New Mexico Aging and Long-Term Services Department
Office of Alzheimer's and Dementia Care

Needs Assessment, Inventory of Existing Services, and Recommendations for New Mexico's Roadmap to Address Dementia and Brain Health

ASPEN SOLUTIONS

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New Mexico Aging and Long-Term Services Department
Office of Alzheimer's and Dementia Care
Needs, Inventory, and Recommendations Report

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List of Acronyms

- AAA = Area Agency on Aging
- ACL = (Federal) Administration for Community Living
- ADOD = Alzheimer's Disease and Other Dementias (used interchangeably with ADRD)
- ADRC = (New Mexico) Aging and Disability Resource Center
- ADRD = Alzheimer's Disease and Related Dementias (used interchangeably with ADOD)
- ALTSD = (New Mexico) Aging and Long-Term Services Department
- APS = (New Mexico) Adult Protective Services
- BOLD = Building Our Largest Dementia (Infrastructure)
- BRFSS = Behavioral Risk Factors Surveillance System (CDC)
- CDC = Centers for Disease Control and Prevention
- DALTCS = (Navajo Nation Department of Health) Division of Aging and Long-Term Care Supports
- DHI = (New Mexico) Division of Health Improvement
- IAAA = Indian Area Agency on Aging
- LPN = Licensed Professional Nursing
- MCO = Managed Care Organization
- NAPA = National Alzheimer's Project Act
- OADC = (New Mexico) Office of Alzheimer's and Dementia Care
- OIEA = (New Mexico) Office of Indian Elder Affairs
- PACE = Program of All-Inclusive Care for the Elderly
- UNM = University of New Mexico

I. Defining Alzheimer's Disease and Other Dementias

Dementia is a collection of symptoms associated with a decline in memory, reasoning, language, and other thinking skills. There are several distinct conditions that cause dementia, but many include a harmful build-up of proteins in the brain, and all cause damage to parts of the brain such as neurons, brain tissue, blood vessels, nerve cells, etc. Although there are several types of dementia, Alzheimer's disease dementia is the most common, accounting for 60 to 80% of cases.[1] Other dementias include Parkinson's disease dementia, other Lewy body dementias, LATE dementia (limbic-predominant age-related TDP-43 encephalopathy), frontotemporal dementia, vascular contributions to cognitive impairment and dementia, mixed dementias (such as Alzheimer's disease dementia mixed with cerebrovascular disease or Lewy bodies), Hippocampal Sclerosis, and more.

The course of dementia, especially Alzheimer's disease, spans many years, sometimes decades. Initially, changes in the brain result in no noticeable symptoms. In more than 90% of people with Alzheimer's disease and other dementias (ADOD), symptoms do not appear until after age 60.[2] In rare cases, known as "early-onset" or "younger-onset" dementia, people develop symptoms in their thirties, forties, or fifties. Most people with Down syndrome develop Alzheimer's dementia at an earlier age, with significant levels of the protein clumps that cause Alzheimer's (beta-amyloid plaques and tau tangles) in their brains by age 40.[3] The risk of developing dementia is higher among people from racial and ethnic minority populations. Hispanic and Latino Americans are 1.5 times as likely to develop ADOD compared to White Americans[4,5], and more than half (54%) of American Indian and Alaska Native people over the age of 70 experience cognitive impairment.[6]

Regardless of when symptoms appear, the changes in the brain that cause dementia are thought to begin twenty years or more before the symptoms. During those years, the brain compensates for changes by using alternate networks of neurons that enable people to continue to function normally. When the brain can no longer compensate, symptoms that interfere with a person's ability to perform everyday tasks begin. Eventually, the ability to carry out basic functions, such as walking and swallowing, are also affected. In the final stages of Alzheimer's and other diseases that cause dementia, individuals often require twenty-four-hour care.[1]

The causes of ADOD are not completely understood but researchers believe they include a combination of genetic, environmental, and lifestyle factors.[1] While there are treatments available to help relieve symptoms, and two that change the underlying biology of Alzheimer's and slow disease progression, no proven cure for Alzheimer's has yet been identified.[1] However, growing evidence supports healthy behaviors, such as preventing traumatic brain injury, not smoking, healthy eating, exercise, educational attainment, social and cognitive engagement, controlling hypertension, maintaining cardiovascular health, getting enough sleep, reducing hearing loss, controlling diabetes, and reducing exposure to air pollution may reduce the risk of brain health decline and dementia or delay the onset of dementia symptoms.[1]

II. Executive Summary

The New Mexico Office of Alzheimer's and Dementia Care (OADC), within the Aging and Long-Term Services Department (ALTSD), commissioned a meta-needs assessment and statewide inventory to better understand existing dementia-related services, organizational capacity, workforce readiness, and unmet needs. This report synthesizes epidemiological data, recent needs assessments, and stakeholder input to identify gaps, priorities, and opportunities for strengthening dementia-related services statewide. The inventory included 125 organizations serving people living with ADOD and their caregivers across urban, suburban, rural, and Tribal communities in New Mexico. Interviews with subject matter experts were conducted to gain deeper insights about the initial analysis of the inventory. Interviewees included eleven experts across aging services, Medicaid, long-term care regulation, advocacy, and community-based service systems. Additional information on evidence-based and best practices were gleaned from other state and national plans.

Findings highlight that ADOD represent a growing public health crisis in New Mexico, with rising prevalence, significant caregiver burden, high costs to Medicaid and Medicare, and pronounced disparities affecting rural, Tribal, and culturally diverse communities. The findings provide a snapshot of the current dementia care landscape and offer critical insights to inform state planning, policy development, and future investments.

While the state has made meaningful progress through coordinated planning, caregiver programs, and public awareness efforts, recent needs assessments consistently identify persistent gaps in access to services, particularly caregiver support, respite, in-home care, transportation, legal and financial planning, and dementia-capable workforce capacity. These challenges are most acute in rural, frontier, Tribal, and culturally diverse communities, where service availability, staffing shortages, and information barriers are pronounced. Across stakeholders, there is strong alignment on the need for improved service coordination and navigation, culturally responsive and non-digital information pathways, expanded workforce training, and sustainable policy solutions. Collectively, these findings underscore the importance of a comprehensive, equity-focused state roadmap that strengthens services, supports caregivers, builds workforce capacity, and aligns New Mexico's efforts with national dementia and healthy brain frameworks.

Key Findings

Overall, the data reflect a system with broad service availability and commitment among providers, but one that is increasingly constrained by workforce shortages, limited capacity for high-intensity services, and uneven access across geography. Organizations and state-level departments demonstrated readiness to collaborate and innovate, yet consistently emphasized the need for clearer coordination, sustainable funding, and practical implementation supports.

Direct Services

1. Core services such as assisted living and residential care, and medication management were available but operating near or at capacity, with fewer than half of providers able to accept new clients. Interviews with subject matter experts emphasized the limited availability of assisted living facilities particularly for Medicaid recipients.
2. Community-based services such as transportation, meals, adult day services, medical care, behavioral/mental health supports, and home health aides, showed greater capacity and

represented opportunities to support aging in place and prevent crises. Interviewees suggested leaning on existing models like the VA rideshare and utilizing care coordinators to connect individuals with Meals on Wheels and other critical services.

3. Legal and financial assistance services were less common but often had unused capacity, suggesting underutilized supports that could be better integrated into care navigation. Interviews and expert input emphasized the need for earlier estate planning and legal directives.

Workforce Development

1. Qualified caregivers were identified as the top workforce need in the inventory as well as from aging services experts.
2. Training was widely offered by survey respondents but varied in depth, frequency, and consistency; barriers included staff shortages, turnover, time, and compensation. Interviewees noted other barriers to training mandates that were not previously supported by funding or adequate follow-up.
3. Higher wages and compensation were the most frequently cited strategies for improving retention, followed by skill development and supportive workplace culture. Interviews also suggested the necessity for clearer career pathways for growth and promotions in the field.

Caregiving Supports

1. Most organizations offered multiple caregiver supports, including respite, education, counseling, and support groups.
2. Overnight respite and day services were critical gaps. These services were offered but organizations reported a low capacity to accept new clients, placing caregivers at high risk of burnout. Interviews reiterated this and suggested using models such as the Hero's Path Palliative Care for overnight respite for families with children.
3. In-home respite, counseling, personal care services, and support groups had slightly higher capacity and may serve as effective early-intervention supports. Experts supported the expansion of respite vouchers through New MexiCare and other methods.
4. Financial assistance and respite vouchers were limited in availability but showed strong potential to expand where offered.

Public Education and Awareness

1. Public education was inconsistent statewide; over 40% of organizations who responded to the inventory survey reported offering none.
2. Top needs included clear, easy-to-find information about dementia, guidance on steps to take after diagnosis, and early detection and diagnosis.
3. Rural and Tribal organizations reported greater unmet need for general dementia awareness and education yet a readiness to offer creative and community-derived solutions.

Government Policy and Sustainability

1. Top priorities for state action included funding for community-based organizations, training, and pilots, and dementia-friendly community development.
2. Organizations completing the survey and interviews with content experts emphasized that funding must be paired with simplified processes, technical assistance, and cross-agency coordination.

3. Other needs and suggestions included the need for preparation for Medicaid and Medicare changes, training for first responders on ADOD, and improved data collection and disease surveillance.

New Mexico has a strong foundation of dementia-related services and committed providers, but growing demand is straining capacity, particularly in residential care, respite, and the workforce. Targeted state leadership focused on early intervention, caregiver stabilization, workforce development, public education, and coordinated policy action, especially in rural and Tribal communities, will be essential to strengthening a dementia-capable system statewide.

III. Recommendations

This section presents recommendations based on the findings of several components of this report: 1) statewide data related to people living with ADOD and caregiving in New Mexico, 2) a meta-analysis of recently conducted New Mexico needs assessments related to ADOD, 3) the results of the 2025 survey of existing services and needs of people living with ADOD and their caregivers, and 4) a review of key strategies at the national and state levels. It is divided into two sections: recommendations for the New Mexico Roadmap for ADOD, and recommended considerations for pilot programs in New Mexico. Recommendations for the roadmap align with the goals of national initiatives such as the National Plan to Address Alzheimer's Disease (2024 Update), the Healthy Brain Initiative State and Local Road Map (2023-2027) and corresponding "Building Our Largest Dementia" (BOLD) Infrastructure grant, and the National Strategy to Support Family Caregivers (2022). They are organized around five goal areas identified by ALTSD: direct services, workforce development, caregiving supports, public education and awareness, and government policy and sustainability. A summary of the needs to which each set of recommendations responds precedes the recommendations.

New Mexico's Roadmap to Address Dementia and Brain Health

I. Direct Services

1. Availability of affordable residential care and assisted living and memory care facilities is a big gap, especially in rural and Tribal areas. There have been closures, especially of smaller home assisted living models, since the COVID pandemic. Additionally, insurance costs are increasing and there are a finite number of facilities that work with Medicaid recipients.

   Recommendations

   a. Provide incentives for facilities to open more beds or ADOD wings for Medicaid recipients who otherwise could not afford the facilities.
   b. Offer grants to assisted living facilities for remodeling facilities, offering expanded transportation services to members, and other operational needs – allowing staff to focus energy on their residents.
   c. Offer advanced training for facilities interested in admitting more complex patients/residents, paired with sufficient reimbursement amounts. Facilities need to be compensated for the extra care required for these residents.

d. Develop or strengthen a real-time escalation process for complex cases to support facilities. Maintain a team of professionals to provide emergency care consultation, or a complex discharge group to support care for these patients.

2. Rural and Tribal areas often face more pronounced challenges in accessing medical care, behavioral health services, and other supports due to long distances to medical centers, transportation challenges, and lack of qualified personnel in rural areas.

   Recommendations

   a. Telehealth expansion could provide broader access to neurologists, geriatricians, psychiatrists, psychologists and other medical services for diagnosis and treatment. Consider partnering with Presbyterian and UNM which have integrated telehealth systems.
   b. Implement a ride share program for people with dementia using the VA rideshare model as a guide.
   c. Support dementia care specialists or navigators to arrange community services such as Meals on Wheels, applying for assistance, finding appropriate medical or other services, transportation, and senior center services.
   d. Consider developing at least one facility that specializes in behavioral health and complex conditions. Having all staff fully trained and co-located in one facility provides more seamless care for individuals with complex diagnosis or conditions, and allows for better monitoring of methadone and other medication assisted treatments.

II. Workforce Development

1. Persistent workforce shortages threaten dementia-capable care statewide. These shortages expand across the dementia care continuum, including direct care workers, respite providers, and specialized clinicians (e.g., neurologists, geriatricians). Capacity gaps are most severe in rural and Tribal communities and contribute to delayed diagnosis, caregiver burnout, and inappropriate institutional placement or discharge.

   Recommendations

   a. Treat dementia care as a recognized specialty, not a general skill. Develop dementia-specific credentials tied to wage differentials and create advanced training pathways so providers can serve higher-acuity residents safely.
   b. Use financial incentives to stabilize the workforce by enhancing reimbursement rates for dementia-trained caregivers, and/or offering tuition assistance or loan forgiveness for clinicians committed to elder/dementia care in New Mexico.
   c. Position workforce investment as a cost-containment strategy, reducing reliance on higher-cost institutional care.
   d. Direct culturally responsive efforts toward rural and Tribal areas, offering workforce development incentives and/or co-developing resources with rural and Tribal partners.
   e. Expand funding for more accessible pathways to nursing, such as the Licensed Professional Nursing (LPN) program.

2. Training requirements exist but are fragmented and difficult to implement. While dementia training is required in some settings, implementation is inconsistent. Trainings are often too advanced for frontline staff, lack a clear approval authority, or are unfunded. Facilities reported

limited capacity to pursue even small grants or training opportunities, leaving state and federal dollars unused.

Recommendations

a. Establish a comprehensive, state-approved, person-centered dementia training framework where ALTSD designates tiered, role-appropriate trainings, and consider working with the Division of Health Improvement (DHI) to enforce competency expectations during licensure and surveys.
b. Make training feasible, not just mandatory. This could be done through paid training time, incentives for completion, and/or integration into onboarding and continuing education.
c. Consider developing a centralized training hub usable by Managed Care Organizations (MCOs), providers, and community partners, and/or integrating dementia training modules into existing training curriculum offered by agencies.

3. Caregiving oversight and workforce development strategies seem fragmented across multiple departments and systems. Caregivers often operate across multiple programs (Medicaid, Aging, DD waivers), with inconsistent standards for training, background checks, and oversight. There is no single coordinating entity responsible for caregiver policy and workforce development.

Recommendation:

a. Create a centralized caregiver strategy and oversight body at the state level. This would help align training, auditing, and background check standards across programs, and elevate caregiving as a core workforce priority tied to system sustainability.

III. Caregiving Supports

2. Families feel overwhelmed and unsupported, especially just after a diagnosis. They frequently report feeling "lost," following a dementia diagnosis, struggling to navigate services, complete applications, and identify appropriate supports. Cultural, linguistic, transportation, and digital barriers compound these challenges, particularly for rural and Tribal families.

Recommendations

a. Expand state-supported navigation that complements Alzheimer's Association services to provide immediate care coordination or navigation by dementia care specialists following diagnosis.
b. Develop and promote the use of a closed-loop referral systems to help with care coordination.
c. Develop a robust, centralized repository of services and resources for families, in which individuals can learn about services in their area and access education resources.
d. Develop culturally grounded, multi-lingual caregiver education. For Tribal areas, use Tribal values and community practices to inform education resources.
e. Enhance financial literacy and preparedness by including legal and advanced care planning in caregiver training.

3. Respite care is the most urgent and consistent caregiving gap. Experts unanimously identified respite as a critical unmet need. New Mexico has extremely limited dementia day programs and insufficient in-home and overnight respite options. Even minimal respite (e.g., one day per week) was described as life-changing for caregivers.

Recommendations

a. Promote education and awareness of caregiving as a behavioral and physical risk factor, and the importance of respite and support for wellness.
b. Expand the New MexiCare program, prioritizing in-home respite as the preferred model and focusing expansion in rural and Tribal communities. Pair respite expansion with workforce training and reimbursement strategies.
c. Provide vouchers for people to get trained in respite and to provide respite services for individuals who cannot afford private pay day centers and other services.
d. Expand dementia-capable adult day health programs, including Tribal-led models.
e. Explore overnight or short-term respite options to prevent crises and institutionalization.
f. Expand transportation services to respite centers and programming. Consider implementing a ride share program for people with dementia using the VA rideshare model as a guide.

4. Home-based caregiving requires practical, low-cost supports. Families need assistance with home safety modifications, monitoring tools, and technology that supports aging in place, especially in rural areas where caregivers must work outside the home.

Recommendations

a. Offer one-time home safety vouchers, toolkits, and funding for non-medical technologies (e.g., sensors, alarms, remote monitoring). Align these supports with existing Medicaid and Aging programs.
b. Enhance care transition programs for people transitioning home from rehabilitation, the hospital, or acute care.

IV. Public Education and Awareness

1. A coordinated, lifespan-oriented prevention framework is needed for broader public awareness related to ADOD. Interviewees emphasized that dementia prevention is not adequately framed as a lifelong brain health issue. Current efforts focus heavily on older adults, missing opportunities for early and midlife risk reduction related to cardiovascular health, diabetes, substance use, head injury, physical activity, education, and social connection.

Recommendations:

a. Establish a statewide, lifespan-oriented brain health prevention framework that aligns aging, public health, behavioral health, and chronic disease initiatives.
b. Integrate brain health into school-based curriculum/programs for children and young adults, including risk and protective factors.
c. Integrate dementia risk-reduction messaging into existing public health campaigns (e.g., heart health, injury prevention, substance use prevention).
d. Promote prevention as both individual behavior change and community-level responsibility, emphasizing social connection, education, and access to care.

2. Consistent, actionable, and hope-oriented public education is lacking. Public awareness efforts were described as fragmented, episodic, and inconsistent, often dependent on short-term funding or only during national public awareness months on dementia. There is widespread public confusion about normal aging versus dementia, when to seek help, and available resources. Fear-based messaging and stigma continue to discourage early engagement.

Recommendations:

a. Develop and maintain a centralized, statewide public education strategy with consistent, evidence-based messaging that includes non-digital pathways.
b. Advance awareness of early detection and cognitive screening, especially for those at risk of younger onset ADOD, and those with Down syndrome, traumatic brain injury, or a developmental disability.
c. Emphasize practical, action-oriented guidance that highlights modifiable risk factors and "what people can do now."
d. Explicitly address stigma by normalizing conversations about brain health, memory concerns, and early planning.
e. Ensure materials clearly outline next steps, including when and where to seek information, screening, or support.

3. Culturally responsive outreach through trusted community channels would be beneficial throughout New Mexico. Experts stressed that generic, one-size-fits-all materials are ineffective, particularly in rural, Tribal, and culturally diverse communities. Language access, cultural relevance, and trust were identified as central to successful prevention and awareness efforts. Community-based settings were viewed as underutilized but critical points of engagement.

Recommendations:

a. Co-develop prevention and public awareness materials with Tribal nations, community-based organizations, and culturally specific partners.
b. Move beyond translation to ensure messaging is culturally grounded and linguistically appropriate, including Spanish-language and Tribal-specific approaches.
c. Invest in dissemination through trusted community settings and messengers, such as community health workers, faith-based organizations, libraries, senior centers, and Tribal gatherings.
d. Support local partners with training, mini-grants, and adaptable toolkits to deliver prevention messaging effectively.

V. Government Policy and Sustainability

1. The state has an obligation to support sustainable goals and outcomes, which rely upon quality research and sound policy development. Top priorities for state action identified in the inventory and interviews included funding for community-based organizations, simplified processes for funding allocation, training and technical assistance, dementia-friendly community development, and data informed decision-making.

Recommendations:

a. Expand research for prevention, diagnosis, treatments, and ultimately a cure. Invest in data surveillance systems, research, and innovation to develop new treatments, interventions, and caregiving approaches and foster collaboration among universities and researchers, health care professionals, and community stakeholders.
b. Build and maintain collaborative public health partnerships, like the Dementia Task Force, and include federal, state, local, and Tribal agencies, healthcare providers, community-based organizations, policymakers, and academic institutions to strengthen capacity and

apply for funding (such as the Centers for Disease Control and Prevention (CDC) "Building Our Largest Dementia" (BOLD) Infrastructure grant).

c. Use data and research to guide decisions, inform policy, and measure outcomes. Support frequent implementation of the Behavioral Risk Factor Surveillance System (BRFSS) optional modules for cognitive decline and caregiving and/or develop a data collection instrument specific to ADOD and Parkinson's.
d. Advance health equity by focusing on disproportionately affected communities. This could include expansion of telehealth and virtual resources for family caregivers in rural and under-resourced communities, focusing on diverse and underserved communities in public health education campaigns, and workforce incentives for placement in rural areas.
e. Prepare for Medicaid and Medicare changes and provide information and support to older adults such as availability of cognitive screening and assessments, annual wellness visits, and cognitive impairment planning through Medicare.
f. Consider developing a dementia-specific waiver for people who meet financial criteria and demonstrate a level of cognitive decline to support costs related to treatments, caregiving, assisted living, and other services to allow individuals to age in place longer.
g. Make Parkinson's explicit in policy language, funding eligibility, and best-practice guidance to strengthen visibility, access, and impact. Since services for people with ADOD are often parallel to services for people with Parkinson's, New Mexico has opportunities to formally recognize movement and sensory-based activities as Parkinson's-supportive best practices, support caregivers of people with Parkinson's, and implement other best practices.

