



New Mexico Aging & Long-Term Services Department

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## Attachment B

### State Plan Goals, Objectives, Strategies, and Outcomes

This section of the State Plan on Aging contains four goals that align with the ALTSD's legislatively established performance measures, the strategic plan, as well as the associated objectives, strategies and outcomes fulfilling the mandate as the State Unit on Aging to effectively administer the Older Americans Act.

#### Goal 1

**Administer and expand core programs that enable older New Mexicans to remain in their residence and community through the availability of and access to high-quality home and community services and supports, including supports for families and caregivers.**

**Objective 1.1 Expand access to information, referral and assistance to evidence-based services that support continuum of care and support resources throughout New Mexico to improve the autonomy, awareness of options, and outcomes for consumers through the Consumer and Elder Rights Division (CERD).**

#### Strategies

- Enhance the Aging and Disability Resource Center operations to increase staff levels to facilitate warm handoffs to ALTSD programs and external partners.
- Modernize and integrate information technology systems to communicate with Medicaid programs across agency programs such as APS and Aging Network.
- Increase Medicare knowledge and eligible benefits access through the Senior Health Insurance Program (SHIP)
- Increase outreach efforts to senior centers, Aging Network, and community partners, including with Tribes, Pueblos, and Nations to help prevent healthcare fraud through Senior Medicare Patrol (SMP).
- Update information access with texting capabilities, on-demand case management, and website updates.
- Enhance resource education and offerings for individuals who live with disabilities and their caregivers.
- Strengthen collaboration with NM Health Care Authority divisions who support these constituents.

- Expand facilitation of counseling sessions with expansion of a CERD presence across New Mexico at Family Resource Center's including in Espanola, Albuquerque, Los Lunas, Roswell and Las Cruces.
- Increase awareness and access to assistive technology by promoting the New Mexico State Assistive Technology Program to ensure information is disseminated to aging service providers and consumers.
- Promote the integration of core OAA programs with non-formula grant programs such as SHIP and SMP to ensure seamless access to services and supports.
- Establish coordinated referral protocols and joint outreach between OAA core programs SHIP and SMP to streamline access and improve service navigation.

### **Outcomes**

- Increase numbers of Medicare-eligible beneficiaries reporting a greater knowledge of the program benefits, policies, and guidelines.
- At least 250 constituents who participate in SHIP counseling surveyed to assess satisfaction. On a 5-point assessment scale, where 3 is 'neutral' and 5 is highly satisfied, the target is that at least 85% of respondents report an average satisfaction score of at least 4 (satisfied).
- Increased outreach activities to educate about identity protection, reporting errors on health care bills, and identifying deceptive health care practices or fraud.
- 10% increase in SHIP/SMP volunteers to grow community outreach efforts.
- 10% increased call volume to the Aging and Disability Resource Center for disability-related topics and resource requests.
- Every CERD colleague or team assigned to a Family Resource Center will meet the per-colleague expectation for facilitating an average of at least 12 options counseling discussions with consumers per business day.
- Each CERD team at a Family Resource Center will participate in at least one community outreach event per quarter in the local community to help educate on Agency services and resources.
- Increase the number of older adults and service providers who report awareness of and access to assistive technology options through NMATP resources.
- Demonstrate collaboration between the NMATP and service providers with outreach events, training sessions, or materials distributed across the state.
- Increase number of older adults and caregivers receiving coordinated services through cross-program referrals and shared outreach activities.

**Objective 1.2 Implement Office of Alzheimer's and Dementia state plan to provide education, training and support for direct care workforce and caregivers.**



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## **Strategies**

- Update ALTSD's Office of Alzheimer's and Dementia Care State Plan for 2026 – 2029 to include strategies that meet the needs of local communities throughout New Mexico by gathering input from various internal and external stakeholders.
- Develop Alzheimer's and Dementia Care Advisory Council to provide subject expertise and guidance and inform office strategy and community needs.
- Gather input from internal and external stakeholders to train and educate direct care workers and caregivers and guide office strategies.
- Establish a standardized statewide data collection system to guide program planning and policy development. Identify and support evidence-based and tested training programs to train and education direct care workers and family caregivers that demonstrate effectiveness and share that information that is easily accessible to family caregivers.

