as men of the same age group, according to aging expert Carroll Estes, founder and former director of the University of California at San Francisco's Institute for Health and Aging and former President of the American Gerontological Society.

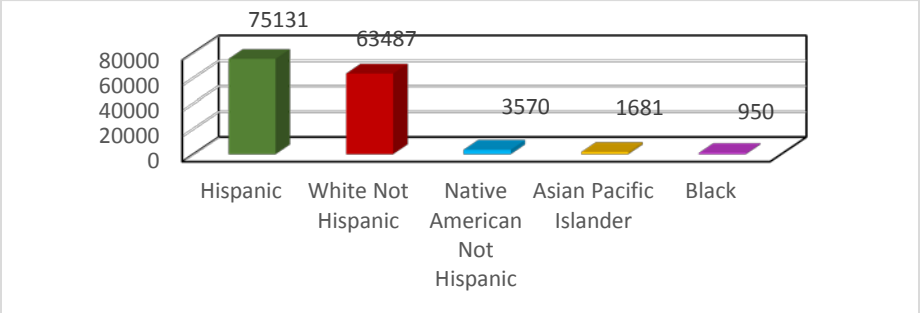
> Low wage jobs, lifelong lower earnings, divorce, and their role as family caregivers are all part of the stories of individual women living in poverty… Older women of color are most vulnerable, even with Social Security. Older Hispanic and African American women experience double the poverty rate of older white women. Compounding their financial difficulties, women live longer, have more chronic illnesses, and high out-of-pocket health costs. . . .[30]

Given the significant aging of the Santa Fe County population (see Figure 8), significant challenges exist in meeting the needs of older adults now and will likely increase in coming years. These challenges will be described later in this report.

D. Race and Ethnicity

Race and ethnicity matter a great deal to everything about life in Santa Fe. The different faces of the population represent varied cultures and traditions, all of which shape the way people think about and respond to health and health care. Racial and ethnic minorities are disproportionately represented among individuals and households that are poor, underserved, and with poorer health outcomes. The federal Office of Minority Health and the World Health Organization have both played instrumental roles in documenting how social determinants such as race and ethnicity shape all aspects of our lives, our health, and our communities. In New Mexico, the state Department of Health's (DOH's) Office of Minority Health and the Con Alma Health Foundation conduct research on the impact of health disparities on individuals and community, documenting how race and ethnicity shape health.[31]

Figure 14[32]
Racial and Ethnic Groups in Santa Fe County



[30] https://www.whatthefolly.com/2012/05/28/transcript-dr-carroll-estes-calls-on-congress-to-improve-social-security-benefits-for-women-of-color/; http://www.justiceinaging.org/justice-in-aging-honors-carol-estes-at-reception)
[31] Lynn Gallagher, *Health Equity in New Mexico*, 11th edition, 2016, NM Department of Health, Office of Minority Health.
[32] The report authors use the taxonomy for showing race and ethnicity adopted by New Mexico Voices for Children, in their work with the Annie Casey Foundation's Kids Count, and used by other researchers. Because the category of "Hispanic" is an ethnic, not a racial category, the easiest and most accurate way to parse the data is to look at Hispanics and other groups of people that are not Hispanic. This ensures that both racial and ethnic categories are included in the same data analysis, without blurring categories. All racial categories are sifted using the Hispanic lens.

Those neighborhoods with higher levels of poverty also have disproportionately high concentrations of Hispanic and Native American people, with lower proportions of persons who are White or Asian and Pacific Islander. The proportion of African Americans (or Blacks) is extremely low in all County census tracts (Figure 14 above). However, there is a higher concentration of poverty among African Americans than in the population at large.

Figures 15a and b show locations and concentrations of persons who are Hispanic or Latino in relation to areas where higher proportions of persons with lower incomes reside in the County and in the Central County area (enlarged). The orange circles on the map represent percentage of Hispanic or Latino individuals – the larger the circle, the higher the percentage who are Hispanic or Latino living in that area. The shaded areas on the map represent percentages – the darker the area, the higher the percentage of individuals living in poverty in that area.

Figure 15a
Poverty and Ethnicity in Santa Fe County – Hispanic or Latino

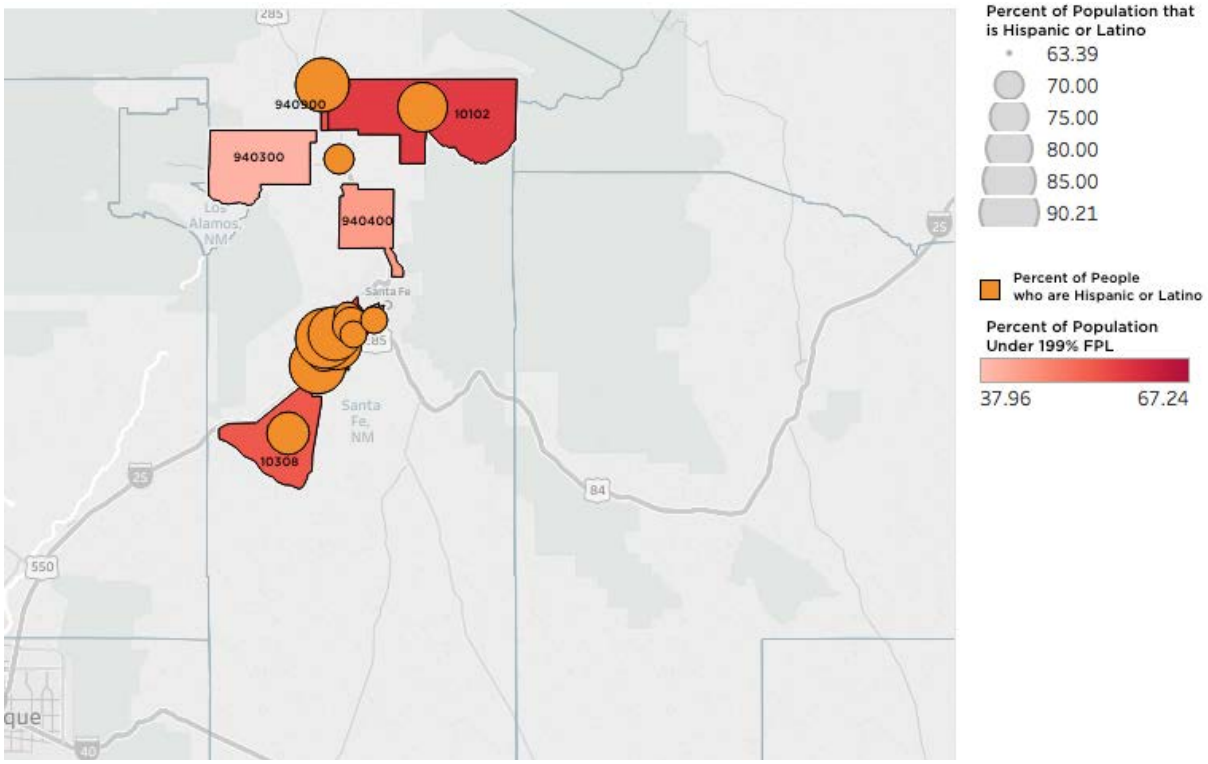
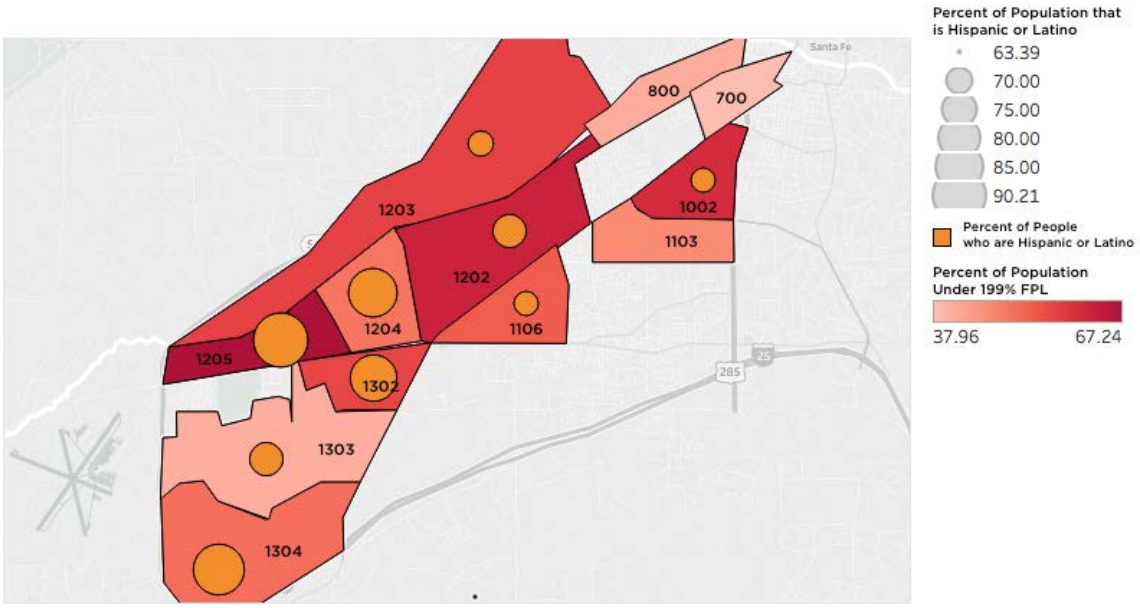
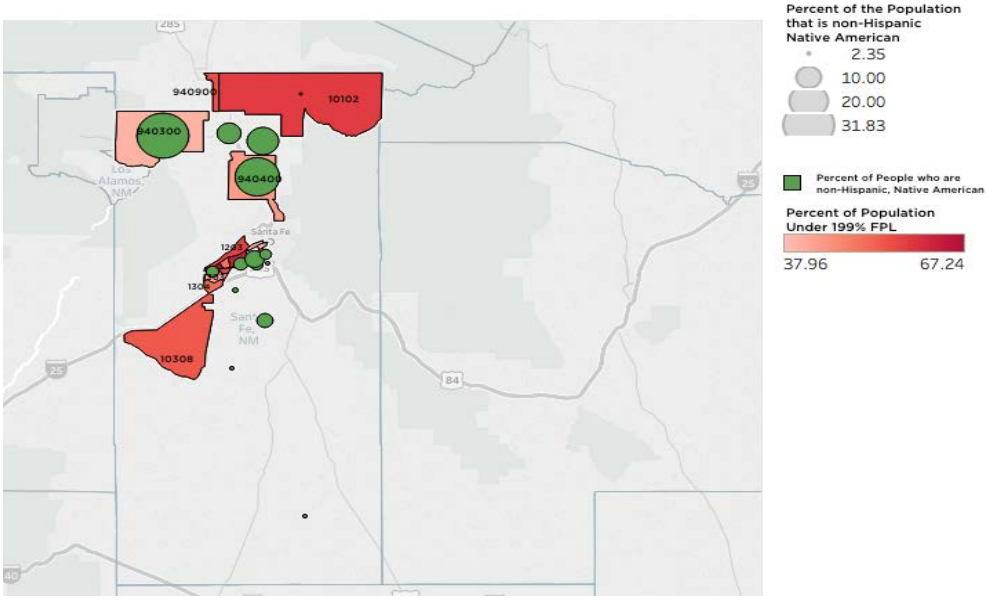


Figure 15b
Poverty and Ethnicity in Central Santa Fe County – Hispanic or Latino



A large concentration of Native Americans live in some of the census tracts with the highest poverty rates, in the North County, Pueblos Plus Area, the City, and just south of the City, as shown in Figure 16 below. The green circles on the map represent the percentage that is non-Hispanic Native American – the larger the circle, the higher the percentage. The shaded areas on the map represent percentage of people under 199% FPL – the darker the area, the higher the percentage. The highest concentration of Native peoples is in North County, therefore there is no enlarged map showing the densely concentrated census tract areas in the City. However, significant numbers of Native Americans do live or use services in the City of Santa Fe, many of which are from tribes or pueblos not located within the boundaries of Santa Fe County.

Figure 16
Poverty and Ethnicity in Santa Fe County – Non-Hispanic Native American



Health disparities shaped by race and ethnicity include poorer health outcomes than the population as a whole.[33] These health disparities reflect the realities faced by racial and ethnic minorities (or majority/minorities), including more limited access to health care. This unequal status has multiple causes in addition to poverty, including a lack of understanding, limited cultural awareness, and/or prejudice and institutionalized racism. Research by the federal Office of Minority Health and NM's Con Alma Health Foundation attest to the root causes for these health disparities, and the importance of addressing root causes that create structures and practices that perpetrate inequality and are not fully utilized or respected by those most in need. Understanding how race and ethnicity contribute to health barriers and gaps is important to addressing the issue systemically.

In the ten (of 50) census tract areas in the County with the highest poverty rates:

- Hispanics represent a majority of the population in 80 percent of the 10 poorest areas.
- Census tracts with the highest percentages of Hispanics show an average poverty rate of 23.2 percent, compared to the County's rate of 15.6 percent.[34]
- Native Americans are strongly represented in the census tracts with higher poverty rates in North County, which have the highest household poverty rates of all areas.

Language represents our principal way of understanding and conceptualizing our world in relation to others. When racial and ethnic minorities speak another language as their primary language (Spanish, Diné, Tewa, etc.), barriers to care are complicated, especially when service providers and health practitioners do not speak or understand individuals' native languages. SF County has a large immigrant population primarily but not entirely a subset of Hispanics or Latinos facing significant economic, social, and health challenges. Barriers to accessing health care can be better understood through knowing more about the County's racial and ethnic minorities, where they are located, their cultures, languages, health coverage, primary providers, and other factors impacting health and health care.

The diversity of the County is underscored in the types of languages spoken by residents. While English is the primary language spoken by 62 percent of County households, Spanish is the primary language spoken by 33 percent of households, Indo-European languages are spoken by three (3) percent of households, and Asian Pacific and other languages are spoken by two (2) percent of households. People whose primary language is other than English may often speak English either very well or well enough to communicate general thoughts and ideas. However, many non-native English speakers may struggle with conversations specific to Western healthcare concepts and interventions, and may even have alternative ideas and beliefs with regard to overall health, such as what impacts illness and when to seek health care.

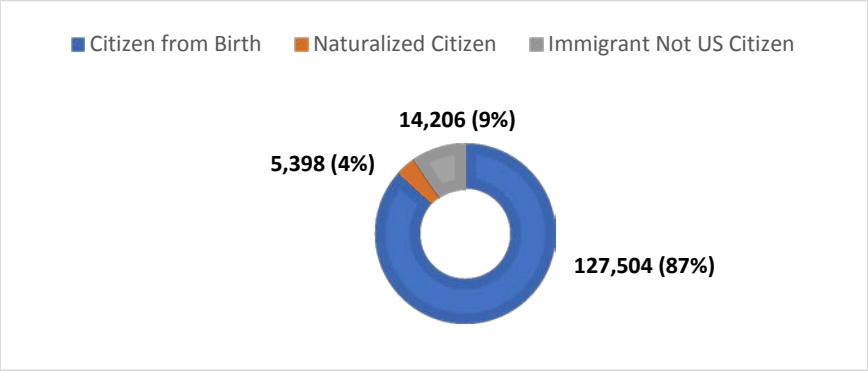
E. Immigration and Citizenship Status

Immigrants (naturalized citizens and non-citizens) represent about 13 percent of the County's population, approximately comparable to the rate for the US as a whole, but more than the state of NM which has 10 percent. This group of people brings a wealth of contribution to the community as a whole, though in some cases, has unique needs and a number of risks that

[33] Definitions of health disparities by the World Health Organization, U.S. Department of Health and Human Services, *Healthy People 2020*, Office of Minority Health, Centers for Disease Control and Prevention, Con Alma Health Foundation, Kaiser Family Foundation, Centers, and other experts in the field.
[34] Data from U.S. Census ACS Factfinder and NM DOH IBIS database.

create challenges with access to health care and other resources. The citizenship and immigrant status of the County's population is depicted in Figure 17 below.

Figure 17
SF County Population by Citizenship Status



NOTE: NM has 6 percent immigrant non-citizens and 3 percent naturalized citizens.

Immigration and citizenship status is an important variable to consider and understand, especially for individuals and families who migrate from Spanish-speaking countries within North America. Those who are naturalized citizens bring a braided history and culture that is in concert with other Hispanic and Latino people native to or with multi-generational presence in this area, and yet different because of the country of origin and unique challenges related to immigration status. Specific immigration stories vary significantly among individuals, though a common thread in most instances of immigration and relocation is the desire to create a better life for oneself and one's family. Furthermore, a significant number of immigrants come to Santa Fe County in an effort find safety – fleeing violence and oppression in their countries of origin. Many immigrants seek to create communities of extended family and look to live in neighborhoods where others from their countries of origin reside. Many immigrants in SF County speak languages other than English as their first language, most commonly Spanish. Though language definitely can sometimes serve as a barrier to accessing health care, immigration status and eligibility for health care benefits and insurance coverage are the greatest barriers for many immigrants in need of health care and support. In addition, many immigrants are fearful of being singled out, marginalized or possibly deported, especially if they are undocumented. Studies conducted with immigrants in California, and conversations with families in NM show a large portion of immigrant families in SF County find safety in their own communities and networks, and fear sharing their status with others not known, despite the Santa Fe City Council's resolution stating support for immigrant-friendly policies. Since the new federal administration took office in January, 2017, all types of immigrants, friends, and providers report a significant increase in fear of deportation across the board, regardless of immigration or citizenship status, along with a wave of calls for information and assistance.[35]

Neighborhoods in the County with the largest percentages of individuals who were not born in the United States and are not citizens are the poorest areas, with the highest proportion of Hispanics and highest levels of uninsured (Figures 18 and 21). These are also the areas with the largest proportion of the population working as described later in this report.

[35] Los Angeles Unified (LA Unified) study quoted for Blue Cross of California Delta Sigma Theta Head Start Project, 1996; Vazquez, Yolanda, *Perpetuating the Marginalization of Latinos: A Collateral Consequence of the Incorporation of Immigration Law into the Criminal Justice System,* 2011, University of Pennsylvania; conversations with immigrant community leaders in SF County such as Somos un Pueblo, and people attending gap analysis town hall events.

Figure 18
People Who Were Not Born in the U.S. and Are Not Citizens, by Small Area, 2011-2015

Small Area	Number	Percentage
98 - Airport Road	4527	25.30%
96 - Agua Fria Village	3324	24.10%
95 - Agua Fria Neighborhood & Downtown	1737	7.20%
97 - Bellamah/Stamm	1205	6.60%
94 - North County/Pueblos Plus	1133	5.70%
93 - Opera Vicinity & North City	667	4.70%
92 - East Foothills & Eldorado	1076	4.60%
99 - South County	495	3.20%

Figures 19a and 19b and Figure 20 include those census tracts that have poverty levels above the County's poverty average of 15.6 percent, with proportions of immigrants highlighted to reflect the proportion of immigrant population in those areas. All of the areas with highest concentrations of immigrant populations are the poorest areas, those at greatest risk, with some of the most significant challenges and barriers to health care. The pink circles on these maps represent the percentage of the population that is foreign born naturalized citizens – the larger the circle, the higher the percentage of such persons. The shaded areas on the maps represent percentage of people under 199% FPL – the darker the area, the higher the percentage.

Figure 19a
Population Under 199% FPL and Proportion of Foreign Born Naturalized Citizens

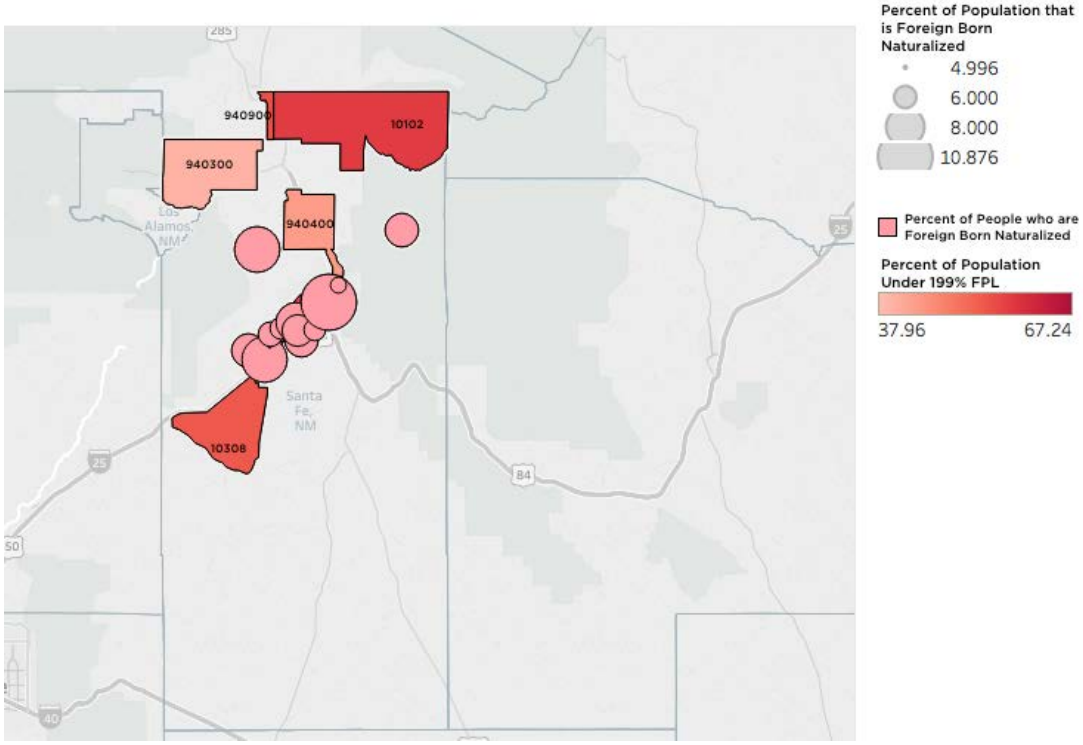


Figure 19b
Population Under 199% FPL and Percentage of Foreign Born Naturalized Citizens (City)

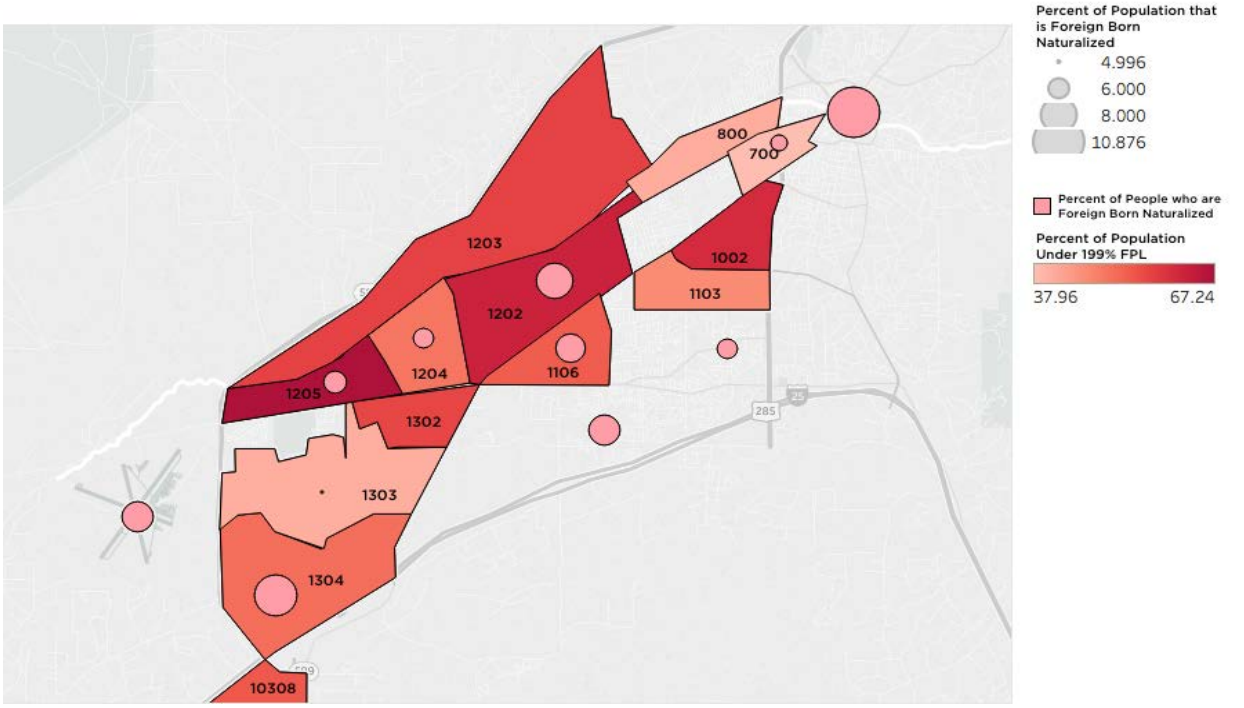
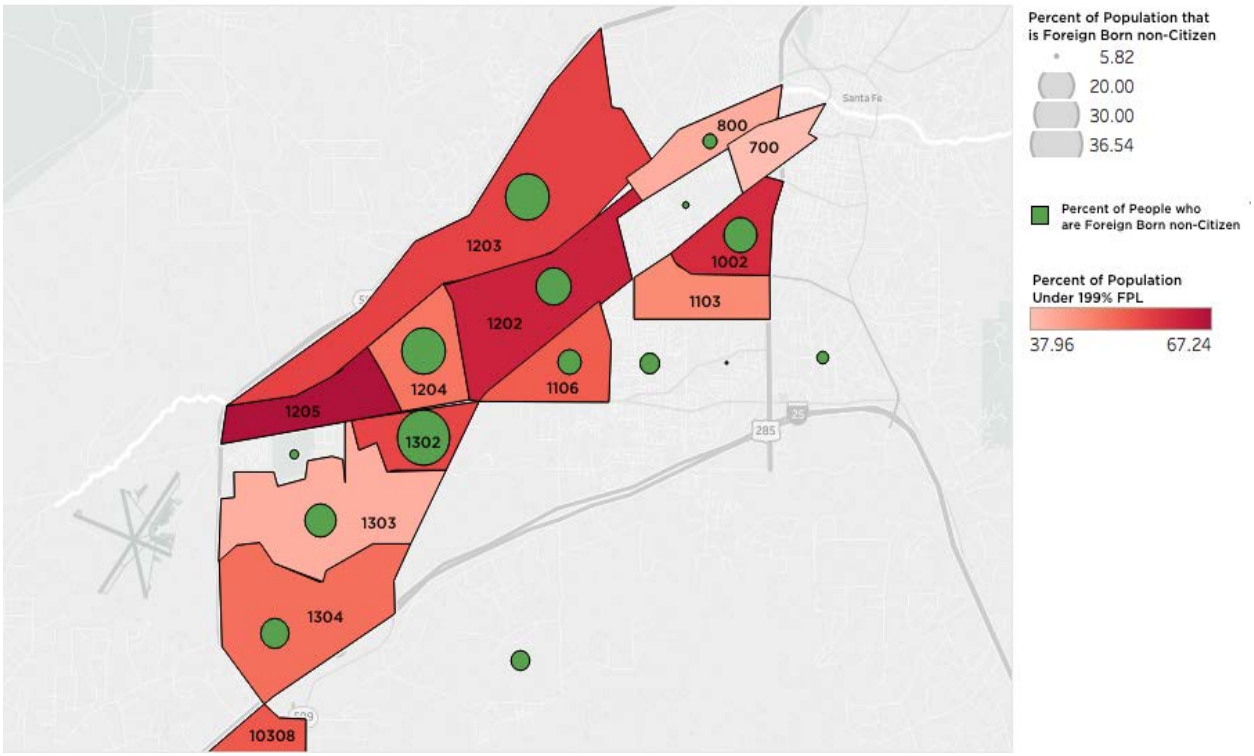


Figure 20
Population Under 199% FPL and Proportion of Foreign Born Non-Citizens (Central)



F. Sexual Preference/Orientation

Santa Fe County, and especially the City of Santa Fe, has one of the most diverse communities of lesbian, gay, bisexual and transgendered people (LGBT) in the country.[36] While it is difficult to determine the exact number or percentage of LGBT persons or households in the United States or any given geographic area, some sources indicate New Mexico, and Santa Fe in particular, has significantly more LGBT persons than other areas. Nationally, estimates are controversial and range from 2.3 percent to 5 percent of Americans considering and reporting themselves to be LGBT.[37] One source indicates the City of Santa Fe has twice as many individuals living in a same-sex partnership as the national average.[38] The American Community Survey of the US Census Bureau reported New Mexico to be among the states with the highest percentage of same-sex couple households (from 1.76 – 4.01 percent).[39] These sources mix national, State, and City numbers and are from different years However, extrapolation from these various counts indicates anywhere from 7000 to 15,000 LGBT individuals and up to 5,000 same-sex partnered households in Santa Fe County.

The County is considered one of the safe places where LGBT people can live with much less fear of reprisal and violence, although such incidents do happen. The Santa Fe Community Foundation's LGBT fund and initiatives throughout the County provide a range of services and supports. Social and support networks, activities, and special events celebrate the LGBT community even though the LGBT population remains a minority, with some specific demographic and health challenges. Lesbian, gay, bisexual and transgender (LGBT) populations have more stressors in their lives, even in a community like Santa Fe with its structural and political supports for diversity. A total of 22.8 percent of LGBT individuals have no health coverage, compared to an overall rate of 17.6 percent for the County at large, making this group more at risk, with more barriers to accessing care. It is extremely difficult to obtain income and poverty information about the LGBT population at County or census tract levels because it is not gathered as a separate data set by the U.S. Census. A total of 29.8 percent of the LGBT population reported frequent mental distress, as opposed to 18.2 percent of the non-LGBT population.[40] LGBT individuals have a suicide attempt rate of 2.9 percent compared to a rate of 0.7 percent for the populations as a whole.[41] The LGBT population also has a higher rate of individuals who have not visited a physician in the past year for an annual check-up and a higher proportion of individuals who smoke. The LGBT population is not monolithic with differences among lesbians, gay males, bisexual, and transgender groups in terms of percentages who smoke, experience depression, have suicidal ideation, and or are subjected to violence and trauma.[42]

[36] Santa Fe has a score of 201 on the "Gay Index," (with 100 being average) by Gary Gates, a demographer at the Urban Institute and co-author of *The Gay and Lesbian Atlas.* Although Santa Fe is listed as one of the top-50 gay-friendly communities in the U.S. by ranker.com; Human Rights Campaign ranks Santa Fe and Eldorado as highest in terms of LGBT equality of all communities in New Mexico. See also, SAMHSA statewide data: https://www.samhsa.gov/data/sites/default/files/NewMexico-2016.pdf.

[37] National Health Interview Survey, CDC, 2014; National Adult Tobacco Survey, CDC, 2013; see www.santafenewmexican.com/news/gay-rights-groups-dispute-federal-survey-s-estimate-of-population-/article_8bbaOF4d-e65b-5d78-be4b-bfaa12 30681b.html.

[38] Gay Index for Santa Fe, NM, retrieved at www.epodunk.com/cgi=bin/gayInfo.php?locindex=17960. Note, this source indicates a large difference between females and males with 2.24 times as many lesbians and 1.78 times as many gay males as the national average. Note that a Trip Advisor article indicates as many as 20 percent of Santa Feans LGBT, but provides no citation for this assertion; see www.tripadvisor.com/Travel-g60958-c73048/Santa-Fe:New-Mexico:Gay.Life.html.

[39] www.census.gov/popultiona/www/socdemo/files/ssex-tables-2009-xls.

[40] 2014 data from NM DOH IBIS Behavioral Risk Factor Surveillance System (BRFSS).

[41] 2011 data from NM DOH IBIS database, the most recent data available.

[42] https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-

G. Families

It is not within the scope of this project to gather separate data about families other than data gathered about households, which include many different types of families. However, the stressors that families face who care for either children and/or older parents cannot be underestimated. Caregiving, whether for children or parents, requires sustained nurture and focused attention on the other, their needs and development. Love for one's family, however constituted, will sustain many caregivers a long way on their journeys. But to be successful, the journeys require some assistance along the way. Few people can run a marathon without the stops that provide food, water, and other support. The same is true for life. Child care and elder care resources do exist, however, they are only available on a private pay basis for all except the poorest community members.[43] People who are poor, on limited incomes, and middle class find that both child care and elder care can be unaffordable, often representing as much as or more than the cost of housing.

As of April 2017, there were 3,617 licensed or certified[44] child care slots within Santa Fe County. These slots exist in child care facilities and within individual licensed or registered homes where children are cared for by caregivers other than their immediate families. Parents, grandparents raising grandchildren, and/or legal guardians can apply for this benefit. Initial eligibility to enroll for a child care subsidy includes having an income at or below 150 percent FPL, which, for example, translates to $30,630 annually for a family of three. Eligibility is determined by gross monthly income and family size, and children can remain on subsidy until their parents or guardians reach 200 percent FPL. The ages of children served in these slots range from six weeks through school-age (up to age 13). Services include full and partial day care, as well as slots within after school and summer programs. However, capacity is limited for infant care within the County. In April 2017, only 504 children in Santa Fe County were receiving child care subsidy from CYFD and being cared for in one of the 3,617 slots, which indicates that 14 percent of the total available slots in the County are currently serving very low-income children and families. The cost of private pay child care is excessive for many County residents and thus, many families depend on friends, relatives or neighbors to care for their children in unregulated settings. Access to quality child care is prohibitive for many, especially in the areas with high poverty populations.

H. Health Insurance Coverage and Access to Primary Care

Health care coverage, having an active relationship with a health care provider, and being able to pay even small co-pays are all challenges for persons living in poverty or with limited incomes. Medicaid expansion in NM has had a strong positive impact on the proportion of people with coverage and is a critically needed support for a significant portion of the population. Coverage levels in the County have improved since the advent of the Affordable Care Act and Medicaid expansion[45] and since Santa Fe County government's emphasis on outreach and enrollment of uninsured individuals. In 2010, the uninsured rate in the County was 26.8 percent, and dropped to 25 percent in 2012, and 20 percent in 2014.

2015/NSDUH-SexualOrientation-2015.htm.

[43] A very limited number of subsidized child care slots are available from NM Children Youth and Families Department (CYFD) for the poorest of the poor; and some providers offer limited scholarships for summer programs for children. Personal Care Services (PCS) for non-medical home care for individuals who are elderly and/or disabled are available for those Medicaid recipients who meet a two-stage screening process, for limited hours; PCS was available on a limited basis for those not on Medicaid through a waiver process that, some time ago, had a three-year waiting period. A few income-qualifying respite care services are available.

[44] By the New Mexico Children, Youth and Families Department (CYFD).

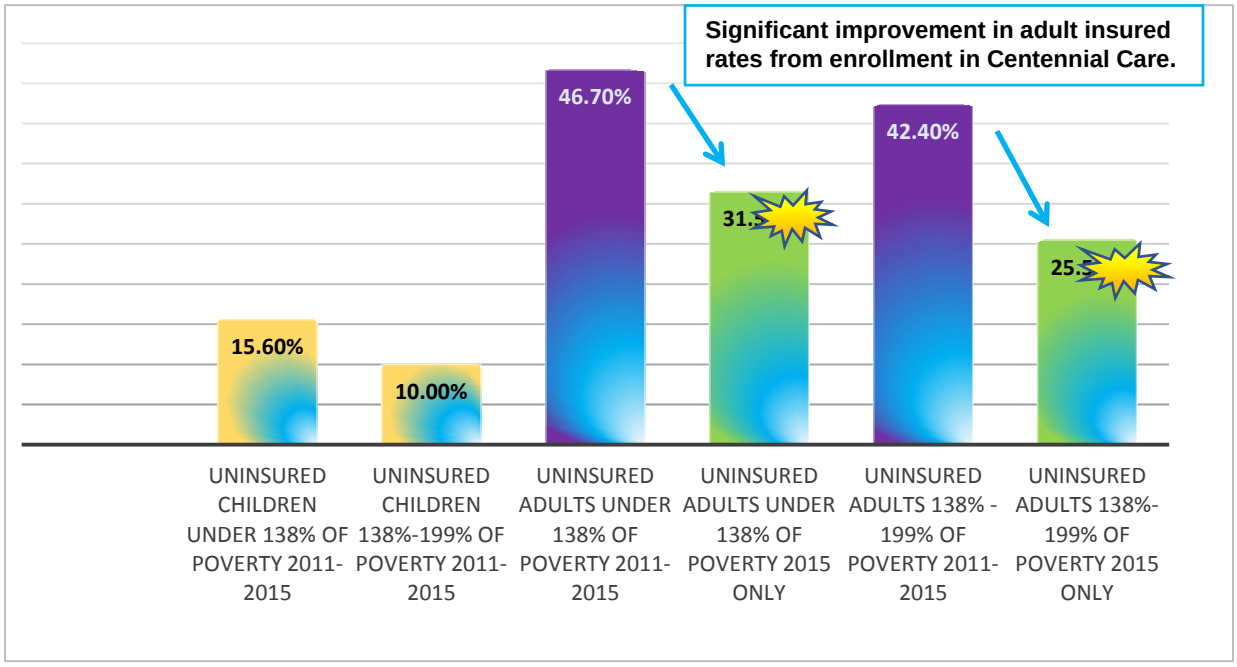
[45] Data from U.S. Census 2006-2008 time period.

Figure 21
Population of Santa Fe County Uninsured, by Small Area, 2011-2015[46]

Small Area	Count	Total Population	Percent
96 – Agua Fria Village	4,917	13,771	35.70%
98 – Airport Road	5,028	17,920	28.10%
97 – Bellamah/Stamm	3,081	18,222	16.90%
94 – North County/Pueblos Plus	3,343	19,924	16.80%
95 – Agua Fria Neighborhood & Downtown	3,894	24,057	16.20%
99 – South County	1,743	15,470	11.30%
92 – East Foothills & Eldorado	2,588	23,621	11.00%
93 – Opera Vicinity & North City	1,499	14,282	10.50%
TOTALS	**26,093**	**147,267**	**17.8%**

The Agua Fria Village and Airport Road areas have higher uninsured rates than the rates for the County as a whole, and South County, East Foothills & Eldorado, and the Opera Vicinity & North City have the lowest uninsured rates. The Bellamah/Stamm, North County/Pueblos Plus, Agua Fria Neighborhood & Downtown have uninsured rates that are close to the County's average of 17.8 percent. The neighborhoods that have the highest proportion of people living in poverty are also the areas with the highest rates of uninsured. Figure 22 illustrates the relationship between poverty, age, and uninsured status, from U.S. Census data.

Figure 22
Uninsured by Age and Poverty Status with Time Comparisons for Adult Enrollments



[46] Source: NM DOH IBIS 2011-2015 data. Note: IBIS population total is 147,267, larger than totals used by the U.S. Census. This NM DOH IBIS data may include overestimations created by margins of error, and represent slightly less than 1 percent difference.

The most important messages in these data are:

- children in poverty or low-income households already had very good levels of coverage prior to Medicaid expansion because of higher income thresholds for children;
- almost half of the lowest income adults (under 200 percent FPL) had no health insurance coverage prior to Medicaid expansion;
- the collective impact of provider enrollment efforts County-wide helped to significantly improve the adult insured rate for poor and low-income adults; and
- additional enrollment work is needed to continue to improve health coverage for adults and reduce uninsured rates of lowest income adults who need health coverage the most.

Before Medicaid expansion and Centennial Care,[47] the Medicaid threshold for adults was very low, and childless adults were not eligible for Medicaid coverage without a special health condition. As a result, a large percentage of poor and low-income adults were uninsured. During the 2011-2015 period, 46.7 percent of adults under 138 percent FPL were uninsured, and over 42 percent of adults between 138 and 199 percent FPL were uninsured. For adults with incomes above 200 percent FPL, rates of coverage improved significantly.

This data slice of a five-year period provides a snapshot in time that reflects the average uninsured rates, from much higher uninsured levels during 2011-2012 to much better coverage rates created by Medicaid expansion during 2013-2015. Although the County has a significant number of children living below 138 percent FPL (29.3 percent), only 15.6 percent of those children were uninsured during this period. Providers' efforts to reach and enroll children were successful prior to Medicaid expansion, with relatively high levels of health insurance coverage for children. However, adults were not doing as well prior to Medicaid expansion. While reports show increases in health coverage for adults through Centennial Care, the need continues for enrollment outreach efforts for children and adults in order to reach more optimum levels of coverage for individuals in Santa Fe County. Individuals who are immigrants without legal standing or undocumented, do not qualify for and are not covered by Medicaid regardless of their economic status, although they can pay for insurance through BeWellNM (NM's health insurance exchange[48]) or for other commercial insurance if they can afford to do so. This portion of Santa Fe County's population is unable to receive health care without having their own resources or without assistance from County government or from non-profit health and human services organizations supported by donations or specialized government grants.

Theoretically, all adults in these two levels of poverty (plus many above 200 percent FPL) are eligible for full Medicaid, or some form of Medicaid, depending upon complex family income, size, and other complex enrollment factors. Yet, many remain uninsured. As indicated earlier, some do not qualify due to legal status. Some who quality do not feel health coverage is a priority or have barriers to obtaining and maintaining even government-provided or subsidized coverage. Work is needed to determine and overcome barriers to enrollment for adults and children, especially those who qualify for Medicaid.

Figures 23a and b show where uninsured adults live in the County and where providers are located relative to where uninsured adults live. Figures 24a and b show similar relationships for uninsured children. The bulk of uninsured adults and children are found in the census tracts with the highest poverty rates, that is, in North and South County, and in the City (bounded by Cerrillos, St. Michael's, and St. Francis Roads; the Agua Fria area; and Airport Road). These

[47] Centennial Care is NM's Medicaid program, described at http://www.hsd.state.nm.us/Centennial_Care.aspx
[48] http://www.bewellnm.com/about-us

figures include the location of many of the County's most frequently utilized providers, indicated with different colors. Note that, although there are some providers located in or near the areas with the heaviest concentration of uninsured individuals, most are clustered along the major transportation arteries: Cerrillos Road, St. Francis Drive, and St. Michael's Drive. These maps show that, generally speaking, providers are less likely to be located in areas where higher proportions of persons who are uninsured live, but rather are concentrated in areas where uninsured rates are lower. The large proportion of poor and lower income adults and even children who are uninsured creates a "culture of the uninsured" within certain census tract neighborhoods, making lack of insurance more normative than having coverage. This is extremely significant in terms of how individuals and families may see health care and access to care as well as how service providers and the community as a whole address the needs of individuals who are uninsured or underinsured. This creates an unhealthy aspect of the Santa Fe County community that negatively affects everyone – insured and uninsured alike.