Considerations for Pilot Programs in New Mexico

1. Dementia-Capable Respite Workforce Pilot: Train and certify local respite providers (including older adults seeking part-time work) with paid training and wage incentives, focused on rural and Tribal communities.
2. Senior Center Resource Coordinator and Respite Pilot: Fund dementia resource coordinators at senior centers or other locations and incentivize centers to offer limited respite services, integrated with referral navigation.
3. Closed-Loop Dementia Referral and Navigation System Pilot: Develop and train providers on use of a HIPAA-compliant statewide portal allowing families to submit a request and receive coordinated follow-up from multiple agencies.
4. Home Safety and Technology Micro-Grant Program Pilot: Provide small grants or vouchers for safety modifications, monitoring tools, and assistive technologies that support aging in place.
5. Complex Dementia Care Consultation / Escalation Team Pilot: Develop and maintain a multidisciplinary team, or regional teams, to support facilities and hospitals in managing high-acuity dementia cases and preventing unnecessary discharges.
6. Expand Telehealth Options Pilot: Support connections with neurologists, psychiatrists, and other mental health and nursing experts, from other states if needed, to provide telehealth services specifically for people with ADOD and for those in rural areas.

IV. State of Alzheimer's Disease and Other Dementias in the United States

People Living with Alzheimer's Disease and Other Dementias

Dementia is a growing public health crisis in the United States. Unless a preventative treatment or cure is identified, the number of Americans with ADOD will increase significantly in the coming years. The number of Americans aged 65 and older living with Alzheimer's dementia is predicted to increase from 7.2 million to nearly 12.7 million in 2050 (this does not include other dementias).[1] Moreover, the U.S. Census Bureau estimates the number of Americans aged 65 and older will almost double to 84 million by 2050. Because the prevalence of people living with ADOD doubles for every five-year period after age 65, the growth in the older population will likely result in a substantial increase in the number of people who will be living with ADOD.[7] Although screening and early diagnosis methods have improved,[7] it is estimated that more than half of people living with dementia are either undiagnosed by their healthcare providers or unaware of their diagnosis.[8]

Caregivers/Care Partners of Those Living with Alzheimer's Disease and Other Dementias

Eighty-three percent (83%) of the help provided to older adults in the United States comes from family members, friends, or other unpaid caregivers,[9] and almost half of all unpaid caregivers (48%) who provide care for older adults do so for an individual with Alzheimer's or another dementia.[10] Nearly 12 million Americans provide unpaid care for people living with ADOD and, in 2024, their care totaled an estimated 19.2 billion hours, valued at more than $413 billion.[1] Significant emotional, physical, and financial stress is placed on individuals with ADOD and their family members. Unpaid caregivers, often family members and friends, provide the majority of care for people with ADOD. The intensive level of care required can negatively impact the caregivers' emotional and physical health, and their ability to engage in paid work. Unpaid caregivers often report symptoms of depression and anxiety, and have poorer health outcomes than those who do not provide such care.[1,11] Hispanic, Black, and Asian American dementia caregivers use less outside/formal services, and report greater depression compared to White caregivers.[1] Furthermore, cultural values such as the "Latino cultural value of putting family needs and loyalty to one's family above one's own needs," (Alzheimer's Association Facts and Figures, 2025, p. 51) may also impact disparities in perceptions and use of outside resources among caregivers.[12, 13]

Cost of Care for Those Living with Alzheimer's Disease and Other Dementias

Additionally, dementia care costs are significant. In 2025, health and long-term care costs for those living with ADOD cost the United States an estimated $384 billion, a number that, without rapid advances in treatment, is projected to rise to almost $1 trillion by 2050. This includes significant increases in government spending through Medicare and Medicaid and out-of-pocket expenses.[1] The total lifetime cost of care for a single individual with dementia has been estimated at $405,262 in 2024 dollars.[14] Seventy percent (70%) of this cost is shouldered by family caregivers in the forms of unpaid caregiving and out-of-pocket expenses, and much of the remaining costs are covered by Medicare and Medicaid.[1,14] These costs may not fully account for the financial impacts on families associated with family caregiver/care partners' health, work productivity, and more.[15]

V. State of Alzheimer's Disease and Other Dementias in New Mexico

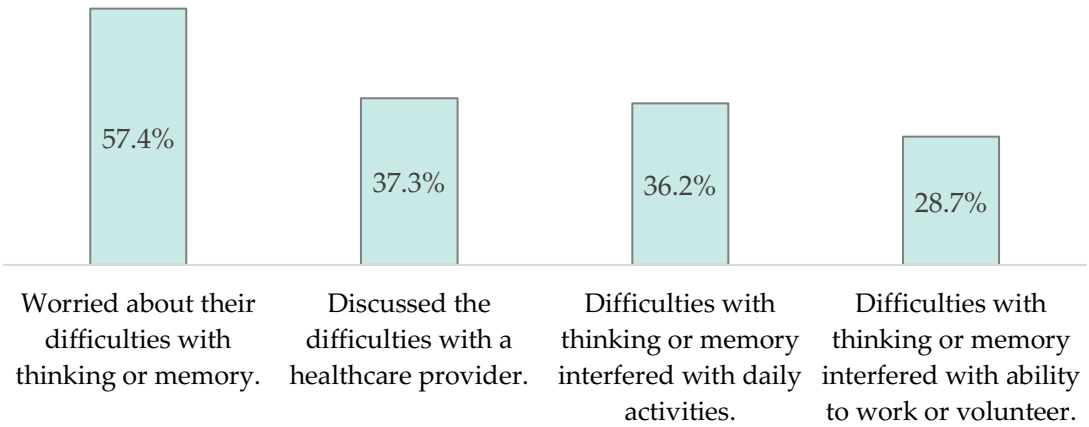
Like in the greater United States, Alzheimer's disease is a growing public health crisis in New Mexico, and the impacts are projected to rise.

People Living with Alzheimer's Disease and Other Dementias

According to 2020 data from the Alzheimer's Association, 46,000 people aged 65 and older (11.8%) are living with Alzheimer's disease in New Mexico (and this does not include other dementias). Additionally, in 2023, 20.2% of New Mexicans aged 45 and older experienced subjective cognitive decline,[16] meaning they reported experiencing difficulties with thinking or memory that increased in frequency and/or severity over the previous twelve months. Of those who reported subjective cognitive decline, 57.4% were worried about the difficulties but only 37.3% had discussed the difficulties with a healthcare provider. About 36% reported the difficulties interfered with daily activities and 28.7% reported the difficulties interfered with their ability to work or volunteer.[16] Alzheimer's Disease was the eighth leading cause of death in New Mexico in 2023.[17] In 2022, 733 New Mexicans died from Alzheimer's disease, a 166.5% increase since 2000.[1] Costs associated with ADOD are significant in the state. Annually, $303 million of Medicaid costs are related to Alzheimer's disease only, and per capita, $28,143 of Medicare spending is on people living with Alzheimer's or another dementia.[1]

Adults with Cogntive Decline Expressed Concern About Their Memory, Thinking, and Daily Activities

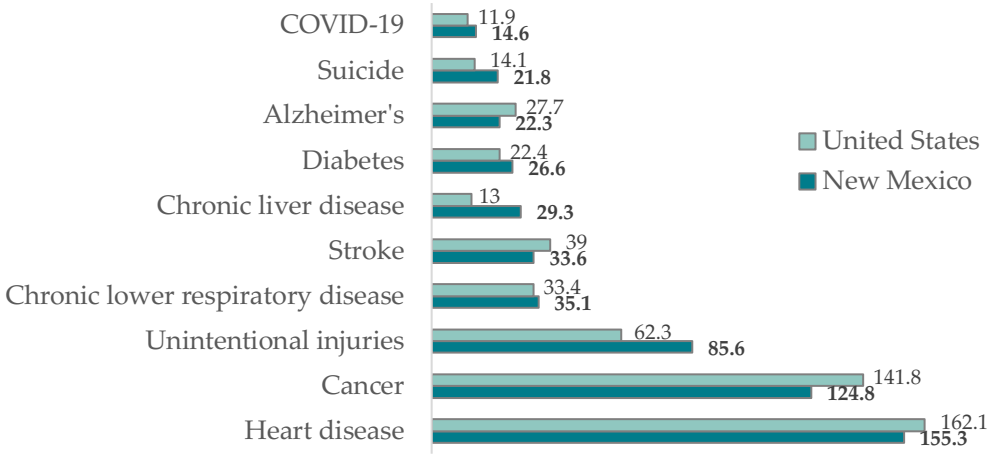
Source: Behavior Risk Factor Surveillance System - NM 2023



Alzheimer's Disease was the Eighth Leading Cause of Death in New Mexico in 2023

Death Rate per 100,000

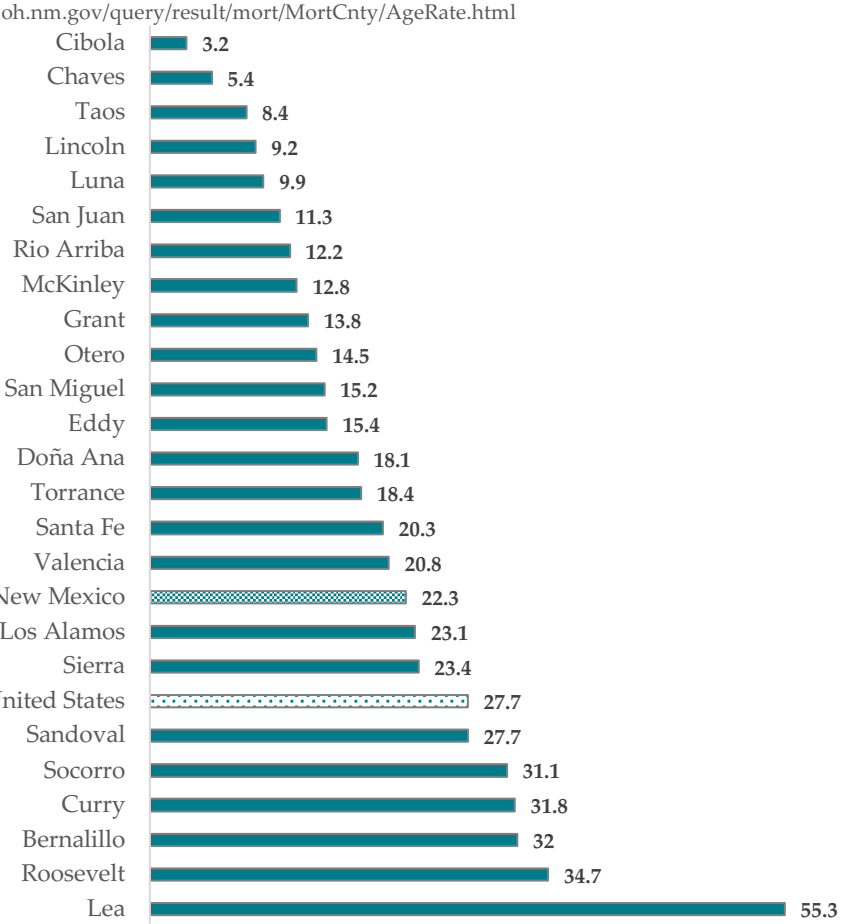
SOURCE: https://ibis.doh.nm.gov/indicator/view/DthRateLdgCause.Cause.html



Alzheimer's Disease Death Rate by *County in NM in 2023

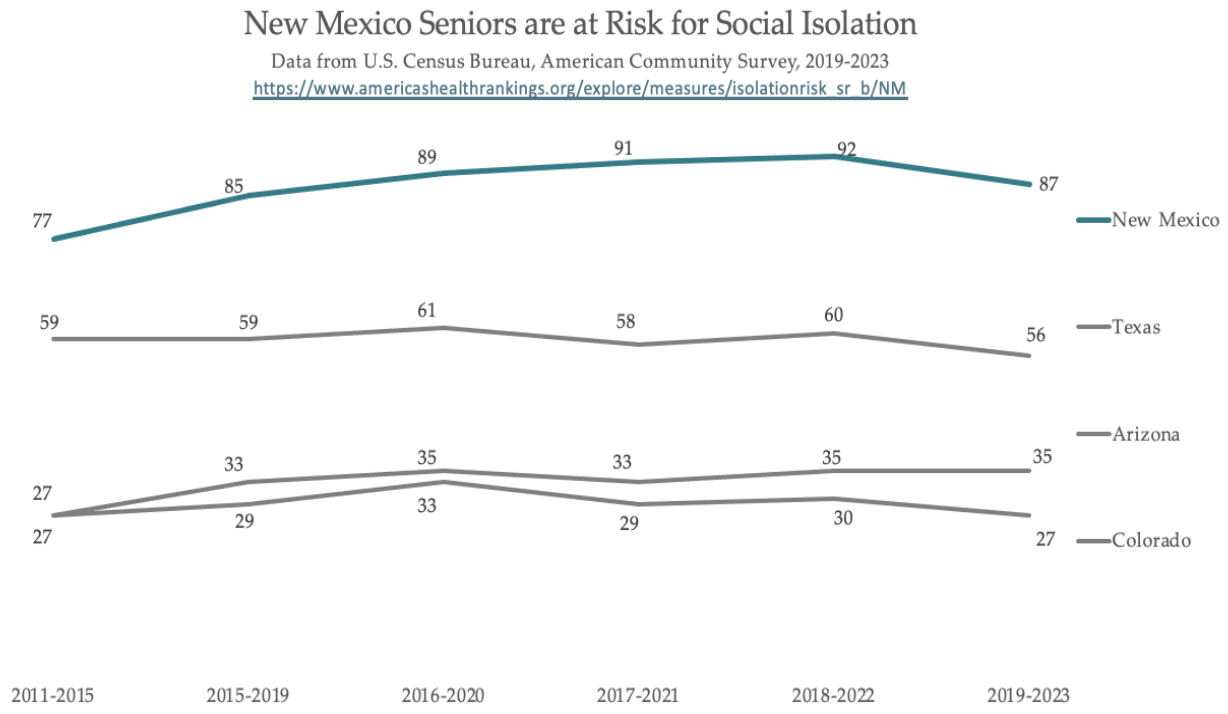
Age-Adjusted Death Rate per 100,000

SOURCE: https://ibis.doh.nm.gov/query/result/mort/MortCnty/AgeRate.html



*Several counties did not have enough data to be included in the chart above, largely due to small populations. They include Catron, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Mora, Quay, and Union.

Social isolation is a significant risk factor for ADOD. According to the 2025 Senior Report from America's Health Rankings, New Mexico seniors experience very high risks related to social isolation.[18] New Mexico ranked 48 out of 50 states, indicating seniors in New Mexico are at greater risk than those in most other states (only Louisiana and Mississippi scored higher). The social isolation index includes living in poverty; living alone; being divorced, separated, or widowed; having never married; having a disability; and having an independent living difficulty among adults aged 65 and older. Normalized values range from zero to 100, with the higher value indicating greater risk. New Mexico's score was 87 out of 100. Additionally, 25.2% of New Mexicans aged 45 and older with subjective cognitive decline live alone.[16]



Caregivers/Care Partners of Those Living with Alzheimer's Disease and Other Dementias

As in the greater United States, unpaid caregivers in New Mexico bear a significant weight in caring for those living with ADOD. One in five adults provides regular care for a friend or family member who has a health problem or disability.[19] About 67,000 caregivers provide care for those living with Alzheimer's disease or another dementia in New Mexico. Together, they provide an estimated 119 million hours of unpaid care, an amount worth 2.5 billion dollars.[1] Sixty-six percent (66%) of all caregivers in New Mexico are female, 43% are between the ages of 41 and 64, and 34% have provided care for five years or more.[19] For caregivers of those with dementia, 30% spend 40 hours or more per week providing care and 67% spend that time on both personal care and household tasks for their friend or family member.[19] Caregiving takes a toll on caregivers. Notably, 31.3% of caregivers of those with Alzheimer's disease in New Mexico have been diagnosed with depression, 12.6% report being in poor physical health, and 64.8% report having at least one chronic condition.[1] Significantly, adult New Mexicans caring for a friend or family member with Alzheimer's

disease, dementia, or another cognitive impairment disorder are three times as likely to experience suicidal ideation compared to non-caregivers and adults caring for a friend or family member without a cognitive impairment disorder.[19]

VI. Current Work Serving New Mexicans Living with Alzheimer's and Other Dementias and Their Caregivers/Care Partners

The New Mexico State Plan for Alzheimer's Disease and Other Dementias 2022-2025 outlined a coordinated, statewide approach to address ADOD through improved awareness, prevention, workforce development, caregiving supports, services expansion, and sustainable policy. It emphasizes cultural competence, rural access, early detection, and integration of dementia care across health and social service systems. One major accomplishment from the New Mexico plan was the development and implementation of the Silver Alert. This is an advisory notification sent to the public from the Department of Public Safety specifically for endangered and/or missing adults over age 50 who have compromised intellectual abilities.

Several additional programs and resources overseen by the New Mexico ALTSD and OADC currently serve people living with ADOD and their caregivers/care partners. The New MexiCare program provides financial and training assistance to family and friend caregivers who support older adults and individuals with disabilities, including those with Alzheimer's disease. The goal of the program is to allow older adults to thrive in their homes and communities as an alternative to long-term facility placements, and to help reduce emergency department visits. The program is designed to ease the stress of caregiving and improve the quality of life for both caregivers and care recipients. Services provided include respite care, training and education, access to support groups, and financial assistance. Another program, the Care Transitions Program, helps individuals who wish to transition from long-term care facilities back into community settings. The program offers long-term support options and short-term assistance connecting individuals to programs and services in their communities. Care transition specialists use a person-centered approach, working with individuals to help assess, advocate for, and follow up on their needs.

Additionally, services such as the Aging and Disability Resource Center (ADRC), Adult Protective Services (APS), and the Aging Network serve people living with ADOD and their caregivers/care partners. The ADRC offers a resource helpline that anyone can call to learn about services in their community, such as care facilities, meal delivery, transportation resources and more. APS investigates cases of abuse, neglect, and exploitation. Their activities specifically for adults with ADOD include protective planning, education, emergency placements, and assistance with personal and home care services. Notably, as reported by ALTSD Deputy Secretary Angelina Flores-Montoya to the New Mexico Legislative Health and Human Services Committee in November 2025, 60 to 70% of investigations are for adults aged 60 and older, and primarily related to self-neglect. Fifty percent (50%) of those cases are for adults with Alzheimer's or another dementia, diagnosed or not. The Aging Network provides several services, such as senior centers, respite services, adult day services, and resources such as meals, food delivery, and transportation, which all reach people living with ADOD. A respite voucher program delivers vouchers through the New Mexico Caregiver Coalition and other partners to those seeking respite support. Finally, public awareness and education efforts,

such as the "Take Action. Talk." campaign and the Conference on Aging, include specific messaging and programming aimed at educating people with ADOD and their caregivers/care partners about the resources available to them. The OADC also offers free monthly webinars by The Alzheimer's Foundation of America to an unlimited number of participants, continuing education for healthcare professionals focused on specialized training for caring for those with ADOD, and statewide training events led by a dementia care training specialist. The Office of Indian Elder Affairs (OIEA), also within ALTSD supports New Mexico's Tribes, Pueblos, and Nations in their development of a comprehensive and coordinated service system of Tribal senior centers and adult day centers. OIEA also managed the Indian Area Agency on Aging (IAAA) and supports the efforts of the Navajo Nation Department of Health's Division of Aging and Long-Term Care Supports (DALTCS).

All of these services supporting people living with ADOD and their caregivers/care partners are nestled in the greater ALTSD, responsible for additional innovative programs such as the Kinship Caregiver Program. A pilot program, the Kinship Caregiver Program, is designed to support kinship caregivers, such as grandparents, aunts, uncles, other relatives, and fictive kin, who are raising children whose parents are unable to care for them. The program provides support on a voluntary basis, helping caregivers find and use programs and services that meet the needs of both the children in their care and the caregivers themselves. Partnerships with private, public, state and Tribal programs allow program navigators to connect caregivers with needed information, services and referrals, including legal assistance and case management.

ALTSD has convened an Alzheimer's and Dementia Task Force as mandated by House Memorial 53. In addition to ALTSD, members include the New Mexico Department of Health, caregiver organizations, Tribal representatives from the So' Tsoh Foundation and the OIEA, a direct caregiver with lived experience, a physician from the UNM Memory and Aging Center, and other partners. Research has informed the task force's key priorities, which include strategies to increase access to services in Tribal and frontier/rural communities through telehealth expansion and other technologies, incorporating the newest research into education, and training for updating dementia related health programs, and increasing resources and support for both people living with dementia and their caregivers. The group is seeking federal dollars and other funding sources to support the development and implementation of the recommended initiatives.

As the current plan expires, ALTSD commissioned a study by Aspen Solutions of needs, gaps, and resources through a meta-analysis of needs assessments, data gathering, and an inventory of gaps and services across the state.

VII. Meta-Analysis of Recent New Mexico Needs Assessments Related to Older Adults and Alzheimer's Disease and Other Dementias

While New Mexico has made progress in meeting the needs of people living with ADOD and their caregivers/care partners, recent needs assessments suggest there is more work to do.

New Mexico Older Adults Needs Assessment, University of New Mexico

The Center for Applied Research and Analysis at the University of New Mexico's (UNM) Institute for Social Research was contracted from 2023 to 2024 by the New Mexico Aging and Long-Term Services Department (ALTSD) to conduct a statewide mixed methods study to assess the needs of older adults, with particular attention to service gaps in rural and frontier communities. **Although the study took a broad view of the needs of older adults, parts of the findings are useful for identifying the needs of those living with Alzheimer's disease and other dementias and their caregivers/care partners throughout New Mexico.** The most relevant findings are as follows.

Service Providers' Perspectives on the Needs of Older Adults

In a survey with 71 service providers, most respondents identified the following existing services as "not adequately meeting older adult needs" (UNM, 2024, p. 165):

- Legal services
- Caregiver support services
- In-home services
- Health promotion and disease prevention services

As the UNM team surmised, "These findings suggest, at least from the perspective of providers, that these services are ideal areas to focus on to meet older adult needs in New Mexico" (UNM, 2024, p. 165).

The UNM team conducted another survey several months later, this time with 64 service provider respondents, which focused on financial and business health. Many of the providers expressed a desire to expand currently available access services, such as transportation, assisted transportation, and case management support. There was also significant interest in expanding community service types like physical fitness/exercise services and senior center activities.

