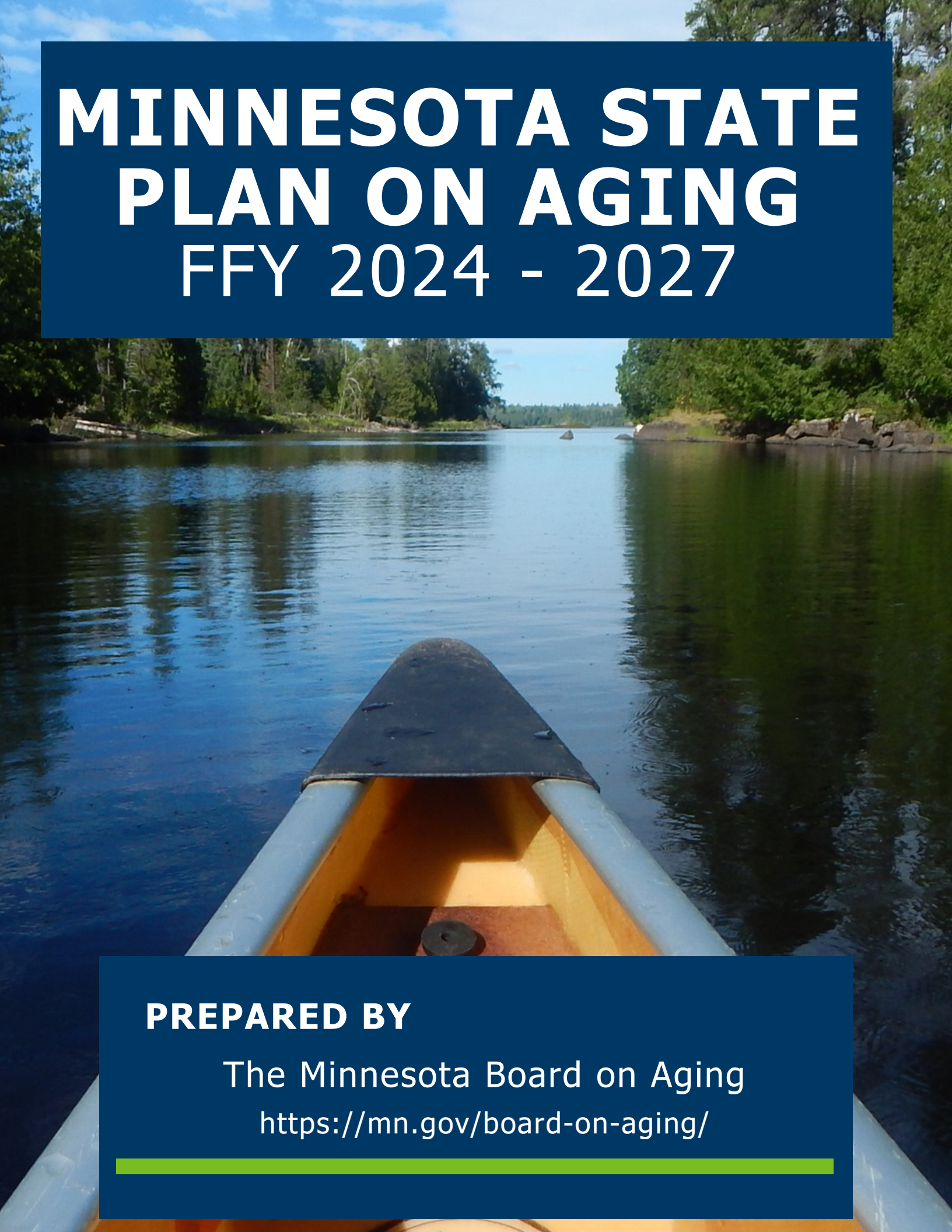


MINNESOTA STATE PLAN ON AGING

FFY 2024 - 2027

PREPARED BY

The Minnesota Board on Aging

https://mn.gov/board-on-aging/

Contents

Verification of Intent

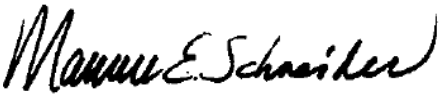
The Minnesota Board on Aging hereby submits its State Plan on Aging for the State of Minnesota October 1, 2023, through September 30, 2027, as required under Title III of the Older Americans Act of 1965.