Figure 23a
Proportion of Uninsured Adults (18 – 64 Years) with Location of Health Providers

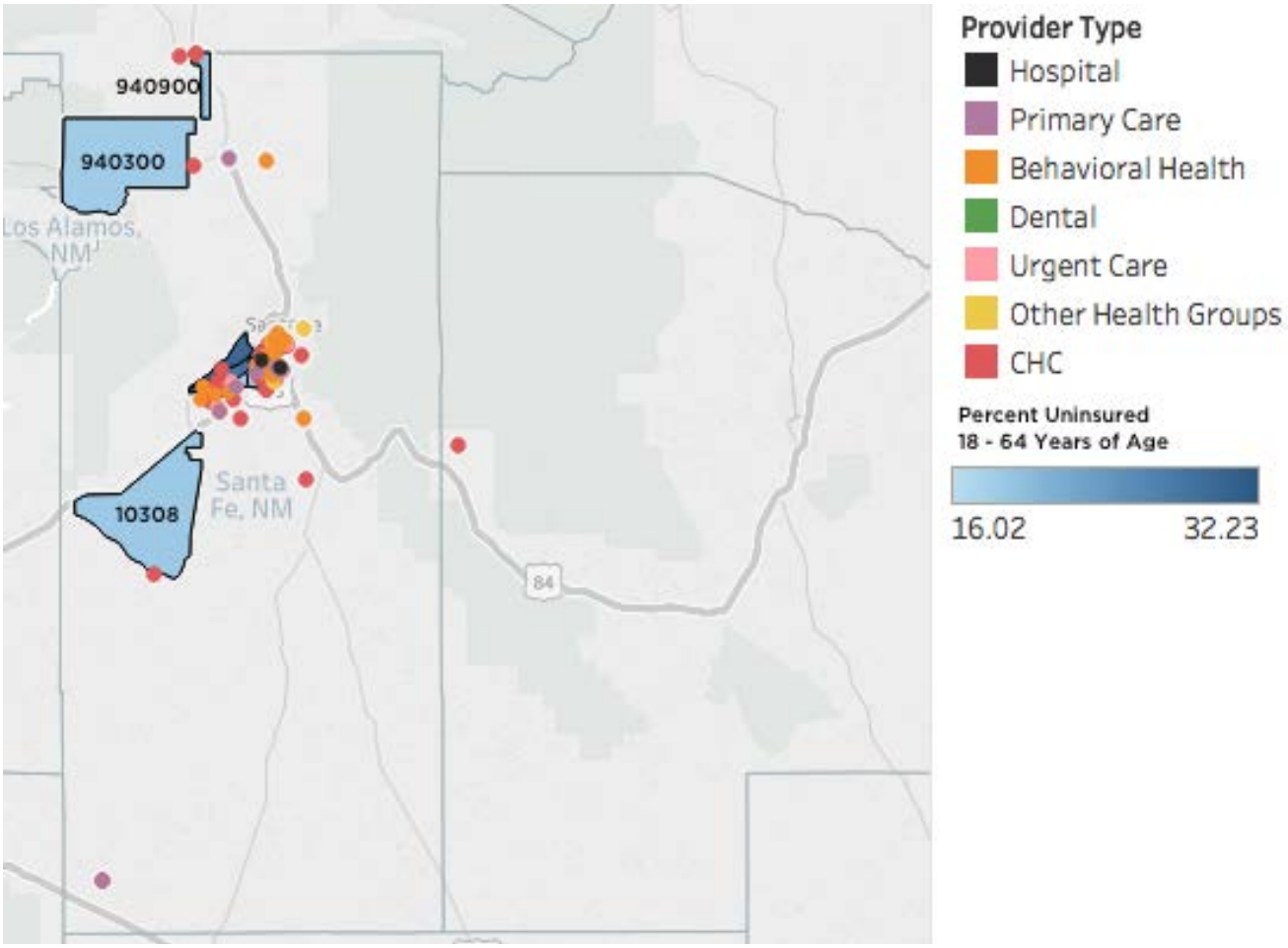
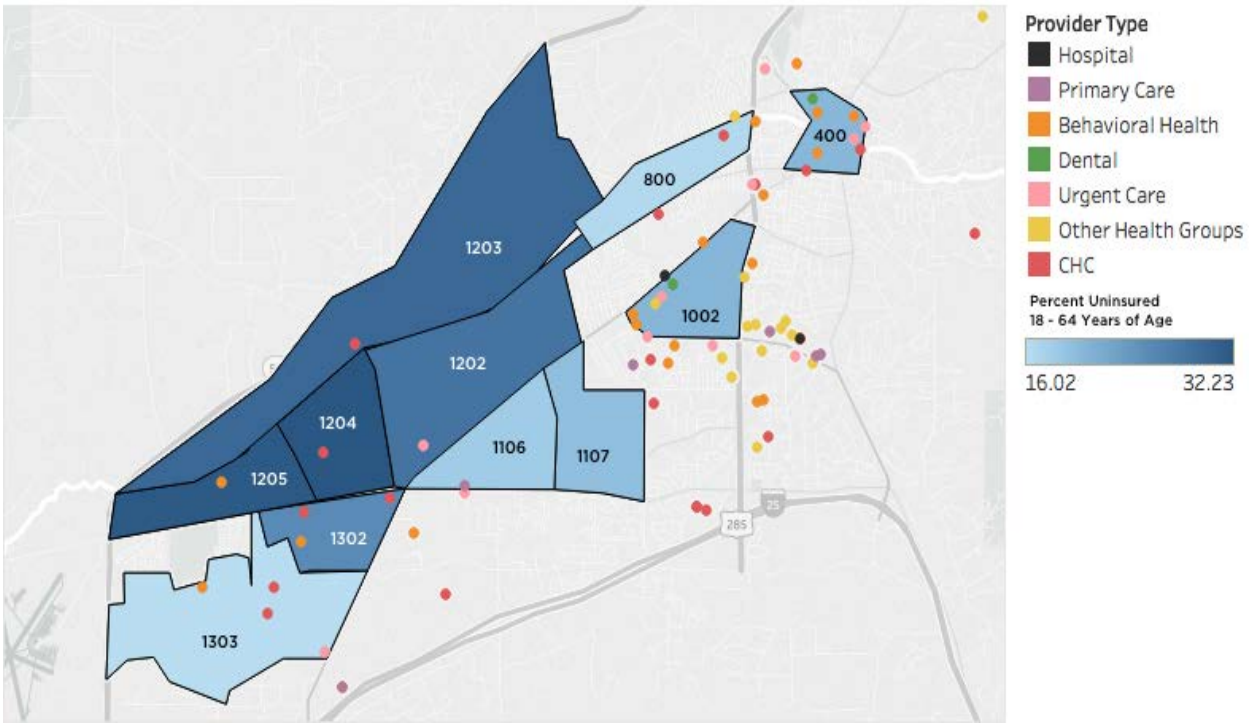
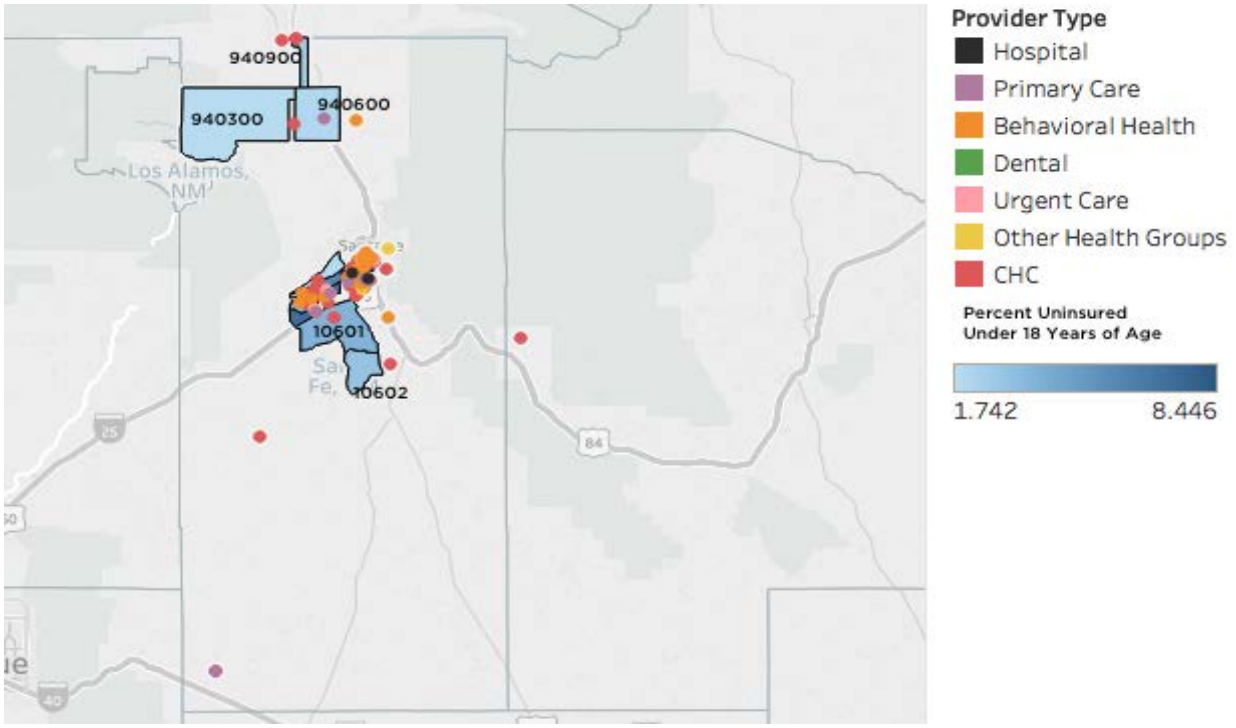


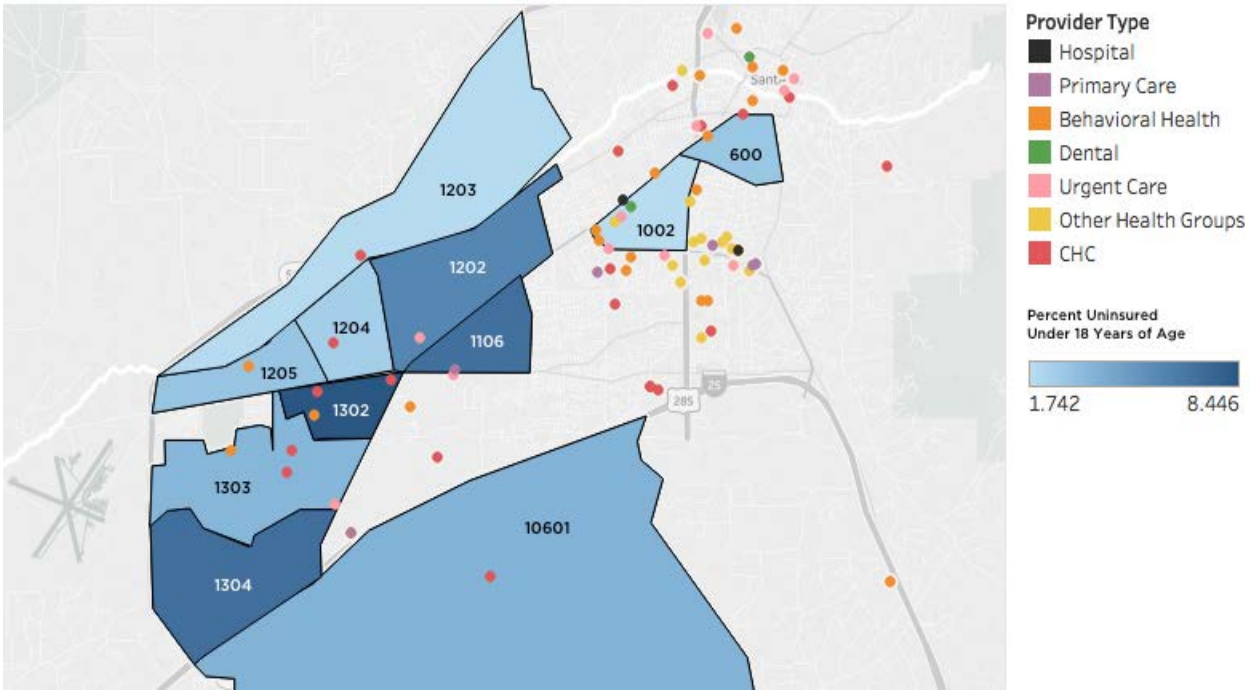
Figure 23b
Proportion of Uninsured Adults (18-64 Years) with Location of Health Providers (City)



Figures 24a
Proportion of Uninsured Children (Under 18 Years) with Location of Health Providers

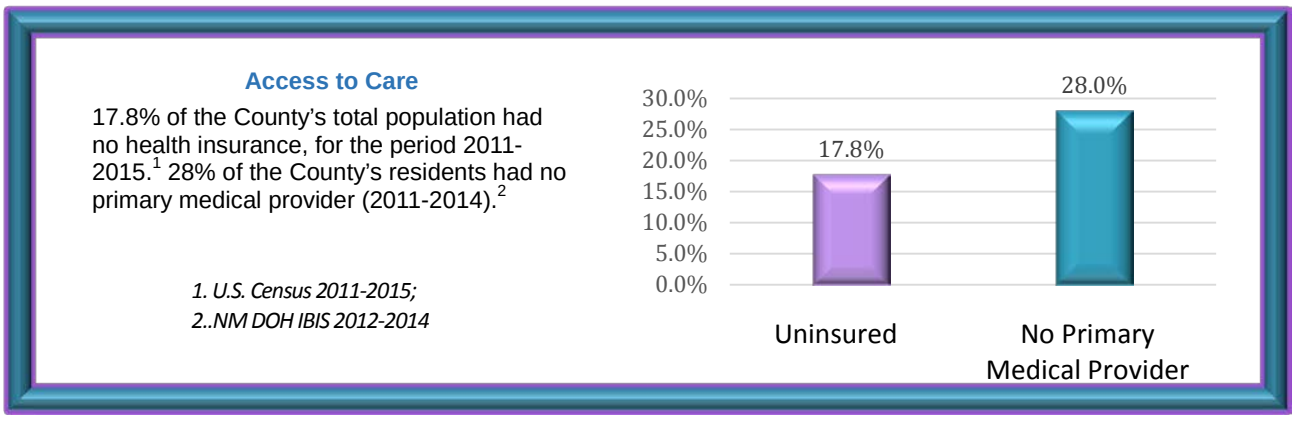


Figures 24b
Proportion of Uninsured Children (Under 18 Years) w/ Location of Health Providers (City)



Another key issue is whether people have a medical home and a primary medical provider with whom they have established a relationship. The idea of having a primary care physician or other practitioner (PCP) as one's medical home is changing, affected by provider shortages, longer wait times created by the increased number of people now insured, and changing mores of young and middle-aged adults who may consider an urgent care center, a community health worker, or an alternative care or non-western medicine practitioner as their primary care practitioner or health home. Still, it is important to note that over one-quarter of County residents report they do not have a relationship with a primary medical provider.[49]

Figure 25
Proportion of Uninsured and Proportion with No Primary Medical Provider



[49] See, https://ibis.health.state.nm.us/indicator/view/HlthCarePriProv.Cnty.html.

I. Employment and Unemployment

One of the myths that has existed for many decades is that poor communities are filled with people who do not work, and who receive public assistance. This myth serves to undermine a closer examination of the roots of health disparities and inequities faced by those who live in poverty, are minorities, or are immigrants. When looking at the neighborhoods, almost all of the areas with higher proportions of individuals and families with lower incomes have average to above average percentages of people in the workforce. This means that high percentages of people living in the poorest communities work, many in multiple part time jobs with low wages and few benefits and may vacillate between periods of work and periods of partial employment. Working and looking for work places stress on families and leaves little discretionary time in which to handle health care issues.

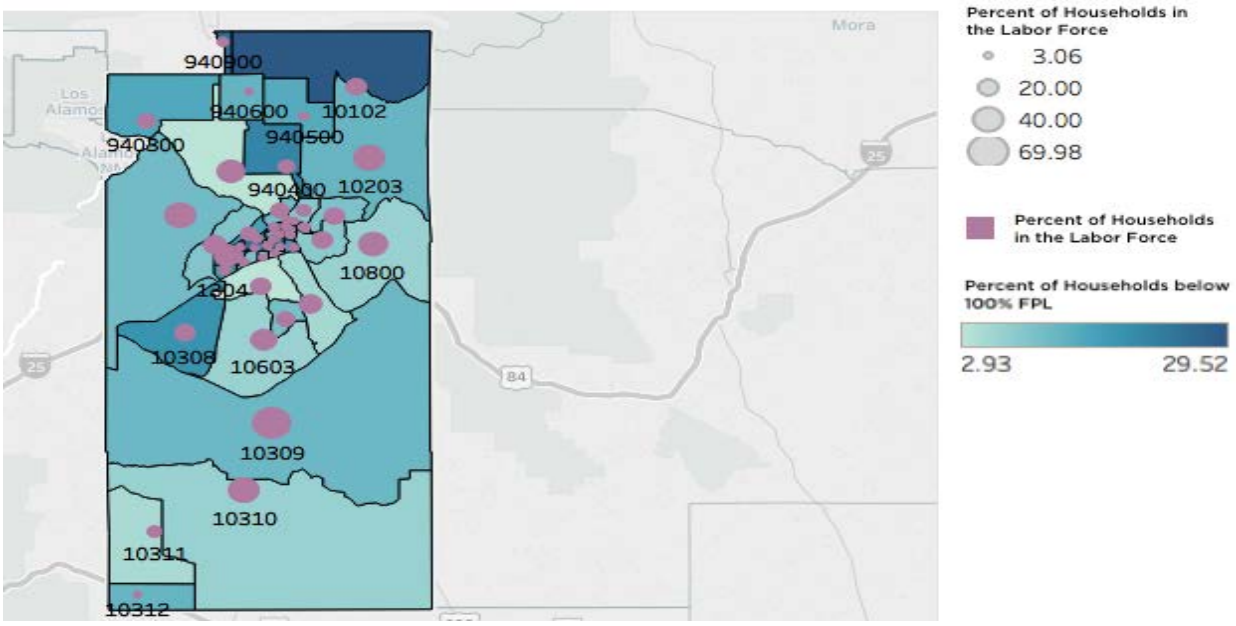
A more detailed analysis of census tract level data from the U.S. Census Department regarding employment provides some important snapshots provided in Figures 26 – 28 below. Overall involvement in the labor force in the 15 census tracts with lowest incomes shows that many of these areas have a very high proportion of people working. It is also true that some of those census tracts (in the north, west and south) have high unemployment rates as well. It is a bifurcated picture, and one that can dispel myths that people living in poverty or with lower incomes do not work.

Figure 26
Population of Santa Fe County in the Workforce, by Small Area, 2011-2015

Small Area	Number	Total Population	Percent
93 – Opera Vicinity & North City	6,948	12,295	56.50%
99 – South County	7,295	12,703	57.40%
92 – East Foothills & Eldorado	12,384	20,454	60.50%
95 – Agua Fria Neighborhood & Downtown	12,749	20,980	60.80%
94 – North County/Pueblos Plus	9,886	16,137	61.30%
97 – Bellamah/Stamm	10,144	15,426	65.80%
96 – Agua Fria Village	7,233	10,402	69.50%
98 – Airport Road	9,835	12,971	75.80%
Totals and Average Percent	**76,474**	**121,368**	**63.2%**

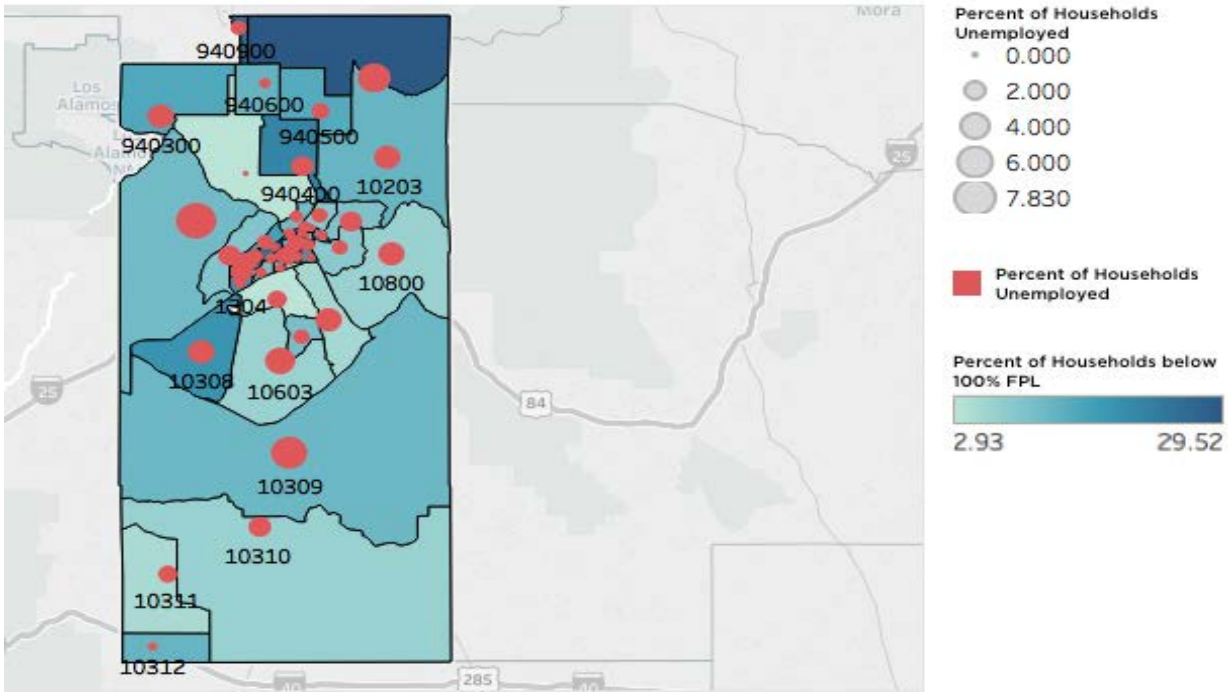
In Figure 27 below, the purple circles on the map represent the percentage of households currently in the labor force – the larger the circle, the higher the percentage in the labor force. The shaded areas on the map represent percentage of households under 100% FPL – the darker the area, the higher the percentage. Circles should be smaller (less people in the labor force) where the map is darker (a higher proportion of people living under 100% FPL).

Figure 27
Populations Living in Poverty and in the Labor Force by Area



In Figure 28 below, the red circles on the map represent the percentage of households currently unemployed – the larger the circle, the higher the percentage. The shaded areas on the map represent percentage of households under 100% FPL – the darker the area, the higher the percentage of households under 199% FPL.

Figure 28
Households Living in Poverty and Unemployed by Area



J. Housing

For many decades, the cost of housing in Santa Fe County, especially within the City of Santa Fe, has been higher than almost all other counties in New Mexico, and higher than costs in many parts of the country. In the early 1990s, the County developed its first loan fund in an effort to provide funding for more affordable housing for people with no or limited incomes and middle class working families. Affordable housing continues to be a significant challenge for many families, including mid-level and frontline health care workers. For families with limited resources, the cost of housing is a significant burden when rent or mortgage payments are much higher proportions of income than the amount (no more than 30 percent) recommended by the federal government.

Housing availability and affordability – especially for rental units – are issues for persons in SF County who are low-income as well as for young professionals, affecting the ability of businesses and healthcare providers to attract and retain workforce. According to a recent Santa Fe New Mexican article on October 2, 2017, 6,480 apartments are needed to meet current demand. Similarly, according to this article, occupancy rates are high (95-98 percent for large apartments), making it difficult to find an available unit even if a household can afford the rent. Many young professionals and critical city/county employees (for example, law enforcement personnel or fire fighters) commute from other areas rather than pay SF County rental housing rates.

To address the issues of housing availability and cost, policies that do not support or encourage the development of affordable housing units may need to be examined in SF County and in the City. For example, not supporting the development of needed infrastructure and not supporting increased density may work against these goals. Similarly, allowing developers to pay a small amount in lieu of providing required numbers of affordable housing units, especially when those funds are not utilized to support housing availability in other ways, may need to be reexamined to determine the best approaches to increasing housing availability and affordability.

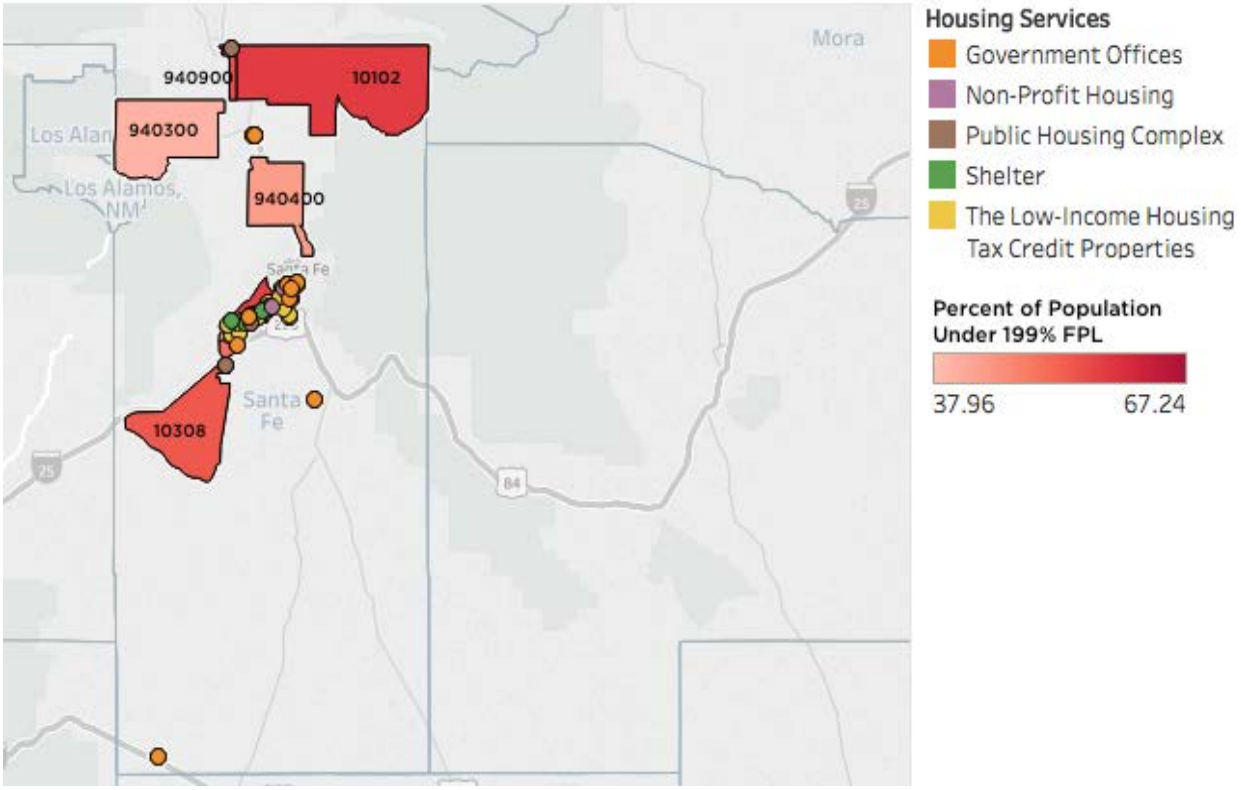
In 12 of the 15 census tracts with the highest proportions of low-income individuals and households, over one-quarter of the population pays 25 to 49.9 percent of their income for rent, with the majority of these neighborhoods showing people pay over 30 percent of their income on rent. However, even larger percentages of the population are paying 50 percent or more of their income on rent in many of the census tracts. In fact, in all 12 of these neighborhoods, over one-quarter of the population pay 50 percent or more of their income on rent. Likewise, the national technical assistance center for the U.S. Housing and Urban Development (HUD) Section 811 program working to address housing capacity and affordability for persons with disabilities indicates that 112 percent of a disabled individual's monthly Supplemental Security Income (SSI) income would be required to rent a one-bedroom apartment in the City of Santa Fe.[50] This means that adults in low-income families are scrambling to make ends meet and have little disposable income, time, or other resources to assure housing stability, while persons with disabilities are likely to be unable to afford housing at all without living with roommates or family members, or in congregate housing settings, few of which exist in SF County.[51]

[50] *Priced Out*, The Technical Assistance Collaborative, Inc., Boston, 2014. Retrieved at http://www.tacinc.org/media/51755/Table%203.pdf

[51] See http://www.aplaceformom.com/care-homes/new-mexico/santa-fe, which lists only five in Santa Fe County; and http://www.referweb.net/icnm/MatchList.aspx?c;;0;;N;0;0;Housing/Shelter%20and%20Accessibility;Supportive%20Housing/Residential%20Facilities;90;Adult%20Residential%20Care%20Homes, which lists only one in SF County. Note also that the NM Governor recently vetoed HB 85 passed during the 2017 legislative session which would have required registration (not licensure) of such "board and care" homes to provide a database of the number, location,

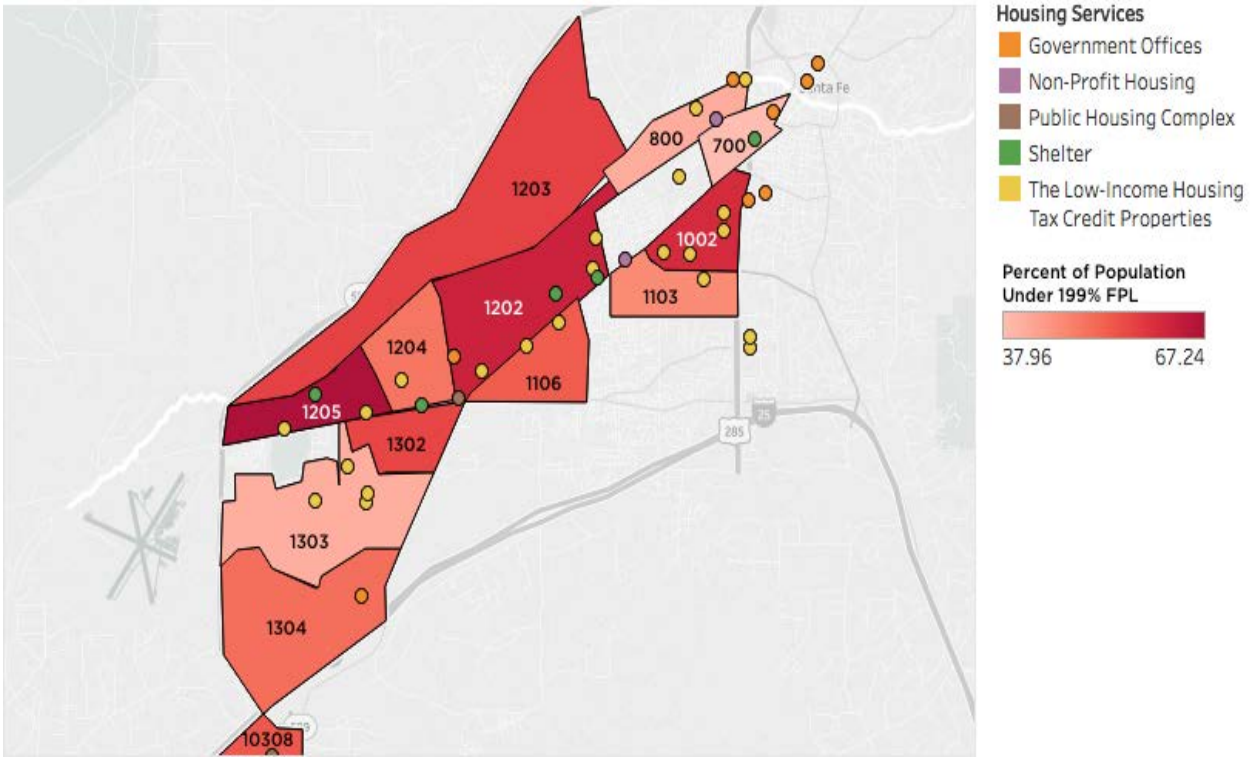
Figures 29a and b show the top 15 neighborhoods in Santa Fe County where the highest percentage of people under 199 percent FPL live along with location of low-income housing or housing services. Census tracts with the highest concentrations of people under 199 percent FPL are located in the southern part of the City of Santa Fe and North County (see also Figures 10a and b), while housing resources are clustered within the City.

Figures 29a
Highest Proportions of Low-Income Individuals and Housing Resources by Area



and owners of such homes along with the number of individuals living in these facilities. Such a database does not currently exist.

Figures 29b
Highest Proportions of Low-income Individuals and Housing Resources by Area (City)



Figures 30a and b show those census tract areas where people spend 25 to 49.9 percent of their income on housing, and maps showing where people live who spend 50 percent or more of their income on housing. Those areas where people spend a disproportionately high portion of income on housing include many but not all of the 15 neighborhoods with the highest proportions of individuals living in poverty. Census tracts with the highest proportion of people paying high proportions of income on rent include the far northwestern part of the county, South County, the Airport Road area, and other neighborhoods along Cerrillos and Rodeo Roads. Many households in other areas also pay a high proportion of income for housing. These households include those considered to be working poor, of limited income, and middle class families with incomes that are stretched such that they have difficulty making ends meet.

Figure 30a
Population Spending 25 – 49.9% of Income on Rent and Housing Resources by Area

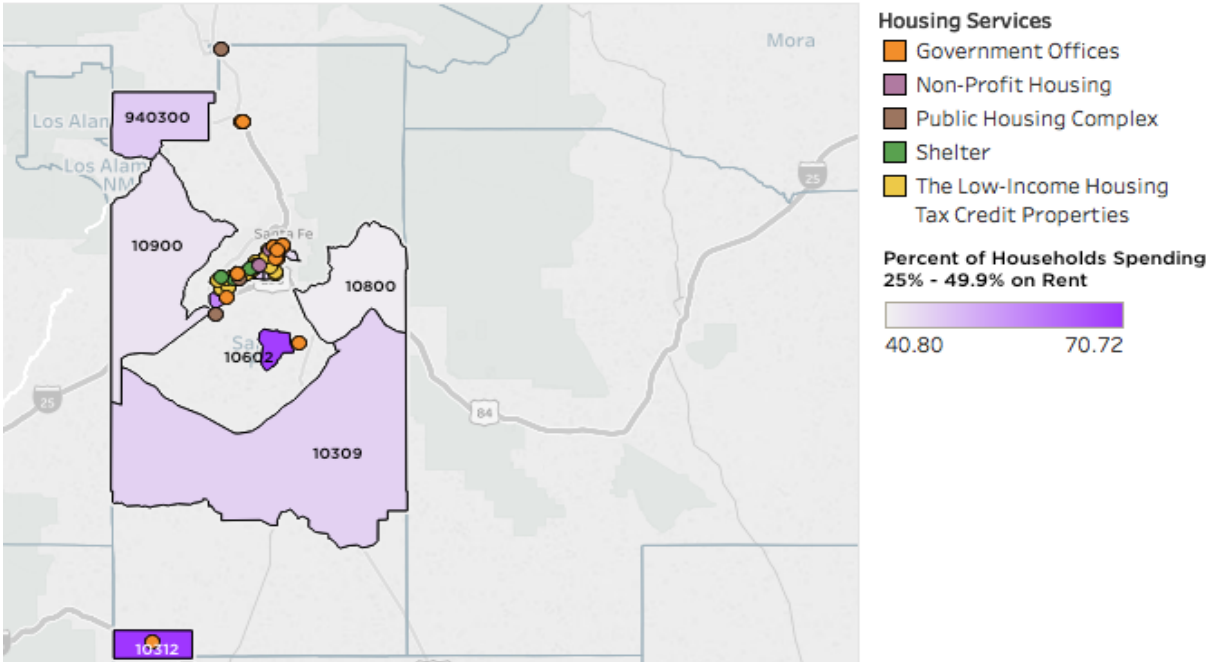
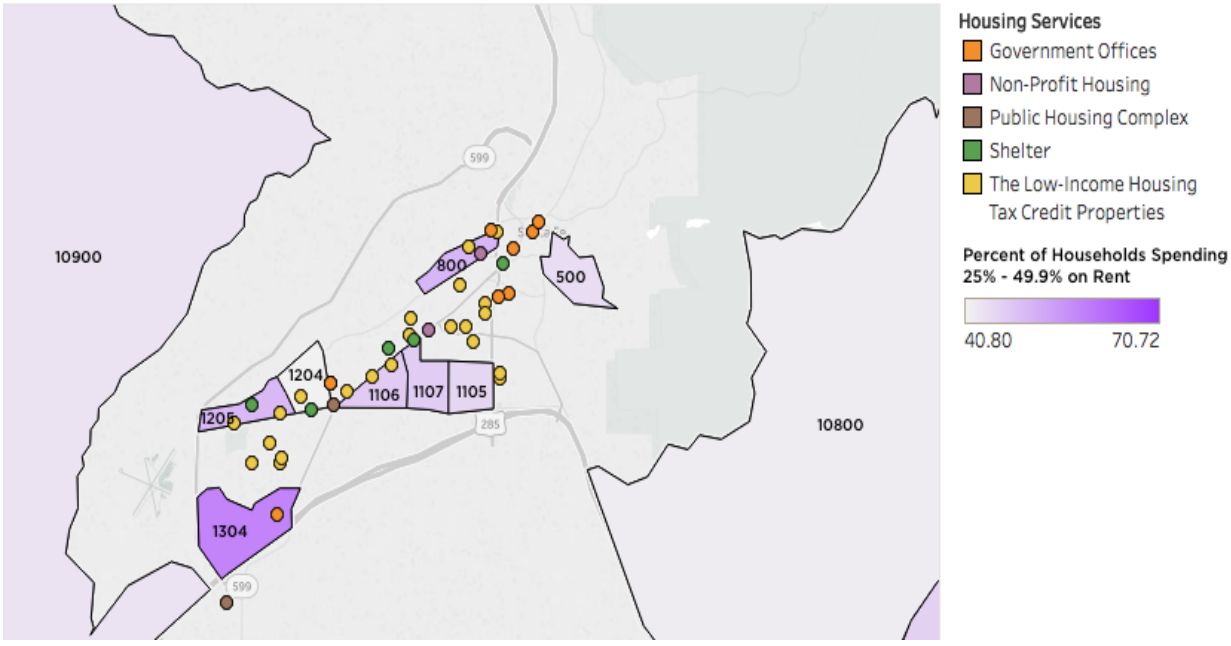


Figure 30b
Population Spending 25 – 49.9% of Income on Rent w/ Housing Resources by Area



Figures 31a and b show where the population that spend more than 50 percent of their income on housing lives. These range from a low of 28.1 percent (light red color) to almost 50 percent of residents. Areas with the highest proportion paying over 50 percent of income on housing include far North County, some of the poorest areas of the City, the Airport Road area, neighborhoods along Cerrillos and Rodeo Roads, and, to a lesser extent, South County. The color-coded overlay shows key housing providers and sites, as well as housing administrative

services locations. Housing resources are found predominantly along key arterial roads, with very few resources positioned in the north and south.

Figure 31a
Population Spending 50%+ of Income on Rent & Housing Resources by Area

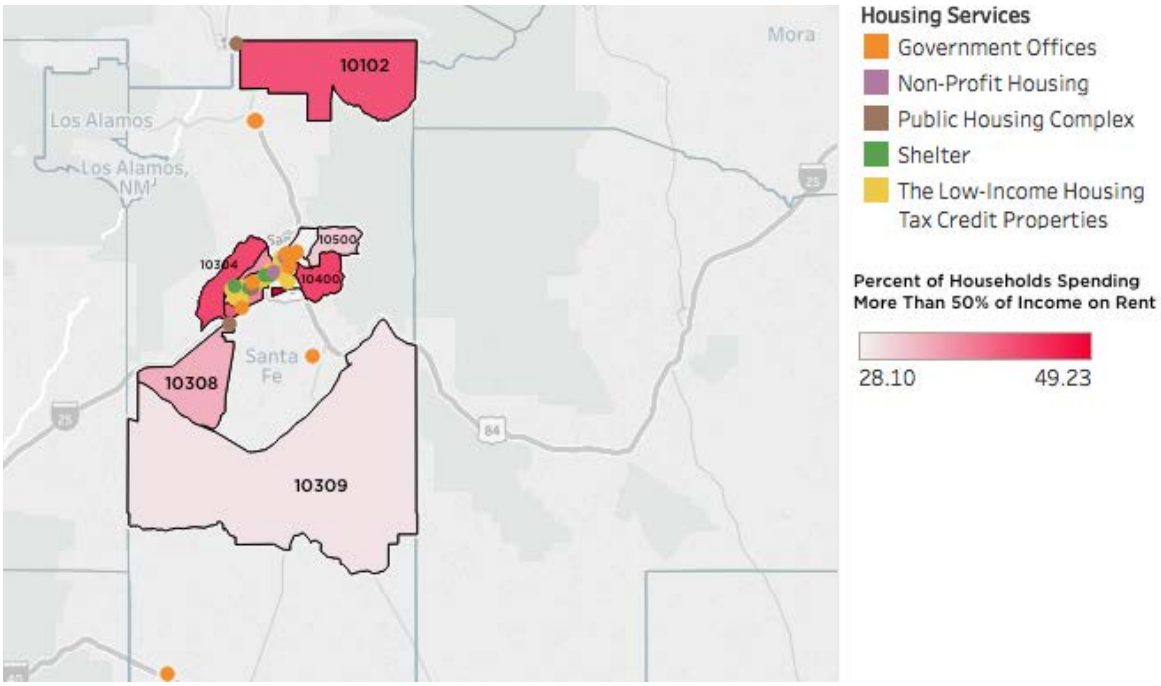
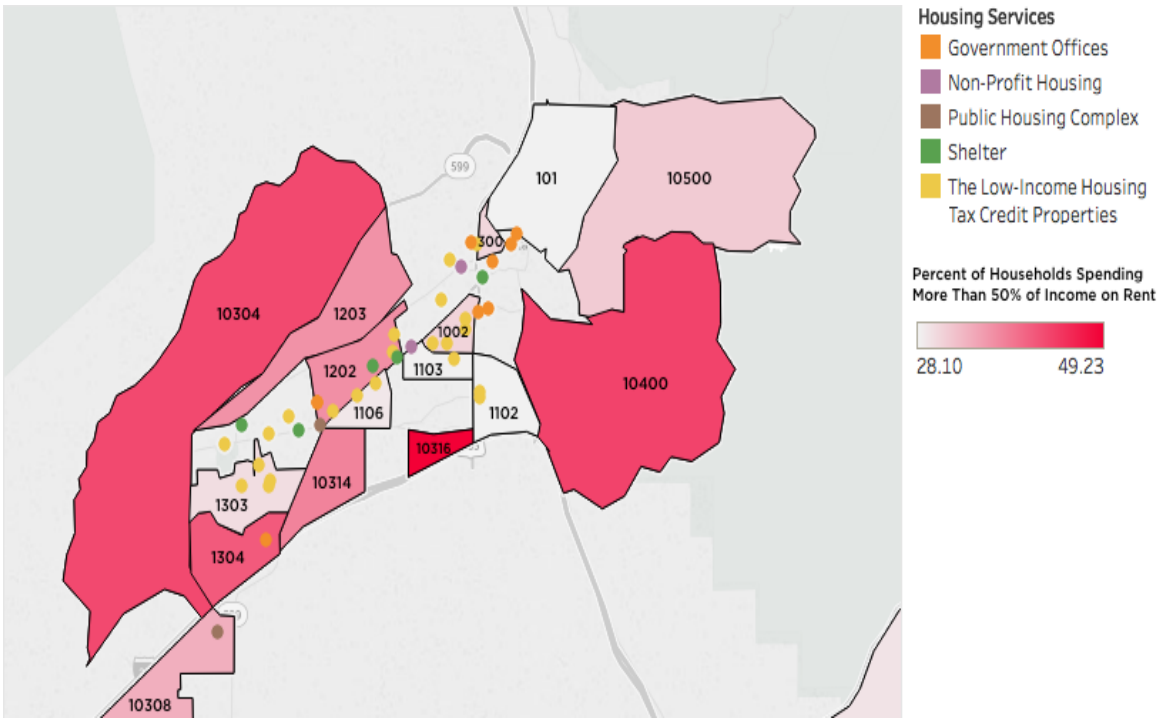


Figure 31b
Population Spending 50%+ of Income on Rent & Housing Resources by Area (Central)



K. Food Insecurity

The Economic Research Service of the US Department of Food and Agriculture[52] paints a stark picture of the impact of food insecurity on health.

> "In general, lower food security is associated with higher probability of each of the chronic diseases examined—hypertension, coronary heart disease (CHD), hepatitis, stroke, cancer, asthma, diabetes, arthritis, chronic obstructive pulmonary disease (COPD), and kidney disease. Food security status is also strongly related to the likelihood of chronic disease in general, to the number of chronic conditions reported, and to self-assessed health. Moreover, differences between adults in households with marginal, low, and very low food security are very often statistically significant, which suggests that looking at the entire range of food security is important for understanding chronic illness and potential economic hardship. Indeed, food security status is more strongly predictive of chronic illness in some cases even than income.
>
> "Income is only significantly associated with 3 of the 10 chronic diseases—hepatitis, arthritis, and COPD— while food insecurity is significantly associated with all 10. In particular, we find that:
>
> - Adults in households with lower food security status have elevated probabilities of chronic disease diagnosis for all of the conditions . . . adults in very low food-secure households are 10.5 percentage points more likely than adults in high food-secure households to be diagnosed with hypertension.
> - Adults in households with very low food security were 15.3 percentage points more likely to have any chronic illness than adults in households with high food security, a 40-percent increase in overall prevalence.
> - Adults in households with marginal food security were 9 percentage points less likely to report excellent health, compared to those in households with high food security, and 1.3 percentage points more likely to report poor health.
> - The number of chronic conditions for adults in households with low food security is, on average, 18 percent higher than for those in high food-secure households."

The NM DOH *Health Highlight Report* indicates Santa Fe County's food insecurity level (13.5 percent) is better than the State's as a whole (17.2 percent).[53] However, this represents data aggregated across the entire County, combining the profiles of people of all income levels in an averaging that can disguise areas of severe shortage called "food deserts." Another measure of food insecurity comes from a review of those families receiving public assistance and SNAP benefits by census tract. The 15 census tract neighborhoods with the highest rates of poor and low-income individuals have a higher percentage of people on public assistance and/or food stamps (SNAP) at 17.9 percent, which seems low considering the poverty level many families face. Barriers to applying for or receiving this assistance may be skewing the number of those who could receive such assistance.

