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COMMUNITY INSIGHTS & IMPACT

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BUILDING A COORDINATED CARE NETWORK FOR NEW MEXICO VETERANS

A Roadmap for Statewide Implementation

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

The D’Aniello Institute for Veterans and Military Families (IVMF) delivers class-leading programs in career, vocational, and entrepreneurship training by providing service members, veterans, and military spouses with the knowledge, connections, and experience they need to navigate the transition between military life and the civilian world and workplace. We provide and share access to programs, resources, and partnerships that help transform lives and support their goals after service.

The D’Aniello Institute also consults with and advises service organizations across the country on effective ways to coordinate care that serves the needs of veterans and the military family community.

In addition, the IVMF delivers research, evaluation, policy insights, and quality-improvement results through a data-informed approach to address evolving challenges facing veterans and their families. Action-oriented and solution-focused, the IVMF empowers partners to measure, improve, and communicate the impact of veteran and military family initiatives.

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SUGGESTED CITATION

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The New Mexico Legislature has funded the D'Aniello Institute for Veterans and Military Families at Syracuse University (IVMF) over two phases to assess the state's veteran services landscape and evaluate the viability of a statewide coordinated care network. Coordinated care networks connect organizations providing a diverse array of services—food banks, shelters, health clinics, employers, and more—to create a "no wrong door" for people seeking help. The IVMF has an established history designing, implementing, and evaluating coordinated care networks across the country through its AmericaServes initiative[1,2] and other technical assistance efforts. Given the IVMF's decade of experience in supporting coordinated care efforts across the country, the New Mexico Legislature funded the IVMF for an initial landscape assessment in 2023, and a community design phase in 2025.

Phase 1 (2022-2023): IVMF's previous work in the state assessed the current landscape of providers and collaboration in New Mexico to gauge the state's readiness to implement a statewide coordinated care network.[3] This work found that veteran-serving organizations strongly supported the idea of a statewide coordinated care network but there existed several unique barriers, especially the rurality of the state, that would challenge any implementation. These challenges highlighted the need for the involvement of these organizations in a design and planning phase to ensure the effectiveness of the network. Based on the findings in Phase 1, the IVMF recommended a Phase 2 of the project that would gather input from New Mexico's veteran-serving organizations to help with the design and rollout of the network.

Phase 2 (2025-2026): In this report, the IVMF focused on the community-driven design and planning of a coordinated care network in New Mexico, emphasizing the implementation challenges raised in Phase 1. In partnership with the New Mexico Department of Veteran Services, the IVMF conducted twelve focus groups across the state and an additional 25 stakeholder briefings and dialogues to gather input from veteran-serving organizations on how the coordinated care network should operate. This input centered on six key topics: network structure, technology needs, leadership, accountability, adoption strategies, and sustainability. During analysis, a seventh topic, implementation, emerged. These seven topics coalesced into three overarching themes:

1. **Model and Implementation:** The geographic spread of resources in New Mexico, alongside its cultural and community diversity pointed toward a regional model for care coordination, with one organization managing multiple navigation offices across the state. Positioning hubs across the state increases navigation access for communities away from the metro center and reduces clients' transportation burden. Management of those offices by one organization then provides clear leadership and mitigates potential collaboration concerns if different organizations ran each regional office. Other considerations for the implementation of the network included the hiring of full-time navigators, the development of a community of practice, the creation of shared norms and procedures, and careful choice of a technology to facilitate intakes and referrals.
2. **Leadership and Accountability:** Care for veterans in New Mexico hinges on strong leadership, clear accountability, and robust data systems. There is a deep need for authentic, veteran-centered leadership that is culturally and regionally responsive. Oversight gaps and inconsistent data collection undermine trust and collaboration, highlighting the importance of baseline metrics, referral tracking, and transparent reporting to measure impact and prevent veterans from falling through the cracks. A successful coordinated care network will require an integrated system that combines transparency, cultural competency, and shared accountability to meet diverse veteran needs.
3. **Adoption and Sustainability:** Key to the rollout of any new product or service is that people actually use it. In line with Rogers' theory for diffusion of innovations,[4] leadership must first generate knowledge of a statewide coordinated care effort, then persuade people to use it, and finally institute structures to ensure sustainability. Each step emphasizes the need for ongoing transparency and communication by leadership, with trust and collective buy-in necessary to facilitate early adoption. Mainstream and later adoption will rely on demonstrable impact of coordinated care. Sustaining the effort into the future then requires balancing continuity of funding, participation, and impact.

The three themes described above summarize a desire from participants to see a coordinated care approach for veterans that is well-integrated with existing systems, communicative, accessible, and driven by strong leadership teams. Based on our findings, the team recommends the following:

- **A Regional Model with Dedicated Navigators:** A regional model, wherein one organization manages the daily operations of offices across the state, allows for regional variation, enhances cultural competency, strengthens trust within local communities, and improves communication and coordination. Full-time navigators then serve as the “brain” of these offices, curating resource lists for their regions, conducting holistic intakes, and referring people to providers that match clients’ needs.
- **Nonprofit Leadership with State Oversight:** Program leadership for a statewide effort is a tradeoff between infrastructure (i.e., state agency) and trust (i.e., nonprofit). Given the powerful emphasis on trust from community representatives, we recommend a public-private partnership. A state agency will serve as the fiscal agent, develop a transparent request for proposals (RFP), select the RFP committee, and support the RFP review. A qualified nonprofit will then manage the rollout and daily operations of the network.
- **Phased Implementation Over Four Years (48 Months):** A phased implementation, which includes a soft regional pilot launch, allows for building of the network’s infrastructure, gradual introduction of regional hubs, refining the network based on early feedback, and scaling the network in a way that supports long-term sustainability. We include a detailed roadmap that provides a step-by-step timeline and deliverables to aid in implementation.

The recommendations outlined in this report reflect the collective insights and priorities of veteran-serving organizations across New Mexico. Through extensive engagement with stakeholders across the state, this community-driven design process has produced a roadmap that considers New Mexico’s unique challenges while building on proven coordinated care principles. By implementing a regional model with dedicated navigators, establishing nonprofit leadership with state oversight, and pursuing phased implementation over four years, New Mexico will be positioned to create a coordinated care network that is not only operationally sound but also grounded in the trust, cultural competency, and local responsiveness that stakeholders identified as essential to success. This approach ensures that the network will serve veterans and their families effectively from day one while establishing the foundation for long-term sustainability and impact.

BACKGROUND

There are more than 40,000 organizations nationwide dedicated to supporting the military-connected community—that is, veterans, military, and their families. Despite the abundance of support resources available (often known as the "Sea of Goodwill"[5]), accessing care and services is a significant challenge for veteran and military families. This is often due to varying eligibility requirements, limited program capacity, and complicated enrollment processes. There is also a shortage of certain services, including housing and mental health services. Difficulty accessing resources, limited services, and not knowing where to turn often leads to those who need resources not seeking them.[6]

One approach specifically designed to address the challenges associated with accessing care and services is navigation systems. Navigation systems are "organizational arrangements designed to support individuals in locating and obtaining valuable benefits, programs, and services."[7] These navigation systems comprise three core elements, outlined in Box 1.

1

Core Navigation System 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.

Michelle Shumate, in her work in Pennsylvania, defined four types of navigation systems to coordinated care: 1) community connectors, 2) demanded directories, 3) healthcare developers, and 4) system integrators.[8] Each of these support navigation in some way with varying degrees of human and technological support. Community connectors are organizations that rely on navigator staff to identify local resources and direct clients to those resources with information. Demanded directories, like 211s, maintain resource lists that clients can access on-demand, typically through a website or app. Healthcare developers extend these efforts further by integrating resource lists and referral tracking into electronic health records accessible by navigators within the health system.

System integrators, a popular design in the military-connected space, then expand the technology component by encouraging adoption of a shared platform. System integrators, especially, utilize closed-network strategies and closed-loop referral platforms. Closed-network strategies clarify which organizations are active participants in the networks that are ready to receive referred clients. Closed-loop referral platforms, meanwhile, track each client's journey through the referral process to ensure they receive help. Several states have invested in this kind of approach as a means of easing access to services for military-connected residents (including Georgia,[9] North Carolina,[10] Rhode Island,[11] South Carolina,[12] and Texas[13]). 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.

The remainder of this section provides a review of the IVMF's first phase of work then sets the context for the current phase of work.

PHASE 1: NEW MEXICO LANDSCAPE ASSESSMENT RECAP

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 New Mexico's readiness to implement a statewide coordinated care network. Between January and March 2023, the team engaged with 41 non-profit and government organizations serving 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, outlined in Box 2.

2

Phase 1 Research Questions

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?

The purpose of these questions was to paint a picture of the current degree of collaboration and coordination in the state since the navigation models described earlier require different levels of investment by the wider community of providers. A single organization can reasonably build and manage a community connector or demanded directory model, but healthcare developer and system integrator models take more collective effort. A clear understanding of infrastructure, capacity, and prior experiences working together then identify the kinds of work necessary to achieve different care coordination approaches. This phase of work revealed two finding, outlined in Box 3.

3

Phase 1 Findings

1. Veterans face significant barriers in accessing and navigating resources, largely due to the concentration of resources in urban areas, transportation limitations, and the state's rurality.
2. There exists a wide range of collaborative efforts varying in formality and structure.

Broadly, veteran-serving organizations expressed strong support for establishing a future statewide coordinated care network, preferring a system integrator approach. Participants in the first phase of data collection viewed the interconnection of resources, a trustworthy and up-to-date resource list, and clear impact as vital. People generally agreed that care should be easily accessible by rural communities, have a clearly defined state role, involve transparent leadership and oversight, have sustainable funding, and offer a detailed implementation roadmap. However, discussions left open several questions on the details of leadership, administration, accountability, the structure of the network, and the long-term sustainability of the network.

Based on these findings landscape assessment, the IVMF recommended the state pursue a community design and planning phase (Phase 2) to gather input from veteran-serving stakeholders to address these remaining questions.

PHASE 2: COMMUNITY DESIGN AND PLANNING PHASE

Following the recommendations laid out in the IVMF's first report on New Mexico's readiness for a statewide coordinated care network, the New Mexico Legislature invited the IVMF to continue its work and facilitate the community design phase the IVMF recommended. This second phase of work engaged veteran-serving stakeholders from across the state to inform the design of a coordinated care model for the state. Efforts focused on gathering input to address key questions related to network design and support, outlined in Box 4.

4

Phase 2 Research Questions

- Network model organization
- Network leadership
- Accountability and oversight
- Technology support
- Adoption strategies
- Funding and sustainability

Using Phase 1 as a guide, the IVMF traveled to New Mexico in May 2025 to collect input from stakeholders across the state via focus groups, briefings, and dialogues. From there, the team analyzed the data to develop the findings in this report and to construct a roadmap for implementing a veterans coordinated care network for the state.

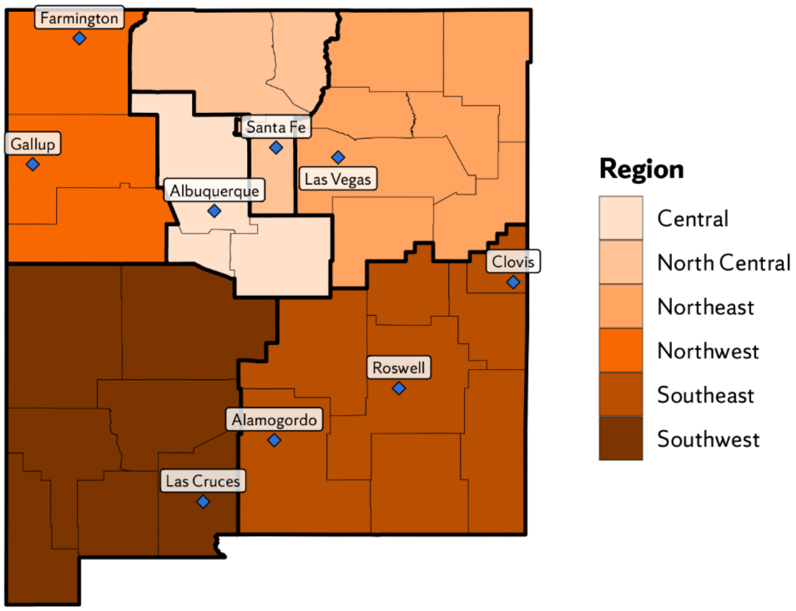
METHOD

DATA COLLECTION APPROACH

Following the methodology from the Phase 1 landscape assessment, the IVMF took a qualitative approach to gather data to inform the design of a statewide coordinated care network, relying primarily on focus groups. Target stakeholders included representatives of state and federal government agencies, nonprofit organizations, traditional veteran-serving organizations, representatives of Native communities, and other groups serving New Mexico's military-connected community. After updating the stakeholder register created in Phase 1, the project team spent three months—from February through April 2025—recruiting participants for focus groups through cold calling, email marketing campaigns, and project socialization at relevant events such as statewide collaborative meetings and conferences.

The team then facilitated 12 focus groups from May 2025 to June 2025. Ten focus groups were in-person at different sites across the state, and two focus groups were virtual. Virtual focus groups ran via Zoom to capture individuals and organizations that were unable to attend in-person sessions. Consistent with Phase 1, the team divided the state into six regions based on the New Mexico Tourism Department[14] then selected focus group sites from each region, prioritizing accessibility, representation, and neutrality of the site. Figure 1 shows where the team hosted in-person focus groups.