Some providers also want to develop new services, particularly in-home services, such as caregiver respite, chore, and homemaker supportive services, as well as case management, transportation and assisted transportation, physical fitness/exercise services, senior center activities, and staff training of and programming for evidence-based health services. Despite the multiple desires to build out these services, respondents reported that critical barriers to expanding services include financial and available personnel within communities. Some providers agreed that they experience challenges recruiting employees to provide direct services and that their agencies/organizations would benefit from training support.

As this section of the UNM report on the perspectives of service providers concludes:

> "Overall, provider responses paint a straightforward picture that service provision across the state is largely dependent on funding and available personnel in communities to provide

direct services. Providers also identified the need for adequate training support. Should these critical resources be met and provided, service providers report they are motivated to expand and develop services to meet older adult needs" (UNM, 2024, p.167).

Older Adults' Perspectives on the Needs of Older Adults

The UNM research team conducted five focus groups, with a total of 45 older adult participants, in two urban and three rural New Mexico communities. Because the focus groups were conducted with a small number of participants who did not compose a representative sample, the findings cannot necessarily be generalized to other parts or across New Mexico. They can, however, provide important insights that need to be further investigated, particularly as the findings may pertain to people living with ADOD.

The following five categories were commonly identified as major needs for older adults in New Mexico, in the focus groups with older adults (UNM, 2024, p. 167):

- Senior center support
- Information support
- Improved service accessibility and availability
- Health support
- Transportation support

Within the category of information support, a frequently discussed topic was the need for information sources that fit within the preferences and limitations of the current senior population, especially with regards to digital information sources that many have difficulty accessing. As the UNM report states:

> "This need for information support cannot be overstated – every focus group involved some degree of older adult participants sharing resources and information with each other amidst confusion about service qualifications and availability. In some cases, seniors attended focus groups with a specific hope of learning more about senior services. Participants from all areas desired more information and clarification about existing services and mostly wanted support to be readily available at senior centers and information provided by non-digital sources like radio, newspapers, and trusted individuals" (UNM, 2024, p. 168).

Some of the findings from the rural focus groups seem to differ significantly from their urban counterparts, particularly in the reasons for their perceived needs. Often the urban older adults who participated in the focus groups were experienced consumers of services and supports, and described seniors' needs in three ways (UNM, 2024, p. 168):

- Expanded availability and accessibility of existing services
- Improved intimacy of senior centers and friendliness of staff
- Reengage older adults in existing services

In contrast, participants living in rural communities described how their needs stem mostly from limited or lack of service provision and senior support. Older adults in the rural focus groups identified the needs for (UNM, 2024, p. 168):

- Improved information centralization, with respect to local languages and trusted sources
- Availability of, and access to out-of-town transportation options – for medical and affordable food access
- Greater access to primary health support services like dental, vision, and hearing
- More socialization and community support services

Alignment of Findings Between Service Providers and Older Adults

There is considerable alignment of findings between service provider survey respondents and the older adult focus group participants. The UNM research team identified ten common service areas that both groups agreed are needed (UNM, 2024, p. 168):

- Access to specialized medical and primary supportive care
- Mental health care
- Different types of transportation, including:
    - After-hours public transportation options
    - Transportation to store
    - Assisted transportation
- Medicare/Medicaid information support
- Digital training/technology assistance
- Affordable senior housing options

As this section of the UNM report concludes:

> "Surveys and focus groups corroborate some of the same narratives about older adult need in the state of New Mexico – particularly that existing services could meet need, if services were expanded and available to more older adults and in more areas. In contrast to surveyed providers though, focus groups strongly emphasize need for information support, especially through comprehensive non-digital resources older adults can readily access within their specific communities. Information support should proactively describe existing services and the ways in which they restrict eligibility, so general confusion about who does or does not qualify can be ameliorated" (UNM, 2024, p. 168).

Although the UNM study aims to identify the needs of the broader population of older adults across New Mexico, many of these findings also have implications for those living with ADOD and their caregivers/care partners. Service provision in New Mexico is largely dependent on funding and available personnel in communities to provide direct services. With adequate resources, service providers are motivated to expand existing services and develop new services to meet the needs of older adults in such areas as transportation, assisted transportation, in-home services, caregiver/care partner support services, and senior center support. With additional support, some of these service providers could also extend their services or provide new services to meet the needs of those living with ADOD and their caregivers/care partners. However, an important issue raised in the UNM study concerns how to best expand *existing* services, both for older adults and those living with ADOD, in urban areas versus establishing *new* services in rural areas. Another finding in the UNM study that has important implications concerns identifying the best ways for the ADOD-affected

community to receive information that is culturally appropriate, relevant, useful, and usable. Clearly, the way in which information is conveyed will determine, in part, how effective it is in prevention, treatment, and maintaining or improving quality of life.

Highlights from Forums in Rural New Mexico About Senior Services

In the spring of 2025, the Alzheimer's Association and the New Mexico OADC conducted a series of forums in rural New Mexico, at which attendees discussed the kinds of ADOD services their communities need. Attendees included family caregivers, people living with dementia, long-term care staff, hospice agency staff, and senior center employees.

Attendees in Tucumcari identified several gaps in their own community, including first responders not being sufficiently trained in ADOD issues and sensitivities, lack of pharmacies, lack of assisted living facilities, lack of home care health services, and inconsistencies in patients' continuum of care services. In their "wish list," they included wanting better ADOD-related education and training, connections to more resources, and more support groups and outreach events. More specifically, they suggested that more Alzheimer's Association information be placed at their hospital and pharmacy, local clinics, the senior center, and home care agencies.

At the forum held in Silver City in May 2025 attendees proposed several solutions for their community to provide better services to members living with ADOD and their caregivers. Their suggestions included building an Alzheimer's adult day care center in Silver City, providing ADOD-specific training and higher wages to professional caregivers, establishing more support groups and a social engagement volunteer program, and training ombudsmen not just in Albuquerque but in sites around the state, including Silver City.

Although not representative of the needs across the state of New Mexico, it is also interesting to consider the types of calls received by the Alzheimer's Association free 24/7 Helpline. Of the 2,236 calls that originated from New Mexico during FY 24-25 to the Helpline, the top five topics requested were 1) Association's programs/services (776 calls), 2) difficult behaviors (191 calls), 3) care options (154 calls), 4) emotional support (108 calls), and 5) housing options (100 calls).

While the UNM study and the community forums shed light on the needs of older adults throughout New Mexico, including those living with ADOD and their caregivers, there seems to be a dearth of information on needs and services, outside of Albuquerque and Santa Fe, specifically for those living with ADOD and their caregivers. Thus, an important part of the 2025 study conducted by Aspen Solutions was a statewide inventory of existing ADOD services and needs.

VIII. 2025 Study of Existing Services and Needs for People Living with Alzheimer's Disease and Other Dementias and their Caregivers in New Mexico

Introduction

In 2025, the ALTSD contracted Aspen Solutions to conduct an assessment of services and needs in New Mexico to inform the development of a new roadmap to address Alzheimer's, other dementias, and brain health more broadly. Aspen Solutions took a two-pronged approach to this assessment. First, they conducted a statewide survey of service providers and organizations. Second, they identified and conducted interviews with eleven content experts. This section provides an overview and analysis of the results of the study. It includes 1) interviewees' opinions about New Mexico's successes and accomplishments related to ADOD over the last few years, 2) information about existing services identified by the survey respondents, 3) the top needs related to direct services, public education, workforce development, and caregiving identified by both survey respondents and interviewees, and 4) recommendations from interviewees for addressing the needs in each area

Survey Collection and Interview Design

With input from ALTSD, Aspen Solutions developed an online survey and promoted it in various ways, including emailing it to service providers and organizations working with seniors using email lists provided by ALTSD. An initial email was sent to 542 organizations and service providers, followed by weekly reminder emails over seven weeks. Postcards with the survey link and QR code were sent to 462 organizations/addresses, and individual calls were made to 111 organizations, followed, whenever possible, by emails reiterating the purpose of the survey and containing the survey link. ALTSD promoted the survey on their social media pages and in their November and December e-newsletters. Following the survey collection, Aspen Solutions developed an interview guide based on the study's objectives, the preliminary findings of the survey, and discussions with ALTSD. The questions covered such topics as New Mexico's accomplishments, challenges, needs, and strategies or best practices related to addressing ADOD that the state should consider as it develops the roadmap.

Completed Surveys and Interviews

A total of 109 surveys were started, seven were excluded due to not providing any services to people living with ADOD or their caregivers, and eleven were excluded due to being largely incomplete. Most of the incomplete surveys only included the organizations' contact and location information but no responses to services offered. **This resulted in 91 surveys for analysis that included 125 organizations since 25% of respondents had multiple locations.** Of the twelve experts invited to participate, eleven participated in roughly 45-minute interviews.

Survey Respondent and Interviewee Organizations

The majority of survey respondents were executive directors, owners, founders or administrators (62.4%), followed by clinical staff (15.6%), and non-clinical director-level staff (5.5%). Other respondents included social workers, navigators, outreach coordinators, professional caregivers, and office managers. Respondents were from nearly every county in New Mexico and several Tribal organizations from at least eight specific Tribes. The interviewees represented organizations across

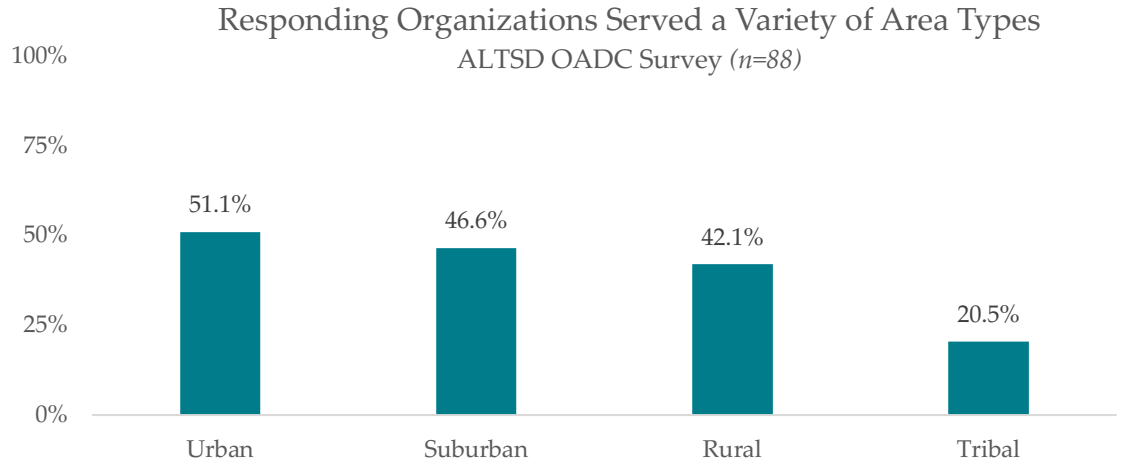
aging services, Medicaid, long-term care regulation, advocacy and education, and community-based service systems.

New Mexico's Successes and Accomplishments Related to Addressing Alzheimer's and Other Dementias

Expert interviewees recognized the positive impacts of statewide efforts such as the New MexiCare program, the Ombudsman program, the Care Transitions Program, the development of the Long-Term Care Division, the current Lifespan Respite Grant work, the work of APS for those living with ADOD, outreach efforts by ALTSD, and legislative funding for assisted living facilities and the Program of All Inclusive Care for the Elderly (PACE). More specifically, they identified New MexiCare's efforts to help people "age in place," the positive outcomes that have resulted from the work of the Ombudsman program and APS, and the dementia training and resources provided to memory care facilities by the Care Transitions Program. They explained the ways in which the development of the ALTSD Long-Term Care Division has allowed the department to streamline initiatives and align their vision and programming so they can serve more people. The said they've been encouraged by ALTSD's outreach in the community – at health fairs, etc., and were excited about the momentum behind the Lifespan Respite Grant work, and its funding of statewide Alzheimer's Foundation of America trainings and community-based organizations that provide respite care. Finally, they applauded the system-wide efforts to "rebalance" the long-term care system by integrating more people needing care into community-based settings and recognized the support from leadership to increase the number of slots in the Long-Term Services and Supports program (through the Medical Assistance Division).

Existing Services for People Living with Alzheimer's and Other Dementias and their Caregivers

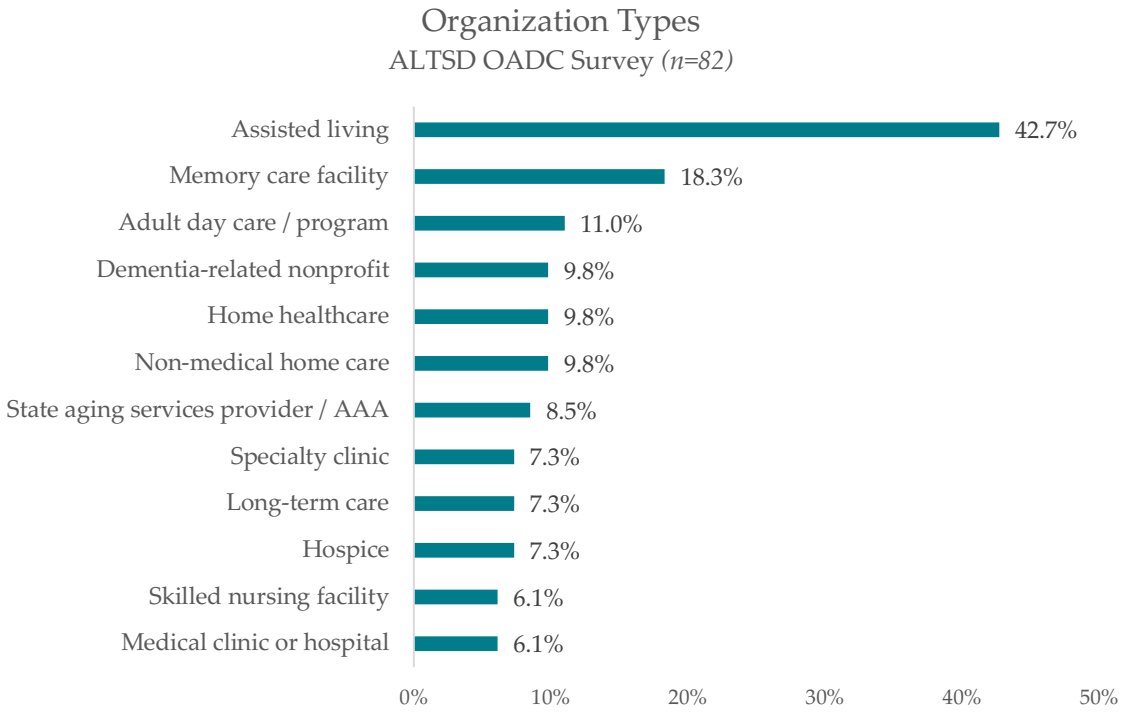
Survey respondents offered information about their organizations, including the types of organizations, the services they offered, their service locations, and their availability of services.



County	Responses
All / Statewide	21
Bernalillo	20
Catron	2
Chaves	3
Colfax	1
Curry	3
Doña Ana	7
Eddy	2
Grant	3
Hidalgo	1
Lea	1
Lincoln	1
Los Alamos	5
Luna	1
McKinley	4
Mora	1
Otero	1
Rio Arriba	3
Roosevelt	1
Sandoval	9
San Juan	3
Santa Fe	12
Sierra	1
Socorro	2
Taos	5
Torrance	1
Union	1
Valencia	8

Tribe	Responses
All	9
Acoma Pueblo	1
Isleta Pueblo	1
Jemez Pueblo	1
Mescalero Apache Nation	1
Nambe Pueblo	1
Picuris Pueblo	2
Santa Clara Pueblo	1
Taos Pueblo	4
Tesuque Pueblo	1

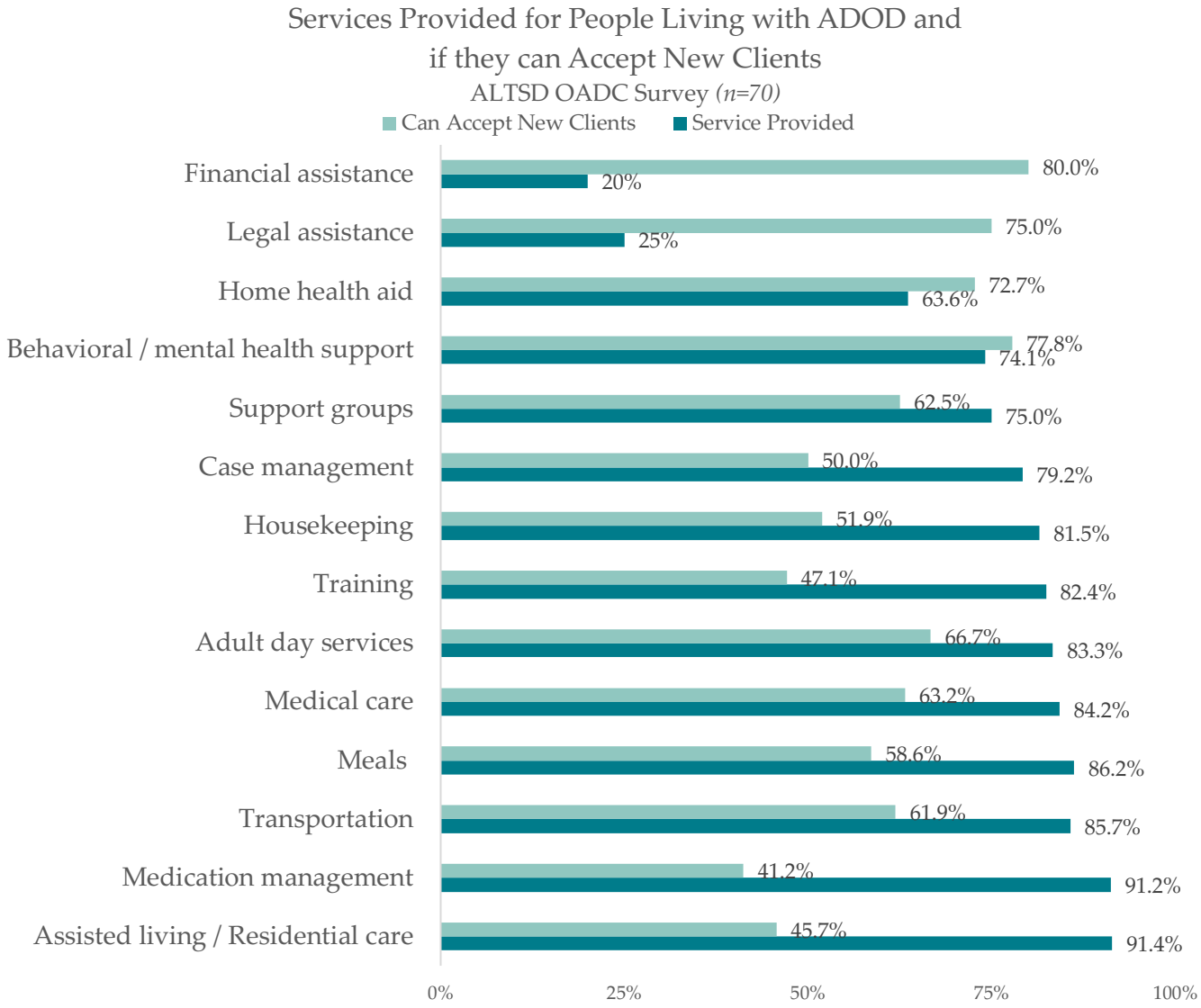
*No responses were provided for the counties of Cibola, De Baca, Guadalupe, Harding, Quay, or San Miguel, and the Tribes of Cochiti, Jicarilla Apache Nation, Kewa, Laguna, Ohkay Owingeh, Sandia, San Felipe, San Ildefonso, Santa Ana, Zia, and Zuni.



The majority of survey respondents represented assisted living (42.7%) and memory care facilities (18.3), which were important organizations to reach for this study. Several organizations identified themselves as adult day care programs, other dementia-related nonprofits, home healthcare organizations, and non-medical home care organizations, followed by Area Agencies on Aging (AAAs), specialty clinics, long-term care providers, hospice, skilled nursing facilities and medical clinics or hospitals. Organizations that selected "other" provided organization types such as caregiver supports, independent living, Tribal health organizations, rehabilitation, end of life or aid in dying, senior centers, counseling centers, support groups, and nonprofit research organizations.

Services Offered

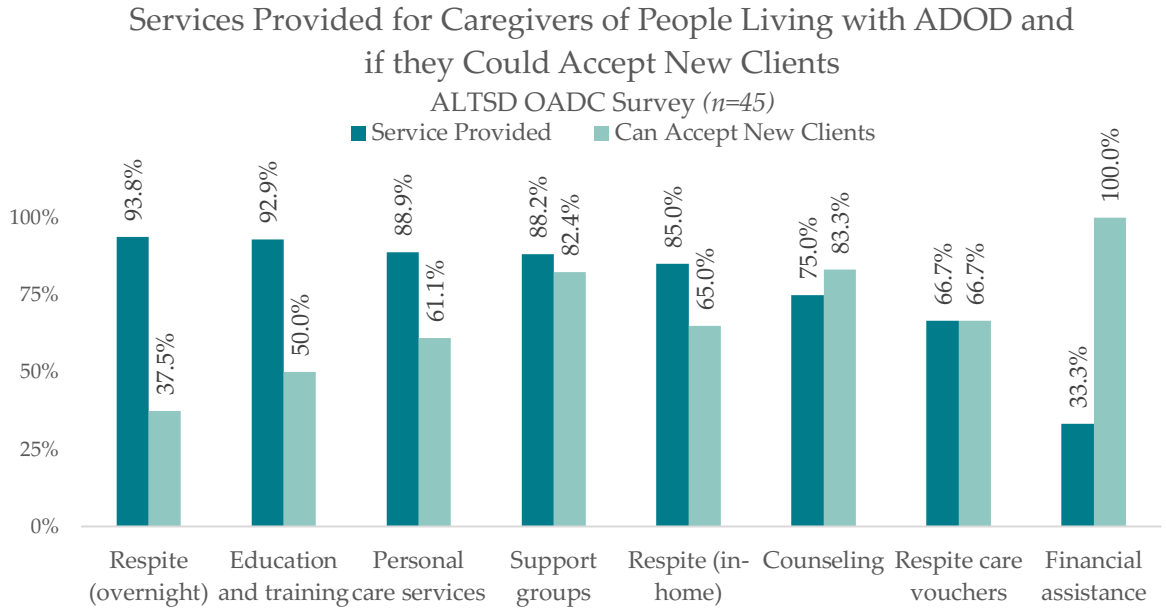
Respondents were asked to indicate the services they offered for people living with ADOD and their caregivers, and whether they could accept new clients for each service. The first graph covers services provided for people with ADOD.



