Syracuse University

D'Aniello Institute for Veterans & Military Families

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Collaboration In Context: The Present and Future of Coordinated Care for New Mexico's Military-Connected Population

ABOUT SYRACUSE UNIVERSITY'S D'ANIELLO INSTITUTE FOR VETERANS AND MILITARY FAMILIES (IVMF)

Syracuse University's D'Aniello Institute for Veterans and Military Families (IVMF) was founded in 2011, as a partnership between Syracuse University and JPMorgan Chase & Co. Headquartered on the campus of Syracuse University and located in the Daniel and Gayle D'Aniello Building at the Syracuse University National Veterans Resource Center, the IVMF was founded as higher-education's first interdisciplinary academic institute singularly focused on advancing the lives of the nation's military, veterans, and their families. The IVMF team designs and delivers class-leading training programs and services to the military-connected community, in support of the transition from military to civilian life and beyond. Each year, more than 20,000 service members, veterans, and family members engage IVMF programs and services, which are provided at no cost to participants. The IVMF's programs are informed by the Institute's sustained and robust data collection, research, and policy analysis team and infrastructure. The D'Aniello Institute's work on behalf of the military-connected community is made possible by gifts and grants from individuals and corporations committed to those who served in America's armed forces and their families. For more information, please visit ivmf.syracuse.edu

CONTRIBUTORS

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Executive Summary

New Mexico has a long history of military presence beginning in the 1540s with the first Spanish explorations into what is now the state's interior. Today, the "Land of Enchantment" is home to five military installations, over 12,000 active-duty service members and more than 140,000 veterans and their families. In 2022, two members of the New Mexico Legislature allocated funds through Central New Mexico Community College (CNM) to the D'Aniello Institute for Veterans and Military Families at Syracuse University (IVMF) to conduct a current state assessment of New Mexico's veteran services landscape. Using information gathered from the current state assessment, the IVMF was asked to provide recommendations for how the state can work toward implementing a coordinated care model for its veterans and military families.

To provide an overview of the current veteran services landscape in New Mexico, the IVMF gathered data on following:

- The demographic and socioeconomic makeup of the veteran community,
- The organizations serving the military-connected community,
- The state of coordination and collaboration among service providers,
- And the needs of veterans and military families

From there, the IVMF sought to answer the following questions to inform its recommendations:

- What do veteran-serving organizations in New Mexico perceive as the next steps to improving collaboration and coordination?
- What are the opinions and considerations of veteran-serving organizations on implementing a statewide coordinated care system?

The IVMF utilized both qualitative and quantitative methods to collect data for this report. Quantitative activities—including leveraging data sets from the U.S. Census Bureau, the U.S. Internal Revenue Service (IRS), existing resource directories, and others—grounded and contextualized qualitative feedback in data and descriptive analysis. Qualitative activities, specifically surveys, focus groups, and one-on-one stakeholder interviews, elicited first-hand contextual information from organizations and other entities serving the military-connected community in New Mexico. In all, the IVMF engaged with individuals from 41 organizations across the state.

Following data gathering activities, the IVMF consolidated its results and findings into five thematic areas:

- A demographic and socio-economic overview of veterans and military families,
- A landscape perspective of providers in New Mexico,
- The needs of veterans and military families,
- The current coordination and collaboration landscape,
- And considerations for the future state of coordination and collaboration

First, when examining demographic and socio-economic data, the IVMF found New Mexican veterans tend to be older and have higher rates of unemployment, poverty, and disabilities compared to national averages. Additionally, around two in three veterans in New Mexico live in an area that is relatively more rural. Of note, the ratio of veterans to non-veterans per county underlines how easy it is for any New Mexican resident to know a veteran no matter where they live. This suggests communities across the state are more likely to interact with and know their veteran population.

Next, the IVMF leveraged data from the IRS and several resource directories to understand the distribution of veteran-serving organizations across the state. The bulk of the 156 organizations the IVMF identified as serving the military-connected community in New Mexico operate in the more urban counties of Bernalillo and Santa Fe with the remaining organizations spread throughout the other 31 counties.

Through its qualitative data collection, the IVMF identified several unmet or under-resourced needs for veterans and military families in New Mexico, including:

- Financial Assistance
- Housing
- Mental/Behavioral Health
- Physical Health and Medical Care
- Substance Use
- Transportation Assistance

In surfacing these needs, the IVMF found that issues in accessing and navigating the Veterans Health Administration (VA), limited organization and provider availability, and transportation to be near-universal challenges across New Mexico. The common thread running through these issues is the state's rurality and corresponding concentration of resources in urban areas. Indeed, resource distribution presented a series of challenges in meeting the needs of veterans living in these regions while also being an underlying cause for the need for certain services, particularly transportation assistance. As such, veterans living far from the resources in urban areas must travel long distances or contend with under-resourced organizations in their areas for services. Put simply, the supply of practitioners accessible to veterans simply cannot meet the demand.

In exploring the current coordination and collaboration landscape, the IVMF found several environmental factors—ranging from infrastructural to individual—that create a context in which collaboration among providers is necessary to serve New Mexico's military-connected population. To that end, the IVMF identified a broad mix of collaborative efforts currently happening between organizations across the state. These efforts range from informal to formal and cover a variety of activities and approaches including information exchanges, veteran collaboratives, and in the case of Santa Fe, a coordinated care network for all city and county residents.

Finally, the IVMF sought to understand the opinions of veteran-serving organizations on implementing a statewide coordinated care system. Participants were overwhelmingly supportive of the concept, sharing that such a model would help to ease access to care for veteran help-seekers, save them time in connecting their clients to services outside of their own organizations, and enhance communication between organizations in their communities. Importantly, when participants were asked an open-ended question on how a coordinated care system should be structured in New Mexico, nearly all independently described a "network of networks" (i.e., an interconnected group of regional networks) model. Participants were also asked to share considerations they felt would be key should the state pursue implementation of a coordinated care network. Some of the most common considerations included 1) the need for stakeholder input on design, particularly from rural communities; 2) the need to identify and articulate the role of the state in the system; 3) the need to define the network leadership and oversight structure; 4) the need to identify means for network funding and sustainability; and 5) the need for an implementation roadmap that can be shared with stakeholders.

Based on the above findings, the IVMF recommends the following:

1. **Implement a Community Design and Planning Phase:** The veteran-serving organizations that participated in this assessment felt that a coordinated care network would be of value to New Mexico. However, considerations including network leadership structure, how best to phase implementation, and funding and sustainability must still be addressed. Additionally, participants were clear that for any collaborative model to succeed, stakeholders needed to be involved in its design to ensure buy-in and adoption. As such, the IVMF recommends the state pursue a design phase that incorporates feedback from community and institutional stakeholders. Ultimately, the design phase should culminate in a recommended roadmap for how New Mexico should implement a coordinated care model.
2. **Use Network Data to Identify Shortages in Services and Resources:** A clear theme emerging from stakeholder interviews and focus groups is that a shortage of services in areas such as healthcare, transportation, and affordable housing is a challenge across New Mexico. Coordinated care systems can help to spotlight these resource gaps by utilizing data collected from across the network to identify opportunities for increasing capacity for services where it is needed. As such, the IVMF recommends that data sharing pathways be created between New Mexico's coordinated care model and key stakeholders such as relevant government and philanthropic entities to help identify the needs of the military-connected in New Mexico and help inform strategy and decision-making related to best meeting those needs.

New Mexicans have deep ties to its veteran and military community. Nowhere is this better evidenced than by the dedicated individuals and organizations that serve this population across the state. However, accessing care as a help-seeker in New Mexico can be a challenge. The state of New Mexico is well-positioned to further its efforts in coordinating care for its military-connected community and in doing so, can both ease access to care for veterans and better connect with its service providers.

Introduction

BACKGROUND AND PURPOSE

Accessing care and services is a well-documented challenge for veterans and military families across the United States.[1] On one hand, this challenge is often not due to a lack of resources; there are over 40,000 organizations dedicated to military and veteran family support nationwide in addition to the services offered by federal, state, and local governments. This abundance of resources, colloquially known as the "Sea of Goodwill"[2] can be overwhelming for individuals to navigate.[3] Individuals who seek help face complicated issues, including varying eligibility criteria, limited program capacity, and complicated enrollment processes.[4] On the other hand, there are well known shortages of certain services available for the military-connected community, particularly housing[5] and mental health[6] services. The above factors combine to create a context that presents a unique challenge for the military-connected community to effectively access care.

One approach specifically designed to address the challenges associated with accessing care and services is navigation systems. Navigation systems, as defined by Michelle Shumate, are "organizational arrangements designed to support individuals in locating and obtaining valuable benefits, programs, and services."[4] These navigation systems comprise three core elements:

1. **Human navigators** who help individuals chart a path to receiving services,
2. **Referral technologies/platforms** that facilitate referral processes, and
3. **A strategy governing how the navigation system intervenes** during the help-seeking process[4]

There are several different examples of navigation systems, but one popular type in the military-connected service space has been a "system integrator" design, also known as a coordinated care network. A coordinated care network utilizes a closed network strategy of participating service providers and closed-loop referral platforms that supports a help-seeking client throughout the entire referral process. This is an approach that several states have invested in as a means of easing access to services for military-connected residents (including Georgia,[7] North Carolina,[8] Rhode Island,[9] South Carolina,[10] and Texas[11]). While each state's model has the common elements of a navigation system described above, they also incorporate specific contextual factors that have led each state to implement its own unique variation of the system integrator model.

In 2022, two members of the New Mexico Legislature, through Central New Mexico Community College (CNM), allocated funds for the D'Aniello Institute for Veterans and Military Families at Syracuse University (IVMF) to assess the current state of New Mexico's veteran services landscape and to provide recommendations for how the State can work toward implementing a coordinated care model for its veterans and military families. The IVMF has an established history designing, implementing, and evaluating coordinated care networks across the country through its AmericaServes initiative and other technical assistance efforts.[12]

Between January and March 2023, the IVMF engaged with 41 non-profit and government organizations serving veterans and the military-connected community across New Mexico. Through a survey, one-on-one stakeholder interviews, and larger focus group sessions, the team explored three questions related to the current and future state of coordinated care in New Mexico:

1. How do veteran-serving organizations in New Mexico characterize the current state of collaboration among veteran-serving organizations in the state?
2. What do veteran-serving organizations in New Mexico perceive as the next steps to improving collaboration and coordination?
3. What are the opinions and considerations of veteran-serving organizations on implementing a statewide coordinated care system?

What follows is the IVMF's landscape assessment report. The report is broken into two main sections: 1) Results and Findings and 2) Recommendations. The Results and Findings section compiles IVMF's findings of a review of the demographic and socioeconomic data of veterans living in New Mexico as well as organizations serving military-connected individuals in the State. It also provides thematic analysis of the qualitative data captured by the IVMF focused on three primary areas of interest listed in Box 1. In examining these areas of interest, the IVMF sought to understand if a coordinated care approach would be viable. The Recommendations section details the IVMF's recommendations for how New Mexico can move toward implementing a coordinated care model based on its team's findings.

BOX 1: PRIMARY AREAS OF INTEREST FOR ANALYSIS

- **The needs of the veteran and military-connected community in New Mexico**
- **Current practices in coordination and collaboration in veteran services in New Mexico**
- **Opinions on a statewide coordinated care network for veterans and the military-connected community**

METHODOLOGY

The IVMF crafted a mixed-methods approach to collect data for this report. The goal was to combine firsthand information from non-profit, government, and other entities serving the military-connected community in New Mexico with descriptive data collected by the U.S. Census and other federal entities. Jointly, these data provide both a broad overview of the military-connected population and those serving them and a deep dive into their current collaborative efforts.

To make our analysis more tractable, we divided the state into regions following the structure used by the New Mexico Tourism Department (see Box 2 and Figure 1: Regional Map of New Mexico (visualization of groupings listed in Box 2)).[13] We corroborated this grouping during interviews and focus groups with local organizations. Additionally, to be mindful of the diverse indigenous population living in New Mexico, we compiled a list of Native/Indigenous communities for our analysis using information from the Tourism Department. We confirmed this listing with information from the New Mexico Indian Affairs Department on federally recognized Pueblos, Tribes, and Nations (listed in the demographic & socio-economic analysis section below).[14]

BOX 2 : REGIONAL GROUPINGS

CENTRAL
- Bernalillo
- Sandoval
- Torrance
- Valencia

NORTH CENTRAL
- Los Alamos
- Rio Arriba
- Santa Fe
- Taos

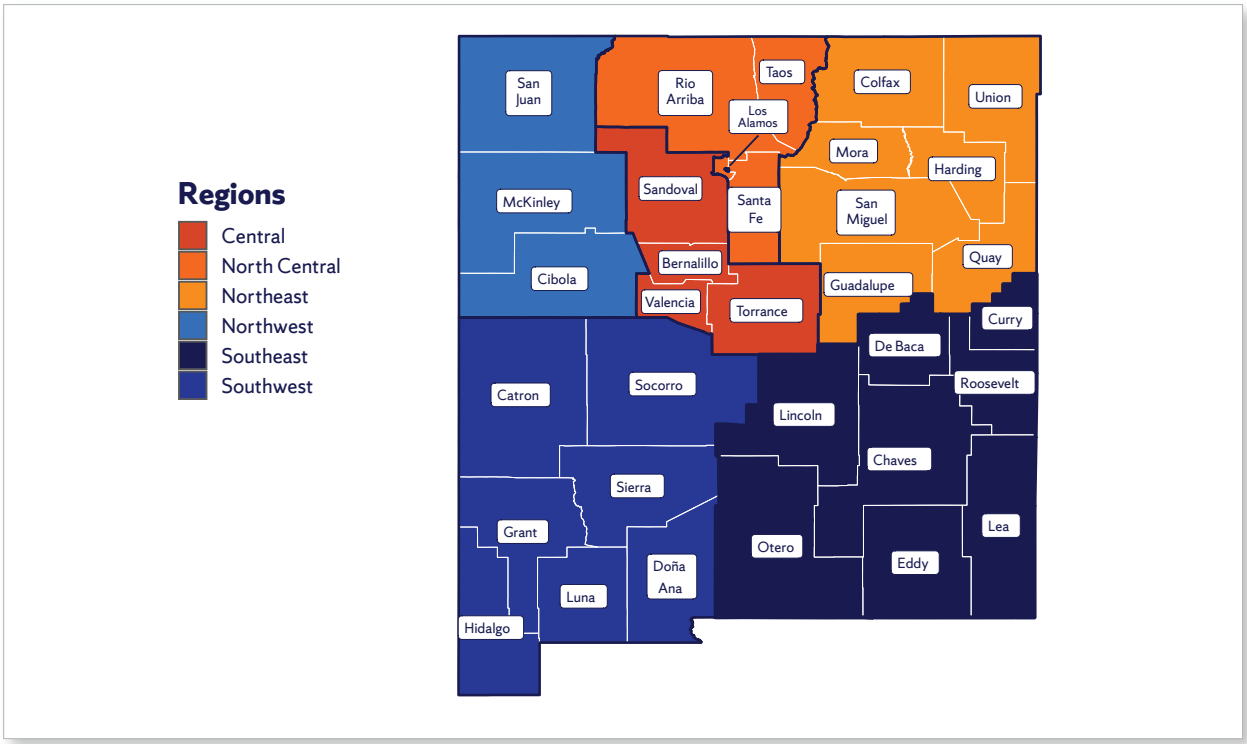
NORTHEAST
- Colfax
- Guadalupe
- Harding
- Mora
- Quay
- San Miguel
- Union

NORTHWEST
- Cibola
- McKinley
- San Juan

SOUTHEAST
- Chaves
- Curry
- De Baca
- Eddy
- Lea
- Lincoln
- Otero
- Roosevelt

SOUTHWEST
- Catron
- Doña Ana
- Grant
- Hidalgo
- Luna
- Sierra
- Socorro

Figure 1: Regional Map of New Mexico (visualization of groupings listed in Box 2). Regions based on New Mexico Tourism Department[13].