Figure 1. Regional Approach and Focus Group Sites



Recruitment limited each focus group to a maximum of 15 individuals, with no more than two people per organization to allow for diverse perspectives. Focus groups lasted between 40 minutes and 1 hour and 45 minutes, averaging 1 hour and 20 minutes in length. Questions focused on ideal network model, leadership, accountability, technology, adoption, and sustainability. Discussions continued until they ended organically or until space reservations closed. The team recorded focus groups to transcribe them for analysis, with one group requesting no recording. For this group, the team instead took detailed notes. The recordings provided over 14 hours of data with 447 pages of transcribed material.

Additionally, the IVMF team conducted 25 stakeholder briefings and dialogues from May 2025 to July 2025, held both virtually and in person. These engagements allowed the team to socialize the project, recruit for virtual focus groups, and deepen understanding of collaborative efforts happening across the state. They also allowed the team to connect with additional stakeholders who may have had interest in the project and insights to contribute. These conversations provided the team with an opportunity to validate and refine insights gathered through focus groups.

ANALYTIC APPROACH

After closing data collection, the team transcribed the discussions using Otter.ai, an AI-powered transcriber. Team members then checked the transcripts for accuracy and corrected any errors. After reviewing for accuracy, the team exported the transcripts from Otter.ai and imported them into NVivo, a qualitative data analysis software, to conduct our analysis.

Team members approached analysis using an abductive approach, combining both deductive and inductive elements of qualitative analysis. Prior to any coding of the data, the team constructed a codebook of 26 codes with the six focus group topics as sensitizing concepts.[15] Sensitizing concepts, as their name suggests, provide a grounding from which to approach qualitative analysis and guide the coding and interpretive processes. In addition to the preconstructed codes, the team also allowed for the emergence of new child codes within those sensitizing concepts and of altogether new concepts.

The team took this abductive approach and analyzed the data in two stages with one person coding all 11 transcripts, one coding the six transcripts from the central and the southern regions, and one coding the five transcripts from the northern regions. The first stage utilized open coding,[16] in which coders read through the transcripts and freely coded text that aligned with the sensitizing concepts. After open coding, the team conducted a coding comparison that revealed low agreement between the coders ($K_{north} = 0.22$; $K_{south} = 0.19$). Coders first independently reviewed quotes where they disagreed then later reviewed remaining disagreements together. Open coding and resolution of disagreements added another 42 codes to the codebook.

After reviewing, the team used axial coding[17] to organize the codes further and to recode any quotes that misaligned with other quotes in the same code. This stage used Mural, a collaborative whiteboard software, to display all the quotes and allow coders to easily rearrange and reorganize them. Doing so ensured each coder reviewed the coding assignment of each quote, enabling coding by consensus. Axial coding resulted in top-level codes and child codes gaining subcodes to better organize interpretation. The result of axial coding contained 176 codes related to the six original top-level codes and the seventh one surfaced through open coding. The team organized these codes into three broader themes which we detail in the results section.

RESPONDENT CHARACTERISTICS

Overall, the effort engaged 108 people representing 46 organizations across the state. Of these, 72 people from 32 organizations took part in focus groups and 37 people from 15 organizations joined in briefings or dialogues. Focus group participation by region was as follows:

Table 1. Counts of Focus Groups and Participants by Region

REGION	FOCUS GROUP SITES	# FOCUS GROUPS	# PARTICIPANTS
Central	Albuquerque	2	27
Northeast	Las Vegas	1	*
Northwest	Farmington Gallup	2	*
North Central	Santa Fe	1	*
Southeast	Alamogordo Clovis Roswell	3	11
Southwest	Las Cruces	1	*
Virtual	—	2	13
TOTAL	—	**12**	**72**

Note: *Participant counts masked for regions with fewer than 10 participants, indicated with an * symbol.*

Participants attended as representatives of a diverse range of nonprofit organizations, government agencies, higher education institutions, and other stakeholders serving New Mexico's military-connected community, as well as representing their own perspectives as veterans, military family members, or other military connected identities. Representation also included members from Pueblos, Tribes, and Nations. Participants occupied a wide range of organizational roles, including frontline staff (e.g., case managers, navigators), program managers, and senior leaders such as executives and founders. This diversity ensured that feedback reflected perspectives from across the service delivery continuum. Additionally, stakeholders engaged through briefings and dialogues represented government agencies, state and federal elected offices, statewide collaboratives and coalitions, as well as non-profits.

THEMATIC FINDINGS

INTRODUCTION

Analysis approached the data through the lens of the six sensitizing concepts described earlier—accountability, adoption, leadership, network model, sustainability, and technology. During open coding, coders noted the recurrence of participant comments related to staffing, norms, procedures, and training. Axial coding later joined together these ideas under “implementation considerations.” After reviewing the quotes represented under each of these parent codes, the team organized them into three themes:

- Model and Implementation
- Leadership and Accountability
- Adoption and Sustainability

Model and implementation describe participants’ thoughts on how to structure a coordinated care network in New Mexico and critical elements to enable its operation. Leadership and accountability then capture the qualities desired in the organization that will manage operations of the coordinated care network and the measures necessary to gauge performance and impact. Adoption and sustainability, finally, detail the factors that prospective partners are evaluating when deciding whether to participate in a collective effort along with ideas for how to ensure longevity of a coordinated care network. The following sections provide detailed findings related to each of these themes.

MODEL & IMPLEMENTATION

The first theme to emerge from the data described the structure, operations, and supporting elements of a coordinated care network. Participants evaluated one of three different models presented by the team for a statewide network with the option to suggest a new, different model if another idea seemed better fitting for New Mexico’s unique context. These models were a fully centralized model with a single navigation hub managed by one organization, a regional model with multiple navigation hubs managed by one organization, and a coalition model with multiple navigation hubs each managed by different organizations. Table 2 describes and differentiates the three models further.

Table 2. Types of Coordinated Care Models

ATTRIBUTE	CENTRAL MODEL	REGIONAL MODEL	COALITION MODEL
Administration	Managed by one organization, with centralized staff	Managed by one organization, with regional staff	Managed by independent organizations with their own staff, who do not answer to a statewide governing organization
Hub Structure	One central hub connected to participating providers around the state (“spokes”)	Multiple regional hubs, each connected to participating providers in their respective regions	Multiple regional hubs, each connected to participating providers in their respective regions
Referral Management	Processed through the central hub and sent to the spokes	Processed through regional hubs and sent to spokes. Maintains relationships with other regional hubs for seamless inter-regional referrals	Processed through regional hubs and sent to spokes. Maintains loose relationships with other hub networks to facilitate inter-network referrals
Partner Management	Recruited and maintained by central hub	Recruited and maintained by central hub, but regional hubs may share that responsibility	Recruited and maintained by regional hubs

Discussions of ideal network structure for the state also elicited thoughts around the daily operations of the network. These thoughts included ideas about staffing, procedures, technology, and training. Given that network structure serves as the backdrop for any other specific implementation details, we first present participants' reactions to structuring a network for the full state then dig deeper into the operational details.

Multiple Hubs Under One Organization

Support for different network models varied and often related to perceived relationships between the Central region of the state with other regions. Many participants recognized that resources tended to concentrate in the central area of the state with "so much [being] Albuquerque-centric and Santa Fe-centric." Some felt that concentration had created a perception of imbalance when it comes to serving veterans in New Mexico outside of the urban areas where "people out there say that they're abandoned." Yet, supporters for centralized models argued that that resources might effectively flow out from the urban areas if a network were governed by "one central authority that has all the information about services that are offered everywhere [in New Mexico], and can refer someone to whatever organization they need to be referred to." Meanwhile, support for regional or coalition models argued that attempts to centralize resources were not practical, stating, "just from our experience of trying to cover statewide, it's difficult to centralize anything", and such a model wouldn't account for regional diversity and unique needs. As one participant noted, "what works in one region is not going to work in another one." Some participants advocated for a coalition model, desiring "a network of regional hubs" where different "organizations can compete to be the coordinated center [hub] for their network." Supporters emphasized that clients and organizations alike would more readily "trust a local source" and that "a collaboration" of organizations working together would best address the regional variations in the state. Overwhelmingly though, participants supported a regional model where one organization manages the network with regional offices spread across the state to facilitate operations and coordination activities.

Participants were adamant that without a strong regional presence to connect to the larger statewide web, "none of the resources [would] flow out" from Albuquerque and Santa Fe, reinforcing rural isolation and resource paucity. Reflecting this sentiment, one participant remarked, "I don't care what's available in Albuquerque. I want to know what's available here [...] and the surrounding [areas]." Beyond a lack of resources or programming, some also expressed frustration at how local service officers were not "getting the support of the [people] above them." Potentially underpinning these resource distribution issues are data collection issues, pointing out that "if you have a veteran that traveled here for care [...] well, he's not really a Bernalillo County veteran. He's maybe a Rio Arriba County veteran." That is, the pre-existing concentration of resources necessarily draws clients to Albuquerque and Santa Fe which may facilitate a higher demand for resources in those areas, creating a cycle that "confounds what the data looks like in New Mexico." Other participants felt that the data collection issue was more systemic, stating "I think in New Mexico, we have a huge problem with data collection to begin with."

Beyond resourcing worries were matters of trust, regional diversity, cultural knowledge, and general accessibility. One participant expressed there "will be more local buy-in if it's regional" with others highlighting "it can reflect the needs of that particular area" and "it would be more acceptable to those rural areas." Additionally, positioning regional hubs across the state makes it "a lot easier for the veteran to go to that location" instead of "forc[ing clients] to turn to telehealth just because they don't have the ability to travel or drive [...] hours to go see somebody in Albuquerque." By placing hubs into communities across the state, a coordinated care effort "can utilize the good things already in-place throughout [those] communities."

Although accessible and adaptable, one participant worried that a regional model "would create a headache" because "everyone want[s] to have their own input," "everybody has their own ideas," and "you [would] have too many people coming in, trying to give too many ideas." Having all the hubs under the same organization should mitigate this issue, but a further step to address it is for the network to have an administrative office that manages the non-navigation aspects of the work. This "command center" could manage network-wide tasks like human resource management, reporting, and grant-writing and avoid "too many cooks in the kitchen" while still allowing for input from regional hubs and other relevant stakeholders. A well-planned structure that can execute numerous operational details is the key to implementation of a successful coordinated care network.

CONSIDERATIONS FOR IMPLEMENTATION

Implementation of a coordinated care model has many considerations for optimal function. Operational considerations raised by participants included hiring and retaining dedicated navigator staff; developing unified norms, standard operating procedures, and training for network members; and understanding requirements for the technology that would support the work. Strategic considerations included establishing a community of practice that fosters good governance of and communication within and beyond the network. In the following sections, we explore these considerations more deeply.

Dedicated Navigator Role and Talent Retention

First among these considerations was the need for any solution to hire for a dedicated navigator role. One participant described the need succinctly: “Whoever’s running this consolidated agency […] that needs to be the job of somebody, calling around to all of these things and breaking them down into the regions, breaking them down into the categories […] and getting all these accesses so that when a veteran comes in […] they’re able to hand them a resource.” Various participants were emphatic that “if you have it [care coordination] added to somebody else’s plate, then it’s not going to succeed” because “most of us don’t have a whole lot of extra time to put in anything else.” A few focus groups pondered the idea of stacking navigation responsibilities onto the work already done by service officers with the Department of Veteran Services, but all generally came to the agreement that “having veteran service officers do this work is probably a really good solution, except they’re already overloaded” with the current demand in the state. Instead, repeatedly, participants reasserted the need for a “dedicated position.”

The role of these navigators would be two-fold. One, they should act as “actual outreach” to providers within the community. Navigators should be “somebody to answer questions, and somebody to send people [clients] to if they have questions that are more complicated” than what a provider can address on their own. They should also be “knowledgeable about services offered elsewhere [and] know how to answer questions […] that aren’t in my [the provider’s] purview.” In other words, navigators must actively cultivate the network of resources in their region and know to which services the network can and cannot connect clients. Two, navigators should serve as the “first point of contact” for the network. “The veteran builds that relationship with the care coordinator [navigator]” and the navigator “make[s] sure that it’s continually followed up on [and] that they’re receiving what they need.” In fulfilling this second role, navigators address a major pain point participants shared from their veteran clients. “If there was just one number I could call, or just one building I could go to, [or] just one person I could talk to, that would be better. I don’t like the run-around. I don’t like going here and there.” Navigators develop relationships with veterans seeking care, monitor referral journeys, guide clients through the sea of information on resources, and build trust and rapport with clients and providers alike. In doing so, navigators act as the brain of a coordinated care network.

> **“I think there does have to be a personal and a technological component to that because, like you were saying, there are some people who don’t want to do a website to use that information. So I think that whether it’s something that just those people at the central hub have access to, or everybody does, you still need the people at the central hub to answer the questions… you’re going to have both sets of people, people who really want to be able to talk to somebody, and people who would really rather have a central hub of information where they don’t necessarily have to talk to someone.”**
>
> *—FG12, P1*

To cover such a breadth of work, navigators must embody a variety of traits. Navigators must “be patient with these veterans,” “have the heart,” “ha[ve] the ability to travel,” “have the expertise,” “[be] well-versed in the community,” “stay on top of constantly changing resources,” and “empathize” with the experiences of their clients. “Getting a group of people who are trained social workers, who are particularly trained to work in the community” enables the work of navigation to go more smoothly and helps “the veteran to build that relationship with the care coordinator.”