While many respondents reported providing a broad range of dementia-related and aging services, their ability to accept new clients varied significantly by service type.

- Core services such as assisted living/residential care, medication management, and training were offered by more than 80% of responding organizations, yet fewer than half reported capacity to serve additional clients. This suggests these high-demand services are operating near or at capacity.
- In contrast, services such as transportation, meals, medical care, and adult day services showed relatively stronger capacity to accept new clients, indicating potential opportunities to strengthen community-based supports that help individuals remain safely at home.

- Behavioral and mental health supports and home health aide services demonstrated both moderate availability and comparatively higher capacity, which may position them as important leverage points for early intervention and crisis prevention.
- Finally, fewer organizations provided legal and financial assistance, but those that did were more likely to accept new clients, pointing to underutilized supports that could be better integrated into care coordination and referral systems.



The caregiving-related data showed that most respondents provided multiple forms of respite, education, and personal care services. However, capacity constraints were particularly evident in high intensity supports.

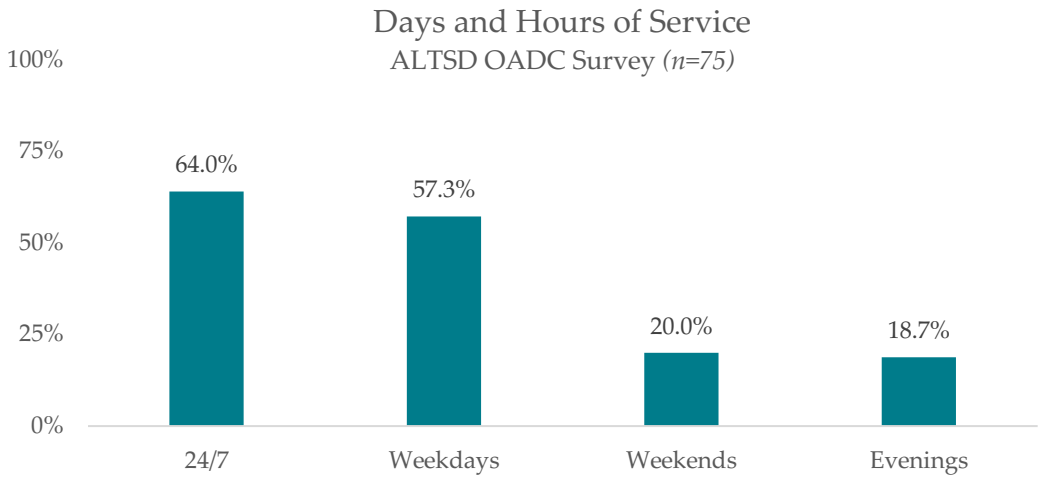
- Overnight respite, while widely offered, had the lowest reported capacity to accept new clients, highlighting a critical gap for caregivers managing advanced dementia or complex care needs.
- Education and training services also appeared to be near capacity, suggesting growing demand for practical skills, disease education, and caregiver preparedness.
- In contrast, in-home respite, personal care services, counseling, and support groups demonstrated relatively greater capacity, positioning these services as important entry points for early support and caregiver stabilization.
- Financial assistance and respite care vouchers were offered by fewer organizations, but those that did provide them reported strong capacity to serve additional caregivers, indicating opportunities to expand awareness, streamline referrals, and integrate financial supports more fully into caregiver assistance programs.

Reasons organizations could not accept new clients included that they were operating at capacity (19%), had staff shortages (14%), or lacked adequate space/facilities (5%). Other reasons included funding shortages that impacted arts and other enrichment services in senior living communities, shortages of volunteers for volunteer-based programs, and limitations due to eligibility

requirements. Staff shortages were most often reported for caregivers (20%), followed by activities/enrichment staff, clinical staff, administrative staff, and housekeepers and dining staff. Most organizations did not offer emergency services (82%), but eight organizations (11% of respondents) offered emergency placement, and four (5.8%) offered psychiatric evaluations and emergency room services.

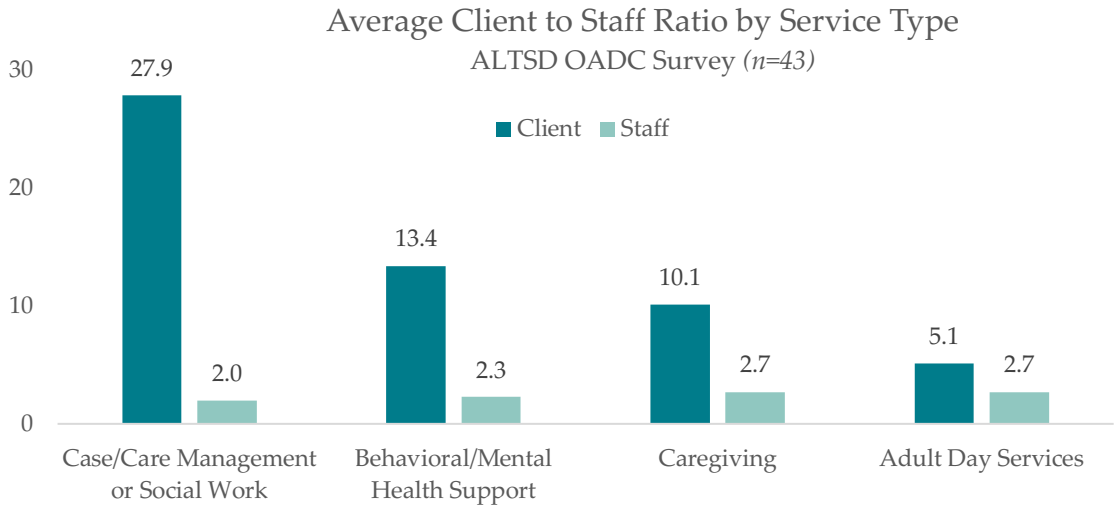
Hours and Days of Service

Most respondents provided round-the-clock services or operated weekdays from 8:00 or 9:00 to 5:00. Weekend and evening services were often reported as being available "by appointment" or "on call."



Staff to Client Ratios

The number of clients to staff per service type was provided by 43 respondents. Their responses were averaged to offer a glimpse at staffing ratios for different services.



Hourly, Daily, and Monthly Rates

- **Hourly:** Very few survey respondents completed this section (n=19), but among those respondents, several reported offering free services for support groups, respite care vouchers, counseling, and education or training on caregiving practices for people living with ADOD.
- **Daily:** Very few survey respondents completed this section (n=19), but similar to the hourly services, several reported offering free services for support groups, counseling, and education or training on caregiving practices for people living with ADOD.

n=19	Free		$10-$25		$26-$100		$101-$200		$201-$300	
	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
Support groups	100%	100%								
Counseling	67%	100%	20%				33%			
Education/training for caregivers	40%	100%	20%		20%		20%			
Personal care services			72%		28%			100%		
Respite (in-home)	17%		17%		67%			100%		
Respite (adult day)	20%		40%		40%	50%		50%		
Respite (overnight)	20%				60%		20%	33%		67%
Respite care vouchers	100%									

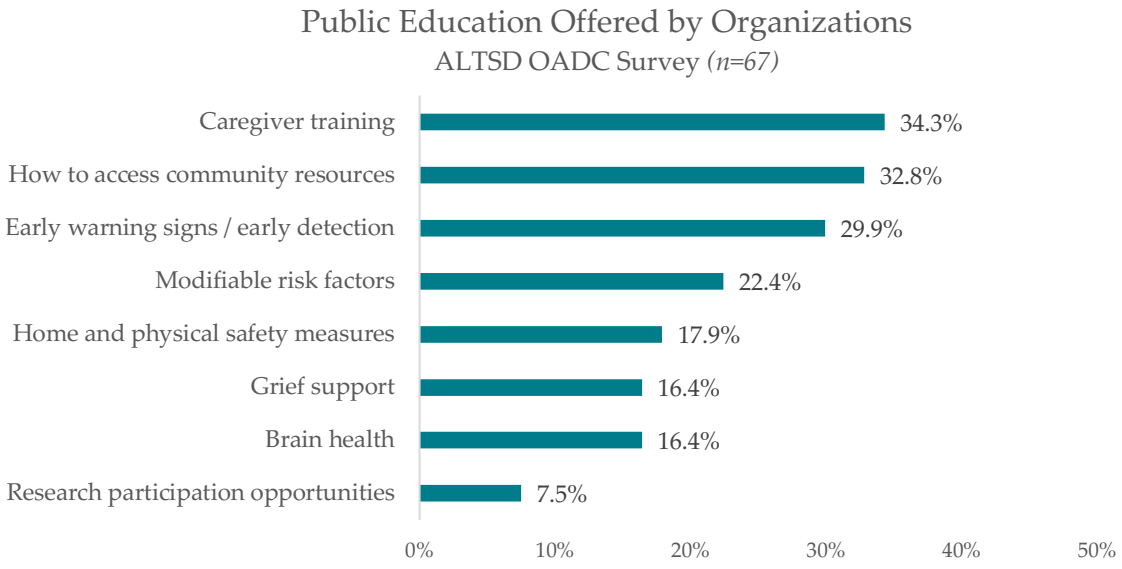
- **Monthly:** Respondents with residential or memory care facilities were asked to provide their base monthly or flat rates, and then the rates according to the tier or level of care necessary for the residents.

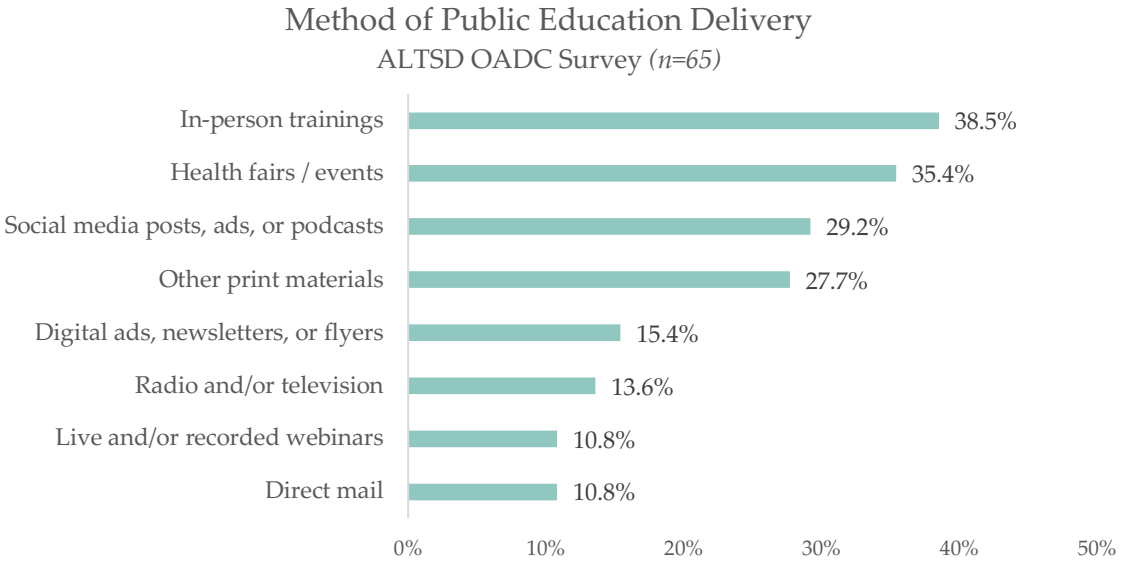
n=25	$1,001-$3,000	$3,001-$5,000	$5,001-$7,000	$7,001-$9,000	$9,001-$10,000
Base Rate	8.7%	43.5%	39.1%	4.4%	4.4%
Tier 1	10%	40%	50%		
Tier 2	10%	20%	60%	10%	
Tier 3	10%		70%	20%	
Tier 4	14.3%		71.4%	14.3%	
Tier 5			67%	33%	

In addition to the rates above, many residential or memory care facilities reported adding a fee for medication management. Although some offered this as a free service (20%), others reported charging as much as $6,000 (20%) per month.

Public Education

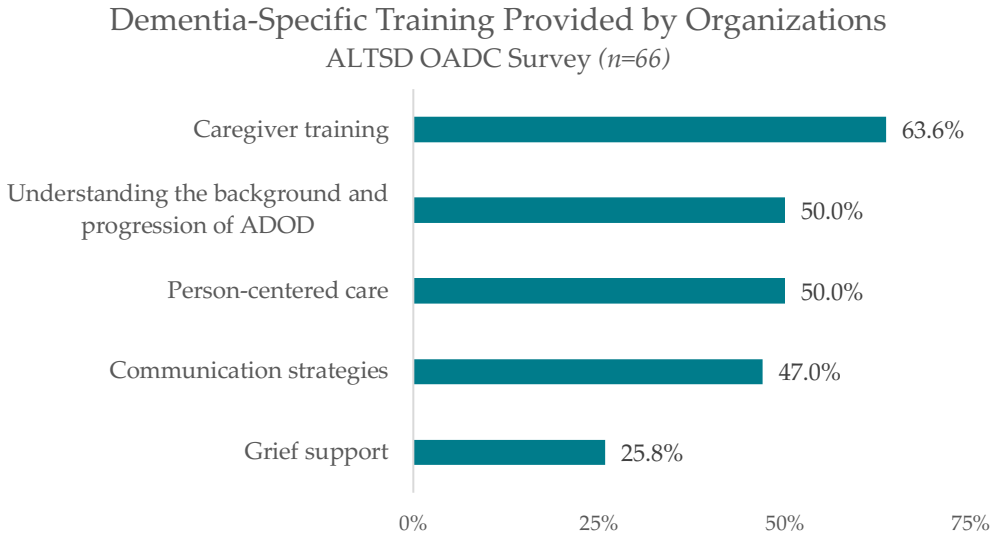
Organizations were asked which types of public education related to dementia they offered. Many organizations did not offer any education related to dementia (43.3%) but the remaining organizations mentioned trainings offered by community health workers, administrators, and partner organizations either in-person or online, or by other methods.

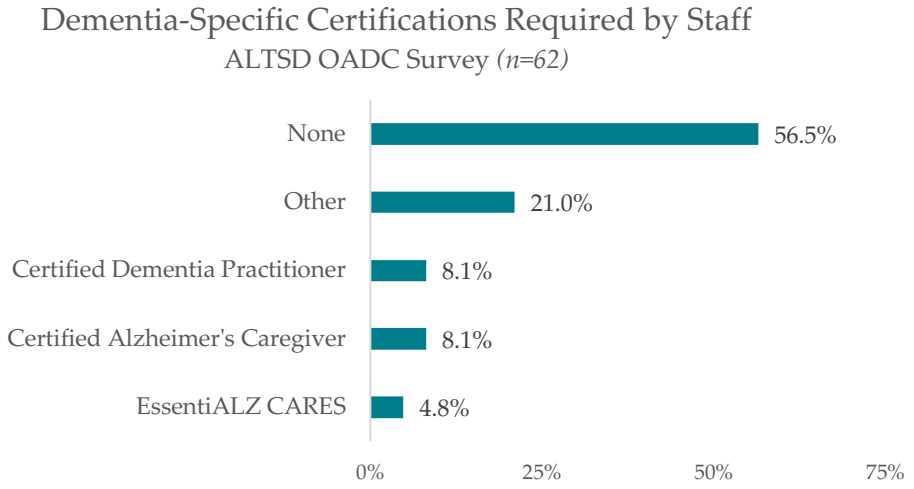




Dementia-Specific Training and Certifications

About 75% of respondents indicated they provided some type of dementia-specific training, while 21% indicated their organization offered none, and 4.5% of respondents did not know. The remaining responses indicated a variety of topics covered, as displayed in the graph below.



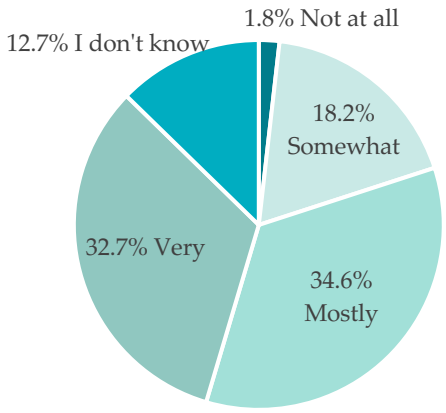


Other trainings organizations indicated were required by staff included in-house or organization-specific trainings such as medication certificates, LPCC, ATR-BC, CNA, med assistance, CMS Hand in Hand: Understanding the World of Dementia Modules 1-5, Prepare to Care, the Art of Caregiving, Relias, and other trainings required by the state or other funding sources.

How often do staff get refreshed dementia training? *(n=65)*					
Never	Annually	Quarterly	Monthly	Weekly	As needed
1.5%	38.5%	10.8%	9.2%	0%	18.5%

Most Respondents thought Training was Mostly or Very Sufficient

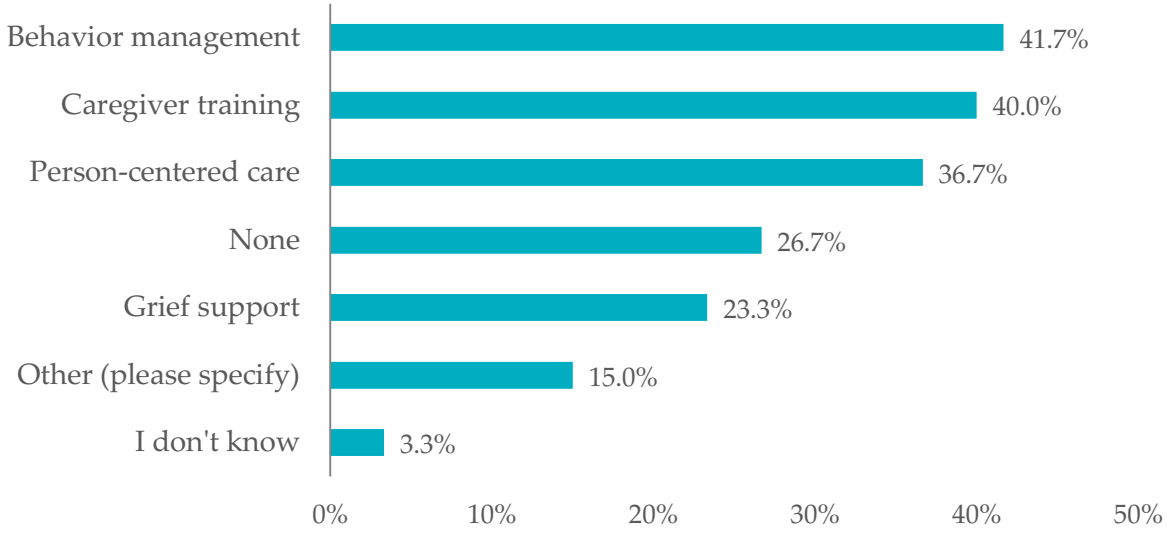
How sufficient is the dementia-specific training that is provided to staff at your organization? (n=55)



Respondents who said training was insufficient gave reasons including that staff were not paid to attend (12%), staff shortages made it difficult to attend training (7%), lack of equipment/technology (7%), or training was not offered frequently enough (7%). One mentioned that staff turnover made it hard to keep up with training, and one said training met federal requirements but was not "in-depth."