Figures 32a and b show the top 15 areas with the highest percentage of people under 199 percent FPL. The color coded points on the map represent food resources such as a food bank, pantry, or government office, from the Food Network resource list and Share NM. The areas

[52] Found at https://www.ers.usda.gov/webdocs/publications/84467/err-235_summary.pdf?v=42942.
[53] NM DOH Health Highlight Report on food insecurity measures the families that have lack of access to enough food for an active, healthy life. Data is from 2014, the most recent year available.

with the highest concentrations of people under 199 percent FPL are located in the southern part of the City of Santa Fe, and North County areas. The majority of food resources are located in the City of Santa Fe but not necessarily in the northern and southern parts of the City, which have the highest concentrations of those with low incomes. These maps are representational of food resource service providers in Santa Fe County and show the main, but not all, food resource providers. The purpose is to demonstrate generally where food providers are located in the County compared to where individuals with lowest incomes live.

Figure 32a
Population Under 199% FPL and Food Resources by Area

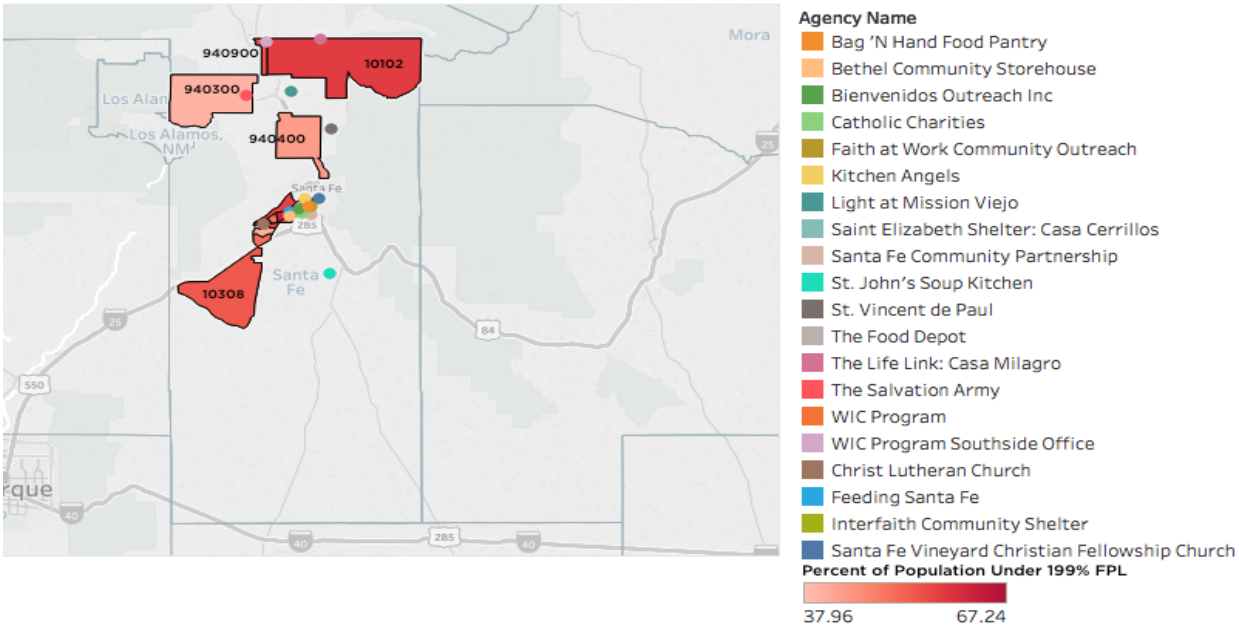
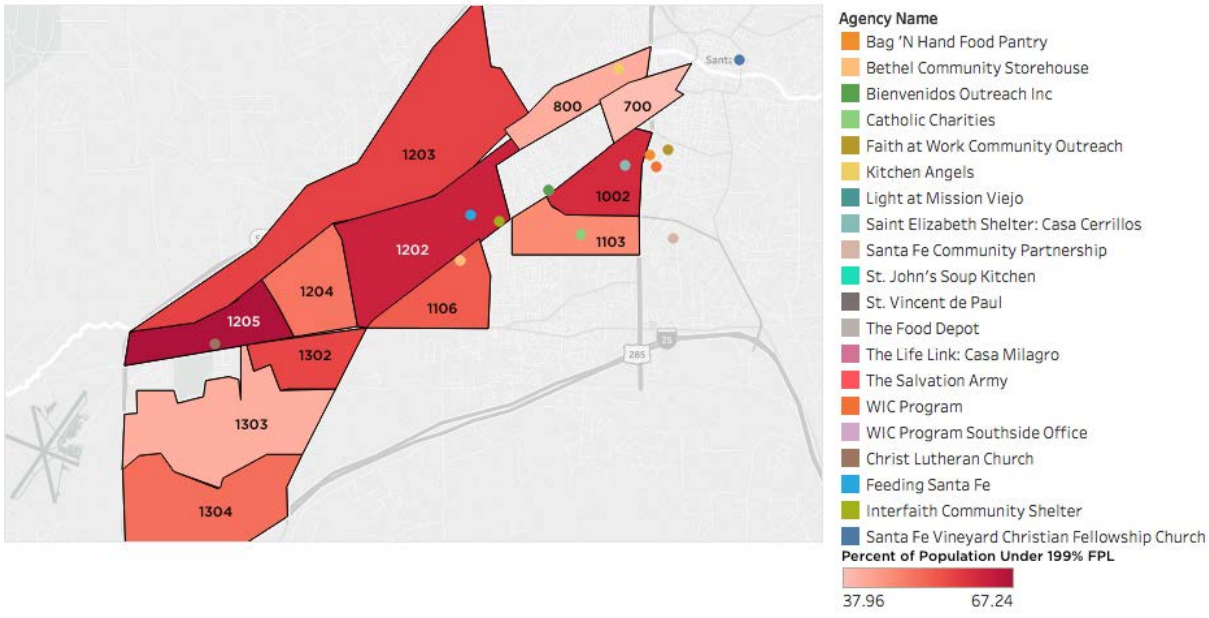


Figure 32b
Population Under 199% FPL and Food Resources by Area (City)



Even though a good number of sites exist providing access to food resources, including free food,[54] many are small organizations with limited capacity and hours of service that are wide ranging. If one looks at those census tracts with the highest levels of poverty (darkest red), the people living in these communities are at some distance from these food resources. Therefore, people with limited transportation options have significant challenges getting to needed resources. This is why these areas are called "food deserts."

Figures 33a – c, from the New Mexico Community Data Collaborative (NMCDC), provide the locations for supplemental food programs[55] showing the areas where people experience the most limitations with food access. Those areas with the most limited food access are marked in darker shades of purple, and are in the north, west, and far southwestern parts of the County, along with some areas that are food deserts within areas of the City where the highest proportions of low-income people live.

Figure 33a
Supplemental Food Programs in Central New Mexico (Santa Fe County and Albuquerque)

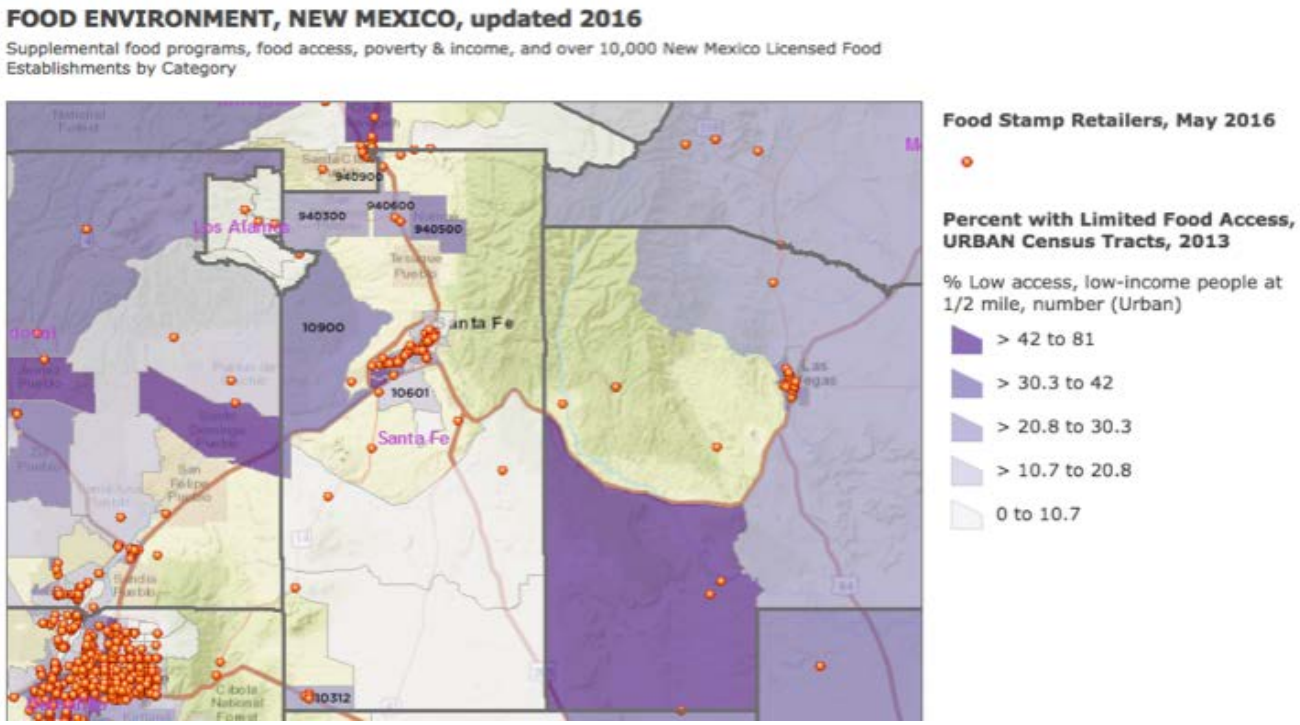


Figure 33b highlights areas within the City of Santa Fe where food access is a significant challenge. Areas in the southern and western parts of the City, around Airport Road, Cerrillos Road, and between Rodeo Road, Agua Fria and Hwy 599 represent areas with limited access.

[54] See http://www.sharenm.org/communityplatform/newmexico for access to additional information about free food resources in Santa Fe County. A farmers market now operates *El Mercado del Sur* in the summer months in south Santa Fe City which helps address the need for fresh and nutritious produce for residents in this part of the County.
[55] Programs in this category distribute food and government commodities and are defined as a program that "provides nutritious foods to middle and low income families with infants and pre-school children (ages birth thru 5) or pregnant and postpartum mothers not receiving W.I.C.[Women, Infants, and Chilren]. They also provide nutritious foods to lower income seniors age 60 and older. Provides general nutrition information and recipes for using commodities. Provides appropriate referrals to all clients. Provides nutrition information in the form of live cooking demonstrations, classes and written materials.
http://www.sharenm.org/communityplatform/newmexico/directory/profile/id/225762/programId/258827

Figure 32c shows the poorest areas in the City in darker shades of purple. Certain food resources are identified, along with green circles which show that some areas are well served with overlapping circles; yet other areas in the southwestern part of the City have few resources.

Figure 33b
Supplemental Food Programs in the City of Santa Fe

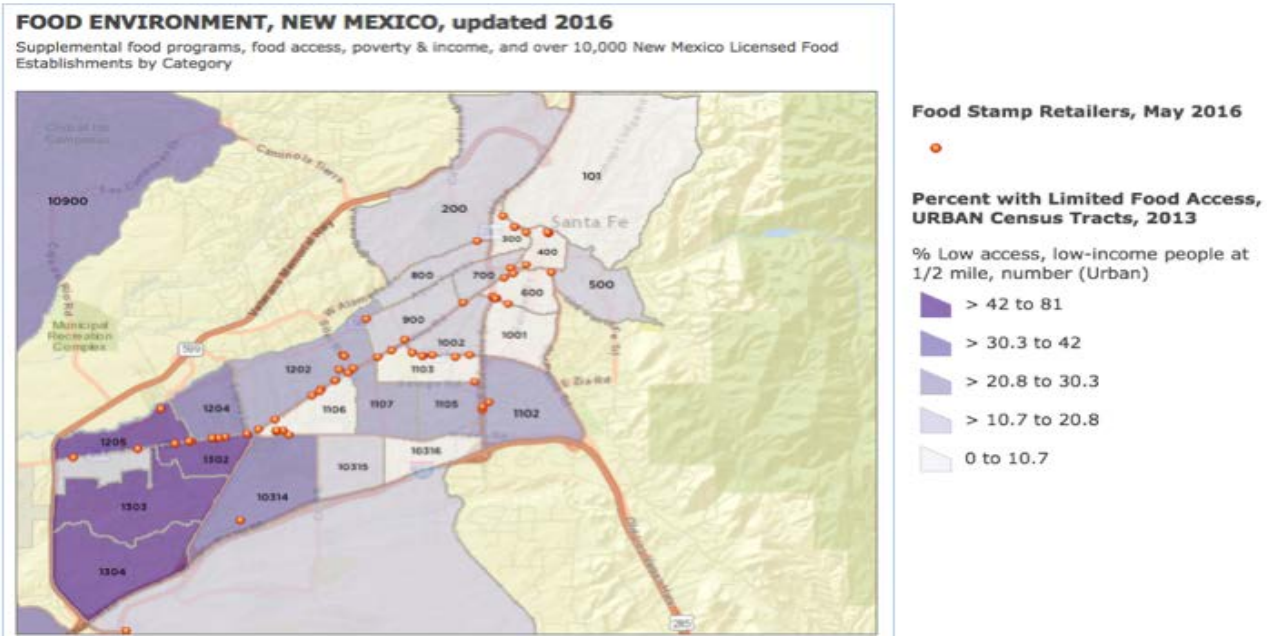
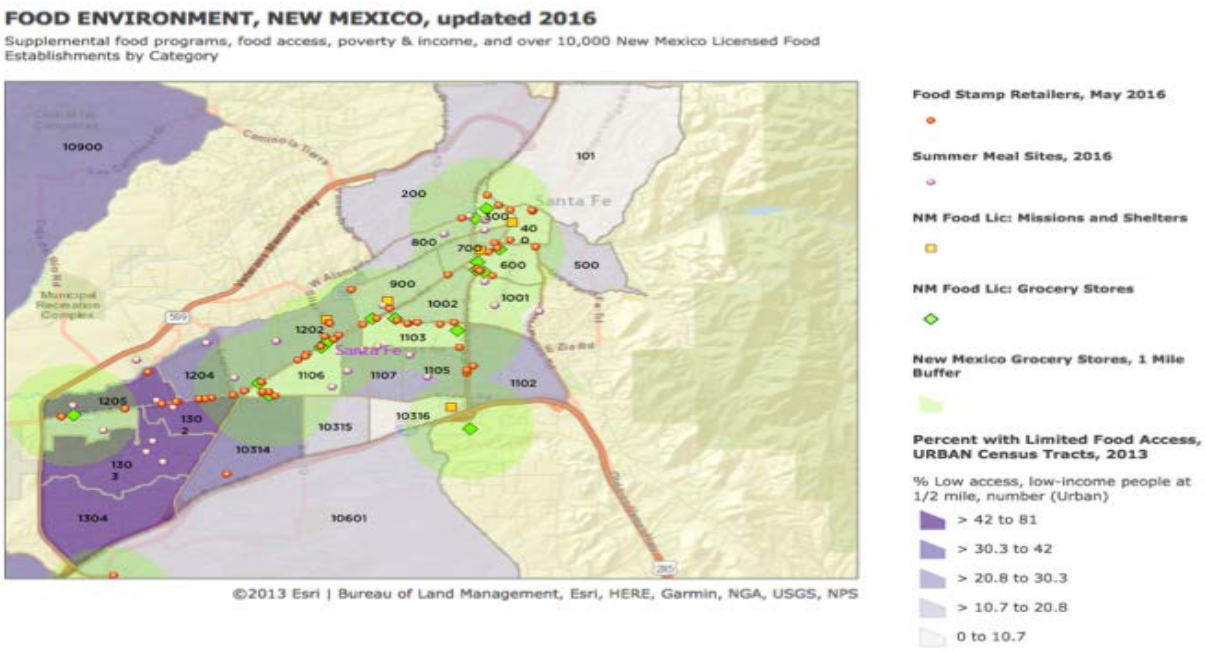


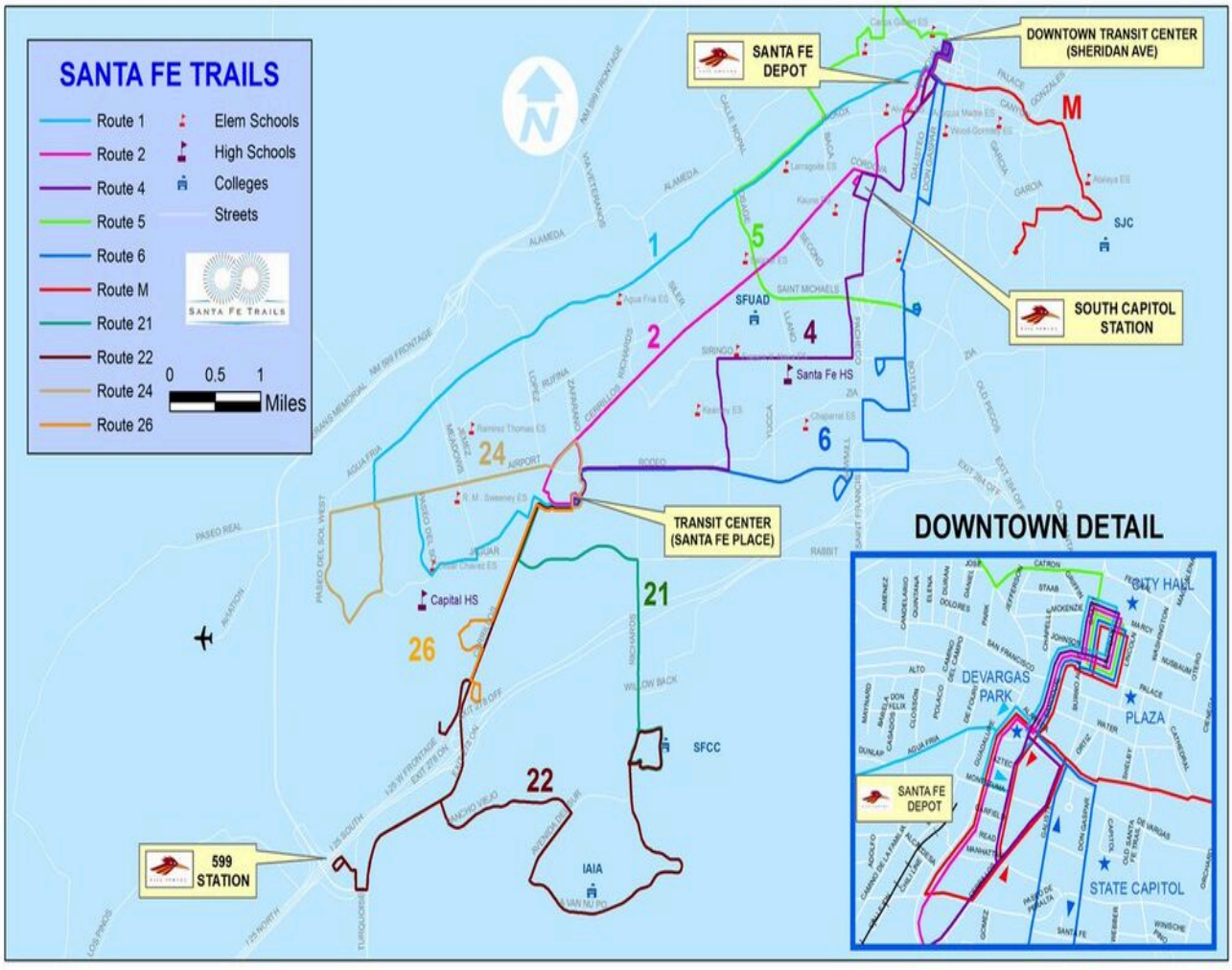
Figure 33c
Supplemental Food Programs in the City of Santa Fe by Areas with Highest Proportion of Low-Income Individuals



L. Transportation

Transportation is a challenge for people who live in poverty or have limited incomes and can serve as a barrier to accessing food, education, public benefits, recreation, and health care on a timely basis. Bus routes and times of service have a significant impact upon access to work, school, services, and health care. Figure 34 shows Santa Fe County bus routes. The hours of operation for these buses vary by route and by weekday versus weekend (Saturday and Sunday).[56] Generally, weekday hours are 5:30 a.m. – 10:30 p.m. on the busiest routes and 8:00 a.m. – 5:30 p.m. on less busy routes. Hours of operation on Saturdays and Sundays are shorter, generally 8:00 or 9:00 a.m. – 5:00 or 6:00 p.m., depending on the route. Some routes do not have service at all on Sundays. For those individuals who may want to or need to work nights, weekends, and other hours not the usual weekday or weekend hours, and who are dependent on public transportation in the City of Santa Fe, find transportation a challenge to employment and self-sufficiency.

Figure 34
City of Santa Fe Bus Routes



[56] Bus routes and hours of operation for Santa Fe trails – the City's bus system – can be found at https://www.santafenm.gov/route_maps_and_schedules.

Although bus routes cover many areas of the County, there are some parts of the census tracts with higher proportions of persons living in poverty or with lower incomes that are a significant distance from the nearest bus route. This is especially true for some neighborhoods around Santa Fe Community College, around Santa Fe Place mall, areas around Airport Road, and between Agua Fria and Cerrillos Roads in the southern part of the City.

Looking at public transportation users by census tract, it is evident that there are many areas where a high proportion of the population depends upon public transportation, and yet lives at some distance from the nearest routes. Figures 35a and b show the entire County, with an enlarged map of the City, including areas with the heaviest concentrations of public transportation users marked in darker shades of blue.

Figure 35a
Public Transportation Users and Government/Housing Resources by Area

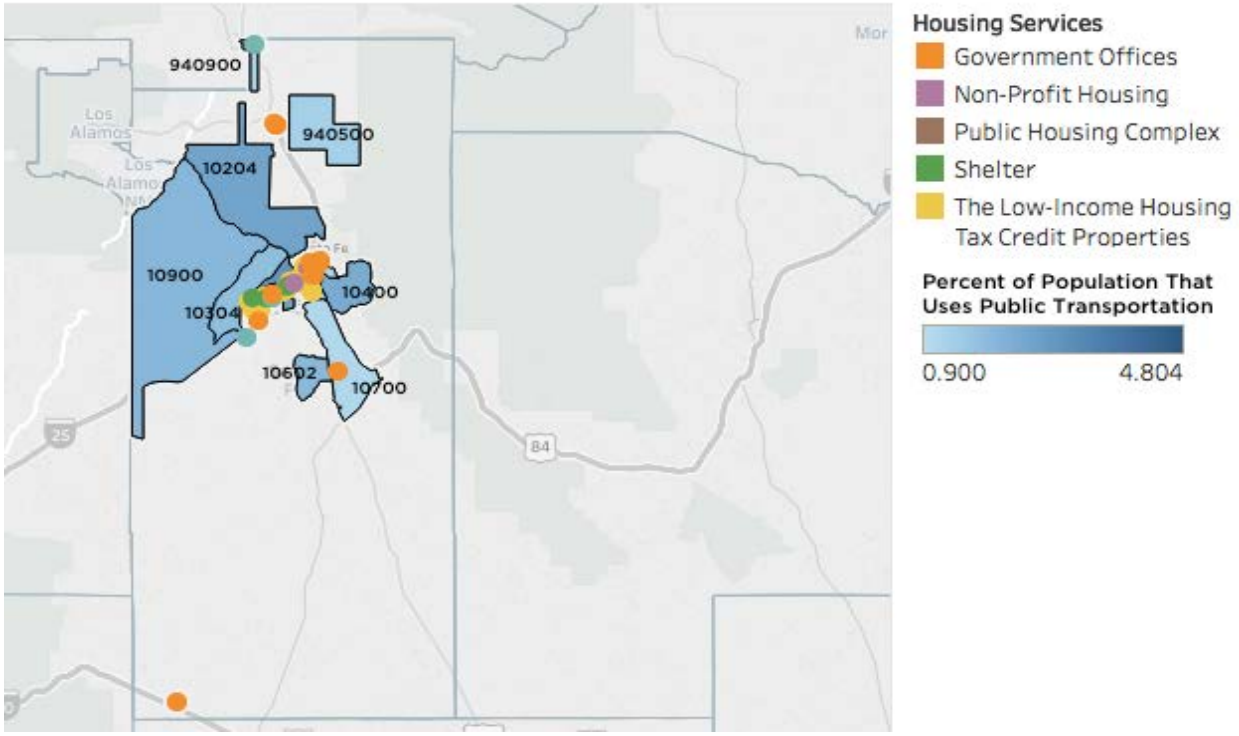
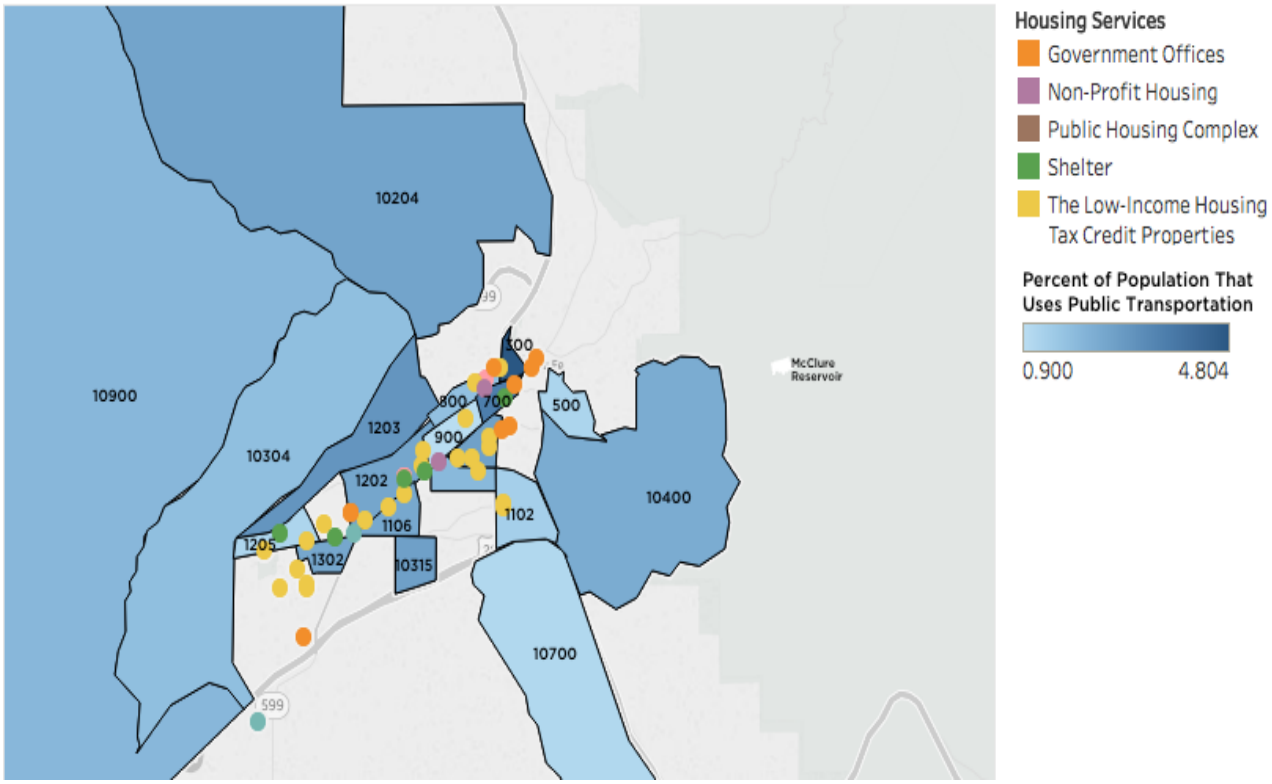


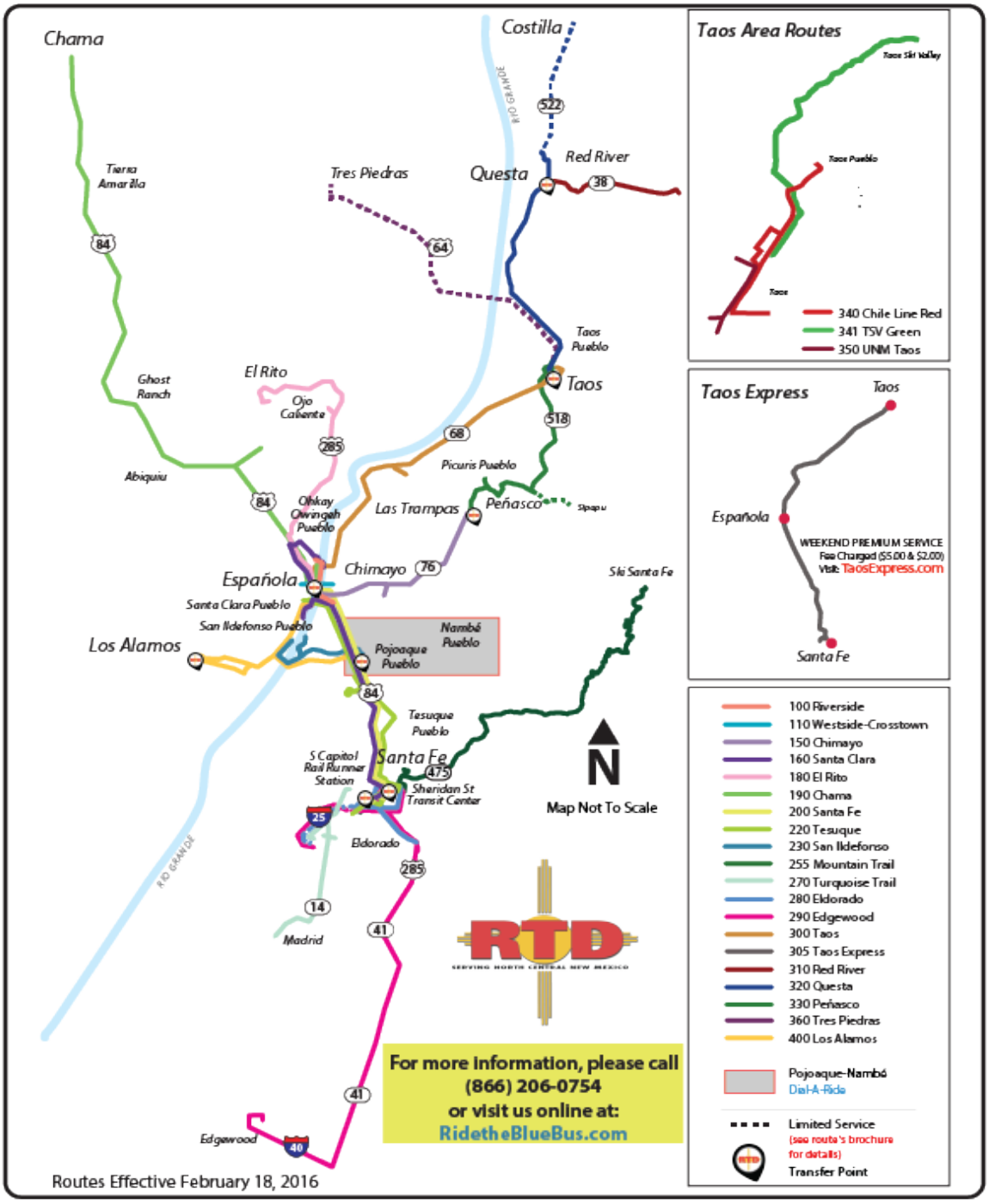
Figure 35b
Public Transportation Users and Government/Housing Resources by Area (Central)



Buses outside the City of Santa Fe operate largely on the main thoroughfares from City to City and operate even less frequently than City buses. North Central Regional Transit District (NCRTD) hours of operation are also dependent on route, but generally buses run from 7:00 a.m. – 5:00 p.m. with no distinction between weekdays and weekends.[57] NCRTD bus routes are depicted in Figure 36 with a comparison of government housing and transportation needs depicted in Figure 35b.

[57] NCRTD routes and schedules can be found at http://www.ncrtd.org/.

Figure 36
North Central Regional Transit District Bus Lines



M. Educational Attainment

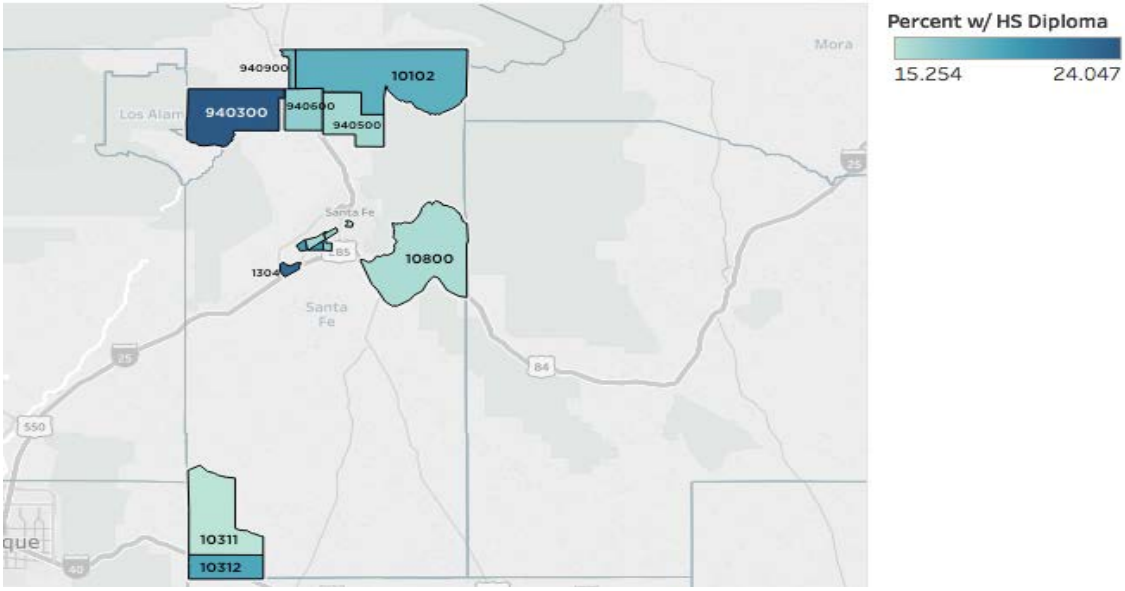
The Census Bureau reports poverty rates by educational attainment for people aged 25 and older. Rates vary considerably by education level. Persons in poverty have lower levels of educational attainment compared to the population as a whole. For example, in 2014, those who had no high school diploma comprise a far greater share of the general population in poverty than those with higher educational attainment.

Figure 37
Poverty Rates by Educational Attainment for Adults Aged 25 and Older – 2014[58]

Education Level	Poverty Rate	% of This Population Living in Poverty	% of Total Population w/ This Educational Level
Bachelor's Degree or Higher	5%	14%	33%
Some College but No Degree	10%	23%	26%
High School Diploma and No College	14%	35%	29%
No High School Diploma	29%	28%	12%
All People Aged 25 & Older	**12%**	**100%**	**100%**

Similarly, in Santa Fe County, the census tracts with the heaviest poverty rates and highest proportion of immigrants have the lowest average rates of educational attainment. Figures 38a and b show areas with higher proportions of individuals with lower educational levels (high school diploma being the highest educational attainment level).

Figure 38a
Percentage with Highest Level of Education Attainment High School Diploma



[58] University of California, Davis, Center for Poverty Research, *How does level of education relate to poverty?,* retrieved at https://poverty.ucdavis.edu/faq/how-does-level-education-relate-poverty; see also, Ladd, Helen F., *Education and Poverty: Citing the Evidence*, Journal of Policy Analysis and Management, March 28, 2012; retrieved at http://onlinelibrary.wiley.com/doi/10.1002/pam.21615/full; *The Link Between Poverty and Education*, The Borgen Project; retrieved at https://borgenproject.org/link-poverty-education/

Figure 38b
Percentage with Highest Level of Education Attainment High School Diploma (Central)

Figures 39a and b show the areas of the County with higher proportions of individuals with educational attainment at the BA or BS degree level.

Figure 39a
Percentage with Highest Level of Education Attainment BA/BS Degree

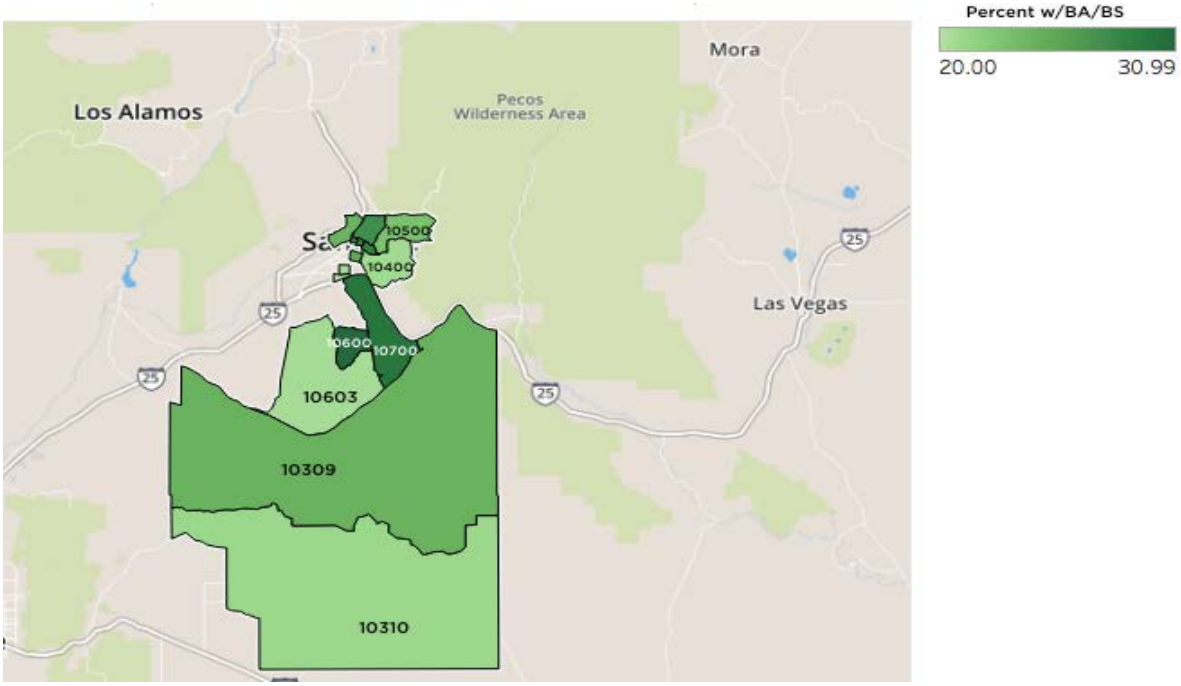


Figure 39b
Percentage with Highest Level of Education Attainment BA/BS Degree (Central)

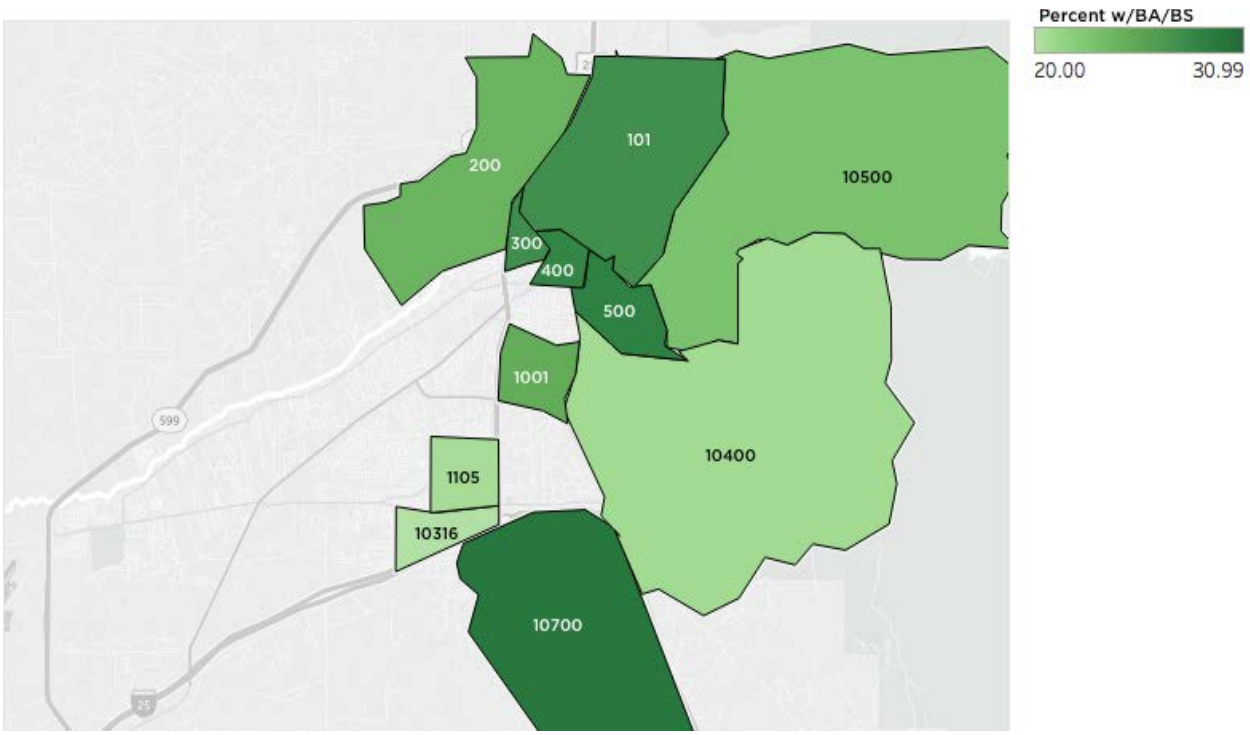
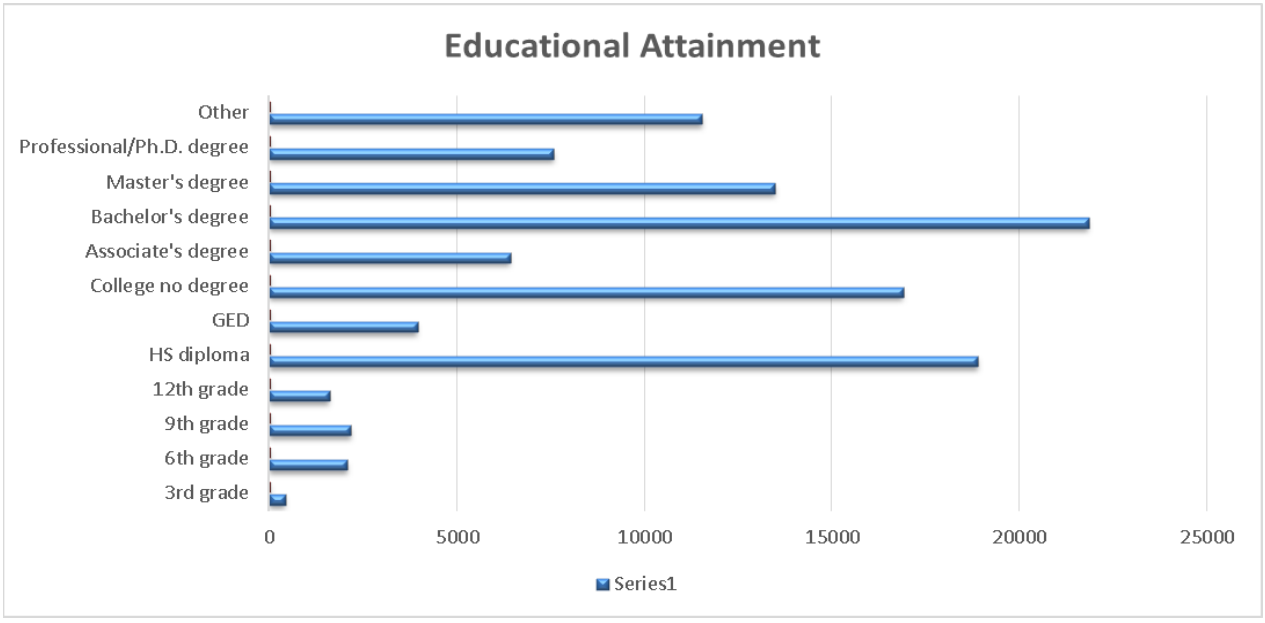


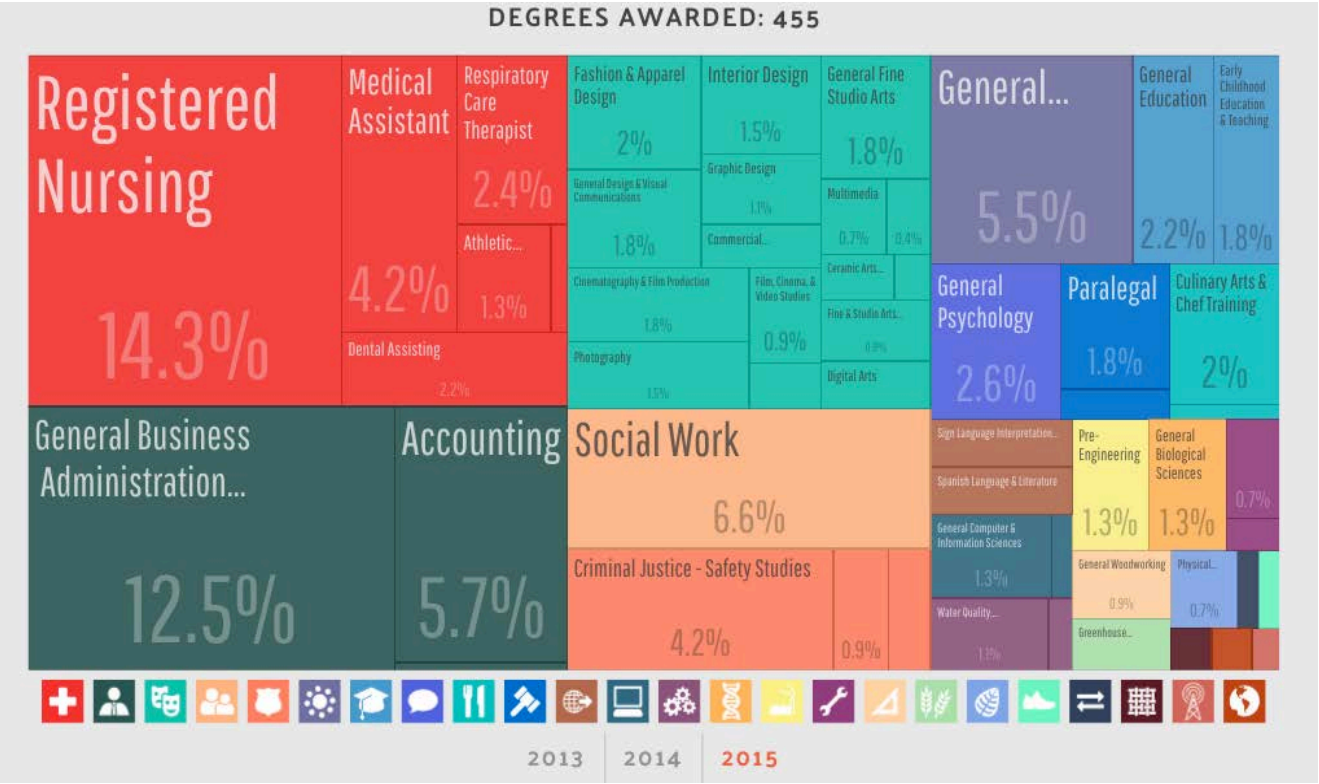
Figure 40 shows educational attainment by levels in the County as a whole.