Enabling the success of such a role means hiring it as its own “full-time job.” Participants from two groups called out that “this really needs funding for a dedicated position” where funding is “built in there to pay to have one person to specifically run that program.” As one participant summarized it, “You’re talking about a physical group of people that are in a command center of some sort, so they have to fund that new entity, that command center of coordinated care.” The solution must “buy into these people that are going to service [clients], and that’s going to be the longevity.” For coordinated care, navigators are an integral part of the work. They serve as community experts, client confidants, referral managers, and resource cultivators. Without navigators, the work of coordination either falls back onto the providers in the community—who are already overburdened just delivering their own services—and onto the clients for whom the current care system encourages withdrawal and drop-off.

“The only way to sustain a model, program, or whatever is to find the right people that are going to be patient with these veterans, that have the heart, that can maybe empathize.” Through building trust with providers and clients, developing institutional knowledge about the resources in their communities, and gaining experience serving the military-connected community, navigators contribute to program sustainability. Care coordination "need[s] a team of individuals like that for the long-term sustainability" of the solution because of the roles they fill in the process. Successful implementation of a statewide coordinated care network means hiring navigators and instituting competitive incentives, including pay and benefits, that ensure staff remain with the network long-term.

Network Norms and Standard Operating Procedures

While dedicated navigator staff are a vital part of a coordinated care effort, so are the norms and procedures that guide both the navigator hubs and provider partners through how to participate. A regional model allows for variations and adaptability to different geographic and cultural circumstances, but a common set of standards sets expectations for program staff, partners, and clients. Participants had numerous recommendations for norms and operations (see Box 5), covering everything from intake to referral journey to long-term follow-up. They commented on models of access for rural areas, minimization of bureaucratic bottlenecks, relationship management with participating providers, and cross-state collaboration. This section first tackles the traits participants emphasized as normative of an effective coordinated care network, digs into how those norms translate into standard operating procedures (SOPs), then closes out with a description of how training should reflect network norms and instruct on SOPs.

Perhaps the biggest norm that participants highlighted was empathy. A coordinated care solution "need[s] to have folks who are willing, who are really caring enough." Many people, especially older veterans "want face-to-face" and "like to hear it from an individual" when they are seeking help for different services. Having facetime with their navigators and providers helps clients feel heard and fosters trust, building the "relationship identification" described by one participant. While invaluable, empathy can incur some operational costs too. As described by one service officer, "Sometimes I schedule so much time with a veteran thinking we're just gonna do a job application [... then] that one appointment might turn into two hours because I'm sitting there just listening and giving that veteran their time to vent." Empathy cultivates a sense of safety and rapport with clients that can surface other issues in need of support, but those issues may require more time and hands-on attention than simply tackling the needs for which a client is immediately seeking help. Further, empathy requires time to provide authentically and must balance against the real need for navigators and providers to preserve their time and energy for all clients.

5

NETWORK NORMS

- Empathy
- Communications
- Minimal bureaucracy
- Privacy

SOPs

- Up-to-date provider information
- Holistic, person-centered intakes
- Timely response to referrals
- Provider follow-ups
- Warm handoffs
- Clear billing processes
- Long-term client follows-up
- Mobile navigation clinics
- Cross-state collaboration
- Provider onboarding

Another closely related norm to empathy is communication. The idea of communication arose as a cross-cutting concept when participants considered how to implement coordinated care. It included how organizations "communicate with one another," "targeted outreach" so that "the veteran know[s] they have another place they can come to for services," "report[ing] back to the veterans," and "follow up" with both providers and clients. An ideal solution should be communicating in ways that promote outreach to client populations, encourage collaboration and cooperation among providers, and ensure transparency of the network's operations and impact to all stakeholders. Communication lies at the heart of coordinated care work whether through marketing to increase visibility, check-ins with providers to track capacity, referrals and handoffs to connect clients to providers, and follow-up to ensure referral responses and monitor client well-being. Navigators and providers must communicate often to successfully coordinate care for clients, and administrators must provide accessible reporting for the public to assess the effectiveness of the solution.

Participants also surfaced two more norms for the operation of a coordinated care solution—minimizing bureaucracy and maximizing client privacy. Participants felt that minimizing bureaucratic bottlenecks was an important step for the network given frustrations at the current system, how backed up it was, and perceived redundancies. One asked, "How do you beat that bureaucracy to make sure people are getting the care that they need in areas where they don't have quick access to services?" Pieces of the bureaucratic challenge include coordination of benefits for those multiply insured through TRICARE, Medicare, Medicaid, or private insurance; navigating care eligibility through the VA, the Indian Health Service (IHS), or a private or nonprofit provider; and data collection needs arising from reporting requirements. Coordination of benefits across insurers "depends on which benefits you're projecting to start using" but can be "extraordinarily frustrating" when dealing with urgent care matters that require quick responses. Providers sending referrals when "they don't know what the clients has to have to be eligible" also creates frustration. Varying eligibility requirements across programs and organizations can make it difficult for clients to navigate the care system and burdens every provider with needing to know every other provider's eligibility requirements. Data collection for reporting purposes can also prove challenging as "gathering that information takes away from client care." These different bureaucratic challenges, in addition to others that likely exist, create barriers to care access and service delivery, and an ideal care coordination solution should work to break these barriers down where possible.

The desire to maintain client privacy, then, works in tandem with minimizing bureaucracy while working in slight tension with the reporting aspects of communication. Participants felt, given the trust-based nature of the help-seeking process and the culture of the military-connected community, that an ideal solution "ha[s] to buy into much stricter confidentiality." One person suggested using "a code so that the providers or the network can identify this person [...] but there's not a name." Implementation of privacy measures remains an open question, but the point stands that providers want to ensure that they comply with legal requirements while also genuinely protecting clients' sensitive information.

Norms like these—empathy, communication, minimal bureaucracy, privacy—serve as guiding points for the implementation of network procedures. Several recommendations for SOPs that span the referral journey arose during focus groups, but one stands as a sort of precondition to the rest. The first and most crucial step, in their eyes, was maintaining a high standard for updating information on both clients and on the available resources in the state and local communities. Participants recommended "coming up with a website or a depository [to] put information in and [keep] it up-to-date" and to "vet resources yearly [...] to double-check all of that information." Maintaining provider relationships through "having those regular touch meetings [...] that continued contact" is important to engaging providers in the network and thereby maintaining updated information about their programs, including services, eligibility, and capacity. Further, regular check-ins with providers can guard against loss of institutional knowledge and disappearance of once-available resources due to the high turnover that is common for non-profit organizations. Having a dedicated person, or dedicated effort, to maintain resource information facilitates accurate and quick referrals.

Key to such referrals are holistic intakes conducted at the time that a client meets with a navigator. Navigators serve as "that initial point of entry for the veteran into [the] network" and are "where the bulk of the information is going to be collected." A holistic intake gathers "all the information about the veteran, what [their] issues are, where [they're] being referred for services" and lays out the groundwork for a client's care journey. "One of the qualities of [a] coordinator [is] not having to share information again" because holistic intakes thoughtfully assess a client's needs in one interaction then build out referrals from that more complete picture of needs. In doing so, they reduce the frustrations clients experience through repeated storytelling and free up some capacity that providers would otherwise spend conducting intakes themselves.

> **"That initial point of entry for the veteran into this network, that's where the bulk of the information is going to be collected, right? I mean, all the information about this veteran, what his issues are, where he's being referred to for services, so that if he comes to you for behavioral health services. All that information is already there...you know, very minimal kinds of information would need to go in, because it's all been inputted at the very beginning. So it really takes huge burden off of the providers like you."**
>
> *—FG3, P5*

After conducting an intake, navigators send out referrals to providers in the network to serve the client's identified needs. "The people there need to be reachable" and providers need to have "responsive points of contact" in their programs to whom the navigator can connect. "They might be busy, but respond. A response is a response." Often, clients arrive seeking help when they are in a moment of crisis or urgent need. Timely responses to referrals are critical to ensuring care access. If a referral goes unaddressed for a normative period of time (e.g., 24 to 48 hours), then "you also do some callbacks if you need to." Care coordinators (i.e., navigators) "have to do follow up" to check "did this person receive the services?" Following up with providers on referrals is critical "so people don't get lost in the sauce." Among the worst outcomes identified by one participant is if a client walks away from navigation feeling "it was too much trouble" such that they "don't even want to go through it anymore." Designated staff roles to receive referrals in provider organizations, up-to-date contact information shared widely through the network, a commitment to receiving and acting upon referrals in a timely manner, and follow-up on unanswered referrals are all imperative to clients accessing care with minimal wait times.

Once a provider has agreed to take on a client for a particular program, warm handoffs need to occur. Warm handoffs are a concept derived from healthcare wherein the transfer of care from one provider to another happens with the client present.[18] They limit clients "retelling their story when [they] move from one program to another" by having navigators share the client's story with the provider while creating opportunities for the client to clarify or add information. Handing off clients in this way "build[s] rapport with the veteran" and "give[s] them that empowerment" to steer the care conversation during the transfer from navigator to provider. This procedure keeps the veteran in the referral process to ensure they receive services appropriate for their needs and is a hallmark of coordinated care. They reduce the frustration and barriers to access engendered by self-navigation, wherein a veteran is given resources and expected to do their own outreach and follow-up.

Throughout the navigation process and especially following the handoff, clear billing processes are necessary. One participant emphasized that the solution needs "some sort of payment structure that identifies and respects the fact that care coordination is an essential component of continued, fantastic care." Focus groups did not discuss any specifics regarding payment, but care coordination or navigation programs usually rely on internal dollars to fund care coordination work. Additionally, when handing clients off to other program, navigators should signal that the client is a veteran as veteran clients may have access to benefits or coverage that can assist with program fees.

Finally, after the referral journey has concluded, persistent and thoughtful client follow-up is key to sustaining the positive effect of the assistance a veteran has received from the network. One person suggested "we follow them for a whole year [...] contacting them every month." Doing so, they expanded, lets them "know they can always come back to our programs" and "establish[es] that relationship" between the client and the care coordination program. Further, it checks "are they still receiving services" and "what else they need" if any recurring or secondary issues have surfaced since the initial request for help. For one veteran participant, they "find a lot of comfort" in the "once a year phone call from the [...] Wounded Warrior regiment." This is especially important for veterans that may feel isolated and unable to ask for help, a frequent issue in the veteran community. Many veterans seek connection, and although they may not have immediate needs, ongoing touchpoints foster a continued sense of trust and care.

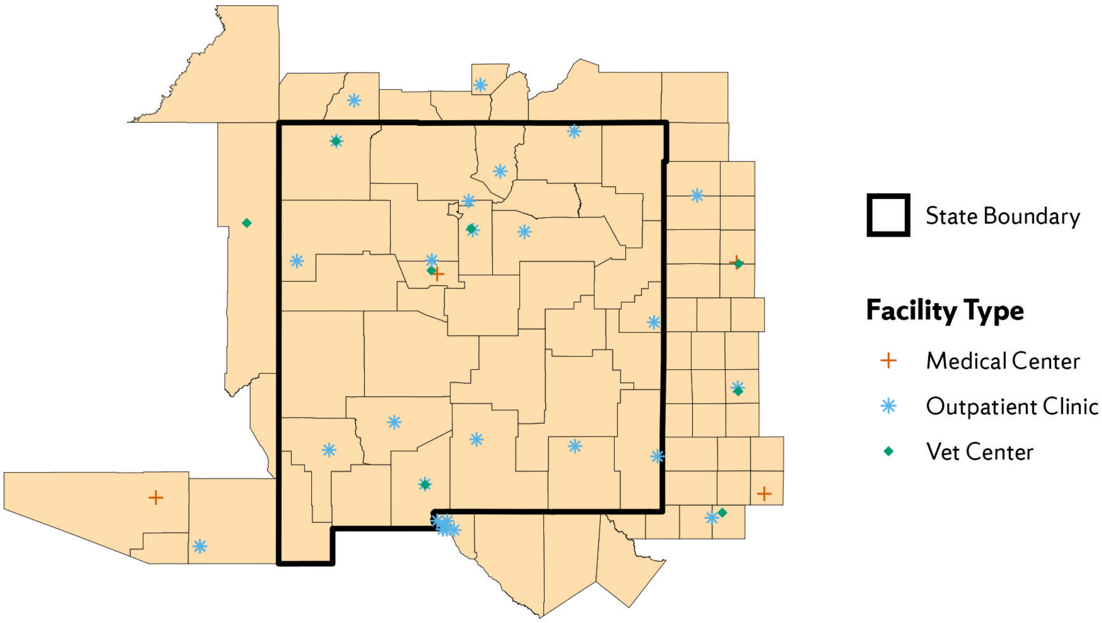
> **"If that means [a] veteran comes to me and they need clothing, or they need shoes, or we've gotten them to stabilize in a home but they need furniture, my inclination is to say, "Oh, you need to go over here and check out this place, and they'll help you out. Talk to so-and-so." My veterans are always gonna say, "Now I have to find another date and time to go over there, find transportation. Can't you just call over there for me?" So, a lot of the times, I'll say, "Why don't we call over there and let's find out? Let's see if they can deliver it here so you can pick it up here," kind of thing."**
>
> *—FG9, P1*

Beyond the referral journey itself, participants also recommended SOPs for the general operation of the network. New Mexico is a highly rural and geographically dispersed state meaning that travel to areas with more resources for care can be a challenge for veterans. One of the challenges in the state is the "vast distances" people must travel to care, "cross-state and in-state [...] talking anywhere from [a] three-hour to six-hour drive." At the time of this report, New Mexico houses 15 outpatient clinics across the state, four vet centers in urban areas, and one medical center (i.e., hospital) in Albuquerque. The concentration of more resources and more advanced services in the metropolitan areas of Albuquerque and Santa Fe means "you also get a disproportionately large representation in Albuquerque and Bernalillo County at large because, for more sophisticated care, most veterans have to travel." To address these twin challenges of resource concentration and population dispersion, participants recommended a mobile component of care coordination, variously referred to as "mobile crisis unit[s]," "mobile vet clinic[s]," or "outreach vans." Having navigators travel to different locales is "super valuable for that psychological component of those frontier communities" and a schedule of sites provides "the consistency of knowing where you're going to be on any given day." Bringing the resources to those far-out or isolated communities can help address some of the access barriers due to lack of transit, awareness, or availability. Mobile approaches can be especially valuable to remote communities to supplement existing health and public infrastructure.