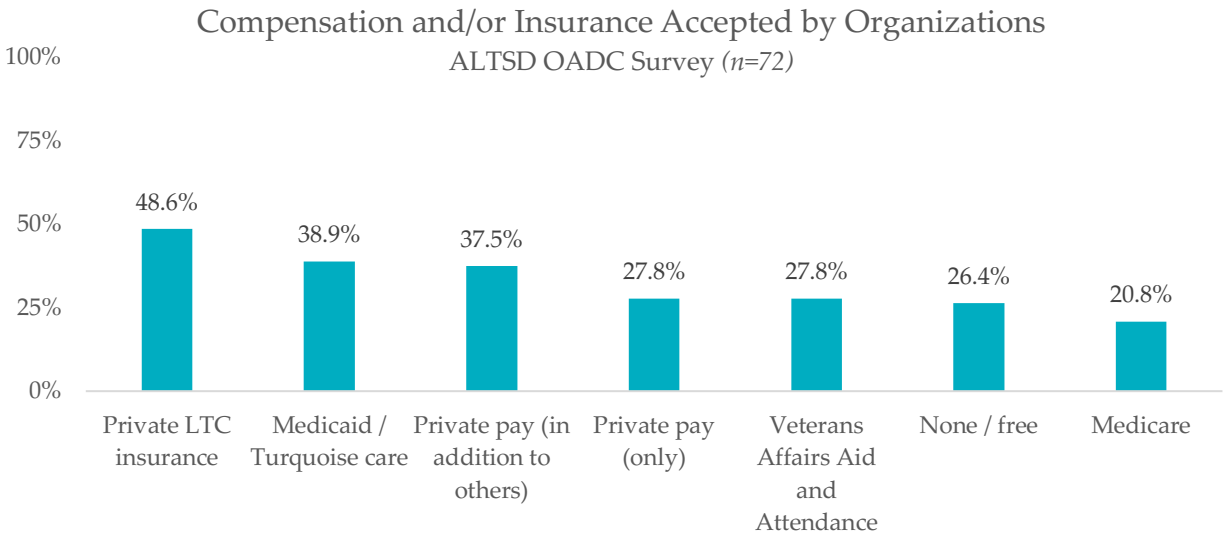
Organizations Identified Training Needed in Behavior Management, Caregiving, and Person-centered Care

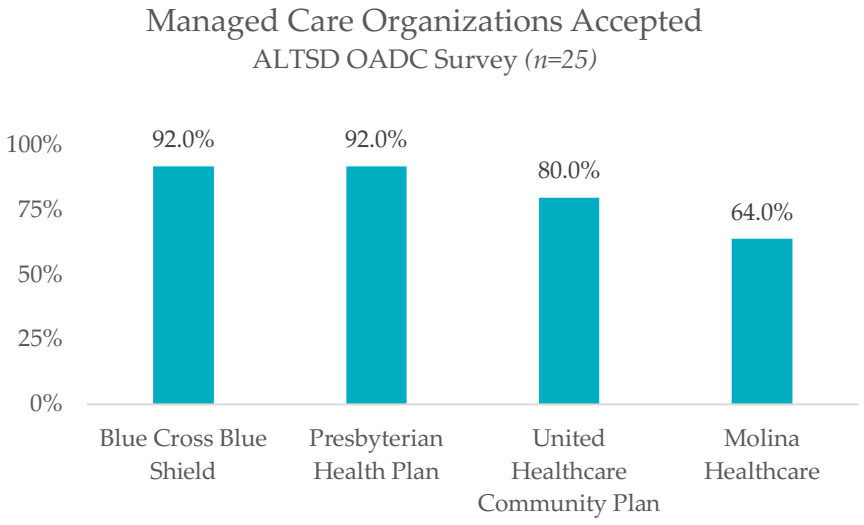
Which type of training is needed by staff at your organization?
Respondents could select all that apply. (n=60)



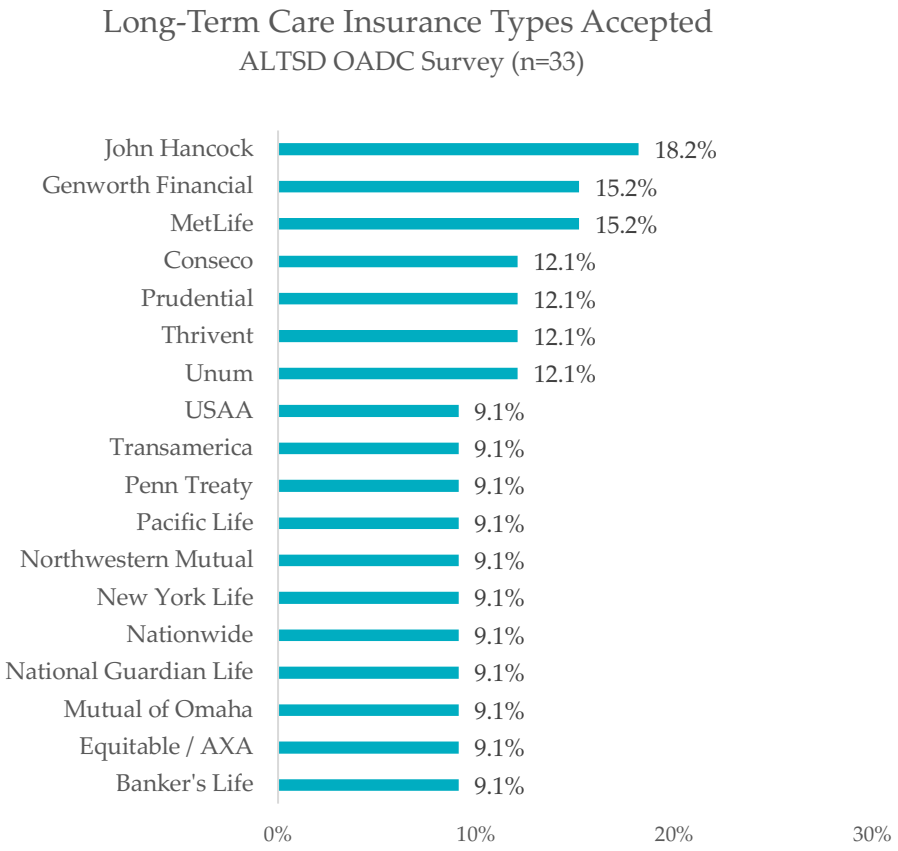
Insurance Types Accepted

Respondents to the survey reported accepting a variety of insurance and payment methods for their services. Some indicated they were getting ready to become eligible to bill for certain insurance or listed specific public benefits they accepted (Community Benefit Medicaid and Department of Labor White Care, and InnovAGE PACE Contract).





Those who indicated the type of insurance accepted at their organization are included in the graph below. Many respondents (48.5%) did not know the specific insurance types accepted at their organizations, and 24% did not take any insurance.



Innovative Approaches

Organizations across the state reported advancing person-centered, community-driven, and integrative approaches to dementia care, often blending evidence-based models with locally adapted strategies. Innovation was most evident in caregiver support, therapeutic programming, workforce models, and environmental design, particularly in rural or under-resourced communities. Rather than relying on a single framework, providers frequently used hybrid models that combined training philosophies, creative therapies, and practical supports to meet complex and evolving needs.

1. Person-Centered Dementia Care

Many organizations emphasized care approaches that prioritized dignity, relationship-building, and individualized support. Common strategies mentioned include training in Teepa Snow's Positive Approach to Care, Validation Therapy, Montessori-informed activities, Eden Alternative–influenced environments, and small-scale or low-resident care models allowing for individualized attention. These support quality-of-life goals and reduce behavioral crises, caregiver stress, and avoidable institutionalization.

2. Arts, Music, and Sensory-Based Therapies

Creative and sensory interventions were among the most widely reported innovations.
Examples included art and music therapy (including speech-language-pathologist–led programs), Snoezelen (multi-sensory) rooms and sensory stimulation tools, healing touch, aromatherapy, and calming environmental design. These are considered low-risk, non-pharmacological interventions that support communication, emotional regulation, and social engagement.

3. Physical Activity and Mind–Body Approaches

Organizations reported expanding beyond traditional activities to include movement-based therapies. Examples included chair exercise, Tai Chi, meditation, balance-focused activities, boxing, pickleball, and interactive cognitive-motor games. These align with evidence linking physical activity to improved mood, function, and overall well-being.[29]

4. Caregiver Support as Core Infrastructure

Caregivers were viewed as essential partners in care, not ancillary recipients of services.
Innovations mentioned by respondents included weekly (not monthly) caregiver support groups and peer-led "communities of care", caregiver counseling, education, navigation services, and NIH-based caregiver education programs and statewide training resources. These address caregiver burnout, workforce shortages, and crisis-driven care transitions.

5. Community-Based Respite and Workforce Models

In response to service gaps, especially in rural areas, organizations reported developing alternative respite solutions such as independent contractor respite caregiver networks, and civic organizations acting as conveners, trainers, and referral hubs. Organizations also mentioned early-stage efforts to establish dementia clinics and adult day services. Organizations demonstrated scalable, community-driven models that could be strengthened through policy, funding, and training support.

6. Safe, Supportive Environments and Technology

Providers reported adapting physical spaces and using technology to balance safety and autonomy. Some of the common strategies included wander guard systems, call lights, floor mats, and locked exits. They also mentioned bright, inviting environments that encourage socialization, and technology-based wandering and monitoring supports. These environmental strategies support aging-in-place, injury prevention, and caregiver confidence.

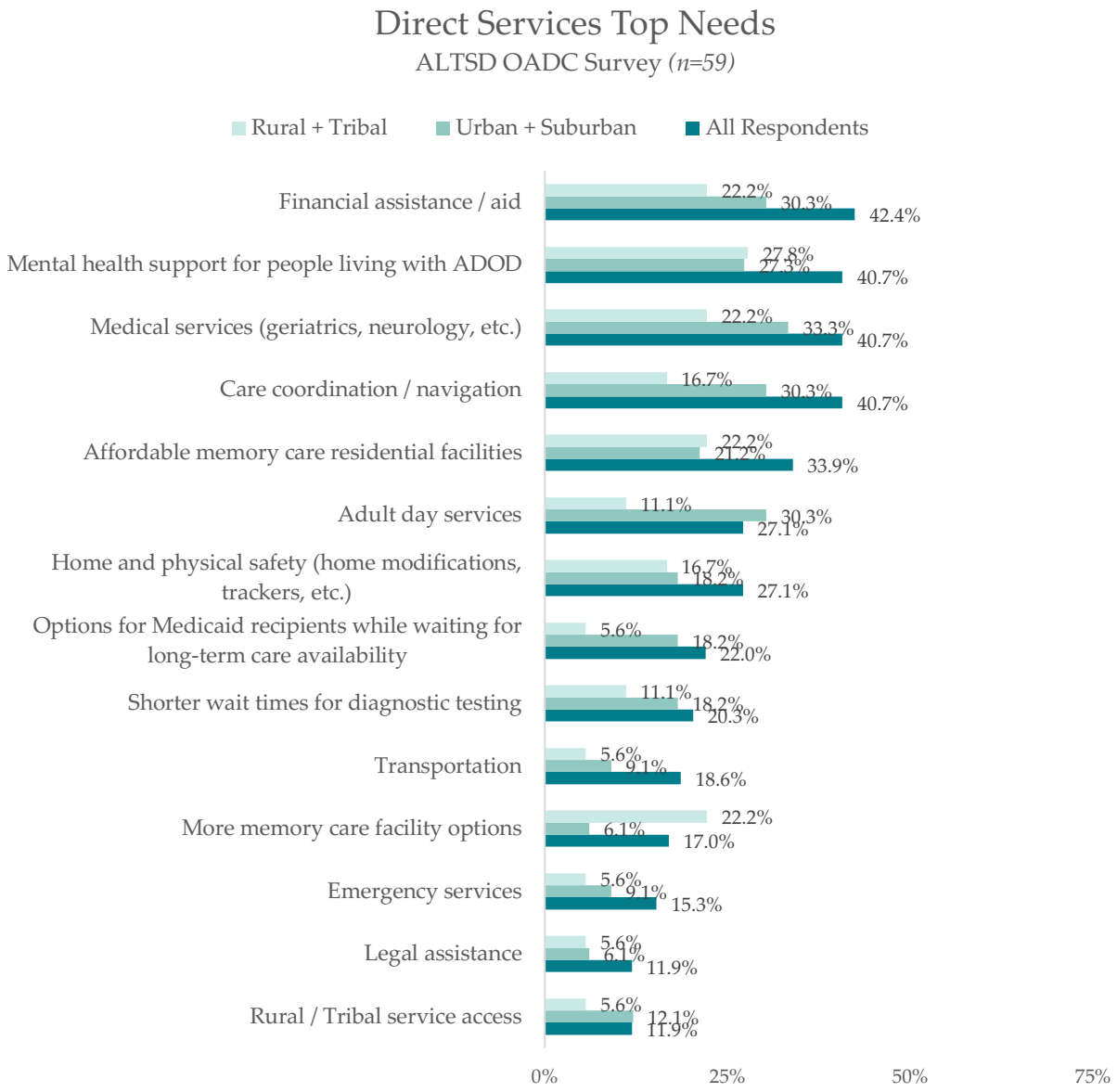
Other Ideas or Stories Shared About Their Work to Address ADOD

When asked if they wanted to share "anything else" about their services, respondents reported that many valuable dementia-supportive practices exist outside formal dementia programs. Environmental design, caregiver problem-solving, respite vouchers, and hybrid service delivery were reported as especially promising and scalable approaches. Organizations appeared eager for collaboration, coordination, and clearer pathways, not just funding. Readiness seemed strong among respondents to participate in state-led pilots, learning networks, and referral systems. Below are some of the highlights offered by organizations:

- **Workforce Development:** The workforce extended beyond licensed clinicians to include respite caregivers, assisted living staff, activity facilitators, and peer supporters. Many were operating without consistent training or system integration.
- **Caregiver Support:** Caregivers were consistently positioned as the primary support system, yet often lacked relief, guidance, and emotional support. Organizations mentioned problem-solving–focused family support models which directly address burnout and crisis prevention.
- **Public Education & Awareness:** Public education was already occurring through nontraditional channels such as assisted living homes, community groups, caregiver platforms, and advocacy organizations. These efforts normalize dementia, reduce stigma, and help families recognize needs earlier.
- **Rural Access & Equity:** Rural organizations expressed unmet needs in rural and retiree-dense communities. They faced limited service availability, transportation barriers, and workforce shortages, yet were innovating with flexible, community-driven models. Relevant practices and ideas shared by providers included:
    - Hybrid service delivery (Zoom and in-person activities).
    - Bringing services directly to people rather than requiring travel.
    - Community-based respite caregiver networks in rural areas.
    - Small, high-touch assisted living environments serving limited numbers.

Needs Related to Direct Services, Workforce Development, Caregiving Supports, Public Education and Awareness, and Government Policy and Sustainability

The final portion of the survey asked organizations to identify key needs and priorities related to direct services, workforce development, caregiving, public education, and government policy initiatives. Collectively, these findings underscored the growing demand for dementia-capable systems, the need for accessible and culturally responsive supports across urban, rural, and Tribal communities, and the importance of aligning policy, funding, and implementation strategies to strengthen services statewide. The insights presented are intended to inform planning efforts and guide the development of actionable, sustainable strategies to better support individuals and families affected by dementia.



The most frequently selected need among all survey respondents was financial assistance (42.4%), followed by mental health support for people living with dementia, medical services such as geriatrics and neurology, and care coordination or navigation (40.7%). The top needs among urban/suburban organizations included medical services (33.3%), followed by financial assistance, care coordination, and adult day services (30.3%). The top needs among rural and Tribal organizations were mental health supports for people with AODO (27.8%), followed by financial assistance, medical services, affordable memory care facilities, and more memory care facility options (22.2%).

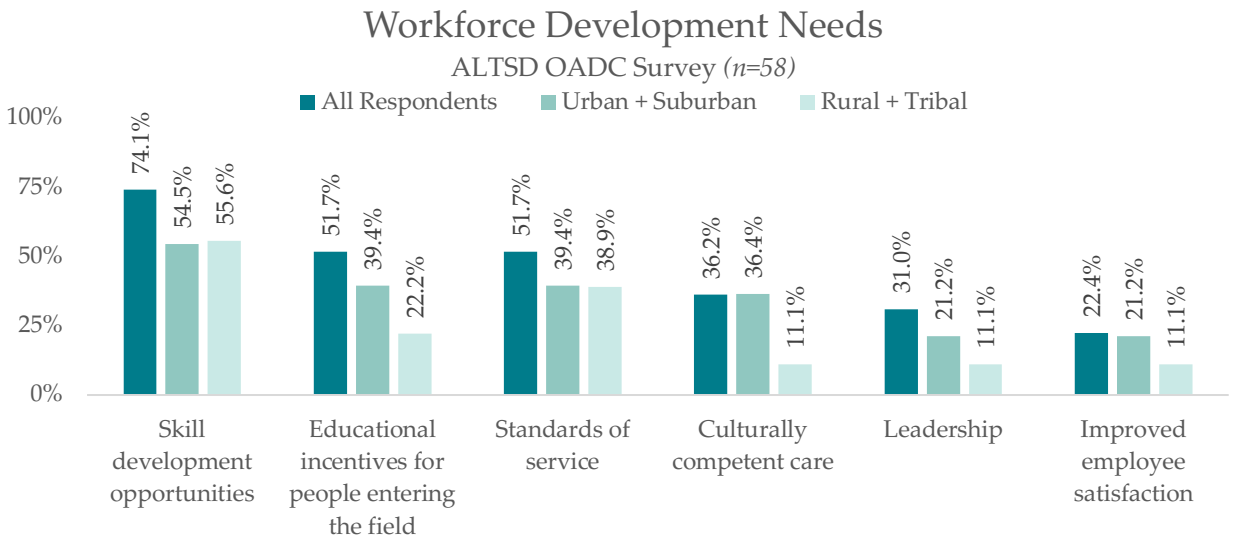
Interviewees also articulated the need for more affordable residential care, assisted living facilities, and memory care facilities, and adult day services, especially in rural and Tribal areas. They mentioned there have been more closures since COVID, especially of smaller home assisted living facilities, primarily driven by the cost of insurance. Multiple interviewees emphasized the need for services and resources that support more complex patients, particularly those with behavioral challenges. Like the survey respondents, interviewees identified the need for better access to medical and mental health support services (especially for those with complex behavioral challenges), and transportation to programs and services. They also identified the need for more funding for existing facilities, specifically for remodeling facilities, offering expanded transportation services, etc.

"For people who need memory care or high-level care, there aren't many options for Medicaid members. […] Facilities have very few insurance options, and the rates are so high that it is increasingly cost-prohibitive for them." – Interviewee

"A lot of facilities want to take more difficult residents but feel stuck in crisis situations and have many other residents to care for." – Interviewee

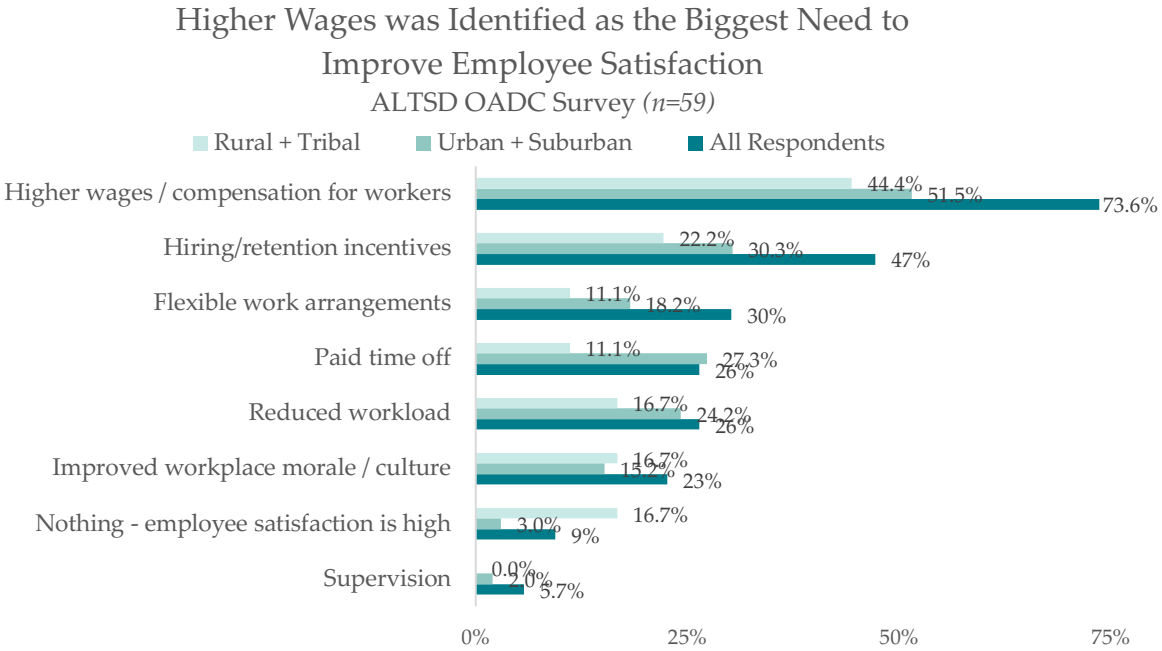
"We can have all kinds of programs but if people can't get there, they're not doing much. […] New Mexico needs transportation solutions." – Interviewee

"Do we want to take care of people with behavioral health issues? Absolutely. They deserve to have the care they need. But we are desperate for resources." – Interviewee



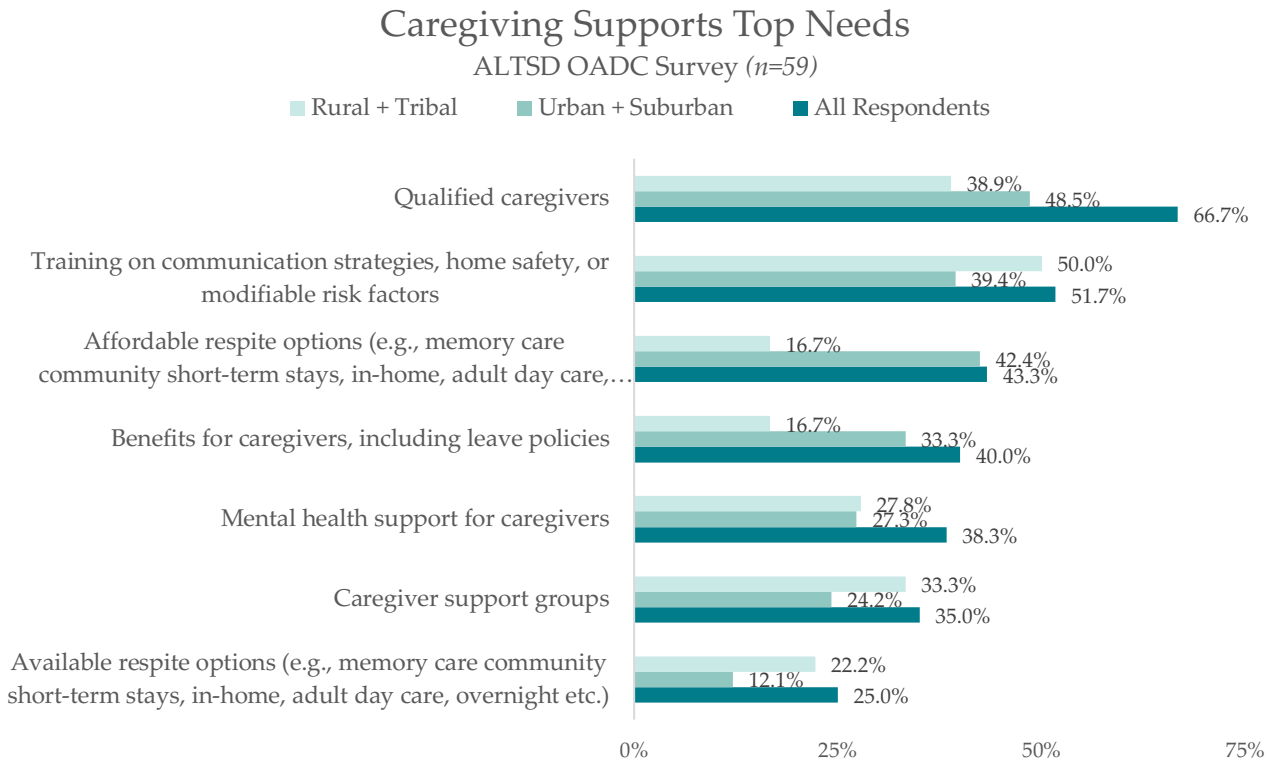
"New Mexico is short on professional care providers." – Interviewee

All survey respondents identified skill development opportunities as the top need for building workforce capacity and identified higher wages as the biggest need for improving employee satisfaction.