Figure 40
Santa Fe County Educational Attainment Levels



The ability to attain degrees without leaving the County is limited. Figure 41 below shows the 455 degrees awarded in Santa Fe County in 2015, and the types of those degrees.

Figure 41
Composition of Student Population by Major in Santa Fe County in 2015



Source: Data USA

N. Collective Impact of Culture, Heritage, Tradition, and Socio-Economic Characteristics

The unique cultures and traditions as well as the mix of socio-economic characteristics in the region represent not a blended reality, but a variegated mix of different population types and perspectives living in shared space. Like an orchestra with its many instruments, the symphony of sound represents a whole that retains the uniqueness of each different instrument and section. To work well, the orchestra must have each part working independently and in sync with others, playing in a framework of mutual listening and respect. The same is true for any multi-cultural community, especially in Santa Fe. Within the County, there is a long history of diversity and assimilation, inclusion and exclusion, respect and marginalization, and most importantly, ongoing discussion about the importance of the three cultures living together in mutual respect, with room for all.

For decades, many healthcare providers have focused on creating environments respectful of all cultures, traditions, and socio-economic levels, with staff reflective of the community. Some providers offer services that include elements of Native traditions of healing and medicines, Hispanic promotoras, and peer-to-peer staff who are themselves part of the community of people being served. However, a number of Native, Hispanic, and LGBT advocacy groups, as well as organizations serving and advocating for low-income individuals and families, have provided feedback recommending that provider organizations continue and even increase

commitment to serving those who are underserved through more diverse, culturally aware, and culturally competent staff and practices. The challenge for those in leadership positions is to select and build health and human services system staff reflective of the population being served. It is also important for providers to regularly seek feedback from the varied groups that are part of the landscape, and to create inclusive and respectful communities with a focus on providing services to those most at risk and on the margins. Those at risk often postpone or set aside proactive health care if they find services offered to be difficult to access or if they experience their issues and opinions are minimized, discounted, or devalued because of their culture, language, beliefs, or lifestyles. The existence of health inequities related to race, ethnicity, sexual preference, poverty, and other social determinants provides an important touchstone to understanding and addressing barriers and gaps.

The combination of demographic social determinants along with the disparate treatment of individuals, families and communities has significant collective impact, especially in areas of the County where there are multiple high risks. For example, families living in the Agua Fria & Downtown neighborhood or in North County/Pueblos Plus, Airport Road, and Agua Fria Village areas who are poor, Hispanic, and immigrants have a series of social determinants that are "stacked" to create significant health disparities (poverty, race/ethnicity, and immigrant status). If some of those families are undocumented or caring for a frail elderly family member, or have both parents working with limited child care options, they have added stresses and health disparities. Another example could be a Native American family living in one of the northern pueblo areas with extended family nearby, all of whom are poor, working multiple low-wage or part-time jobs. When those families encounter a car breakdown or other emergency, that event can create added pressure. Figure 42 below demonstrates this potential collective impact by providing a rating and ranking of social determinants by small areas of the County.

Looking at how social determinants combine in neighborhoods with the highest proportion of persons living in poverty or with limited incomes, the health inequities and barriers become very clear. These health inequities and barriers are either mitigated or worsened by health behaviors and health conditions, analyzed in the next section of this report.

Figure 42
Collective Impact of Demographic Social Determinants by Area

Legend: High Risks = 5; Moderate Risks = 3; Low Risks = 1

Area	Poverty	Racial & Ethnic Pops	Proportion of Older Adults	Proportion Uninsured	Adults Uninsured	Immigrant Population	Children in Poverty	Elderly in Poverty	Average Rating
95 - Agua Fria Neighborhood & Downtown	5	5	4	3	4	5	5	4	4.375
94 - North County/ Pueblos Plus	5	5	2	3	4	3	5	4	3.875
98 - Airport Road	4	5	1	4	4	5	5	3	3.875
96 - Agua Fria Village	3	3	2	5	5	4	5	2	3.625
97 - Bellamah/Stamm	2	2	3	2	4	2	3	3	2.625
99 - South County	2	2	2	1	3	1	1	2	1.75
93 - Opera Vicinity & North City	1	1	4	1	1	1	2	1	1.50
92 - East Foothills & Eldorado	1	1	3	1	1	1	1	1	1.25

HIGHLIGHTS – POPULATION DATA AND DISPARITIES (1)

1. *The largest concentration of people among the 147,108 population of Santa Fe County are adults ages 50 – 70 years old; the smallest between ages 20 and 35. The County's proportion of older adults 65 and older is expected to increase by 62 percent by 2030, more than the state or the nation, with very old individuals the fastest growing group.*

2. *The County has slightly more women than men.*

3. *English is the primary language spoken by 62 percent of County households. Spanish is the primary language spoken by 33 percent of households.*

4. *Neighborhoods with higher than average poverty rates also have a high proportion of individuals who are Hispanic, immigrant, or Native American, with lower proportions of Whites or Asians/Pacific Islanders. While the proportion of African Americans/Blacks is extremely low, the concentration of poverty among African Americans/Blacks is higher than in the population at large.*

5. *Neighborhoods with the largest percentage of foreign born non-citizens are the poorest areas with the highest proportion of Hispanics and individuals who are uninsured. These same neighborhoods also have the largest proportion of the population working. Nine percent of the County's population is comprised of immigrants who are not U.S. citizens (although some of these individuals may be legal residents).*

6. *Neighborhoods with higher proportions of individuals and families with lower incomes have average to above average percentages of people in the workforce.*

7. *Compared to the non-LGBT population, the LGBT population has significantly higher rates of mental distress, suicide attempts, smoking, and individuals who have not visited a physician in the last year.*

HIGHLIGHTS – POPULATION DATA AND DISPARITIES (2)

8. *Only 14 percent of the available child care slots in the County are currently serving low-income children and families.*

9. *Medicaid expansion and provider enrollment efforts have improved the adult insured rate for poor and low-income adults; however, the rate of uninsured is still higher in the County than in the state as a whole.*

10. *In 12 of the 15 census tracts with the highest proportions of low-income individuals and households, over one-quarter of the population pays up to 50 percent of their income for rent and over one-quarter pays 50 percent of their income or more for housing.*

11. *Census tracts with the heaviest poverty rates and highest proportion of immigrants have the lowest rates of educational attainment.*

12. *Santa Fe County's food insecurity level is better than the state's as a whole; however, the 15 poorest census tracts have a higher percentage on public assistance and/or SNAP (food stamps).*

13. *Bus routes and times of service are challenges for individuals who are dependent on public transportation for access to work, education, public benefits, recreation, and health care.*

14. *The combination of age and sex with race, ethnicity, and poverty – along with housing costs, transportation challenges, the rate of uninsured, and food insecurity – creates a unique mix of social determinants that represent assets as well as challenges impacting health.*

15. *The Agua Fria Neighborhood & Downtown, North County/Pueblos Plus, Airport Road, and Agua Fria Village are the areas of the County with the highest risk factors; the Opera Vicinity & North City and the East Foothills & Eldorado areas are the areas with the lowest risk factors. The Bellamah/Stamm and South County areas have medium overall risk.*

III. HEALTH INDICATORS, BEHAVIORS, AND RISKS

Santa Fe County's overall health profile is better, on average, than the state as a whole. However, a number of serious challenges exist to affect access to and utilization of care. These health risks and health-related behaviors have been identified by the Kaiser Family Foundation[59] as important drivers of community well-being and contribute to health system barriers and gaps. This section of the report will describe the community's health challenges and high risks, bearing in mind the health issues outlined in some of the most recent health planning documents,[60] for example:

- *Santa Fe County in 2013: A Community Health Profile*
- *Santa Fe County Health Action Plan FY 2015-2017*
- *Santa Fe County Senior Services: Strategic Plan 2016-2020*
- *Santa Fe County's DOH Health Profiles* and *Community Snapshots*
- *Robert Wood Johnson Foundation's (RWJ) County Health Rankings and Roadmaps*.

An analysis of health risk and outcome data in CSD publications and conversations with CSD staff has identified the following as critically important health issues for Santa Fe County.

Figure 43
Santa Fe County Health Risks and Goals

	Health Risks	SFC	NM	Related CSD Goals & Priorities
1	Lack of insurance, access to care	17.8% (2011-2015)	17%	Increase health insurance enrollment.
2	Lack of access to primary care provider	28% (2011-2014)	30.3%	Increase enrollment.
3	Low birthweight babies	9.7% (2013-2015)	8.8%	Reduce low birth weight babies.
4	Alcohol related deaths (per 100,000)	27.3% (2010-2014)	27	Reduce alcohol abuse.
5	Overdose related deaths (per 100,000)	29.4% (2010-2014)	24.3	Reduce drug abuse.
6	Youth suicide deaths (per 100,000)	19.6% (2009-2013)	14.9	Reduce suicides.
7	Lack of healthy food consumption	-	-	Increase healthy food consumption.
8	Falls, injury death rate (per 100,000)	90.3 (2011-2015)	87.8	Serve older adults at risk.

Behavioral Health Areas (4-6) are shaded in yellow.
Source: U.S. Census Data 2011-2015 for # 1. NM DOH IBIS data for #s 2 – 7.
NOTE: # 1 and #s 3-7 are part of SF County's current Health Action Plan FY 2015-2017.

This section describes these health risks with the understanding these health issues are broad and complex. The section also compares Santa Fe County health rankings with other counties in the State and the nation. This section also describes key community initiatives focused on addressing some of these issues. CSD's focused approach, prioritizing its goals and strategies, and working collaboratively in sustained activity with other government and community organizations is increasingly important in the current and emerging policy and funding environment.

[59] Kaiser Family Foundation provides some of the nation's cutting edge research and publications on health care access, barriers, gaps as well as other systems issues. www.kff.org.
[60] Santa Fe County documents can be found at https://www.santafeCountynm.gov/community_services; DOH document at https://ibis.health.state.nm.us/community/highlight/report/GeoCnty/49.html; and the RWJ document at http://www.Countyhealthrankings.org/search?search_api_views_fulltext=Santa%20Fe%20County&f[0]=content_type_search_label%3ARankings%20Data

A. Goals 1 & 2: Increasing Access to Health Insurance and Care

Access to care has long been a priority of CSD, other related government entities, foundations, advocacy groups, and providers. The advent of the Affordable Care Act (ACA) and Medicaid expansion have had a significant impact improving access to care in New Mexico and in Santa Fe County. Prior to Medicaid expansion, children in the state had better coverage levels and more coverage options than adults, and had substantially better access to care. However, in 2015, one fourth of adults still had no health insurance coverage. According to a presentation to the Legislative Finance Committee in July 2016, Santa Fe County saw a 13 percent increase in Medicaid funded behavioral health services in 2014 and 2015. This increase was one of the smallest increases among all counties reported although is consistent with the increases reported for larger NM counties. Whether SF County could see additional increases if more individuals were enrolled is unclear, but these data do offer a potential opportunity for SF County residents and providers if increased enrollment efforts are successful. Uninsured individuals usually defer all but the most emergent health situations, creating long term health risks and chronic conditions that become increasingly expensive for people and for the health care system over time.

Access to care is complex, and shaped by multiple factors including health behaviors, individual and population-based risk factors, cultural norms, language, and provider and system issues. Having insurance coverage is one of if not *the* key factor influencing a person's access to care. With coverage, there are many options; without coverage, resources and options are limited. Gaps in services needed but not covered impact access to care as do provider locations, hours of operation, and staffing capacities. Those providers that remain near fully staffed, with some night and week-end hours significantly improve people's access to care. Providers located in or near communities are more well-known, trusted and accessible than those located many miles away. One concept that is increasingly referenced is the need "to develop community-based services in natural settings, shaped by the people in the community, and hiring, where appropriate, from the community."[61]

CSD has addressed the access to care issue in multiple ways:

- Outreach and marketing to the community, working in partnership with Health Action New Mexico and other providers, to let people know about the benefits of enrolling in Medicaid or other ACA provided insurance options;
- Providing Medicaid enrollment assistance and help enrolling people in other public benefit programs, thereby increasing their access to care;
- Partnering with government and provider networks in the County to encourage benefits enrollment at all levels;
- Providing information and referral to help people with no coverage access free or sliding fee heavily subsidized care;
- Identifying and funding access to care for high-need/high-risk groups with a number of strategies geared toward increasing the different ways one can access services, including mobile vans, extended hours of care from some providers, and services at schools and housing projects; examples are CSD's leadership in partnership with CHRISTUS St. Vincent's, Presbyterian Medical Services (PMS), La Familia, Southwest Care Center, Santa Fe Recovery Center, Santa Fe Mountain Center, Edgewood and Pecos FQHCs, and other community agencies to expand services to high-need or high-risk people who may or may not have Medicaid as a payer source and regardless of legal status;

[61] U.S. Department of Health & Human Services, *Healthy People 2010* and *Healthy People 2020*, at https://www.healthypeople.gov/.

- Funding of care navigation services to expand access to care for those with the lowest incomes or at greatest risk; and
- Providing funding for high-need/high-risk people with incomes up to 400 percent FPL for health care services not funded through another payer source through the Health Care Assistance Program (HCAP).

The Health Care Assistance Program (HCAP) in Santa Fe County is governed by the Indigent Act of 1978 and funded by County gross receipts tax. HCAP exists to assist uninsured and underinsured residents of the County with medical expenses. Under County Board of Commissioners (BCC) Resolution 2014-47, the program assists underserved, low-income residents, regardless of immigration status, with services provided by non-profit providers, including primary care services, dental care, alcohol and substance use disorder treatment, and navigation services, in addition to ambulance services. (The program also pays for cremation services for indigent County residents.) The County is considered the payer of last resort and cannot cover services covered by any form of insurance or other programs. By BCC resolution, hospital bills are not eligible for coverage by the program because the County pays into the New Mexico Human Services Department's Safety Net Care Pool Program for uncompensated care for area hospitals. For-profit providers are also not covered, nor are physician charges, or laboratory services.

HCAP provided $1.9 million in financial support for individuals in need through payments to 17 different providers during Fiscal Years 2015 and 2016. The vast majority of this funding went to support primary care, behavioral health care, and dental care. During this time, HCAP provided funding for services for 1,060 females and 604 males. Although a number of people served by HCAP funding had no insurance coverage, the majority of HCAP expenditures were for those on Medicare (482), with some on Medicaid (79), and some on Medicare and Medicaid (16).

The HCAP data system was recently updated, and the old system did not have the capability of aggregating data. During the time the funding has been operational and statistics have been kept[62] HCAP was the source of funding for services for a variety of age groups, including teens through 30s (532), adults in their 40s and 50s (695), and adults 60 and older (794).

HCAP began funding a Health Care Advocate in June 2016, a position which had never existed in either the County or elsewhere in the State. The Advocate served 77 people in the first year (FY 2017). The Advocate assists the indigent population of the County with locating additional financial resources for medical expenses, often navigating healthcare providers' various financial assistance programs.

Common concerns have emerged for people who seek help from HCAP. The most common unmet needs include durable medical equipment, assistance with health insurance premiums, prescription assistance, and paying for hospital bills. In FY 2018, HCAP responded to some of these needs by funding durable medical equipment and prescriptions at non-profit pharmacies. The charity fund at Christus St. Vincent Regional Medical Center (CSV) covers hospital facility fees but does not cover diagnostic exams, laboratory fees, or bills from CSV's contracted physicians. Currently, HCAP does not cover these expenses, representing a remaining unmet need for the indigent population of the County. No other financial assistance programs help with these bills so indigent individuals are left with large hospital-related bills they are unable to pay.

[62] Some of the HCAP numbers do not correlate, primarily because of the differences between earlier and updated HCAP systems, and different time periods were used for different types of data. After the HCAP IT upgrade in 2016, the program has been collecting more complete data, better for analyses.

Given the effort to increase enrollment in public insurance programs, CSD has begun the process of shifting the use of HCAP funds from reimbursement for claims to targeted contracts designed to fund specific services to address goals and desired outcomes established by CSD, with input from the Health Policy and Planning Commission (HPPC), in the SF County Health Action Plan described earlier in this report.

Areas where structural or systemic gaps in coverage and access to care are significant include types of services (behavioral health and dental care), population groups served (seniors, immigrants, and low-income working families), and times and places of available services. These are described briefly below as well as more fully in other sections of this report.

1. Behavioral Health Care Access and Funding Issues

Because of its relationship to health, other health care outcomes, and other government costs, and because of New Mexico's unique recent history in this area, behavioral health needs continue to emerge in various aspects of this gap analysis. Medicaid is the single largest payer for mental health services nationally,[63] and one of the largest for addiction services. Hence, how Medicaid reimburses services often drives how services are structured and provided. Medicaid reimbursement for Comprehensive Community Support Services (CCSS) is currently limited by NM HSD to agencies with specific certification requirements promulgated long ago and not necessarily currently relevant to today's needs, especially if the ultimate goal is to reduce use of higher levels of care and shift resources from bed-based to community-based care. The result is significant limitations on availability of these services. Peer support services by certified peer practitioners are funded only in a group setting unless the peer practitioner is able to bill for CCSS. Certain types of behavioral health care are not reimbursed by Medicaid, are heavily rationed, or are reimbursed in such a way or at such low rates that providers must limit or shift the activity to remain viable. This means the mix of Medicaid funded services provided is targeted to client and community need, but with the mix and proportion of services modified to meet budget constraints.[64]

Other behavioral health services are needed, and some provided, with limited or no Medicaid reimbursement. Although a number of providers offer supportive and outreach services by peers, community health workers, and promotoras, as well as other frontline low-cost services often staffed by peers or those similar to people served, many of these services are not covered by Medicaid. Medicaid also covers limited residential care, and limited services to assist with supported employment or other recovery supports. While Life Link provides significant housing services utilizing HUD and other non-Medicaid funding, lack of affordable and supportive places to live results in significant homeless populations of persons with mental illness and/or addiction issues. Naloxone/Narcan medication distribution and training are very much needed, and are offered through some community-based providers. Prescribers and programs for medication assisted treatment remain limited and often difficult to access. Providers sometimes manage to deliver non-Medicaid funded services through a mix of funding, including grants and contracts, as well as small excess revenues generated through a few types of care. However, most

[63] www.cms.medicaid.gov/behavioralhealthservices.

[64] For the past few years, HSD's Medicaid Office has developed updates to its behavioral health fee structure in an effort to address the challenge of its outlay given the budget shortfall created by the level of Medicaid expansion and increasing amounts of state match required. Many behavioral health services have received small reductions; larger cuts have been made to behavioral management services (BMS), social detox and others. A fee schedule can be found at the HSD Medicaid Managed Care website.

providers must carefully manage the level of care they can provide in this manner, as it can be overwhelming and skew a provider's mix of services, as well as create financial challenges.

Many people who are incarcerated have behavioral health issues closely tied to criminogenic factors that led to incarceration.[65] In some counties in New Mexico, the drug overdose death rate is closely tied to the few days following an inmate's release, when they return to the level of substance use prior to incarceration, which they are unable to tolerate after going through detoxification while incarcerated.[66] For a number of years, there were challenges with jail to community transitional supports because of difficulties with coordination between judicial, jail, social service/health and community providers. However, Santa Fe County's Jail Initiative has been addressing this issue to facilitate reintegration and reduce recidivism. One significant recent change in policy to allow jail detainees to sign up for Medicaid prior to release has helped secure access to care for these individuals immediately upon release.[67] NM HSD is proposing to increase assistance in this area through its 1115 waiver renewal in 2018.[68]

2. Dental Care

A similar disconnect exists for dental care, especially routine and preventive dental care often not covered in most health insurance plans. Medicaid covers some dental care for eligible children, but provides little for adults except extreme service needs affecting medical health. Pulling rather than repairing or reconstructing a damaged or affected tooth is a typical result. To have any kind of significant dental care requires adults to purchase a private pay dental discount plan or dental insurance. CSD has partnered with dental providers to fund dental care for uncovered children and adults. One recent event at the Santa Fe Convention Center had people lining up for services hours before the event opened for business. Overall, dental care is something often deferred because of cost.

3. Services for Older Adults

As indicated in Section II of this report, Santa Fe County faces a "Silver Tsunami" or "Age Wave"[69] with unprecedented percentages of older adults in the population over the next few

[65] Nationally, studies show that approximately 20 percent of the incarcerated have a mental illness, and 30% to 60% of inmates have substance abuse problems (depending upon the state). New Mexico's behavioral health risks are and have consistently been among the highest in the nation, according to data from NM DOH IBIS. "Mental Illness In America's Jails And Prisons: Toward A Public Safety/Public Health Model," Dean Aufderheide, Health Affairs, April 1, 2014

[66] Rio Arriba County has one of the highest behavioral health risks in the state, and is one of two Behavioral Health Investment Zones, where NM BHSD has invested in community-wide initiatives to address and stem the tide of drug overdose deaths. RAC's integrated community initiatives at Narcan distribution and case management in jail for community reintegration have contributed substantially to the reduction in drug overdose deaths. *Salud! RACHC 2016 Health Profile*, Anne Hays Egan.

[67] Families USA, at http://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map, depicts Medicaid laws by state regarding inmates, whether Medicaid is fully suspended, time-limited in suspension, or maintained. New Mexico's policies were, through 2016, full suspension; however, the policies have been modified to enable those working with inmates to help them apply for and receive Medicaid prior to release, to ensure needed medications (often related to behavioral health) are available upon release.

[68] See HSD's *Centennial Care 2.0 – Section 1115 Demonstration Waiver Renewal Concept Paper, May 19, 2017*, at www.hsd.state.nm.us.

[69] See, Egan, Anne Hays, *How an Aging Social Impact Calculator Can Help Your Community,* News and Society: Economics, September 1, 2017, at https://ezinearticles.com/?How-a-Social-Impact-Calculator-on-Aging-Can-Help-Your-Community&id=9782592, for a short description of the concerns regarding the use of these terms, and for use of the terms "seniors" and "the elderly." While the term "seniors" is used in this report, the authors try to utilize people first language to describe adults who are of an age to be considered "seniors" and try to utilize the terms "older" or

years. Older adults, especially those who become frail as they age, have few home supports available to them. Older adults on Medicaid as well as Medicare may qualify for personal care services, which provide limited in-home non-medical supports. Other individuals on Medicare may qualify for limited types of assistance, usually related to a hospitalization episode. For people who are not covered by Medicaid, and even many who are, limited in-home care supports are available that do not require private pay. The fall rate for older adults is high, and will continue to increase as the population ages without needed in-home and other social supports. The County's senior centers and home delivered meals represent much needed "water in the service delivery desert" for seniors, although knowing about these services and activities and transportation to these centers and services is still reported as an issue (see later section of this report describing outcomes of town halls).

Present service capacity in Santa Fe County is insufficient to meet the current and future demand, given the number of older adults in the County and the expected increase in those numbers in the next few years. Available services are often unaffordable, especially for those in middle incomes. The types of services needed range from accessible and cost-effective in-home care to access to quality residential nursing facilities. Basic services such as socialization, access to healthy foods, safe exercise opportunities, and accessible non-medical transportation are also identified as insufficient by providers as well as seniors themselves.

4. Care for Immigrants

Serving immigrants regardless of legal standing has been a priority for City and County government and some area providers. Recent shifts in federal immigration policy have created a palpable wave of fear among many immigrant communities. Many immigrant families are deeply fearful of potential deportations, and this fear can result in reduced community activities, including accessing public resources for food, benefits, transportation, and health care.[70]

As described in Section II of this report, immigrants live in a number of communities throughout Santa Fe County, though primarily in the south side of the City and Agua Fria areas. Both documented and undocumented immigrants have much higher poverty rates than the population at large. Although immigrants who have legal standing within the U.S. have access to Medicaid and other public benefits, those who are undocumented do not have coverage in New Mexico. (Some states, like New York, provide state-specific coverages parallel to Medicaid.[71])

"elderly" as adjectives describing one aspect of the individual and his/her needs rather than to describe the whole person.

[70] As early as 2009, immigration law and policy experts were writing about the links between racism and border patrol actions to stop suspected undocumented immigrants ("Institutional Racism, ICE Raids, and Immigration Reform," by Bill Ong Hing, *University of San Fransisco Law Review*, Vol. 44, p. 1, 2009), and various New York Times articles https://www.nytimes.com/2017/06/09/opinion/lawyers-for-detainees.html?/.) The increased activity by federal ICE agents since early February, 2017, has been documented by a variety of reporters, including major news outlets. It has created fear among many immigrant communities, both documented and undocumented, as many who are documented have undocumented relatives. Linguistic barriers exacerbate fear, as many immigrants report being afraid that they will be arrested and possibly deported, regardless of legal standing, according to staff at Health Action New Mexico, and some statements made at Town Hall events.

[71] *New Mexico State Immigration Laws*, by Findlaw, www.findlaw.com; *Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*, U.S. Centers for Medicare and Medicaid, www.cms.gov; *Coverage for Lawfully Present Immigrants*, regarding Health Insurance Exchange options for documented immigrants, www.healthcare.gov; and article by New York Legal Assistance Group regarding state-based Medicaid benefits for undocumented immigrants. NM Center for Law and Poverty has a *Resource List: Health Care for Immigrants in New Mexico* at www.nmpoverty.org, and NM HSD's Medicaid office has fact sheets and other information at https://nmmedicaid.acs-inc.com/static/index.htm.

The importance of providers understanding, respecting, and integrating cultural norms, traditions, and language into service delivery cannot be overstated. Individuals and families who come from Hispanic, Native, Asian, African American, and European cultures often have different beliefs, expectations, and standards for care. Additionally, cultural traditions and preferences often play a major role in accessing care. Providers also indicate that the cultural divide is a very important issue they work to address by having an increasingly diverse and multi-lingual/multi-cultural staff. Living in a community with such a mix of backgrounds and experiences, one can expect to find many instances where providers engage in behaviors that are felt as uncaring or disrespectful. Much of this can be improved though a deep commitment to respecting others, and holding diversity as a core value. This includes staff diversity, staff training, use of traditional practitioners and practices in achieving health, and ongoing dialogue with the communities served. These strategies can help address problems stemming from lack of understanding[72] sometime perceived as lack of welcome.

5. Care for Low-Income People Who Also Work

Children have a higher income level for Medicaid eligibility; therefore most children of working families with low incomes do have some level of coverage for care. However, working adults with low incomes have many issues with coverage and access. Data in the previous section demonstrated that adults who live at up to 200 percent of poverty and above still have very low rates of insurance coverage even with recent improvements in enrollment. This lack of coverage causes delayed attention to preventive care and inability to seek or pay for care until the condition has progressed to a stage where outcomes are often less favorable.

6. Provider Relationships, Locations, Hours, and Staffing Issues

Provider locations, hours of operation, and staffing levels significantly impact access to care. Location disparities are described in Section III of this report. Almost one third of County residents indicate they have no primary care provider, according to U.S. Census data also reported earlier. This lack is shaped by multiple factors, including shifting preferences about building relationships with providers, difficulty finding available primary care physicians, cultural norms, behavioral health issues, and severe staff shortages within some areas of the provider community. Some providers and service recipients report that people often find it more helpful to build a relationship with a community health worker, peer counselor, or other type of health care provider than with a primary care doctor. It will likely take the U.S. Census years to catch up with tracking this trend, if indeed it is a trend.

Although many non-profit providers have added offices, mobile services, or on-site services in many communities, location of services is an identified gap. Providing more services in communities closer to where people in greatest need live, or more mobile services to reach those locations and populations, would help to address this gap. The challenge for providers is one of scale. Smaller providers are faced with already overstretched budgets, and expanding services can represent activity that is unsustainable financially. Creative solutions are needed in partnership with communities served and providers attempting to serve those communities. CSD is already working with many providers to offer resources for care navigation and access, certain types of mobile services, services in housing projects and schools, and services in partnership and/or co- located with other providers in communities with the greatest needs. Because staff

[72] A famous example of cultural illiteracy comes from American automobile expansion into South America in the 1970s, selling the Chevy Nova. Spanish speaking people were not interested in a car with a name of No Va, meaning “no go.”

and financial resources are limited and traditional models often challenged, initiatives need to be creative, flexible, well-targeted, and carefully scaled in order to maximize resources and limit the negative impact of inevitable missteps.[73]

B. Goal 3: Low Birthweight Babies

Santa Fe County's rate of live births having a low birthweight (meaning under 2500 grams or about 5½ pounds) is 9.7 percent. This compares to 8.8 percent in New Mexico as a whole and 8.0 percent nationwide.

Low birthweights can be caused by many factors, but generally, the lower the birthweight, the higher the rates of death or chronic illnesses, resulting in longer term health issues and higher healthcare costs.[74] Some of the small areas with the heaviest proportion of Hispanic and Native American people have smaller percentages of low birthweight babies than do some areas with heavier concentrations of non-Hispanic and non-Native peoples. However, according to research conducted by a range of experts, multiple, complex factors affect low birthweight, including substance use (especially the use of opioids and smoking), poverty and its stressors, domestic violence, preference for shorter time periods between pregnancies by certain groups of women, and scheduled deliveries, as well as other factors.[75]

Key prenatal care, hospital, and primary care providers have been working to address this issue in recent years with improvements in maternal outreach and prevention efforts. PE/MOSSA staff has made presumptive eligibility enrollment in Medicaid a priority, and the Women, Infants, and Children (WIC) program has worked to reach more women at potential risk. The provider network has an increased level of collaboration, with more "warm hand-offs" between different types of providers, offering clients more integrated care. However, because birth weight is shaped by multiple demographic, social, and behavioral factors, making sustained long term impact will be dependent upon changing health risks in these multiple related areas. CSD has made significant efforts to impact the percentage of low birth weight babies born in the County, including funding two large programs at La Familia and Las Cumbres to identify at-risk, pregnant mothers to offer pre-natal care, smoking cessation, and treatment of substance use disorders among these moms-to-be. Their experience suggests the outcomes of such efforts may have limited results if the woman does not have a stable and safe place to live for herself and her young children, and if she does not have transportation, food, and other necessary basic living supports.

C. Goals 4, 5, & 6: Behavioral Health Issues, Including Alcohol, Drugs, and Suicide

1. Behavioral Health Risk Factors

[73] Inevitable missteps refers to the normal developmental process for any new initiative, which is an iterative process involving both positive strategies and new ways of addressing challenges as well as missteps. Starting small and building, using what experts call a 'rinse and repeat' process in developing initiatives is a strategy often recommended by experts to improve the odds of success developing new initiatives while minimizing risks and missteps. "*Why Most Business Start-Ups Fail*," Harvard Business Review; *Organizations and the Change Imperative*; Business Performance; *Innovation and Integration*, Hawaii Department of Health.
[74] NM Department of Health, IBIS, https://ibis.health.state.nm.us/community/highlight/report/GeoCnty/49.html
[75] *Transforming Health, Strengthening our Community: CHRISTUS St. Vincent 2017-2019 Community Health Needs Assessment*. *Los Alamos County LACHC Health Profiles*, 2012-2013 and 2015-2016 with data correlations between low birthweights and altitude, as well as among Asian American mothers, and high-income professionally employed women.

The latest Behavioral Health Barometer for New Mexico, Volume 4, produced by SAMHSA in 2017,[76] indicates that in most cases, New Mexico's behavioral health indicators were similar to those of the nation in 2014-2015. However, in Santa Fe County, some outcomes – for example, youth deaths by suicide and all deaths due to opioid addiction[77] – are often more severe than those of the State as a whole and hence of the nation. These data indicate that about 4.5 percent of NM adults 18 or older experience a serious mental illness (SMI). About 44.2% of adults with any mental illness (about 20.5 percent of all adults) received treatment in the past year. Generally, adults with serious mental illness receive treatment at higher rates, but only about two-thirds receive appropriate specialty care nationwide. About 63,000 adults in NM (4.1 percent of all adults) had serious thoughts of suicide, similar to the rate for the nation as a whole.

For adolescents, about 11.5 percent or 19,000 of those aged 12 – 17 experienced a major depressive episode, also about the same as the national average. However, NM's rate for adolescent depression has increased in the last few years while the nation's rate has stayed about the same. Of these 19,000 adolescents, only about 34 percent received treatment for depression. Similarly, in NM about 15,062 individuals were enrolled in substance use treatment in 2015, a significant increase from 2011 and 2013, but a slight decrease from the number receiving treatment in 2012. Generally, only about 10 percent of the 21.5 million Americans who could benefit from treatment of a substance use disorder receive that treatment. According to the 2016 Surgeon General's Report on Alcohol, Drugs, and Health,[78] 27 million people report current use of illicit drugs (including marijuana) or misuse of prescription drugs while 66 million report binge drinking in the past month.[79]

While most of these data are national and state level data,[80] scaled to SF County's population size, these data suggest the following for Santa Fe County:

- Almost 25,000 adults likely experience some form of mental illness in a given year;
- Only about 11,000 of those adults with a mental illness receive treatment;
- About 6,500 adults experience a serious mental illness, somewhere between 1,600 and 3,000 of which experience major psychotic or bipolar disorders;
- Only about 4,400 of adults with SMI receive treatment;
- About 2,300 adolescents experience a major depressive episode;
- Only about 780 of these adolescents experiencing depression receive needed mental health treatment;
- About 12,000 individuals in SF County likely use illicit drugs or misuse prescription drugs;
- About 10,000 individuals could benefit from treatment for addiction;
- Only about 1,000 of these individuals receive needed treatment for addiction; and
- About 6,000 adults and over 1,000 children and youth in SF County have serious thoughts of suicide in a given year.

[76] Found at https://www.samhsa.gov/data/sites/default/files/2015_New-Mexico_BHBarometer.pdf.
[77] See https://www.nytimes.com/interactive/2016/01/07/us/drug-overdose-deaths-in-the-us.html from the Surgeon General's Report.
[78] The report can be found at https://addiction.surgeongeneral.gov/.
[79] By comparison, national CDC data in 2014 showed about 22 million Americans with diabetes, between 58 to 71 percent received preventive treatment for the disease; see https://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm . By 2017, this number has risen to 30 million Americans; see https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
[80] Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

The facts for those enrolled in Medicaid show an equally grim picture about unmet need. A recent report completed by the University of New Mexico (UNM)[81] on the state's behavioral health services shows overall New Mexico has a much higher death rate from alcohol and drug related problems than the U.S. as a whole. The majority of Medicaid funded behavioral health clients were young, female, and Native American with many related health costs for those with behavioral health diagnoses, including inpatient care, skilled nursing, pharmacology, and other costs. Out of all Medicaid clients with an active behavioral health diagnosis (12,232), only 68.1 percent (8,328) of these individuals had a behavioral health provider visit during 2014 – 2015. Of those, 47.1 percent were using prescribed medications. These data indicate a complex mix of factors affecting access and service gaps. The report states:

> "Based on the January 2017 Health Resources and Services Administration's Health Professional Shortage Area data, 44.2% of the need for mental health care in the United States has been met, but only 23.1% of the New Mexico population's need has been met, leaving 1,211,555 New Mexicans without adequate mental health care access. . . .
>
> "Among adults who perceived a need for treatment but did not receive it during 2008 to 2014, the top reason for not receiving treatment was cost (61.1%), followed by accessibility (31.6%) and personal reasons (32.2%, including not having felt the need for treatment at the time, thinking treatment wouldn't help, and being concerned about being committed or having to take medicine).
>
> "Treatment rates for substance abuse are far lower than those for mental illness. Only 7.6% of New Mexico individuals 12 years or older with alcohol dependence or abuse received treatment each year from 2010 to 2014, and only 12.3% of those with drug dependence or abuse received treatment."

This UNM report is focused only on the Medicaid population, which has a greater number of health disparities than does the population at large. However, given the high proportion of public mental health dollars that comes from the Medicaid program, the report offers a stark picture of the challenges faced by those with the greatest poverty and other disparities. The behavioral health gaps indicated by this UNM report, and further described in this gap analysis report, are complex in nature, fueled by social determinants, health risks, allocation of resources, health provider shortages, and cultural issues. Another interesting finding in the UNM report is the lack of diversity in the state's provider population: 39 percent of psychiatrists are female; 1.4 percent identify as Native American, and 15 percent identify as Hispanic.[82]

According to data provided in Figure 44 from the NM Department of Health's IBIS data system, behavioral health risks in Santa Fe County are not the highest or the lowest in the state.[83] These risks include mental health conditions and substance use with attendant health and behaviors that impact health, including motor vehicle crashes, other unintended accidents, incarceration, suicide, and loss of employment, family, and/or home. Even when the County's rates are better than the state as a whole, the economic impact of untreated behavioral health is enormous and has been well-documented by researchers in the field.[84]

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[81] http://psychiatry.unm.edu/divisions-centers/crcbh/docs/NMBehavioralHealthNeedsAssessment2017_Online.pdf.
[82] *New Mexico Behavioral Health Needs Assessment*, by Deborah Altschul and Jessica Reno, UNM Health Sciences Center, January, 2017.
[83] NM DOH IBIS data on behavioral health, https://ibis.health.state.nm.us/indicator/.
[84] Economic impact of untreated mental and substance use disorders has been well-documented by the U.S., *Health Care and Health Systems Integration, and the 2013 National Survey on Drug Use and Health (NSDUH) – 2013*, Substance Abuse and Mental Health Services Administration (SAMHSA), https://www.samhsa.gov/health-care-

Figure 44
Behavioral Health Indicators in Santa Fe County

	SFC	NM Avg	Years	Comparisons
Alcohol related deaths	55.2	57.2	2011-2015	13 counties higher rates; 9 lower; 11 similar
Alcohol related chronic disease deaths	24.7	25.2	2009-2013	
Alcohol related injury deaths	27.3	27.0	2009-2013	
Deaths due to drug overdose	32.0	24.7	2011-2015	5 counties higher rates; 19 lower; 9 similar
Adult suicide deaths	20.9	21.2	2011-2015	
Youth suicide deaths	19.6	14.9	2009-2013	
Self-reported frequent mental distress	16.70%	18.10%	2012-2014	

Source: DOH IBIS

Some behavioral health risk factors are measured through the Behavioral Risk Factor Surveillance System. Figures 45 and 46 represent just two of the large number of maps developed by the New Mexico Community Data Collaborative (NMCDC)[85] and provide some key behavioral health snapshots of Santa Fe County risk factors by area. Figure 45 shows mental distress reported by those in census tracts with higher proportions of individuals living in poverty or with low incomes and higher proportions of racial and ethnic minorities (largely non-Whites). Figure 46 shows binge drinking rates reported in critical high-risk neighborhoods in the County. New research shows that County-level poverty rates are associated with higher rates of suicide and alcohol use.[86]

health-systems-integration; *Healthy People 2020*, U.S. Department of Health and Human Services; "The Neglect of Mental Illness Exacts a Huge Toll, Human and Economic," Editors, Scientific American, 2002; Disease Control and Prevention's "Burden of Mental Illness," https://www.cdc.gov/mentalhealth/basics/burden.htm; "What's the True Cost of Untreated Mental Illness?" by Bridget McCandless, MD, 2014, *Health Care Foundation of Greater Kansas City*; American Psychiatric Association, Alliance of Community Health Plans, Voices for Children, managed care organizations like the Managed Markets Network, and many others.