All required assurances and plans to be carried out by the Minnesota Board on Aging which is the state unit on aging and has been given authority as defined in Minnesota statue 256.01 and 256.975 to develop and administer the State Plan on Aging in accordance with all requirements and purposes of the Act are on file.

The State Plan, when approved by the U.S. Assistant Secretary for Aging, constitutes authorization to proceed with activities under the plan.

Kari Benson, Executive Director Date: 6/30/2023

Minnesota Board on Aging



Maureen Schneider, Interim Chair Date: 6/30/2023

Minnesota Board on Aging

Executive Summary

Minnesota consistently performs well on a range of metrics, including overall resident health, volunteerism rates, and quality medical care. This success can be attributed in large part to the services and supports provided by the **Minnesota Board on Aging (MBA)** and **Department of Human Services (DHS)**, which enable older adults to live with autonomy, dignity, and maximal independence. Minnesota took early action to recognize and prepare for demographic shifts toward an older population. In 1997, Minnesota launched Project 2030, an effort to understand how demographic trends would impact our communities and the futures of older Minnesotans. Why 2030? That's the year baby boomers start to turn 85 years old, a milestone age when many individuals require additional support and possible transition to congregate settings. Through Project 2030, Minnesota took proactive measures to prepare for this turning point, which led to the *MN2030 Looking Forward* strategic planning effort that prepared Minnesota to pursue the status of an Age-Friendly State.

In December 2019, Minnesota began the process of becoming an Age-Friendly State, kick started by the Governor's Executive Order 19-38, which established the Governor's Council on an Age-Friendly Minnesota. As directed by the executive order, the Council on **Age-Friendly Minnesota (AFMN)** released eight preliminary recommendations in 2020. These preliminary recommendations, along with the eight Age-Friendly Status Checks documents helped to guide the five Minnesota State Plan Goals:

1. Advance equity and eliminate disparities, while empowering rural and diverse communities and respecting the sovereignty of Tribal Nations
2. Make aging in community truly possible for all Minnesotans
3. Support families, friends and neighbors in sustaining their caregiving roles
4. Promote and support healthy aging for all Minnesotans
5. Dismantle ageism and promote older adult rights, autonomy, and protection

The Minnesota State Plan will serve as a work plan for the MBA and its partners. This document outlines key demographic information, important concepts and innovative ideas that will help shape and drive the future of Minnesotans. Additionally, this State Plan prioritizes equity and disparities reduction at a new level and reflects on a statewide commitment to listening to, learning from, and empowering historically underserved Minnesotans.

In 2020, the MBA developed a strategic planning directive focusing on diversity, equity, inclusion and access (DEIA). Many points in this document reference 'equity' and the MBA is committed to advancing equity in service outcomes and addressing disparities experienced by the following groups with the greatest social and economic need:

- Low-income
- Identify as American Indian
- Identify as Black, Asian Pacific Islander, and/or Latine
- Veterans
- Live with a disability, including those living with mental health conditions and mental illnesses
- Identify as lesbian, gay, bisexual, transgender, queer (LGBTQ+)
- New immigrants
- Limited English proficiency
- Live in rural areas
- Identify as solo (defined as individuals who, by choice or circumstance, function without the support system traditionally provided by family[1])

[1] *A Backup Plan for Solos: Health Care Decision Making for People Aging Alone,* Citizens League, 2019 https://citizensleague.org/wp-content/uploads/2019/02/Solos-Project-Final-Report-2-2019.pdf

Aging and Living Well in Minnesota

As with many other states, Minnesota's population is becoming both older and more diverse. Thoughtful planning ensures that we seize the opportunities to build upon the knowledge and experience of older adults, as well as strategically respond to support all Minnesotans, as we grow older, to age with dignity and respect, build upon their invaluable contributions as older adults, whether as workers, volunteers, caregivers or entrepreneurs. We must continue to recognize that as we age, older adults contribute to our families and communities, and we need to strive to create systems that enable us to do so for as long as possible. Additionally, we must prioritize developing supports that will help older adults access the assistance needed when the time comes, ensuring that aging with dignity and maintaining independence is a priority.