In addition to the items included above, one organization suggested that organizations could provide more opportunities for employees to learn and grow in the field. Interviewees emphasized the ways in which persistent workforce shortages threaten dementia-capable care statewide. They consistently identified shortages across the dementia care continuum, including direct care workers, respite providers, and specialized clinicians (e.g. neurologists and geriatricians). Capacity gaps, they said, were most severe in rural and Tribal communities and contributed to delayed diagnosis, caregiver burnout, and inappropriate institutional placement or discharge. They consistently agreed

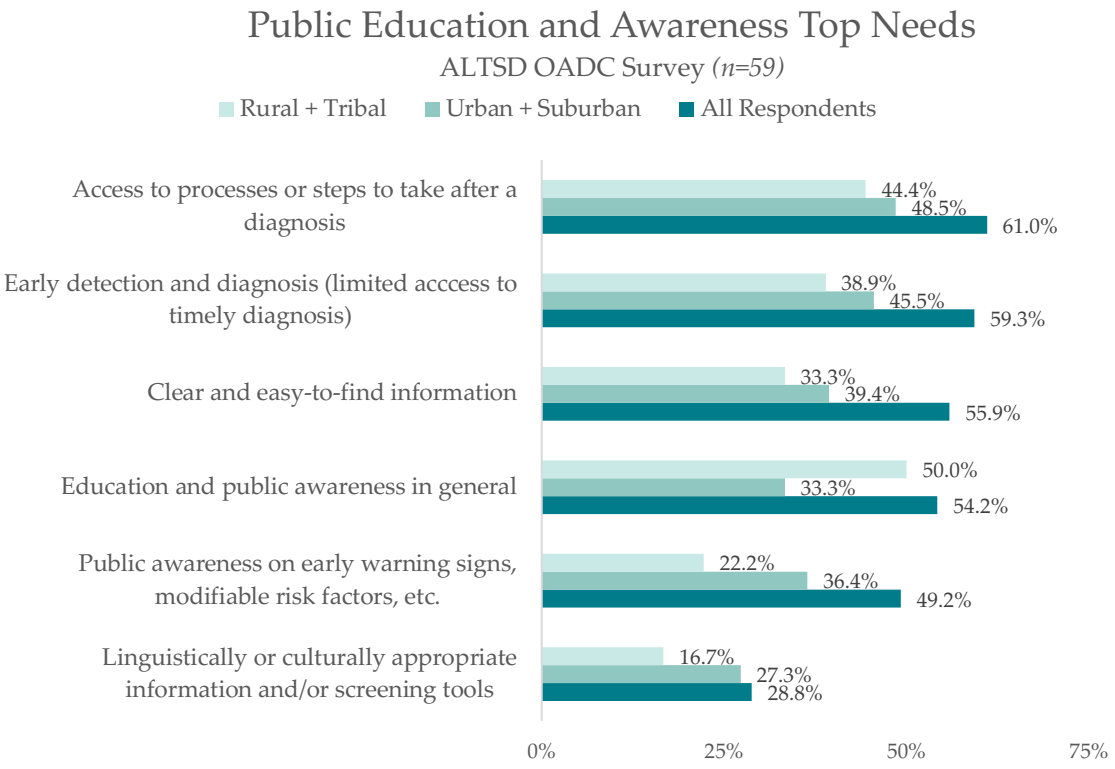
with survey respondents that expanding the dementia workforce and increasing dementia-specific training were critical, particularly for behavior management and person-centered caregiving.



Qualified caregivers was the top need identified across all survey respondents (66.7%), but rural and Tribal organizations identified training on communication strategies, home safety, or modifiable risk factors as the top need (50%).

Interviewees reiterated how overwhelmed and unsupported caregivers feel, especially just after a diagnosis. Families frequently feel "lost," struggling to navigate services, complete applications, and identify appropriate resources. Interviewees emphasized the ways in which cultural, linguistic, transportation, and digital barriers compound these challenges, particularly for rural and Tribal families. They agreed with survey respondents that respite care resources are insufficient, especially in rural and Tribal areas, and identified a need to better coordinate and share learning across agencies and organizations focused on caregiving.

"Living with someone with dementia can be very overwhelming. We need more respite for family caregivers, in-home preferred." – Interviewee

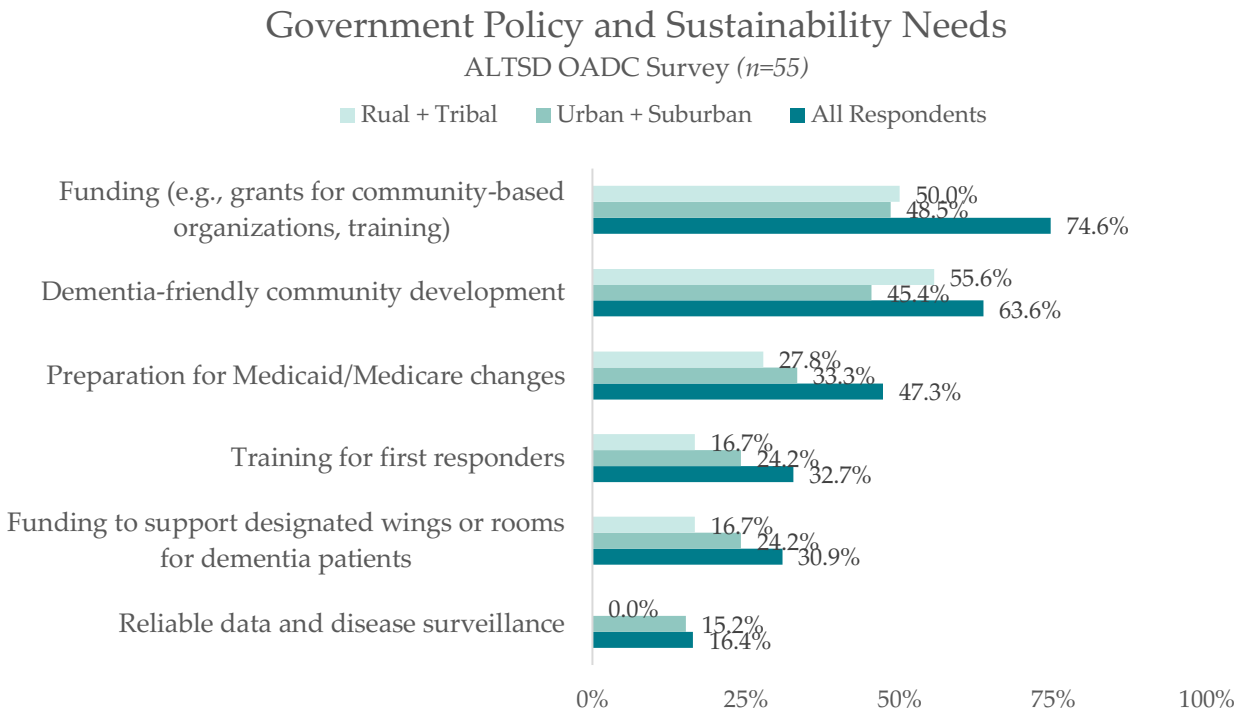


The top needs across all survey respondents included access to processes or steps to take after a diagnosis, and early detection and diagnosis. These were also among the top needs for organizations with service areas in urban or suburban settings, as well as those in rural or Tribal settings. Organizations in rural or Tribal settings were more likely to identify education and public awareness about ADOD in general as a top need (50%), compared to the urban/suburban organizations (33%).

Interviewees emphasized that dementia prevention is not adequately framed as a lifelong brain health issue. Efforts that focus on older adults miss opportunities for early and midlife risk reduction related to cardiovascular health, diabetes, substance use, head injury, physical activity, education, and social connection. Additionally, interviewees agreed with survey respondents that early detection and diagnosis needs improvement, and that education resources need to be multi-lingual and culturally appropriate.

"There's a huge lack of awareness about symptoms, lack of access to early diagnosis, and lack of knowledge about treatments. […] A lot of seniors in the state are getting their diagnoses too late." – Interviewee

"We need, for example, not just translation into Diné but also learning from Tribes about their practices and values around aging and developing or adapting resources accordingly." – Interviewee



Funding for community organizations via grants or training was identified as a top need among all respondents, as well as dementia-friendly community development. Dementia-friendly community development is a public health approach focusing on brain health, early diagnosis, and caregiver supports. It aims to reduce the stigma of ADOD, increase awareness, and create inclusive environments where people with dementia and their families can flourish by addressing policies and environments such as businesses and public spaces.

Interviewees also identified the need for funding to strengthen and expand services. They emphasized the need for government grant applications and reporting to be simplified and spoke about the challenges of making progress in collaboration with government agencies that experienced substantial staff turnover or agenda pivots. They emphasized the need for legislation to be written with careful thought toward implementation and evaluation. They highlighted a specific concern that the "nursing facility level of care" required for people to qualify for certain services may exclude some people with ADOD who perform well on physical assessments (or even cognitive ones when they're having a "good day") but would meet requirements if more attention was given to cognitive impairments or the assessments done another day. One interviewee also shared concerns that long-term care facility violation reports by state ombudsman were not always properly investigated. Finally, interviewees spoke about the lack of frequently updated statewide dementia and cognitive decline data.

"New Mexico lacks strong statewide dementia and cognitive decline data that is recent and updated."
– Interviewee

Parkinson's Disease

Parkinson's disease services were present but under-identified by survey respondents**.** Although most organizations described dementia-focused services, several Parkinson's-specific practices and needs emerged across responses. Parkinson's services were most often integrated within broader dementia or aging programs, rather than offered as standalone supports. Many effective practices already existed, especially in movement, sensory support, and access-focused delivery, but were often framed generically as dementia or aging services.

Current Parkinson's-Relevant Practices

- Supportive day programs serving people with Parkinson's dementia, providing structured engagement and caregiver respite.
- Movement-based activities aligned with Parkinson's best practices, including chair exercise, boxing, Tai Chi, pickleball, and balance-focused movement.
- Sensory and relaxation supports, such as sound tables, music therapy, meditation, and aromatherapy.
- Hybrid service delivery, offering Parkinson's activities and support through both Zoom and in-person formats to reduce access barriers.

Parkinson's disease was often not explicitly named, even when services were highly relevant. Supportive, non-medical interventions were more commonly referenced than clinical care. Parkinson's caregivers benefited from general caregiver supports but rarely received Parkinson's-specific education. Gaps mentioned by organizations included limited Parkinson's-specific caregiver education and support, and few clearly identified Parkinson's-only programs, especially in rural areas. New Mexico has an opportunity to formally recognize movement and sensory-based activities as Parkinson's-supportive best practices.

Recommendations Related to Direct Services, Workforce Development, Caregiving Supports, Public Education and Awareness, and Government Policy and Sustainability

Many "recommendations" were embedded in the survey respondents' identification of needs. For example, the need for educational incentives for people entering the workforce identifies a solution to the need for workforce development. Interviewees were specifically asked to identify strategies, best practices, resources, innovations, and solutions for the state to consider and offered their recommendations accordingly. Responses from interviewees are presented below, organized by the five goal areas: direct services, workforce development, caregiving supports, public education and awareness, and government policy and sustainability.

Direct Services

Recommendations offered by interviewees to meet the needs related to direct services included:

1. Expand New MexiCare and make it more accessible to Tribal communities.
2. Develop and train providers on the use of an online, HIPAA-compliant referral system in which families submit a request and receive coordinated follow-up from multiple agencies. Consider connecting the in-home assessments conducted by New MexiCare to the referral system.
3. Develop a dementia care specialist/navigator/coordinator program in which coordinators are assigned to families immediately after they receive a diagnosis and consider employing resource navigators at senior centers.
4. Set up a transportation rideshare program through Uber or Lyft (similar to the VA rideshare program in some states) for people living with ADOD with ride coordination available by phone rather than the app.
5. Provide funding for adult day health and assisted living facilities and consider tying it to requirements such as providing transportation.
6. Provide incentives for nursing facilities to open more beds for Medicaid members in their memory care units.
7. Develop an ADOD-specific complex discharge committee or real-time escalation case consult for facilities to access when they need support with complex clients.

Workforce Development

"New Mexico should professionalize the approach of giving a credential and better pay to caregivers with dementia training and recognize caregiving as a technical specialty. […] If we made more of an investment in the least expensive care settings, we could keep people out of the more expensive care settings."
– Interviewee

Recommendations offered by interviewees to meet the needs related to workforce development included:

1. Ensure medical providers are trained to properly diagnose and treat people that have the signs and symptoms of ADOD.
2. Professionalize caregiving by increasing wages, offering enhanced reimbursement for those trained in dementia, and offering hiring incentives and loan forgiveness for those entering

the dementia workforce. Consider providing in-state tuition support for people who dedicate a certain number of years to elder care after graduation.

3. Expand funding for more accessible pathways to nursing, such the Licensed Professional Nursing (LPN) program.
4. Create pathways for growth for those in the workforce.
5. Develop and distribute dementia training resources, incentivize training, make it part of the onboarding process for new hires, and consider making it mandatory across the board. For state employees, add an ADOD training to the existing training portal.
6. Provide specific advanced training that helps facilities admit more complex patients, and reimburse facilities for more complex patient admissions.
7. Train more people to provide respite care. Make sure young people getting trained have proper training to the person receiving care has confidence in the care they're getting, and consider employing seniors who are looking for flexible, part-time work to provide respite care.

Caregiving Supports

"These should be safe places with trained professionals where families feel comfortable taking their loved ones." – Interviewee

"Even having one day a week of respite would transform a lot of caregivers' lives." – Interviewee

Recommendations offered by interviewees to meet the needs related to caregiving supports included:

1. Expand respite care options, including dementia day centers, in-home respite care, and overnight respite care.
2. Consider developing respite sites for people to get respite trained, maybe through vouchers.
3. Consider streamlining efforts and services by centralizing government agencies that work on caregiving under one entity, and/or facilitate more convenings of caregiving divisions and agencies for greater coordination, and input on policy and decision making.

Public Education and Awareness

"The upstream [dementia] interventions don't just address dementia. They also address heart disease, diabetes, [and other health concerns]. So maybe there could be a statewide public health campaign about these modifiable risk factors." – Interviewee

Recommendations offered by interviewees to meet the needs related to public education and awareness included:

1. Fund and implement evidence-based prevention programs statewide.
2. Launch statewide education campaigns about prevention and modifiable risk factors, early symptoms and diagnosis, and what to do after a dementia diagnosis, including a short video explaining the new blood test and how to get it.
3. Develop and maintain a public education strategy that includes working with parters to develop community-specific, multi-lingual, culturally appropriate resources.
4. Invest in dissemination of education resources through trusted community settings and messengers, such as community health workers and senior centers.

5. Support local partners with training, mini grants, and adaptable toolkits to deliver prevention messaging effectively.

Government Policy and Sustainability

"Make funding available for evidence-based prevention programs. Bring the research about what we know works in senior centers and the community, and let's do it!" – Interviewee

Recommendations offered by interviewees to meet the needs related to government policy and sustainability included:

1. Increase data on dementia prevalence. Consider collecting the BRFSS data more frequently or develop a separate tool related to dementia.
2. Strengthen caregiver background checks and audits.
3. Develop or follow through with efforts to develop a waiver specific for people with ADOD with new rates and income guidelines.
4. In addition to the existing requirement to report abuse, neglect, and exploitation within 24 hours, require similar 24-hour reporting of any involuntary discharge of a patient from a facility.
5. Ensure long-term care facility violations are properly investigated.
6. Build a stronger relationship between ALTSD's Long Term Care Division and the Health Care Authority.
7. Make the grant application and reporting process simple and accessible by offering a "lunch and learn" for long term care facilities to learn about grant opportunities and processes. Also, work to get the leadership of the state's two main nursing home operators on board with applying for grant opportunities, and let facilities use the data they're already collecting for grant reporting and evaluation.
8. Maximize initiatives with federal dollars whenever possible, including applying for the CDC BOLD grant if/when there is another funding cycle.

IX. Review of Key Strategies at the National and State Levels

To inform the development of New Mexico's Roadmap, Aspen Solutions reviewed recent national and state plans to address ADOD.

Overview of National Plans

Three relevant and recently updated national plans that address ADOD are the National Plan to Address Alzheimer's Disease (2024 Update), the Healthy Brain Initiative State and Local Road Map (2023-2027), and the National Strategy to Support Caregivers (2022).

The National Plan to Address Alzheimer's Disease is a comprehensive plan developed under the National Alzheimer's Project Act (NAPA) that aims to prevent and effectively treat Alzheimer's disease and related dementias (ADRD) by 2025. It outlines goals to enhance care quality, expand support for caregivers, and improve public awareness. The latest update from 2024 provides progress reports and outlines ongoing strategies to meet the plan's objectives.[7]

Established by the CDC and the Alzheimer's Association, the Healthy Brain Initiative is a nationwide effort that integrates brain health into public health practice. It focuses on risk reduction, early detection, and supporting caregivers through strategic partnerships and data-driven approaches.[19] The Healthy Brain Initiative Roadmap provides twenty-four actionable steps for public health agencies to promote cognitive health and support people living with dementia and their caregivers/care partners.[18] It aims to specifically equip state, local, and Tribal public health agencies to engage in dementia risk reduction and caregiver support as public health priorities. A separate Healthy Brain Initiative Roadmap for American Indian and Alaska Native Peoples (2024) provides actionable steps specifically to address ADOD in American Indian and Alaska Native communities. Developed by Tribal leaders, physicians, and public health experts and researchers, it promotes health equity by using a strength-based approach and respects Tribal sovereignty and traditions.[21] To help implement the Healthy Brain Initiative, the CDC introduced the BOLD Infrastructure for Alzheimer's Act in 2019 with five-year grant award opportunities for state, local, territorial, and Tribal areas. Many state plans have been developed in alignment with the Healthy Brain Initiative Roadmaps.

The National Strategy to Support Family Caregivers released in 2022 by the Administration for Community Living (ACL), offers nearly 500 actions to support family caregivers across various sectors. It emphasizes the importance of caregivers in the long-term care system and provides a framework for enhancing their support. The 2024 progress report details the federal government's implementation efforts, highlighting completed actions and ongoing initiatives to support caregivers. This strategy supports all family caregivers, including those caring for children, adults with disabilities, Veterans, and older adults with dementia.[22]

Overview of State Plans

Four state plans composed of promising strategies to address ADOD include the Montana Alzheimer's Disease and Related Dementias State Plan 2025 (referenced below as "Montana"), the Virginia Dementia State Plan 2024-2027 (referenced below as "Virginia"), the Maryland State Plan to Address Alzheimer's Disease and Related Dementias: 2022-2026 (referenced below as "Maryland"), and the Arizona Alzheimer's Disease and Related Dementia State Plan 2024-2029 (referenced below as "Arizona"). Recognized by the New Mexico OADC, the Montana and Maryland plans include similar priorities to New Mexico's priorities and align with key strategies in the national plans. The Virginia and Arizona plans, developed in 2024 and intended to guide the states' work through 2027 and 2029 respectively, offer additional recently developed examples that also align with key strategies in the national plans. Montana, Maryland, and Virginia are three of 43 state, local, territorial and Tribal areas that received BOLD grants. Each state plan provides a road map or blueprint for a statewide comprehensive public health approach to dementia and brain health.

Key Strategies Across National and State Plans

While the three national and four state plans described above vary in their approaches, several common strategies are employed across them. Below is a review of key strategies, followed by examples of how they are carried out in the state plans. Strategies are organized by the five goal areas identified by the OADC: 1) direct services, 2) workforce development, 3) caregiving supports, 4) public education and awareness, and 5) government policy and sustainability.

A. Direct Services

In response to the need to increase access to high quality dementia care and support, national and state plans employ the following key strategies:

1. Enhance care quality and efficiency by promoting person-centered, culturally appropriate care across care settings. This is a key strategy in the National Plan to Address Alzheimer's Disease, and is employed across the state plans in a variety of ways:

- Ensure state-funded services adopt person-centered, dementia-capable approaches and policies (Virginia, p. 32).
- Educate health care professionals about best practices for dementia care, focusing on a comprehensive, interdisciplinary, team-based, person-centered approach (Montana, p. 13; Maryland, p. 26).
- Direct efforts toward populations disproportionately or uniquely affected by ADOD (Maryland, p. 28).
- Implement comprehensive, multi-disciplinary, person-centered dementia care approaches that address the complex needs of both patients and their caregivers (Arizona, p. 30).
- Make care safer by educating the public about the signs of elder abuse and the resources available (Arizona, p. 30).

2. Improve coordination of care and navigation across the course of the disease. This is a key strategy employed by the state plans, specifically emphasized in the Virginia and Montana plans:

- Promote interdisciplinary memory assessment centers and fund dementia care navigators who provide care coordination services in addition to community screening and education (Virginia, p. 36).
- Promote the use of standardized protocols for referrals and follow-up care after screening or diagnosis (Virginia, p. 36).
- Support integrated care systems between primary, acute, and long-term care settings with an emphasis on minimizing transitions, repeat hospitalizations, and emergency department visits (Virginia, p. 36).
- Enhance care coordination with particular attention to change in care settings (Montana, p. 14).