[85] See www.nmcdc.maps.arcgis.com/home/index/html

[86] Kerr, W. C., Kaplan, M. S., Huguet, N., Caetano, R., Giesbrecht, N., & McFarland, B. H. *Economic Recession, Alcohol, and Suicide Rates: Comparative Effects of Poverty, Foreclosure, and Job Loss*. American Journal of Preventive Medicine, 52(4), 469-475. doi:10.1016/j.amepre.2016.09.021

Figure 45
Mental Distress Among People in Areas with Largest Concentrations of Poverty and Non-White Racial/Ethnic Populations

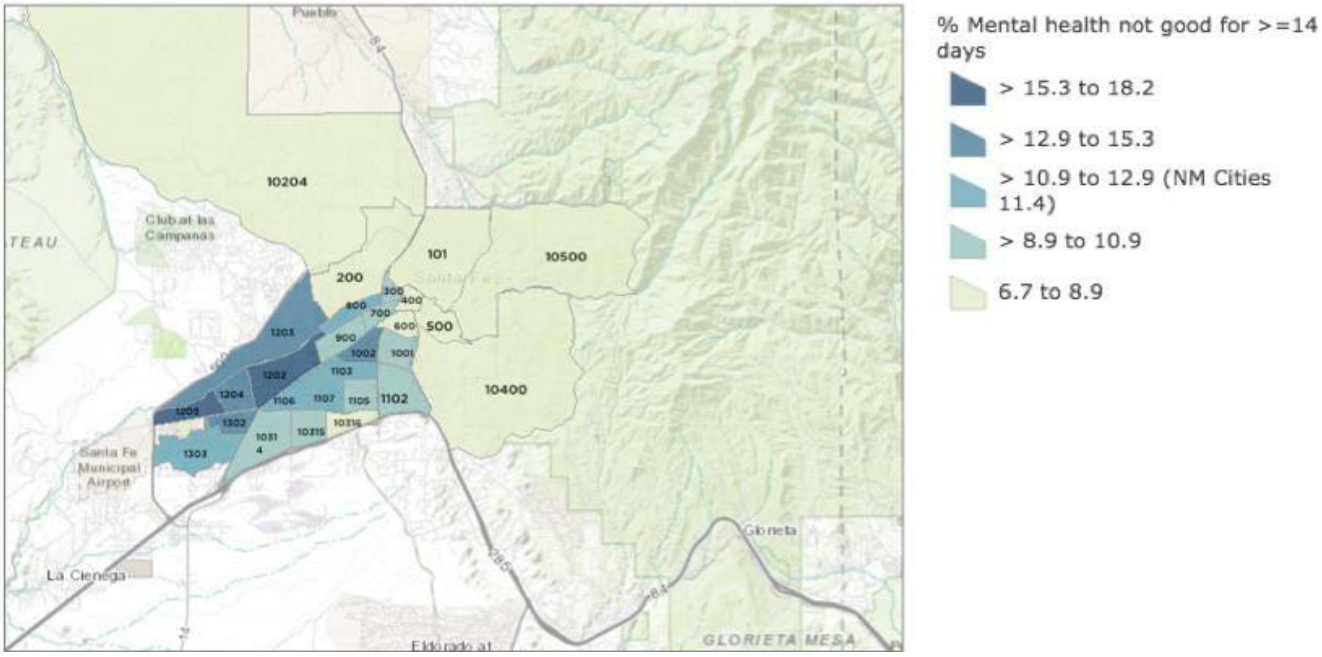
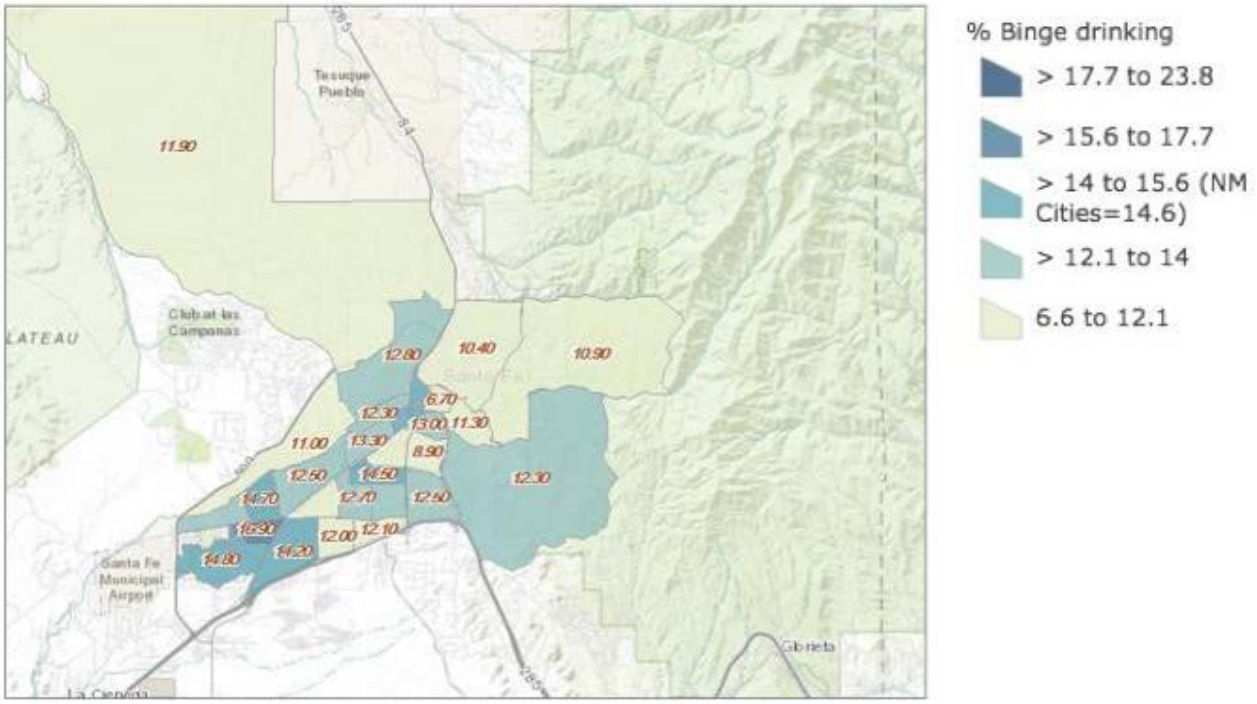


Figure 46
Binge Drinking in Areas with Higher Proportions of People Living in Poverty or with Low incomes



Unfortunately, the behavioral health system in Santa Fe County and throughout the state has experienced a combination of disruption, funding shifts, and underfunding for many years.[87] A total of 15 behavioral health providers experienced significant waves of change and closures due to State of NM decisions during 2013 – 2014. The resulting loss of specialized providers and funding changes were disruptive for many community members in services at the time and seeking services subsequently. The system continues to be challenged, even as the level of disruption has abated. Some of the larger Santa Fe County providers and federally qualified health centers (FQHCs) have stepped in to help meet the significant behavioral health needs of County residents. However, like other jurisdictions, SF County is seeing significant homeless populations with behavioral health needs and high use of the County jail and local hospital emergency departments for persons with behavioral health issues that could and should be served sooner and with better results.

The State's Medicaid expansion provided needed health and behavioral health care to many more New Mexicans. Yet, some structural gaps still exist, including longstanding provider requests for clarification and expansion of Medicaid funding for case management beyond the Core Service Agencies allowed to bill for Comprehensive Community Support Services (CCSS). However, HSD has needed to carefully ration limited resources due to the inability of the State Legislature and the Governor to agree on sources for new revenue. As a result, the State's portion of the cost burden expands each year, and managing these costs by reducing costs in other more intensive levels of care is difficult at best. For the County, additional funding for critical community support and treatment services could have a significant positive impact on other County costs such as costs of incarceration and law enforcement.

Behavioral risks in the County include the fact that addiction, like many other chronic diseases, has high recidivism and relapse rates, a response to which must be built into the service delivery system without moral judgments. These relapses can be frustrating and costly for the individual, their family, service providers, policymakers and the public at large. Santa Fe County has over twice the number of annual drug overdose deaths compared to state and national averages.[88] Though efforts are underway to help address this phenomenon, such as the distribution of naloxone through first responders and the Santa Fe Public Schools, continued substance use prevention and access to quality BH treatment is absolutely critical. Untreated trauma and exposure to violence continue to plague the community, while significantly impacting the health and well-being of County residents. Efforts to further inform and educate the local healthcare workforce (and population as a whole) on how trauma and violence impact physical, emotional, and behavioral health are critical to creating a healthy and thriving community.

2. CSD's Current Efforts and Challenges

CSD has undertaken significant initiatives in the behavioral health arena. These include:

[87] *Parity or Disparity: The State of Mental Health in America 2015*, Mental Health America reports New Mexico as one of the states with the highest level of need, and lowest level of access with respect to behavioral health services, and with an overall ranking of 46th among 51 states and territories ranked. The disparity between need, services, access, and funding represent the key elements considered. *The Behavioral Health Needs and Gaps in New Mexico* report, P.S. Hyde and the Technical Assistance Collaborative, 2002, demonstrated that 15 years ago, approximately 400,000 individuals in the state suffered from some form of behavioral health disorder, using complex multi-factoral analysis. SAMHSA and the U.S. Surgeon General indicate this figure could be as high as 30 percent or over 41,000 individuals in Santa Fe County today. Given the high proportion of behavioral health risks in the County, combined with the disproportionate impact of poverty, race, ethnicity, and other social determinants, the target population group needs well-funded, consistent and well-integrated behavioral health services.

[88] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- *Mobile Crisis Response Team (MCRT)* – A partnership with Presbyterian Medical Services to reduce suicide and escalation of mental health crises. First responders and community agencies access a team of mental health professionals to de-escalate the situation on site. The MCRT conducts extensive follow up and linkage to needed behavioral health services post-crisis.

- *Residential treatment for individuals with substance use disorders* – Thirty-day stays at Santa Fe Recovery Center for lower-income Santa Fe County residents.

- *Medication assisted treatment (MAT)* – A coordinator for La Familia Medical Center's outpatient Suboxone treatment program serves pregnant women and their partners as well as all community members, and a Behavioral Health Peer Support Coordinator serves County residents in the Suboxone program at the Pecos Valley Medical Center.

- *Behavioral health navigation services* – Support for community service agencies, including SF City Fire Department's MIHO program, Life Link, area shelters and others to connect residents who have severe mental illness and/or substance use disorders with needed treatment and social services.

- *Coordination for overdose prevention coalition* – In partnership with Santa Fe Public Schools, Santa Fe Prevention Alliance, and Santa Fe Opiate Safe (SOS), the SOS Coordinator brings together stakeholders including medical providers, first responders, public schools, and community members to combat the overdose epidemic via the CDC's three evidence-based practices: MAT, naloxone to prevent death from overdoses, and changing prescriber behavior.

- *Naloxone education and distribution via first responders, probation and parole, schools, and community organizations* – Harm reduction specialist with SOS (see above) trains first responders, school and community agency staff, and frontline community members on overdose prevention, distribution of nasal Narcan, and tracking use and reversals County wide.

- *Support for Corrections re-entry program* – To reduce recidivism, re-entry specialists enroll inmates in Medicaid and navigate motivated inmates with mental illness and/or substance use problems into outpatient or inpatient treatment on release. A third re-entry specialist has been hired to ensure connection to community resources upon release.

- *Funding for detoxification services* – CSD funds detoxification services including support for an enhanced social detoxification program.

- *DWI leadership and program services* – CSD leads the County's efforts to reduce the incidence and consequences of individuals driving while intoxicated.

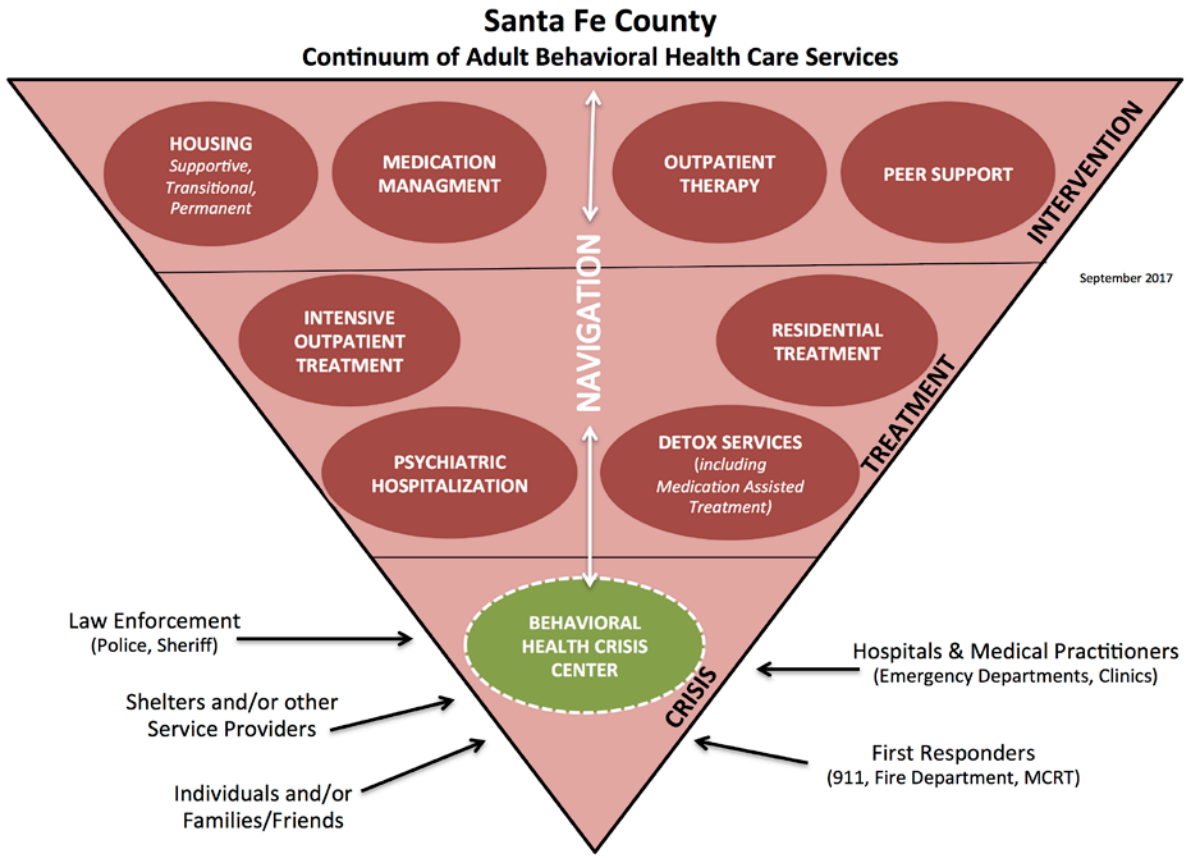
A new County initiative is the Behavioral Health Crisis Center, a collaborative, strategic, and innovative approach working with law enforcement, first responders, and providers to address a complex and challenging set of needs. In November 2016, Santa Fe County voters overwhelmingly approved a capital bond issue to provide funding for a facility in Edgewood to help address health issues in that area and to provide funding for a County-owned building to house this new crisis center to address the needs of individuals experiencing a behavioral health crisis, their families, providers, first responders, and the community at large. A majority of

voters also voted affirmatively on an advisory question to support the County Commission imposing an additional gross receipts tax to address behavioral health service needs, including operation of this crisis center.

As a result, on June 27, 2017, the Santa Fe County Commission approved an increase of one-eighth of a cent to the County's Gross Receipts Tax beginning in January 2018. These actions will provide approximately $2 million in capital funds and $1.5 million in operating funds for a new behavioral health crisis center. CSD is currently working with providers, law enforcement and other first responders, persons with lived experience of behavioral health conditions, and their families to plan this center and the services to be offered. One critical recent action was to move an existing contract for a social detox center from the local hospital to the Santa Fe Recovery Center, a specialty addiction treatment provider, which is enhancing those services with more medical supervision and supportive services.

These efforts come at a time when preliminary analysis by the Santa Fe Community Foundation of a community effort funded by the City called Law Enforcement Assisted Diversion (LEAD) to help keep drug users out of jail by offering counseling and support is showing success and reducing taxpayer costs for some offenders.[89] Partnering by CSD with LEAD and other local programs has resulted in Figure 47 showing how a new crisis center would work within the larger community-based system of services.

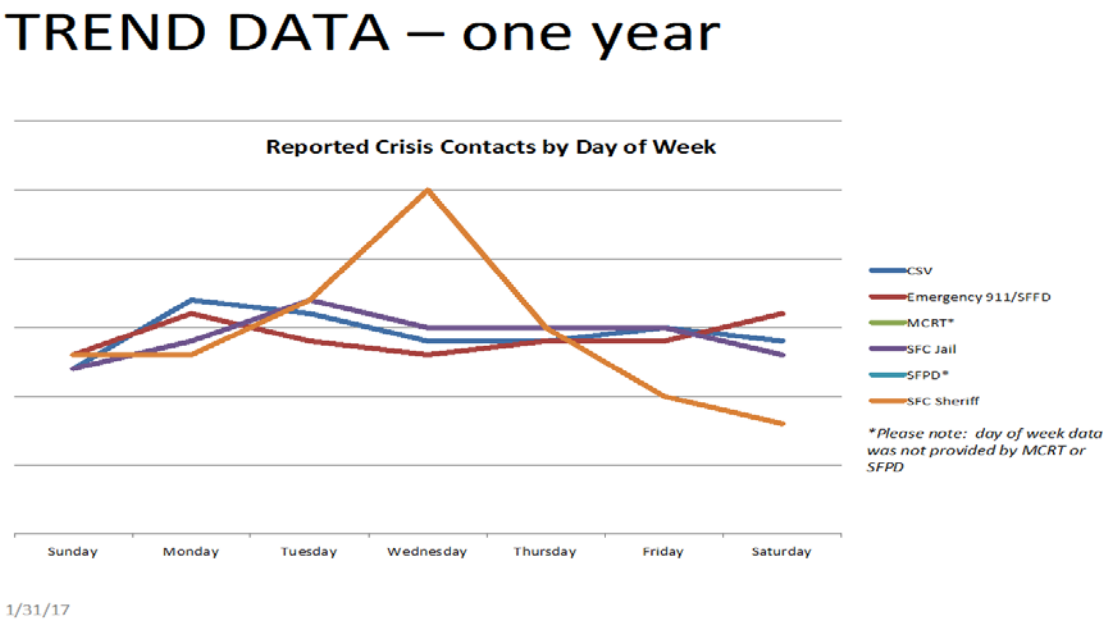
Figure 47

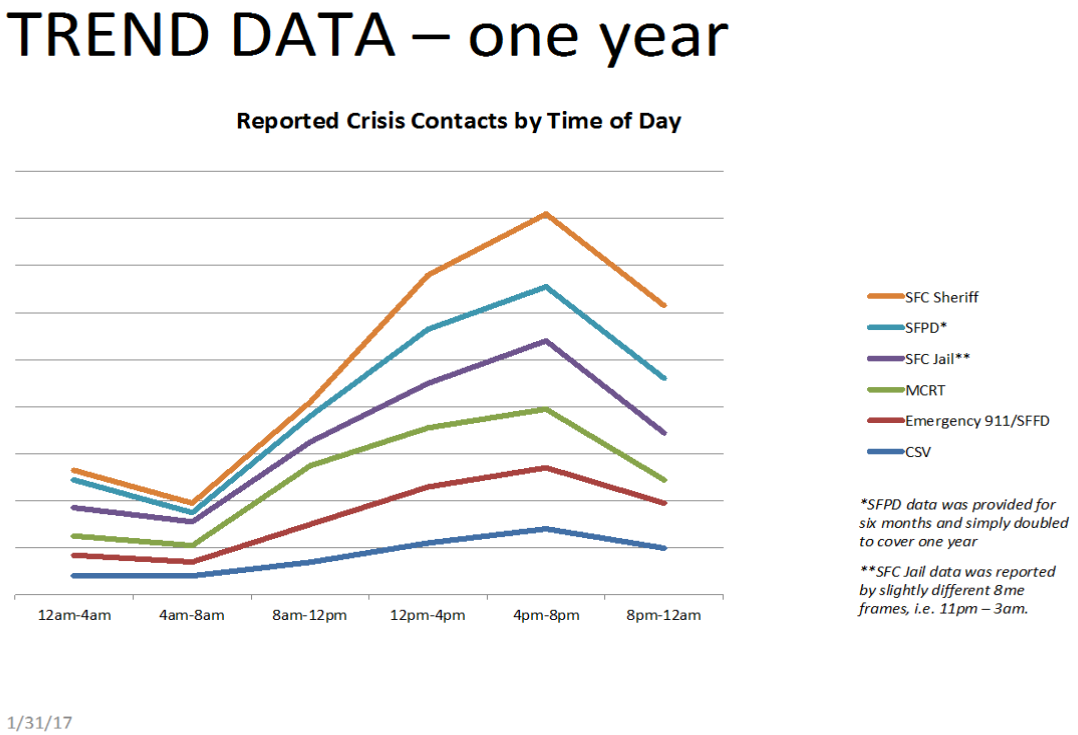


[89] *Diversion Program Limits Jail Time, Saves Tax Money*, Santa Fe New Mexican, May 30, 2017.

Data provided by first responders and community providers showed the following days, time of day, and volume (a duplicated count) of behavioral health related crisis calls and events.

Figure 48
Santa Fe County First Responders and Provider Behavioral Health Crisis Calls





3. Prevention

In addition to planning for and dealing with behavioral health crises – SF County, especially through its Health Policy and Planning Commission (HPPC) – has recognized the importance of planning for prevention efforts across the lifespan. While prevention can have a definite impact on health conditions over a lifetime, behavioral health is probably the most susceptible to positive impact from prevention activities. For example, understanding the role of and addressing the rate of teen pregnancy can have an impact on the health of both parents as well as of the child and of society. The teen birth rate in NM for 15 – 19 year olds in 2015 was 4th highest in the nation at 34.6 births per 1,000 girls ages 15 – 19 compared to 22.3 for the country as a whole.[90] The number of births per 1,000 girls was lower in 2014 in Santa Fe County than in many other NM counties at 23.7 compared to 34.2 in the state as a whole.[91]

With the increasing understanding of the role of adverse childhood events (ACEs) in current and future health and behavioral health issues,[92] especially for youth and women, and the increased understanding of the role of trauma of all sorts on the behavioral health (mental illness and substance use) of individuals and their families and communities,[93] it is increasingly important to address these issues early and in a trauma-informed manner.[94] Data are not readily available to understand the amount of trauma or ACEs in SF County populations compared to the rest of the state or to the nation. However, conditions prevalent in SF County, including the proportion of poverty, individuals with immigration experiences, indigenous populations, veterans,[95] incidents of domestic violence, and proportion of children who are victims of child abuse and/or neglect,[96] trauma is definitely an issue for most of those who need community-based and publicly supported services the most.

Intervening early and in appropriate and evidence-based ways is critical to preventing later problems and higher cost services. An important approach to dealing with at-risk children and families is home-visitation programs,[97] including screening for substance use and mental health issues. Increasingly, research is showing that early and appropriate intervention for First Episode Psychosis (FEP) experienced by youth and their families can prevent the dysfunctionality often associated with untreated early psychosis.[98] Prevention efforts at younger

[90] The National Campaign at https://thenationalcampaign.org/data/compare/1701.
[91] NM IBIS at https://ibis.health.state.nm.us/indicator/complete_profile/BirthTeen.html.
[92] SAMHSA at https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences and CDC at https://www.cdc.gov/violenceprevention/acestudy/.
[93] SAMHSA at https://www.samhsa.gov/capt/tools-learning-resources/trauma-adverse-childhood-experiences-implications-preventing-substance and https://www.samhsa.gov/trauma-violence.
[94] SAMHSA at https://knowledge.samhsa.gov/resources/trauma-informed-care-opportunities.
[95] NM as a whole had about 9.6 percent of its population in 2014 were veterans. Santa Fe County was very comparable at 9.4 percent with 17 counties having a higher percentage than Santa Fe. Nationally, about 7.6 percent of the population was veterans in 2014. NM was 13th highest in the country. See NM Department of Workforce Solutions Veterans Profile at https://www.dws.state.nm.us/Portals/0/DM/LMI/2015_Veterans_Profile.pdf.
[96] NM IBIS at https://ibis.health.state.nm.us/indicator/complete_profile/ChildAbuse.html.
[97] U.S. Department of Health and Human Services, Administration on Children and Families, at https://homvee.acf.hhs.gov/.
[98] See the National Institute of Mental Health (NIMH) at https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml for a description of the latest research on FEP; https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml for a description of RAISE, an FEP specific treatment intervention now funded in all states and territories through SAMHSA block grant dollars; see https://blog.samhsa.gov/tag/raise/#.WT3BsevyvZ4.

ages to address what is called the prodromal syndrome[99] are showing great promise in helping to stop or mediate the negative life course of psychotic disorders. Likewise, school-based and home-based prevention programs for problematic behaviors (for example, the Good Behavior Game[100]) and substance abuse and substance use disorders (for example positive parenting and learning good decision-making) show great promise.[101] Unfortunately, prevention efforts are not always well-understood and are not often well-funded. They are frequently considered expendable or less of a priority when resources are tight. In SF County, six schools have adopted the Good Behavior Game with more scheduled to bring up the program for elementary ages in the next school year. The Santa Fe Prevention Alliance[102] brings together a coalition of over 40 community organizations to address substance use in the community by taking a prevention approach with youth. Prevention programs such as these will need additional support to impact the behavioral health issues impacting the County's overall health and well-being.

D. Goal 7: Healthy Food Consumption

In recognition of the importance of food security and healthy food consumption described in Section III of this report, CSD has committed in its Health Action Plan to increase the consumption of healthy foods specifically, the percentage of adults and adolescents who consume five or more fruits and vegetables per day. CSD has also committed in the future to reducing the level of Type 2 diabetes among adults, and obesity as measured by Body Mass Index. The County pursues these goals by advocating for fresh local fruits and vegetables for schools and supports community gardens and farmers' markets, especially for seniors and especially in areas where large numbers of low-income individuals live. The County also works hard to provide nutritious meals for seniors through its senior center programs, and has increased its use of fresh rather than frozen foods significantly. Santa Fe County is a supporter and active participant of the Food Policy Council.[103]

Food security for all County residents will take more resources including addressing transportation issues, the location of food banks and fairly priced commercial food resources in areas of the County known as food deserts, and nutrition education for children, youth, and families, including how to grow, purchase, and use inexpensive foods for appealing food preparation. The state offers a number of such programs through the Supplemental Nutrition Assistance Program (formerly known as the food stamps program). Working with providers throughout the community, a comprehensive mapping of County food assets would help address this critical health goal for County residents.

E. Goal 8: Fall Injury Death Rate and Serving Older Adults at Risk

1. Service Challenges and Funding Issues for Seniors

[99] I.e, Prodrome syndrome is the period pre-psychotic break, when symptoms are vague and easy to miss, especially in teen years. See, Molly Larson, Elaine Walker, and Michael Compton; *Early Signs, Diagnosis and Therapeutics of the Prodromal Phase of Schizophrenia and Related Psychotic Disorders*; 2010; at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2930984/.
[100] See Paxis Institute at http://goodbehaviorgame.org/.
[101] See SAMHSA prevention programs at https://www.samhsa.gov/prevention and https://www.samhsa.gov/prevention/samhsas-efforts. See also, National Institute on Drug Abuse (NIDA) at https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/acknowledgments.
[102] See http://santafepreventionalliance.com/.
[103] See the County's Health Action Plan report card at http://www.santafedatahub.org/santa-fe-county-health-action-plan-report-card.html.

The fall injury death rate reports falls or health complications that result from falls and lead to death, which primarily occur among older adults. It serves as one indicator of the health and wellbeing of older adults, and can point to a cluster of other related needs that require attention. Santa Fe County's fall rate is greater than the state's average (90.3 per 100,000 compared to 80.8).[104] Given the fast growing older adult population in the County, the gap is likely to continue to widen.

Alzheimer's disease is another major health challenge for older adults, with limited information available through the NM DOH IBIS system. The demographic trend data indicate since the Age Wave for the county is faster and deeper than for the state at large (which places the state fourth in the country in terms of older adults by 2030), the possibility of Alzheimer's disease, falls, and other older adult specific conditions as being even more severe in Santa Fe County in the next 10 to 20 years.

Given the demographic trend, or "Silver Tsunami," described in Section II of this report, the needs and health risks faced by older adults will become a key concern in future years. Health disparities and lack of access to many types of care among poor and limited income older adults will continue to grow and may be an overwhelming issue for seniors and their families if not planned for now. As indicated earlier in this report, older adults fall into three primary categories: young old (ages 55-69); middle old (70-84); and old old (85 and older). The older adult age group in general is the fastest growing cohort in NM, with the old old the fastest growing subcategory. The data narrative section describes Santa Fe County's growth rate of older adults is larger and faster than the growth rate in the State as a whole. This is juxtaposed against a service delivery system that is comprised of Agency on Aging socially funded services (e.g., senior centers, meals on wheels, etc.), and Centers for Medicare and Medicaid funded healthcare services.

Community-based senior centers provide an excellent mix of services for older adults of all ages and income levels and are a resource of core nutritional, transportation, and wellness programs with other services brought in to meet the needs of communities served as budgets allow. Senior centers supported by the County and the City of Santa Fe are listed in Figure 49.[105]

Figure 49
Senior Centers Supported by Santa Fe County and the City of Santa Fe

Within Communities in Santa Fe County

- Edgewood Senior Center (Edgewood, NM)
- El Rancho Senior Center (El Rancho, NM)
- Santa Cruz Senior Center, aka Abedon Lopez Community Center (Santa Cruz, NM)
- Chimayo Senior Center, aka Bennie J. Chavez Community Center (Chimayo, NM)
- Eldorado Senior Center, aka Ken and Patty Adam Center (Eldorado in Santa Fe, NM)

Within the City of Santa Fe

- Luisa Senior Center (Luisa St)
- Mary Ester Gonzales Senior Center (Alto St)
- Pasatiempo Senior Center (Alta Vista St)
- Ventana de Vida Senior Center (Alta Vista St)
- Villa Consuelo Senior Center (Camino Consuelo St)

Medicaid pays for limited amounts of home care services through the NM Human Service Department's Community Benefit Services (formerly Agency Based Community Benefit Program). These include a mix of services to help individuals who are elderly remain at home,

[104] NM DOH IBIS data, 2011-2015.
[105] See https://www.santafecountynm.gov/community_services/seniors for more information about SF County senior centers and services; and https://www.santafenm.gov/division_of_senior_services for more information about SF City senior centers and services.

including personal care services, homemaker services, home health aides, private duty nurses, respite care, and other in-home care. Unfortunately, these services rarely meet an individual's complete needs and most of these same services are not available to older adults with incomes too high to qualify for Medicaid yet with personal or household budgets too tight to afford to pay for in-home services. Older adults on limited and fixed incomes find the review of care options a sobering experience. Ongoing payments for in-home care can devastate the assets of many older adults, even those who have substantial savings. People who are aging or have aging spouses with in-home care needs find they will have to spend down their assets in order to qualify for Medicaid. Older individuals sometimes choose a reverse mortgage before taking the painful step of acknowledging their reduced circumstances and impoverishment created by outliving available resources. Without key elements of needed care during this time, health can decline and resources become even more limited before help is provided.

Caregivers also find the resource issue a painful one. When an elderly parent or sibling's care is beyond what can be provided in the home, family members often find themselves and their own resources stretched to help provide the care for an aging family member who has modest resources such that Medicaid eligibility is not possible and yet are inadequate for the care needed in advanced years or due to significant health conditions. Paid in-home caregivers are also inadequate given the numbers of aging individuals and younger individuals in the workforce. These issues will only get worse as the County's population trends continue.

Figures 50a and b show that senior services, like other critical services, are not always located in areas of the County with the highest needs.

Figure 50a
Low-Income Seniors and Senior Service Providers by Area

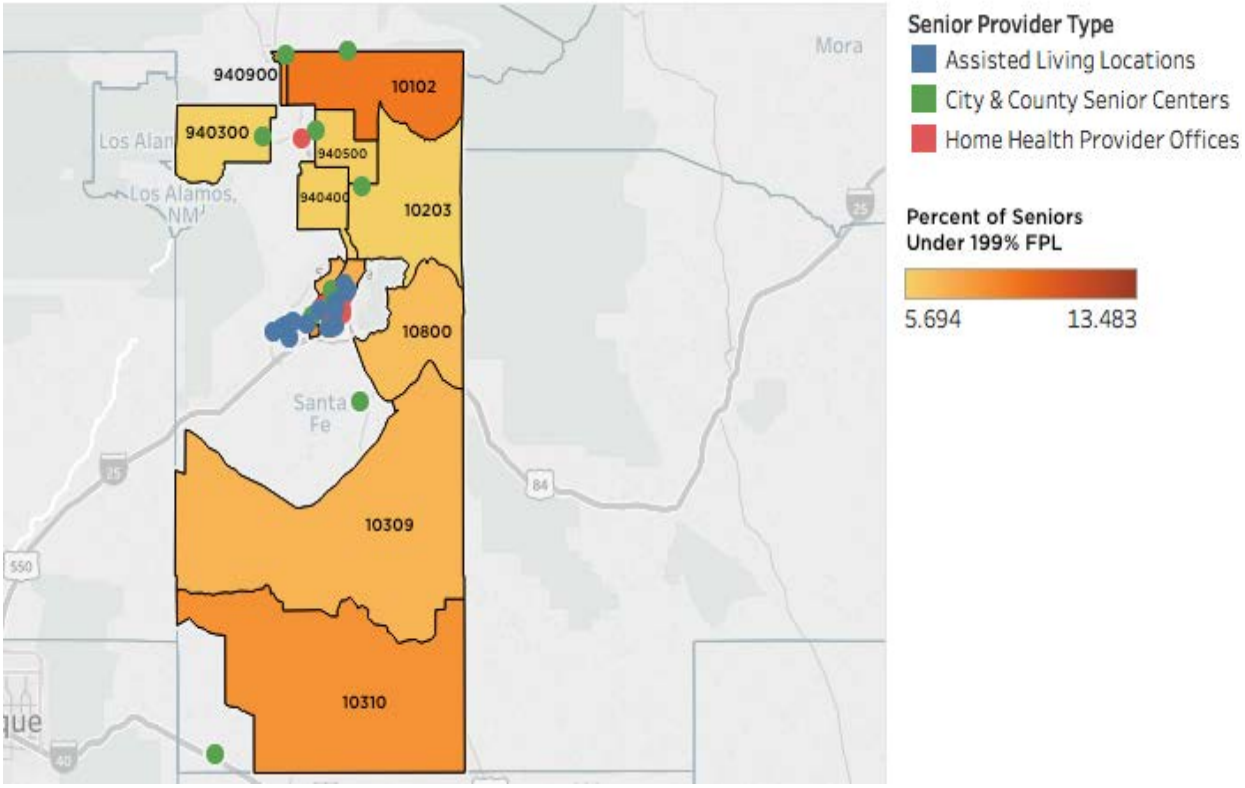
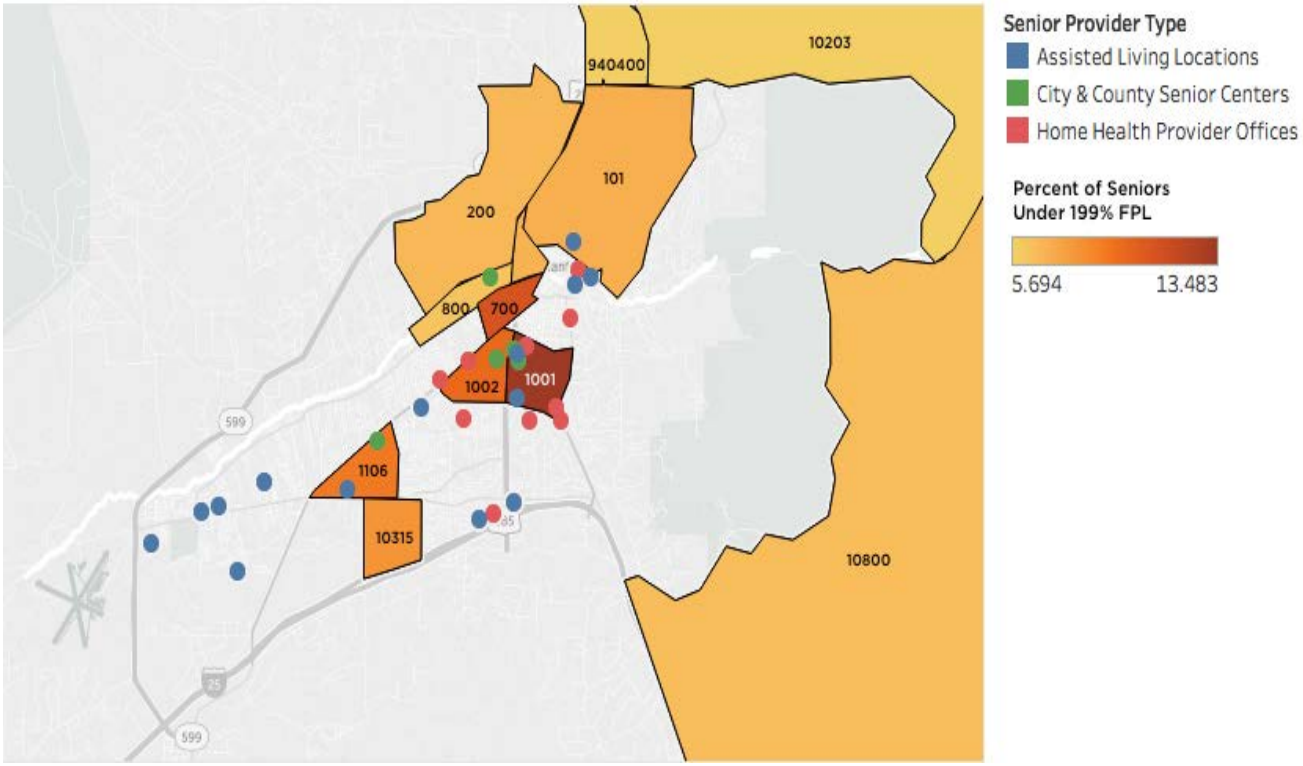


Figure 50b
Low-Income Seniors and Senior Service Providers by Area (City)



With the significant growth in persons who are elderly in Santa Fe County, and increasing needs among this population, only two nursing homes (Casa Real and Santa Fe Care Center) provide for rehabilitation and assisted living and accept Medicare and Medicaid, and they are both very poorly rated by the Centers for Medicare and Medicaid.[106] Non-medical home care is available to elderly individuals who are on Medicaid *and* who have significant health issues that create a situation where they have difficulties with multiple Activities of Daily Living (ADLs).[107] The State of New Mexico's Centennial Care insurers, or managed care organizations (MCOs), have care coordinators that handle screenings including Health Risk Assessments to determine if an elderly person qualifies for a range of Agency Based Community Benefit Services (ABCB). The ABCB services include personal care services, in-home nursing, home modifications, and a range of other services. However, these services are only available to people on Medicaid, including those who are dually eligible for Medicaid and Medicare. They are not available solely through Medicare.[108]

Non-Medicaid eligible elderly individuals who live on fixed incomes must budget carefully and

[106] https://www.medicare.gov/nursinghomecompare/results.html#loc=SANTA%20FE%2C%20NM&lat=35.6869752&lng=-105.937799; see also, Thom Cole, *Pair of for-profit nursing homes have long history of neglect*, Santa Fe New Mexican, July 22, 2017, at http://www.santafenewmexican.com/news/health_and_science/pair-of-for-profit-nursing-homes-have-long-history-of/article_88fd1b5f-41db-51eb-b3ca-35b3f3521067.html; and Thom Cole, *Federal government cracks down on troubled casa real*, Santa Fe New Mexican, September 3, 2017, at http://www.santafenewmexican.com/news/local_news/federal-government-cracks-down-on-troubled-casa-real/article_d3e9244e-0370-55a7-8874-a4f494477602.html; see also SF New Mexican, October 7, 2017.

[107] ADLs generally include self-care activities such as feeding ourselves, bathing, dressing, grooming, and transferring from one position to another, and may include working, homemaking, and some leisure activities.

[108] http://www.hsd.state.nm.us/providers/managed-care-policy-manual.aspx.

have few options for home-based care other than private pay. Therefore, many elderly individuals who find they are starting to need help at home defer the decision for financial reasons. Younger friends, neighbors and family members often help out around the house until life becomes increasingly difficult and fraught with risks. The five (soon to be six) CSD sponsored senior centers provide critical community support by offering meals and activities for older adults who are no longer as active as they were in earlier years but who are still very much involved in the community. As people begin to have significant physical limitations, they can face a period in their lives when ADLs are compromised and continuing to weaken. This is when people are most likely to fall, or face other health risks. However, since few in-home non-medical services are covered by Medicare, those least costly and most easy to develop care options get deferred, often at the expense of costly hospitalization and rehabilitation later.

Recent studies by the Urban Institute and the Kaiser Family Foundation show that the national percentage of older adults with disabilities and ADL limitations is increasing and will continue to increase. Given the demographics of this age group described in Section II or this report, Santa Fe County can expect even more drastic increases. The Urban Institute's testimony before the federal Commission on Long Term Care indicated that an increasing proportion of older adults on limited incomes are required to spend down assets in order to qualify for Medicaid, therefore a significant increase in spending down and Medicaid expenditures for critically needed nursing home care is projected for the coming years. Longitudinal studies by the University of Michigan show many older adults who end up spending down to qualify for Medicaid have had severely limited incomes for the decade prior to coming onto the program.[109] This means their needs for care are often more significant (and likely more costly) than they would have been had they received such assistance earlier. This represents a high-risk group of older adults who are in need and experience gaps in care, and are deferring services for approximately a decade during which time they are stretching and spending down their own limited resources.

A study by AARP in 2011 on Aging in Place found that 90 percent of older adults nationwide wish to remain in their homes as they age. They do not want to move into assisted living or nursing homes, and often seek in-home care services before choosing to leave their homes. Increasing numbers of older adults investigate options such as reverse mortgages to pay for costs of home care when limited budgets no longer suffice and to avoid leaving home and/or spending down to go into a Medicaid nursing home facility.[110] Santa Fe has a growing number of facilities that offer a combination of independent and assisted living, and in at least one case, the facility also offers nursing level of care if needed. However, these facilities are expensive and require significant upfront or move-in costs.[111] They also generally require moving out of a home and shifting to condo or apartment living. The only two facilities for low-income individuals are poorly rated by CMS and by former residents and their families.[112]

A growing number of non-medical home care services are available, but mostly for those able to self-pay. One important program provides non-medical home-based supportive services through volunteers for limited income senior adults who are the most elderly and frail (Coming Home Connection). This small non-profit has a few staff members who recruit and train volunteers who are each assigned an older adult to visit weekly. This important program provides quality supports for homebound elderly individuals, but is able to meet only a small fraction of the need.

[109] See http://www.urban.org/sites/default/files/publication/24456/904599-Income-and-Wealth-of-Older-Adults-Needing-Long-Term-Services-and-Supports
[110] See http://reversemortgagedaily.com/2011/12/21/aarp-survey-finds-90-of-people-65-want-to-stay-in-their-homes/
[111] See http://www.elcastilloretirement.com/ and http://www.montecitosantafe.com/ for two examples.
[112] See caring.com at https://www.caring.com/local/nursing-homes-in-santa-fe-new-mexico/; see also footnote 106.

The U.S. Centers for Medicare and Medicaid Services (CMS) report that Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) cover eligible home health services to include: intermittent skilled nursing care, physical therapy, speech therapy and occupational therapy. These services are usually covered for a limited period of time, often following an illness requiring hospitalization, or for a specific medical condition. Medicare provides coverage for certain types of durable medical equipment, sometimes for a limited period of time. Medicare does not cover 24-hour-a-day care at home, homemaker services, personal care non-medical services, or home delivered meals. Any services provided in the home must be ordered by a physician and coordinated through a home care agency.[113]

Those people who purchased long term care insurance in previous years may find such insurance an important resource for those who could afford this coverage. However, many long term care (LTC) plans are offered now with a wide-range of benefits. Some of these early plans were not quality products. In the past five years, many long term care insurance carriers have left the market, and others have significantly raised rates, making policies unaffordable for many. According to Consumer Reports, even high quality plans still have qualifying conditions, limitations, exclusions, and premium increases that make such policies an important but increasingly costly option for the last years of life.[114]

As indicated in Section II of this report, the US Census Bureau projects a 62 percent increase in the number of older adults in Santa Fe County between 2000 and 2030, when older adults will outnumber all people under the age of fifty-five.[115] A larger proportion of elderly individuals are married, widowed, and divorced than is found in the population at large. One in five older adults is widowed, and 35 percent of elderly individuals live alone. They report that "people over age 65 who live alone are at risk for social isolation, limited access to supportive services, and inadequate assistance in emergency situations." That is especially true for those who are "middle-old" (age 70 to 84) and "old-old" (age 85 and up). Older adults self-report their mental health status to be better on average than other age groups, but report physical health to be worse. However, suicide rates among older adults are some of the highest and depression is a serious health condition for this age group.[116] Figure 51 shows which payer sources cover services for seniors, along with gaps.

Figure 51
Services Available for Seniors by Public Payer Source

	Primary Care & Some BH	Dental	In-patient	Medical In-Home Care (Limited)	Senior Center Activities – Meals/Exercise /Transportation	Non-Medical In-Home Care	Assisted Living	Nursing Home
Medicare	X		X	X				
Medicaid	X		X	X		X		X
CSD HCAP	X	X	X		X			
Private Pay	X	X	X	X		X	X	X
City (Limited)	X				X	X		

[113] See https://www.medicare.gov/coverage/home-health-services.html.
[114] See http://www.consumerreports.org/cro/2012/08/long-term-care-insurance/index.htm.
[115] US Census Bureau as cited at *https://www.stvin.org/workfiles/pdf/9-2016Chip-Final-AD-Edit-v2.pdf*.
[116] See information at Suicide Prevention Resource Center at http://www.sprc.org/search/older%20adults; see also CDC at https://www.cdc.gov/aging/mentalhealth/depression.htm, and American Association for Marriage and Family Therapy, at https://www.aamft.org/iMIS15/AAMFT/Content/Consumer_Updates/Suicide_in_the_Elderly.aspx.