Given that this report attempts to provide a statewide view of collaboration and veteran needs, we relied on an array of different methods to solicit information from stakeholders. As such, our sampling approach is similarly complex. To describe our methodology more completely and coherently, we split these elements out. First, we describe our sampling approach, which specifies groups we considered to be key stakeholders for the project and how we identified them. Then, we cover the several instruments we used to garner data for this report. There, we will cover the archival data we used to provide a more quantitative overview of the military-connected population in New Mexico, and the novel data collection we performed to dive more deeply into our areas of interest (see Box 1).

SAMPLING APPROACH

Our team gathered original qualitative information through surveys, targeted one-on-one stakeholder interviews, and focus groups between January and March 2023. We used a key informant design[15], so participants in our qualitative research included leaders and operational staff in non-profit organizations and government entities serving veterans and the military-connected community in New Mexico. Our initial sampling frame targeted 96 individuals representing 87 organizations. Ultimately, the IVMF connected with 75 individuals representing 41 organizations.

The sampling frame for these methods used two non-probability sampling strategies. First, we engaged in purposive sampling to identify key stakeholder groups relevant to the research questions posed, including:

- Native/Indigenous communities
- State government entities
  - *Legislative representatives*
  - *New Mexico Department of Veterans Services (DVS) field officers*
- U.S. Department of Veterans Affairs (VA) entities
  - *VA Medical Centers (VAMCs)*
  - *Veteran Centers*
  - *Veteran Integration Centers (VICs)*
- Non-profit entities serving the military-connected population

After our purposive approach, we took a snowball approach to solicit participation in surveys, interviews, and focus groups. We generated the seeds for this snowball approach using two methods. First, we used the list of all field officers and tribal liaisons that New Mexico DVS maintains on their website as seeds. Second, we compiled a list of other federal, state, and community organizations serving the military-connected population by consulting with a local collaborator and by researching several secondary resources, including:

- Existing resource directories, such as:
  - *2-1-1 of Northern New Mexico*[16]
  - *2-1-1 United Way of North Central New Mexico*[17]
  - *ABQ Coordinated Resource Guide - Veteran*[18]
  - *FindHelp*[19]
  - *New Mexico Aging & Disability Resource Center*[20]
  - *Santa Fe County Resource Directory*[21]
  - *SHARE New Mexico*[22]
  - *United Way of Central New Mexico*[23]
- Datasets from the US Internal Revenue Service (IRS),[24]
- Existing lists of Supportive Services for Veteran Families (SSVF) grantees

We then sorted these organizations into the regional groupings described in Box 2 and compiled a list of stakeholders who served the whole state to maximize representation across regions and stakeholder groups. After creating this list of seed organizations, we applied a 3-level stopping rule for interviews, meaning we allowed ourselves to reach out to organizations 2 degrees of separation from the initial list we cultivated. We also agreed to stop data collection if we reached theoretical saturation: if we stopped hearing new perspectives from participants and subsequent responses only corroborated what previously participants voiced. This approach expanded the reach of our qualitative instruments while optimizing team effort.

Outreach for these efforts occurred over several different media. We contacted seeds and snowball organizations via targeted emails and phone calls introducing the IVMF, explaining our purpose, and inviting them to engage with us via survey, interview, and/or a focus group (as appropriate). We distributed the survey over social media and encouraged organizations to distribute invitations to their colleagues in other organizations serving the veteran and military population. We also asked survey respondents and interviewees to identify other organizations with whom we should speak at the close of each survey and interview, respectively. To further encourage responses, we later conducted the survey via phone too, in which a member of the research team would read out questions to the respondent and record their responses directly into Qualtrics.

INSTRUMENTS

Demographic & Socio-Economic Overview

The demographic analysis examines the distribution of veterans and non-veterans of different demographics and socio-economic experiences across New Mexico. Data for this analysis primarily come from Table S2101 of the Census' 2020 5-year American Community Survey (ACS)[25], which compiles data on demographics and socio-economic experiences split out by veteran status. We use these data to surface a broad understanding of the distribution of veterans across New Mexico and some of their life circumstances.

Additionally, we collected further data from the Census and other federal agencies to enhance our understanding of the rural experiences in New Mexico. In our initial conversations

with local stakeholders, we learned that New Mexico is a highly rural area in the United States, so we wanted to explore how this could potentially translate to experiences among the military-connected community. To that end, we rely on Waldorf and Kim's Index of Relative Rurality (IRR) which assigns a score onto a set of geographies based on how relatively rural they are to each other.[26,27] A zero indicates a highly urban area among the set of geographies, and a one indicates a highly rural area.

To compute the IRR, we included data from the U.S. Office of Management and Budget's (OMB) 2013 Rural-Urban Continuum Codes[28] to understand the role of rurality in New Mexico. OMB's Rural-Urban Continuum Codes segment counties into metro or non-metro groups based on their population size and adjacency to a metro area (i.e., county). Using these codes, we identified each county's spherical distance from a metro county, with metro counties marked as 0 miles away from themselves. We then combined each county's distance from a metro with three other data points from the Census' ACS and urban area relationship files (i.e., population; population density; % urbanized land). We rescaled each of these metrics according to Waldorf and Kim's algorithm and took the average to generate a single relative rurality score for each county. We present this rurality index alongside our other demographic findings.

Provider Landscape

We leveraged the IRS Exempt Organizations dataset25 as well as the data gleaned from the resource directories discussed above to build an analysis sample of 156 organizations that had self-identified as veteran-serving, either to the IRS or to the resource directories (it should be noted that some organizations that were found in the directories also existed in the IRS database, though they were not categorized as Veteran-Specific). When conducting research on resource directories, we identified key search terms that would return results for organizations within our criteria:

- "Veteran"
- "Military"
- "Veteran Services"
- "Veteran Human Services"
- "Military Families"

For our analysis, we included only organizations from the IRS database labeled as W30 (i.e., veteran-specific) under the National Taxonomy of Exempt Entities (NTEE) coding[29]. Later, using the resource directories mentioned previously, we mapped additional organizations to the original Exempt Organizations dataset. Doing so joined them to their revenue and location data, and added additional NTEE codes to the analysis beyond W30. However, we note that we only included organizations that appeared concurrently in the resource directory, not all organizations using the codes beyond W30. The final list of NTEE codes is:

- J: Employment, Job Related
- L: Housing, Shelter
- P: Human Services – Multipurpose and Other
- T: Philanthropy, Voluntarism and Grantmaking Foundations
- W30: Veteran Specific

We analyzed revenue and location data with the purpose of understanding the geographic distribution of physical and financial resources, as well as organizational spread across the state.

Survey

We conducted a survey of organizations serving the military-connected population via Qualtrics. The survey had three purposes: 1) to raise awareness of IVMF's research efforts in New Mexico; 2) to recruit organizations for focus groups; and 3) to surface an initial reading of the state of veteran's needs and attitudes from organizations concerning the current and future states of collaboration in New Mexico. Through a mix of closed- and open-response questions, it covered four topics based on our research questions:

- Current Practices in Coordination & Collaboration in Veteran Services
- Use of Technology in Serving Veterans
- Accessing Veteran Services in Rural & Indigenous Communities
- Opinions on a Statewide Coordinated Care Network for Veterans and Military-Connected Individuals

As noted above, we initially distributed the survey via emails to our sampling frame and a limited social media push. Later, to further encourage responses, the team cold called organizations to administer the surveys. In these cases, IVMF staff would read participants the questions and record responses in Qualtrics. Though the survey ran concurrently with the stakeholder interviews and focus groups (from February 2023 until April 2023), we performed a preliminary analysis of the survey responses to inform the questions for the interviews and focus groups.

Ultimately, the survey initially received 113 responses; however, not all of these were valid. One respondent did not consent to participate in the survey. 61 participants completed less than 10% of the survey. We used a screener question to screen out 16 respondents who described their organization as not explicitly serving the military-connected population. We later reversed this screening question rule to be more inclusive. Of the remaining 35 responses, 18 came from three organizations. We consolidated the responses from these three organizations into a single response each. This gives us a final total of 20 unique organizations responding to our survey, with a response rate of 19%.[i,30]

For the multi-response organizations, we elaborate on our cleaning process. Two organizations had two responses each, so we chose the most complete response for those. The last organization had 14 unique responses, so we merged the 14 responses into one aggregated response to represent the organization's collective opinions. For free-text questions, we joined all responses together to retain the organization's sentiments for each question. For fixed-choice questions where all that organization's respondents gave the same response, we merged responses. For fixed-choice questions where responses varied, we retained responses shared by 50% or more respondents; otherwise, we recorded the response as NULL.

Given the broad coverage of the survey, its results appear throughout the report instead of in a dedicated section.

Interviews

We conducted eight audio-recorded interviews between January and March 2023. Interviews were held virtually via Zoom and ranged in length from 45 minutes to 90 minutes. Interviews were invitation-only, to prioritize deeper conversations with organizations that have a heavy emphasis on serving the veteran and military community. Questions in the interviews centered around the four topics covered by the survey but probed further into interviewee's perspectives. Each interview included one interviewer from the team, one notetaker, and one or more interviewees representing their organization.

After completing all interviews, we compiled the notes from each interview and performed a coarse thematic analysis structured by the topics and questions used in the interviews. We report on these findings in the Thematic Analysis section.

Focus Groups

Our focus groups took a deeper dive into three topics, emphasizing collaboration and coordinated care:

- The current coordination and collaboration landscape,
- Opinions on implementing coordinated care in New Mexico,
- And next steps toward coordinated care

We facilitated seven focus groups across New Mexico, reaching 37 people from 23 different organizations. We targeted the regional groupings listed in Box 2 above, and selected host cities from each region:

- Albuquerque (Central)
- Clovis (Southeast)
- Farmington (Northwest)
- Las Cruces (Southwest)
- Las Vegas (Northeast)
- Santa Fe (North Central)
- Truth or Consequences (Southwest)

The sessions lasted between one to two hours and continued until discussions organically ended or until space reservations closed. Once we completed all focus groups, we transcribed the discussions using Otter.ai and analyzed the discussions through Dedoose using a grounded theory qualitative coding approach[31]. The three topics mentioned above sensitized our analysis. We report on our findings in the Thematic Analysis section.

[i] A 2022 meta-analysis of online surveys in published research found that the average response rate is about 44%

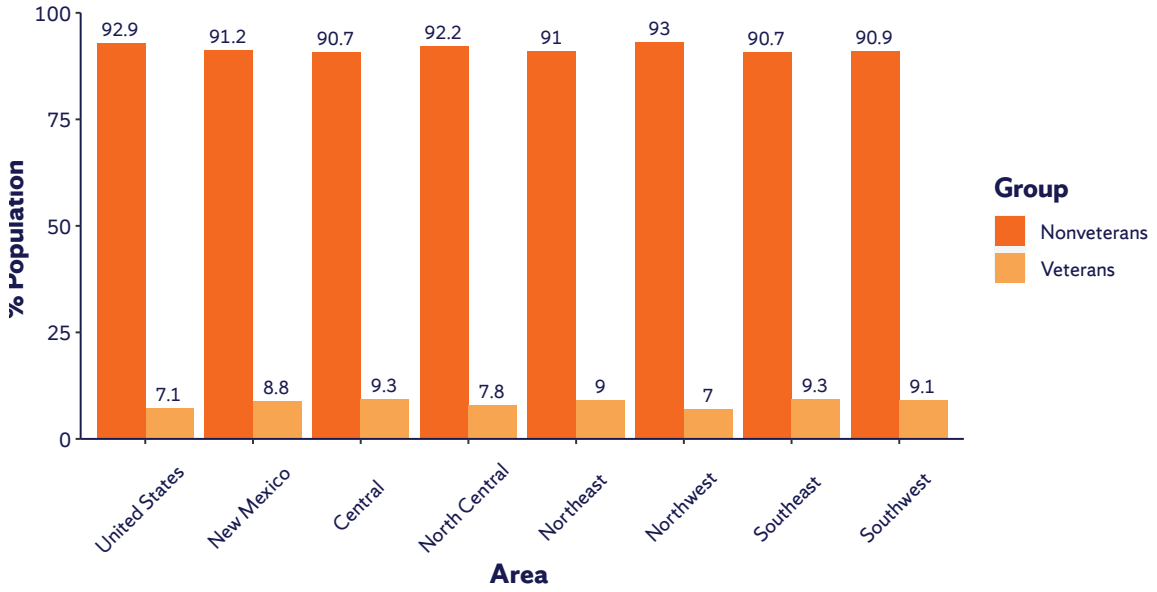
Results and Findings

DEMOGRAPHIC & SOCIO-ECONOMIC OVERVIEW

We start our analysis by first considering the population who would be the ultimate beneficiary and target of a coordinated care effort—the military-connected population. Compared to the national rate (7.1%), New Mexico has a slightly higher percentage of veterans (8.8%) comprising its population. Across the six regions we outlined, the proportion of veterans is similar. The Central (9.3%), Northeast (9.0%), Southeast (9.3%), and Southwest (9.1%) regions have higher concentrations of veteran individuals whereas the North Central (7.8%) and Northwest (7.0%) regions have lower concentrations relative to the state average. Figure 2 visualizes this comparison and highlights the relative similarity of veteran distribution across regions.

Altogether, New Mexico has a population of 12,680 active-duty service members and over 140,000 veterans. Figure 3. Concentration (left) and distribution (right) of veterans in New Mexico. The left plot shows each county's concentration of veterans, which is the number of veterans in a county divided by the population of the county. The right plot shows the distribution of veterans across the state, which is the number of veterans in a county divided by the number of veterans in the state. displays how these veterans are spread across the state in two ways. The first plot on the left shows the concentration of veterans per county, which is the number of veterans in a county relative to the county's overall population. County concentrations range from 3.8% in Lea County to 16.2% in Otero County. In other words, 1 in 25 people in Lea County, and nearly 1 in 6 in Otero County, are veterans. The key finding from this plot is that regardless of where you go in New Mexico, there's a reasonable chance that a random person you encounter will be a veteran.

Figure 2. Distribution of veterans and non-veterans across New Mexico regions. Data drawn from Table S2101 of the 2020 U.S. Census American Community Survey's 5-year estimates[25].