3. Increase public knowledge and use of services for people living with dementia and their caregivers. This is an emphasis of the Healthy Brain Initiative Roadmap, and employed by the state plans in a variety of ways:

- Create ways for communities to network with each other about existing services and resources (Montana, p. 14). One way Montana has done this is through their own robust online Aging and Disability Resource Center with specific categories for brain/memory, caregiving, etc.
- Build and promote a central source for resources and information such as Dementia Capable Virginia (Virgina, p. 35).
- Increase access to services through a centralized repository for resources and by establishing more support centers or online platforms that provide 24/7 assistance and information (Arizona, p. 28).

4. Expand access to specialty care, such as psychiatric, geriatric, and palliative services. Three state plans employ a variation of this strategy:

- Expand psychiatric, geriatric, and palliative services for minorities and other under-served populations, including through the use of telehealth, telemedicine and other emerging technologies (Maryland, p. 29).
- Expand behavioral health services (beyond psychiatry) (Montana, p. 14; Maryland, p. 29) and evidence-based programs/strategies to address dementia-related neuropsychiatric symptoms (Maryland, p. 29).
- Include expansion of the PACE program and similar services (Virginia, p. 31).

5. Expand early cognitive screening for people with dementia risk factors, and ensure access to new treatments. Multiple state plans emphasize the importance of increasing early screening – through service expansion, workforce development, and public education (see "Public Education and Awareness" and "Workforce Development" sections below):

- Advance early cognitive screening for people with dementia risk factors, including those at risk for younger onset Alzheimer's, or those with Down syndrome, traumatic brain injury, and developmental disability (Montana, p. 13).

- Ensure access to new treatment options and the most advanced technology for diagnosis (Montana, p. 14).
- Promote the use of Project ECHO to improve dementia-related knowledge and capabilities of rural and regional healthcare workers, emphasizing accurate and early detection and diagnosis/referral (Virginia, p. 34).

6. Expand and promote legal, financial, estate, and health care decision support services for people living with dementia and their families. Several state plans include actions directed at this strategy:

- Support estate and end-of-life planning through webinars for older adults, published documents called MontGuides, and estate planning clinics with families of people living with dementia (Montana, p. 9).
- Educate the public about advance care directives and end-of-life wishes by encouraging the inclusion of a dementia provision in advance care directives and health care powers of attorney (Montana, p. 12), and encouraging caregivers and people living with dementia to complete estate planning documents (Montana, p. 16).
- Encourage state agencies and private sector organizations to promote state-specific legal and financial resources (Montana, p. 16).
- Enhance financial literacy and preparedness by including legal and advanced care planning in caregiver training (Maryland, p. 35-36).

B. Workforce Development

In response to the need to build a diverse, interdisciplinary workforce with the training and skills to provide high-quality dementia care (i.e., "a dementia capable workforce"), state and national plans employ the following key strategies:

1. Increase dementia-specific training for the workforce, including healthcare workers, first responders, and legal and financial services personnel. A key strategy of the National Plan to Address Alzheimer's Disease and the Healthy Brain Initiative, promoting dementia specific training is also employed by all four state plans:

- Educate health care professionals about best practices for dementia care, focusing on a comprehensive, interdisciplinary, team-based, person-centered approach (Montana, p. 13; Maryland, p. 26).
- Train healthcare providers to have open, honest conversations with patients and family members/caregivers about the dementia prognosis and assist them in making compassionate decisions (Montana, p. 13).
- Educate health professionals about standard ADRD screening assessments and diagnostic tools and ensure primary care providers are adequately prepared to evaluate, diagnose, and discuss ADRD-related diagnoses with patients and their families or caregivers (Maryland, p. 24).
- Integrate dementia-specific training modules into existing trainings offered by agencies (Virginia, p. 34).

- Require regular training for law enforcement and first responders on best practices for interacting with people living with dementia (Montana, p. 14).
- Source and implement dementia-specific training for legal and financial service personnel, including general-practice attorneys, prosecutors, judges, magistrates, victim advocates, court clerks, bank tellers, accountants, financial advisors, loan officers, and collectors (Virginia, p. 35).
- Ensure dementia and brain health training is part of the curriculum of all healthcare educational institutions and part of ongoing education (Montana, p. 12).
- Partner with health systems, associations, and agencies to ensure appropriate screenings are being trained on and implemented (Arizona, p. 31).

2. Address dementia-capable workforce shortages by building a network of trained and certified workers, and offering incentives. The Maryland and Montana plans incorporate specific strategies to address workforce shortages:

- Build a network of trained and certified community health workers skilled in engaging people living with dementia, their families, and health care providers (Maryland, p. 27).
- Invest in nurse practitioners and physician assistants to specifically fill the gap of physician shortages (Montana, p. 14).
- Encourage health care and direct service workers to pursue careers focused on geriatrics populations by offering financial incentives such as loan forgiveness, tuition assistance, stipends, and scholarships (Maryland, p. 31).

C. Caregiving Supports

In response to the need to improve and expand support for informal/personal/family caregivers/care partners, state and national plans employ the following strategies:

1. Recognize and value family caregivers as essential partners in health care and long-term services and supports. A key component of the National Strategy to Support Family Caregivers, this strategy is also used in the state plans:

- Promote the inclusion of the designated caregivers for people living with dementia in the care team, emphasizing caregiver-provider communication, person-centered decision making, coordinated care across care settings (Montana, p. 15), and care planning (Maryland, p. 34).

2. Prioritize caregiver support through community resources and caregiver education. This is a key strategy in both the National Plan to Address Alzheimer's Disease and the National Strategy to Support Family Caregivers, and employed in all four state plans:

- Support best-practice, culturally appropriate training programs for unpaid caregivers, connecting unpaid caregivers/care partners to information and education about dementia and the caregiving process (Virginia, p. 35).
- Inform caregivers about the services and supports available to them (Virginia, p. 35).

- Expand the delivery and accessibility of free statewide ADOD-capable caregiver workshops and trainings offered by existing local and national organizations (Maryland, p. 35).
- Support funding for the expansion of telehealth and virtual or web-based resources for family caregivers, especially in rural and under-resourced areas (Montana, p. 12).
- Increase the state's capacity to support caregivers to enhance the safety and quality of care (Arizona, p. 30).

3. Address the health and wellness of the informal/family caregiver.

- Promote education and awareness of caregiving as a behavioral and physical risk factor that requires public health attention (Maryland, p. 37).
- Expand and increase access to caregiver-focused wellness and support programs that include evidence-based interventions (Maryland, p. 37), such as education programs, counseling referrals, respite, and others (Virginia, p. 37).

4. Ensure financial and workplace security through paid leave policies, flexible scheduling, and caregiver tax credits. Another key component of the National Strategy to Support Family Caregivers, this strategy is included in all four state plans:

- Use tax incentives to support caregivers with the purchase of technology, respite care services, and other costs (Virginia, p. 37).
- Establish workplace policies that support caregivers, such as flextime, telecommuting/remote work options, referral services, etc. (Montana, p. 16).
- Expand and promote paid or unpaid leave options, and consider ways to adequately reimburse caregivers/care partners for the services they provide (Montana, p. 16).
- Promote supportive policies and programs for employees who are caregivers and model health worksites for employees (Arizona, p. 31).

D. Public Education and Awareness

In response to the need to increase public awareness, prevention, and early detection of ADOD, national and state plans employ the following key strategies:

1. Promote early detection and diagnosis by reducing stigma, normalizing discussions about memory concerns, and encouraging regular cognitive screening. This is a key strategy shared by the National Plan to Address Alzheimer's Disease, the Healthy Brain Initiative, and the National Strategy to Support Family Caregivers, and employed by the state plans in a variety of ways:

- Deliver public service announcements, television commercials, and educational programs (Montana, p. 9).
- Develop language to include in education materials, campaigns, and literature to reduce stigma surrounding the disease and its progression (Montana, p. 15).
- Collaborate with existing organizations to deliver education and reduce stigma (Virginia, p. 35).

- Build ongoing relationships with community groups in diverse and underserved communities to identify needs, reduce stigma, and increase early detection and diagnosis (Arizona, p. 31).
- Fund public health campaigns to educate the public about early signs of cognitive impairment, the value of early detection, and the importance of discussing changes in memory and thinking with health care professionals (Arizona, p. 31).
- Build a strong state government collaborative effort with other stakeholders, including Tribal governments, to ensure broad public awareness, prevention, early detection of dementia, and healthy brain initiatives (Montana, p. 12).
- Invest in programs and initiatives aimed at early detection and intervention such as community outreach programs, health professionals training, and regular cognitive screening promotion for at-risk populations (Arizona, p. 31).

2. Promote education about healthy brain aging and modifiable risk factors throughout the lifespan. This is a key strategy of the Healthy Brain Initiative, and employed by three state plans:

- Implement multi-pronged public awareness campaigns about dementia and healthy brain aging (Maryland, p. 22-23; Montana, p. 12).
- Embed information on brain health and modifiable risk factors of dementia in broader public health campaigns (Virgina, p. 40).
- Collaborate with related public health efforts to encourage risk reduction strategies, including healthy lifestyle behaviors (Virginia, p. 41).
- Support dementia care navigators in their role as community educators (Virginia, p. 35).

3. Ensure public education efforts reach rural, under-resourced, and higher risk populations, and messaging is culturally responsive. This is a strong theme throughout the state plans:

- Promote awareness and direct education campaigns toward these populations (Maryland, p. 23; Virginia, p. 41).
- Ensure all efforts are made to identify and reach populations at high risk (Montana, p. 12).
- Build collaborative relationships to include rural, Tribal, and underserved communities in program planning and implementation (Montana, p. 15).
- Provide evidence-informed training and resources for health care providers to facilitate culturally sensitive conversations about brain health across the lifespan with patients and caregivers (Arizona, p. 29).

4. Educate children and young adults about brain health and dementia. Another key strategy emphasized by the Healthy Brain Initiative, a focus on educating children and young adults, is adopted by three state plans:

- Include brain health messaging in school-based health programs from middle school through college (Montana, p. 12), or from K-12 through college (Virginia, p. 41).

- Incorporate specific topics related to brain health into school-based health programs, including risk and protective factors, impact of diet and nutrition, social engagement, cognitive stimulation, physical activity, etc. (Maryland, p. 25).

E. Government Policy and Sustainability

In response to the need for efforts addressing ADOD to be sustainable, to be built on high quality research, and to be supported by sound policy, state and national plans employ the following strategies:

1. Expand research for prevention, diagnosis, treatments, and ultimately a cure. A key strategy of the National Plan to Address Alzheimer's Disease, this is carried out in the state plans in a variety of ways:

- Fund and lead dementia research initiatives through partnerships with local research institutes and universities, and build collaborative relationships among national, regional and state research organizations (specifically the Alzheimer's Association and the BOLD Centers of Excellence) (Montana, p. 16).
- Provide support to researchers by directing them to dementia and caregiving-related data sources, developing a research consortium network, etc. (Virgina, p. 39).
- Promote public research participation through education, incentives, fostering university-community partnerships, etc. (Virginia, p. 39).
- Consider creating an interstate research consortium to identify other states facing similar ADOD-related challenges, share research resources, and advance research in high-priority areas (Maryland, p. 39).
- Continue to invest in research and innovation to develop new treatments, interventions, and caregiving approaches by funding research initiatives, supporting clinical trials, and fostering collaboration among researchers, healthcare professionals, and community stakeholders (Arizona, p. 28).

2. Review legislation and regulations for licensing professions and facilities, and ensure training requirements are standardized. The Maryland and Virginia state plans emphasize strategies to review and standardize dementia-specific training requirements:

- Convene stakeholders such as advocacy groups, caregivers, and providers to identify gaps in ADOD care (Maryland, p. 27).
- Standardize training for health care professionals and all direct service workers (Maryland, p. 27).
- Review licensing and protocols for long-term facilities and advocate for the standardization of dementia care practice assessments, service delivery, training, and oversight (Virginia, p. 31).

3. Expand availability of and access to Medicare, Medicaid, and other state-administered services. This is a key strategy among the state plans that supports strategies under the other four goal areas as well:

- Increase awareness that cognitive screening is available through Medicare (Virginia, p. 35).
- Promote healthcare providers' use of the Medicare Annual Wellness Visit (Maryland, p. 24; Montana, p. 16) and the Medicare-reimbursable follow-up Cognitive Assessment and Care Plan Services (Maryland, p. 24) or Cognitive Impairment Care Planning Visit (Montana, p. 16).
- Leverage underutilized benefits from the Centers for Medicare and Medicaid Services incentives by providing education and tools to healthcare systems and providers (Maryland, p. 31; Montana, p. 14).
- Expand and promote paid and unpaid leave services available to employees who are caregivers, such as the Family Medical Leave Act (FMLA), extended leave, or Medicaid (Montana, p. 16).

4. Build collaborative partnerships among federal, state, local, and Tribal agencies, healthcare providers, community-based organizations, policymakers, and academic institutions. A variation of this strategy is included in the National Plan to Address Alzheimer's Disease, the Healthy Brain Initiative, and the National Strategy to Support Family Caregivers, and included in the state plans:

- Create collaborative public health-health care advisory groups and partnerships to strengthen and build capacity within organizations (Montana, p. 13).
- Form partnerships to identify existing innovative programs (Montana, p. 14) and potential strategies (Maryland, p. 27-28) that address workforce development, care access, and quality of care.
- Build a strong collaborative effort to ensure broad public awareness and education, prevention, and early detection (Montana, p. 12).
- Foster university-community partnerships to further research and development, address community needs, and promote research opportunities (Virginia, p. 39).
- Develop dementia-related pandemic and emergency preparedness plans (Montana, p. 12).

5. Use data and research to guide decisions, inform policy, and measure outcomes. Emphasized by the National Plan to Address Alzheimer's Disease, the Healthy Brain Initiative, and the National Strategy to Support Family Caregivers, this strategy is also employed in the state plans:

- Support implementation of the BRFSS optional modules for cognitive decline and caregiving (Virginia, p. 44; Montana p. 16) and use the data to inform and develop programs and policies (Virginia, p. 44).
- Use data gained from needs assessments to identify barriers and guide services planning to support gaps and enhance availability and accessibility of services (Maryland, p. 37).
- Develop and implement a set of dementia-related, outcome-based performance measures (Maryland, p.45).
- Define and track performance and evaluation measures identified in the Healthy Brain Initiative Road Map series (Montana, p. 16).

- Use quantitative and qualitative data to inform the state plan's ongoing implementation, review data with input from priority populations, and contract the services of an evaluator to capture progress made toward implementation (Arizona, p. 32-33).

6. Advance health equity by focusing on disproportionately affected communities. A key component of the Healthy Brain Initiative, this strategy is employed by the state plans in several ways that support the other four goal areas as well:

- Identify challenges to conducting dementia clinical trials and health service research in underrepresented and underserved populations, such as rural and Tribal communities (Montana, p. 17), and develop ways to increase participation (Montana, p. 17; Virginia, p. 39).
- Support funding for the expansion of telehealth and virtual resources for family caregivers in rural and under-resourced communities (Montana, p. 12).
- Focus on diverse and underserved communities in public health education campaigns (Arizona, p. 31).
- Increase services to populations disproportionately or uniquely affected by ADRD, including racial/ethnic minorities, individuals living with developmental and intellectual disorders, those living alone or socially isolated, those with early-onset Alzheimer's disease, and those living in underserved and under resourced communities (Maryland, p. 28-29).

X. Research Design, Methodology, and Limitations

Review of Research Objectives

As stated in the scope of work from the New Mexico ALTSD and as further refined in discussions with ALTSD, the objectives of this study were to:

- Conduct a meta-analysis of various national and state dementia-related needs assessments and plans, including a review of key strategies from other state plans.
- Conduct a New Mexico statewide inventory of dementia-related services and providers.
- Draft statewide goals and SMART objectives to be considered for the New Mexico State Roadmap to Address Dementia and Brain Health (drafted in a separate document from this one).
- Provide recommendations for dementia-related programs and considerations for pilot programs.

Overall Research Design

To fulfill the above research objectives, Aspen Solutions designed a mixed-method study that included an extensive review of existing quantitative and qualitative information, a statewide survey with organizations that provided services to those living with ADOD and caregivers of people with ADOD, and qualitative interviews with specific content experts. Aspen Solutions carried out this study in three stages, including:

Phase 1: Review of existing information
Phase 2: Statewide survey of ADOD service providers
Phase 3: Interviews with content experts

Each of these phases and their related methodologies are described below.

Methodology

Phase 1: Review of existing information

To complete specific sections of this report, in September and October 2025, Aspen Solutions reviewed, synthesized and interpreted various databases, published and unpublished reports, and other documents. These data sources, as organized by report section, included:

Sections I, IV, and V: Defining Alzheimer's Disease and Other Dementias, State of ADOD in the United States and New Mexico:

- Facts and figures on ADOD, from Alzheimer's Association publications
- National Plan to Address Alzheimer's Disease: 2024 Update
- New Mexico Indicator Based Information System (IBIS)

For the complete list of references used, see List of References, items 1-20.

Section VII: Meta-Analysis of Recent New Mexico Needs Assessments:

- New Mexico Older Adults Needs Assessment (Wilkins, et al., 2024)
- Notes from the Alzheimer's Association on a series of forums they conducted with the New Mexico OADC in rural New Mexico

Section IX: Review of Key Strategies at the National and State Levels:

- National Plan to Address Alzheimer's Disease (2024 Update)
- National Healthy Brain Initiative, 2025
- Healthy Brain Initiative State and Local Roadmap for Public Health, 2023-2027
- Healthy Brain Initiative Roadmap for American Indian and Alaska Native Peoples 2024
- National Strategy to Support Family Caregivers
- Various states' plans to address ADOD, including New Mexico, Montana, Maryland, Virginia, and Arizona

For the specific references used, see List of References, items 7, 21-28.

In mid-October, Aspen Solutions submitted a draft of these report sections to ALTSD, which then provided their feedback in November. Based on their feedback, Aspen Solutions conducted additional reviews of needs assessment reports and state plans and on November 21, submitted a revised draft of these portions of the report to the ALTSD team for review.

Phase 2: Survey of dementia-related services

To collect the information needed for developing an inventory of dementia-related services, as well as to gain additional information on perceived needs, from October through December, Aspen Solutions conducted an online survey with organizations that served people living with ADOD and their caregivers.

Questionnaire: The data collection instrument consisted of an online Survey Monkey questionnaire made up of 61 closed-ended and short-answer questions. The questionnaire was developed in August and September by Aspen Solutions with input from several content experts and then pretested with five different types of ADOD service providers and specialists. After revising and further fine tuning the questionnaire, a draft was sent to ALTSD, which provided additional input that was then incorporated, and gave final approval in mid-October. A copy of the questionnaire can be made available upon request.

Procedures: The target group for the online survey was high-level administrators of organizations that provided services to people living with ADOD and/or their caregivers throughout New Mexico. To reach this group, from September through November, Aspen Solutions emailed the survey to 542 individuals, as identified in the DHI facilities contact list, a list of organizations provided by Health Link, and a list of respite providers who were invited to the ALTSD Caregiver Summit in early 2025. Of the 542 emails sent, 57 "bounced" back. Following the initial emails, online weekly reminders were sent to those who had not yet completed the questionnaire, as well as 462 reminder post cards via snail mail. Aspen Solutions also advertised the survey, with a QR code to the questionnaire, in *Prime Time* magazine and ALTSD's e-newsletter. In addition, invitations to the survey were posted on ALTSD's Facebook and Instagram pages. Lastly, Aspen Solutions made 111 phone calls promoting the survey to organizations on the DHI, Health Link, and respite provider contact lists that had not yet responded.

Respondents: As a result of these efforts, by December 30, 109 respondents had completed parts of the survey. A description of survey respondents is in section VI.

Data analysis. To analyze the survey data, Aspen Solutions first exported the data into Excel. After sorting and cleaning the data within Excel, team members then ran the appropriate frequencies, counts and percentages, depending on specific survey questions. To examine the relationships between specific variables, team members also conducted cross-tabulations of specific questions by type of service and geographic area.

Phase 3: Interviews with content experts

To glean additional information around the past efforts of ALTSD and recommendations for New Mexico's new ADOD Roadmap, Aspen Solutions conducted a series of interviews via Zoom with various content experts.

Interview guide: The interview guide was developed by Aspen Solutions, based on the study's objectives, preliminary findings of the survey with ADOD service providers, and discussions with ALTSD. The questions covered such topics as the accomplishments of and challenges facing ALTSD, the state's largest needs related to ADOD, and possible strategies and best practices ALTSD should consider when developing the state's new ADOD Roadmap. A copy of the interview guide can be made available upon request.

Sample of Interviewees: Those interviewed for this study were purposively selected content experts, based on recommendation by ALTSD and other content experts. Of the twelve experts invited to participate, eleven participated in the interviews, lasting about 45 minutes each.

Data analysis: To analyze the interview data, Aspen Solutions conducted a content analysis of the extensive notes taken during the interviews. More specifically, after reading the notes several times, team members identified major themes within the data, organized mostly by question, and then noted areas of convergence and divergence.

Limitations

This report reflects the collection and use of reliable and valid quantitative data and trustworthy qualitative data. However, as with nearly all studies, there are particular limitations to this study. For each phase of the study, these limitations include:

Phase 1, Review of existing information. A major limitation within the early sections of the report was the lack of information available for Aspen Solutions to review. This was particularly true when describing the state of ADOD in New Mexico, where much of the statistical data in the New Mexico IBIS database and other reports were somewhat dated. Similarly, and contrary to expectations, there was little information available for Aspen Solutions to conduct a meta-analysis of recent ADOD New Mexico needs assessments. As a result, the Aspen team relied primarily on a recent study conducted by the University of New Mexico on the needs of older adults in New Mexico, as well as information provided by the Alzheimer's Association. A review of data from the ALTSD Caregiver Summit was also included in the scope of work but the data was not available by this report deadline and

therefore, is not included. To compensate for this gap in information, Aspen Solutions incorporated several needs-related questions in its survey of ADOD service providers.