> **“Okay, I think the mobile unit idea is brilliant. It does something for the human resource that works in the mobile unit, in providing a stability of a work environment and the consistency of knowing where you’re going to be on any given day. You have a schedule. The community has your schedule if you make the connection. Yeah, I like the mobile unit thing in it. It means you don’t have to have a person in every location.”**
>
> *—FG3, S9*

Participants also emphasized the need for cross-state collaboration as a feature of the network. The first phase of our work revealed that veterans along the borders of New Mexico often visit VA facilities in Arizona, Colorado, and Texas out of convenience.[19] The VA hospital in New Mexico is in Albuquerque, which can require a significant travel commitment that includes long drives—“in-state, you’re talking anywhere from a three- to six-hour drive; cross-state, you’re talking 88 miles”—and overnight hospital stays even for folks located in New Mexico. VA medical centers (i.e., hospitals) in Tuscon, Arizona; and Amarillo and Big Spring, Texas are shorter drives for people living in southwest and southeast New Mexico respectively. Similarly, people in the southern area of the state, especially near Las Cruces, may travel to El Paso, Texas for care because of the six outpatient clinics located in El Paso alone. Figure 2 visualizes the distribution of these care facilities. Conversely, many veterans enter New Mexico from neighboring states to seek services with one program mentioning “they’re getting a lot of veterans from Texas […] and I have to service a lot of the Arizona veterans.” Cross-state collaboration with veteran serving organizations, including VA providers, is key to filling some of the resource gaps experienced by border communities.

Figure 2. VAMCs and CBOCs in and around New Mexico



Lastly, to ensure smooth operation of the network across all the partners participating, there must be a procedure in place “to educate every component that’s going to be involved.” At the highest level, training needs to explain “this is what we want to do [and] this is how it’s going to impact how we want it to work.” Providers coming on board should understand the mission of the network, its primary service (i.e., navigation and connection), and what partnership with the network requires of partners (i.e., maintaining updated information, responding to referrals). People felt that “in-person training” or “knee-to-knee would be optimal” because “when you’re dealing with a [virtual] module, it gives you very specific information [and] there’s no troubleshooting.” However, considering potential feasibility issues with onboarding every provider in-person, people agreed that online modules can be beneficial since they “give us time to pause then come back to it.” Regardless of approach, people agreed that there would need to be “implementation support up front” and “somebody that’s cognizant of whatever system it’s going to be run.” Moreover, there should be “ongoing training [… because] somebody leaves, somebody new comes in, [and] they’ll be like, ‘Oh, I don’t know what to do.’” Strong onboarding practices that familiarize providers with the norms, procedures, expectations, and requirements of the network and their participation will help providers make better use of the network. Moreover, ongoing training habits combined with the check-ins on referrals and contact information will ensure that providers remain connected to the network despite any turnover their programs experience.

This collection of norms and SOPs identified by participants serve as the guidelines for an ideal coordinated care network. They define what staff, partners, clients, and stakeholders can expect of the network when interacting with it. Most importantly, they describe how the navigators doing the care coordination (i.e., the brain) communicate and interact with the providers delivering the care (i.e., the muscles).

Technology

Facilitating communication between navigators (i.e., the brain) and providers (i.e., the muscles) of the network often requires a technological element due to the interorganizational nature of coordinated care. In this way, technology acts as the connective tissue of a coordinated care network, transmitting client and request information across the boundaries of different care organizations. The team asked focus groups to share which technologies they used to refer clients to other organizations and what attributes a new technology would need to exhibit for them to use it for referrals. Most had experience with case management software (e.g., Salesforce), resource directories (e.g., 211, SHARE New Mexico), and communication tools (e.g., email, phone, social media), and a few had experience with referral management software (e.g., Unite Us, FindHelp). Experiences with different tech platforms varied widely, with perceptions of those platforms ranging from useful and user-friendly to cumbersome and prohibitive.

This range of experiences translated into a clear set of requirements for the technology that will facilitate the network. First among these are that the technology must be usable. Common complaints about prior and extant technologies used for referrals included that they are “not user-friendly,” “fairly cumbersome,” and “a little bit clunky.” Some may be customizable but require “your IT to build the entire thing.” As such, people across seven of the focus groups emphasized the need for the platform to promote “accessibility,” have “ease-of-use,” and be “easy to navigate [and] intuitive.” Technology is as important to the functioning of a coordinated care network as the navigators or partners. It allows for easier tracking of referrals, management of resource information, and reporting on performance. To that end, the technology needs to be accessible enough that navigators and partners use it for data entry and referral management so that the functional benefits of the platform emerge.

Also necessary to achieve those benefits is that the platform centralizes information on clients, requests, and resources. One major challenge in managing a resource directory is that “things are changing so quickly” in communities. “The phone numbers have changed. Things have updated. I have outdated information I give out. That person is no longer there.” Coordinated care networks operate in highly fluid environments where program capacities and staff are in constant flux. One day, the point of contact for a program may work there; the next day, they may be on leave or gone entirely. Participants perceived having “some entity taking the time to say, ‘Okay, these are all the resources we have. Let’s get them and update them,’” as highly valuable given that the time it takes to update existing resource directories is both necessary and difficult to budget. However, “having a database that all the players have visibility over is really, really important” and helps network members learn what “we all can glean from this area.” Centralizing data storage makes it easier to maintain information in the long-term and can also support reporting by minimizing duplication of clients or resources in the database.

At the same time, centralizing data, while convenient, can promote security risks by housing information in a single place. Given that “a lot of veterans don’t even want to give their name, much less have their information reside in a database,” “building a database that is really, really, really secure is essential.” The platform should comply with HIPAA and other data protection laws and best practices. Although not all the data in the system or all the partners in the network might be subject to HIPAA, it can provide strong guardrails for the selection of a platform to manage storage and transfer of data that is sensitive, if not formally protected health information.

Interoperability, or the ability of a system to “talk” to other systems, can then support usability, security, and centralization. A few participants noted that it “would be nice if all the systems talk too” since, in many cases, organizations use altogether different systems. The result is that “for the referrals […] you have to document it, whatever it is, twice” because “the systems don’t connect.” Lack of interoperability in existing systems increases the burden of data entry and can confuse staff about which systems receive which information. “If the systems talked to each other more efficiently […] it would make it a lot easier.” Beyond the benefit for organization staff, interoperability improves continuity of care for clients as it translates more seamlessly across organizations’ different platforms. Although a high bar to meet, selecting an interoperable platform for a coordinated care network would be invaluable.

> **“Then to plug them into another system, the systems don’t connect. So it’s easy as a company coming in, being wined and dined, and be like, “This is so cool, but these don’t talk, and now your employees are spending all this time.” I have to check it in through this system, open another page, then open another page. I’m just going through the training, and I have like 20 passwords, and I have to move the veteran over. Even to check in a veteran, an older veteran is going to be sitting there like, “I have to fill out all this paperwork on this computer.” Less is more.”**
>
> *—FG2, P9*

Ultimately, participants’ requirements for a technology platform boiled down to a need for a platform that was user-friendly, contained up-to-date client and resource information, and that communicates essential information about a client’s services and history to the organizations who are involved in their service journey. Automation in the platform, interoperability between systems, security of data, and the ability to extract data for reporting also fueled participant concerns. Selection of a platform that maximizes satisfaction of these requirements will likely foster greater adoption among the network and higher engagement among network partners.

Community of Practice

Outside the daily operations of the network, one of the strongest recommendations from participants was the establishment of a collective for training and peer support, also known as a community of practice. As defined by Wenger (1998), a community of practice is a joint enterprise, continuously defined by its membership, operated through mutual engagement, producing shared resources developed by its membership.[20] In the context of a coordinated care network, a community of practice is a learning collective of service providers that shares insights and best practices among each other.[21] Such communities of practice have been established in other areas with veteran coordinated care networks to support coordinated care work and the needs of the military connected community.[22,23]

Across focus groups, participants welcomed the idea of establishing a community of practice to support a statewide network. One called for “the opportunity for service providers to come together and to talk about what they have available [and] what services they’re offering.” This broad call translated to specific requests for “consistent meetings,” “a 45-minute call once a month,” or even “a summit once a year.” Ideas for the topics of these meetings varied, including “educating each other about each other’s resources,” “cross-communication,” “cross-training,” and “talk[ing] about different things that they’re going through.” A community of practice can create opportunities to learn about each other’s work, the resources brought to bear, and strengthen the shared knowledge base of providers and navigators serving the New Mexico military-connected community.

Moreover, they felt that it would engender collective successes by breaking down silos. Through cross-training and learning the services of other providers in the area, navigators and other providers can learn “this is the person who can take care of this, [and] this is the person who can take care of that.” Taking it further, one participant highlighted that “an outlet for your resources to convene consistently and discuss [is] where legislation starts.” A common space and time to hold a forum that allows for issue identification, problem solving, planning, and advocacy is invaluable when engaging in a collective effort that affects community members differently and requires different inputs of them. A community of practice then “could unify that voice … and say ‘Okay, this is really up to us as nonprofits and providers of services to buy in.’”

Participants felt that a community of practice in New Mexico would unify the veteran serving organizations and providers with clear communication and a strong, common message that they could all take to their communities and to their government representatives. Development of a community of practice could draw from similar collectives that exist in the state, modeling efforts like the New Mexico Alliance of Health Councils, the Veterans Coalition of Grant County, the Southwest Partnership for Development, the Bridge of Southern New Mexico, or Bridging the Badge. There are also other veteran-focused communities of practice that exist outside of New Mexico from which elements could be borrowed. Regardless of template, a community of practice should enable the lead organization and its partners to come together to understand the current landscape in which the network is operating, identify any issues facing parts of the network or the network as a whole, and create space to pave a way forward for the network.

> **In all seriousness, the sustainability aspect of it, we have got to get an alliance of veteran serving organizations that speak to one another, that speak the same language in terms of what is the assessment of the needs of our veterans. We're saying the same thing. We have the same talking points when we go to the legislature. If we don't create that, we're not going to be successful. I'll continue to be successful in my lane, and the VIC will continue to be successful in their lane. But in terms of creating a larger, coordinated approach to caring for our veterans, we won't be successful.**
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> *—FG8, P1*

LEADERSHIP & ACCOUNTABILITY

The second theme related to leadership, oversight, and accountability of the network. Leadership, in this case, refers to the organization responsible for managing the daily operations of the network and ensuring its function. Oversight, meanwhile, describes the organization or organizations responsible for ensuring the network demonstrates effectiveness and produces positive impact. The practices that then enable leadership and oversight organizations to monitor function and performance form the accountability structures for the network.

In this section, we will first report participants' thoughts regarding potential leadership for a coordinated care network. Following, we describe their ideas on how to oversee such a network and hold it accountable to clients, partners, funders, and the wider public.

Leadership Rooted in Cultural and Regional Competency

When discussing the demographic of New Mexico, focus group participants highlighted how New Mexico's culturally and geographically diverse veteran population creates unique challenges for coordinated care. They emphasized that leadership should exhibit "cultural competency." In the context of New Mexico, this value embodies several ideas. Leadership should have "not just Native population competency, but cultural as it relates to the regional differences [...] of our state" and should be able to "talk to veterans in their own language." New Mexico is home to "quite a number of tribal governments" with the "reservations and Pueblos that are sovereign entities." As one participant notes about Native communities in the state, "each one is different [...] and each has their own veteran needs." Moreover, participants shared that different regions of the state are so geographically and culturally diverse, they are akin to "different countries". The state's size and geographic spread compound these challenges with programs that "pull in from different parts" of the state and some even "getting veterans that come from Texas."

> **Not just the native population competency, but cultural as it relates to the regional differences in diversity of our state, because the eastern part of the state and the southern part of the state and the northwestern part of the state are like three different countries.**
>
> *—FG3, P9*

Part of working with such diverse communities means navigating different languages and cultural contexts. One participant cited "language barrier[s]" as a challenge they experience when providing or accessing care. Having "information made available in multiple languages [...] whether that is English, Spanish, [or] the Native languages" can make it easier for people coming from different cultures within the state to access care. For others, "it's understanding the climate they're coming from, the environment [they're] living in." Some areas of New Mexico are "incredibly rural." There are people "who do not have internet," who "don't have transportation," and who "don't even have cell service." A lead organization will need to be able to learn and cross these different cultural lines—Native, Spanish, and English languages; metro and rural differences; and military, veteran, and familial experiences.

With respect to rural communities, one participant stressed the need "to be flexible a little bit in operation" because "people can be a little independent-minded" and "hav[ing] somebody come in from the outside [...] may be viewed with skepticism." One recommendation was to use "the good things that we already have in place throughout the communities." Of particular value might be faith-based groups and organizations given that "local church leadership [...] is where lots of small communities meet, and what they care about." In short, "working with existing entities [...] without trying to tell them what to do or not do." Providing this kind of autonomy is vital given that many communities and organizations around the state experience "this fundamental lack of trust" for people perceived as outsiders.