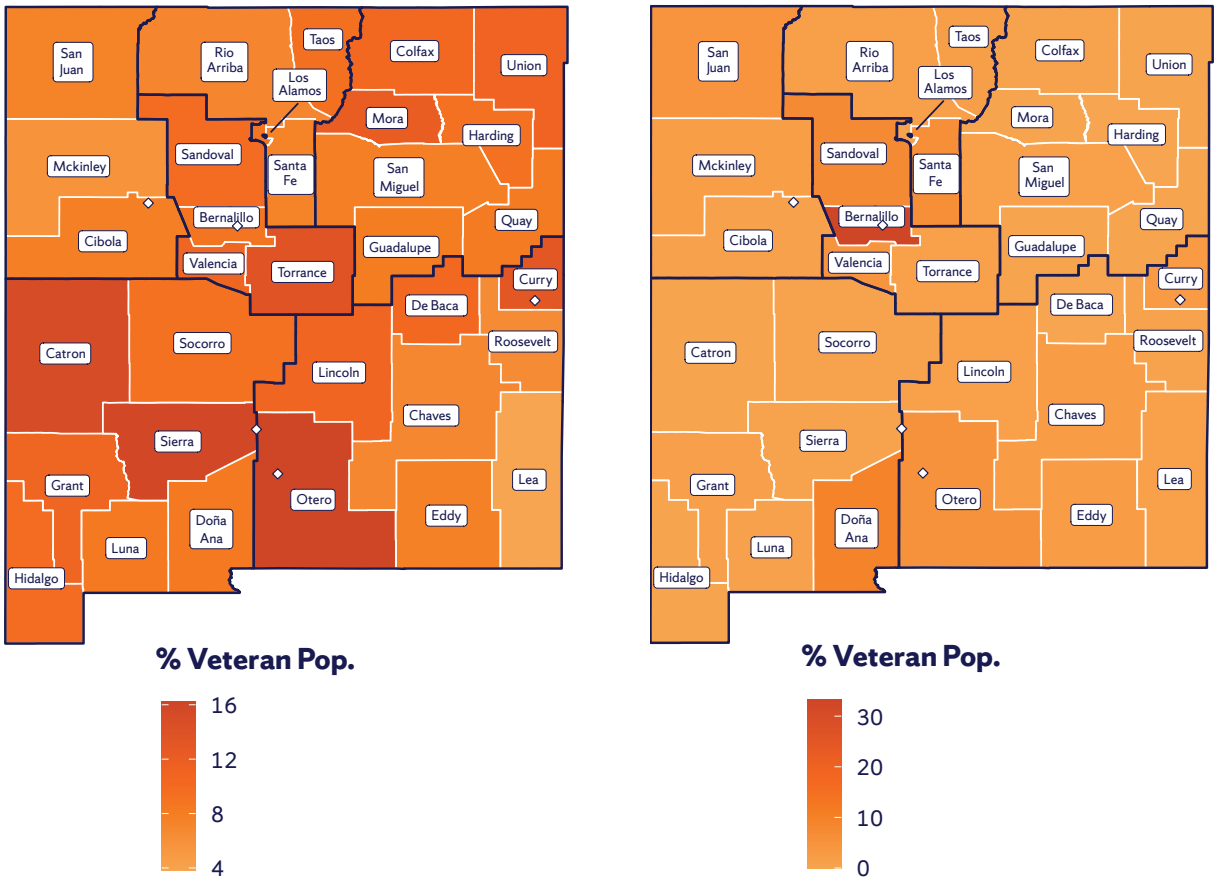
The right plot, however, shows the distribution of veterans across the state. Unlike the concentration plot, it shows how many veterans reside in each county relative to the *total veteran population in New Mexico*. For example, the smallest portion of New Mexico's veterans live in Harding County (<0.1%) whereas the largest portion live in Bernalillo County (33.3%). This means that although most of the state's veterans live in Bernalillo County, the odds of randomly encountering a veteran in Bernalillo (1 in 11) are much lower than in other counties.

We highlight the contrast between these two plots because it brings a key perception into focus. In a sheer volume sense, most of New Mexico's veterans live in the Central region (46.6%) around the urban center of Albuquerque. However, looking at the concentrations of veterans, there are similar concentrations across the Central (9.3%), Northeast (9.0%), Southeast (9.3%), and Southwest (9.1%) regions. Thus, while most of New Mexico's veterans do live in the Central region, the ratio of veterans to non-veterans elsewhere in the state gives the impression of a high volume of veterans everywhere throughout the state. We make this statement not to encourage allocation of resources to any area, but to highlight how easy it

BOX 3: NEW MEXICO NATIVE/ INDIGENOUS COMMUNITIES

- Acoma Pueblo (Sky City)
- Cochiti Pueblo
- Isleta Pueblo
- Fort Sill Apache Tribe
- Jemez Pueblo
- Jicarilla Apache Nation
- Laguna Pueblo
- Mescalero Apache Tribe
- Nambe Pueblo
- Navajo Nation (Diné)
- Ohkay Owingeh Pueblo
- Picuris Pueblo
- Pojoaque Pueblo
- San Felipe Pueblo
- San Ildefonso Pueblo
- Sandia Pueblo
- Santa Ana Pueblo
- Santa Clara Pueblo
- Santo Domingo Pueblo
- Taos Pueblo
- Tesuque Pueblo
- Zia Pueblo
- Zuni Pueblo

Figure 3. Concentration (left) and distribution (right) of veterans in New Mexico. The left plot shows each county's concentration of veterans, which is the number of veterans in a county divided by the population of the county. The right plot shows the distribution of veterans across the state, which is the number of veterans the number of veterans in the state. Thick borders represent the regions described in Box 2 and visualized in Figure 1. Data drawn from Table S2101 Bureau's American Community Survey's 5-year estimates.



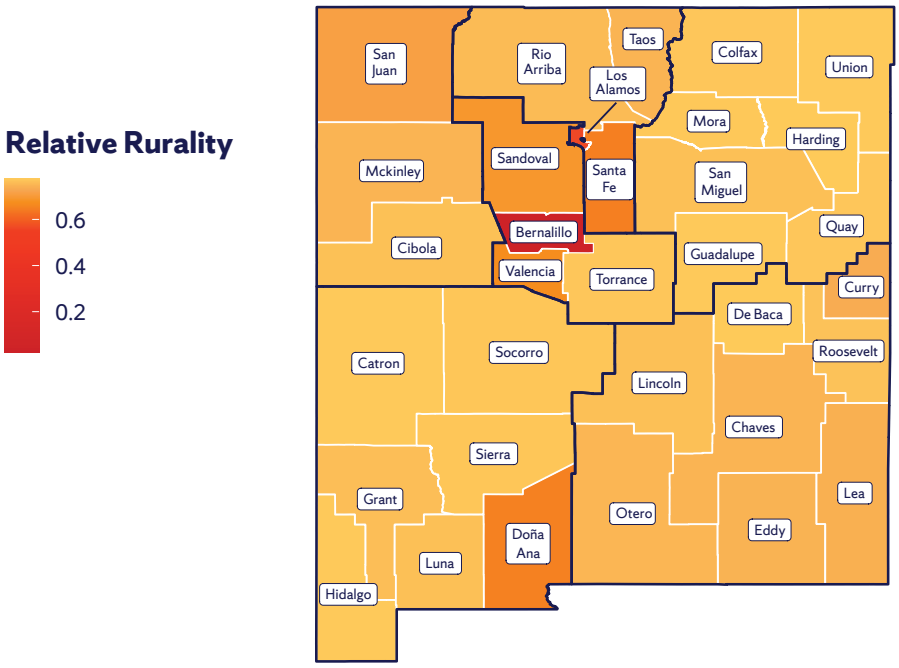
is for any New Mexican resident to know a veteran regardless of whether they live in the Central region. This statistic sheds light on how intertwined the veteran and non-veteran communities in New Mexico are.

Table 5 and Table 6 then dig further into the demographics of the veteran population. Compared to national rates, New Mexico has a greater rate of Native American veterans (4.9% vs. 0.8%), multiracial veterans (5.1% vs. 2.9%), and veterans of another race not tracked by the Census American Community Survey (5.3% vs. 1.6%). New Mexico also has a far greater rate of Hispanic veterans (30.9% vs. 7.3%). This shift in distribution arises from a lower rate of Black/African American veterans (4.0% vs. 12.0%) and Asian veterans (0.5% vs. 1.7%). Of note are the Northwest, Northeast, and Southeast regions of New Mexico. The Northeast region houses the largest concentration of Hispanic veterans (52.5%), multiracial veterans (7.3%), and veterans of races not tracked by the Census (14.4%). The Northwest region, which overlaps with the Navajo Nation, has an expectedly high concentration of Native veterans (31.9%). Finally, the Southeast region has the highest concentration of Black/African American veterans (6.3%). This distribution reflects the cultural makeup of New Mexico as a state.

Looking next at age, the veteran population in New Mexico also tends to be older. Compared to national rates, New Mexico has a slightly larger 55-64 population (19.5% vs. 17.8%) and a slightly larger 65-74 population (27.1% vs. 26.1%), with slightly smaller concentrations of 18-34, 35-54, and 75+ veterans. Additionally, most veterans in New Mexico served during the Vietnam era (38.2%), followed by Gulf War era veterans from both pre-9/11 (21.5%) and post-9/11 (20.3%), with the smallest concentrations from the Korean era (7.7%) and WWII era (2.6%). Regionally, the youngest veterans tend to live in the Southeast and the oldest vets tend to live in the Northeast.

The socioeconomic status of veterans in New Mexico reflects this skew in age. Table 7 shows that, relative to national trends, New Mexico has higher rates of veterans dealing with unemployment (5.0% vs. 4.3%), poverty (7.9% vs. 6.7%), and disability (31.8% vs. 29.5%). Unemployment rates among veterans are highest in the North Central (8.7%) and Northeast (8.0%) regions, which coincides with urbanity and age respectively. Poverty rates are highest in the Northwest (11.7%) and Southwest (9.4%), corresponding with infrastructure challenges facing the Navajo Nation and rurality. Then, disability rates are highest in the Northeast (44.3%) and Northwest (38.5%), again corresponding with age and infrastructural issues. These rates demonstrate that New Mexican veterans face various difficulties more often than the average veteran in the U.S.

Figure 4. Index of Relative Rurality (IRR) for the counties of New Mexico. The IRR normalizes a group of locations against one another such that the highest index is relatively the most rural and the lowest index is relatively the most urban. Thick borders represent the regions described in Box 2 and visualized in Figure 1. Data drawn from the U.S. Census Bureau's 2020 TIGER Shapefiles and the OMB's 2013 Rural-Urban Continuum Codes.



The rural context in which veterans face these issues plays a key role. New Mexico is one of the most rural states in the U.S., described by several of our interview and focus group participants as "not just rural, but frontier." This description alone conjures an image of the relative rurality of New Mexico compared to other states. Figure 4 goes on to show the relative rurality of New Mexico's counties to one another using the Index of Relative Rurality (IRR). Notably, we rescaled the coloration of the map to better show the contrasts among counties. The rescale shows Bernalillo as the most urban county (IRR = 0.03), and Harding as the most rural county (IRR = 0.78). The rescaled legend emphasizes that most of the counties in New Mexico are highly rural with Albuquerque serving as a substantial urban core for the state. In turn, this means that a substantial portion of veterans (i.e., the 66.7% outside of Bernalillo County) are living in a rural context. In subsequent sections, we'll elaborate how challenges present in the rural context feed into care challenges.

PROVIDER LANDSCAPE ANALYSIS

To visualize the extent of services available to veterans and the military community in New Mexico, we analyzed data gleaned from the IRS and several New Mexico-focused resource directories. Our objective was to understand the distribution of organizations across the state and its component regions, as well as the distribution of organizational revenue, where possible. This analysis focuses primarily on veteran-serving organizations we identified but will also touch on general organization resource distribution.

New Mexico is serviced by more than 10,800 IRS designated tax-exempt organizations, representing nearly $5 billion in revenue.[ii] To narrow our focus to organizations serving the veteran and military-connected community, we selected organizations that we identified as veteran/military serving. For the purposes of our analysis, we defined this as organizations that have at least one program dedicated to serving the military-connected population[iii], either self-declared or as designated by the IRS NTEE classification[iv,30]. We leveraged the IRS Exempt Organizations dataset[25] as well as the following resource directories:

- 2-1-1 of Northern New Mexico[16]
- 2-1-1 United Way of North Central New Mexico[17]
- ABQ Coordinated Resource Guide - Veteran[18]
- FindHelp[19]
- New Mexico Aging & Disability Resource Center[20]
- Santa Fe County Resource Directory[21]
- SHARE New Mexico[22]
- United Way of Central New Mexico[23]

With our working definition of a veteran serving organization, we narrowed our IRS dataset to include organizations with an NTEE code of W30 (i.e., veteran-specific), returning 39 organizations that met our criteria[v]. In searching resource directories, we identified key search terms that would return results for organizations within our criteria (e.g., "Veterans," "Military," and "Veteran Services"). In this manner, we identified an additional four IRS exempt organizations that were not coded W30, for a total of 43 IRS exempt organizations across 5 NTEE codes[vi]. We additionally identified 113 organizations not listed in the IRS's Exempt Organizations database that serve veterans and military-connected community, for a grand total of 156 military-connected serving organizations in the state of New Mexico. These organizations represent local, state, and federal government entities, non-exempt organizations, and other organizations not listed in the IRS database with missions or stand-alone programs focused on the veteran and military community.

[ii] Analysis of general dataset of exempt organizations excludes organizations with PO boxes as primary addresses, zip codes mapped to multiple counties, and organizations with no identifiable county in address data (n=4004)

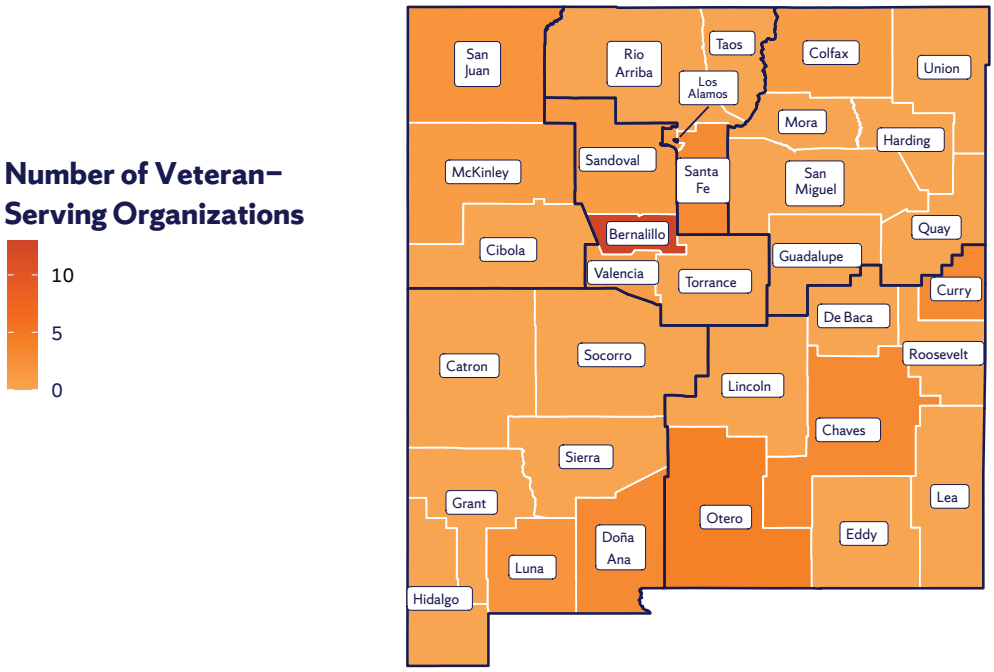
[iii] Military-connected population is defined as: veterans, military families, active duty military, National Guard/Reservists, survivors, and caregivers.

[iv] Note: analysis of revenue will not include services offered by organizations not listed in the IRS Exempt Organizations database, as there is no readily available information on revenue (n=113).

[v] Some W30 organizations were dropped from the initial analysis - further investigation determined that they did not provide services to veterans or the military community (n=2)

[vi] Additional IRS codes for organizations include: J (Employment, Job Related); L (Housing, Shelter); P (Human Services - Multipurpose and Other); T (Philanthropy, Voluntarism and Grantmaking Foundations).