Growing older

Currently, about 1.3 million (or 23%) of Minnesotans are age 60 or older. Of those, 107,000 (or about 8%) are people of color.[2] And recently, for the first time, Minnesota's 65-plus population eclipsed the number of school-age children. These changes are not happening uniformly across the state, greater Minnesota is collectively older than the Twin Cities metro. Residents of rural and small-town Minnesota are more than twice as likely to be age 80 or older than residents in urban parts of the state.[3] By 2033, older residents (65-plus) will make up 32% of rural Minnesota counties compared to 19% in urban counties.[4]

Older adults living in rural areas often face significant challenges in accessing essential services, such as caregiver support, transportation assistance, housing, and healthcare. Unfortunately, as more rural hospitals and nursing homes close these challenges are becoming more acute. The Rural Health Research Center at the University of Minnesota underscores the critical role that states play in supporting older rural residents, given that many aging-related resources and services originate at the state level.

Minnesota's **long-term services and supports (LTSS)** system is being called on to meet increased demand associated with these demographic shifts. For example, demands in additional funding for long-term services and supports, **Area Agencies on Aging (AAAs)**, and other state agencies are instrumental in helping older rural residents age in place by allocating resources to rural communities.[5] In Minnesota, AAAs, Live Well at Home® grants, MBA Dementia grants and GEAR grants are working to build up service capacity, test innovative approaches, and provide choices for older residents in rural Minnesota communities.

Through statewide data gathering, and stakeholder engagement this plan prioritizes addressing workforce shortages, caregiver burnout, as well as the diverse residents and geography of Minnesota. Its goal is to

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[2] *Population 60 Years and Over in the United States*, American Community Survey 5-year estimates, U.S. Census Bureau, 2021. https://data.census.gov/table?q=aging+minnesota+&g=040XX00US27&tid=ACSST5Y2021.S0102.

[3] *Greater Minnesota: Refined and Revisited*, Minnesota State Demographic Center, 2017. https://mn.gov/admin/assets/greater-mn-refined-and-revisited-msdc-jan2017_tcm36-273216.pdf

[4] *Rural Healthcare in Minnesota: Data Highlights*, Minnesota Department of Health, 2022.

https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf

[5] *Aging in Place in Rural America: What Does It Look Like and How Can It Be Supported?*, Rural Health Research Center, University of Minnesota, 2021. https://rhrc.umn.edu/project/aging-in-place-in-rural-america-what-does-it-look-like-and-how-can-it-be-supported/

ensure that services and supports will be available to us, and to the family, friends and neighbors who care for us, when and where we need them.

- **We are becoming more diverse**

Minnesota's demographic shifts also include an increase in our racial diversity. From 2013 to 2018, the state's population of black, indigenous and people of color grew by 18%, adding more than 167,000 people, while the non-Hispanic White population, currently comprising 79% of the population, saw only 1% growth in the same period. Projections indicate that populations of color are expected to increase, with over one million additional residents by 2053, exceeding one-third of the total population.[6] Conversely, the number of non-Hispanic White residents is projected to decline within the next decade.

This demographic shift has significant implications for aging-related services and supports, as cultural norms, expectations and circumstances can vary considerably when it comes to aging. Providers must be prepared to offer respectful, culturally sensitive care to older Minnesotans from a range of backgrounds. And efforts must be accelerated to shift resources to diverse communities to serve their older members.