Then, there are the differences unique to the military-connected population. As two participants in the same session noted, military culture "is a culture in and of itself" and one that likely merits "additional trainings" because of that distinction. For some people, this simply means "approaching them [veterans] in a way that makes them feel like they're not being less of a soldier" by seeking help. For others, it means preference for staff with prior military experience. As one participant shared, "my strong skill is [being] a foul-mouthed, good old Army girl." Beyond bridging the military-civilian divide though, leadership should understand that different eras of service bear different experiences. For example, Vietnam-era veterans "not only [came] home to a world where you couldn't ask for help; [they] got anti-help."

Meeting the kind of diversity present requires intentional partnerships, language access, and respect for tribal sovereignty. A leader of a statewide coordinated care network would need to demonstrate cultural competency—or at least sensitivity, responsiveness to regional differences, and a readiness to learn and bridge different communities across the state. Coordinated care cannot rely on standardized approaches that may work in serving other veterans. Instead, navigators need to adapt to the cultural contexts and prioritize relationship building as a core strategy. Ultimately, participant perspectives highlight that a one-size fit all approach will not work in New Mexico, and leadership must adapt to the cultural and geographic realities of each region.

Capable and Veteran-Centric Leadership

In addition to cultural competencies, participants emphasized the importance of technical competency and altruism of leadership within coordinated care networks. The lead organization needs to "know the needs and services for our local veterans." They need to be able to "explain to the veteran what they're doing for them" and need to "understand the budgeting and changes in legislation, both statewide and federally." As the previous section reinforced, network leadership must show that they understand differences by region and that their staff have a clear knowledge of how their program operates, what it does for clients, and what it does not do. The leader of a coordinated care network focused on veterans, military, and their families must keep pace with legislation and procedures "because benefits are changing so frequently" and participants want "a veteran-centric organization [...] that can share information with all these agencies and really be that expert in [...] New Mexico."

Demonstrating such competency necessarily involves a degree of transparency from the lead organization. Transparency aims to build trust by "keeping track of the data [...] to make sure that you are actually doing what you say you're doing." Such effort is paramount since trust is a deeply embedded issue for people in the state "based on their heritage, their experience, or anything else like that" and has led "a lot of people [to be] leery [that] something's not gonna be successful." As one participant noted with the introduction of a new program like this, "It's hard enough to win over one veteran; now you got to overcome an entire state full of them who already have trust issues." Participants noted that "they [leadership] need to be transparent," have "bilateral communication" up and down the network structure, and that the network must "report back to veterans." For veterans, trust and accountability are deeply linked, highlighting the need for clear oversight, data tracking, and reporting to ensure VSO promises to translate to action.

> **"And with today's warfighter, they're not joiners. They don't want to join a lot of these organizations, and they're unwilling to be involved if it looks like you're using them as a prop to profiteer off of their blood and pain."**
>
> *—FG6, P10*

Participants pointed out that veterans do not want to engage in activities that leverage their experiences for show and profit. For this veteran participant, authenticity was non-negotiable, "if I get the sense that you're helping me and that that help is not indeed altruistic, pound sand, man. I don't even want to talk to you." The priority of the lead organization responsible for daily management should be "helpfulness above all else [...] helpfulness and knowledgeability." People want to see "empathy in the leadership of the organization" and that its staff "treat our veterans with respect." When it comes to serving veterans, trust and genuine, veteran-centered leadership are essential as any perception of self-serving motives can alienate veterans and undermine engagement. For organizations, this means demonstrating transparency, prioritizing service over optics, and ensuring that leadership practices reflect a commitment to veterans' well-being rather than organizational gain or publicity.

The demands for such leadership circle back to "the fundamental distrust" veterans and many others in New Mexico have, arising from inconsistent accountability, unclear processes, and unreported outcomes. Stakeholders interpret delays, lack of responsiveness, and follow-through as signs of inauthenticity. Therefore, transparency must go beyond public messaging and ensure visible, structural changes with downstream data reporting and clear benchmarks. Ultimately, the close link between trust and accountability forms the foundation for effective, authentic, veteran-centric leadership.

Gaps in Oversight and Data Systems

Addressing the trust-accountability connection means thinking through how to oversee the network and monitor its performance. Many participants emphasized the need for performance and impact data from a coordinated care network, with one describing data as "improvement in the agency." Yet, a participant from another focus group called out, "in New Mexico, we have a huge problem with data collection," later pushing that "we really need to work on data collection."

A natural starting place, "in order to show progress or success, [is] to have a baseline set of metrics." Baselines "set benchmarks at work in quality" and clarify "what best practices are working" and not. They allow the lead organization, and other stakeholders, to "detect anomalies" and "see if something's off [...] within different communities." Critically, baselines establish a standard against which to compare the effort of a network. As participants called out, baselines can identify communities or services that have insufficient support to match the demand they are experiencing. Likewise, baselines can serve as a guideline against which to test new procedures and practices. Data gathered against baselines "can show where you can improve" and "identify where [you] are failing."

A report from the IBM Center for the Business of Government identified four categories of data relevant to referral (i.e., coordinated care) networks.[24] These are: 1) quality control metrics, 2) demand metrics, 3) supply metrics, and 4) process metrics. Largely, participants' recommendations for data to report on internally and externally, reflect these categories. First, participants were emphatic about the need to track client feedback and outcomes (i.e., quality control). People wanted to hear directly from participants things like "I got this need met," "I did not get my need met," "I no longer need this service," and "This is where I need more help." Client feedback can provide more pointed guidance for problems in the navigation process. It can also provide "success stories [...] to see it's actually working." Alongside feedback were desires for more formal measures of outcomes. Outcome data help stakeholders see "what's happening for the veterans," "what's happening with those referrals" and show that the "network is working." Examples of outcome data might include changes in client well-being, employment or housing status, or food or financial security. Data like these demonstrate that the program connects clients to actually helpful resources.

People also expressed significant interest in supply and demand metrics, pointing out that determining "root cause[s]" of veteran needs was paramount to directing funding to the right places. For some participants, this meant learning "what is the biggest need" in their region or the state. For others, this meant taking a more nuanced view. One person compared the services across the state to "one big pot of gumbo where everybody is contributing something to make that pot." Building on this analogy, another participant in the same session highlighted that the state "need[s] to know how much of each ingredient [service] is being used [...] because the services in Artesia are going to be different from Albuquerque [...] and everything like that." Such an understanding is critical because once "you [...] understand the actual demand, then you enter the capacity issues." Taking measures of demand for the different services available via navigation in tandem with other measures like rejection rate, response time, or client feedback can start painting a picture of which services need more capacity in different areas of the state.

> **"I want to see what do our veterans actually report that they need. We can come up with 1000 programs, but if we're not addressing, kind of what the root cause is, it does no good. We can fund everything, but if we're not funding the right things, we're still not having an impact. What are the issues that our veterans across the entire state? What are they facing?"**
>
> *—FG5, P5*

The potential to understand capacity issues will likely rely on process metrics. Definitions of capacity vary by service and managing that kind of data inside a single system would prove challenging. For example, beds in a shelter, food stocks, open hours available to schedule for appointments, financial reserves for income assistance, and job openings in the state could all reflect capacity. Instead, a coordinated care network can more likely proxy capacity issues through tracking "status updates on referrals," "how long it took to get [a] person into care," and whether a client "is no longer in need of services" for which they sought help. People want to "know that the handoff took place" and that the receiving provider was able to take on care of a client. Outside capacity, process data—including case information—show "what has already taken place," "where you can pick up to help," and allow navigators and providers to "know what goes on" with the clients they refer.

A key challenge to these data efforts, however, is that historically "there [has been] nobody who has the time to go in and look holistically and say, 'if you guys talked about this, you can do this.'" This concern likely stems from issues in certain state programs where "so many different agencies have somewhat of a partial oversight authority, but it's not well-defined." One participant complained, "there's nobody to hold us accountable [...] nobody that makes it make sense," in response to certain mandates the State has made. To address this, people recommended an "oversight committee [to whom] all [this] information will be reported, whether that be a commission, board of directors, or something of that nature." Such a committee might comprise stakeholders from different regions, sectors, or services, all with vested interests in veteran services.

Beyond the oversight committee, participants suggested the lead organization have "one central authority" or a "command center" that would manage these network administrative efforts and enforce standards. Providers want to see that others "are actively participating and putting in just as much effort." They want to know that the lead organization and other providers are "pulling their weight and making sure that this is going good." Careful monitoring of referrals by navigator staff can protect against veterans "fall[ing] through the cracks" and instead "mak[e] sure that those services took place." This kind of administrative oversight holds the navigator staff within the lead organization accountable and holds the providers who have agreed to receive referrals from the network accountable. Both kinds of oversight, administrative and managerial, are vital to the performance and functioning of a network. Without clear roles and accountability structures, navigators and providers struggle to maintain consistent standards and uphold mandates, leading to inefficiencies and frustration.

Collectively, these findings highlight the desire for an integrated system that supports collaboration through a robust data infrastructure that can capture data on quality, supply, demand, and process. Participant feedback on data collection emphasizes how baseline measurements can identify the quality of services delivered and can enable the network to operate strategically, through long-term interventions and resource allocation, instead of reactively. The connections participants drew among management, oversight, data practices, and quality of care all point to the interdependence of these elements and how they shape both service delivery and trust within the network. By gathering these data, leadership can show how promises translate into measurable results, reinforcing authenticity and accountability while combatting mistrust the veteran population may have toward navigation programs. A coordinated care model network succeeds when there is a combination of transparency, cultural competency, and shared accountability to meet the needs of veterans.

ADOPTION & SUSTAINABILITY

The last theme to emerge from the analysis is the connection between adoption and sustainability. In this context, adoption reflects the short-term uptake of the statewide coordinated care effort and the factors that drive organizations to become participants in a wider network. Sustainability, meanwhile, captures the long-term persistence and maintenance of an active coordinated care solution. The analysis reveals a tight entwining of these two concepts, which is expected given the collective nature of a network approach to supporting care in a geography. A network approach means outcomes and effectiveness necessarily rely on the engagement and participation of network partners; in this case, organizations providing services to the military-connected population.

To guide the structure of this theme, we first present results related to adoption of the solution with the results around sustainability following. Further, we ground the analysis in Rogers' diffusion of innovations theory.[25] As its name suggests, the theory describes the steps by which a product, service, or idea diffuses through a target audience, and the factors that influence those different steps. In particular, it identifies five key elements—1) the innovation itself, 2) the adopters, 3) the channels for communication, 4) the passage of time, and 5) the broader social system—that differentially impact five stages of the adoption process—1) awareness, 2) persuasion, 3) decision, 4) implementation, and 5) continuation. Table 3 below summarizes how the themes of participant feedback fits into these factors and stages:

Table 3. Elements Influencing Coordinated Care Adoption

ADOPTION FACTOR	ADOPTION STAGE		
	AWARENESS	PERSUASION	CONTINUATION
The Innovation	–	Trust Utility & Impact	Trust Utility & Impact
The Adopters	Attitudes	Attitudes Incentives Participation Costs	Participation Costs
The Channels for Communication	–	Outreach and Marketing	–
The Social System	–	Champions Collective Buy-In Trust	Collective Buy-In

Attitudes as the Baseline

Before exploring the adoption stages properly, we focus on participants' thoughts around attitudes. A crucial point to keep in mind when pushing for innovation is, no matter how beneficial they may be, innovations are disruptive if for no other reason than they involve a change from the status quo. Research frames responses to such disruptions as attitudes toward change. These attitudes govern how people react to changes in their environment, their operations, their relationships, and more. People range in their responses to change with some being change-averse, others being change-tolerant, and still others being change-seeking.

One participant summarized the experience of change-averse people as, "you have resistance to anything new, resistance to having to learn how to use [a] new system." The same participant expands that such attitudes can mean, "when something … beneficial comes along, people bring cynicism into it." When another focus group shared their thoughts on how to encourage adoption of coordinated care in their area, one participant worried, "it might be one of those things that is a slow start here just because of how much shake-up there's been here." Another added, "everybody was kind of afraid that everything was going to fall apart like it did before."

Layered onto these attitudes are attitudes toward collaboration. The collective, relational (i.e., network) approach required to coordinate care across multiple provider organizations necessitates a degree of collaboration among those organizations. As our team explained the concept of coordinated care to participants and its reliance on referrals, some raised concerns based on their own experiences trying to refer clients. First among these concerns was experiences of competition or "territorial[ity]" with other organizations serving the military-connected population. For some organizations, simply serving the same client base as them "is seen as competition." Such organizations "don't want to share their resources" and "don't want to cooperate." Competition has obvious implications against a collaborative effort like coordinated care. Coordinated care, in whatever form, requires referrals from one organization to another. If one or more providers in a community view referring clients to another organization as supporting their competition, then those providers may be reticent to participate in a coordinated care effort. At best, they may be willing to receive clients from such a network but may take time or persuasion to direct clients into it.

The second concern folks voiced related to disconnection of organizations within communities. "We're very siloed," expressed one participant. "There's a lot of different messages and opportunities … but they all very much work in silos," explained another. Coordinated care can help address this issue to an extent. By linking providers together via navigation services, maintaining an updated directory through a shared platform, and facilitating a community of practice, coordinated care can encourage relationships and communication among a broader group of providers. However, one participant warned, "what we do not do well in this state is … talk to each other," suggesting that there may be some initial difficulty in onboarding providers.