Figure 5. Distribution of veteran-serving organizations by county (inclusive of IRS exempt organizations and organizations identified in resource directories). Excludes organizations with no county affiliation. Thick borders represent the regions described in Box 2 and visualized in Figure 1. Data drawn from U.S. IRS Exempt Organizations Business Master File, Census Bureau 2020 Zip Code Tabulation Area Relationship Files & Census Bureau 2022 TIGER Shapefiles



The bulk of the veteran-serving organizations analyzed are in the more urban areas of Bernalillo County (37%) and Santa Fe County (10%), with an additional 10% classified as state or national level organizations with no county affiliation. Bernalillo (IRR = 0.025) and Santa Fe Counties (IRR = 0.561) were the two most urban counties identified in the relative rurality analysis[vii]. 18 counties had 5% or fewer of the remaining share of organizations, and 13 counties had no organizations. This indicates that they either had few organizations that identified as veteran-serving to the IRS and/or had few organizations registered to the resource directories that we researched (see Table 1). This mirrors the concentration of all IRS exempt organizations in New Mexico—61% of all exempt organizations operated in Bernalillo, Santa Fe, and Doña Ana Counties. The remaining 39% operated in one of the other 31 counties or had no county affiliation (see Table 3).

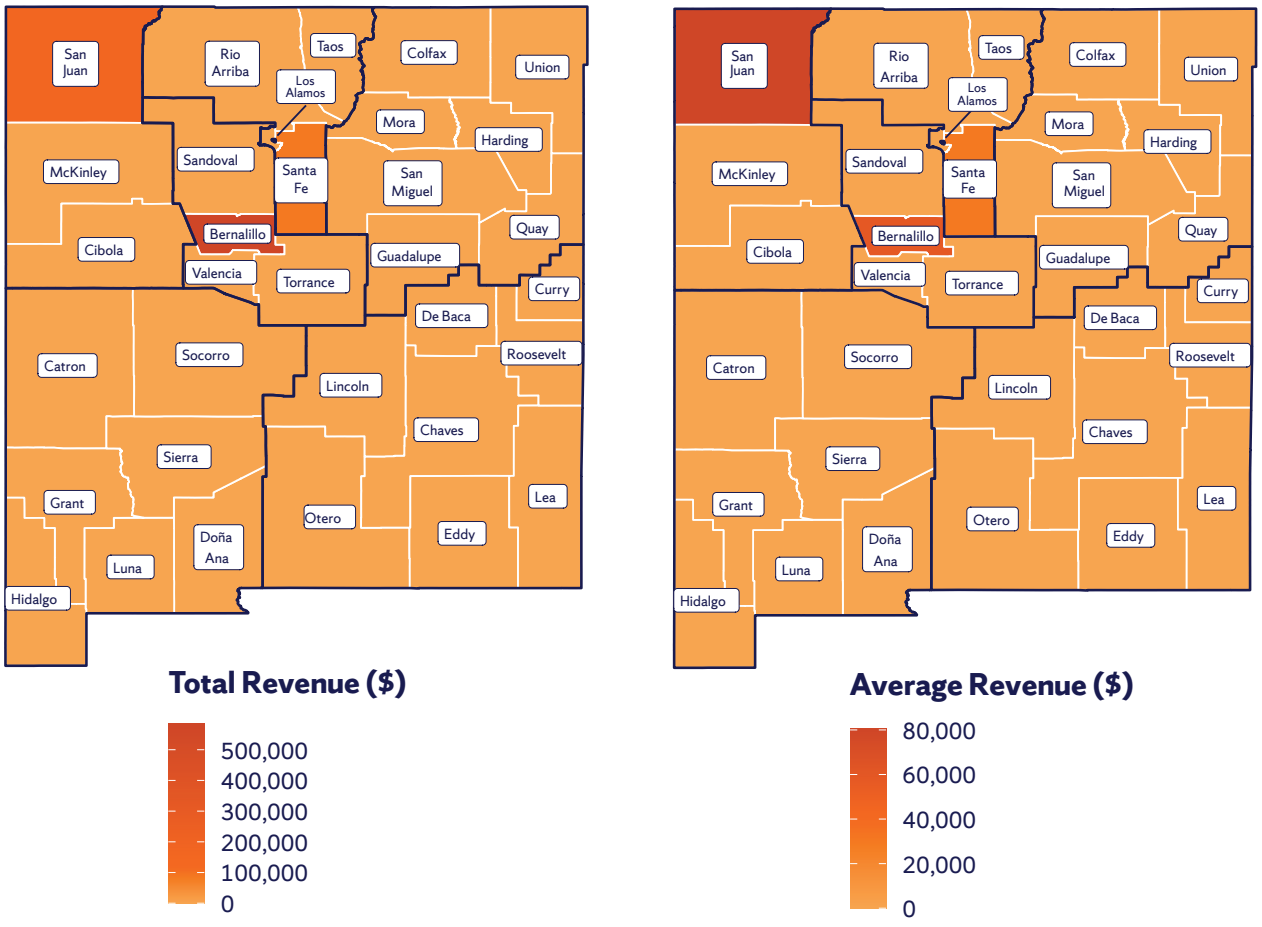
Analysis of IRS exempt organizations shows a high concentration of organizational revenue in more relatively urban areas. Revenue from all 43 IRS exempt organizations in our sample totals over $30 million, with an average revenue of $800K per organization. Of those, 39 are classified as W30 (i.e., veteran-specific) organizations, representing over $800K in revenue[viii]. Revenue reported by organizations to the IRS was concentrated exclusively in Bernalillo (67%), San Juan (19%), and Santa Fe Counties (10%).[ix] Average revenue per organization was highest in San Juan County, followed by Bernalillo County and Santa Fe County. Notably, San Juan County had three organizations in the analysis sampling frame, as opposed to Bernalillo (55) and Santa Fe (15). While San Juan has more money per veteran-serving organization, it also has few veteran-serving organizations overall—the more urban areas of Bernalillo and Santa Fe have more organizations, but fewer

[vii] For more on the Index of Relative Rurality, see the Instruments subsection of the Methodology section.

[viii] It should be noted that "Veteran-Specific" has its own NTEE classification (W30), and organizations classified with other NTEE codes were excluded from our initial analysis of the IRS Exempt Organizations dataset. However, the military-connected community is not exclusively served by organizations that are classified in this manner by the IRS.

[ix] San Juan County (IRR = 0.708)

Figure 6. Total and average revenue distributions for veteran-serving organizations (inclusive of IRS exempt organizations and organizations identified in resource directories). Excludes organizations with no county affiliation. Note that organizations not identified in the IRS database do not have revenue data in the analysis frame. Thick borders represent the regions described in Box 2 and visualized in Figure 1. Data drawn from U.S. IRS Exempt Organizations Business Master File, Census Bureau 2020 Zip Code Tabulation Area Relationship Files & Census Bureau 2022 TIGER Shapefiles



dollars per organization. Organizations in the remaining counties in our analysis reported no revenue to the IRS or were not found in the IRS dataset, so any revenue would not be included in analysis. Additionally, some counties had no organizations in our sampling frame and, thus, reflect no reported revenue. A partial explanation this could be that statewide or nationally-federated organizations with branches in New Mexico may report their income from headquarters in other states or counties.

It should be noted that our analysis doesn't fully cover the breadth of organizations outside of the IRS exempt organizations dataset. Missing revenue data on organizations that we could not map from the resource directory research to the IRS dataset further limits our analysis. Nevertheless, these findings indicate a concentration of financial and physical resources in more urban areas. As reflected in the demographic and socio-economic analysis, the concentration of urbanity aligns with the concentration of organizations. Monetary and physical presence skews towards relatively urban areas in the state, which could be a function of the population of the areas, as well as underreporting of organizations and revenue available in areas of greater rurality.

For a summary of tax-exempt organizations and revenue, see Appendix A: Community Organizations & Collaborative Tables.

THEMATIC ANALYSIS OF QUALITATIVE INSIGHTS

The IVMF also engaged with non-profit and government organizations serving veterans and the military-connected community across New Mexico through a survey, one on one stakeholder interviews, and larger focus group sessions. These instruments explored three questions related to the current and future state of coordinated care in New Mexico:

1. How do veteran-serving organizations in NM characterize the current state of collaboration among veteran-serving organizations in NM?
2. What do veteran-serving organizations in NM perceive as the next steps to improving collaboration and coordination?
3. What are the opinions and considerations of veteran-serving organizations on implementing a statewide coordinated care system?

The following sections analyze the major takeaways from participants' responses—in particular, veteran needs and their causes, the current coordination and collaboration landscape, and considerations for the future state of the coordination and collaboration in the state of New Mexico.

VETERAN NEEDS

Across the survey, focus groups, and interviews, organizations identified several areas where the military-connected community lacked or had inadequate access to services. The most common and critical needs identified by participants were:

- Financial Assistance
- Housing
- Mental/Behavioral Health
- Physical Health & Medical Care
- Substance Use
- Transportation

Participants also voiced other needs specific to their areas of operation. These include education on benefits eligibility, education assistance, employment services, family support, peer support services, recreation, substance abuse services, support for LGBTQ+ veterans, and transition assistance.

In the following sections, we explore the reasons participants discussed as to why these needs go underserved or even wholly unserved.

Common Challenges in Providing Services

The reasons that the needs highlighted above are going under or unserved are part of a complicated tangle of social, economic, and geographic issues. These issues combine to create barriers to accessing services for veterans and military community. Some of these issues are chronic problems experienced in veteran and military communities around the country, while others may be more common to the state. The issues identified by our analysis include problems with the VA, rurality and geographic spread, scarcity of providers and professionals, and affordability of services.

One of the main problems cited in our qualitative analysis was issues accessing and navigating the VA. Participants noted that accessing medical care services was a major pressing need for veterans and the military community, but that accessing it through the VA was incredibly difficult. Likewise, veterans seeking mental and behavior health services are often subject to similar challenges as those accessing medical care services. Medical and mental health care covered by the VA is mostly accessible only in urban areas, largely at the VAMC in Albuquerque. In other areas, participants described VA medical facilities as sparsely staffed and underfunded. Urban areas, however, are not immune to the issues of supply and demand. Survey respondents from Bernalillo County and Santa Fe County noted that veterans still must wait a very long time to be seen for services through the VA, taking many months to get off the wait list and see a provider. When asked what resources were missing or under-resourced in their community, one Santa Fe survey respondent noted, "[It] takes a long time to get into the VA in a lot of ways, even if you already have a primary provider over there. Vision care is difficult to access (6 months to appointment)." Another survey respondent out of Bernalillo County noted "…It is very hard to access health-related services due to long wait times for appointments and long distances for travel."

Another facet of this problem is limited organization and provider availability. Participants remarked that providers are not as available and medical professionals do not want to practice in rural areas. Put simply, the supply of mental health practitioners readily accessible to veterans cannot meet the demand. Medical and mental health providers are scarce in clinics outside of urban areas, so accessing a mental health counselor at all may require travel to the VA in Albuquerque or other major population centers (even outside of the state). Participants noted that non-VA facilities are available in the community, but that the VA may not cover those services. Veterans and providers perceived that they could receive care either through the VA or a private practice, but not both simultaneously. It is worth noting the VA does have a community care program that allows veterans to see community providers when VA cannot provide the care needed. Moreover, VA community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans.[32] A few respondents shared personal experiences where the VA would not cover community care services despite apparently meeting the VA's eligibility criteria. One respondent in Santa Fe noted "When we get people who are veterans… the option for them with us for medical care is they [exclusively] either see one of our providers, or they get linked in with the VA for medical care, because you can't have two primary care physicians."

Resource distribution is a common thread running through these problems. As was noted in the demographic & socio-economic overview and provider landscape analysis, New Mexico's population and organizations are concentrated in the areas of least relative rurality—Bernalillo and Santa Fe Counties. Given the issues in provider scarcity highlighted above, accessing full services requires that patients travel to urban areas (usually the cities of Albuquerque or Santa Fe), presenting a barrier for those who are unable or unwilling to make that trip without assistance of some kind. These circumstances result in extremely long wait times and travel times for appointments, ranging from "hours" to "days." One survey respondent noted, "There are social networks for veterans in the rural areas, but transportation is the biggest issue. A VA appointment can be a multi-day event involving hotels and staying "in town". This is extremely stressful on the veteran and their family." Transportation services are limited, and often are only available for transit to VA appointments, leaving gaps in access to other providers. As such, veterans will seek services from VA facilities in neighboring states if those facilities are closer than New Mexico VA facilities. Amarillo, El Paso, Tucson, Phoenix, and Durango are often more convenient than Albuquerque.

> *Durango [Colorado] is a big place for medical action. It's only an hour away. I personally got two appointments going up there. There's a lot of people going all the way to Albuquerque. Albuquerque's like four hours away [from Farmington]." - FGP 1*

A more specific issue is access to affordable housing for the veteran and military community. Participants anecdotally noted that New Mexico has a large veteran homeless population, and the shelters do not have the space to accommodate the overwhelming demand despite the presence of many housing organizations. As of January 2022, a point-in-time (PIT) count found that 1,283 individuals were experiencing homelessness in New Mexico.[x,33] Veterans accounted for 5.5% of that PIT count, made up 9% of the unsheltered homeless count, 9% of the emergency shelter count, and 0.9% of the transitional housing count in the state.[xi,33] In comparison, veterans accounted for 5.6% of the 2022 national homeless population.[xii,5]

Participants noted that affordable housing is scarce and additional support is necessary for veteran housing.

Affordability issues were particularly prominent in discussions with organizations based in urban areas (Santa Fe and Albuquerque), but issues with housing and homelessness touches more rural areas as well. Trends in general population housing and homelessness mirror these problems in the veteran and military-connected population. A May 2023 legislative report from the New Mexico Legislative Finance Committee preliminarily indicated that the general population homelessness in New Mexico had increased by about 48%.[34] The same report also indicated that emergency shelter capacity has more than doubled since 2016, but affordable housing has declined by 50% since 2020. One participant from Santa Fe noted, "... Affordable housing has been my biggest challenge...I've been here 35 years, [I] how hard it is to get housing, and it keeps getting worse and worse, where they keep getting excluded. And, you know, again, 'I've got to move back with family members in Dallas', or...wherever they can just to just to find a place that they can afford, on the check that they get...".

Challenges in Meeting Needs

Participants cited several reasons for why these needs are going unmet in their communities. These reasons are often intertwined, including:

- Challenges in providing services to Native and Indigenous communities,
- Generational divides,
- Lack of infrastructural resources,
- Long driving distances to urban centers,
- Organization underfunding,
- Spotty transportation services,
- Strain on state/federal agencies

Many of these challenges reflect the rural, "frontier" society of New Mexico. On one hand, the more remote towns where many veteran and military communities have formed provide a tight circle of support and community. On the other, their geographic spread also places them far away from the resource concentrations of the more urban areas in Bernalillo County. This separation leads to lack of knowledge on and access to benefits and resources. Many veterans are unaware of the benefits they are entitled to receive or how best to navigate the systems to meet their needs. Engagement with providers can counter this lack of knowledge, but such interactions happen less frequently because providers struggle to reach the more remote areas regularly.

[x] Point-in-time homelessness counts captured in January 2023 by the New Mexico Coalition to End Homelessness were not published as of the date of this report's publication.

[xi] January 2022 Balance of State Total Counts of Individuals Experiencing Homelessness:
- Unsheltered (n=391)
- Emergency Shelter (n=785)
- Transitional Housing (n=107)

[xii] 2022 national point-in-time homeless population:
- Overall (n=582,462)
- Veteran population (n=33,129)

This highlights a resource access problem. Many remote areas, especially Native and Indigenous reservations, lack access to infrastructure such as running water, reliable internet and cellular services, and electricity. They also lack providers convenient to their locations. Without those resources available, connecting individuals to services becomes exponentially more difficult. They must turn to resources outside their area to meet needs, incurring another set of challenges. Transportation is one critical need that directly underpins the delivery of other services. As already noted, clients must travel long distances to receive services, which is time-consuming, expensive, and not always logistically feasible. Several participants commented that their clients struggle to access VA-connected services, other veteran serving organizations, and even general-population-serving resources.