## **Outcomes**

- Raise overall persons reached through outreach by 5% each year.
- Maintain advisory council structure with network and stakeholders.
- Expand reach to caregivers by 5% each year.
- Increase the number of caregivers accessing services (respite care, adult day care services, training, education)
- Increase public awareness on early signs of Alzheimer's
- Assess availability of county level data on Alzheimer's diagnosis and resources

## **Objective 1.3 Expand community supports, referrals, transportation and legal assistance with Title III B Supportive Services**

### **Strategies**

- Implement a Community Health Worker program to inform seniors of local resources for referral and outreach in appropriate internal and external programs.
- Collaborate across state agencies, local governing bodies, MCO and hospital services, and religious groups to support transportation services.
- Prioritize legal assistance in each planning and service area with Legal Developer input and oversight.
- Expand Care Companion Program volunteers in long term care facilities statewide to provide companionship to residents.

### **Outcomes**

- Increase access to transportation options every year, by legal percent required
- Increase legal assistance services in underserved areas.

- Train and certify 100% of the Community Health Workers as Long-Term Care Ombudsman and maintain a 75% retention rate year over year.
- Increase Care Companion volunteer opportunities

## **Objective 1.4 Reduce hunger, food insecurity, and malnutrition while promoting socialization and overall well-being. Title III-C Nutrition Services**

### **Strategies**

- Partner with AAAs and providers to expand meals to rural and identified gap areas.
- Implement grab-n-go meals services to consumers with behavioral health barriers.
- Expand in-house food pantries and food box availability for at-risk older adults and individuals with disabilities.
- Promote and develop nutrition education and “meal programming” with AAAs
- Establish pilot programs such as restaurants or grocery store vouchers to address food insecurity and related social determinants of health.
- Collaborate with AAAs, partner state agencies, and MCOs on value added benefits for older adult nutritional needs and those eligible or accessing SNAP, food box distribution, and senior farmers market vouchers.
- Senior Cafe model at health clinics to address gap in food services and socializing.
- Conduct statewide nutrition risk screening using standardized tools such as the DETERMINE checklist or Nutrition Screening Initiative in congregate and home-delivered meal programs.
- Increase access to nutritious meals through enhanced outreach to underserved populations, including rural communities, Tribal elders, and isolated older adults.
- Expand nutrition education and counseling services focused on healthy aging, chronic disease prevention, and culturally relevant dietary practices.
- Collaborate with Adult Protective Services staff to complete nutritional assessment of consumers and referrals for home delivered meals and referral process to AAAs.

### **Outcomes**

- Implement formal referral process for APS clients to AAA and direct service providers in year 1 this plan to reduce food insecurity.
- Improve other social determinants of health such as mental health, stress levels, social isolation, and community engagement.
- Evaluate cost-effectiveness, funding opportunities, and interest from local policymakers or community organizations to continue or scale up the model or pilot programs after the initial phase.



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- Reduce the risk and prevalence of malnutrition among older adults in New Mexico

## **Objective 1.5 Build infrastructure for Long-Term Care Division to align services and provide person-centered home and community-based services.**

### **Strategies**

- Establish organizational structure for LTC division including staff model and roles.
- Integrate home and community-based services technology to promote person-centered services and case management.
- Streamline operations to enhance process efficiency and customer experience.
- Enhance caregiver support to include Alzheimer's and dementia programming and support transitions from facility-based care back to the community.
- Conduct long-term care facility assessment report to analyze and assess quality of facility with aims to offer recommendations and strategies to improve quality.
- Establish and strengthen community partnerships, including with Tribes, Pueblos and Nations to improve access to home and community-based services programs including caregiver training, tools, respite and adult day care resources.
- Develop data system to track long-term care utilization, service gaps, and outcomes of those being served
- Increase long-term care caregiver workforce through career development
- Assess caregiver needs and resources with internal and external stakeholders
- Implement participant-directed, person-centered service planning to ensure clients are actively engaged in care planning decisions, supported by culturally responsive tools and guidance.

### **Outcomes**

- Improve caregiver knowledge and confidence through training and supports
- Include person-centered care models in ALTSD's HCBS programs.
- Increase the number of community partnerships formed with healthcare providers, community-based organizations, and advocacy groups.
- Reduce caregiver burnout, as measured by standardized tools.
- Data driven decision making and planning
- Create a caregiver action plan to address needs in year 1 of this plan
- Percent of participants with personalized care plan goals and meeting goals

## **Objective 1.6 Strengthen home and community-based supports (HCBS) and services**

### **Strategies**

- Expand HCBS services via the New MexiCare program, Veteran Directed Care Program,

and Care Transitions focused on older adult continuum of care.