The last worry about joining a collective effort involved potential "loss of autonomy." Collective efforts, like coordinated care, often demand adherence to a set of agreed-upon standards or procedures. Such rules can invite a "fear of dilution what [organizations] are out there for." That is, organizations may worry about experiencing mission drift by committing themselves to an effort distinct from their immediate programmatic scope. One participant speculated, "I think every organization wants to do and push their own thing." Coordinated care aims to balance the missions of individual organizations with the collective mission of improving care access, yet the perception that coordinated care might demand some sacrifice from partners could cool desire to participate.

> **“You kind of have to know where to go and get the resource, and that is something that is mind-boggling to me. I’m used to knowing where the resources are as a social worker, you’re supposed to know. You get the ropes of things, and you have to know who to navigate with. It’s like this section of clients are mine, but this section also needs this person. So why can we not have this collective sharing aspect?”**
>
> *—FG1, P7*

Beyond attitudes toward change and collaboration, there are two other sets of attitudes that will likely influence organizations’ willingness to join a coordinated care effort. These are attitudes toward leadership and attitudes toward implementation. With respect to leadership, participants expressed worry over having a government agency manage day-to-day operations given the current climate of distrust toward government alongside historical and cultural wariness of government among military and Native populations. Likewise, participants communicated strong support for a regional model that builds on local capacities and improves local access. Leadership or implementation that ignores these preferences would likely discourage organizations from participating.

These aspects of adopters’ attitudes in general (i.e., toward change and collaboration) and in reaction to coordinated care specifically (i.e., leadership and implementation) will shape whether people adopt during the early, mainstream, or later stages of rollout. Given communities’ experiences with competition, historical experiences with government, and loss of capacity, attitudes toward coordinated care might first be apprehensive or guarded. By no means do such attitudes mean that coordinated care will fail. Instead, it emphasizes the critical nature of the following sections: building knowledge and persuading organizations to join.

Building Knowledge of Coordinated Care

The first step noted in Rogers’ adoption process[26] is to facilitate knowledge or awareness of the solution. One participant spoke plainly about the need for building knowledge by pointing out, “you gotta have awareness that the program exists.” If would-be adopters lack awareness of a coordinated care solution’s rollout in the state and knowledge of what participation entails on their behalf, then it will be challenging for them to join in the first place. When thinking through the knowledge-building step, participants noted a couple of key challenges in the state.

To start, there is already a regular lack of resource knowledge in many communities. By lack of resource knowledge, we mean that people are either wholly unaware of the existence of certain services or programs (i.e., resources) in their communities or they misunderstand key elements of those resources. Sometimes, “it is [a] lack of knowing what they’re capable of doing,” meaning that providers lack knowledge about the services that other organizations in local communities provide. Other times, “it’s [a] lack of information of … what those organizations actually do.” In these cases, organizations know about the presence of other services in their community but may misunderstand eligibility, capacity, or other details about the service. When misrepresentation of those services happen, “[clients] come to us already [ticked] off because we have to tell them, ‘No, that’s actually not right.’” Worse yet, “not everybody’s on the same page,” which can lead clients to receive different answers from different organizations when asking about the same issue (e.g., benefits, healthcare, service access).

This lack of resource knowledge can occur in clients as well. One participant, “is concerned … that the information isn’t getting out to the vast majority of the population.” Providers may not always readily recall the existence of a service or realize its relevance to a particular client. In such situations, it can be helpful when a client has knowledge of a resource relevant to themselves. For example, a client who knows about the existence of coordinated care and sees its relevance to their own situation can then request a trusted provider to connect them with coordinated care.

To address this issue, participants emphasized the need for consistent and persistent messaging about the solution. “You … need to be there to disseminate it,” said one participant, addressing two points related to marketing. First, the lead organization needs to make strong efforts to promote the solution and communicate about it to the state at large. Second, the lead organization needs people physically present in communities to disseminate and share information. This is especially true of more rural communities where participants across several focus groups highlighted, “it’s all word of mouth.” More specific requests included, “hav[ing] a way of communicating that the care coordinator shows up there,” and explaining for providers, “how it would help our veterans in how we already service them.”

> **"The buy-in and implementation is your biggest roadblock. I think we're going to do something, you got to get the buy-in and explain or show how it's going to improve the process. If the process does not look like it's going to be that much, you don't have the buy-in yet, people will [go], "Why do we need to do this? We've been doing this, and it's worked for many years."**
>
> *—FG12, P2*

Responses like these build a picture of what organizations need to know to make judgments about participating. At minimum, organizations need to know that the coordinated care solution exists. This means a name for the program or network and a clear leader responsible for rollout, implementation, and all the facets those entail (e.g., training, onboarding, etc.). Beyond minimum, organizations would benefit from knowing the expectations and procedures of organizations becoming part of the coordinated care solution; any financial costs to participate; and the expected benefits to their clientele.

Building organizations' knowledge about the solution enables them to make informed decisions about their ability to join. Although coordinated care aims to have a low barrier to entry, the effort costs of training on technology, keeping information updated, and inputting referrals all affect organizations differently. Not every organization may immediately have the capacity or infrastructure to join. Yet, if they understand how coordinated care operates and benefits clients, and how they can help clients access coordinated care, then they may still refer clients to the lead organization through other means.

Moreover, the extent to which the coordinated care solution in New Mexico reflects the feedback from participating organizations, the more likely they are to feel their time investments so far have been meaningful. Such feelings are persuasive. Demonstrating and communicating how the solution will partner with provider organizations creates, "that welcoming for [a] program to jump on board." By contrast, should the lead organization undervalue outreach and marketing, there is a real risk of misinterpreting or misunderstanding it as happens with other programs throughout the state. As one participant worried, "I think the other [issue] is the dissemination of wrong information about what this will do or how this will work."

Knowledge development thus requires two efforts. First, the lead organization must develop a clear, internal understanding of its intended operations. Once this internal understanding crystallizes and becomes stable over iterations, the lead organization can be confident that they know what they will ask of partner organizations. Second, the lead organization will need to facilitate knowledge of the program externally through marketing and outreach. This work paves the way for the lead to persuade potential adopters to participate in a coordinated care solution.

Persuading Adopters to Participate

Considering the attitudes participants voiced, persuasion will necessarily play a larger role in this report, and the forthcoming coordinated care solution. Individual and cultural experiences, potential costs and benefits, struggles with current supply and demand, and the nature of change itself all suggest that persuasion will be pivotal to the success of a collective effort like coordinated care. Fortunately, participants were direct about what would influence their decisions to join a coordinated care network. They identified many factors a lead organization should address in its knowledge-building and marketing to encourage adoption among providers across the state.

Foremost, coordinated care needs to "identify a real problem that everybody knows exists." Put differently, there needs to be a visible problem statement that addresses a well-known struggle faced by New Mexico communities. There are several problems that coordinated care can help address. First, participants called for a "one-stop shop … to meet all those basic needs" or at least a "central website or database where it has services … broken down." The collaborations that coordinated care fuels alongside having a database with dedicated staff to maintain can increase providers' awareness of each other and the services available locally, nearby, and farther away. Coordinated care also reduces some of the geographic dispersion among resources through identifying and promoting the visibility of local resources. In doing so, it helps with the "isolation and remoteness" people experience that leaves them "feeling they're abandoned [and] that all things only happen in Albuquerque." Further, the information infrastructure that coordinated care builds can also assist with baseline capacity issues by identifying resources in communities that are overloaded or altogether missing. Layering a community of practice on top of a database can create opportunities for providers to meet and re-meet can then further a sense of collaboration among providers and enable advocacy for further resourcing. In short, coordinated care can tackle several problems in social care, outlined in Box 6.

6

Issues in Social Care

- Navigating clients to services outside those provided by any given organization
- Improving resource knowledge among providers and clients
- Elevating the visibility and use of underutilized programs
- Collecting data to support advocacy for services

However, care coordination does come with two challenges of its own—one innate to any innovation, and one innate to care coordination. Any innovation, no matter how beneficial or efficiency-gaining, entails costs. For coordinated care, “a lot of it is passive … passive pieces of lost client time, lost production time that total up to staff feeling less effective.” Participating in a collective effort costs each adopter time from their own organizational efforts while staff spend time training on the solution and entering information for referrals. Participants also worried about “loss of autonomy” and potential costs as prior efforts required that organizations “had to pay” to license technology.

7

Benefits of Data-Sharing & HIPAA-Compliant Platforms

- Minimizing costs organizations incur through providing navigation in-house
- Improving warm handoffs of clients through data sharing

The other challenge related to coordinated care itself is the tradeoff between data sharing and retelling. Ideally, coordinated care involves minimizing the number of times that a client has to retell their story, but doing so requires data sharing among navigators and providers. Some participants asked, “how do we get around HIPAA?” while another noted that “most people don’t have a good understanding that continuity of care, discharge information from one covered entity to another covered entity is not a HIPAA violation.”

Selecting a HIPAA-compliant platform and having the lead encourage data sharing and warm handoffs can enable coordinated care to address two additional problems with providing coordinated care, outlined in Box 7.

Beyond tackling known problems and having thoughtful procedures, participants voiced two other critical factors the lead organization should consider when rolling out the solution. The most frequent of these factors was trust, which surfaced in all 12 of the focus groups we hosted. Trust came in many variations, to include: trust in leadership, trust in other partner organizations, and trust in the solution itself. The section on leadership already covers trust in leadership but the context of adoption really emphasizes the values of visibility, transparency, and trustworthiness. “A face for the organization,” or the solution in this case, makes partners feel like they better know who is steering the work and can make participation seem less risky.

Trust in partners then surfaced through the aforementioned attitudes toward collaboration alongside other issues like distrust of institutions (e.g., government) and the need to vet providers. Trust appears to be an invaluable resource in New Mexico with individuals and organizations alike leaning heavily on people and partners they trust. Champions, trusted community organizations, who are willing to pilot the solution are critical. As one participant explained, “you’ve got to figure out a way to get above—endorsed by all of us, validated by all of us—to go beyond the clutter of what we’re already smoked with.” Wherever the lead organization establishes regional hubs, “having people from the community help people in that community helps a lot.” From there, prior community collaborations suggest the need to “buil[d] it on preexisting relationships.”

Champion partners, like those in Table 4, can help promote the solution through their own use and marketing of it.

Trust in the solution then centers around the utility and impact of the solution, and the accountability of leadership. This kind of trust applies more to mainstream and late adopters because some folks are simply more risk-averse. Several people emphasized that “it needs to be useful,” they need to “see that … it’s a successful program,” and that “it enhances the lives of local veterans.” For these adopters, adoption “is kind of a chicken and an egg.” “It [the solution] being effective will determine what kind of

> **“Everyone’s localized in little regions, and if they feel like they have a voice in their corner of the world, they’re gonna definitely listen to this person. They’re gonna definitely know that they can trust a local source.”**
>
> *—FG9, P1*

Table 4. Key Partnerships for Coordinated Care in New Mexico

SECTOR	EXAMPLES
Faith-Based Organizations	Catholic Charities, Interfaith Coalitions, Health Ministries, Local places of worship
Higher Education Institutions	Community Colleges, Universities
Native & Tribal Organizations	Bureau of Indian Affairs, Indian Health Services, Navajo Chapter Houses, Tribal Governments
State Agencies	Department of Aging and Long-Term Services, Department of Veterans Services, Department of Workforce Solutions, Health Care Authority
Veteran Serving Organizations	American Legion, Disabled American Veterans, Military Order of the Purple Heart, Paralyzed Veterans of America, Veterans of Foreign Wars

uptake there is." If those would-be adopters can see the solution has a demonstrable positive impact on the solution's members and the adopters' clientele and does not incur heavy costs for partners will encourage them to participate.

Ultimately, people look around themselves to make decisions on whether to adopt an innovation; if trusted partners and champions are on-board, if the solution is improving lives, if it is easy to use and low-cost, then organizations will want to participate. Central to this observation is that for the solution to work, people must use it. People want to "see the buy-in from other organizations." They want to "make sure they are actively participating and putting in just as much effort." With a collective effort like coordinated care, "the system is only as good as those organizations that are using it." Concretely, this means that the lead organization must work both quickly and consistently when they reach the marketing stage to build the early momentum necessary to achieve network launch.

The other factor folks suggested were incentives. Put simply, "feed them and they will come." This comment is open to wide interpretation, but it suggests a few things. The lead organization will "have to buy into it and buy it out." Full-time navigator staff whose sole job is navigating clients to resources and curating the network is a major incentive to participate because it offloads that work from organizations providing other direct services. Also, to "keep those people in those areas, we have to give them incentives to stay." Our previous report acknowledged challenges with brain drain—trained and specialized community members leaving an area—due to poor pay, benefits, or hours.[27] Incentives like these, that encourage navigators to remain long-term, are vital to the health of a network because despite how well the lead organization maintains the resource database, regular turnover of navigators would deteriorate the quality of the solution and of partners' relationships with the solution.

Rather than financial incentives for organizations to participate, the lead organization should emphasize the innate incentives of participating. These incentives are outlined in Box 8.

There are thus only a few factors that New Mexico organizations shared they are really paying attention to when it comes to persuasion. They want to see that the solution addresses a real problem that communities know exists. They want to be able to trust the solution and those involved in it, which a lead organization can achieve through key partnerships and early impact. Finally, they want to see that the solution has the buy-in of those using it and that financial incentives do not drive their participation. These factors can all empower adoption across the state and set coordinated care up for long-term sustainability.