Challenges in Serving Native & Indigenous Communities

Native and Indigenous peoples residing on federal reservations in New Mexico face additional challenges. The lands of 23 Native and Indigenous nations, tribes, and pueblos cross or wholly exist within New Mexico's state borders with nearly 5% of the state's veterans being Native American. Although we made efforts to engage with organizations that served a diverse range of Native and Indigenous communities, participants in our qualitative research mostly cited the Navajo Nation (Diné). Thus, much of the commentary on the needs of the Native and Indigenous population reflects perspectives on that nation and their tribal lands, with some general ideas related to the other nations. Some commentary comes from organizations who have Navajo members working and engaging in that space, but most are from organizations with no particular ties to that nation.

> *Some services cannot be provided if clients are outside a certain distance, and they do not have the support of financial ability to travel very far to get those services." - SR 1*

The issues, pressing needs, and circumstances discussed early also apply to Native and Indigenous veterans, especially challenges in resource access that are part and parcel with New Mexico's population spread and resource distribution. These problems often are magnified for this population. Participants noted a lack of VA resources on the Navajo Nation. The veteran community there must travel outside of their lands to access healthcare covered by the VA, which proves to be incredibly difficult. Moreover, participants shared hesitation and difficulties in reaching out to Native and Indigenous communities. Feeding into this hesitation are the long and difficult history with non-Native governments, and the sovereignty of Native and Indigenous communities which creates additional bureaucratic layers.

Participants responses reflect this tension in that they declared their services were open to Native and Indigenous peoples, yet few said that they worked directly on tribal lands. One participant noted that they had to be invited onto their lands to engage with them. Other participants remarked that some members of the Native and Indigenous nations preferred more traditional approaches to medical and mental health care and so would not use their VA benefits. Participants stated that providers must find a way to provide culturally competent medical and mental healthcare geared toward their beliefs and practices. Another participant noted that Native and Indigenous people have their own ways of supporting their military-connected communities within their tribal lands including chapter houses and Nation/Tribe-specific programs and organizations (e.g. Navajo Nation Veterans Administration, Zuni Veterans Services Program). Both Native and non-Native organizations have expressed a diversity of thought and a desire to engage with veteran-serving organizations and the VA. Some nations wish for improved connections to these organizations, and others are satisfied with what they have established within their communities to bring services to their veterans.

> *So just reaching out to veterans in those spaces is challenging for me. And as you'll know, there's still no electricity, in some areas, running water, broadband. So we can't even access telehealth if it were presented to us because we just don't have that...So those are some of the challenges on the nation, which is still a part of New Mexico. I live in [redacted], which is pretty much a third world country." - FGP 2*

Generational Challenges

The substantial generational divide among New Mexican veterans also presents challenges. As noted previously, 38% of New Mexico's veterans served during the Vietnam War era (1955-1975), and 70% of the state's veterans are ages 55+. On the other end of the age spectrum, 42% of the state's veterans served during the Gulf War and Post-9/11 eras (1990-present) and 30% are ages 18-54. This strong distribution into two distinct age and service era groups creates a generational divide that manifests in two ways: older veterans being at odds with how veteran serving organizations currently operate, and younger veterans becoming disconnected from traditional veteran-focused social and civic engagement.

The way that veterans access benefits and services has evolved over time. Much navigation happens online through technology systems, emails, phone calls, and other electronic means of communication. Information on changes to benefits is readily available on websites accessible through computers and smartphones. When soldiers separate from the military, they go through a transition assistance program (TAP) that explains their newly acquired veteran benefits and offers career and employment training.[35] Participants noted that TAP and other similar services and information were not so readily accessible to the older generation of veterans, which contributes to their

lack of knowledge on what they are entitled to receive. One participant stated, "The younger generation, I could tell him, look at the website, go here, I'll send you the link. Or when they get their decision letters, the older guys want to come in, they want you to explain everything to them." It is worth noting that younger veterans do experience ineffective transition support as well. One participant noted that TAP is not necessarily effective even for younger veterans because of rapid delivery of information and a lack of regard for its value during the transition phase. Meanwhile, older veterans prefer face-to-face and direct human connection to receive information. These differences in information sharing, as well as technology literacy challenges among the older generations, create obstacles to connecting older veterans to benefits in the more modern navigation system.

Social engagement is another core component of the veteran experience, and one where there is a marked difference between the generations. Younger generations of veterans are less apt to join community events, veteran social organizations, and to come work in veteran serving organizations. Older veterans are the opposite, tending to band together into veteran social organizations and finding meaningful support with one another. These older veterans often are retirees, and thus have more time to spend on this engagement work. Participants noted that veterans value the social engagements because they can make it easier to connect to services with fellow veterans helping each other travel to their appointments, alert each other to services, and encourage one another to use their benefits. A 2018 study on veteran service organizations (VSO) supports this anecdotal evidence. A survey of over 400 veterans showed that participation and identification with a VSO reduced social isolation and increased benefit-finding.[36] They also highly value these social connections because of how the public and government treated them when they first separated from the service and returned to their homes, which bleeds into service provision engagements. Participants noted that older veterans could spend hours with their care providers just talking because they "[want] to be told what [they] did matters…because for so many years…the history of the VA and stuff showed 'em…that they didn't matter."

Younger veterans often do not engage in such social groups because they are an active part of the workforce and are raising families, which are significant pulls on their time. They also have ways to engage with their peers outside of face-to-face interactions with social media offering them engagement at the tap of a button. The COVID-19 pandemic then further heightened their reluctance to engage in veteran social organizations. Social media, Zoom meetings, and other digital engagement methods became the new normal, and a return to in-person interactions has not fully happened. Put simply, younger veterans may not see a real need to join this kind of organization, the way their older counterparts do. Participants noted that having veteran involvement in the community and in service provision made a difference in how well veterans were engaged and served.

Recruiting younger veterans would be necessary to keep that momentum going with their elder veterans. However, this issue extends beyond New Mexico. Veterans in other states face similar social-generation gaps. A featured article from Colorado discusses the struggles of military social groups to attract and retain younger members. Older members of these organizations struggle in recruitment, and one participant noted that "they haven't been able to really recruit any…younger guys to do those things…so it would take… involvement from some of the younger generations and wanting to do it." Unfortunately, these organizations often die along with their members.[37]

> *I know some guys from the VFW and a couple of guys that are involved with the DAV, mostly Vietnam vets. Yeah, they seem to be the most active group around here. But a lot of them are retired and they have time, you know. So they're very active in a lot of the things where younger people, unfortunately, I see like VFW and DAV, and those things going by the wayside. These newer generations, even the end of Generation X and Millennials and stuff just aren't involved in those type of things like the older generations were right now. They don't see a benefit of being a member of the VFW like the older guys." - FGP 3*

CURRENT COORDINATION & COLLABORATION LANDSCAPE

To address this diverse array of needs, organizations in New Mexico have strived to collaborate with varying success. Their efforts have ranged from informal to formal and cover a variety of activities to support the military-connected population in their communities. However, there are also many environmental pressures and collaborative challenges that these organizations have faced when trying to work together. Considering the breadth and depth of issues raised by focus groups, interviews, and survey respondents, this section will first explore the additional environmental pressures organizations face, the collaborative efforts they engage in, and how those efforts merit their own challenges.

Environmental Pressures

When asked about the current state of collaboration in New Mexico, participants cited numerous ways in which the environment constrains their efforts. To describe these issues in a coherent way, we focus on the six most frequently mentioned by participants and organize them into macro, meso, and micro levels. In the social sciences, macro typically refers to the dynamics of large social systems, often how the interactions of organizations influence culture, policy, and the economy. Meso describes the experiences of individual organizations or groups within an organization, and micro conveys the behaviors of individuals.

Starting at the macro (societal) level, two tightly interrelated issues contribute to client needs. First, we heard about several infrastructural issues. Across the state, there are challenges in delivering internet connectivity to communities, whether by broadband or cell signal. As one participant put it, "if the wind blows real hard, you may not be tied to the Cloud for a bit." Likewise, participants on or near the Navajo Nation explained how in their area, and in other rural areas, people may have signal that works in one area but "won't work for the next 50 miles." In the absence of digital communication, face-to-face is also challenging due to poor or absent roads that become "impassable" after "a lot of rain [or] snow." Tied in with some communities' difficulty accessing transportation or electricity, it can be very difficult for organizations to effectively connect individuals with services.

Second, these infrastructural issues compound two other socioeconomic factors: economic prosperity and education. Participants across the state mentioned hardships in retaining young professionals. In Las Cruces, we heard how people will seek training at local universities for social work, medicine, or psychiatry, then either leave the local care systems or the state altogether. When asked why those people leave, respondents answered "pay" and "education." Young professionals can earn higher pay in private care in New Mexico, or in other states. Likewise, when considering settling down, those same professionals have "look[ed] at our education system" and said, "That's not good enough for my kid. I don't want to go there." These infrastructural and socioeconomic challenges are producing brain drain, where the young professionals who would facilitate a place's stability and growth move away, leaving behind a state with an aging population and reduced professional capacity. In the words of one participant, "There are not a lot of doctors and nurse practitioners that want to come to places like this."

> *One of the things that we see in healthcare and education: they'll hire a doctor...the [spouse] says, 'I don't like it here,' so they leave. Then, trying to attract somebody else, they look at our education system, which they will answer, "Well, that's not good enough for my kid. I don't want to go there." - FGP 4*

Meso (organizational) issues then amplify this brain drain. Participants mentioned two pressures that further hinder service delivery: geographic spread and restrictive policies. Geographic spread occurs in two varieties, the spread of people and the spread of clinics to serve those people. As Table 4 shows, nearly half of the state's population lives within the four counties constituting the Central region (Bernalillo, Sandoval, Torrance, and Valencia). The remaining half are spread out across the rest of the state's vast geography. To service this distributed population, New Mexico has a single VAMC in Albuquerque.

The VAMC serves as the state's specialist care center for New Mexican veterans. However, for many New Mexicans, this drive is infeasible. We heard people making trips from "four hours" to "three days" with some clients riding up one day, having their appointment the next, and returning home on the third. As a result, New Mexican veterans often seek care from 12 VA outpatient clinics spread across relatively more metropolitan areas of the state or clinics and VAMCs in neighboring states, including: Amarillo, El Paso, and Lubbock in Texas; Tucson and Phoenix in Arizona; and Durango in Colorado.

Restrictive policies make even this challenging. Except for those living in or near Albuquerque, most people will have to identify transportation for their VAMC appointments, whether driving themselves or riding with someone. The DAV can transport people for within state appointments but "cannot cross state lines." Similarly, the New Mexico Department of Veteran Services offers round-trip rides to veterans with VA and VA-approved appointments through their Rural Veterans Transportation Program, but the program is currently limited to residents of 15 counties.[38] The VA may reimburse travel costs, dependent on disability rate, but the veterans "must be registered with that location." Beyond VA care, seeking care from community or state organizations is also challenging because of "various definitions" of who is a veteran and "hav[ing] a solid listing of ... eligibility criteria." One participant lamented, "You tell them, 'You're eligible for this,' then they're not, then that jeopardizes the relationship you have with them." These restrictive policies, at organizational, state, and federal levels, in combination with the placement of clinics and other macro issues can make accessing care prohibitive for individuals.

Micro (individual) level issues provide a final layer of difficulty. The primary issues reported at the individual level were technology illiteracy and exploitation. Technology illiteracy serves as a barrier to access as "a lot of people can't use computers, so virtual [tools] wouldn't help them." However, in some cases, clients just "want the face-to-face." With a state as geographically dispersed as New Mexico and the shutdowns imposed by the COVID-19 pandemic, some people want that sense of connection and care from another human being instead of reaching into the virtual ether. Technology, whether due to illiteracy or resistance, can both facilitate or hinder care depending on individuals' receptiveness to it.

Exploitation, meanwhile, may either create a barrier or generate frustration among clients such that they refuse to seek care. On one hand, organizations may be exploitative. Bad actors may "raise the rent" of veterans benefitting from the HUD-Veteran Affairs Supportive Housing program (HUD-VASH) or "scam" people with false promises of "giving 100% [disability]." These malicious organizations prey on the earned benefits of veterans and push the military-connected population from seeking care in the first place. On the other hand, individuals may also exploit resources in the community. One participant told a

story of a person who would "come [to the VFW], the next day go to the other post, the next day go to the Legion." Another participant contested the existence of these individuals. If real, these individuals can exhaust resources in a community and leave people in actual need shorthanded. If rumors, the misinformation can lead organizations to be more restrictive with their assistance, limiting access in the future.

Collectively, organizations in New Mexico face several powerful environmental pressures that radiate across levels of society. Macro, meso, and micro pressures all create a context in which collaboration is both necessary and difficult to effectively address the needs of the military-connected population. To that end, organizations have engaged in various efforts to address those needs within the constraints of the environment.

Current Collaborative Efforts

Austin and Seitanidi[39,40] provide a valuable framework to understand the various efforts organizations are engaging in to support the military-connected community. They portray collaboration as a continuum, ranging from surface-level, low-touch partnerships to deep, transformative ones. As these partnerships grow in depth, they often also grow in complexity and formality. A philanthropic or transactive partnership involves the flow of resources to perform work with minimal mutual engagement. By contrast, integrative or transformative partnerships involve substantial mutual learning and programming, even to the extent of mission and effort alignment. Often, deeper collaborations come with the intent of benefiting local communities and addressing systemic issues.

In New Mexico, we similarly see collaborative efforts ranging across this continuum. More informal (transactive) activities include sharing information, joint outreach, and networking among service providers. Many organizations find it valuable to "educate other organizations" and "post events that are coming up" to "get the word out to veterans" and ensure that other organizations in their area know what services are available. They perform this outreach via flyers, social media, in-person events, newspapers, and radio to maximize visibility. Efforts like these have promoted awareness of the 988 National Suicide Prevention Hotline, services covered under the Mission Act, and other community-based offerings.

Of equal value is the integrative work that organizations do with one another. One participant described their "big hurdle" as "trying to get everybody to talk to each other." In urban areas like Albuquerque, Santa Fe, and Las Cruces, there are a relatively larger number of providers each experiencing their own changes in service offerings and eligibility criteria. Two efforts trying to facilitate this networking are the Network of Veteran Organizations (NOVO) and the work done by Quiet Listeners in northern New Mexico. NOVO and Quiet Listeners have both been working to develop catalogs of organizations serving veterans both to improve awareness of and facilitate referrals among those organizations. Keeping providers knowledgeable of each other can reduce search time for clients seeking services beyond a given organization's offerings.

This benefit is valuable when considering that much of the collaboration among organizations happens via referrals and co-programming. For some organizations, referrals are "99% of what goes on." Some, like the CONNECT network in Santa Fe or the Diné Naazbaa Partnership on the Navajo Nation, extend these efforts by working to coordinate care for the military-connected population. More commonly, organizations co-program with one another, whether "putting together a conference," "processing claims," or "do[ing] workshops." Many of these events happen around military-focused holidays like Memorial Day, Veterans Day, or Armed Forces Day. Outside these holidays, organizations regularly work together to design and host events that will benefit their communities. One participant nicely summed their work up as "hustling." People serving this community often are "hustling" to connect their clients to care, to process paperwork and forms through for clients, and to break down other barriers to access.

To tackle these barriers more formally, a variety of collaboratives come together to engage in more transformative work. These include the San Juan County Veterans Collaborative, the Santa Fe Navigator Group, and various Veterans Advisory Boards across the state. These meetings vary widely in their intents, but all share the common goal of advancing care for veterans in their areas. For example, the San Juan County Veterans Collaborative regularly hosted a veterans breakfast that doubled as a way to connect with veterans and bring new organizations into the fold. The Las Cruces Veterans Advisory Board holds a monthly meeting that "talk[s] about everything in terms of coordinated care." However, more strategic efforts are challenging for communities to achieve for reasons we will discuss in the following section.