2. CSD's Current Efforts and Challenges

The County supports five senior centers and is scheduled to open a sixth senior center in 2018 off of Highway 14 to serve the communities of Cerrillos, Madrid, San Marcos, La Cienega, and Galisteo. The areas of the County with the highest concentrations of older adults living in poverty or with low incomes include North County, South County, and some census tracts within the City around Cerrillos Road. However, there are few services available in the areas with the highest proportion of low-income seniors except neighborhoods near Cerrillos Road, and many are not accessible for reasons outlined above.

CSD developed its first four-year *Senior Services Strategic Plan 2016 – 2020*[117] (SSSP) utilizing service data from FY 2013 to the time of the plan's development during FY 2016. This plan identifies the "Silver Tsunami" as an issue for SF County, quantifies many of the needs identified in this report, and indicates the following priority actions:

- Expand existing services in geographical areas with highest and growing demand;
- Improve operational efficiencies in order to leverage and maximize limited resources;
- Launch the new senior center on Highway 14 to serve the underserved population in this area; and
- Identify resources and develop systems to provide new services such as chore services and case management.

The SSSP makes recommendations and suggests strategies to decentralize services, reorganize senior center services (to maximize resources), and plan for growth (including adding the new senior center and new services as indicated above). The priority goals are to:

- Increase the number of seniors served through existing services;
- Increase seniors' consumption of healthy foods;
- Increase access to home-based support services;
- Reduce incidents of falls and fall-related injuries among seniors; and
- Increase seniors' social networking and physical activity levels.

The SSSP indicates the County will need to expand congregate and home-delivered meal and transportation services through senior centers five (5) to (ten) 10 percent annually to keep up with the demographic trend. However, funding through the federal Administration on Aging and the New Mexico's Aging and Long Term Services Department (ALTSD) is flat or decreasing, so CSD may be faced with increasing funding needs simply to meet future state and federal funding cuts and increasing need for services.

These priority actions, recommendations, and goals provide the right direction for the work of County government over the next few years to address the identified gaps. The current service delivery system has a range of care options for those on Medicaid; and a wide range of options for those who have the means to pay for their care. Those caught in the middle have few resources available to them for in-home care, assisted living, nursing home care, long term care, and respite services. These are among the most significant gaps in the service delivery system.

[117] This plan can be found at https://www.santafeCountynm.gov/media/files/SeniorServicesStrategicPlanFInal.pdf

F. Santa Fe County's Health Rankings

According to the Robert Wood Johnson Foundation ranking of counties based on a number of factors and various data sources, Santa Fe County fares better in some areas and worse in others compared to the nation as a whole and compared to other counties in New Mexico.[118] According to these data, Santa Fe County ranks third best in NM in terms of overall health outcomes and length of life, just after Sandoval and Los Alamos counties and just above Bernalillo County. Figure 52 shows some of these comparisons.

From these data, notable areas of concern for Santa Fe County, compared to NM as a whole, include low birthweight, excessive drinking, the number of mental health providers, the number of uninsured, high school graduation rates, air pollution, drinking water violations, and severe housing problems. Compared to the top performing counties in the nation as a whole, many other factors are areas of concern, including children in single-parent households, children in poverty, teen births, sexually transmitted infections, alcohol impaired driving deaths, access to exercise opportunities, food environment index, violent crime, education levels, dentists and physicians, and poor or fair health, and poor physical and mental health days. While Santa Fe County does well compared to the rest of New Mexico, it is clear from these data that the County as a whole could do better in a number of areas to improve the health of its residents and of the community as a whole.

[118] See http://www.countyhealthrankings.org/app/new-mexico/2017/rankings/santa-fe/county/outcomes/overall/snapshot. Note the data here may not be the same as other data in this report due to different time frames or different definitions.

Figure 52
Health Rankings for Santa Fe County Compared to New Mexico and the Nation[119]

Health Factor	Santa Fe County	Top U.S. Performers	New Mexico	Rank
Health Outcomes & Length of Life				3
Premature Death	7,200	5,200	8,200	
Quality of Life				5
Poor or fair health	17%	12%	20%	
Poor physical health days	3.7	3.0	4.1	
Poor mental health days	3.6	3.0	3.8	
Low birthweight	10%	6%	9%	
Addt'l Health Factors				2
Health Behaviors				2
Adult smoking	14%	14%	18%	
Adult obesity	14%	26%	24%	
Food environment index	7.0	8.4	6.3	
Physical inactivity	11%	19%	19%	
Access to exercise opportunities	81%	91%	73%	
Excessive drinking	15%	12%	14%	
Alcohol-impaired driving deaths	23%	13%	32%	
Sexually transmitted infections	420.6	145.5	554.3	
Teen births	39	17	51	
Clinical Care				3
Uninsured	20%	8%	17%	
Primary care physicians	960:1	1,040:1	1,320:1	
Dentists	1,200:1	1,320:1	1,620:1	
Mental health providers	160:1	360:1	280:1	
Preventable hospital stays	20	36	43	
Diabetes monitoring	84%	91%	73%	
Mammography screening	62%	71%	57%	
Social & Economic Factors				6
High school graduation	69%	95%	70%	
Some college	58%	72%	59%	
Unemployment	5.4%	3.3%	6.6%	
Children in poverty	19%	12%	27%	
Income inequality	4.9	3.7	5.2	
Children in single-parent households	38%	21%	40%	
Social associations	9.4	22.1	8.2	
Violent crime	314	62	590	
Injury deaths	94	53	97	
Physical Environment				18
Air pollution – particulate matter	6.5	6.7	6.4	
Drinking water violations	Yes			
Severe housing problems	22%	9%	18%	
Driving alone to work	75%	72%	80%	
Long commute – driving alone	25%	15%	25%	

[119] The Foundation also provides a margin of error for each of the factors. That data is not included here, but can be found on the website noted in the previous footnote.

HIGHLIGHTS – HEALTH RISKS (1)

1. *Overall, Santa Fe County ranks higher than most other New Mexico counties on many health risks and health outcomes, but lower than the highest ranking counties in the U.S.*
2. *Gaps in services needed but not covered as well as provider locations, hours of operation, and staffing capacities impact access to care.*
3. *CSD has prioritized lack of insurance, low birthweight babies, alcohol and overdose related deaths, youth suicide, and healthy food consumption as critical service needs. Falls and injury death rates and lack of access to primary care are additional risks in the County.*
4. *The CSD Health Care Assistance Program provides critically needed healthcare assistance for people in need when no other payer source is available.*
5. *Medicaid is the single largest payer of mental health services, and one of the largest for addiction services, and therefore often drives how services are structured and provided. Certain types of behavioral health care are not reimbursed by Medicaid, are heavily rationed, or are reimbursed at such low rates providers must limit or shift service activities to remain viable.*
6. *Disruption to the State's mental health system and pressure on the State's Medicaid system has resulted in inadequate funding and service capacity throughout the State, including in Santa Fe County.*
7. *Routine and preventive dental care is often not covered in most health insurance plans, including Medicaid, especially for adults.*
8. *Santa Fe County has a high rate of low birthweights compared to the State as a whole and to the nation.*
9. *The recently exacerbated wave of fear among immigrant communities inhibits their access to food, public benefits, transportation, and health care.*
10. *Comprehensive food assets mapping is needed to provide information and assist with coordination and advocacy efforts.*

HIGHLIGHTS – HEALTH RISKS (2)

11. *Santa Fe County's fall rate is greater than the State's average and will likely increase with the County's rising older adult population*
12. *Santa Fe County has a higher rate of alcohol and drug related deaths than the state as a whole; higher rates of binge drinking and mental distress are associated with areas in the County with higher poverty rates.*
13. *The County is estimated to have about 25,000 adults with any mental illness, of which an estimated 6,500 adults experience serious mental illness. Only about 11,000 of these adults receive needed treatment.*
14. *About 780 of the 2,300 adolescents experiencing a major depressive episode receive needed treatment, and only about 1,000 of the 12,000 individuals needing treatment for substance use disorders receive that needed treatment.*
15. *Only about 1,000 of the 10,000 County residents who need treatment for substance use disorders receive it.*
16. *Prevention efforts, including early screening and home-visitation programs for at-risk children and families, as well as early intervention for youth at risk of or experiencing first episode psychosis, hold great promise and need to be expanded.*
17. *The County's work to fund a mobile crisis response team and create a behavioral health crisis center hold great promise and have significant community support.*
18. *Even though most adults wish to remain at home as they age, Medicaid and Medicare provide limited in-home medical or non-medical support for seniors and persons with disabilities. Without family support or ability to pay privately, in-home services and supports are often not available. The availability of in-home service providers is inadequate to meet the current and future need.*
19. *Only two nursing homes in Santa Fe County accept Medicare and Medicaid, and both are poorly rated by the Centers for Medicare and Medicaid.*
20. *Senior centers supported by the County and the City offer critically important food, transportation, and social activities for the County's seniors. The County's Senior Services Strategic Plan needs to continue and be fully implemented.*

IV. HEALTH CARE PROVIDER AND SYSTEM ISSUES

Because of its diversity and population needs, the State and the County have developed a system of primary care, behavioral health care, and public health responsive to many of the needs identified in this report. The Community Health Center (CHC) network,[120] relationships of providers with teaching institutions and hospitals, and community-rooted advisory groups such as the Health Policy and Planning Commission are extremely important and vibrant but limited resources in SF County. Challenges exist in health workforce shortages and structural and systems issues shaped by policy and funding. This section describes some of these challenges.

A. Health Professional Shortages

New Mexico has significant shortages in health care providers, as measured by the Health Resources and Services Administration (HRSA) in its Health Professional Shortage Areas (HPSA) data reports.[121] Note that HRSA defines an HPSA as a geographic area, population group (such as a low-income population), or facility (such as an FQHC) designated by HRSA as having shortages of primary medical care, dental or mental health providers. Santa Fe County has significant provider shortages in primary care, behavioral health, institutional care, hospital care, dental care, and care for specific population groups (for example, geographical areas, poverty designations, and Native Americans). Figure 53 shows examples of HPSAs in SF County. HPSA shortages are rated on a scale of 1-25, based upon the severity of the shortage. Ratings above 10 indicate significant issues; ratings from 15 to 20 indicate severe issues.

Figure 53
Health Professional Shortage Area Designations in Santa Fe County with Ratings

HPSA Name	Discipline Class	Designation Type	Score
Santa Fe PHS Indian Hospital	Dental Health	Indian Health Service Facility	20
La Familia Medical Center	Mental Health	Comprehensive Health Center	19
Santa Fe PHS Indian Hospital	Mental Health	Indian Health Service Facility	18
La Familia Medical Center	Primary Care	Comprehensive Health Center	17
La Familia Medical Center	Dental Health	Comprehensive Health Center	17
Santa Fe IHS Hospital	Primary Care	Indian Health Service Facility	16
Cerrillos/Madrid/Edgewood	Primary Care	HPSA Geographic	16
Low-Income - Santa Fe County	Mental Health	HPSA Population	15
Penitentiary of New Mexico	Primary Care	Correctional Facility	12
Penitentiary of New Mexico	Mental Health	Correctional Facility	12
Santa Fe Recovery Center	Mental Health	Other Facility	12
Penitentiary of New Mexico	Dental Health	Correctional Facility	9
San Ildefonso Pueblo Health Program	Primary Care	Native American Tribal Population	7
Tesuque Pueblo Health Program	Primary Care	Native American Tribal Population	7

[120] See https://findahealthcenter.hrsa.gov/index.html# for a map of CHCs in SF County. For a good description of a federally qualified health center (FQHC) and other types of community health centers, including rural health clinics, see http://www.ncsl.org/portals/1/documents/health/CHCPrimer811.pdf.

[121] From HRSA's data warehouse on HPSAs; NM data dates range from 1979 to 2017. Database reflects periodic updates rather than a set publication date.; see https://search.hrsa.gov/search?q=health+professional+shortages+santa+fe+County&btnSearch=SEARCH&site=datawarehouse&output=xml_no_dtd&client=datawarehouse&lr=lang_en&proxystylesheet=HDWRedesign&oe=UTF-8&ie=UTF-8&ud=1

Shortages of health care mid-level professionals (nurses, physician assistants) exist in most NM communities, and certainly in SF County. Access to primary care has become increasingly difficult nationally since the 1960's, and SF County has experienced similar growing difficulties. Physician shortages are primarily due to: increased numbers of retirements, the growth and aging of the nation's population, and a reduction in the number of medical students accepting placements in primary care residency programs. Community Health Centers struggle to proactively plan to address professional staff recruitment and retention issues, which disproportionately impact health organizations serving persons with limited incomes, and migrant/immigrant communities, often located in communities with few resources and high proportions of medically underserved and at-risk populations.[122] According to Data USA, the proportion of various types of providers to population in Santa Fe County are as follows:

- Primary Care – 1 To 106
- Dentists – 1 To 85
- Mental Health – 1 To 652
- Other – 1 To 87

According to the CDC, in 2012, nationally 46.1 primary care physicians and 65.5 specialists were available per 100,000 population. Compared with the national average, the supply of primary care physicians was significantly lower in NM at 36.2 per 100,000 population, just slightly higher than Georgia, Mississippi, Nevada, and Texas.[123] According to the Kellogg Foundation, NM has only 71.5 percent of its needed mental health workforce,[124] and only 33.36 percent of the dentists needed.[125] Yet, according to the American Dental Association, dentists in the U.S. are expected to increase through 2035.[126]

A recent study by UNM using 2015 data and presented in November 2016 to the Legislative Health and Human Services Committee[127] noted healthcare workforce shortages in NM as a whole, especially in less-populated counties. The study showed Santa Fe County at or well above benchmarks for primary care providers (physicians, nurse practitioners/specialists, and physicians assistants) and somewhat above benchmark for surgeons and psychiatrists. Obstetricians/gynecologists were just below benchmark in Santa Fe County in 2015. The study shows NM as a whole is losing psychiatrists and pharmacists while gaining most other physician types as well as nurses and dentists. Santa Fe County is remaining steady for most primary care practitioner numbers while many other populated counties are gaining such practitioners. The study also notes the aging of the workforce and warns about future shortages. While nothing specific about Santa Fe County is noted, the aging of the County's population as a whole, noted in Section II of this report, suggests the issue of an aging workforce may be even more problematic in the near future for Santa Fe County. UNM makes specific

[122] Krystal Knight; Christina Miller; Rachel Talley; Melissa Yastic; Kaitlin McColgan, Michelle Proser *Health Centers' Contributions to Training Tomorrow's Physicians Case Studies of FQHC-Based Residency Programs and Policy Recommendations for the Implementation of the Teaching Health Centers Program,* 2010, National Association of Community Health Centers, Inc.
[123] https://www.cdc.gov/nchs/products/databriefs/db151.htm
[124] http://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Practitioners%20Needed%20to%20Remove%20HPSA%20Designation%22,%22sort%22:%22desc%22%7D
[125] http://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[126] http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0616_1.pdf
[127] See Item 5 at https://www.nmlegis.gov/Committee/Handouts_List?CommitteeCode=LHHS&Date=11/14/2016.

recommendations for the State to consider, with special attention to behavioral health practitioner issues.

Maps in figures in earlier sections of this report depict the provider network by provider type and location, especially related to census tract areas that have the greatest concentrations of persons of limited means. Although SF County has many different types of providers, most are relatively small and clustered within the boundaries of the City of Santa Fe. People who live in outlying areas often have to travel long distances to reach key providers, in many cases outside the County boundaries (for example, in Albuquerque to the south or Espanola to the north). During the past few years, a number of providers have added locations on the south side or other locations within the County or City to better serve people considered most in need. One type of multi-service community health centers for persons with limited incomes are located throughout the County as depicted in Figures 55a – c below. These include the following HRSA designated FQHC service sites[128] (Figure 54).

Figure 54
Federally Qualified Health Center Service Sites In or Serving Santa Fe County

- Edgewood Center – Edgewood, NM
  First Choice Community Healthcare, Inc.
- Pecos Valley Medical Center, Inc. – Pecos, NM
- El Centro Family Health – Espanola, NM
  (Multiple sites, some of which serve SF County residents)
- Las Clinicas Del Norte, Inc. – Pojoaque
  Pojoaque Valley School Based Health Clinic (a CHC[129])

La Familia Medical Center Sites

- La Familia Dental Clinic – Santa Fe, NM
- La Familia Southside Clinic – Santa Fe, NM
- La Familia Healthcare for the Homeless – Santa Fe, NM
- La Familia Medical Center – Santa Fe, NM

Presbyterian Medical Services, Inc. (PMS) Sites

- Santa Fe Community Guidance Center – Santa Fe, NM
- Santa Fe Family Wellness Center – Santa Fe, NM
- Ortiz Mountain Health Center – Cerrillos, NM
- Presbyterian Medical Services – Santa Fe, NM

PMS School Health Sites/Programs

- Eldorado Community School Health Center
- Monte del Sol Charter School Health Center
- Teen Health Center – Capital High School
- Teen Health Center – Santa Fe High School
- Healthy Tomorrows Van – Santa Fe High School
- Cesar Chavez Elementary School Health Center
- El Camino Real Academy Health Center
- Ortiz Middle School Health Center
- Capshaw Middle School Health Center
- Ramirez Thomas Elementary School Health Center
- Mandela School/De Vargas Middle School Health Center
- Atalaya Elementary School Health Center
- Academy at Larragoite Health Center
- Aspen Community Magnet School Health Center
- New Mexico School for the Arts Health Center

[128] From https://findahealthcenter.hrsa.gov/index.html# using search query Santa Fe, NM with a distance of 25 miles.
[129] A Community Health Clinic is a program recognized by HRSA but is not designated or funded as an FQHC.

Figure 55a
Federally Qualified Health Center Sites in Santa Fe County (North)

Figure 55b
Federally Qualified Health Centers in Santa Fe County (City)

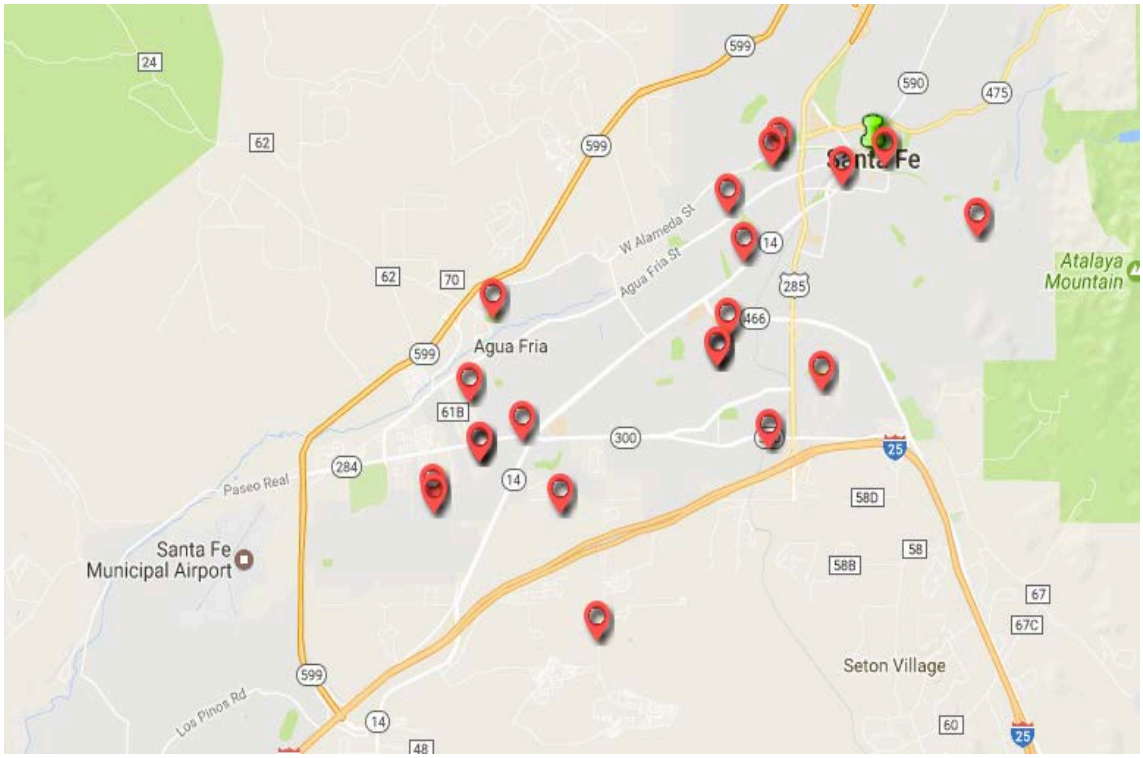
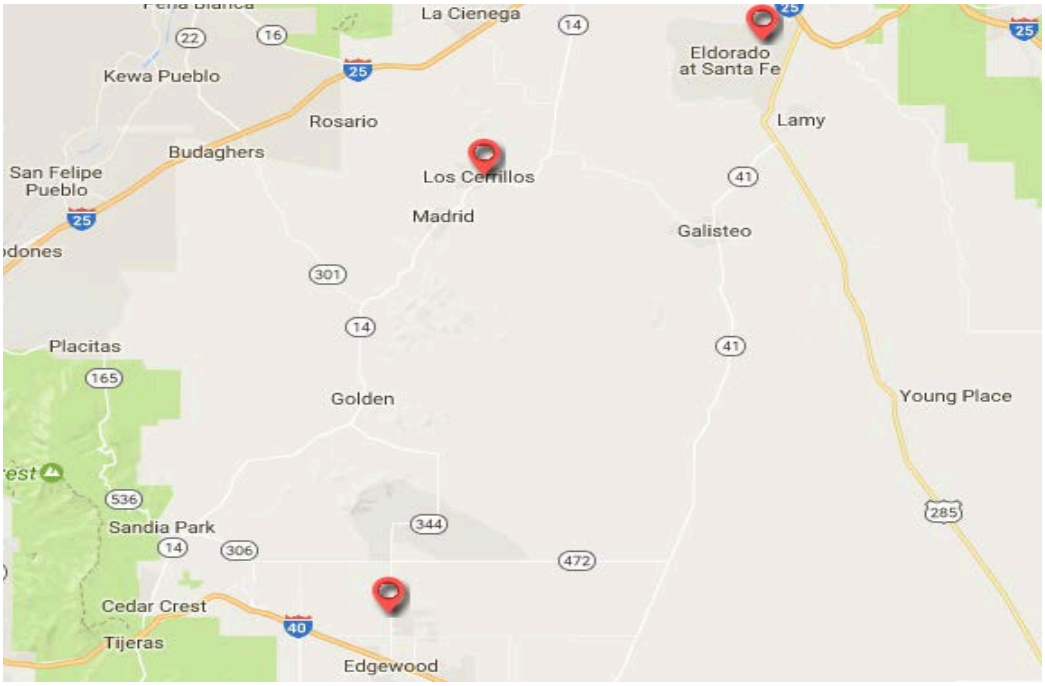


Figure 55c
Federally Qualified Health Centers in Santa Fe County (South)



B. Provider Challenges Addressing Workforce Shortages and Misalignment

Pay scales in most non-profit and government facilities are not equivalent to pay scales in the proprietary market for many, though not all, classifications of health care professionals. The Con Alma Health Foundation conducted research and published reports on NM health care shortages, and identified the following as key issues impacting health shortages:

- The pipeline shortages in key health faculty positions at colleges and universities;
- Lack of close alignment between education programs and available jobs;
- Limited loan repayment assistance and/or incentives for newly graduated health professionals who face repayment of large student loans;
- Special challenges faced by rural communities;
- Significant levels of retirement of professionals during the coming decade;
- Low level of racial and ethnic diversity among health care professionals;
- Santa Fe County's small cohort of young adults moving into the workforce, and its impact on health and allied health education, training, recruitment and placement;
- Funding and policy challenges.[130]

The health care workforce that is retiring is primarily male and white, not reflecting the diverse population of the state. This workforce is not being replaced by enough new professionals in the numbers and with the diversity needed to provide adequate health care in the future.[131]

[130] *The Power of* Partnership, Project Diversity, Con Alma Health Foundation, 2010, a report on the nursing pipeline program to improve diversity in nursing.
[131] Buerhaus*, Impact of Health Care Shortages on Hospital Patient Care*, 2008, and Terry Schleder, MPH, *Building a 21st Century Health Care Workforce in a Diverse Rural State: A Funder's Perspective & Evaluation Framework for*

SF County providers, especially those whose mission is serving low-income or culturally specific populations, face unique challenges related to funding for critically needed services, especially rates paid or budgets set by public insurance and publicly funded programs. (See later sections of this report describing the provider survey, as well as key informant interviews and town halls.) Yet, while there are shortages throughout the County's health care sector for certain types of staff and level of service delivery, health care is the third largest employment sector in the County. The NM Department of Workforce Solutions indicates the health care sector's change in proportion of all jobs went from 10 percent in 2002 to 13.1 percent in 2013 and 14 percent in 2014, with and health care and social assistance at 16.1 percent for 2015. The healthcare industry is projected to represent 20 percent of all jobs in the U.S. by 2024. Employment growth in the health care and educational services industries is projected to lead that of all other industries in numeric growth.[132] Health care receipts and expenditures of $498 million grew over 50 percent for the period 2002-2012, the highest level of overall growth in a sector of the economy in the County. Continued growth is expected for the coming years, projected to be 28.8 percent growth between 2010 and 2020.[133]

Significant health care growth and substantial shortages are happening at the same time because much of the growth has come in the subsectors of health care that are in: a) private pay areas serving middle-income to high-income residents; b) home health care providers with low wage jobs for proprietary companies creating profits by minimizing worker pay; and c) the health insurance industry with thousands of jobs created due to Medicaid expansion and the ACA Health Information Exchange. These factors have little impact upon HPSAs, as most of these HPCAs are in nonprofit and government sectors, which have been experiencing reductions in many types of funding. Even with overall growth in the healthcare industry, significant gaps in targeted areas have the most impact for those serving primarily low and limited income populations which are high priorities for Santa Fe County, especially CSD.

An analysis by the NM Legislative Finance Committee (LFC)[134] suggests that even though there are healthcare shortages as outlined by HRSA, some of the gap issues could be addressed, at least in part, through more carefully delivered care utilizing a range of strategies targeted to different types of patient needs and utilizing resources more effectively. In other words, patients with chronic conditions, hospital high utilizers, and people with other challenging conditions (one percent who utilize 22 percent of healthcare resources) require much more intensive, ongoing contact. However, those who are healthy need a different, less intensive level of care.

C. Structural Shifts and Their Impact on Providers and the System

Health care is one of the fastest growing industries in the U.S., NM, and SF County.[135] During the past 25 years, health care – along with social services – has experienced a series of

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Innovation & Impact of Health Career Pipeline Programs, 2010, and Project Diversity: The Power of Partnership, Con Alma Health Foundation.

[132] *Innovation and Impact of Health Career Pipeline Programs,* 2010, and *The Power of* Partnership, Project Diversity, Con Alma Health Foundation, 2010.

[133] New Mexico *State of the Workforce Reports for 2014 and 2015,* and *Economic and Industry Snapshot: Santa Fe County/MSA New Mexico*, 2014, NM Office of Workforce Solutions; *Employment Projections 2014-2024*, Bureau of Labor Statistics.

[134] *Adequacy of New Mexico's Healthcare Systems Workforce*, 2013, Department of Health and Allied Agencies, Legislative Finance Committee, 2013, at https://www.nmlegis.gov/handouts/LHHS%20100213%20Item%202%20A-1-2Department%20of%20Health%20Adequacy%20of%20New%20Mexicos%20Healthcare%20Systems%20Workforce.pdf.

[135] Carroll L. Estes, Robert Alford, Anne Hays Egan, *Social Policy & Aging,* Chapter Four, "The Transformation of the

massive changes and structural shifts that have had a serious collective impact on the healthcare system and NM communities. Some of these big changes have included managed care and cost containment initiatives in the 1990s and early 2000s. The Patient Protection and Affordable Care Act (ACA) in 2010 expanded both private and subsidized health insurance coverage through health exchanges, as well as Medicaid expansion – in NM with Centennial Care. With these large changes came additional financing for expanded Medicaid populations and for innovations in FQHCs and for newly expanded certified community behavioral health clinics (CCBHCs)[136] in some parts of NM, as well as for existing certified mental health centers (CMHCs) for some purposes. However, these new resources are at risk as the federal government considers significant changes in these and other large federal healthcare programs.[137] Likewise, state changes specifically to existing behavioral health organizations within NM, caused significant disruption to this sector of the state's health delivery system beginning in 2013.[138]

In addition to these large changes, health information technology has revolutionized healthcare delivery systems, creating both stress and opportunity. Federal funding, information technology, and electronic health records (EHRs) are shifting in response to: a) changes in provider funding streams created by the ACA; b) the need for greater accountability, quality, and innovation, including the need to share information about individual patients and to track outcomes for patient populations; and c) budget constraints. States have followed a similar pattern and many states face budget deficits related to the fiscal crisis of 2008-2012 and reduction in global prices for oil and gas.[139] NM is one of those states, resulting in – among other things – reductions in Medicaid reimbursement rates for many health services for low-income individuals.[140]

D. Impact of External Requirements on Providers

Many providers in SF County have been dealing with shifting Medicaid, Medicare, state, certification, and quality requirements that are extremely time consuming and challenging. Although discussions have occurred for decades about creating more user-friendly data platforms using open architecture with ability to work and communicate across organizations and programs, this vision has not yet become reality. Many efforts to simplify the data challenges facing providers have only been marginally successful and sometimes create barriers and costs for providers, as well as barriers to offering health care.[141] Providers will increasingly face challenges related to developing and maintaining streamlined and patient-focused services that show strong health outcomes and meet quality standards with specific

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Nonprofit Sector: Systemic Crisis and the Political Economy of Aging Services, Sage Publications, 2001.

[136] See https://www.samhsa.gov/section-223 and https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/ for descriptions of this new program. NM received a grant to develop CCBHCs in some areas of the state, but not in Santa Fe County.

[137] See http://nmpovertylaw.org/wp-content/uploads/2017/04/Report-ODonnell-AHCA-Impact-on-Medicaid-New-Mexico-2017-04-26.pdf for an analysis of proposed changes on NM health care and NM health economy.

[138] See 2014 publication of the Legislative Finance Committee describing challenges and possibilities for the NM behavioral health care system at https://www.nmlegis.gov/lcs/lfc/lfcdocs/resultsfirst/Evidence-Based%20Behavioral%20Health%20Programs%20to%20Improve%20Outcomes%20for%20Adults.pdf; and see earlier description of changes to behavioral health in NM in the 1990s at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4281511/. See also SAMHSA's BH Barometer for NM in 2013 at https://www.samhsa.gov/data/sites/default/files/New_Mexico_BHBarometer.pdf and in 2015 at https://www.samhsa.gov/data/sites/default/files/2015_New-Mexico_BHBarometer.pdf

[139] Studies by the Center on Budget and Policy Priorities, for example, *Extracting Lessons for State Finances: What Other States Should Learn from Energy-Producing States' Revenue Woes,* Elizabeth McNichol and Erica Williams, February 14, 2017, at www.cbpp.org.

[140] http://www.hsd.state.nm.us/uploads/files/Medicaid_Provider_Rate_Proposal_042616.pdf

[141] Health Insight, New Mexico's expert feedback provided by Sheila Coneen, 2014.

expected outcomes and targets. Quality Improvement as a well-integrated systemized process is challenging for many providers and often requires a level of research, expertise, systems development, and technical assistance that are difficult to locate and fund.

Providers are usually quite aware of cultural issues that facilitate or impede good care and which can create their own barriers to care. Especially providers serving low-income and/or disenfranchised populations are generally aware of gaps for those with limited incomes, and racial, ethnic, non-English-speaking, age-related, and LGBT population groups. However, such providers are not always aware of the perceptions of their own organization's gaps, or of the best approach to serving such populations. For example, persons who are primarily immigrant or Spanish-speaking may not be comfortable in a provider agency unless the practitioner they see speaks fluent Spanish and indicates an understanding of immigrant communities. A transgender individual many not feel comfortable with a health care practitioner who does not understand the unique physical health needs he or she faces. Building a system that is diverse, reflective of constituencies served, respectful of differences, and able to address significant barriers created by health inequities is challenging at best.

Responding to these health provider and system gaps will require a range of strategies that are responsive to the complexities of the health care system. These strategies need to be broad and systemic, as well as focused, nuanced, and varied in their ability to address a range of issues, including: a) root causes for health inequities; b) provider and service issues; c) the changing funding landscape; and d) shifting policy frameworks. The Accountable Health Community (AHC) model developed by the federal Centers for Medicare and Medicaid Services (CMS)[142] and being developed and led locally by CSD[143] can provide opportunities to address some of these challenges collaboratively.

E. Information Technology Developments and System Difficulties

Information technology has lowered the barriers to data access and sharing for providers, payers, and service recipients, but it has raised the level of expertise needed to manage information and data. By leveraging information technology, providers have better access to data and can use it more effectively to track progress and outcomes of patients, share data with patients, and shift their practice to a patient-centered care framework through ongoing health care monitoring and management, sometimes electronically or via telehealth networks rather than face-to-face. Adoption of information technology has also enabled providers to be more efficient, with many of the previously repetitive tasks being integrated into software routines that enable providers to access data more efficiently, analyze issues more comprehensively, and share knowledge with service utilizers and other stakeholders. Ideally, the technology can provide for a more patient-driven system that has a faster learning curve, and a more data and outcome-driven quality improvement process. When operating well, health care can become more transparent with service utilizers having access to a greater wealth of information about themselves and their health conditions, as well as about provider ratings and options. Providers have the opportunity to, with patient permission, share data among themselves to reduce lag time and improve interagency cooperation and cross-agency teamwork. However, the ideal is often much more easily envisioned than the actuality is implemented, especially across provider agencies or even across programs. Policymakers and payers are increasingly committed to data as such information tells them where money is being utilized with what results. Such data

[142] See https://innovation.cms.gov/initiatives/ahcm for a description of the CMS work on this AHC model.
[143] see https://www.santafefoodpolicy.org/wp-content/uploads/2015/04/C.-Building-an-Accountable-Health-Community-in-Santa-Fe-County.pdf for a description of CSD's approach to building an AHC for Santa Fe County.

can lead to changes in allocation of resources and cost savings by redistributing limited funds to the most compelling needs. This kind of data capacity and use enables the shift to value-based care, where quality and outcomes drive service utilization, program deployment, and funding decisions. This value-based care approach is still in the nascent stage but is a direction for SF County providers and leaders to watch and employ as they create the AHC and a healthier community.

The rise of information technology systems or healthcare informatics has resulted in challenges, false starts, parallel processes, and changes mid-stream to something new. This should be expected when considering the information revolution is a massive shift, underway only in the last 20-25 years. Experts have been saying for some time that this information revolution is a seismic shift somewhat comparable to the Industrial Revolution of the late 1800s and early 1900s.[144] The process is anything but neat. Such an approach requires resources (time, knowledge, funding) and will have a significant impact on providers who are unable to find such resources or are unable to adapt to the requirements of value-based care driven by sophisticated information technology and data mining and utilization capacity. For decades, providers have been challenged to develop technology that is responsive to current and future needs. Too frequently, multiple platforms are used for different programs and services, by varying types of organizations or even within organizations, and by a wide range of funders. The result is a set of systems cobbled together with multiple software platforms. These closed-architecture and siloed information platforms are gradually giving way to more integrated and user-friendly systems. However, a wide variety of data challenges need to be understood and addressed in order for health systems to maximize data-sharing capacity at individual and population levels while still ensuring patient privacy and confidentiality issues are fully addressed.[145] Managing these issues has been challenging for many systems architects, providers, policymakers, and funders.[146]

SF County has a disproportionately large number of non-profit provider agencies, many of which are small in size.[147] Large health and/or human services organizations with diversified funding are best positioned to ride the inevitable waves of change with the interface between systems and data, as they are often better able to invest in system development and maintenance as well as staff training and support to deploy such systems. The future may require or cause the elimination of some providers or the consolidation of smaller entities to face the future together as a larger system of services. Any provider billing third party payers and reporting to certain funders are required to have a minimum level of IT capacity now, and will be required to improve that capacity in the future. While providers are adopting electronic health records (EHRs) at a higher rate, the transition has been rocky, with providers using over 300 different health data software systems, which are not fully open source and interoperable.[148] Smaller and mid-sized

[144] *Why the Tech Revolution is the Industrial Revolution of our Time*, Paul Hudson, The Edge, March 29, 2013.
[145] See CMS at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html?gclid=CMXD2rCLp9QCFUMaaQodYPgHqw regarding the 1996 Health Insurance Portability and Accountability Act (HIPAA) standards; and SAMHSA at https://www.samhsa.gov/newsroom/press-announcements/201701131200 regarding 2017 revised regulations for confidentiality of addiction treatment records.
[146] *Managed Care: What Went Wrong, Can it Be Fixed?* GSB Staff, Stanford Graduate School of Business, 1990; Paul Starr and Sandra Starr, *Reinventing Vital Statistics: The Impact of Changes in Information Technology, Welfare Policy, and Health Care*, 1995, Public Health Reports 110, Princeton University;
[147] *The Economic Impact of Nonprofits in New Mexico*, Jeffrey Mitchell, UNM Bureau for Business and Economic Research (BBER), 2006 with Dolores Roybal, Anne Hays Egan and Carlota Baca. Total nonprofits in SF County were reported at almost 800, many of which are small. Total nonprofits for Bernalillo County, with a much larger population, were not quite twice as many, leaving SF County with a disproportionately high number of nonprofits per capita.
[148] Information from Health Insight New Mexico and its work with NM's health care information and electronic records conversion.

agencies have more limited funds, less organizational capacity, and fewer IT and data analysis resources, especially those providing general human services rather than healthcare services. The work CSD is doing to develop greater health care information system capacity among agencies it funds is proactive and can make a significant difference in providers' ability to move toward successfully using data-driven systems in community-rooted and patient-centered care.

F. Provider Frameworks, Types, Challenges, and Collaborative Opportunities

SF County has many different types of agencies, organizations, groups and networks using different frameworks defined by:

- Primary types of people served (seniors, low-income, immigrants, indigenous, Spanish-speaking, etc.)
- Types of services provided (primary care, dental, behavioral health, food, housing, etc.)
- Type of organization (non-profit, business for-profit, governmental)
- Levels of care (inpatient, outpatient, rehabilitative, etc.)
- Organizational size and staffing (or staff/volunteers)\
- Locations
- Primary payer sources (Medicaid, Medicare, grants and contracts, donations, etc.)
- Screening or eligibility criteria.

All of these factors are important in developing a comprehensive list of provider and service resources in Santa Fe County which many different organizations attempt to do, including CSD.[149] However, these resource lists are often out of date as soon as they are published as providers change and programs begin and end or expand and decrease as resources are available. Many people with the greatest needs are served by multiple providers across the spectrum of care. They may have some of their needs met; some unmet because they are unable to find and access resources that are available; and some are unmet because the services are not available, accessible, or affordable. CSD has recently engaged with sharenm.org[150] to provide more up-to-date resources, and is beginning to require its providers to keep their information up-to-date at this source.

G. Cultural Factors Unique to New Mexico and Santa Fe County that Shape Health Care

Over 12 percent of Santa Fe County residents are born outside the U.S., the majority of whom do not hold U.S. citizenship. According to Data USA,[151] 90.3 percent of the County's population is U.S. citizens, lower than the national average of 93 percent. While the majority of the SF County population is Hispanic, with non-Hispanic Whites a close second, a total of 4.2 percent of the County's population is reported as being Native American,[152] compared to 10.6 percent for the state as a whole. Four pueblos are within the County's boundaries – Tesuque, Pojoaque, Nambe, and San Ildefonso – representing about 3,200 tribal members.[153] A significant number of other tribal members live throughout the County, but not on tribal lands. These four pueblos

[149] See https://www.santafeCountynm.gov/media/files/ResourceDirectory2017.pdf for CSD's provider resource directory, most recently published in 2017. See also the resource guide for those who are "precariously housed," published by Santa Fe Need and Deed in 2015 at http://www.santafeneedanddeed.com/wp-content/uploads/2012/07/SantaFeResourceGuide.pdf.
[150] See https://www.sharenm.org/communityplatform/newmexico/county/index/name/santa_fe_county.
[151] See Data USA at https://datausa.io/profile/geo/santa-fe-County-nm/#demographics.
[152] U.S. Census Bureau, www.census.gov/quickfacts
[153] The number of tribal members living on the pueblos varies depending on information source, year, and whether just tribal members or others living within the pueblo boundaries are counted.

are represented, and for some issues served, by Eight Northern Indian Pueblos Council (ENIPC). Each pueblo has unique needs and some have resources on tribal lands providing health and/or human services. While tribal members are exempt from the requirement to have health insurance, they are encouraged to enroll in Medicaid and other public or commercial coverage. Many healthcare services for Native Americans are provided through the Santa Fe Service Unit of the Indian Health Service (IHS) which serves nine pueblos in central NM with a local hospital providing inpatient care and clinic services located on Cerrillos Road in the City of Santa Fe and field clinics located on Santa Clara, Cochiti, and San Felipe pueblos. This IHS service unit provides the following services for tribal members:

- Inpatient
- Urgent Care
- Family Medicine
- Internal Medicine
- Pediatric Medicine
- Prenatal
- Psychiatric Medicine
- Behavioral Health
- Physical Therapy
- Audiology
- Dental
- Optometry
- Pharmacy
- Nutrition
- Laboratory
- Public Health Nursing
- X-Ray Services

While IHS strives to provide critical care and support for many Native Americans, not all services are readily available through IHS, especially when specialty care is needed or a tribal member lives far from the facility. IHS, as may other community providers, faces practitioner shortages and other challenges that can adversely affect accessibility and availability of services. Continued coordination among tribal and local governments, as well as non-profit service providers, is essential to address the health needs of the County's indigenous residents.

The significant diversity found among the County's people and institutions contributes to a unique community experience, including for residents' health and the health care system. The variety of people and the organizations serving them represent a wide range of assets though they also face many challenges in meeting healthcare needs, including limited resources (workforce, funding, and services) and negative perceptions of what the variety of peoples and cultures bring overall community health. Gaps exist at multiple levels and can be reduced or eliminated once understood, with targeted strategies stemming from a framework that is both accountable and community-guided. Cultural issues can contribute to health disparities and gaps and can impede development of health care and human services to reduce those gaps. At the same time, cultural issues can be the most important strengths and assets to bring to bear reductions in those gaps and disparities. The importance of understanding and respecting the different races, ethnicities, cultures, and traditions cannot be overstated. Understanding and appreciating the deep toll that poverty, racism, and lack of access take on people, communities, and health systems is critical to creating a healthier community in SF County.