- Develop strategies for long-term financial sustainability to include financial assistance to caregivers, respite care, adult day care, training, and resources.
- Partner with state agencies, Tribes, Pueblos and Nations, community organizations, and technical assistance partners to develop strategies to increase and retain caregiver workforce.
- Implement Care Transition Program via Community Care Corp to support older adults in underserved and rural communities transitioning from nursing facilities to homes with volunteer-based transportation, chore services, and companionship.
- Provide technical assistance under the Community Care Corp grant to Tribes, Pueblos and Nations interested in developing volunteer-based transportation programs.
- Integrate participant-directed care plan models into case management for HCBS.
- Integrate aging network services with ADRC and other HCBS programs
- Develop shared referral tools and electronic communication systems between AAAs and Medicaid HCBS providers.
- Provide ADRC personnel on cross-program eligibility/ service coordination training.
- Facilitate community-based options for older adults at risk of institutionalization
- Implement monthly targeted outreach to increase awareness of programs and provide service coordination for older adults who are community-dwelling and at risk of institutionalization and residents of nursing facilities who can transition home.
- Expand collaboration among nursing facilities, MCOs, PACE, Albuquerque Housing Authority, and AAAs for discharge planning and HCBS supports.

## **Outcomes**

- Increase New MexiCare program participants by 50% in first year of this plan.
- 10% participant growth each year in Veteran-Directed and Care-Transition program.
- 75% of caregivers in ALTSD self-directed care programs attend caregiver training.
- ALTSD caregiver plan created and implementation to start in year 2 of this plan.
- Administer Community Care Corps volunteer program and increase the number of volunteer hours supporting older adults, adults with disabilities, or caregivers
- Increase number of referrals between OAA and Medicaid HCBS services.
- Increase the number of training sessions or joint initiatives conducted.
- Increase number of successful transitions from facilities to home with HCBS.
- 90% of discharged nursing facility residents who do not return within 6 months

## **Objective 1.7 Strengthen and support New Mexico's direct care workers and caregivers across New Mexico**



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## **Strategies**

- Develop work group and partnership across state agencies including the HCA, Workforce Solutions, and the National Direct Care Workforce Strategies Center to identify and prioritize key actions to streamline efforts to support caregivers and direct care workers.
- With state agencies, community partners, including Tribes, Pueblos, and Nations, advocate for workforce development training, promote recruitment, and retention of direct care workers.
- With partners, advocate for improved wages, benefits, and career pathways for direct care workers and caregivers serving older adults.
- Coordinate Title III-E caregiver services with Lifespan Respite Care Program Align National Family Caregiver Support Program efforts with New Mexico's federally funded Lifespan Respite Care Program to improve access to respite services, adult daycare services, caregiver training, and referral systems.
- Promote training, referral systems between community partners, Tribes, Pueblos and Nations, self-directed caregivers, and respite providers.
- Coordinate with the Administration on Aging's National Technical Assistance Center to support Kinship Families
- Establish formal coordination with National Technical Assistance Center to share best practices, access resources, and enhance local kinship care program.
- Support kinship and grandfamily caregivers through outreach, support groups, legal assistance, referrals, and individualized care plans with goal setting.

## **Outcomes**

- In collaboration with state agencies, develop and present business case to promote and advocate to advance HCBS systems.
- Increase the number and accessibility of joint professional training for caregivers and direct care workers with community partners
- Expand the number of respite services available for caregivers and families, focused in rural and tribal communities.
- Launch pilot program in five counties over 3 years to increase access and the number of formal supports and referrals to kinship families.
- Document the number of grandparent/kinship caregivers served with specialized programs, legal support, or information/referral services.

## **Goal 2**

**Promote equity and well-being for older adults with greatest economic and social need across New Mexico by responding to social determinants of health, including food and housing security, social support and connection, employment and meaningful**



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**engagement, and access to information and health services.**

**Objective 2.1 Provide opportunities for consumers, caregivers, and providers to develop sustainable opportunities to address determinants of health within the Aging Network Division.**

**Strategies**

- Expand volunteer transportation program to new AAA non-metro counties
- Launch a pilot program for specialized pharmacy services to provide medication management, reviews, and consultation with a focus on needs of seniors.
- Assess feasibility of pilot program for mobile health services for seniors. The pilot may include check-ups, vaccinations, health screenings, support chronic conditions, and other preventive care.
- Develop partnerships with the NM Department of Veteran Services, hospitals, and new specialized passenger services to implement transportation of older adults to medical appointments.
- Provide technical assistance and training to NM's four AAAs, including Indian and Navajo AAAs, to broaden consumer base and implement a non-profit business, entrepreneur management structure with diverse services and funding streams.
- Crosstrain ALTSD staff to support consumers to provide integrated services.
- Collaborate across state agencies to address digital divide to apply various formats and languages to reduce barriers to receiving information.