Supporting all these activities are various technologies. The classic technologies we see enabling all this work include phone, email, and, more recently, social media. Many of organizations' interactions with clients and among each other occur over these media. Meanwhile, tracking of any efforts or service delivery most often occurs either via Microsoft Excel or in-house case management software. More complex arrangements exist in Santa Fe, which uses Unite Us, and in the Permian Basin and on the Navajo Nation which use WarriorServe. Opinions about Unite Us are mixed with some finding it useful and others finding it to be "too much work." WarriorServe is still early in its adoption lifecycle, so opinions have yet to settle on it. Yet, use of such diverse technologies can present obstacles as well. In the next section, we cover how collaboration itself, in addition to the environment, produces its own challenges.

Current Collaboration Challenges

In our discussions with participants, both through interviews and focus groups, six major collaboration challenges came up. These challenges appear to exist at three different levels as well and are:

- Fundamental challenge
  - > *Capacity shortages*
- Intermediary challenges
  - > *Resistance to collaboration*
  - > *Turnover*
  - > *Communication issues*
  - > *Lack of interoperability*
- End-point challenge
  - > *Poor provider follow-through*

We start our discussion with the fundamental challenge, capacity shortages, as it sets the scene for the rest. The term "capacity" is a heavily loaded one, however, so we unpack it first by examining capacity at three different levels:

- **individual capacity**, which refers to the resources a person has in order to do their job successfully, often considered in terms of time, knowledge, and skills;
- **organizational capacity**, which refers to the resources an organization has in order to provide its service(s) successfully, often considered in terms of funding, staffing, and materials;
- and, **community capacity,** which refers to the resources a community has in order to service its population, often considered in terms of resource availability and redundancy.

These three levels align closely with the micro, meso, and macro levels of environmental pressures that were discussed earlier. In New Mexico, we heard respondents most often describe shortages at the individual and community levels, though shortages in organizational capacity are likely too. At the individual level, participants reported "wearing many hats," noticing "that we're all overloaded." A major challenge for staff members was "having the time [to] take away from doing your job to network and discuss some of these things." These shortages at the individual level likely emerge from staff members assuming additional responsibilities to ensure their clients connect with care. Balancing direct service delivery to clients with searching for providers who can offer additional services was a poignant tension people faced. By having to hunt for providers or avenues for clients to access the additional services they need, people are left short on time to do any kind of strategic, higher-level work that could mitigate the flow of clients.

At the organizational level, the greatest challenge is staffing. Many organizations "don't have a lot of numbers [staff]." This issue seems to stem from the brain drain experienced by many New Mexico communities. As one participant put it, organizations are "competing for a few wore-out, old people." This shortage of people amplifies the loss of continuity and institutional knowledge when organizations experience turnover. It also feeds into community capacity issues where certain in-demand services either cannot serve the full population of clients or are wholly unavailable. A common complaint was "we don't have the level of services that we need for veterans." These include services such as mental health, specialist care, transportation, benefits navigation, housing, and unemployment.

> *What I find working with different people like you guys [other providers], is that we're all overloaded. We all have more clients on our caseload or more demands on our time than what we can fulfill. And so we all fall short to somebody, someday, in a request that comes our way." - FGP 5*

Such broad shortages, often felt more strongly in rural contexts, have promoted a general resistance to collaboration within some organizations. Especially sharp phrases used to describe this resistance included "pride," "turf war," and "contest." Some organizations "don't play well with others" whether that involves refusing to share information, refusing to refer clients, or refusing to enroll clients in services. At face value, such resistance can come off as the presence of bad actors who prioritize their own organization's visibility or growth. However, such behavior appears rational when considered in the context of scarcity. If people are one of the greatest shortages in the state, then clientele are likely to be an equally great shortage. Fear of losing clients is a valid concern for these organizations, especially considering the thin margins of nonprofits. Loss of clients could lead to loss of funding that in turns dissolves the organization, leaving its staff unable to address their own needs and ultimately leaving the community with one less resource. Understandably, a resource-scarce environment can produce competitive behaviors arising from fear of loss.

This fear is made tangible by the high turnover in organizations all over the state. One participant explained, "The resources that we contact, their information has changed, they no longer exist, they no longer have funding." Small community-based organizations can dissolve over a short period of time if their services go unused, whether due to lack of visibility, poor partnerships, or a drop in demand. Moreover, this turnover occurs in the state DVS and VA organizations as well. Veteran service officers, clinicians, and other points of contact can leave at any time. Depending on how well-documented their work was, turnover can result in loss of institutional knowledge and even dissolved partnerships. NOVO has experienced this with their registration counts—the number of organizations actively self-registering with NOVO—regularly fluctuating due to individual turnover at organizations rather than dissolution of the organization itself. It emphasizes the point that relationships often exist between individuals within organizations and not between organizations themselves. These turnover issues ultimately make it difficult to maintain any resource directory without "dedicated staff" focused on cultivating a "solid listing of the resources [and] their eligibility criteria."

Compounding the turnover are communication issues between organizations and different systems. On the service side, a participant working with the VA admitted, "I have no vast knowledge of everything available outside of the VA." The fact that each organization has their own internal resource directory best reflects this challenge. One organization is aware that some resources are active, and others are inactive. Another organization's directory may then add to that, corroborate it, or conflict with it. Siloed information prevents those processes. NOVO and Quiet Listeners are both working on this issue to identify a way to maintain accurate resource listings for communities.

Another communication issue is the lack of interoperability between technology systems. Different systems—such as those used by the VA, the DVS, and community providers—use different data structures, maintain different information, and do not interface with each other. This makes some information, like character of discharge, easily accessible to public agencies but difficult to access for community organizations. Similar interoperability issues exist between DVS and VA for state and federal databases. Interoperability issues ultimately produce conflicting information between different systems and duplicate the work across those systems. A client seeking care from community, state, and federal organizations will have to provide their information and re-tell their story for each distinct care system they cross, creating an inefficient and potentially re-traumatizing path to care.

These five issues—capacity shortages, resistance to collaboration, turnover, communication issues, and lack of interoperability—produce a sixth, symptomatic issue: poor provider follow-through. Most focus groups had a story where "nobody called [the veteran] back," staff "letting [the] phone ring and ring," and receiving "lip service" from providers. These are painful, upsetting stories experienced by both clients and providers seeking services for their clients. However, whether to treat this as a root cause or a symptom has important implications. As a root cause, poor provider follow-through would indicate the existence of many bad actors occupying the space out of greed or some other selfish reason. As a symptom, poor provider follow-through indicates that organizations, and thereby staff, "are overburdened" and unable to keep up with caseloads. The tone of participants across focus groups and interviews was that while collaboration was poor, nearly all organizations in this space are in it because they care about the military-connected population and want to help. To us, this suggests that poor follow-through is a symptom of the other issues described earlier.

Despite all these challenges, both environmental and collaborative, organizations maintain the grit and determination to press on. They see their work with passion and expressed interest in ways that they could continue evolving to better serve their communities. In the next section, we cover participants' feedback on how best to work toward coordinated care in New Mexico.

FUTURE STATE CONSIDERATIONS

Finally, after considering the current state of their collaborative efforts, we asked participants across data collection efforts to share their opinions on possible future states for coordinated care. Specifically, we asked participants to evaluate the proposed model, identify what they considered an ideal solution for the state, and describe what they perceived as next steps in their communities. Given the broad nature of these questions, priorities varied substantially with some apparent correlation with proximity to an urban core.

However, participants across the state largely agreed on one thing—that coordinated care would be valuable. Responses ranged from the reluctant "no" to the enthusiastic "absolutely!" Of the 34 unique responses to the survey (before consolidation), 18 respondents (53%) supported coordinated care, 8 (24%) were on the fence, and 2 (6%) opposed it. The remaining 6 (18%) offered no opinion. Meanwhile, focus group participants expressed highly favorable opinions of coordinated care, with people describing the idea as "beneficial," "invaluable," and even "necessary." Such an idea was particularly supported by organizations who were "not familiar with the services that are available" and expressed that no one organization "can be everything to everyone." Before jumping into such a model, however, people "wanted more information", sharing worries about how they are "spread thin" and wondering if "the state will put enough money in".

Despite these largely positive responses to coordinated care, participants surfaced various tensions when considering how best to implement coordinated care. Over the next few sections, we unpack the ideals participants described when imagining coordinated care, tensions they perceived in implementing it, and considerations for encouraging its adoption.

Ideals & Values

When asked about their ideal implementation of coordinated care, participants highlighted four key values:

- Supporting, not replacing, existing efforts,
- Accountability and transparency,
- Accessibility of services,
- And sustainability

During this assessment, we saw many organizations acting as community collaborators and navigators, providing direct services to meet a critical need they see missing in their communities. When our team described navigational work, these organizations made the connection that this was precisely what they had been doing. In many instances, those acting in these roles did so without external funding support. To be clear, most providers perform some of the same functions of a human navigator when they assist their clients with referrals to other organizations.

As one respondent put it, nearly every organization they worked with was "hustling." When asked to elaborate, they described "hustling" as a balance between directly providing services to clients and seeking out providers who can serve their clients' other needs. Coordinated care could potentially centralize these search efforts into a single place, giving service providers more room to provide services. However, this exact rebalancing of effort is of concern to organizations already helping clients navigate resources in their communities.

Notions of "pride" and "territoriality" came up when asking some organizations about joining a coordinated care network. Some expressed fear that a network or other organizations might "steal their resources," thus leaving them in a weakened position to provide their services. This worry emphasizes the close-held value that whatever implementation of coordinated care arises should support rather than replace the work communities are already doing. Successful analogies of this already exist within DVS and the VA as they fund "the good work [organizations] are already doing."

> *For example, the Fox Grant that we talked about earlier with the VA, one of the things that they measure for that grant for eligibility and they prioritize [in] awards is the actual footprint and the impact that you can have. So if there's a coordinated care network here in our state, the Goodwill folks, the VIC folks, can talk about having a bigger impact, a bigger footprint, because they're connected to all these other organizations. And it would be sort of a tide that lifts all the boats here in New Mexico sort of deal, allowing us to qualify for greater federal funding." - FGP 6*

Alongside supporting existing efforts, respondents also expressed a desire for accountability and transparency. Feelings about this ideal were particularly strong in some locations with one participant stating, "I want strict accountability." Their reasoning came from prior experiences of sending clients to other providers only for the client to "never get a call back or fall through the cracks." After poor follow-through by other organizations, "[clients] don't trust me." Accountability and transparency in this sense means a robust data layer. Data that track different aspects of operations can highlight strong and weak points of the system, thereby allowing leadership to respond with targeted interventions.

However, the desire for accountability extends to leadership as well. Perhaps more strongly than accountable providers, people wanted accountable leadership for such a system. In one participant's words, they "want a real person whose feet are held to the fire." Albeit strong language, it emphasizes the need for visible leadership that acts in service to its constituent providers. Accountability in this sense means having processes and structures in place that elevate the voices of providers and coordinators and offering means to address dysfunctional leadership. Participants were not yet at a stage to voice what these structures might be, but we offer suggestions for how to elicit these in our recommendations.

One thing they could voice, though, was that the structures affecting clients must minimize bureaucracy. To juxtapose two participants' thoughts, "I think the centralized process would be beneficial" but "it can't be a bureaucratic process." This concern reflects issues with the current DVS and VA care systems. Time to care for each system can be extensive, ranging from days to months. These delays may occur for a variety of reasons, but one that acutely stung providers was bureaucracy. The need to fill out various forms, re-tell stories, and connect with the "right" people make the current systems feel arduous and inaccessible for both providers and clients. Given the already bureaucratic process of existing systems, providers firmly expressed that any additional layers, like coordinated care, must minimize their own bureaucracy to maximize accessibility.

Accessibility extends beyond paperwork too. Two pressing needs mentioned earlier also feed into the accessibility of care—finances and transportation. The distances people currently must travel are a challenge that coordinated care alone cannot solve. A few programs mentioned by participants offer transportation for some appointments, but the policies governing these programs limit where and when people can use that transport. Thinking forward, participants believed that the system would need to come with a transportation component that could connect people to services only available in-person.

Likewise, participants also expressed concern about financial accessibility. As Tables 6 and 7 show, the average veteran in New Mexico is older than 55 and many of them live with a disability. Further, a couple of our focus groups discussed how many New Mexican veterans are "retirees" and "live on Social Security, pension," or some other kind of fixed income. In these fixed-income scenarios, financial accessibility is key to ensure that the cost of care does not deter people from pursuing it.

Closely tied to the issue of financial accessibility is long-term sustainability of the system. Participants discussed sustainability in terms of funding, staffing, and system providers. Many models of coordinated care maintain funding through grants or budget lines with local and state governments[41], a model that participants also expected. As one asked, "Is the State going to put enough money in it to fund these employees … around the state?" Such a scenario guarantees the system at least a steady stream of funds to maintain their operations and potentially expand in the future.

Funding considerations like these are especially important when considering the number of staff necessary to successfully operate across a state. Currently, New Mexico's DVS has 22 field officers, including 4 regional supervisors and 1 tribal liaison. The field officers assist with benefits claims and other service navigation but are "overburdened." Participants expect that

proper coordinated care will "need a whole team." However, socioeconomic conditions in New Mexico, particularly pay and education, may make it challenging for such a system to maintain a sufficient level of staffing to operate well.

Likewise, these funding and staffing concerns also feed into resourcing concerns. With issues like turnover, brain drain, and vetting, participants worried about how such a system would sustain not only its funds and staff, but also the providers servicing the system's clients. Participants acknowledged that this is an issue beyond the scope of the system's boundary, but felt it was a critical piece to the system's operations. One participant's "struggle … with veteran organizations is the transient nature of people." In an ideal scenario, funding, staffing, and resourcing would all involve a sustainable model to ensure smooth, long-term operation of the system and thus care of clients.

Beyond these four ideals—grassroots development, accountability, accessibility, and sustainability—our participants also shared various concrete realities they anticipated. In the next sections, we cover issues that they foresaw in implementing such a system, however ideal.

Implementation Tensions

When discussing the rollout of a coordinated care system, respondents across our data efforts shared divergent opinions. We present these as a series of tensions that push the design of a system in one direction or another but require a decision of some kind. The three tensions participants surfaced are:

- The model of the care system,
- The leadership of the system,
- And, the flexibility of the technology solution

In choosing a coordinated care model, many options are available for communities. Fundamentally, the approach should meet the community where they are currently but account for their future goals. This can become a challenge when there are competing interests, resource constraints, and beliefs in terms of what the goals should be for a community. For New Mexico, identifying an approach that would meet the varying needs of a geographically spread and demographically diverse population is essential.

Participants voiced three different models they could foresee working for New Mexico, a single network that spans the state, county-level networks that interconnect, and a set of regional networks as a middle choice. A statewide approach would situate a single network hub in the center of the state, likely in Albuquerque or Santa Fe given their population density and location. The county-level model would place a navigator in each county who would be responsible for knowing the resources in their county and referring clients across counties as needed. Finally, the regional model would mirror the current structure of the DVS with a few hubs that would cover multiple, non-overlapping counties.

Of these three models, most participants favored the regional approach. From a system perspective, people perceived that the regional model would capitalize on local expertise. In one participant's words, "they [local providers] know their people, they know their resources." From a client perspective, a regional model would also mirror the "distributed ops" and "chain of command" that the military-connected community is familiar with. Both aspects could potentially improve the efficiency of a regional approach.