HIGHLIGHTS – PROVIDER AND SYSTEM ISSUES

1. *Santa Fe County has significant Health Profession Shortage Areas in primary care, behavioral health, institutional and hospital care, dental care, and care for specific populations.*

2. *Some studies show Santa Fe County better off than some other New Mexico Counties for primary care and dental practitioners. However, the aging of the healthcare workforce, limited educational opportunities and the cost of health care education, along with lack of diversity, and funding and policy challenges, create considerable concern for the future healthcare workforce.*

3. *Recent and proposed structural, payment, and policy shifts at the state and federal level have left many providers struggling to keep up with funding, information technology, and regulatory requirements. Workforce and infrastructure needs are often deferred.*

4. *Santa Fe County has a disproportionately large number of non-profit providers, many of which are small in size with a limited mission. Larger organizations with diversified funding are often best positioned to ride the waves of change currently in play in the health and human services environment. Provider consolidation may be likely.*

5. *Given the ongoing shifts within the system, access to accurate information about current service availability can be challenging for providers and the public. Collaborative efforts are significant but are often experienced as unfocused with multiple activities drawing on limited provider capacities.*

6. *Cultural issues can be important strengths and assets for providers and for the community, but can also contribute to health disparities and gaps. Providers must and try to be cognizant of and address these issues.*

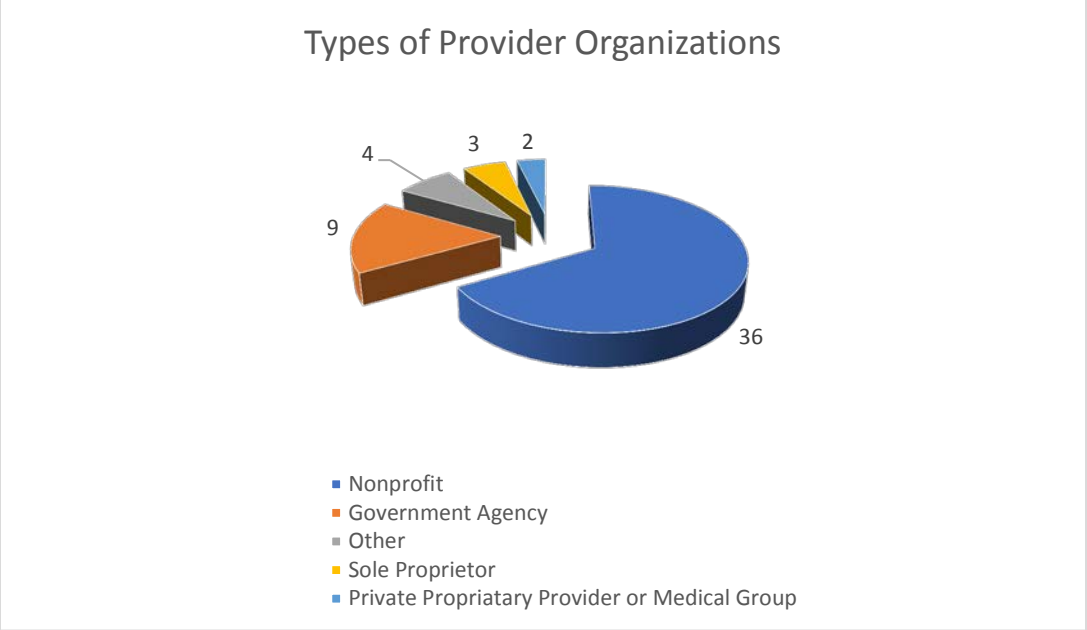
V. PROVIDER SURVEY

A survey was sent to over 125 providers selected by CSD representing a range of health and human services providers in SF County. Providers were chosen based upon the services they provide and population groups they serve related to the goals for this gap analysis. The purpose for this survey was to gather information from a sample of providers about their services, people served, priorities, and challenges as well as their assessment of barriers, gaps, and future strategies. A total of 56 responses were submitted to the web-based provider survey[154] representing a range of agency types.[155] The vast majority of the large major organizations serving low-income individuals responded. A significant number of those surveyed provided additional information via emails and follow-up phone discussions.[156] Not all the respondents answered all of the questions; the total number of people answering each question is shared in the analysis. The survey questions and the list of those who responded were provided to CSD; however, responses are reported in the aggregate to maintain confidentiality.

A. Types of Organizations Responding

A total of 66.67 percent of the respondents were nonprofit organizations. Government agencies represented 17 percent and the balance were other types of organizations such as practice groups and sole proprietors.

Figure 56
Types of Provider Organizations Responding to Survey

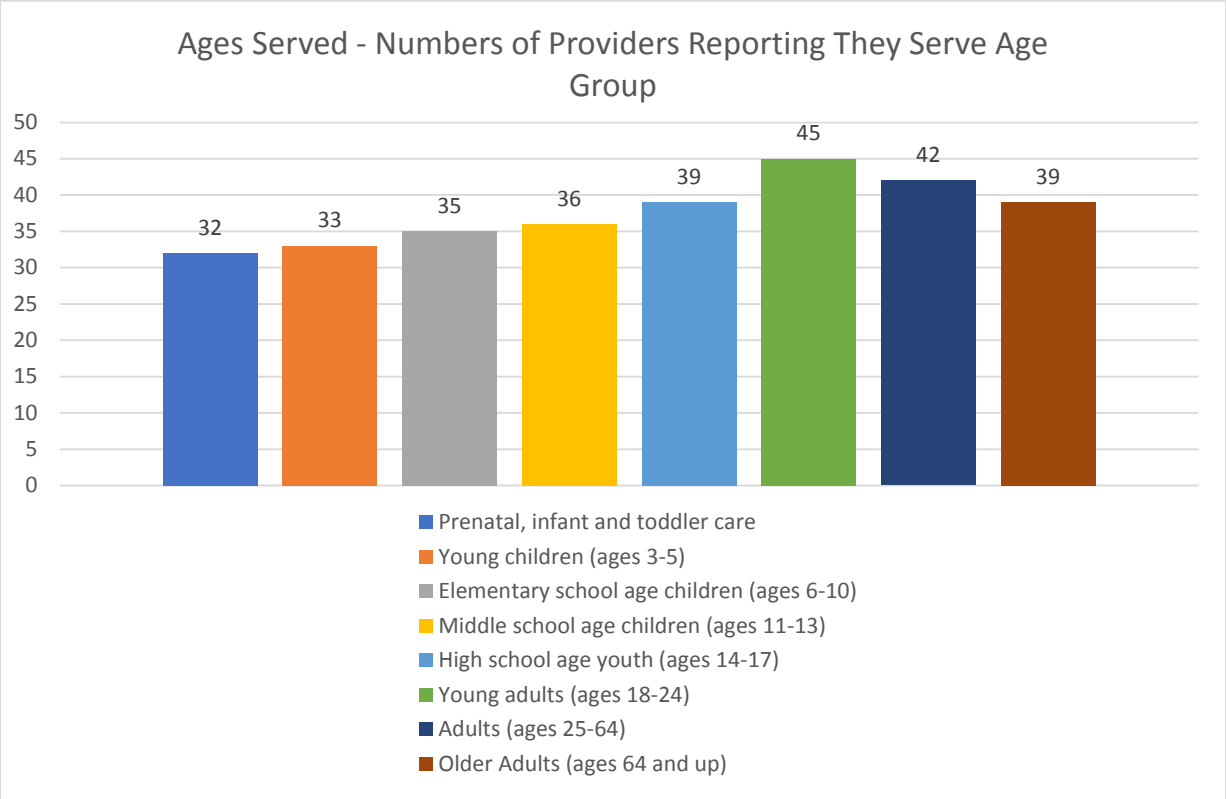


[154] Of the 56 responses, three agencies with separate programs provided multiple responses which represented just 4 of the 56. This is not a significant overweighting of the sample.
[155] One notable exception was providers specifically serving Native Americans. Even with repeated attempts, IHS was unable to respond and only one of the pueblo service providers responded. Similarly, one provider completed the survey after the analysis was conducted, so they are included on the provider list, and their thoughts are included, but their data was not woven back into the quantitative analysis because of time constraints.
[156] This is not a fully representative or random sample of the provider network, but rather a filtered representative sample targeted to CSD priorities. At some point, CSD may find it useful to conduct a comprehensive analysis and mapping of the entire provider network, which is outside of the scope of this project.

B. Age Groups Served

Providers who responded serve all age groups in the County. Young adults, adults, high school aged youth, and older adults are those most frequently served. The fewest services provided are for those at the youngest end of the age spectrum. The differential between the most served category (45) and least served (32) is relatively small, showing services are offered to people across the age spectrum. Most of these providers serve multiple age groups, with the average provider serving 75 percent of all age categories.

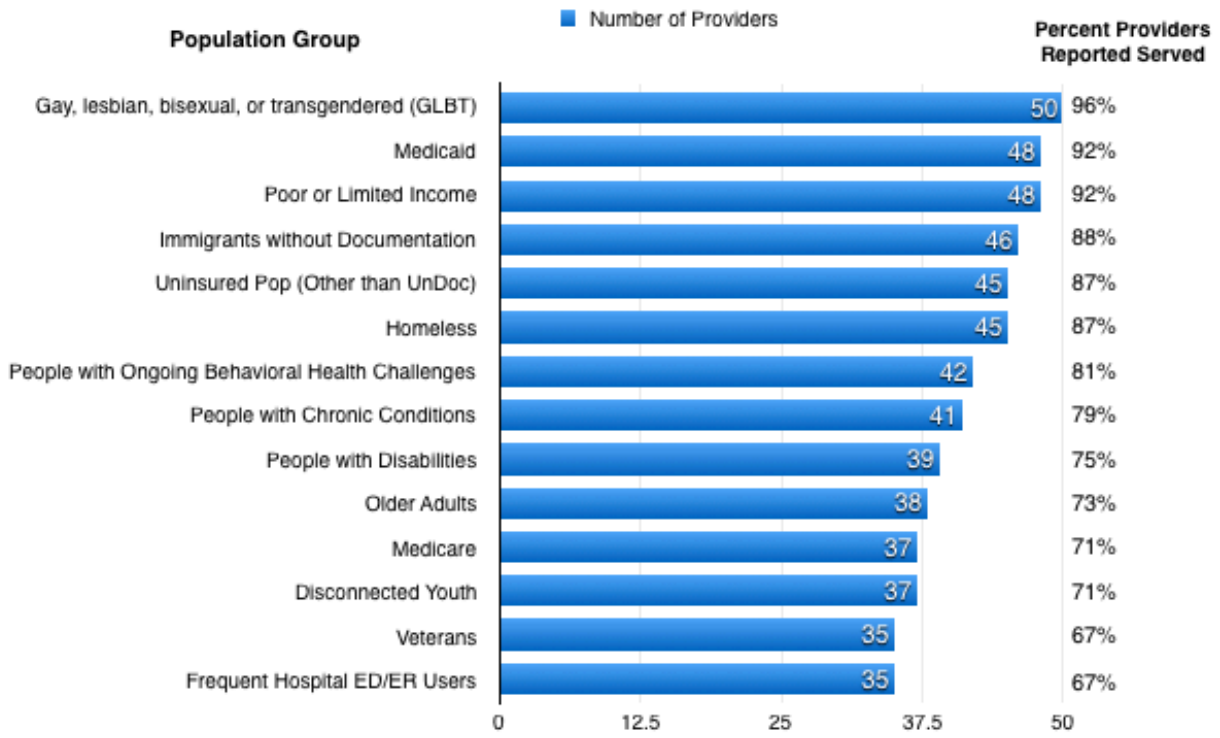
Figure 57
Age Groups Served by Responding Providers



C. Populations with Significant Health Disparities

CSD's priority is to serve or facilitate the provider network serving people who are at higher than average risk or have high need based upon their demographic characteristics, behavioral factors, and/or serious health conditions. Fourteen different categories were listed that relate to people in need and at risk as shown in Figure 58 with the number of providers serving each category in descending order. The legend to the right provides detail about each population category. Across this group of 52 providers, the average responder sees at least 11 of these 14 at risk population groups. This indicates many of these (and perhaps other) providers in Santa Fe County serve a large proportion of people in priority populations for CSD as well, thereby reflecting strong alignment among CSD and non-profit and government providers' missions, target populations, and service priorities.

Figure 58
Populations Served by Responding Providers



Almost all responding providers reported seeing people who are Medicaid recipients; however, not all providers bill Medicaid. A total of 92 percent of providers reported they serve people who are on Medicaid, but just 44 percent reported actually billing Medicaid. Although Medicaid enrolled people are being served, services provided are either non-medical services not covered by Medicaid or are Medicaid billable services but the provider is unable or unwilling to become Medicaid certified. This lack of certification as a Medicaid provider could be due to lack of credentialed practitioners, or lack of some of the essential characteristics required by the state of New Mexico to become Medicaid certified. In some cases, providers may simply feel the cost of being certified and of billing (including being subject to audit by the state) is not worth the amount that would be collected for the limited billable services provided.

Fewer responding providers serve elderly and/or disabled people on Medicare (though some are dually eligible for and enrolled in Medicaid, too). Even fewer providers reported billing Medicare. Obtaining Medicare certification status can be even more challenging than Medicaid certification for many providers.

As would be expected, significant internal alignment exists between the number of providers that reported serving Medicaid clients (48) and those reporting they serve those who live in poverty or with limited incomes (48). Similar alignment exists between providers serving older adults (38) and those on Medicare (37). Less than half of the providers serving people who are insured by these two federal programs reported billing to these programs, likely for the same reasons described above.

Santa Fe's commitment to diversity as a community is reflected in the large number of providers that reported serving those who live in poverty; are lesbian, gay, bisexual, and transgender

(LGBT) people; are undocumented immigrants; and/or are uninsured. Although this inclusivity may not be surprising given both the culture and the overarching requirements accompanying federal funding, the level of reported inclusion seems high. This group of providers is serving people with the greatest health disparities and risks across the board.

D. Provider Sources of Revenue

A total of 52 providers reported, on average, five different sources of revenue. Federal and state grants and contracts, donations, and foundation funding are most frequently cited. Third party payer funding through Medicaid, other insurance, and Medicare are reported by fewer agencies than contract and grant income and donations. This represents a diverse base of revenue, more diverse than one finds in the State's nonprofit sector as a whole.[157]

Figure 59
Provider Sources of Revenue

Revenue Source	# Providers (of 52 responding)	% Providers
Federal grants or contracts	34	65%
Donations	29	56%
State contracts	26	50%
Foundation funding	25	48%
Private or self-pay	23	44%
Medicaid	23	44%
Other third party insurance	19	37%
SF County contract	18	35%
City contracts	17	33%
Medicare	15	29%
SFC HCAF/HCAP	12	23%

A 2006 statewide study of the County's non-profit sector showed that non-profits (and local governments, as well as other types of agencies) leverage many additional investments by federal and national funders, which seems to hold true for this group of primarily non-profit and governmental providers.[158] Most of these providers have worked to build diversified budgets, and have developed multiple sources of funding for services provided for those who are uninsured and for services not fully covered through billings or other reimbursements. When the survey responses to the question about revenue sources were analyzed by provider type, significant differences between nonprofit and other types of agencies emerge within this sample. Figure 60 compares the revenues of these two key types of providers responding to the survey.

[157] The health and human service providers in this survey sample represent larger than average nonprofits in the State, with a higher than statewide percentage obtaining federal and State grants and contracts, as well as other funding, according to data and reports from the Urban Institute's National Center for Charitable Statistics, Guidestar, and other national research organizations.

[158] Jeffrey Mitchell; *The Economic Impact of Nonprofit Organizations in New Mexico*, by UNM BBER, 2006. UNM BBER worked closely with NGO New Mexico and the New Mexico Association of Grantmakers (Carlota Baca, Dolores Roybal and Anne Hays Egan) for research and dissemination. The report also demonstrated that healthcare represents the largest proportion of the sector. The economic impact of nonprofits in leveraging revenues and job creation is significant. This is also true for local governments.

Figure 60
Provider Sources of Revenue By Provider Type

Revenue Source	Non-profit Providers N = 36	Other Providers N = 18
Fee for service, private self-pay	54%	9%
Medicaid	49%	36%
Medicare	34%	9%
Other third party insurance	40%	18%
Santa Fe County contract	40%	27%
Contracts with other counties	23%	0%
Santa Fe County's Health Care Assistance Fund	26%	9%
City contracts	46%	9%
State contracts	66%	9%
Federal grants or contracts	74%	64%
State legislative apportionment	0%	0%
Funder (national, private or community foundations)	69%	0%
Donations	80%	0%

Both nonprofits and other agencies show significant reliance upon federal grants and contracts. Non-profit providers reported more diversity in funding sources overall (based in part on funding restrictions for government and profit-making agencies). Most budgets depend on City and state contracts as well as Medicaid, Medicare, and other federal revenue. Further analysis and discussions about these differences may more clearly identify gaps and challenges, as well as create new opportunities for both types of agencies. These government-related sources of revenue are in flux in the current state and federal policy environment with the potential for increasing barriers and gaps. This will be addressed later in this section regarding provider responses to questions about challenges.

E. Priorities for Current Services

Respondents were asked to list their top three priorities for their current work. A total of 52 respondents listed priorities. The answers covered a number of topics, the most frequently cited were the need to address problems with access, expand services to meet gaps, support asset-based health prevention and wellness; and address growing behavioral health needs. In follow-up discussions, providers mentioned other issues that relate to these broad themes. The impact of Medicaid expansion, and addressing those needs was seen by many as an important access issue, along with providing more services in or near communities where those with the greatest health disparities live, and having more resources for care navigation, information, and referral.

Provider focus was primarily upon meeting needs, expanding access, and building services much more than on responses to such surveys 20-25 years ago when the priority for government was often to “provide more funding.” A key word analysis was conducted on provider answers, and Figure 61 shows the most frequently mentioned current priorities.

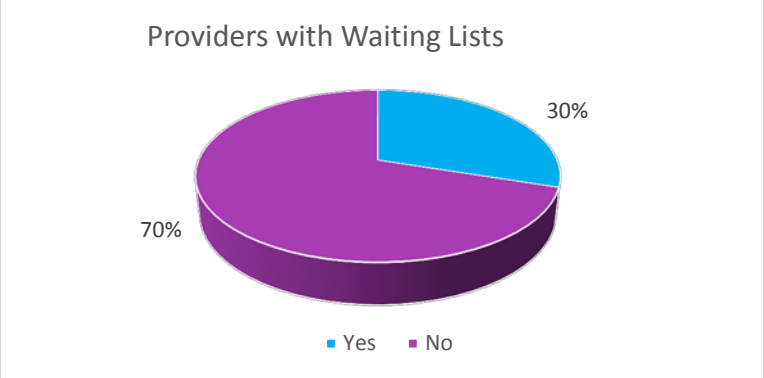
Figure 61
Most Frequently Mentioned Priorities by Responding Providers

Topic	Respondents Mentioning Topic
Access	31
Expand Services, Fill Needs, Gaps	27
Health & Wellness	19
Behavioral Health	16
Housing and Homelessness	14
Staff Skill Building	13
Organizational Development and Capacity Building	13
Families & Children	12
Info/Referral and Benefits	11
Basic Needs – Food and Clothing	10
Funding	9

F. Waiting Lists

Waiting lists and wait times are important indicators of access, a primary issue mentioned by respondents as a concern. When asked if their agency had a waiting list, 70 percent of survey respondents reported no waiting list. However, while some providers do not maintain a formal waiting list, the time it takes from a request for an appointment to receiving the appointment can be long – sometimes several weeks – and waiting times to see the practitioner once in the provider's building is often noted as an issue by persons receiving services.[159]

Figure 62
Percentage of Providers Reporting Waiting Lists



[159] See http://hrms.urban.org/briefs/federally-qualified-health-centers-options-reviews.html, https://www.ncbi.nlm.nih.gov/pubmed/25072878, and http://www.rwjf.org/en/library/research/2014/04/access-to-care-and-availability-of-new-patient-appointments.html re waiting times for appointments at FQHCs and waiting times at clinics; see also http://www.gao.gov/assets/680/676120.pdf for a Government Accountability Office Assessment of IHS efforts to address patient wait times for appointments and to see practitioners once on site.

Providers were asked to comment on the size of their waiting list, average wait times, and what they would need to reduce the waiting list. In written comments about needs and challenges, many providers reported that Medicaid expansion has created a large wave of new clients now seeking services, many with previously unmet needs. Several providers reported that wait times have increased over the past two years, and some waiting list issues have been finessed by creating more restrictive service requirements and limiting the numbers of people who can be served in order to handle the challenges of a growing workload amid financial constraints. The following are some of the comments made by providers:

- *It's a 1-2 week wait.*
- *There may be a 2 week wait, as this is a small staff working to act as quickly as possible.*
- *Average one week wait; sometimes can accommodate walk-ins.*
- *Long waits due to limited slots available.*
- *Have a one-week wait as we're short staffed.*
- *We are limited in the numbers we can serve due to resources allocated to programs.*
- *We are serving a third of the need; more resources are required to serve 100 percent of the need.*
- *Interest list is large; wait list includes those fully screened once vacancies occur.*
- *Waiting can run into months; need funding for expanded services.*
- *Need more human resources; some wait times can run up to a year.*
- *Multi-year waiting list for a large group of people.*
- *Wait times depend upon the program.*

These comments indicate an extremely strong desire to serve those in need but who cannot be served primarily because of funding and staffing constraints. High, unmet needs were mentioned by the majority of providers making comments. In the follow-up phone interviews, the majority of providers interviewed indicated Medicaid expansion combined with policy changes and budget cuts in many areas has created significant pressures for providers. A few providers mentioned the importance of working to develop creative service delivery and funding strategies to serve the same number or more individuals even as resources become scarcer.

G. Service Gaps

Providers were asked to identify issues they considered as major difficulties for individuals accessing services and barriers to care contributing to service gaps in the County. Comments about gaps are categorized into six important areas framing these comments in Figure 63.

Figure 63
Most Frequently Listed Issues Contributing to Service Gaps, in Order of Priority

Legend
A – Access related issues (#s 1, 5, 7, 11)
ARS – Age-related services (older adults and youth at risk) (#s 7, 9)
BH – Behavioral health (#s 4, 8, 11-13)
CBS – Community-based services focused on risks & health disparities (#s 2, 3, 6-13)
HD – Services to address social determinants & health disparities (#s 1, 3, 6, 8, 10, 11, 12, 13)
OD&S – Organizational development and systems issues (#s 2, 7, 11, 12, 13)

Order	Area or Issue	Explanation/Comments
1	A HD	Hours of operation – need to include more night and week-end options.
2	CBS OD&S	Streamlining services – need to be simpler, closer to home, easier to access, less "red tape."
3	HD CBS	Housing – more affordable housing of all types is needed (transitional, subsidized, below market, etc.)
4	BH	Behavioral Health – range of additional services needed to rebuild BH system, more case management
5	A	Access issues – identify and continue to address cultural, technological, distance, enrollment
6	HD CBS	Transportation problems – target communities with greatest transportation challenges; bring mobile services in, use navigators, and develop more small-scale transport options.
7	A CBS OD&S ARS	Non-medical home care, personal care, and community-based services for persons who are elderly – needed for many income groups, is not covered by many insurance providers; Medicaid provides some personal care services (PCS) and other community-based services.
8	HD CBS BH	Transitional institution to community – develop navigators to help people overcome barriers, access resources and build skills needed for a successful transition.
9	CBS ARS	Safe programs before/after school youth – expand resources for school age youth during out of school time.
10	HD CBS	Basic needs (food and clothing) – continue to provide a basic needs safety net, provide information to help people access services.
11	HD CBS OD&S BH	Free or low cost health care – develop strategies for reducing direct costs and co-pays for the poor and near poor.
12	HD CBS OD&S BH	More integrated health care – continue to work to integrate care, referrals and service coordination.
13	HD CBS OD&S BH	Shift in service emphasis toward better targeted and more low cost options – shift emphasis and payment upstream.

Follow-up phone discussions with some providers and review of materials identified a few other issues relating to topics identified in earlier sections of this report. A number of the larger, multi-site providers mentioned that staffing is one of the key challenges for many reasons including

but not limited to difficulty recruiting newly credentialed doctors and mid-level professionals. Even though salaries may be competitive, the cost of living is often too high for many young and middle-aged professionals, especially if they have families and are still paying off school loans. Providers also mentioned workforce retention as a challenge for professional staff as they may find better career advancement, salary opportunities, and education for their children in other states with larger urban areas, or even in the larger urban areas of NM. Interviewees mentioned potential staff sometimes expresses concern about the quality of the public education system in NM and particularly in SF County which creates a challenge for recruitment and retention. Some providers mentioned that effective recruitment and retention are critical to maintaining systems supporting quality services; sometimes a "fit" issue arises that may or may not be able to be addressed. Some professionals being recruited find SF County is not a good fit because of high housing costs, educational issues, the community's size, or the particular ambiance of the County and of its primary "City Different." However, others find appealing the nature of the County and its diverse community with a vibrant arts culture, exciting outdoor environment, progressive policies, and a provider network committed to addressing health disparities.

Quite a few providers talked about ongoing shifts in the health policy and financing landscape. They perceived some of the service gaps to be related to the way Medicaid, Medicare, and other third party payers classify (ICD-9 or now ICD-10 codes) and reimburse different types of services, but not all needed services are covered. Others mentioned their challenges with delivering services in a holistic community-based way while billing in codes and increments disaggregate services, often not covering the full cost of care or the full array of needed services to achieve the outcome the individual needs. In addition, most mid-sized to large providers that bill multiple payer sources deal with multiple data silos on an ongoing basis. Trying to create data crosswalks between those silos represents an ongoing challenge for these providers.[160] Today's IT environment involves increasingly sophisticated planning, analysis, data, and IT work, requiring a level of organizational and systems capacity challenging for many.

Other providers discussed the importance of ensuring the health care system has adequate resources to provide navigation, case management, information and referral, and assistance accessing services for people in communities where they live. Having this focus on navigation for access and proximity of services can address many of the issues identified. Some providers talked about the benefits of mobile services to go to where individuals live in various communities and outlying areas. One mentioned example is CSD's mobile van providing health screening for seniors, behavioral health and suicide prevention screening, and other basic health services for targeted populations in various locations around the County.

H. Current and Future System Priorities

Providers responding to this survey and the follow-up interviews outlined key priorities reflective of their experience but also in alignment with the needs identified in the town halls and key informant interviews described later in this report. These priorities include:

- *Health Care Access* – Even when services are available, some residents have trouble getting to or paying for them because of:
    a. challenges enrolling in health insurance;
    b. unaffordable coverage/premium costs or co-pays;

[160] HealthInsight and other groups have worked with the State of New Mexico to identify and analyze problems relating to data silos and inadequate electronic records. They indicate over 300 different data management programs are used by NM providers, and describe efforts to simplify, streamline, and integrate these significant IT challenges. Santa Fe County is also investigating and addressing IT issues in a project which parallels this gap analysis.

c. inability to take time off from work to seek services;
d. primarily daytime hours of provider operations;
e. focus on caring for one's children first, deferring care for oneself;
f. distances to travel to a provider or resource, and transportation challenges;
g. cultural barriers including differences in culture and language, feeling overwhelmed by the complexities of accessing and managing health care, concern about being treated disrespectfully, and/or fear about possible deportation of oneself and family, regardless of citizenship status.

- *Growing Needs in Certain Areas and Populations* – Especially in the southern part of the County as well as in specific parts of Santa Fe, and especially for the aging population;[161] this brings the need for new facilities and for expanding mobile and in-home services.

- *Types of Services Provided* – Because providers offer services they believe are most needed, easiest to provide, in areas of provider expertise, and billable, not all needed services are available. Medicaid and Medicare funding taxonomies and limitations have a disproportionate impact in shaping the mix of services available with significant gaps, especially in types of behavioral health care, including case management and care navigation, social detox, skill-building, and peer supports. Funding limitations also create a significant deficit for in-home services for seniors. The County and City senior centers and HCAP contracted services are keys to addressing some of these needs. Volunteer visiting programs such as Coming Home and other faith-based and neighborhood resources are scattered but also critical for populations with these needs.

- *Specific Service Needs* – Especially in areas related to social determinants and health disparities, gaps include lack of affordable housing with long waiting lists for all types of subsidized and affordable housing; transportation challenges, especially for families living in the 15 census tracts with the highest proportion of low-income individuals and with long distances to travel for work, food, health care, and other services.

- *Quality of Care Issues* – These are related to cultural differences and misunderstandings, inadequate staffing and staff training, and provider pressures to work with growing numbers of people leading to overwhelming workloads and expectations. Waves of retirements now and in the coming 10-15 years, recruitment, retention, cultural issues, and staff fit with the community and provider environments are exacerbating these issues.

- *Organizational and System Issues* – Created by the fast pace of change and growth in health care is causing providers to feel they are constantly running to catch up.

- *Funding Challenges* – Reductions in reimbursement rates and changing state and federal funding is affecting all providers. Ongoing investments in organizational and network systems and structures are critically needed. However, when funding is tight, organizational capacity building, infrastructure, and facility maintenance are often deferred, along with support for staff and their needs.

[161] According to research and publications by the Con Alma Health Foundation and other resource organizations, NM is moving from 39th in proportion of older adults to total population in 2010 to 4th in 2030. Santa Fe County's older adult population is growing even more rapidly.

- *Policy Changes Impacting Providers and the System* – The fast-changing and currently volatile policy environment creates both opportunities and challenges for individual providers and the system as a whole. Even opportunities can create pressure if providers are chasing grants, and trying to understand and adapt to changing funding and policy approaches, and new expectations or requirements for existing funding.

When asked to describe what they consider to be their most important future priorities, if resources were available, these providers had many different suggestions, including:

- *Expand Services* – including establishing stronger safety net services, and fill identified gaps, especially rooted in or closer to communities in which people with the greatest number of challenges and health disparities live (primarily the 15 census tracts with the highest proportion of low-income individuals and neighborhoods where significant numbers of frail and at-risk older adults with resources live);

- *Behavioral Health Services* – Offer more community-based behavioral health services with a range of options and service settings, with services and supports linked to helping overcome key drivers such as employment, transportation, housing, child care, and basic needs (food, clothing, utilities);

- *Address Social Determinants of Health* – Ensure important needs related to health disparities and impacting health (housing, transportation, food, employment, and child care) are understood; involve providers in a broader and more inclusive yet more deeply community-rooted system;

- *Prevention* – Shift the service delivery system to focus "upstream" on targeted prevention activities; At the same time, reduce the utilization of expensive hospital, emergency department, and institutional care by shifting high utilizers to more community-based services with more case management resources to help people address and overcome challenges; assist with enrollment and accessing benefits, navigation, and information and referral to more effectively access available resources.

These priorities mirror many of the needs and gaps found in this analysis, and serve as a blueprint for many of the recommendations found later in this report. Although the survey and follow-up conversations and material reviewed represent the work of just a portion of the community's hundreds of providers, they offer an important window into the providers' world. The issues and needed solutions raised by the providers responding to this survey are frequently in close alignment with the County's mission and strategies, with a deep understanding of the mix of issues that shape health care, broadly defined, and the agencies within the SF County health and human services systems.

HIGHLIGHTS – PROVIDER SURVEY

1. *A total of 52 providers responded to the provider survey, serving a wide range of age groups and population types. The average responder serves 75 percent of all age categories and services 11 of 14 identified population groups.*
2. *Provider funding is diversified, with the average having five different sources of revenue. Non-profit providers generally have more fund sources than commercial or government providers.*
3. *Most providers (92 percent of responders) see people who are Medicaid and/or Medicare recipients, but less than half of these providers bill those sources due to the type of service provided not being reimbursable or the difficulty in being a provider who can bill such sources.*
4. *When asked about priorities, responding providers indicated access, expanded services, prevention and wellness, and growing behavioral health needs.*
5. *While most providers reported having no waiting lists, many did acknowledge often long waits for appointment times.*
6. *Community needs identified include expanded provider locations and hours of operation, streamlining of services, housing for low-income individuals and workforce, a range of behavioral health services (especially case management and navigation), transportation and basic needs, before and after school programs, and a shift toward more preventive upstream services.*
7. *Provider challenges identified include growing need for services in certain geographic areas and population groups; accessing housing for clients and staff; quality of care issues in part due to inability to address critical workforce issues; the fast pace of change and growth in health care; and inadequate funding for services and infrastructure due to low rates and/or changing requirements.*
8. *Priorities recommended by providers include expansion of services, especially behavioral health services; addressing social determinants like housing, transportation, employment, and child care; shifting the service delivery system to focus on upstream targeted prevention activities; and using current services more efficiently by addressing the needs of high utilizers of institutional services, assisting with accessing public benefits, more navigation, and better information and referral capacity.*

VI. WHAT THE PEOPLE SAY – TOWN HALLS, KEY INFORMANTS, AND PROVIDER GROUP MEETINGS

Despite the existence of significant health disparities and risks within Santa Fe County, the community is full of individuals, families and organizations who are not only invested in improving health conditions for the entire community, but who generously gave of their time, energy and expertise to help this Gap Analysis team identify significant gaps and strengths within the health and human services system in Santa Fe County. Through a series of town hall community conversations, meetings of relevant provider groups, and individual key informant interviews, extensive information was gathered from experts within the community on how access – or in many cases lack thereof – to healthcare services and supports for basic needs is impacting the health and well-being of County residents.

"Motivation, collaboration and working together, along with collective impact strategies around jobs, security and overall well-being, will help our community become healthier. Wellness is a process….time and trust are needed to make changes."
– Eric Lujan, Board Chair, Health Action New Mexico

A. Barriers to Good Health Outcomes

Participants shared concerns regarding financial instability and income inequality existing extensively throughout the County. Particular cultural and ethnic groups are disproportionately impacted by poverty and insufficient income, which often requires individuals and families to work multiple jobs and at times, go without health care and basic needs directly impacting health outcomes. Community members and local experts validated data on social determinants, described in earlier sections, and how health disparities work in their local communities.

"My biggest concern is that there is no safety net for so many of our people. We need to enhance our social networks and support one another in obtaining holistic health. Care, commitment and connection are critical for a healthy community."
– Reverend Talitha Arnold, United Church of Santa Fe

Extensive input was provided with regard to living wages in the County, particularly that a need exists to continue attracting new industries and employment opportunities. Though progress has been made to increase the minimum wage for many individuals and families, current standards do not support a living wage given high costs of housing, food and other basic needs, especially within Santa Fe City limits.[162] Disproportionate numbers of people of color continue to live in poverty or at very low-income levels. Many individuals and families, including those with two-parent households are required to work multiple jobs in order to make ends meet and often times, children are left on their own with limited guidance from adults. This lack of guidance can contribute to poor eating choices and lack of physical activity for many children and youth.

[162] Many employers pay the required living wage ($11.09 per hour as of March 2017). However, this requirement covers businesses licensed by and their employees doing work in the City of Santa Fe as well as any contractors, not the entire County. The cost of living in Santa Fe is 16 percent above national averages, according to Sperling's *Best Places to Live*.

Access to affordable food, specifically fresh fruits and vegetables, as well as foods high in vitamins and nutrients, creates a huge barrier for many individuals and families within the County. Many families have to travel extensive distances to obtain fresh food and often times, the cost of healthy foods exceeds one's budget.[163] Furthermore, some informants expressed that over time, many families have lost traditional ways of preparing foods native to New Mexico and therefore, presumably more cost-effective. As a result, many residents consume foods high in preservatives and low in nutrition, which has an obvious negative impact on holistic health.

The high cost of living not only impacts families in low-income brackets, but also creates a workforce barrier. Many healthcare organizations experience significant difficulty recruiting and retaining professionals within the field. With high levels of student loan debt often accompanying a newly graduated or licensed healthcare provider, many new practitioners find it more realistic to secure employment in more urban areas of the state or elsewhere in the country.

Another significant barrier to obtaining and maintaining health and well-being includes the lack of healthcare coverage. A number of individuals and families within the County remain without health coverage in spite of Medicaid expansion and the Affordable Care Act (ACA) subsidies for health insurance on the health insurance exchange.[164] Furthermore, many individuals who do have coverage continue to struggle with co-pays for care and coverage deductibles. Specialty services are often covered minimally and necessary testing (x-rays, mammograms, and other preventive screenings) often come at a high out-of-pocket price. Though noteworthy improvements have been made with the existence of the ACA, and many low-income individuals (such as those experiencing homelessness) can now be insured, significant fear exists that these improvements will subside or be removed altogether. A need exists to continue looking at alternative ways to provide healthcare coverage for those who are marginally eligible for coverage, as well as those who continue to be ineligible such as undocumented immigrants.

Though access to health insurance for Santa Fe County residents has increased over the past years, support for accessing dental care remains challenging for many. The high cost of dental care and lack of dental health insurance coverage are the primary reasons many individuals and families go without dental care; however, shortages in dental care professionals in the area also contribute to the lack of care. Villa Therese Catholic Clinic provides basic dental services one hour each weekday at low or no cost to many Santa Fe County residents, though they primarily provide basic dental care (such as fillings and extractions) and are located in an area of town (near the National Cathedral in downtown Santa Fe) that is challenging for many to access. Until recently, a private dental group provided mobile services at Pete's Place (the Interfaith Community Shelter), though this service stopped as the group was sold to a for-profit company. Similarly, the NM Dental Association provided a free one-day dental clinic in April 2016 at the Santa Fe Convention Center, providing over $1 million in dental services for over 1200 individuals who otherwise could not afford this care, utilizing over 1000 volunteers.[165] Wait times were long, but recipients were grateful for the services received. La Familia provides basic dental care to many, as does the Santa Fe Place Dental Care office, though resources and access to more specialty dental care (such as oral surgery and treatment for TMJ) are very challenging for individuals and families to access. Wait-times are significant, and specialty services are limited. In sum, access to cost-effective dental services remains a significant barrier to the overall health County residents.

[163] These assessments are borne out by the food distribution maps, shown earlier.
[164] New Mexico's health insurance exchange can be accessed at https://www.bewellnm.com/.
[165] See Delta Dental at https://www.deltadentalnm.com/About/Company-Overview/Serving-Our-Community.aspx.

Immigration status and inability to obtain necessary employment, education, and health care due to lack of legal documentation continue to create barriers to good health and access to services within the community. Many immigrants are working and contributing to the economy[166] and yet without legal status are ineligible for many supportive health and human services. This creates an issue for immigrant families as well as for providers who serve them. Non-governmental supports and additional grant funding are required to continue supporting the health and wellbeing of many individuals within the community, many of whom are fearful of seeking medical services, including preventive health care, and other human services due to the need to provide personal information.[167] Many immigrants often feel they are discriminated against or are unwelcome, and therefore are hesitant to access care. Cultural insensitivities and lack of awareness serve as barriers that directly impact the overall health of the community.

One in three women in New Mexico has or is currently experiencing domestic violence in their lives. With this high incidence of violence and the consequent emotional and physical trauma (including traumatic brain injuries), sensitive health screening and care are critical. Insufficient understanding of the cycle of violence for women, children, and older adults who are in abusive living situations, and the physical and psychological symptoms that result from the accompanying fear and trauma, prevent many healthcare practitioners and community members from being able to recognize and treat survivors in a manner that can help increase their overall wellness.

Trauma not only impacts individuals currently living in violent situations, it is an insidious health determinant that impacts many generations of families within Santa Fe County and the state as a whole. Research has begun to show the significant impacts trauma at any age and toxic stress,[168] especially among young children, have, not only on the physical body, but on the emotional and behavioral states of human beings[169] across the globe. Many diseases, including obesity, chronic pain and addiction to name just a few, are now seen by many as direct results of trauma and toxic stress. Research continues to describe how traumatic experiences, including unconscious ones, reside in our bodies well past the actual incidence that created the trauma. As such, healthcare treatment needs to acknowledge and develop new ways of treating ailments often the direct result of trauma and stress. Not fully understanding the impacts of trauma, including adverse childhood experiences[170] (ACEs) and other situations that create stress and trauma, creates a huge barrier to overall community health. Trauma and stress specifically impact particular segments of the population such as immigrants, Native Americans, veterans, victims of domestic violence, and those with significant financial stressors, toxic stress and trauma do not discriminate and therefore impact us all.

B. Health Promotion

Today, when technological advancements move at an exceptionally fast pace, Americans as a

[166] U.S. Chamber of Commerce, *Immigration Myths and Facts*, 2013, at https://www.uschamber.com/report/immigration-myths-and-facts

[167] Some states, such as New York, have developed state-funded Medicaid parallel plans for undocumented immigrants to ensure adequate health care is available for all. *Maximizing Health Care for New York's Immigrant Populations*, Empire Justice Center and New York State Health Foundation. Data on immigrants is available from the Hastings Center.

[168] Toxic stress is a term mental health professionals use to describe adversive or abusive experiences, particularly in childhood, that can affect brain architecture and brain chemistry; see https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/ACEs-and-Toxic-Stress.aspx.

[169] Bessel A Van Der Kolk, et al., *Psychological Trauma*, American Psychiatry Association Publishing, 2003; see also https://books.google.com/books/about/Psychological_Trauma.html?id=Dp2gi8t8zLEC.

[170] See Centers for Disease Control and Prevention at https://www.cdc.gov/violenceprevention/acestudy/.

whole have become more sedentary than ever before. As such, across the board individuals within Santa Fe County express the need to actively and aggressively promote health through a variety of mechanisms, including through use of technology and social media. Health literacy and training are key to helping individuals and families understand what it takes to promote and maintain health as well as how best to utilize health coverage and health services.

"Zumba keeps me healthy! It helps me maintain balance both physically and mentally, and provides me an opportunity to socialize with others."
– Andrea Suarez

Many believe connection to the land and outside green space are essential to health promotion. Improvements throughout the County in bike trails and access to parks continues to grow; however, many believe the need exists to further market these opportunities and encourage individuals and families to be active and access the various recreational centers and parks within the County. Cost-effective gym memberships and access to free or low cost exercise classes allow parents to engage in physical activity, interact socially with other community members, and provide positive role-modeling for their children. However, many activities are focused on adults and do not provide child care on-site – something that would be of great benefit to many mothers and parents throughout the County. In addition, many programs available to children and youth are often cost prohibitive for many families, with increasing challenges for low and middle-income families to cover out-of-school time care, especially during summer months. Likewise, seniors do not always find exercise facilities or trails safe and convenient for them, even those at senior centers. Recommendations were made throughout the information gathering processes to make activities that promote health and movement more accessible to the community as a whole and keeping in mind the needs of specific age groups and family configurations.

Despite a growing understanding of the importance of eating well and maintaining a physical lifestyle, additional marketing and campaigning need to be done to further educate the community on the benefits of living a healthy lifestyle. Many believe that a large-scale, quality public awareness campaign with consistent messaging, assertive marketing, along with connection to low-cost or no-cost activities and fresh, healthy foods and produce would be of great assistance in helping to promote health throughout the County. An example of a creative way to promote health is a recently launched initiative in Pecos. This new "Park Rx" program is an innovative partnership between the Pecos Valley Medical Center and the parks and recreation department. Medical practitioners are prescribing exercise to their patients and providing them with a punch card that allows them to frequent walk paths and parks at no cost. This initiative promotes physical movement as well as connection with green space and the environment.

Home visitation, especially for new parents,[171] is another service that is helping to promote health and wellness for the youngest residents and their families. With regular home visits by a trained professional, parents are able to gain information about the physical, social, and emotional development of their babies, as well as support in obtaining basic needs and connection to various community resources. Parents are supported in providing their infants and

[171] National Conference of State Legislatures, *Home Visiting: Improving Outcomes for Children*, 2017, at http://www.ncsl.org/research/human-services/home-visiting-improving-outcomes-for-children635399078.aspx; see also http://www.sharenm.org/communityplatform/newmexico/earlychildhood for a report on the effectiveness of NM home visiting programs.

young children with a healthy beginning and in turn are provided opportunities to meet other new parents and improve and promote their own health and well-being. Parents are encouraged to access routine health care for themselves and their children and move away from higher-cost interventions such as visits to the emergency department when unnecessary. Families are valued and empowered to take control of their health by a model of care some believe should be implemented universally and with other populations, such as seniors.

By building on the strengths of individuals and families, while encouraging them to continue growing, developing, and enjoying life throughout the lifespan, we will continue to promote a healthy community.

"The expression of joy promotes health."
Alan Oliver, Executive Director, Thornburg Foundation

C. Systemic Challenges

In general, many individuals within the community believe the overall approach and psychology of the healthcare system is out of date and defunct. Rather than focusing on a person's or a community's deficiencies, the system needs to shift its focus to people as community assets so that people are valued and treated with dignity with each individual's strengths built upon to attain and maintain personal health and the culture of various populations built upon to attain and maintain community health. Many community members and service providers indicate that long-standing institutions and leaders are out of touch with the reality of the community, which greatly impacts the quality and availability of services provided.

Of no surprise, the largest challenge identified within the community relates to insufficient funding and resources for health and human services and supports. Limitations with regard to providing insurance coverage, as well as insufficient reimbursement rates for services covered at the state and federal levels, have great implications for County residents. Many community members – providers of care and consumers of care – believe the system is fragmented and does not incentivize health, but rather thrives on illness.

"We need to adjust our interventions to meet the needs of the client of today, not the client of yesterday." – Marsie Silvestre, Former Executive Director, Esparanza Shelter

Many healthcare organizations and administrative leaders recognize the need to leverage existing resources and collaborate more. A need exists within the County to create administrative and operational efficiencies, while effectively targeting limited funding so that it has the highest impact on the greater community. This includes more effective ways of sharing data and records, as well as communicating among providers and individuals themselves regarding holistic health. Of critical importance is the need to integrate both physical and behavioral health care and services, especially in the area of chronic pain management. Though historically physical and behavioral health have been viewed as separate issues, more awareness is rising with regard to the need to integrate care, with behavioral health seen and deployed as a part of overall health, perhaps as a specialty health issue like cardiology or neurology but not as a separate function or practice, and not just from a quality of care perspective but from a financial and ethical standpoint as well.