**Outcomes**

- Increase transportation volunteers by 10% in each county every year of plan
- Implement at least two pharmacy pilot programs during three years of this plan
- Assess effectiveness of volunteers and pilot programs each year
- Increase the number of licensed and insured transportation passenger services
- Access to information with digital media in senior centers via SMART TVs and live information sharing.

**Objective 2.2 Improve coordination between the Senior Community Service Employment Program (SCSEP/Title V) and other Older Americans Act programs to enhance service integration and support economic security for older adults.**

**Strategies**

- Facilitate regular coordination meetings between Title V program staff and AAAs to align outreach, referral, and service delivery efforts.
- Develop shared training opportunities for Title V and OAA program staff to strengthen

cross-program understanding and collaborative case management.

- Expand training opportunities for older adults returning to the workforce in collaboration with NM Higher Education institutions.
- Implement senior employee liaison support into ALTSD programs
- In partnership with the Department of Workforce Solutions, quantify and qualify the economic impact this demographic contributes to both consumer spending and tax revenues.

### **Outcomes**

- Target a 10% change in older adults' enrollment in educational institutions in fields that require specific skills or certifications.
- Formulate collaborations higher education institutions and local employers, resulting in job opportunities for older adults.
- Increase number of referrals between SCSEP and OAA programs (e.g., nutrition, caregiver support, transportation).
- Improve employment and service outcomes for older adults through integrated support services.

### **Objective 2.3 Target services using standardized definitions of greatest economic and social need**

#### **Strategies**

- Adopt and disseminate standard definitions consistent with 45 CFR § 1321.3 across the aging network and integrate into AAA contracts, Area Plans, and service delivery policies.
- Provide training for AAA staff and providers to ensure consistent application in client assessments and outreach.

#### **Outcome**

- Increase the number of AAAs incorporating standardized definitions in local targeting plans. Provide training for AAA staff
- Increase the percentage of clients served who meet the criteria for greatest economic/social need.

### **Objective 2.4 Assess and address access barriers to expand service needs of older adults from rural, underserved, and culturally diverse communities, including LGBTQ communities, and adults living with chronic conditions, such as HIV/AIDS <sup>15</sup>**

## **Strategies**

- Review and align service planning with the focus areas of the FY19 OAA Title IV funded resource centers<sup>16</sup> (e.g., transportation, mental health, disabilities).
- Conduct regional needs assessments and stakeholder engagement with corresponding populations, including disability advocates, with Tribes, Pueblos and Nations, and community health workers to design and implement targeted outreach strategies.
- Prioritize linguistically and culturally competent materials to improve awareness and access.

<sup>15</sup> <https://acl.gov/programs/strengthening-aging-and-disability-networks/national-resource-centers>

<sup>16</sup> IBID

- Assess needs of LGBTQ older adults to improve access to services.
- Partner with state agencies, community partners, Tribes, Pueblos, and Nations, and local organizations to advocate, expand and enhance referral pathways.
- Conduct training to increase provider awareness of aging with chronic conditions and HIV-related needs.
- Expand use of mobile units, virtual service delivery, and community-based volunteers to reach rural and frontier areas.
- Replicate and share successful rural access models across regions.

## **Outcomes**

- Number of program modifications implemented based on assessment results.
- Increase the number of outreach events targeting populations reflected in underserved, rural, culturally diverse and historically marginalized communities.
- Number of innovative strategies to be implemented to increase rural access.
- Growth in service delivery to rural ZIP codes.

## **Objective 2.5 Address social determinants of health (SDOH) among high-need older adults including social isolation and health effects**

### **Strategies**

- Incorporate SDOH indicators into client assessments across AAAs.
- Expand service offerings to address housing, transportation, nutrition, social engagement, and digital inclusion.
- Provide training for staff and volunteers to recognize and respond to social isolation risk.
- Support engagement programs such as senior companion services, virtual classes, and intergenerational activities.

### **Outcomes**



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- Number of clients assessed for SDOH-related risk factors.
- Number and type of interventions provided to address SDOH needs.
- Increase the number of clients screened for social isolation.
- Increase the number of interventions implemented to promote social connection.