8

Non-Financial Incentives for Network Participation

- Low barrier to entry
- Creation of additional capacity
- Access to additional clientele
- Access to additional resources for existing clientele
- Demonstrable impact

Sustaining Coordinated Care Long-Term

Decision is beyond the scope of this work and the first set of results discusses implementation, so this section now turns its attention to continuity, or sustainability, of the solution long-term. From the focus groups and analysis of the data, three intertwined elements of continuity stand out: 1) funding, 2) impact, and 3) participation. Obviously, for the solution to sustain in both the short- and long-term, it will need funding to address the financial costs of operation (i.e., staff and technology). One participant worried, "Could New Mexico even afford a hub? Probably not." Affordability is a valid concern, but the majority of financial costs for the solution are in staffing and technology licensing. Staff will need pay and benefits; technology has licensing fees; and if the solution includes a mobile component, then there will either be reimbursement for miles or purchase and maintenance of fleet vehicles.

Considering such concerns about affordability, especially if a nonprofit leads the solution, participants felt it was critical for the effort to receive legislative (i.e., State) funding to ensure longevity. As one participant phrased it, “if it is going to be a program that has the ability to be bold, and the ability to have sustained funding … I think it is going to require legislative funding.” Fortunately, New Mexico has a sizeable revenue—$13 billion in FY 2025—which the Department of Finance and Administration has managed year over year such that the State maintains a solid reserve fund—$3.6 billion in FY 2025.[28] The current state of the budget means that funding coordinated care through the State is a feasible possibility. However, despite the intuitive alignment of State funds with providing a statewide service for its public, a few participants held reservations about the potential politicization of any State-funded effort. Specifically, those few worried that when “a new leader is voted into that position, we [will] have a different focus.” This can be a legitimate concern if members of the New Mexico legislature, the Governor, or the appropriate Cabinet Secretaries either see poor returns on the investment or hear little about the impact of coordinated care on the public. Returning to the importance of ongoing communication and transparent reporting, such procedures allow stakeholders to understand the performance of the solution.

In addition to legislative funding, some participants felt that grants and donorship could provide valuable dollars to support the growth and rollout of the solution. One participant suggested the solution should “have a cent[ral] hub” to tackle grant-writing, and another remarked that “the more decentralized the funding […] is, the better it is.” Various participants suggested financial partnerships with the VA, the traditional veteran-serving organizations (i.e., VFW, DAV, American Legion), and with private philanthropies and private sector organizations. An administrative office could have a role dedicated to grant-writing and pursuing funds from federal government, relevant associations, and foundations. Regardless of the funding approach, all participants demanded accountability for the funds—translating to publicly available budgets and expense summaries.

To then sustain any kind of funding long-term, and any kind of long-term participation, the solution must also demonstrate continuity of impact. Comments about the importance of impact were various but firm. “If it isn’t working, it’s a waste of time,” aptly summarizes most participants’ feelings. Coordinated care needs to be effective not just in the short-term rollout period, but in the long-term steady state of the network too. Funders and providers both need to see that the resources and effort put into the network continuously results in positive impact for clients directed into it. There should be a clear vision for the maximal outcome of statewide coordinated care—e.g., every veteran in New Mexico connects to services that improve their well-being within two days—and movement toward that goal, but there should also be realistic expectations of how long that vision will take to achieve. Such a vision provides measures of scaling (e.g., population reach, wait time, average change in well-being) and shows how the network makes continuous positive impact over both short and long terms.

> **“The biggest thing is it needs to be useful. It needs to give us the information needed. Every one of us have clients. Each client has different needs, whether it be food, clothing, furniture, healthcare, getting their medications, transportation, each one of those pieces is all going to be different. But, if it’s useful in all of those aspects, then I can see it as being something that would be used on a regular basis.”**
>
> *—FG1, P3*

Continuity of participation is then the final, vital element of sustainability for a coordinated care effort. If the solution loses navigator staff (i.e., "the brain") or its technology platform (i.e., "the connective tissue"), then it will be difficult for partner organizations (i.e., "the muscles") to continue participating in the network. Coordinated care places the lead organization in a lynchpin position for the state such that if "there's not a transfer of knowledge or anything … in place to continue that" then there could be a significant loss of continuity. Likewise, if the solution demonstrates limited or negative impact, or if it fails to achieve a critical mass of adopters, then partners will likely be reluctant to continue participating. Participants emphasized two procedures when discussing this concern, both related to vetting providers. Most obviously, the lead organization needs to vet providers prior to onboarding to the network as "some of these organizations aren't that good." There are, unfortunately, exploitive or lazy actors in the veteran services space, and ensuring they do not exploit clients via coordinated care is paramount. Less obviously but still crucially, the lead organization also needs to monitor onboarded providers for responsiveness and activity. As one participant observed, "the system is only as good as those organizations that are using it." Part of coordinating care is ensuring that partners are timely and providing effective services. If some providers are not, then the lead has to be ready to re-train those providers or trim them from the network.

Sustainability of the solution, then, cannot separate these elements from one another. Funding is necessary for impact and participation; impact is necessary for funding and participation; and participation is necessary for funding and impact. Sustaining the solution long-term means tracking each of these elements against data that capture those elements. Equipped with those data, the lead organization can then monitor where it needs to bolster its efforts to ensure that coordinated care can remain a reality for military-connected New Mexicans.

One final, critical note related to sustainability is that while care coordination is a valuable and viable addition to New Mexico's care system, it alone cannot address baseline capacity issues in the state. Again, people in every focus group noted "a lack of healthcare," the presence of "healthcare deserts," the inability to "create a network when there's nothing there," and how after the loss of an organization in a community "it just seems like everything crumbled." Many communities across the state lack resources of some kind or another and coordinated care does not innately create more resources. It links them together and it offloads time and effort spent navigating onto dedicated navigators, but it will not add hospitals, shelters, food banks, employers, or any other service to a community. Legislators and advocates should instead look to coordinated care as a source of data and information on the services needed by and under-resourced in different communities.

RECOMMENDATIONS

Pulling from findings from our stakeholder conversations and dialogue, focus groups, and our experience with coordinated care networks, we present the following recommendations to effectively design and implement New Mexico's coordinated care network.

RECOMMENDATION 1: A REGIONAL MODEL WITH DEDICATED NAVIGATORS

Many participants highlighted the importance of having staff embedded in local communities, working face-to-face with clients to ensure delivery of high-quality services. A regional model helps achieve this by positioning navigator hubs across the state in a way that minimizes the amount of time and distance people must travel to access services. Adding a mobile component to these hubs that enables navigators to drive to communities within their region can further promote accessibility. Moreover, regional models enhance cultural competency, strengthen trust within local communities, improve communication and coordination, and can be more far-reaching and impactful.

Facilitating such a model requires hiring for the full-time navigator position. Each hub around the state should have sufficient staff to manage the caseload of clients seeking care coordination services. A common complaint among staff from programs across the state was the lack of capacity to handle their current caseloads, let alone assume further responsibilities. Hiring staff dedicated to solely navigation and care coordination reduces the strain on program staff responsible for delivering services, supports sustainable implementation of the network long-term, and increases partner buy-in. Dedicated navigators also improve the quality of care for clients accessing the network.

The network should then institute two additional layers of support. First, it should either create a separate administrative office or elect one hub to manage administrative tasks in addition to navigation work. Participants variously called out that the network must report to its stakeholders and the public, seek out additional funding where appropriate, conduct marketing and outreach, and manage support functions related to technology. In the spirit of separating responsibilities, allocating an office and hiring staff dedicated to that administrative work leaves navigators free to focus on care coordination. Second, participants called for the creation of a collective that enables network opportunities, ongoing education, and time to share best practices. A community of practice[29] broadly fits this request. Building such a learning community will also add to the long-term sustainability of coordinated care and encourage problem-solving with and among organizations who engage in the work daily.

RECOMMENDATION 2: NONPROFIT LEADERSHIP WITH STATE OVERSIGHT

When deciding on who should lead daily network operations, the team evaluated two options: a state agency and a non-profit. Table 5 lays out the attributes that the team considered when examining which organizations should manage the network. Participants' discussions of model, accountability, and adoption suggested that critical features to assess in selecting a lead agency

Table 5. Key Leadership Attributes of Nonprofits and State Agencies

KEY ATTRIBUTES	NONPROFIT ORGANIZATION	STATE AGENCY
Community Trust	Culturally competent, embedded in their communities, and generally trusted, but could be limited in knowledge	Often the go-to source for veteran-related questions, but there exists mistrust due to historical issues and political interference
Organizational Infrastructure	Many nonprofits in the state tend to be local, with only a few having reach across multiple regions	Central and regional offices make services more accessible, but transportation remains a challenge
Flexibility and Adaptability	Policies are less rigid, allowing for more innovation in a timely manner, but are subject to funding	Bureaucratic complexities, such as strict policies and procedures, can slow innovation, but standard operations promote equity
Sustainability vs. Continuity of Leadership	More stable in the face of political turnover (e.g., change in Governor) compared to a state agency, but more sensitive to changes in the funding environment	More fiscally secure, but more vulnerable to executive turnover and changes in political environment

or organization are extant trust in communities, current organizational infrastructure, the speed at which the organization can adapt to changing environments, and the stability of its funding and leadership.

Both nonprofit and state organizations bring strengths and limitations for leading network operations. Nonprofits have strong trust and are highly flexible, but state agencies have robust infrastructure and stable funding. Considering this balance of traits, our team recommends that New Mexico select a nonprofit to roll out implementation of the network, hire staff, and manage the actual care coordination work. Meanwhile, a state agency should act as fiscal agent, oversee implementation, facilitate reporting, and hold it accountable to the milestones laid out in Recommendation 3. A public-private partnership balances the strengths of each type of organization and allows both to capitalize on those qualities in the management and oversight of the network.

Selection of a lead nonprofit should then unfold via a request for proposals (RFP) process. An RFP solicits proposals from nonprofits, in this case, to implement the network. Interested nonprofits can apply and a committee of stakeholders representing veteran interests in the state will evaluate proposals and select from them which nonprofit will lead the effort. The committee should comprise state agencies, healthcare organizations, veteran-serving organizations, Native government or leadership, and individual advocates. Similarly, an ideal candidate should be well-known in the state, exhibit cultural competence or the ability to trained in such, and have the expertise to support referral technology and the reporting requirements necessary for managing the network.

Once selected, the lead organization will be responsible for rolling out operations across the state. To demonstrate progress, the team recommends that the selected organization host publicly open in-progress reviews twice per year. Annually, the lead organization should also share a network activity report with all network partners and the public. These meetings and reports will report on network priorities, data, and other relevant information. The team also recommends allocating funding for two third-party organizations: a technical assistance provider for the roll out, and an external evaluator to inform data collection and support reporting requirements. Third-party evaluation will further ensure transparency and accountability of the network's operations.

RECOMMENDATION 3: PHASED IMPLEMENTATION OVER FOUR YEARS

To ensure effective rollout of the statewide network, the team recommends funding a phased implementation over four years (48 months). Phasing the rollout allows for building of the network's infrastructure, gradual introduction of regional hubs, refining the approach based on early feedback, and scaling the network in a way that supports long-term sustainability. Below is a brief overview of our recommended timelines and steps with further detail in the companion roadmap document.

Table 6. Overview of Coordinated Care Phases

PHASE	DURATION	KEY MILESTONES
Phase 1: Network Lead and Technology Selection	Months 1-6	Lead organization selected and contract executed Closed-loop referral technology selected
Phase 2: Network Buildout and Soft Launch	Months 7-18	Theory of change completed Network staff hired and trained All regions soft-launched and engaged in pilot operations
Phase 3: Full Implementation and Steady State Operations	Months 19-42	Network achieves full statewide operations Four in-progress reviews completed
Phase 4: Program Review and Renewal	Months 43-48	Program evaluation completed Evaluation and sustainability recommendations presented to state legislature and governor's office Sustainability measures implemented (if applicable)

The four phases outlined summarize how to take the network from design and idea to full-scale implementation. The first phase establishes organizational and technological infrastructure for the network, prioritizing selection of the network's lead organization and the platform over which referrals will occur. The second phase transitions to early operations and shifts attention to building the internal capacity of the hubs and the external partnerships necessary to coordinate care statewide. The third phase then marks the network's move to steady operation, during which it focuses on coordinating care at scale across the state while establishing rhythms for transparency and continuous improvement. The fourth and final phase concludes the initial rollout with a formal assessment of the network's impact and performance, and it determines whether the network should continue as-is, adjust, or cease operation.

As noted above, taking a phased approach over a longer period creates time for necessary selection processes (e.g., leadership, technology, staffing) and for learning and refinement to occur. Investing upfront in the network's infrastructure and theory will support its development and longevity in the long-term by establishing tools, norms, procedures, and reporting criteria. With those supports and the time afforded to learn, the network will be able to adjust and course-correct as necessary while it expands into the different markets of New Mexico.

CONCLUSION

The first phase of our work assessed the desire for and the viability of a coordinated care network in New Mexico. Participants in focus groups, interviews, and surveys widely agreed that a coordinated approach to care for veterans would be valuable to military-connected folks in the state. However, there remained open questions related to the tangible realities of implementing a network. This second phase of our work sought to address those questions of model, leadership, sustainability and develop a roadmap by which the State can establish a network for New Mexico's veterans, military, and their families. This roadmap envisions the development of a regional model staffed with dedicated navigators, governed by the leadership of a statewide private-public partnership, phased in over the next four years for optimal scaling, sustainability, and incorporation of lessons learned in early phases. With the right funding, leadership, and effort, regionally structured coordinated care stands to help the military-connected community in New Mexico access services more readily, leveraging the strengths of the existing raft of organizations and resources for a holistic, person-centered approach.