Reported disconnects among the leadership of managed care organizations (MCOs) and public leaders, including the lack of transparency within the system as a whole, greatly impact access to and quality of care throughout the County. Many individuals and families experience first-hand the lack of connection and care coordination among private practitioners, publicly funded community health services (county, state, and federal), and hospitals. Without clear

communication, collaboration and community-wide protocols, it is easy for assumptions to be made and for healthcare practitioners to believe a given patient is being cared for elsewhere. For example, many believe Native Americans are adequately cared for through IHS programs, but this is not the case for many reasons, including professional shortages within the IHS system. The numerous systemic challenges greatly impact overall service delivery, as many well-meaning providers and service recipients simply give up.

The culture of the system needs to change to promote health and wellness rather than concentrate on illness, and to build on assets and strengths rather than focus on deficiencies.

D. Support for Providers

Throughout the County, people have expressed difficulty recruiting and retaining qualified practitioners to serve County residents. In addition to the high cost of living (including housing) and amount of student loan debt many providers accrue throughout the course of their studies, individuals have also expressed a dissatisfaction with the public school system, as well as difficulties obtaining relevant employment within the state for their significant others. Specialty care practitioners are even harder to recruit, especially in the areas of rheumatology, dermatology, and neurology. In more rural areas of the County and surrounding areas, such as Pecos, NM, healthcare centers experience difficulties recruiting even more general care providers such as pediatricians, psychiatrists and healthcare administrators. Midlevel practitioners (such as registered nurses and social workers) are even harder to come by, which puts a significant strain on both physical and behavioral healthcare providers.

"It is not cost effective to be a medical practitioner here in Santa Fe County." – Dr. Merritt Ayad, Santa Fe County Detention Center

The complexity of the current managed care system is an issue of concern for many healthcare providers. Each of the four managed care organizations (MCOs) within the state covers different services and has different formularies for medication. As such, it can be a significant burden on healthcare providers (and those who support them) to know the details and requirements involved in treating illness and getting service claims paid. Preventive services are often not reimbursed at all. Due to the struggles involved with managed care and public funds, many practitioners choose not to see (or to see only a few) low-income patients, which in some cases places an unnecessary burden on non-profit organizations focused on those with the lowest or with no income.

In addition to the financial and bureaucratic burdens many healthcare providers carry, the severity of illness and complexity of patients being served in Santa Fe County is of equal or greater concern. Few, if any, opportunities exist for local healthcare providers to gather together to discuss the social determinants of health impacting County residents and the struggles they encounter every day. Most healthcare professionals and first responders enter their professions with a sincere desire and commitment to helping others; nevertheless, given the acuity of illness and dysfunction that many residents regularly experience, many providers feel at a loss in terms of how to promote healing and improve peoples' lives.

"We need bold leaders to shift the narrative." – Elsa Lopez, Somos Un Pueblo Unido

Ensuring care and support for health and human services providers, caregivers, and first responders is critical to maintaining a healthy and balanced healthcare system. If individuals

and agencies charged with ensuring safety, maintaining and protecting well-being, and providing care are stressed, the community at large will suffer. Although CMS is increasingly funding initiatives focusing on coordinated healthcare, systemic issues, health disparities, integration, and community-based care, many of the funding streams providers manage are still operating in "silos." Few resources are available for this type of consistent integrated systems collaborative work without agencies simply adding this time and activity to already full schedules in order to address community issues.

E. Policies and Practices to Improve Health

"We are spending too much money on punishment rather than treatment. Youth in jail want nothing more than to be clean and healthy….jail won't help, treatment will." – Deacon Trujillo, San Isidro Catholic Church

As previously stated, the healthcare system needs to shift from a focus on deficiencies to a focus on assets. Hence, it is essential to look at what is working well within the community and build on that positive capacity. Currently, the governments of the City of Santa Fe and Santa Fe County are actively working to enhance services and supports for residents. Key informants indicate that if the City and County governments would partner more, and include local hospitals, providers, and public schools, great potential exists for creating a community of care that builds on individual, family, and community strengths. By strengthening the relationships between pillar institutions throughout the County, existing resources can be better targeted, utilized, and leveraged. Ultimately, this will provide more effective and efficient wrap-around care for all, including individuals and families with exceptionally high needs. Furthermore, many community members believe that enhanced partnerships among all levels of government can result in joint ordinances, commitments, and collaborative funding plans for future services.

One creative idea was to co-locate integrated community health centers addressing both physical and behavioral health issues in existing police or fire substations. Another idea was to co-locate social work staff in each location in which first responders are presently housed. Finally, many community members voiced the need to allow funding to be used in a more flexible manner to provide for high needs clients and/or to provide support for services or goods the general healthcare system does not cover.

Policies and practices that reward healthy partnerships, ongoing communication, cooperation, and collaboration among providers and caregivers, are critical to creating an Accountable Health Community. Providing space for honest dialogue, conflict resolution, strategic planning and creative ideas for addressing health concerns will undoubtedly help clarify how best to implement policies and practices to support health.

F. Priorities

In addition to the more general issues previously mentioned impacting health and well-being, a number of specific priorities arose regarding health and human service needs within Santa Fe County. The issues of most concern to community members, healthcare providers, and other stakeholders throughout the County include gaps in: a) housing availability and affordability; b) behavioral health care for mental illness and addiction; c) services and supports for seniors; and information about and navigation of existing resources and supports. Each of these is addressed in more detail below.

1. Housing

Concerns related to housing are both broad and deep. Safe, secure, and accessible housing in all of its forms represents the greatest priority for many individuals and families within the County, and is believed by many participants in this project to be at the root of health inequities and issues facing County residents. The issue of affordable, permanent housing for all is much larger than simply housing homeless individuals, as the current cost of housing (especially in the City of Santa Fe) is prohibitive for many, including some healthcare practitioners and first responders. First responders reported 60 percent of all officers serving in the Santa Fe Police Department and 70 percent of fire fighters serving in the Santa Fe Fire Department (SFFD) live outside of Santa Fe County. Furthermore, SFFD reportedly recruits individuals from out-of-state; although once they arrive, they are often unable to afford to live within the City limits.[172]

Of additional concern and a priority for many are the numbers of individuals and families within the County who are precariously housed. This includes individuals who may actually have a residence, but it may be overcrowded or lack general upkeep and maintenance, including in some cases, basic electricity or plumbing. The cost of all types of housing in Santa Fe County is high, especially for the many individuals in wage-earning jobs. Community members reported having to pay in excess of $700 per month to simply rent a space within a trailer park, not including the cost of the actual home structure or trailer itself. This creates an excessive burden on families and often prohibits access to other critical needs such as healthy food, reliable and efficient transportation, and health care, especially preventive health care. Seniors in particular often live in substandard housing due to fixed incomes and lack of in-home support for home maintenance and food preparation. Residential senior care housing is exceptionally expensive and thus inaccessible to most. Government run or subsidized residential senior homes in Santa Fe County are at capacity with multi-year waiting lists, forcing a number of seniors with significant illness to live in shelters throughout the County.

Many residents such as seniors, individuals with disabilities, and individuals with or in recovery from mental illness or addiction to drugs or alcohol are in need of supportive housing. For some, such as seniors, supportive housing options may offer in-home meal provision, support with cleaning, transportation to medical appointments, etc. In the case of individuals with mental illness and/or addiction, supportive housing may provide on-site or access to therapists, case managers, and social workers; access to medication management; drug/alcohol free social activities; or on-site 12 step groups.

In addition to the need for affordable and supportive housing, access to low-income and/or government subsidized housing is at an all-time low. At the current time, there are only three government sponsored affordable housing units in SF County and waiting lists for government funded vouchers for housing are extensive (lasting a minimum of two years and sometimes much longer). Rules for accessing affordable government operated or sponsored housing often preclude individuals with addictions or criminal history and generally preclude use of substances in the housing itself. Some informants suggest the County needs to consider “wet housing” or housing that allows individuals to drink or use substances. Experiences of other communities

[172] In the 1990s, planners created a housing loan fund in an effort to fund and democratize housing throughout the City and County. This fund supported many housing initiatives. Socially responsible developers partnered with planners to create a range of housing options for nurses, firefighters, and other City and County employees. However, the cost of housing development has continued to rise, with the stock of affordable housing diminishing. Wait times for publicly supported affordable housing units are still quite high. A wide range of sustainable, subsidized, and affordable models is needed, along with creative financing.

such as Seattle suggest the Housing First model[173] and/or housing that allows legal substance use helps individuals drink less and be ready to address addiction issues after housing is secure, safe, and stable.[174]

Individuals and families without a safe, consistent home are at higher risk of encountering and developing chronic health problems, including toxic stress and trauma. It is no doubt that the issue of housing is of highest priority for the many community members who provided input and information to this process.

2. Behavioral Health

With rates of addiction and death by overdose higher in Santa Fe County than in the State and the nation as a whole, all groups and informants interviewed voiced a deep concern for the general lack of behavioral health services throughout the County. Of particular concern is the lack of sufficient services for individuals in immediate need and for individuals needing intermediate types of services either to prevent escalation of an urgent or emergent situation to a crisis and after crises situations to prevent relapse or return to a crisis state. Of utmost importance to most is the need for all levels of treatment for those with substance use disorders – from drug use prevention services for youth and children in elementary schools to inpatient detox treatment for individuals with opioid addiction to longer term recovery housing and supportive services. The impacts of substance use and attendant disorders plague the SF County community, and it is rare to find a family who has not been directly impacted by the effects of addiction to alcohol and/or other drugs.

A comprehensive array of behavioral health prevention, intervention, treatment, and community support services is lacking in the County. Access to inpatient care – hospital psychiatric stays for individuals with severe behavioral health issues – is limited and many community members voicing concern and frustration in their attempts to access this level of care, especially during times of crisis. Though some crisis services for mental illness and substance use do currently exist, many believe the County needs to build upon the existing foundation and increase capacity for mobile crisis services. Furthermore, many first responders and physical health practitioners feel at a loss when it comes to working with individuals and families struggling with behavioral health needs, and believe additional training and support are needed to further understand a nd better meet the complex needs of such individuals and families. Community members very much support the idea of a place where residents can go in times of crisis, and shared the need for systemic, organized and collaborative navigation services to support individuals and their families, and to provide consistency and support in terms of accessing additional services and assistance post crisis.

Given what CDC calls the epidemic of addiction[175] within the community and the lack of sufficient services across the continuum, individuals and families spoke passionately about the need to increase access to quality behavioral healthcare treatment. Throughout the series of information gathering events, it became clear that limited access to addiction treatment is available within the County and therefore, many individuals are forced to detox in jail. It was reported that 67 percent of Santa Fe County Detention Center inmates presently have mental health problems, with up to 80 percent having an addiction issue. Many jail inmates experience

[173] See https://endhomelessness.org/resource/housing-first/.
[174] See http://www.rehabs.com/are-wet-house-facilities-really-helping-alcoholics/. See also Seattle's consideration of housing for homeless individuals in which substance use is allowed, http://www.seattletimes.com/seattle-news/health/innovative-solution-to-homelessness-housing-where-drug-use-is-ok/.
[175] See www.cdc.gov/opioidoverdose.

dual mental and substance use disorders, as well as poly-addiction to multiple substances. As a result of addiction and incarceration rates, many grandparents are left having to raise their grandchildren as their own children struggle with these disorders.[176]

Detoxification services appear to be a huge gap in the community system of care, which creates a feeling of loss for many trying to support individuals in need of or requesting treatment. Presently, both tribes and other government agencies refer people out of state in order to obtain inpatient treatment, an option that is costly and is detrimental to families, as children and other family members are then separated from their loved ones. Health coverage for inpatient detoxification is often spotty or rigid in terms of services covered, and even when such treatment is covered, rates may be low and hospitals are reluctant to provide this service. Without sufficient follow-up residential treatment and recovery supports, detoxification services may be a cost without a positive outcome from the health system's perspective. Similarly, ambulatory or social detoxification services without sufficient medical supports create concerns for provider organizations and practitioners alike unless a collaborative relationship with a health care facility is in place.

Many professionals and service recipients alike are advocating for more flexible funding to cover services or goods that would aid in the recovery process, though are not covered by typical and existing fee structures. Given the complexity of addiction, it is critical that services and supports are available when an individual is ready to make a change; delays in accessing services or lack of treatment services altogether pose a huge risk not only to individuals and their families, but to the community as a whole. Providers feel discouraged in their ability to help folks as intervention and treatment services are so limited. They, along with families and first responders, are frustrated with having to deal with the same individuals time and time again without sufficient resources to address the addiction so that recovery is possible.

In addition to the need for inpatient drug treatment services and psychiatric hospital stays,[177] interviewees reported a need for additional outpatient treatment that provides a quality understanding of the culture of addiction and the complexities of individuals experiencing addiction. The need for flexible funding and higher reimbursement rates for complex needs was expressed time and time again. The level of frustration and desperation many are feeling due to this epidemic was evident.

Another critical component to addressing behavioral health needs is to continue advocating for behavioral health parity. Many individuals advocated for an increase in community mental health clinics and preferably, an integration of behavioral health treatment within community health clinics. Given the shortage of behavioral health professionals, many individuals suggested enhanced training for primary care physicians so they are better able to serve patients with mental illness and addiction. It was suggested that more PCPs become Suboxone[178]

[176] Although Santa Fe County's number of grandchildren being raised by grandparents runs close to the State average, the rate of increase between 2005-2009 and 2011-2015 is above the State average, and the proportion of grandparents actually responsible for grandchildren is significantly above the State average, indicating a fast-growing trend with significant financial consequences. *Grandparents Raising Grandchildren in New Mexico*, Anne Hays Egan with John W. Egan, Con Alma Health Foundation, 2017.

[177] While the CHRISTUS St. Vincent (CSV) Healthcare System has been the only emergency department (ED) and inpatient unit in Santa Fe County for many years, other nearby inpatient units exist in Albuquerque and the state-operated psychiatric hospital in Las Vegas (BH Institute). However, gaining access to these facilities is difficult. Respondents often expressed frustration with CSV in particular. Presbyterian Healthcare Services' development of a new hospital and health system in the south end of the City will not provide an additional BH inpatient unit, but may provide opportunities for further collaboration on needed BH services often experienced in EDs and inpatient units.

[178] A combination of buprenorphine and naloxone. See https://www.suboxone.com/.

prescribers and all medical staff receive cultural competency training especially in terms of treatment of behavioral health patients. Nevertheless, negative attitudes, misinformation, prejudicial judgments, and unrealistic expectations of individuals experiencing and being served for behavioral health issues undoubtedly impact the quality of care they receive. Frankly put, some believe few professionals are properly trained and truly interested in treating those with serious mentally illness (SMI), in part because no training hospitals specific for such individuals and diagnoses exist within the State and because medical and nursing education provide no or insufficient training about the treatment of these illnesses. Many patients reported being treated poorly and being misunderstood by certain providers within the community, which discourages them from seeking or returning for treatment. Others reported getting assistance from key providers within the County and being very grateful for that support. In addition to supporting individuals themselves, respite care and support services for caregivers and family members are critically needed as well.

It was further reported that the lack of behavioral health services in general is causing inappropriate referrals to other community agencies such as the local domestic violence (DV) shelter, whose staff is generally not trained as behavioral health clinicians. Survivors of domestic violence are showing up with higher incidences of opioid and other prescription medication addictions, which impacts the milieu in the domestic violence shelter.

Many informants shared their belief that the County jail has become the de facto mental health hospital and detox center for County residents with 67 percent of Santa Fe County Detention Center inmates presenting with mental health problems, and up to 80 percent presenting with recent use of alcohol and/or other substances. Once individuals serve their time, experience detoxification, and are ready to reintegrate into the community, very few transitional options are available for detainees upon release. Recent investment by CSD to pay for re-entry staff working at the jail has increased connections for detainees being released. A number of groups are working on enhanced transitional services, although an organized and well-communicated plan is essential to its success.

3. Services for Seniors

Of special concern to most groups and informants encountered during this project is the treatment and care of older adults, especially the many seniors living in isolation with limited family and social supports to assist in their everyday lives. It was repeatedly reported that often times, senior meal deliverers are the only people who have regular physical contact with such older adults. Unfortunately, their time and availability to really support seniors is limited. Many informants suggested increasing the involvement of volunteers from faith-based communities to help in the support of seniors, recognizing the current system is ill equipped to deal with the rising numbers of seniors in need of regular in-home care.

Specific issues of concerns as related to seniors are the living conditions in which many seniors reside, including substandard housing - homes in need of repair and living spaces that pose great risks for falls and other unintended injuries. Access to healthy foods for seniors and limits on what senior food program staff can provide in terms of transportation to medical and other necessary appointments are other issues that concern many Santa Fe County residents. Though some services do exist, they are few and far between and require enhancements in order to meet both current and growing need.

Though many seniors wish to remain in their homes, the cost of in-home care is excessive, making this service unattainable for many elder residents with limited incomes who do not

qualify for Medicaid funded in-home services and who cannot afford to pay for out-of-pocket costs. Providers of services for seniors reported that Medicare reimbursements are insufficient and untimely, while prepaid health plans often require individuals to pay for services and care upfront, which is not always possible. For individual seniors unable to remain in their homes, the cost of residential care often exceeds their fixed incomes. As a result, long waiting lists exist for publicly funded residential care for seniors. Thus, families and other caregivers are often left on their own to figure out how to adequately and appropriately care for aging loved ones.

As is the case for other specialty groups, the lack of appropriate care and resources is creating inappropriate referrals to other services such as shelters which are not equipped to deal with significant medical needs. Many believe short-term beds are needed, especially for elderly women with significant medical needs, as well as enhanced capacity for respite and medical care for elderly individuals experiencing homelessness. Many shelters require their guests leave the shelters during daytime hours. With no place to go, seniors are left in vulnerable situations and at risk for harm or further illness.

Some local providers specialize in outpatient care for seniors, although these providers face huge gaps when they feel the need to refer a senior to specialty care, specifically gerontological health care, inpatient geriatric behavioral health services, or specialty care in rheumatology, dermatology, and neurology. Not having sufficient places and/or specialists to which to refer patients, many primary care practitioners are left to address the health and well-being of the County's seniors as best as they can. It is believed an increase in mobile services to provide nutritious meals, in-home care and support, transportation to medical appointments, and home visitation by healthcare professionals following hospital discharge is one way to alleviate some of the issues seniors living in isolation are facing. An increase in cost effective, high quality supportive housing opportunities for seniors is considered essential to bridging the many gaps in care experienced by many SF County adults who are older.

As detailed in an earlier section of this report, informants and participants described the huge service gap for older adults with limited incomes and those with medium incomes. An older adult on Medicaid is eligible for Agency Based Community Benefit Services (ABCB) which includes personal care services, adult day care, home care, home renovation/retrofitting, and nursing home level of care if needed. However, it is tough for Medicare recipients to qualify for Medicaid according to some benefits enrollment specialists in NM. Those older adults with limited incomes find it extremely difficult to pay for in home care, and when they can pay, finding qualified home care professionals is often difficult.

4. Navigating the Existing System

Despite the many gaps in the existing service delivery system, many providers and community agencies are working hard to address the needs of the community. Nevertheless, many reported the need for a comprehensive place or site for obtaining information regarding the availability of existing resources, including clear communication with regard to how to access said services. Although most agencies have their own websites and marketing materials, many providers and community agencies reported not knowing where to go to get information on service availability beyond their respective agencies. Clients and family members also expressed not knowing where to go to get information and support when they are in need. Even though some resources for information do exist, for example Share New Mexico at www.sharenm.org, these resources are not well-known and are often considered insufficient for individuals and families seeking care or service resources.

Community members and providers alike are in favor of more communication and collaboration among individual programs and funders, to include a website or phone app that provides up-to-date information on service availability, including current capacity and wait times, as well as the processes for referring patients for care. Suggestions were made to have the website or app be a comprehensive and holistic site for resources and to market the information through public schools, churches and other existing community structures. Marketing of the site is critical and must include messaging that highlights wellness, provider alignment and the strengths and resiliency of the community as whole.

In addition to having a single point or place to gather information, many informants stressed the need for continued provider alignment. Though resources are limited, many believe that quality and accessibility of care can be improved by working to better align existing services. Suggestions were made to incentivize cooperative work and provide flexible funding to organizations or collaborations that work closely and communicate regularly with their community partners. Other ideas to improve navigation of the existing system and enhance provider alignment included providing cross-agency professional development opportunities and assisting agencies in finding ways to share data and build administrative efficiencies. Many individuals shared concerns about the wages of staff in the healthcare field, especially those serving behavioral health needs. As such, recommendations were made to encourage living wages for healthcare staff across the County and to provide incentives across agencies in order to attract and support professionals within the community.

> ***"We combine the values of social justice with the principles of fiscal responsibility."***
> ***– Jeff Thomas, Southwest Care Centers***

While providers, town hall participants, and key informants indicated the need for providers and advocates to collaborate and align efforts, many noted that Santa Fe County providers are invited to or expected to attend multiple meetings, called by a variety of different individuals or entities, often without clarity about the purpose or desired outcome of the meetings. Many do not feel comfortable if they do not attend or fail to send a representative to these meetings. Yet, they expressed concern meetings should be more productive and time better spent if the conveners coordinated and consolidated the meetings, and if the purpose was identified and clear outcomes, purpose, or action steps were identified for each meeting convened.

G. Other Cross-Cutting Themes

Several cross-cutting issues were raised by many providers, key informants, and town hall participants about services of all kinds. Three of these cross-cutting issues were stated often enough as to be highlighted here.

1. Cultural Competency

As indicated in other parts of this report, attitudes, bias, misinformation, prejudice, and/or outright discrimination are often experienced by service recipients and their families, especially as related to behavioral health, immigration status, and homelessness (as well as related to poverty, race, and ethnicity). Informants reported being treated poorly and as second class citizens in certain settings, especially in the hospital emergency room and/or when encountering human service providers or other members of the public. Specifically noted were the following:

- Misunderstanding or lack of understanding regarding the disease of addiction;
- Quality and sensitivity of services provided;
- Ongoing training needs regarding the complexity of current conditions and fears faced by immigrants;
- Access to traditional ways of preparing local foods;
- Insensitivities around aging and LGBT status and their healthcare needs; and
- Need to shift the lens from looking at things and people (such as low-wage workers) as deficits or problems to be solved to seeing them as assets for and in the community ready to help create community solutions.

Some people contacted by this project's consulting team reported they are often not comfortable in many provider settings, and find them to be difficult to navigate, confusing, time-consuming, and some- times disrespectful. Others made sure to call out specific providers or situations in which providers were particularly helpful and made a real difference in their lives.

2. Enhanced Resources

"It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped."
– Hubert H. Humphrey

While it may go without saying that informants and participants universally expressed a need for additional resources for health and human services, many recognized today's challenge is how to utilize existing resources more efficiently and how to assure services currently available are not reduced as the pressure to control or reduce government funding continues or even increases. Many expressed the importance of the County making clear that investment in human resources – people within the County – is good for the community, for businesses, for the economy, and for providers within the community, and therefore are good for everyone. People expressed the need to help the general public, especially those concerned about the tax base or the appropriate use of tax dollars, to understand the impact such dollars have on individuals and families as well as the health and safety of the community as a whole.

Participants and informants generally indicated a need for the following types of resources:

- Flexible funding and reimbursement mechanisms to address issues impacting the effectiveness of more traditionally reimbursed services;
- In-home services (especially for seniors and those with significant disabilities);
- Mobile services across the board; take the services to where the people are;
- Navigation cross-agency, coordinated, and clearly communicated rather than program-specific with limitations on the things navigators can do for individuals and families;
- Prevention to address health issues earlier to prevent onset of more difficult to treat conditions as well as early and universal prevention efforts to enhance health, prevent illness, and address social determinants impacting health and well-being; and
- More extensive and easier to access necessary specialty care.

3. Transportation

Informants and participants noted the critical need for transportation to support education,

employment, health and fitness activities, health-promoting socialization, family caregiving, and access to needed health and human services. The request for mobile services recognizes the need to take services to where people live to minimize transportation barriers. In addition, the following needs were noted:

- Improved public transportation, especially within the parts of the County outside the City;
- More mobile services by providers; one of several examples is Pecos where people reported dependence on family and friends for rides; enhanced van and mobile care is needed as Pecos Valley Medical Center has a van, but no way to be reimbursed for mobile services;
- Assistance with reliable transportation, especially for those with difficulty transporting such as if unable to walk without assistance or if in a wheelchair; and
- Bus stops and schedules are difficult to access and do not coordinate with necessary work hours; buses are difficult for those without full mobility, who are sick, who have children or other family members to manage, and who are trying to stay clean and sober.

HIGHLIGHTS – TOWN HALLS, KEY INFORMANTS, & PROVIDER GROUPS

1. *Eight town halls, 22 key informants, and five provider groups identified many barriers to good health, including: a) high cost of housing, food, and other basic needs; b) lack of health and dental coverage; c) immigration status resulting in inability to obtain necessary employment, education, and health care; and d) ongoing and untreated trauma and chronic stress.*
2. *The health care system is fragmented and thrives on illness rather than incentivizing health. Health promotion and public awareness; access to low or no-cost health activities and fresh and healthy foods; and home visitation for new parents are critical for the health of all Santa Fe County residents.*
3. *Healthcare organizations and leaders need to leverage existing resources and collaborate more to create administrative and operational efficiencies. Providers need help: a) recruiting and retaining staff; b) aligning resources, locations, and programs; and c) creating opportunities to discuss social determinants and to advocate for their common interests.*
4. *Priorities for services include: a) affordable housing for all residents, including those with low income, seniors, and non-profit staff as well as city and county first responders; b) behavioral health care of all kinds; c) services and supports for seniors, including use of volunteers and more in-home care; and d) information about and navigation of existing resources and supports.*
5. *Cultural competency, enhanced amounts and types of resources, and better public transportation were identified as additional community needs.*

VII. THEMES AND RECOMMENDATIONS

All the input and data described in this report suggest Santa Fe County's needs are significant and hence, recommendations could be extensive. Challenges described offer opportunities too numerous to address all at once. Major populations for increased attention include seniors, persons with behavioral health challenges, and persons/families at high risk due to income or circumstance (including immigration status, language, disability, etc.). Significant service gaps include housing resources, navigation assistance to access current services, and workforce and provider capacity issues today and for the future. Throughout these key issues, cultural approaches, prevention/early intervention (especially in behavioral health), and social determinants of health emerged as critical themes.

HIGHLIGHTS –

THEMES AND RECOMMENDATIONS

Populations

- *Seniors*
- *Persons with Behavioral Health Needs*
- *Persons at High Risk Due to Low Income or Circumstance*

Service Needs

- *Housing*
- *Behavioral Health*
- *Senior Services*
- *Navigation*
- *Workforce & Provider Capacity*

Cross-Cutting Needs

- *Cultural Issues*
- *Prevention/Early Intervention*
- *Social Determinants*

Recognizing the themes from the combination of data analysis and qualitative input from providers, key informants, and the general public, and considering the priorities and efforts already under way by SF County government, the recommendations in this section emerge from this gap analysis. CSD as the County agency leading community services is the recipient of these recommendations via this gap analysis report. However, CSD cannot accomplish or even lead all of these efforts. Many of the recommendations indicate collaborators or partners needed to accomplish the task. Ultimately, it will take the County community as a whole, including providers and advocates as well as government, funder, faith, and business leaders to accomplish the goals and actions identified here to make a more accountable and healthier Santa Fe County community for all.

A. Housing

1. Embrace, prioritize, and work to support creation of affordable housing.

    a. Embrace and implement the SF County Housing Authority's Five-Year Plan and the City of Santa Fe Affordable Housing Plan.
    b. Find and create subsidy forms of capital to incentivize the creation and development of a range of affordable housing, including supporting investment in infrastructure and higher density areas with water and sewer services.
    c. Create zoning for multi-family development in all parts of the County; streamline development review processes for affordable housing projects and units.
    d. Provide housing vouchers for practitioners with student loans working at non-profit health and human services agencies.

e. Advocate with HSD and the NM Mortgage Finance Authority to collaborate to create supportive and scattered site housing for persons with serious mental illness and persons with special needs, using a housing first model.
f. With City, County, State and community partners, advocate maintaining existing federal housing development options.
g. Working with City and County planners, socially responsible developers, and innovative funders, expand housing subsidies, loans, and grant funds to be used in innovative ways to subsidize housing costs for low and middle-income residents.

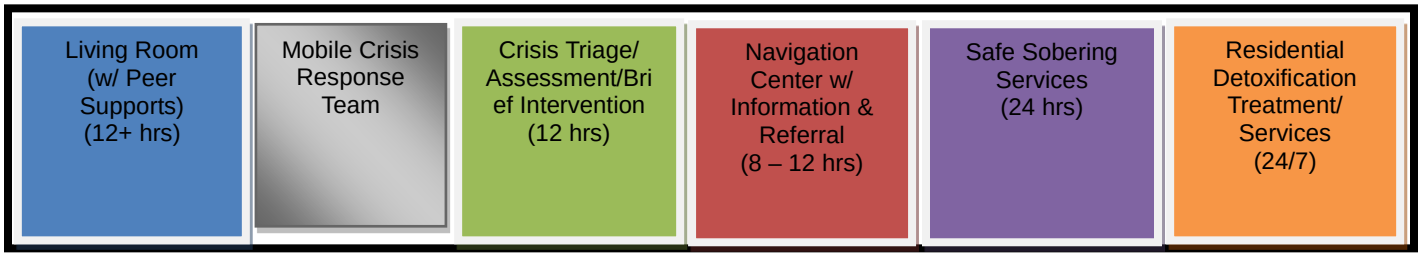
2. Build on Pete's Place (the Interfaith Community Shelter) and other shelter services.

   a. Provide year-round shelter and food for men as well as women.
   b. Assess needs and create shelter, medical, and navigation services for persons with disabilities and/or complex medical needs.
   c. Expand Life Link's consumer drop-in center hours and/or create a separate drop-in center for social and service supports for persons who are homeless.
   d. Consider how to support and/or expand on St. Elizabeth's and Youth Shelters and Family Services' shelter and transitional living facilities and programs.

B. <u>Behavioral Health</u>

1. Hire a BH Services Program Manager for CSD to guide the implementation of behavioral health priorities and coordinate interagency initiatives with the City, State, federal government, and community providers; consider use of an intern or fellow to extend capacity, provide research assistance, and bring in new ideas.

2. Create the BH Crisis Center to include the following direct and co-located services, with agreed upon protocols for client flow, medical clearance, and decision-making among City and County law enforcement, emergency and other first responders, community providers, community hospitals, and community groups representing voices of service recipients and families. Include training and support for caregivers and first responders about managing crisis situations as well as expanded treatment guardian and other capacity to seek or provide immediate stabilization and/or services for persons unable or unwilling to consent to services.



3. With input from community providers and persons with lived experience of behavioral health issues, develop a BH services strategic plan (like the *Senior Services Strategic Plan*) identifying priorities and action steps, including plans and responsible parties for a range of evidence-based prevention, treatment, rehabilitative, and recovery services. The plan should include service goals for inpatient, residential, and outpatient detoxification, psychiatric, psychological, medical, and counseling

services as well as rehabilitation and recovery supports, including family and peer-delivered services and housing and employment supports.

4. Work with community partners to create a behavioral health step down unit for individuals ready to leave behavioral health inpatient units or the State hospital facility in Las Vegas, and are in need of transition or follow-up care prior to returning to independent living.

5. Work with City and County law enforcement to assure all officers and deputies have opportunities for Crisis Intervention Team (CIT) training;

6. Consolidate (or better coordinate) high utilizer programs addressing the needs of individuals with significant BH issues (for example, LEAD, MIHO, HUGS).[179]

7. Work with the State of NM and the National Council on Behavioral Health to expand Mental Health First Aid training throughout SF County.

8. Seek funding and advocate to implement specific prevention programs such as youth/young adults experiencing first episode psychosis (FEP), high risk youth experiencing prodromal syndrome symptoms, and Zero Suicide approaches in health systems; work with partners to support prevention programs addressing behavior management (for example, the Good Behavior Game), substance use, suicide, teen pregnancy, and violence prevention and conflict resolution training for youth.

9. Work with schools, health systems, the Santa Fe Prevention Alliance, and the State of NM to implement a universal screening program for all at risk families, including screening for ACEs and other health and behavioral health risk factors; prioritize home visiting and related services to meet identified needs for those at most risk.

C. Services for Seniors

1. Continuing implementing the *Senior Services Strategic Plan*, especially opening of the new senior center and increasing services at existing centers. Engage CSD's senior advisors group to help with planning, outreach, and advocacy.

2. Work with the Santa Fe Community College to create a curriculum and classes for in-home caregivers.

3. Enhance transportation options for non-medical purposes; work to link Medicaid recipients with MCO provided transportation for medical needs.

4. Enhance mobile services for seniors, for example, designated home visitation services for seniors living in isolation without family or other community supports;

5. Work with Santa Fe County and City parks and recreation departments to create and market safe, accessible walking trails and exercise programs designed for seniors

[179] These programs are Law Enforcement Assisted Diversion (LEAD) funded by the City; Mobile Integrated Health Office (MIHO) operated by the City Fire Department; and High Utilizer Group Services (HUGS) operated by CHRISTUS St Vincent and funded in part by the County.

and persons with disabilities and/or limited mobility, especially in North County, South County, and southern parts of the City.

6. Make concerted efforts to market senior services and events in locations where seniors might be or places they might listen, for example, in grocery stores, churches, health facilities, assisted living facilities, and on radio, television stations, senior focused social media, etc.; utilize seniors and persons who live with disabilities for advice on such efforts.

7. Work with faith communities, churches, synagogues, and other places of worship or socialization and other non-governmental entities[180] to increase community and volunteer capacity, especially for home-bound seniors and persons with disabilities; consider creation of a County-sponsored volunteer program for seniors using seniors who are able and available to provide such assistance to other seniors.[181]

8. Work with hospitals, practitioner groups, and community funders to develop pooled funding for in-home care for those designated most at risk but have no payer source for such services; consider negotiating discounted rates with high quality home care providers; consider premium assistance for long term care insurance for younger families for whom such insurance will be critical as they age, but who are not likely to have the resources for private pay services.

9. Work with senior and disabled advocacy groups to identify targeted State and federal policies to preserve and/or enhance resources and services for seniors and persons with disabilities.

10. Consider development of low-cost or sliding scale memory care services and/or facility, in conjunction with CHRISTUS St. Vincent, the new Presbyterian Health Services facility, and other local providers or funders.

D. Navigating and Enhancing the Current System

1. Create a comprehensive coordinated capacity for on-line and person-to-person real time up-to-date crisis assistance and information for law enforcement, providers, and the general public about available services and resources, with immediate connection to counseling or navigation assistance if needed. Fund a position or organization to be responsible for updating real time information and work with or incentivize providers to contribute and keep resource information up-to-date; consider partnering with existing data and crisis line capacity such as the State of NM's NMCAL,[182] the City 911 service, or ShareNM.org,[183] include opportunities for training and technical assistance for providers, persons receiving services, family members, and caregivers.

2. Coordinate navigation services so those in need of assistance have a primary care or medical home with a primary navigator; assure multiple case managers, care

[180] One such example is the Village model of care, developing here in Santa Fe County.
[181] Los Alamos Retired and Senior Organization (LARSO) has an excellent model for such a volunteer program, led by Pauline Schneider.
[182] NM Crisis Assistance Line, operated by the State of NM's BH Services Division, a division within HSD; see http://www.nmcrisisline.com/about-us/news/.
[183] See https://www.sharenm.org/communityplatform/newmexico.

coordinators, and/or navigators either defer to the primary navigator or assist without duplication or inconsistency of efforts.

3. Consider funding free-agent navigators not connected with a program or agency, to supplement the navigators funded through the recent CSD navigation contracts with community services organizations.

4. Create or expand use of community health workers, promotoras, community engagement teams, peer outreach workers, and other forms of engagement and navigation using community members as navigators and non-service oriented engagement sites (for example, churches, gyms, restaurants, community centers, churches and synagogues, etc.).

5. Aggressively work to increase enrollment of children and adults into any available health insurance coverage, especially Medicaid; provide health literacy training (in English and Spanish) to assist individuals to utilize coverage effectively; identify and plan for resolution of barriers such as fear, lack of understanding, or cost of premiums, co-pays, and deductibles.

6. Facilitate increased sharing of individual data for care coordination purposes as well as population-based data for planning purposes; train providers, and implement compliant IT opportunities; create and distribute a simple straight-forward explanation of consent and confidentiality laws and regulations (for example HIPAA and 42 CFR Part 2[184]) for providers and service recipients, including what kinds of information can (and should) be shared with and without consent.

7. Work with providers to locate health and other human services in or near areas where populations with highest needs reside; identify opportunities for mobile services to take services to locations where high-need populations live, work, or recreate; include creation of healthy and fresh food resources and transportation to food outlets for individuals living in “food desert” areas.

8. Work on increasing multi-cultural capacity, competency, and a welcoming practice environment by:

    a. Working with Native American pueblos in Santa Fe County, ENIPC, IHS Santa Fe Health Unit, and the State’s Indian Affairs Department to develop priorities for advocacy for health needs of indigenous populations in Santa Fe County.
    b. Collaborating with providers and funders to provide incentives or pay differentials for Spanish-speaking staff and assure materials in Spanish are available are in reception areas of all government and non-profit provider organizations.
    c. Following the lead of faith communities by creating and displaying signs at all government and non-profit provider organization buildings indicating “Immigrants Are Welcome Here.”
    d. Collaborating with the NM Primary Care Association and other practice groups to offer cross-agency training and support for County and provider staff that move from the standard diversity training to a focus on celebrating differences and

[184] Health Insurance Portability and Accountability Act governs consent and confidentiality of all health records; see https://www.hhs.gov/hipaa/index.html; 42 CFR Part 2 implements federal laws governing special consent requirements for substance abuse diagnosis and treatment records; see https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs.

strategies for building mutual respect and full inclusion; identify those providers that model multi-cultural competency in specific areas and highlight what they do that works for the rest of the provider community.

9. Assist providers with workforce issues by:

    a. Working with the City of Santa Fe to create consolidated or coordinated health and human services planning and approaches for all residents within the County;
    b. Creating a single provider forum or association where all provider issues can be vetted and considered with joint strategies for resource development, advocacy, problem solving, and staff training and support;
    c. Engaging with other group leaders to minimize the number of public input and provider meetings and maximize provider meeting efficiency and effectiveness;
    d. Working with current or new provider association/forum and the Santa Fe Chamber of Commerce to create a focused collaborative workforce recruitment and training strategy among critical government and non-profit healthcare providers to share practitioner time and cost; increase practitioner incentives; develop internships and other training opportunities with teaching hospitals or schools; and assist practitioners to address housing, education, and other barriers to living in SF County;
    e. Identifying associations and funders with knowledge about programs to assist newly credentialed and recruited health professionals to defer some of their student loan costs and/or cover critical expenses; work with SF County funders to create a fund for such expenses; and
    f. Working with the SF County Public Housing Authority to identify barriers and create staffing capacity for affordable housing projects.

VIII. CONCLUSION

Santa Fe County's Community Services Department has focused for a number of years on understanding the health of the community, with its diverse assets and needs, health strengths and weaknesses. The various health assessments and plans and the established collaborations and goals position the County to target its leadership, strategic initiatives, and resources on those actions designed to deliver the best outcomes for SF County residents.

The needs are clear, and gaps are significant and longstanding. The greatest challenges as well as the greatest opportunities lie in:

- Prioritizing among the various issues and opportunities identified to bring focus to specific goals and activities;
- Providing inspired and well-informed leadership for the County, its residents, and its organizations, and sharing that leadership with other key organizations as needed;
- Developing focused strategies with specified action plans to leverage those collaborative relationships and community resources;
- Targeting limited resources in a manner supported by the collaborative network of providers, funders, elected and government officials, and the community as a whole;
- Helping network partners and providers build upon their strengths, leverage their resources, and address weaknesses to build their own effectiveness;
- Building diversified funding from a range of sources to support priority initiatives through the County and among different provider networks;
- Creating a broad-based level of community, political, financial, and policy support for identified health priorities and the collaborative work needed to achieve collective impact; and
- Educating and engaging the public and community partners about priorities, successes, needs, challenges, and opportunities to keep the community as a whole engaged and supportive of County efforts to create a healthier community.

Ultimately, community health requires leadership and collaboration with a shared vision and focused priorities. By identifying priorities and action steps to build on existing strengths, partnerships, and efforts, Santa Fe County can help create a healthier and safer community for all its residents.

Community health requires leadership and collaboration with a shared vision and focused priorities.

APPENDIX A:
ACRONYMS USED IN SANTA FE COUNTY HEALTH SERVICES GAP ANALYSIS REPORT

- aka – also known as
- AARP – Formally known as American Association of Retired Persons, now just AARP
- ABCBS – Agency Based Community Benefit Services
- ACA – Affordable Care Act
- ACE – Adverse Childhood Event(s)
- ADL – Activities of Daily Living
- ALTSD – Aging and Long Term Services Department (State of NM)
- BCC – Board of County Commissioners
- BH – Behavioral Health
- CCBHC – Comprehensive Community Behavioral Health Clinic
- CCSS – Comprehensive Community Support Services
- CDC – Centers for Disease Control and Prevention (U.S. DHHS)
- CHC – Community Health Center
- CHNA – Community Health Needs Assessment
- CIT – Crisis Intervention Team
- CMHC – Community Mental Health Center
- CMS – Center for Medicare and Medicaid Services (U.S. DHHS)
- CSD – Community Services Department (County of Santa Fe)
- CYFD – Children, Youth and Families Department (State of New Mexico)
- DHHS – Department of Health and Human Services (U.S.)
- DOH – Department of Health (State of NM)
- DV – Domestic Violence
- ED – Emergency Department
- EHR – Electronic Health Record
- ENIPC – Eight Northern Indian Pueblos Council
- FEP – First Episode Psychosis
- FPL – Federal Poverty Level
- FQHC – Federally Qualified Health Center
- HCAF – Health Care Assistance Fund (CSD)
- HCAP – Health Care Assistance Program (CSD)
- HIPAA – Health Insurance Portability and Accountability Act
- HPPC – Health Policy and Planning Commission (SF County)
- HPSA – Health Professional Shortage Area
- HRSA – Health Resources and Services Administration (DHHS)
- HSD – Human Services Department (State of NM)
- HUD – U.S. Department of Housing and Urban Development
- HUGS – Higher Utilizer Group Services (CHRISTUS St. Vincent Health System)
- IBIS – Indicator Based Information System (State of NM)
- ICE – U.S. Immigration and Customs Enforcement
- IHS – Indian Health Service (U.S.)
- IT – Information Technology
- LARSO – Los Alamos Retired and Senior Organization
- LEAD – Law Enforcement Assisted Diversion (The Life Link)
- LFC – Legislative Finance Committee (State of NM)
- LGBT – Lesbian, Gay, Bisexual, Transgender
- LTC – Long Term Care
- MAT – Medication Assisted Treatment
- MCO – Managed Care Organization
- MCRT – Mobile Crisis Response Team
- MIHO – Mobile Integrated Health Office (City of Santa Fe)
- NIDA – National Institute on Drug Abuse (DHHS)
- NIMH – National Institute of Mental Health (DHHS)
- NM – New Mexico
- NMCAL – NM Crisis Assistance Line (State of NM)
- NMCDC – New Mexico Community Data Collaborative
- PCP – Primary Care Physician (or Practitioner)
- PE/MOSAA – Presumptive Eligibility/Medicaid On-Site Application Assistance
- PMS – Presbyterian Medical Services, Inc.
- RFP – Request for Proposals
- SAMHSA – Substance Abuse and Mental Health Services Administration (DHHS)
- SDOH – Social Determinants of Health
- SF – Santa Fe
- SFFD – Santa Fe Fire Department
- SMI – Serious Mental Illness
- SNAP – Supplemental Nutrition Assistance Program (U.S.)
- SOS – Santa Fe Opiate Safe
- SSI – Supplemental Security Income
- SSSP – *Senior Services Strategic Plan* (SF County CSD)
- UNM – University of New Mexico
- U.S. (or US) – United States

APPENDIX B:
LIST OF FIGURES IN SANTA FE COUNTY GAP ANALYSIS REPORT