Phase 2, Survey of dementia-related services: The findings of the survey were limited in several ways. The first was that contact information for ADOD service providers across the state of New Mexico was limited. Aspen Solutions relied heavily on obtaining contact lists from ALTSD, which ended up being a facility list from DHI from 2024, which was limited and required extensive reformatting, and a list of invitees to the 2025 Caregiver Summit, which Aspen Solutions did not receive until midway through the survey period. To obtain the contact information for additional ADOD service providers, Aspen Solutions purchased a provider list from Health Link, which, unfortunately, was not as targeted toward ADOD organizations as hoped. As a result, the survey is not based on a complete or near-complete sampling frame of all ADOD service providers across the state. In addition, there is probable but unknown selection bias amongst those who completed the survey. Lastly, delays in receiving ALTSD's feedback, suggested changes, and approval of various parts of the study meant limited time to conduct the survey. These factors all contributed to the low response rate of 22.4%, despite extensive follow-up efforts, including reminder emails, postcard mailings, and phone calls. This low response rate, coupled with an incomplete sampling frame and probable selection bias in respondents, meant that the inventory of ADOD services was not complete and the findings from the survey cannot be generalized beyond those who participated. Nevertheless, because of the positions and extensive knowledge of those who did complete the survey, this study provides important insights on the types of services available and the various needs of ADOD service providers in parts of New Mexico.

Phase 3, Interviews with content experts: The major limitation with this part of the study was lack of time, due to the delays with the survey (see above) and the need to complete this report by the time the State Legislature began its session in January 2026. This resulted in not being able to conduct as many interviews as desired. Nevertheless, the interviews conducted provided much of the information needed to fulfill the study's objectives, particularly regarding content for the future New Mexico ADOD Roapdmap.

Because of these various limitations, the findings of this study cannot be generalized to all areas of the State, nor can the inventory of services be considered as exhaustive of all dementia-related services in New Mexico. Nevertheless, because of the relevance and quality of the data collected, this study offers important insights, as well as provides a partial list and description of ADOD services in New Mexico, which can be expanded upon by further investigations.

XI. Directory of Survey Respondent Organizations by County

Organizations are categorized by the counties in which they are located. Some organizations serve areas beyond the county in which they're located. The colored dots indicate that respondents identified the following about the organization:

• = *offers services for people living with ADOD*
• = *offers services for caregivers of those living with ADOD*
° = *offers services specifically for those living with Parkinson's Disease*

Bernalillo County

A Love for Life•••°
4108 Alcazar St. NE
Albuquerque, NM 87109
Phone: 505-584-9700
Email: ed@aloveforlifellc.com

A Love for Life - Bear Canyon•••°
7534 Bear Canyon NE
Albuquerque, NM 87109
Phone: 505-485-3302
Email: ed@aloveforlifellc.com

A Love for Life - Park Avenue•••°
1711 Park Ave SW
Albuquerque, NM 87104
Phone: 505-485-3302
Email: ed@aloveforlifellc.com

Albuquerque Uptown Assisted Living•
7611 Indian School Rd. NE
Albuquerque, NM 87110
Phone: 505-321-3004
Email: annavgarcia4@yahoo.com

Alzheimer's Association•••°
6731 Academy Rd. NE
Albuquerque, NM 87109
Website: www.alz.org/newmexico
Phone: 505-266-4473
Email: dsmithburg@alz.org; Contact Form: www.alz.org/contact-us

Ambercare, Belen••
420 N. Main Street
Belen, NM 87002
Website: www.ambercare.com
Phone: 505-864-8272

Bear Canyon Rehabilitation•
5123 Juan Tabo Blvd. NE
Albuquerque, NM 87111
Website: www.genesishcc.com
Phone: 505-292-3333

Beehive Homes•°
4811 Hardware Drive NE, Suite D1
Albuquerque, NM 87109
Website: www.beehivehomes.com
Phone: 505-554-2702
Email: nmanning@beehivehomes.com

Beehive Homes of Albuquerque West•°
6000 Whiteman Dr. NW
Albuquerque, NM 87120
Website: www.beehivehomes.com
Phone: 505-270-9989

Beehive Homes of Four Hills•°
13450 Wenonah SE
Albuquerque, NM 87123
Website: www.beehivehomes.com
Phone: 505-332-8058
Email: jessica.beehivefourhills@gmail.com

Beehive Homes of Four Hills 2•••
13450 Wenonah SE
Albuquerque, NM 87123
Website: www.beehivehomes.com
Phone: 505-299-1203
Email: sarah.beehivefourhills@gmail.com

Beehive Homes of Four Hills 4••°
13450 Wenonah SE, Suite 104
Albuquerque, NM 87123
Website: www.beehivehomes.com
Phone: 505-308-8824
Email: shybeehiveoffourhills@gmail.com

Beehive Homes - San Pedro Village A••°
6401 Corona Ave. NE, Ste. A
Albuquerque, NM 87113
Website: www.beehivehomes.com
Phone: 505-796-9139
Email: amber@beehivenm.com

Beehive Homes - San Pedro Village B••°
6401 Corona Ave. NE, Ste. B
Albuquerque, NM 87113
Website: www.beehivehomes.com
Phone: 505-821-9675
Email: amber@beehivenm.com

Beehive Homes - San Pedro Village C••°
6401 Corona Ave. NE, Ste. C
Albuquerque, NM 87113
Website: www.beehivehomes.com
Phone: 505-821-9358
Email: amber@beehivenm.com

Beehive Homes - San Pedro Village D••°
6100 Wilshire Ave. NE, Ste D
Albuquerque, NM 87113
Website: www.beehivehomes.com
Phone: 505-821-1592
Email: amber@beehivenm.com

Beehive Homes - San Pedro Village E••°
6100 Wilshire Ave. NE, Ste E
Albuquerque, NM 87113
Website: www.beehivehomes.com
Phone: 505-797-1294
Email: amber@beehivenm.com

Beehive Homes - San Pedro Village F••°
6100 Wilshire Ave. NE, Ste F
Albuquerque, NM 87113
Website: www.beehivehomes.com
Phone: 505-821-0082
Email: amber@beehivenm.com

Bellamah House LTd., Co.•
11601 Bellamah Ave. NE
Albuquerque, NM 87112
Phone: 505-294-5344
Email: reneellatesha@yahoo.com

Carefirst Assisted Living•
8604 Camino Osito NE
Albuquerque, NM 87111
Website: www.carefirstnm.com
Phone: 505-856-8553
Email: johnk@carefirstnm.com

Carefirst of NM Inc dba Willowwood•
1008 Chiricahua Court SE
Albuquerque, NM 87123
Website: www.carefirstnm.com
Phone: 505-856-8553

Carefree Living Assisted Living•••°
10916 Juan Tabo Pl. NE
Albuquerque, NM 87111
Website: www.carefreelivingnm.com
Phone: 505-299-8000
Email: carefreeliving505@gmail.com

Casa Del Valle ALF•
2111 Raven Lane SW
Albuquerque, NM 87205
Phone: 505-877-0275
Email: gsandoval29084@gmail.com

Casa Subina LLC•°
222 Sandia View Rd NW
Albuquerque, NM 87107
Website: www.casasubina.com
Phone: 505-264-0759
Email: anita@casasubina.com

Casa Subina LLC•°
6519 Sun View Rd. NW
Albuquerque, NM 87120
Website: www.casasubina.com
Phone: 505-264-0759
Email: anita@casasubina.com

Casita Senior Living•°
9846 Academy St. NW
Albuquerque, NM 87114
Phone: 505-525-2568
Email: manager@casitanm.com,
monica@casitanm.com

El Paraiso Management Services•°
5600 Mcleod Rd NE Ste. G
Albuquerque, NM 87109
Phone: 505-299-5111

Everest Assisted Living•
7524 Bear Canyon NE
Albuquerque, NM 87109
Website: www.everestassistedliving.com
Phone: 505-821-9547
Email: everestassistedliving@yahoo.com

Family Caregiver Center of New Mexico•
P.O. Box 36735
Albuquerque, NM 87176
Website: www.familycaregivernm.org
Phone: 505-494-4021
Email: info@familycaregivernm.org

Harmony Home Health and Hospice••°
5700 Harper Dr. NE, Unit 250
Albuquerque, NM 87109
Phone: 505-828-2273

Haven Care - Birch House•
5320 Van Christopher NE
Albuquerque, NM 87114
Phone: 505-291-1491
Email: Lori@HavenCareNM.com

Haven Care - Cottonwood House•
5305 Queens Ct.
Albuquerque, NM 87109
Phone: 505-822-0393
Email: lori@havencarenm.com

Haven Care - Evergreen House•
10400 Calle Contento NW
Albuquerque, NM 87114
Phone: 505-898-3080
Email: lori@havencarenm.com

Haven Care - Fir House•
3500 Comanche NE, Building F, Suite 200
Albuquerque, NM 87107
Website: www.havencarenm.com
Phone: 505-275-2275
Email: tim@havencarenm.com

House Calls of New Mexico - Guide Program••
2129 Osuna Rd. NE
Albuquerque, NM 87113
Phone: 505-792-8230
Website: www.housecallsnm.com

Mayberry Senior Services•••°
5528 Eubank Blvd NE, Suite 1
Albuquerque, NM 87111
Website: www.mayberry.life
Phone: 505-271-0000
Email: jessica@mayberry.life

New Mexico Aging Services - Office of Indian Elder Affairs*
8500 Menaul Blvd. NE, Suite B590
Albuquerque, NM 87112
Website: www.agingnm.gov
Phone: 505-316-5292
Email: oiea.info@altsd.nm.gov
Collaborates with internal ALTSD departments for services/resources

New Mexico Foot and Ankle Institute•°
4343 Pan American Fwy NE, #234
Albuquerque, NM 87107

New Mexico Ramp Project••
P.O. Box 90354
Albuquerque, NM 87199
Website: www.nmramp.org
Phone: 505-400-1776
Email: executivedirector@ramp.org

NextDoor HomeCare LLC••
4308 Carlisle Blvd., Suite 205
Albuquerque, NM 87107
Website: www.nextdoorhomecare.com
Phone: 505-226-6946
Email: a.sccheer@nextdoorhomecare.com

Optum•°
2929 Coors Blvd. NW, Suite 200
Albuquerque, NM 87120
Phone: 505-839-2300
Email: holly.couture@optum.com

Presbyterian Healthcare Services•
8100 Constitution Place NE
Albuquerque, NM 87110
Phone: 505-724-7300

Senior.One••°
320 Gold Avenue SW, Suite 1001
Albuquerque, NM 87102
Phone: 505-888-2191

Starlight House•
9109 Galaxia Way NE
Albuquerque, NM 87111
Phone: 505-270-0941
Email: starlightongalaxia@gmail.com

Tender Heart••°
6809 Medinah Ln. NE
Albuquerque, NM 87111
Phone: 505-328-2203
Email: lynne.blake@gmail.com

Touched by a White Dove Assisted Living•°
1605 Cardenas Dr. NE
Albuquerque, NM 87110
Phone: 505-232-0882
Email: thehud4@gmail.com

UNM Center for Memory and Aging•
1823 Camino de Salud
Albuquerque, NM 87106
Website:
www.unmhealth.org/services/neurology-neurosurgery/memory-and-aging-clinic.html
Phone: 505-272-1754 or 505-272-3315
Email: jknoefel@q.com

Westridge Village••
3130 Vista Grande NW
Albuquerque, NM 87120
Phone: 505-328-2203
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Catron County

Presbyterian Medical Services
Reserve, NM 87830

Chaves County

Beehive Homes of Roswell
2903 N. Washington Ave.
Roswell, NM 88201
Website: www.beehivehomes.com
Phone: 575-623-2256
Email: caitfitz91@gmail.com

Casa Maria Skilled Nursing Facility
1601 S. Main St.
Roswell, NM 88203
Website: www.casamariahc.com

Chaves County JOY Centers, Inc.
1822 North Montana Avenue
Roswell, NM 88201
Website: www.joycenters.org
Phone: 575-623-4866
Email: admin@joycenters.org

End of Life Options New Mexico
% Delta Management
500 Marquette Ave, Suite 280
Albuquerque, NM 87102
Website: www.endoflifeoptionsnm.org
Phone: 505-393-1321
Email: info@eolonewmexico.com

Sunset Villa Skilled Nursing Facility
1515 S. Sunset
Roswell, NM 88203

Colfax County

Beehive Homes of Raton
1465 Turnesa St.
Raton, NM 87740
Website: www.beehivehomes.com
Phone: 575-271-2341
Email: nmorgan@beehivehomesnm.com

Curry County

Beehive Homes of Clovis
2305 North Norris St.
Clovis, NM 88101
Website: www.behivehomes.com
Phone: 575-366-5003
Email: abarrows@beehivehomesnm.com

St. Anthony Healthcare and Rehabilitation Center
1400 W 21st St.
Clovis, NM 88101
Website: www.genesishcc.com/stanthony
Phone: 575-762-4705

ENMRSH, Inc.•°
2700 E. 7th
Clovis, NM 88101
Phone: 575-742-9002
Email: cathy.bryant@enmrsh.org

Doña Ana County

Ambercare, Las Cruces••
3870 Foothills Rd.
Las Cruces, NM 88011
Website: www.ambercare.com
Phone: 5750-523-8885

The Arbors••
373 Del Rey Blvd
Las Cruces, NM 88012
Phone: 575-405-5646
Email: joy@vistaliving.com

Blue Horizon Boutique Assisted Living and Memory Care•°
2707 Spitz St.
Las Cruces, NM 88005
Website: www.bluehorizonmemorycare.com
Phone: 575-642-8787
Email: jshannon.bhp@gmail.com

El Paraiso Management Services•°
1155 S. Telshor 305
Las Cruces, NM 88011
Phone: 575-652-3184
Email: rchacon@elparaisomgmt.com

Haciendas at Grace Village, LLC•
2802 Corte Dios
Las Cruces, NM 88011
Website: www.gracevillagelc.com
Phone: 575-524-1020
Email: janet@gracevillagelc.com

House Calls of New Mexico - Guide Program••
3870 Foothills Rd.
Las Cruces, NM 88011
Website: www.housecallsnm.com
Phone: 505-792-8230

Village at Northrise - Desert Willow II and Morningside••°
2884 N. Roadrunner Parkway
Las Cruces, NM 88011
Website: www.thevillageatnorthside.com
Phone: 575-522-1110

Eddy County

GoodLife Senior Living and Memory Care••
801 Cherry Lane
Carlsbad, NM 88220
Website: www.goodlifeseniorliving.com
Phone: 575-234-2000
Email: admincarlsbad@goodlifeseniorliving.com

Northgate Unit of Lakeview Christian Home••°
1905 W. Pierce St.
Carlsbad, NM 88220
Website: www.lakeviewchristian.com
Phone: 575-885-3161
Email: jknox@lakeviewchristian.com

Grant County

Ambercare, Silver City
1290 E. 32nd Street
Silver City, NM 88061
Website: www.ambercare.com
Phone: 575-388-0222

Millie's Assisted Living
600 N. Hudson St.
Silver City, NM 88061
Website: www.milliesassistedliving.com
Phone: 575-534-9172
Email: milliescnter@gmail.com

Sunset Vista Inc.
3650 N Fowler Ave
Silver City, NM 88061
Phone: 575-538-9095
Email: sunsetvistainc@gmail.com

Lea County

Beehive Homes of Hobbs
1928 W. College Lane
Hobbs, NM 88242
Website: www.beehivehomes.com
Phone: 505-591-7023
Email: starla@beehivehomesnm.com

GoodLife Senior Living and Memory Care
1706 N. 2nd St.
Lovington, NM 88260
Website: www.goodlifeseniorliving.com
Phone: 575-602-5179
Email: adminlovington@goodlifeseniorliving.com

Beehive Homes of Hobbs 2
1920 W. College Lane
Hobbs, NM 88242
Website: www.beehivehomes.com
Phone: 505-492-0038
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Lincoln County

GoodLife Senior Living and Memory Care
108 Vision Drive
Ruidoso, NM 88345
Phone: 575-315-0758
Email: adminruidoso@goodlifeseniorliving.com

Los Alamos County

Los Alamos Retirement and Senior Organization
1101 Bathtub Row
Los Alamos, NM 87544
Website: www.larso.org
Phone: 505-662-8920
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Beehive Homes of White Rock
110 Longview Dr.
White Rock, NM 87544
Website: www.beehivehomes.com
Phone: 505-226-1311
Email: danica@beehivehomesnm.com

Luna County

Beehive Homes of Deming•°
1721 South Santa Monica
Deming, NM 88030
Website: www.beehivehomes.com
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Email: amandavalenzuela84@yahoo.com

Quality Life Management Dba Willow Manor•
815 W. Adobe Dr.
Deming, NM 88030
Website: www.willowmanor.net
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McKinley County

Beehive Homes of Gallup•°
600 Gurley Ave.
Gallup, NM 87301
Website: www.beehivehomes.com
Phone: 505-863-8900
Email: trudi@beehivehomesnm.com

Bonney Home, Inc.•
2021 Barbara Ave.
Gallup, NM 87301
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Mora County

Mora Valley Community Health Services••°
P.O. Box 209
Mora, NM 87732
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Otero County

Beehive Homes of Alamogordo•°
1106 San Cristo
Alamogordo, NM 88310
Website: www.beehivehomes.com
Phone: 575-437-9001
Email: mlawson@beehivehomesnm.com

Christus Southern New Mexico••°
2539 Medical Dr, Complex A, Suite 104
Alamogordo, NM 88310
Phone: 575-466-5840

Rio Arriba County

Rio Arriba County Senior Programs••
P.O. Box 127
Tierra Amerilla, NM 87575
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Email: ljpadilla@rio-arriba.org

Roosevelt County

Beehive Homes of Portales•°
1420 S. Main
Portales, NM 88130
Website: www.beehivehomes.com
Phone: 575-356-0466
Email: jstacy@beehivehomesnm.com

Sandoval County

Beehive Homes of Bernalillo•°
200 ‘s Posse Rd.
Bernalillo, NM 87004
Website: www.beehivehomes.com
Phone: 505-867-9100
Email: shortshank112216@gmail.com

Beehive Homes of Bernalillo 2•°
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Beehive Homes of Enchanted Hills•°
6336 Enchanted Hills Blvd.
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Beehive Homes of Rio Rancho•°
204 Silent Springs
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Beehive Homes of Rio Rancho 2•°
2709 Chessman
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Casa de Paz Senior Assisted Living•°
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Rio Rancho, NM 87124
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Casita Senior Living•°
5141 Georgia Pl. NE
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Website: www.casitaseniorlivingnm.com
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ESTEAM Health•°
300 Plaza Muchomas
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Haven Care – Dogwood House•
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Healing Harmonies New Mexico•••°
4686 Corrales Road, Suite 4WC
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Jemez Senior Program
129A Canal St.
Jemez Pueblo, NM 87024
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Retreat Healthcare
4075 Jackie Rd. SE
Rio Rancho, NM 87124
Website: www.retreatnm.com
Phone: 505-891-1234
Email: nursing@retreatnm.com

The Suites Rio Vista
2410 19th St. SE
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San Juan County

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St. Michael's Namaste House LLC
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Email: acarverlabrum@gmail.com

Santa Fe County

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Christus St. Vincent's
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Beehive Homes of Santa Fe•°
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Life Circle••°
1800 Espinacitas St., Suite A
Santa Fe, NM 87505
Website: www.lifecirclenm.org
Phone: 505-418-1300
Email: director@lifecirclenm.org

The Memory Care Alliance••°
1541 S. St. Francis Drive
Santa Fe, NM 87505
Website: www.thememorycarealliance.org
Phone: 505-310-9752
Email: admin@thememorycarealliance.org

Santa Fe Parkinson's Disease Action Group°
Website: www.santafepdaction.org
Email: peggy@santafepdaction.org

Senior Services Division of the City of Santa Fe••
1121 Alto Street
Santa Fe, NM 87501
Website: www.santafenm.gov/community-services/division-of-senior-services
Phone: 505-955-4721
Email: ssd@santafenm.gov

Coming Home Connection••°
418 Cerrillos Rd., Suite 23
Santa Fe, NM 87501
Website: www.cominghomeconnection.org
Phone: 505-982-2468
Email: info@cominghomeconnection.org

Vista Hermosa••
2929 CII Vera Cruz
Santa Fe, NM 87507
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Email: brenda@vistaliving.com

Vista Listens••
2019 Galisteo St., Suite A1
Santa Fe, NM 87505
Phone: 505-477-1138
Email: hello@vistalistens.com

Vista Living Care••
402 East Rodeo Road
Santa Fe, NM 87505
Website: www.vistaliving.com
Phone: 505-596-4661

Sierra County

Ambercare, Truth or Consequences••
908 N. Date Street
Truth or Consequences, NM 87901
Website: www.ambercare.com
Phone: 575-894-1828

Socorro County

Ambercare, Socorro
832 Highway 60
Socorro, NM 87801
Website: www.ambercare.com
Phone: 575-838-1503

Bird and Compass Therapy, LLC
114 Manzanares Ave. E
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Taos County

Lion's Club of Taos, Inc.
PO Box 199
Taos, NM 87571
Website: www.lionscluboftaos.org
Phone: 575-758-0404
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Taos Pueblo
230 Rotten Tree Rd.
Taos, NM 87571
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Phone: 575-758-7824

Union County

Clayton Nursing and Rehab Center
419 Harding St.
Clayton, NM 88415
Website: www.genesishcc.com/clayton
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Email: carolyn.kear@genesishcc.com

Valencia County

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Center for Ageless Living
5A Thomas Rd.
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Phone: 505-865-8813
Email: suzette@nmagelessliving.com

GoodLife Senior Living and Memory Care
1650 N. Los Lentes Rd.
Los Lunas, NM 87031
Phone: 505-866-6100
Email: adminll@goodlifeseniorliving.com

South Valley Care Center
1629 Bowe Lane SW
Los Lunas, NM 87031
Website: www.southvalleycare.com
Phone: 505-877-2200
Email: dgipson@southvalleycare.com

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