> *I think that could be really handy for our community, depending on how thorough they were and what it looked like to be able to say, 'If I connect you with this person, I know that eventually you're going to access all the resources that are available to you.'…And so that each of us don't have to be experts on all of that." - FGP 7*

Yet, despite the broad favor for this model, people also shared concerns. One worried that with a regional approach, the system "can't cross those compartments." In other words, the system needs to allow interconnection across regional networks. As one participant in Farmington noted, "[We] have helped people in Roswell and other parts of the state who aren't part of our area." The regional networks must be able to share information and referrals to best serve clients. Additionally, even with a regional model, participants desired a "command level aspect … that can oversee those [hub] organizations."

Central to this first tension are issues of equity and resourcing. The statewide model potentially requires the least resources since it would involve a single hub organization operating in the center of the state. With only a single hub using resources (i.e., funds, staffing), issues of equitable distribution of those resources are less of a challenge. Both the regional and county models require setting up and maintaining multiple hubs across the state plus a central organization to oversee and administrate those hubs. The presence of multiple hubs then opens the question of how to fairly resource those hubs so that they can operate successfully.

Closely related to the system's model is its leadership. When asked who should lead the system, responses primarily fell into two camps—the DVS or the community. Supporters for DVS leadership suggested that the DVS felt like a "natural fit" given that "the State has the foundation already." Field officers in some areas are already performing navigational work, helping connect clients to services. Further, the DVS already has a guarantee of funding each year through the state budget which could potentially ease set up issues. However, DVS staff are already "overburdened" with some feeling that the DVS is also "underfunded."

Beyond these resource considerations, participants also expressed concerns about the community's prior experiences

with the DVS. The consensus was that "some veterans don't want to work with the government" and that letting DVS lead the system would "alienate a good portion of the veteran service organizations." Thus, despite the potential fit for DVS to lead the network, such leadership would merit caution. Most participants instead desired some form of leadership by a community organization. Though they did not name it explicitly, their discussions largely described what the network governance literature calls a network administrative organization (NAO)[42].

An NAO is a standalone organization separate from the service providers in a network whose role is to oversee, manage, and govern the network. NAOs can take on many forms, but often are separate from the day-to-day of provider organizations. This separation allows them to focus on data processing, management, and fundraising. NAOs may act as a fiscal passthrough for the network, slotting some money for their own operations then distributing funds for the operation of other organizations. In this way, NAOs act as facilitators of the network, reducing the amount of search and fundraising network providers need to perform.

Regardless of the decision, this tension highlights two issues as well—trust and autonomy. The state-led model offers a potentially more streamlined network launch, allowing the system to spin up quicker. However, this may come at the cost of trust, resistance to system adoption, and a sense of community autonomy from the state. State leadership implies the system being beholden to state policies. A community-led model could allow for greater trust and autonomy by building on the efforts that already exist across the state, but with greater startup and maintenance costs. Either decision could produce an effective system with the appropriate processes and design.

The third tension has implications for the operations of the system but is distinct from the tensions discussed so far. This tension, implicit in the conversations with interviewees and focus groups, is whether the system should adopt a unimodal or multimodal approach to its technology solution. A unimodal approach implies the system using a single technology to coordinate care across the system. This might mirror the Unite Us platform in Santa Fe or the WarriorServe platform on the Navajo Nation, or a different platform altogether as this market has matured. Meanwhile, a multimodal approach would involve the presence of multiple technological platforms adapted to the technology literacy and infrastructure of different communities.

When speaking with providers across the state, most, if not all, advocated for a multimodal approach. Some expressed concern about the "computer literacy" of people across the state and others remarked on the "lack of broadband internet" or "lack of electricity." Moreover, some providers recalled experiences, especially with elderly clients, "who want that face-to-face" interaction. These concerns certainly raise the value of a multimodal approach. A virtual solution cannot help those who either do not know how to access it or are fully unable to access it in the first place. Likewise, it cannot help those who do not want a virtual solution. To that end, participants suggested a system that incorporated various technologies such as "Zoom," "conference calling," "email," and "social media." In tandem, there would also exist in-person options for those who prefer face-to-face or "brick and mortar" interactions.

Although a robust set of ideas, they are not without their intrinsic challenges. Focal among these challenges is interoperability. The more technologies the system uses, the more procedures the system must develop to incorporate those workflows. In an ideal setting, there is a common model or standard toward which these different technologies funnel. This standard allows unique workflows that still adhere to a unifying process. For example, the system could permit hubs to use whatever technology works best for them but require hubs to upload all cases to a shared database. In this way, hubs can perform intakes in different ways, but referrals follow a single process.

The issues undergirding this tension are equity, again, and interoperability. A unimodal approach can be streamlined and simple. From a process standpoint, it only requires developing procedures for that single modality. However, if the literacy or infrastructure is absent for a community to adopt that modality, then that community cannot access the system. By contrast, a multimodal approach is flexible and adaptable but is more complex. It requires a greater level of thought in developing standards to link those distinct technologies to a common process. This interoperability, in some cases, can create more work for users. Ultimately, technology decisions impact the daily operations of the network. Recognizing what is feasible and where communities are is necessary to make an informed decision on this tension.

Collectively, these three tensions home in on one other issue that is fundamental to coordinated care, adoption. Networks are only successful to the extent that network partners buy in to the network. If provider organizations disagree with the idea or implementation of a coordinated care system (i.e., network), then the system loses those partnerships. In the next section, we explore the considerations that participants raised when thinking about how to facilitate adoption of a coordinated care system.

Adoption Considerations

Adoption was such a significant concern among participants that we felt it merited a discussion of its own. By nature, adoption is to do something different, a new idea or product. Communities already implementing a coordinated care model can attest that detractors and cynics resist adopting new initiatives. No matter what the New Mexico legislature and community decide, there will be opposition. This opposition was already evident in the communities we spoke with that have implemented similar models and is a normal part of doing work that involves system change. Rogers' diffusion

of innovations theory[43] is a hallmark model capturing the resistance to and adoption of innovations.

Initial resistance to innovations can surface for numerous reasons. Despite the generally positive responses to coordinated care, many participants expected that "not everybody's going to use it" because "[it's] one more thing" that is "in addition to the ones that already exist." This is a realistic assumption, and one that paves the way to acknowledging what those points of resistance are. In our discussions with providers, they highlighted four points that could influence communities' adoption of a new coordinated care system:

- Prior history with poor leadership and failed programs,
- Investment and advocacy by local champions,
- Technological flexibility,
- And the use of incentives

The first point is communities' prior history. As mentioned previously, many communities and providers are wary of the potential for DVS leadership of the system. Their distrust risks "alienating" those organizations when the system starts rolling out. Likewise, there have been similar programs attempting to improve care in the past. When describing coordinated care to one participant, they reflected that "it seems like a rehash of a program tried years ago." That same participant elaborated that there have been previous efforts that start up "then two years later, it's dead."

These kinds of false starts leave communities cautious to invest their already overused resources into another new system. In the words of one jaded participant, "the elevator speeches gotta match the actual services." Moreover, communities have their own internal divides with some organizations not "want[ing] to connect because we do this thing by ourselves." Getting organizations to see past prior experiences and evaluate a new program on its own merits can be a challenge. Realistically, the system will have to demonstrate some benefit or return on investment before widespread adoption occurs.

> *The only thing I can say is that if you're going to come into [our] community, you got to be here for the long haul. You know, you can't just say, "I'm going to be here for a two year program and see how it works out. And then maybe we'll get an extension for another two years." You know you got to come in with the long haul, and you've got to expect that there's gonna be resistance." – FGP 8*

One way to facilitate early adoption is to identify and involve local champions. Trusted partners and well-known community leaders have community connections that can facilitate conversations about the changes. For example, when talking about a couple of the indigenous nations, a participant noted, "They're going to trust each other more than they'll trust you, and they'll trust me more than they trust you because I'm a veteran too." Membership organizations like the Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), American Legion, and the various lodges also act as trusted groups within communities. Involving these organizations early in the design and development of systems can foster trust, which lies at the heart of adoption.

Communities want to trust that clients will "get a call back" and not "fall through the cracks" when referred into a coordinated care system. This piece is key because help-seeking is a highly trust-driven process. It takes trust for a military-connected individual to reach out to a provider. It takes trust when a provider refers a client that the receiving organization can provide care. It takes trust that the system will ultimately benefit the client and not exploit, exhaust, or harm them in the process of seeking care. This kind of trust takes time to develop but having systems that "track a veteran from the initial point … to the [point where] services were rendered" can facilitate development of that trust.

Speaking to technology and data, taking a flexible approach to technology can also encourage adoption. As mentioned in the previous section, a unimodal approach could exclude certain communities who lack technological maturity or infrastructure. By meeting communities where they are, the system can reduce barriers to entry, even with the intent to fold communities into a more advanced solution later. Most importantly, however, technology cannot "overcome the importance and significance of personal relationships." Many veterans appreciate the personal interactions they receive while engaging in the help-seeking process. If the system carefully balances human touch with technological support, it may also encourage adoption by maintaining aspects of the work that draw staff in the first place.

Finally, barring all other efforts, one participant wondered "if there are ways to incentivize adoption," arguing "that's an area that … [we] really need to focus on." Rogers discusses how incentives can encourage a greater rate of early adoption by giving people an additional reason to change. However, it is important to recognize that incentives alone may not encourage long-term change. The system itself, over time, needs to merit its continued investment by organizations. This may occur through demonstrable impact on the military-connected population, improved efficiencies for organizations garnered by joining the system, or perhaps more wide-scale effects through investment in population health and infrastructure.

Each of these considerations has merit given the fundamental importance of adoption in networked work. Addressing prior history, involving local champions, being technologically flexible, and offering incentives can all facilitate adoption of a novel system like coordinated care. In the next section, we weave together the ideas from our data collection efforts and lay out our recommendations for how New Mexico can implement coordinated care in a way that fosters short- and long-term adoption.

Recommendations

1. IMPLEMENT A COMMUNITY DESIGN AND PLANNING PHASE

The veteran-serving organizations that participated in this assessment felt that a coordinated care network would be of value to New Mexico. Additionally, a vast majority felt a network of networks model would be the best approach for both veterans and service providers across the State. However, several questions remain including network leadership structure, how best to phase implementation, and funding and sustainability. As such, the IVMF recommends the State pursue a design phase to definitively answer these and other questions. Ultimately, the design phase should culminate in a roadmap for how New Mexico should implement a coordinated care model. A list of recommended activities for the design phase are detailed below.

Hold Listening Sessions with Community Stakeholders to Inform Network Design

Human service providers best know their community's strengths, challenges, and needs when it comes to serving their military-connected population. Listening sessions with community stakeholders will help to ensure a better understanding of each community's unique circumstances and will be crucial for designing a coordinated care model for New Mexico. This is especially true for both rural and Native/Indigenous communities that have unique needs and challenges. Insights from these stakeholders will also be key to informing the overall structure of the network (e.g., network governance and oversight).

It is also worth noting that the success or failure of a coordinated care model is often determined by the commitment and contribution of the community providers who are part of it. Community listening sessions will ensure that stakeholders have, as one interviewee put it, "skin in the game" on network design. This is especially important in the case of New Mexico: as several participants shared (unprompted), initiatives that are perceived as being "brought in from the outside" without consultation and contribution from New Mexicans seldom succeed. Community involvement will help to set a strong foundation for the network in the long term.

Explore a Flexible Model to Meet Communities Where They Are

In conducting this assessment, the IVMF found that not all regional communities in New Mexico are currently well-positioned to fully implement a coordinated care model. However, it was clear that all communities would benefit from having a convener regularly bring together providers serving military-connected families to share information and explore additional avenues for collaboration. As outlined by Austin and Seitanidi35,36, this continuum (from convening to formal coordinated care) introduces the opportunity to design tailored models per region. For example, one region may be prepared to fully implement a transformative coordinated care model while another would be better starting off with a lighter touch convening activity. The promise of this approach is that it allows regions to immediately enhance their coordination and collaboration activities based on where they are while also moving them all toward coordinated care at their own pace. Meeting communities where they are and allowing them to define the terms of their growing coordinated care activities is essential for initial buy-in and continued support.

Seek Insight on How to Design Network Leadership and Oversight

The feedback from participants that the preferred approach for coordinated care in New Mexico is a network of network design with an organization at the center overseeing the regional operations was an important finding and one that raised numerous questions that require additional consideration. These include the following questions:

- How should network leadership be structured?
- How will regional lead organizations be selected?
- How will network data be gathered and disseminated?
- What is the network governance structure and how will parties be held accountable?

Further work must be done in partnership with relevant stakeholders to develop answers to these and other questions to set a clear strategy.

Gather Input from and Involve Key Institutional Stakeholders

There are two notable organizations that will play a key role in the development, implementation, and steady state operation of coordinated care in New Mexico: NMDVS and the VA New Mexico Healthcare System. A design phase must include engagement with these stakeholders to discuss the following:

- Programmatic roles and responsibilities: Both NMDVS and the VA New Mexico Healthcare System play an important role in providing services to the military-connected community across New Mexico. Involving their staff and ensuring their respective programs are incorporated into the network design will be vital for the efficacy of the effort.
- Network Administration: In addition to programmatic offerings, several participants offered that NMDVS was potentially well-positioned to act as the statewide administrative body overseeing the regional networks and overall effort. This concept should be explored further with NMDVS to assess feasibility and fit.
- Sustainability: Coordinated care in New Mexico will require on-going investment. State funding is an established means of ensuring sustainability for veteran and military family coordinated care efforts. Discussions and planning with NMDVS and the New Mexico Legislature regarding funding will be vital for the design and implementation of the effort.

Chart a Path for Implementation

Rollout of an initiative as multifaceted as a coordinated care network is best done in stages. This is especially true for a regional networked approach with its additional layers of complexity. As such, using the data gathered from the above activities, the design phase should culminate in an implementation roadmap that would provide clear next steps for each community including which region(s) would pilot a coordinated care effort along with a phased timeline and model for the remaining regions. Importantly, this roadmap would also provide the basis for budgeting and long-term sustainability planning for the network.

2. USE NETWORK DATA TO IDENTIFY AND ADDRESS SHORTAGES IN SERVICES AND RESOURCES

A clear theme emerging from stakeholder interviews and focus groups is that a shortage of services and resources in areas such as healthcare, transportation, and affordable housing is a challenge across New Mexico. However, it is worth noting here that coordinated care networks are often dependent on the resources that exist where they operate. And while networks can leverage national and statewide programs for some service areas, resource gaps may still exist at the local level. In other words, if a service such as primary healthcare has reached its capacity in a community, the network will often have the same limitation. As a result, navigators operating within a coordinated care model may struggle to connect help-seekers to certain services. On the other hand, coordinated care networks can spotlight these resource gaps by utilizing data collected from across the network to identify opportunities for increasing capacity for services where it is needed.[44] And, of course, coordinated care is still an effective way to improve the well-being of veterans and the military-connected community by facilitating access to care and services that do exist in communities. Therefore, the IVMF recommends the following activities be incorporated into the design and implementation of a coordinated care model in New Mexico:

- **Acknowledge the Boundaries of Coordinated Care:** As mentioned above, coordinated care networks will often have the same gaps in services as the communities where they operate. This should be made clear to participating providers and other stakeholders during the design phase to ensure they are aware of both the benefits and the possible limitations of coordinated care. Similarly, stakeholders should be made aware of the potential of using network data to highlight resource gaps.
- **Create Data Sharing Pathways:** Once coordinated care networks begin operating in New Mexico, they will be gathering numerous data points, including the needs of help-seekers and the success rate of connecting those individuals to services. To make the most of this information, data sharing pathways should be created between the network(s) and key stakeholders (i.e., relevant government and philanthropic entities) to help identify the needs of the military-connected population in New Mexico and inform strategy and decision-making related to best meeting those needs.