- **Tribal Nations**

The State of Minnesota values the relationships we are actively building with the Tribal Nations whose geography overlaps that of the state. This guides us to follow our established government-to-government approach to seek consultation and participation by representatives of the Tribal governments in policy development and service program activities. The MBA has partnered extensively with Indian Country leadership to update the planning and service area of the MN Indian Area Agency on Aging (MIAAA).

There are two distinct Tribal Nations within Minnesota, the Dakota and the Ojibwe, which include 11 federally recognized tribal governments. The four Dakota communities include Lower Sioux Indian Community, Prairie Island Indian Community, Shakopee Mdewakanton Sioux Community, and Upper Sioux Community. The seven Ojibwe communities include Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Mille Lacs Band of Ojibwe, Red Lake Nation and White Earth Nation. In Minnesota, the Native American 60+ population is about 9,100[7]. More information on serving older adults in the Tribal Nations is in the Older Americans Act - Title VI section.

The Minnesota Board on Aging

The Minnesota Board on Aging (MBA) is Minnesota's federally designated State Unit on Aging. The 25-member board is appointed by the Governor and represents diverse backgrounds, ages, interests, and communities across the state. The MBA has three major roles: administrator, advisor, and advocate.

Administrator. The MBA administers federal and state funds to deliver a wide range of in-home and supportive services to older adults and family, friends and neighbors involved in their caregiving. To deliver these supportive services the MBA manages two direct service programs:

- Office of Ombudsman for Long-Term Care
- Senior LinkAge Line®

[6] *Long Term Population Projections for Minnesota*, MN State Demographer, December 2020. https://mn.gov/admin/assets/Long-Term-Population-Projections-for-Minnesota-dec2020_tcm36-457300.pdf.

[7] *Population Data Age 60 Plus by State*, AGID, 2021. https://agid.acl.gov/.

Additionally, the **Older Americans Act (OAA)** instructs the MBA to designate a statewide network of Area Agencies on Aging (AAAs). The MBA partners with Minnesota's AAAs and others to administer and oversee the effective use of the OAA and state funds to support older Minnesotans.

Advisor. The MBA provides objective, unbiased information and promotes public education on ways we can all meet the changing needs of the state's older population so we can all live well and age well.

Advocate. The MBA promotes state and local policies that allow older adults to age well and live well at home. The Board promotes policies to the state legislature, the Governor and state agencies that accurately reflect the needs and interests of older Minnesotans.

Age-Friendly Minnesota

Age-Friendly Minnesota (AFMN) is a collaborative statewide effort to make our systems and communities more inclusive of and responsive to older adults. The AFMN Council's members include leadership from nine state agencies and representatives from greater Minnesota, age-friendly and faith communities, and Tribal Nations. One of its key efforts is developing the state's first *Multi-Sector Blueprint for an Age-Friendly Minnesota*, which is envisioned as a cross-sector plan that engages and coordinates the work of a range of partners, old and new, related to aging.

As one of the member state agencies, the Minnesota Board on Aging plays a critical role in advancing the vision of an Age-Friendly MN. This State Plan on Aging includes several strategies that involve partnering with AFMN, as well as others that are aligned with our shared goals. These goals encompass a range of important objectives, including promoting equity and reducing disparities, fostering coordination among state agencies, and creating livable communities that cater to the needs of Minnesotans at every stage of life. Some of these partnerships are through the **Age-Friendly Minnesota Grants Program**, launched in late 2022, which is granting out $2.9 million over State Fiscal Years (SFY) 2023 and 2024 to encourage age-friendly community work across the state. The grant program is prioritizing diversity, equity, inclusion and accessibility (DEIA) to ensure that historically underserved communities will benefit from this funding.

The aging network is a crucial component in AFMN, with AAAs leading age-friendly efforts across Minnesota's diverse regions. Through various strategies, such as providing technical assistance to communities, educating municipal leaders, and partnering with foundations, these agencies play a critical role in ensuring that older residents have access to high quality services that enable them to remain in their homes and communities of choice. Minnesota has earned a strong reputation for its commitment to supporting the well-being of its aging population.