### Goal 3

**Reduce occurrences of abuse, neglect and exploitation while improving outcomes in communities and long-term care settings and preserving the rights and autonomy of older New Mexicans.**

**Objective 3.1 Expand Adult Protective Services to vulnerable adults to support access to services and provide resources.**

#### Strategies

- Expand transportation and in-home services, including personal care, homemaker assistance, meal delivery, respite care and emergency placements.
- Enhance legal aid partnerships to provide older adults with comprehensive support for guardianship issues, elder financial abuse, and property disputes, ensuring that legal barriers do not exacerbate existing challenges.
- Assess opioid misuse to focus on prevention, intervention, and support services to reduce the associated risks that lead to abuse, neglect, and exploitation.
- Combat isolation and foster social connectedness by collaborating with programs for social engagement, senior centers, and virtual connections to foster community involvement, emotional support, and volunteer companions.
- Strengthen financial exploitation prevention by collaborating with financial institutions to develop policies and procedures that identify and report financial exploitation of older adults.
- Create a proactive risk assessment tool to allow individuals to self-identify risk of abuse, neglect, or exploitation to integrate community resources, mental health services, and family engagement.
- Expand Multidisciplinary Teams to include ALTSD, law enforcement, health professionals, social workers, and legal experts to collaborate on complex cases to ensure a holistic response to addresses needs of individuals and communities.
- Upgrade to an integrated case management system to enhance tracking, reporting, and case prioritization.

#### Outcomes

- Implement a proactive risk assessment tool to screen at least 1,000 individuals within three years to identify risks of abuse, neglect, or exploitation and connect to appropriate

resources.

- In two years, each APS region will form an MDT with at least five new partners from fields such as healthcare, first responders, legal aid services, and senior services providers. Measured by attendance and meeting records.
- Within two years, APS will establish partnerships with at least five financial institutions to improve identification and reporting of elder financial abuse to mitigate financial abuse. Success measured by number of reports received by financial institutions and number of investigations completed and reports received.
- Within two years, 200 older adults will join in-person or virtual social programs, with at least 60% reporting increased well-being. APS will recruit 15-20 new volunteers to support these efforts and collaborate with public libraries and senior centers to host monthly community companion events. Assess monthly and yearly participants and number of events completed in a calendar year.

### **Objective 3.2: Grow the LTC Ombudsman volunteer program to one volunteer assigned per facility to supplement the staff Ombudsman facility responsibilities**

#### **Strategies**

- Expand and strengthen networks to recruit volunteers via collaboration with other ALTSD divisions, community partners, and local schools.
- Develop and maintain a volunteer training plan implementing updated training materials and resources.
- Create a volunteer retention plan to prioritize retention and recognition and support in-person, coordinated peer support with training opportunities with volunteer coordinator.
- Routinely gather feedback from volunteers and monitor recruitment and retention strategies for effectiveness and ongoing development.

#### **Outcomes**

- Participate in at least four community events a month for volunteer outreach and recruitment by Ombudsman team.
- Increase number of volunteers by at least 25% each year.
- Raise the number of weekly volunteer visits by 25%.
- Target a 50% retention of new volunteers.

### **Objective 3.3 Enhance systems and supports to mitigate abuse, neglect, exploitation for vulnerable adults**

#### **Strategies**

- Increase APS funding for emergency placement and related home services including personal care, chore assistance, meal delivery, and respite care.

- Establish a Mobile Behavioral Health and Nurse Response Team to address high-risk self-neglect cases and provide immediate intervention for at-risk seniors and to assess cases needing placement and guardianship.
- Strengthen partnerships with community organizations (e.g., food banks, senior centers, and home modification programs) to improve resource accessibility.
- Expand investigative caseworker staffing statewide to enhance response capacity to a growing aging population.
- Leverage technology to improve resource navigation, referrals, and service coordination.
- Increase transportation access for APS clients in rural areas.

### **Outcomes**

- Over three years, APS will expand access to in-home services, including personal care, homemaker assistance, meal delivery, and emergency placements by 20%, as funding allows. Progress will be tracked through service utilization data, number of individuals served, and funding changes
- Within three years, APS will launch mobile behavioral health and nurse response teams in at least two high-need areas (areas will be identified by highest reports of self-neglect) to provide immediate help in high-risk self-neglect cases. Outcomes will include the number of clients assessed and stabilized, faster response times and fewer repeated self-neglect reports.
- APS will increase investigative caseworker staffing by 10% statewide within three years to improve responsiveness to the growing aging population. This will be measured by new hires, changes in caseload distribution, and improvements in response time to 100%.
- A digital resource navigation and referral system will be created within three years to help APS clients better access services. Success measured by referral counts and reduced reports of service gaps.