Conclusion

In preparing this report, the IVMF found a unique set of factors—demographic, socio-economic, environmental, and organizational—that create a context in which it is difficult for New Mexican veterans to access care and services. Veterans living in New Mexico tend to be older and have higher rates of unemployment and poverty compared to national averages. Many (2 in 3) also live in an area that is relatively more rural where there are fewer service providers to meet their needs. As a result, New Mexican veterans often find themselves traveling long distances to population centers both in and out of state to receive services—particularly for medical and mental healthcare. This, in turn, drives the need for transportation services for veterans to receive care.

Veteran serving organizations in New Mexico have worked to collaborate to meet this array of needs with varying levels of success. A mix of efforts, including information exchanges and veteran collaboratives, are active in the state but confront challenges such as capacity shortages, turnover, and communication issues that can stymie further collaboration between organizations. However, nearly all the organizations we spoke to are in this space because they care about the population they serve and expressed interest in ways that they could continue evolving to better serve their communities.

When considering all the above, the IVMF found New Mexico to be well-positioned to pursue a coordinated care system for its military-connected community. Indeed, the unique circumstances and challenges New Mexico's veterans and veteran-serving organizations face—especially those living and operating in rural and Native/indigenous communities—highlights the potential of a coordinated care approach to better connect individuals to care and organizations to one another. What's more, the majority of the 41 veteran-serving organizations we engaged with were both supportive of a coordinated care approach and had a clear vision for how it could best be implemented statewide.

However, these same circumstances and challenges are what drove the IVMF to recommend a community design and planning phase prior to any implementation of coordinated care efforts in the state. This process would ensure a model is tailored to best serve New Mexico's military-connected population no matter where they live and help to develop buy-in from service providers, setting a strong foundation for the model. As the state of New Mexico moves forward in building their coordinated care system, they must engage the diverse breadth of the veteran and military-connected community and veteran-serving organizations to design networks grounded in the structure and responsive to the needs of each unique community.

APPENDIX A: COMMUNITY ORGANIZATIONS & COLLABORATIVES TABLES

Table 1: Veteran-Serving Organization and Revenue Distribution by County in New Mexico

County	Number of Organizations	Total Revenue ($)	Average Revenue ($)
Bernalillo	55	29,959,699.00	2,723,609.00
Santa Fe	15	87,927.00	29,309.00
Doña Ana	8	0.00	0.00
Otero	8	0.00	0.00
Sandoval	6	0.00	0.00
Chaves	5	0.00	0.00
Curry	5	0.00	0.00
San Miguel	5	0.00	0.00
Taos	4	0.00	0.00
San Juan	3	160,767.00	80,383.50
Luna	3	0.00	0.00
McKinley	3	0.00	0.00
Rio Arriba	3	0.00	0.00
Valencia	2	36,714.00	18,357.00
Colfax	2	0.00	0.00
Los Alamos	2	0.00	0.00
Sierra	2	0.00	0.00
Eddy	1	0.00	0.00
Lincoln	1	0.00	0.00
Socorro	1	0.00	0.00
Catron	0	0.00	0.00
Cibola	0	0.00	0.00
De Baca	0	0.00	0.00
Grant	0	0.00	0.00
Guadalupe	0	0.00	0.00
Harding	0	0.00	0.00
Hidalgo	0	0.00	0.00
Lea	0	0.00	0.00
Mora	0	0.00	0.00
Quay	0	0.00	0.00
Roosevelt	0	0.00	0.00
Torrance	0	0.00	0.00
Union	0	0.00	0.00
No County Affiliation	22	0.00	0.00

Note. Data Sources: U.S. IRS Exempt Organizations Business Master File & Census Bureau 2020 Zip Code Tabulation Area Relationship Files. Table covers all IRS organizations that are veteran serving, including W30 coded organizations and organizations found in resource directories

Table 2: W30 - Veteran-Specific Organization and Revenue Distribution by County in New Mexico

County	Number of Organizations	Total Revenue ($)	Average Revenue ($)
Bernalillo	13	583,474.00	58,347.40
Otero	4	0.00	0.00
Santa Fe	3	87,927.00	29,309.00
Chaves	3	0.00	0.00
Curry	3	0.00	0.00
Doña Ana	3	0.00	0.00
San Juan	2	160,767.00	80,383.50
Luna	2	0.00	0.00
Colfax	1	0.00	0.00
Los Alamos	1	0.00	0.00
McKinley	1	0.00	0.00
Sandoval	1	0.00	0.00
Valencia	1	0.00	0.00
Catron	0	0.00	0.00
Cibola	0	0.00	0.00
De Baca	0	0.00	0.00
Eddy	0	0.00	0.00
Grant	0	0.00	0.00
Guadalupe	0	0.00	0.00
Harding	0	0.00	0.00
Hidalgo	0	0.00	0.00
Lea	0	0.00	0.00
Lincoln	0	0.00	0.00
Mora	0	0.00	0.00
Quay	0	0.00	0.00
Rio Arriba	0	0.00	0.00
Roosevelt	0	0.00	0.00
San Miguel	0	0.00	0.00
Sierra	0	0.00	0.00
Socorro	0	0.00	0.00
Taos	0	0.00	0.00
Torrance	0	0.00	0.00
Union	0	0.00	0.00
No County Affilliation	1	36,714.00	36,714.00
Total	39	868,882.00	22,279.03

Note. Data Sources: U.S. IRS Exempt Organizations Business Master File & Census Bureau 2020 Zip Code Tabulation Area Relationship Files. Table covers all IRS organizations that are veteran serving, including W30 coded organizations and organizations found in resource directories

Table 3: All IRS Exempt Organizations and Revenue Distribution by County in New Mexico

County	Number of Organizations	Total Revenue ($)	Average Revenue ($)
Bernalillo	2583	1,924,134,189.00	1,003,198.22
Santa Fe	1015	1,108,317,658.00	1,473,826.67
Doña Ana	541	165,749,355.00	433,898.84
Sandoval	320	37,642,472.00	160,180.73
San Juan	307	467,179,270.00	2,301,375.71
Otero	175	280,060,877.00	2,373,397.26
Eddy	162	149,030,335.00	1,405,946.56
Chaves	159	40,188,398.00	379,135.83
Lea	156	40,586,742.00	397,909.24
Valencia	145	25,886,727.00	287,630.30
Curry	125	31,622,746.00	445,390.79
Los Alamos	124	21,010,084.00	205,981.22
Taos	114	109,749,752.00	1,219,441.69
Grant	99	9,780,475.00	135,839.93
McKinley	86	102,920,945.00	1,871,289.91
Lincoln	68	6,488,295.00	129,765.90
San Miguel	63	55,417,085.00	1,259,479.20
Roosevelt	60	36,603,859.00	851,252.53
Luna	53	2,708,276.00	79,655.18
Rio Arriba	49	14,856,721.00	464,272.53
Sierra	48	19,121,848.00	531,162.44
Colfax	47	1,696,698.00	54,732.19
Socorro	40	8,362,489.00	278,749.63
Cibola	28	43,282,738.00	2,278,038.84
Torrance	20	67,795.00	5,215.00
Quay	18	1,325,484.00	110,457.00
Hidalgo	14	25,127,858.00	5,025,571.60
Union	13	20,282,742.00	2,028,274.20
Catron	13	1,367,944.00	113,995.33
Guadalupe	9	6,840,297.00	977,185.29
Harding	4	0.00	0.00
De Baca	2	0.00	0.00
Mora	2	0.00	0.00
No County Affiliation	151	61,522,283.00	564,424.61
Total	6813	4,818,932,437.00	28,846,674.39

Note. Data Sources: U.S. IRS Exempt Organizations Business Master File & Census Bureau 2020 Zip Code Tabulation Area Relationship Files. Table covers all IRS organizations in New Mexico, but excludes organizations found in resource directories not otherwise found in the IRS dataset. Table excludes organizations with PO boxes as primary addresses, zip codes mapped to multiple counties, and organizations with no identifiable county in address data (n=4004).

APPENDIX B: DEMOGRAPHIC AND POPULATION TABLES

Table 4. Population Distribution Across New Mexico.

	COUNT				REGION PROPORTION		STATE PROPORTION	
Area	**Full Population**	**Veterans**	**Non-Veterans**	**Active Duty†**	**Veterans**	**Non-Veterans**	**Veterans**	**Non-Veterans**
United States	252,130,477	17,835,456	234,295,021		7.1	92.9		
New Mexico	1,602,533	141,558	1,460,975	12,680	8.8	91.2		
Region								
Central	709,677	65,925	643,752	3,608	9.3	90.7	46.6	44.1
North Central	194,660	15,164	179,496	111	7.8	92.2	10.7	12.3
Northeast	49,875	4,468	45,407	37	9.0	91.0	3.2	3.1
Northwest	163,948	11,539	152,409	222	7.0	93.0	8.2	10.4
Southeast	252,651	23,376	229,275	8,061	9.3	90.7	16.5	15.7
Southwest	231,722	21,086	210,636	641	9.1	90.9	14.9	14.4

Note. Data drawn from the 2020 Census American Community Survey. Region proportion indicates what portion of a given region is veterans or non-veterans. State proportion indicates what portion of the state's veteran and nonveteran population come from that region. †Data on active-duty residence drawn from 2020 Measuring Communities survey led by Purdue University.

Table 5. Veteran Gender, Race, and Ethnicity Distribution.

	GENDER		RACE							ETHNICITY
Area	**Male**	**Female**	**White**	**Black or African American**	**American Indian or Alaska Native**	**Asian**	**Native Hawaiian or Pacific Islander**	**Some other race**	**Two or more races**	**Hispanic or Latino (of any race)**
United States	90.9	9.1	80.8	12.0	0.8	1.7	0.2	1.6	2.9	7.3
New Mexico	89.8	10.2	80.1	4.0	4.9	0.5	0.1	5.3	5.1	30.9
Region										
Central	88.9	11.1	80.0	4.9	3.3	0.6	0.0	5.7	5.5	31.4
North Central	93.5	6.5	82.4	0.7	3.4	0.5	0.3	7.3	5.4	39.2
Northeast	93.4	6.6	77.4	0.2	0.8	0.0	0.0	14.4	7.3	52.5
Northwest	90.2	9.8	58.2	2.0	31.9	0.1	0.5	3.4	3.9	16.3
Southeast	88.5	11.5	83.7	6.3	1.0	0.5	0.2	3.5	4.9	21.3
Southwest	90.7	9.3	87.3	3.0	1.3	0.3	0.0	3.8	4.3	37.1

Note. Data drawn from the 2020 Census American Community Survey. In each row, the denominator for the percent is the number of veterans living in the area according to Table 4.

Table 6. Veteran Age and Service Era Distribution.

	AGE (IN YEARS)					SERVICE ERA				
Area	**18-34**	**35-54**	**55-64**	**65-74**	**75+**	**Gulf War (post-9/11)**	**Gulf War (pre-9/11)**	**Vietnam Era**	**Korean War**	**World War II**
United States	8.8	23.4	17.8	26.1	23.9	20.6	21.4	35.2	7.6	2.9
New Mexico	8.1	22.2	19.5	27.1	23.1	20.3	21.5	38.2	7.7	2.6
Region	7.4	23.5	19.3	27.5	22.2	20.4	23.3	38.7	7.7	2.5
Central	3.2	18.9	18.9	30.1	29.0	10.6	15.9	42.7	7.7	3.4
North Central	1.9	15.4	27.6	30.0	25.0	10.9	16.5	44.0	9.0	2.3
Northeast	9.2	24.1	18.1	26.7	21.9	17.6	20.9	34.8	7.6	2.6
Northwest	13.7	23.8	19.5	22.7	20.3	28.3	25.1	32.5	7.4	2.7
Southeast	8.2	18.8	19.9	28.2	24.9	21.2	17.3	39.9	7.8	2.0
Southwest	90.7	9.3	87.3	3.0		1.3	0.3	0.0	3.8	4.3

Note. Data drawn from the 2020 Census American Community Survey. In each row, the denominator for the percent is the number of veterans living in the area according to Table 4.

Table 7. Veteran Unemployment, Poverty, and Disability Status Distribution

		POVERTY STATUS		DISABILITY STATUS	
Area	**Unemployment**	**Below**	**At or above**	**With**	**Without**
United States	4.3	6.7	93.3	29.5	70.5
New Mexico	5.0	7.9	92.1	31.8	68.2
Region					
Central	5.1	7.2	92.8	29.3	70.7
North Central	8.7	7.7	92.3	32.3	67.7
Northeast	8.0	5.8	94.2	44.3	55.7
Northwest	5.7	11.7	88.3	38.5	61.5
Southeast	5.6	7.3	92.7	29.4	70.6
Southwest	3.0	9.4	90.6	36.0	64.0

Note. Data drawn from 2020 Census American Community Survey. Unemployment rate for each of the regions is the average across the representative counties instead of a direct computation. The denominator for poverty and disability status is the count of the civilian population 18 years old and over for whom poverty status is determined. The numerators, respectively, are the counts of those living below/at or above the poverty threshold and those living with/without a disability.

Table 8. Relative Rurality of Counties in New Mexico

COUNTY	POPULATION	POPULATION DENSITY	% URBANIZED LAND	RUCC CLASS	DISTANCE TO METRO COUNTY	RELATIVE RURALITY
Bernalillo	528,047	502.13	18.23	Metro	0.00	0.03
Catron	3,037	0.48	0.00	Rural	106.59	0.77
Chaves	47,736	8.69	0.41	Micro	118.59	0.74
Cibola	20,481	4.98	0.14	Micro	68.95	0.76
Colfax	9,900	2.91	0.12	Rural	106.26	0.77
Curry	33,718	26.49	1.14	Micro	142.45	0.73
De Baca	1,144	0.54	0.00	Rural	84.49	0.77
Doña Ana	163,574	47.43	1.99	Metro	0.00	0.65
Eddy	42,461	11.23	0.63	Micro	147.73	0.74
Grant	21,979	6.13	0.35	Rural	94.09	0.76
Guadalupe	3,578	1.30	0.00	Rural	62.10	0.77
Harding	368	0.19	0.00	Rural	123.47	0.78
Hidalgo	3,252	1.04	0.00	Rural	114.16	0.77
Lea	49,127	12.35	0.70	Micro	189.68	0.74
Lincoln	16,167	3.70	0.35	Rural	65.79	0.76
Los Alamos	14,653	148.28	9.71	Micro	31.22	0.56
Luna	17,666	6.58	0.28	Micro	54.83	0.76
McKinley	51,174	10.37	0.25	Micro	64.15	0.74
Mora	3,910	2.24	0.00	Rural	67.53	0.77
Otero	48,386	8.08	0.21	Micro	66.17	0.75
Quay	6,386	2.45	0.13	Rural	134.24	0.77
Rio Arriba	29,945	5.64	0.25	Micro	57.57	0.75
Roosevelt	13,912	6.28	0.21	Rural	141.92	0.76
San Juan	92,293	18.47	1.03	Metro	0.00	0.71
San Miguel	22,461	5.25	0.15	Micro	65.30	0.76
Sandoval	110,956	33.02	1.38	Metro	0.00	0.69
Santa Fe	123,086	71.15	2.72	Metro	0.00	0.64
Sierra	9,267	2.45	0.20	Micro	57.72	0.77
Socorro	12,947	2.15	0.08	Micro	49.43	0.77
Taos	26,976	13.53	0.86	Rural	76.49	0.74
Torrance	12,175	4.02	0.00	Metro	0.00	0.77
Union	3,272	0.94	0.00	Rural	155.42	0.77
Valencia	58,499	60.56	3.7	Metro	0.00	0.67

Note. All decimal values rounded to two digits. Population density is population per square mile. Distance to metro county is in miles.

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