APPENDIX A:
STATEWIDE COORDINATED CARE ROADMAP

PROJECT OVERVIEW

The New Mexico State Legislature is interested in building a statewide coordinated care network to better connect veterans and their families to services. Starting in 2022, the D'Aniello Institute for Veterans and Military Families at Syracuse University (IVMF) has undertaken extensive engagement with community-based veteran-serving organizations and other key stakeholders statewide to inform the design of this network.

This document translates that community input into an actionable roadmap for implementation. It outlines key activities, objectives, and milestones across each phase of the project—designed to guide state leaders and implementation partners from design to launch to steady state operations.

PROJECT DURATION

Four Years

Summary Timeline

PHASE	DURATION	KEY MILESTONES
Phase 1: Network Lead and Technology Selection	Months 1-6	Lead organization selected and contract executed Closed-loop referral technology selected
Phase 2: Network Buildout and Soft Launch	Months 7-18	Theory of change completed Network staff hired and trained All regions soft-launched and engaged in pilot operations
Phase 3: Full Implementation and Steady State Operations	Months 19-42	Network achieves full statewide operations Four in-progress reviews completed
Phase 4: Program Review and Renewal	Months 43-48	Program evaluation completed Evaluation and sustainability recommendations presented to state legislature and governor's office Sustainability measures implemented (if applicable)

PHASE 1: NETWORK LEAD AND TECHNOLOGY SELECTION

Duration: 6 months (Months 1 through 6)

Phase Overview

This foundational phase establishes the organizational and technological infrastructure for New Mexico's coordinated care network. The primary focus is identifying and contracting with a lead organization that will serve as the operational backbone of the network, while simultaneously selecting the closed-loop referral technology that will enable coordinated service delivery.

To support these efforts, the fiscal agent engages a technical assistance provider with expertise in coordinated care network implementation—such as the IVMF or Social Impact Network Consulting— to support the lead organization selection process and early implementation activities. The fiscal agent also engages with an independent evaluator, such as UNM's Prevention Research Center, to assist in key evaluation and framework design activities.

The phase begins with developing a request for proposals (RFP) and assembling a review committee that includes both public, private, and nonprofit partners—ensuring the selection process reflects the diverse stakeholders of which the network will be comprised. Note that members of the review committee must relinquish their ability to submit an RFP application. Following a competitive review, the selected lead organization will enter into a formal contract with the fiscal agent that will run for the duration of the pilot period. Concurrently, the fiscal agent leads a technology selection process to identify the closed-loop referral platform that will serve as the network's tool of record. IVMF recommends that network leadership consider the referral management platform selected by the New Mexico Health Care Authority (NMHCA) for the YES New Mexico initiative to ensure continuity and consistency across state systems.

By the close of this phase, the network will have secured committed leadership and core technology infrastructure, positioning it to move into active implementation.

Objectives

- Complete request for proposals (RFP) process and select lead organization
- Lead organization enters contract
- Closed-loop referral technology is selected
- Independent evaluator engaged and evaluation framework established

Milestones

- Technical assistance provided engaged (Month 1)
- Independent evaluator engaged (Month 2)
- Closed-loop referral technology selected as tool of record (Month 5)
- Evaluation framework established (Month 6)
- Lead organization is selected and enters contract to operate statewide network (Month 6)

Key Activities

ACTIVITY	DESCRIPTION	TARGET DATES (PROJECT MONTH)
RFP Drafted	Fiscal agent, with support from technical assistance provider, develops RFP for lead organization and companion scorecard	Month 1
Technical Assistance Provider Engaged	Fiscal agent engages a technical assistance provider with expertise in coordinated care network implementation	Month 1
Independent Evaluator Engaged	Fiscal agent engages an independent evaluator to design program evaluation framework and establish baseline measures	Months 1-2
Review Committee Assembled	Fiscal agent assembles RFP review committee with public and private partners	Month 1
RFP Released	RFP released and socialized broadly	Months 2-4
Technology Options Reviewed	Fiscal agent reviews closed-loop referral technology options and develops selection recommendation	Months 2-4
Evaluation Framework Developed	Independent evaluator develops evaluation framework in coordination with fiscal agent and technical assistance provider	Months 3-6
Proposals Reviewed and Lead Organization is Selected	RFP responses are reviewed by the committee, scored, and a lead organization is selected	Month 4
Selection Announced	Selection is socialized broadly with stakeholders	Month 4
Contract Drafted and Executed with Lead Organization	Contract is drafted by fiscal agent and executed by lead organization	Months 4-6
Technology Selected	Closed-loop referral technology is formally selected as the tool of record for network activity	Month 5
Technology Licensed	Technology solution is licensed by fiscal agent	Month 6

PHASE 2: NETWORK DEVELOPMENT AND REGIONAL SOFT LAUNCHES

Duration: 12 Months (Months 7 through 18)

Phase Overview

This twelve-month phase transitions the network from design to early operations. With the lead organization under contract and technology platform selected, attention shifts to building the internal capacity and external partnerships necessary to deliver coordinated care statewide.

The phase opens with the lead organization developing a theory of change and a logic model alongside key stakeholders . This exercise documents the core justifications for the development of the network, and then articulates the network's intended short-term outcomes and long-term impacts, identifies the preconditions and resources necessary to achieve them, and maps how specific activities and interventions will drive progress. This creates a logic model that informs network operations, performance measurement, and strategic decision-making. Alongside this effort, the lead organization begins developing network standard operating procedures, service delivery standards, and other foundational documents as appropriate. Concurrently, the lead organization hires and trains full-time network staff, including regional coordinators who will manage day-to-day operations in their areas.

Leading off from the theory of change and logic modelling exercises, and together with the evaluative framework developed in Phase 1, a protocol for data collection will be developed. This includes identifying fields of interest for collection that serve operational needs and programmatic evaluation. This will also include development of metrics calculable from the data collected, that serve as ongoing pulse checks for network health and growth and support long-term evaluation of the network.

A central feature of this phase is a soft-launch period using a phased-in regional approach. The state's regions are divided into two groups: the first group begins pilot operations in month 12, with the second group following three months later. This staggered launch allows network leadership to test operations in a controlled environment, identify and address issues in real time, and refine processes before the network's formal launch. By month 18, all regional networks will be operational and engaged in pilot activities, positioning the network to transition to full implementation in month 19.

Objectives

- Lead organization leadership conducts theory of change process in partnership with key stakeholders
- Coordinated care network hires and trains staff
- Network partners are identified and onboarded per region
- Regions are brought online through a phased-in approach

Milestones

- Theory of change and logic model completed, establishing shared framework for network operations and long-term planning (Month 10)
- Data collection protocol established (Month 12)
- Network staff, including regional coordinators, hired and trained (Month 12)
- First group of regions soft-launched (Month 12)
- Second group of regions soft-launched (Month 15)
- All regions soft-launched and engaged in pilot operations (Month 18)

Key Activities

ACTIVITY	DESCRIPTION	TARGET DATES (PROJECT MONTH)
Theory of Change and Logic Model Completed	Leadership at the lead organization leadership conducts theory of change and logic model process alongside key stakeholders to inform network operations and long-term planning	Months 7-10
Data Collection Procedure Developed	Protocols for collecting operational and programmatic data within the technology platform are created, including fields of interest and metrics calculable from such data	Months 7-12
Foundational Network Documents Developed	Lead organization develops network standard operating procedures, service delivery standards, and other foundational documents	Months 7-12
Network Staff Hired	The lead organization hires full time network staff, including regional coordinators	Months 7-10
Network Staff Trained	Network staff are trained on the closed-loop referral technology, coordinated care activities and best practices, and on data collection protocols and its importance to network function	Months 10-12
Pilot Group of Network Partners are Identified, Trained, and Onboarded into Network	Network staff by region identify and onboard provider partners into the network	Months 10-12
First Group of Regions Soft-Launched	The first group of regions networks soft-launch and begin pilot operations for a total of six months	Months 12-18
Second Group of Regions Soft-Launched	The remaining group of regions soft-launch three months following the first group and begin pilot operations for a total of three months	Months 15-18

PHASE 3: STEADY STATE

Duration: 24 months (Months 19 - 42)

Phase Overview

This two-year phase marks the network's transition from pilot to full statewide operation. Building on lessons learned during the soft launch, all regional networks move into steady-state operations beginning at month 19.

During this phase, the network focuses on delivering coordinated care at scale while establishing rhythms for transparency and continuous improvement. The lead organization hosts public in-progress reviews twice per year, reporting on network activity, emerging trends, and outcomes data to stakeholders and the public. These reviews create regular opportunities to assess performance, celebrate successes, and identify areas for refinement—ensuring the network remains responsive to the needs of New Mexico's veteran and military family community.

By the close of this phase, the network will have established a track record of sustained operations and demonstrated its value through consistent data collection and public accountability.

Objectives

- Network is in full operation statewide, collecting data, and providing in-progress updates to network stakeholders and the public on a regular cadence

Milestones

- Network achieves full statewide operation across all regions (Month 19)
- Four in-progress reviews completed, establishing a consistent cadence of public reporting and stakeholder engagement (Month 42)

Key Activities

ACTIVITY	DESCRIPTION	TARGET DATES (PROJECT MONTH)
Steady State Operations	Network is in full operation, connecting military-connected individuals to services statewide	Months 19-42
In-Progress Reviews are Held	Lead organization hosts public in-progress reviews twice per year to report on network activity, trends, and any other relevant information	Months 24, 30, 36, 42

PHASE 4: PROGRAM REVIEW AND RENEWAL

Duration: 6 months (Months 43 - 48)

Phase Overview

This six-month phase concludes the initial project period while laying the groundwork for the network's long-term future. Steady-state operations continue throughout, ensuring uninterrupted service delivery to veterans and their families as the network undergoes formal assessment.

The lead organization partners with an independent evaluator to conduct a comprehensive program evaluation, examining network outcomes and operational effectiveness across the pilot period. Concurrently, the lead organization and fiscal agent develop a long-term sustainability plan that identifies funding streams and legislative opportunities to support continued operations. By month 46, the final evaluation report is completed and presented to the state legislature and governor's office alongside sustainability recommendations.

Assuming demonstrated network success, the final months of this phase focus on implementing measures to secure the network's future—positioning it for uninterrupted operations beginning in month 49 and establishing coordinated care for veterans and military families as a lasting fixture in New Mexico's service landscape.

Objectives

- Complete comprehensive program evaluation and present findings to state leadership
- Establish long-term sustainability plan for network operations beyond the initial project period

Milestones

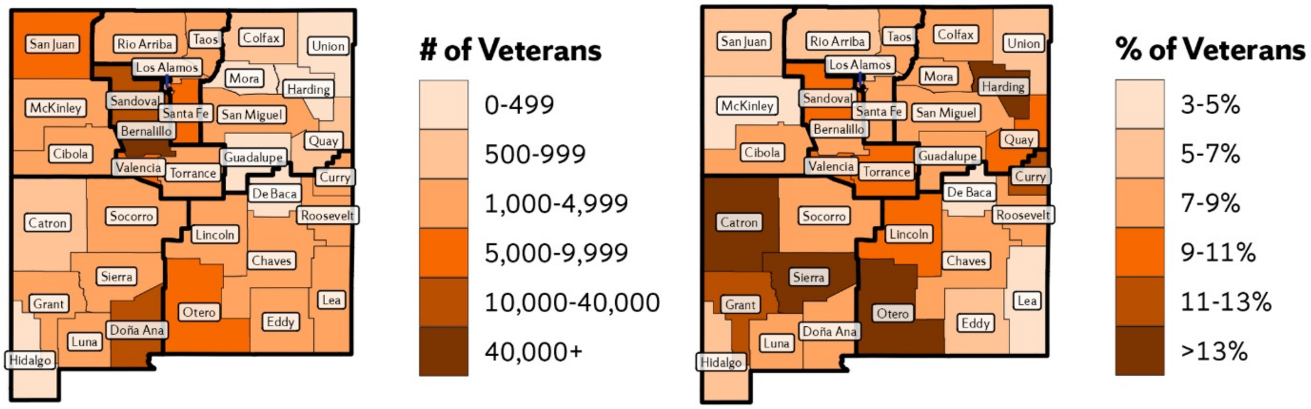
- Independent program evaluation completed (Month 46)
- Evaluation findings and sustainability recommendations presented to state legislature and governor's office (Month 47)
- Sustainability measures implemented to ensure continuity of network operations (Month 48)

Key Activities

ACTIVITY	DESCRIPTION	TARGET DATES (PROJECT MONTH)
Network Operations Continued	Steady-state operations continue during this phase	Months 43-48
Program Evaluation	Lead organization partners with independent evaluator to assess network outcomes and operational effectiveness	Months 43-46
Sustainability Planning	Lead organization and fiscal agent develop long-term sustainability plan, identifying funding streams through legislative opportunities for continued operations	Months 43-46
Legislative and Executive Briefings	Evaluation findings and sustainability recommendation are formally presented to the state legislature and governor's office by fiscal agent and lead entity	Month 47
Sustainability Actions Implemented (if applicable)	Assuming network success at the end of the pilot period, relevant measures are taken to ensure long-term sustainability of network; including uninterrupted operations of the network beginning in month 49 and onward	Months 47-48

APPENDIX B: ADDITIONAL TABLES/FIGURES

Figure 3. Veteran Population and Proportion by County in New Mexico



Data is drawn from 2023 American Community Survey 5-year estimates.[30]

Numerator is count of veterans in a county. Denominator is total population in a county.

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