### **Goal 4**

#### **Assist Tribes, Pueblos and Nations in accessing Title III funding and enhance coordination between Title III and Title VI programs**

#### **Objective 4.1: Analyze current Title III/Title VI systems and develop recommendations to improve access and coordination.**

### **Strategies**

- Hire a TPN consultant to conduct an analysis and develop recommendations with the input from Tribal stakeholders, including Tribal elders, Title VI Coalition, NM Indian Council on Aging, existing providers, AAA's and the ALTSD Policy Advisory Board, among others.

- From a tribal advisory workgroup.
- Map and assess current funding, age requirements, provider capacity and readiness, and service delivery landscapes.
- Review best practices and collect appropriate qualitative and quantitative data to inform the planning.
- Present findings and recommendations on a new Title III service delivery mechanism to Tribal stakeholders for final review and input.
- Integrate recommendations into State Plan and/or State Plan amendments.

### **Outcomes**

- Improved partnership with Tribal stakeholders, better coordination between Title III and Title VI programs and ongoing planning that reflects the unique legal and political status of TPNs and tribal citizens.

### **Objective 4.2 Improve communication and outreach regarding Title III opportunities**

#### **Strategies**

- Conduct stakeholder analysis to tailor messaging and outreach methods
- Develop a multi-channel communications plan
- Create a centralized Title III information hub that includes Title III allocations to NM Tribes.
- Customize materials
- Establish feedback loops to improve communication effectiveness

#### **Outcome**

- Expanded outreach efforts resulting in improved effectiveness and efficiency in TPN's access to Title III funding.

### **Objective 4.3: Address and develop opportunities for tribal providers to apply and access Title III funding and provide Title III core program sources.**

#### **Strategies**

- Develop and disseminate a culturally appropriate funding opportunity guide.
- Provide technical assistance workshops to support Title VI providers in understanding eligibility, application processes, partnership opportunities, etc. for accessing Title III funding.
- Provide sample reporting tools and access to peer learning sessions to support compliance.
- Based on Title III/Title VI analysis and stakeholder input, develop Title III funding

mechanism and management processes.

- Provide support and training of Title III compliance and reporting requirements, and core program services benefiting elders, with a focus on those with the greatest economic and social needs, in efforts to support independent living within communities. These services may include nutrition programs, senior center or adult day care operations, caregiver support, health promotion and disease prevention, transportation or legal assistance.

### **Outcomes**

- Establish a process for the New Mexico Tribes, Pueblos and Nations interested in applying for Title III funding.
- Establish at least three ongoing collaborative networks (e.g., regional forums, advisory councils, or peer support groups) that engage tribal providers in regular dialogue and knowledge-sharing.

### **Objective 4.4: Strengthen coordination between Title III and Title VI programs to promote equitable access and service delivery for American Indian Elders**

### **Strategies**

- Implement and sustain a Tribal consultation and coordination process and continue regular meetings with Title VI program directors and Tribal AAAs.
- Enhance outreach and communication between Title III AAAs and Title VI programs by developing outreach materials and expanding access to information through newsletters, webinars, and public forums in both Title III provider centers and Tribal provider centers.
- Build referral pathways and establish shared protocols for coordination between Title VI, Title III and state general funded programs.
- Increase participation of Title VI representatives in advisory councils, public hearings, and planning workgroups to elevate tribal perspectives in service planning and oversight.
- Ensure future services provided under Title III and related programs are culturally appropriate and offer training to providers to support integrating traditional knowledge into service models.
- Require AAAs to develop and implement targeted outreach plans for older Native Americans residing off reservation, in coordination with Title VI programs, Tribal partners and stakeholders.
- Incorporate feedback from Tribal consultation into state planning and resource allocation to identify service gaps and support programmatic integration.

### **Outcomes**



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- A consistent and respectful Tribal Consultation process is implemented.
- Communication and coordination between Tribal and non-Tribal AAAs are strengthened.
- Increased awareness and access to Title III and VI services for Tribal providers, American Indian elders and caregivers.
- Increased network and referral systems established between Title VI and Title III programs.
- Tribal voices are actively included in participation, planning and oversight.
- Satisfaction with services among Tribal elders and caregivers improves and tribal provider services provision are supported both on and off reservations.