Multi-Stage Needs Assessment on Aging

Beginning in 2021, Minnesota conducted a multi-stage needs assessment focused on the state's older residents. The assessment was to inform plans and priorities of DHS, MBA, and the AFMN Council. It also represented a key step in the AARP Network of Age-Friendly States and Communities, which Minnesota joined in January 2022. This work started with the **Status Check Briefs** which provided updates and explored the approaches and impact of the aging network over the years 2020-2021. The briefs served as a basis for a series of structured discussions with AAAs, MBA board members and MBA staff over several months. Through these discussions, we sought to identify priority needs and opportunities related to the development of this State Plan, see **Attachment D** for the Status Check Briefs. Additionally in 2017, four key service access issues were identified through the Gaps Analysis work: shortages in **crisis services, housing, transportation**, and **workforce** and since then the state and partners have been working towards creative solutions to Addressing Gaps.

Status Check Briefs Key Findings

- ✓ Need for more equitable and culturally responsive services
- ✓ Sustaining a quality, caring workforce to serve older residents and support caregivers
- ✓ Create transportation options and pursue affordable, equitable, appropriate housing
- ✓ Recognize and treat social connection as essential
- ✓ Increase access to broadband and technology

After completing the Status Check Briefs, the state engaged Rainbow Research, a contractor, to conduct **targeted phone interviews**, **statewide surveys,** and **focus groups.** Our aim was to reach historically underserved groups, including People of Color, Native Americans, members of the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Queer) community, low-income residents, rural communities, veterans, and those with disabilities. Additionally, DHS contracted with the National Resource Center on Native American Aging (NRCNAA) to engage American Indian Tribal and urban Elders in the survey, ensuring that their voices were heard, and their unique needs were considered.

DHS built on Rainbow Research's work and developed a longer survey organized into ten sections - nine domains plus demographics. The survey included some questions from the Rainbow Research survey, AARP's livability questionnaire, and additional sources, as well as some original questions. At a high-level, **Table 1** displays some of the key findings from the statewide and American Indian and Urban Tribal Elders Survey that tie together the needs described throughout this state plan. Minnesota will build on the work completed through the needs assessments by continued collaboration with our community partners. For a summary of the needs assessment activities see **Attachment E.**

Table 1

Question	Statewide Survey	American Indian and Urban Tribal Elder Survey
Housing: needs modifications or significant repairs to their current residence to remain safely at home	50%	53%
Caregiving: Regularly help an aging family member or friend take care of themselves	35%	48%
Caregiving: Rely on friends and/or family to help with daily tasks	18%	48%
Transportation: Lack of transportation negatively impacts my life	19%	36%
Social Participation and Inclusion: often of sometimes lack companionship	42%	36%

The MBA also utilized the 2022 LGBTQ Aging Needs Assessment Report[8], conducted by University of Minnesota Geriatrics Workforce Enhancement Program (GWEP) and Rainbow Health, with support from Minnesota Department of Human Services. The report presents the results of a survey and highlights key recommendations in four critical areas. These include **trauma-informed care**, the development of programs and services for **"solos,"** support for LGBTQ+ **caregivers**, and the need for more **data.** The survey and assessment results highlight areas Minnesota must continue to build upon for us to age in the communities we choose.

[8] *2022 MN LGBQT Aging Needs Assessment Report*, Rainbow Health, 2022. Report can be found at: https://www.agefriendlymn.org/

In addition to the public engagement and data collection mentioned in this section, the State Plan on Aging was posted for an official 30-day public comment period for individuals to provide feedback on the 2024-2027 State Plan on Aging as well as the Intrastate Funding Formula. The public comment period opened on April 3, 2023, and closed May 3, 2023.

A total of 2,230 public comments were received through online survey, letter, voicemail, email and signatures. Public comments received were used to further inform the State Plan and IFF process.

Understanding Intersectionality - Continuing our journey

Despite its reputation for a high quality of life, Minnesota experiences some of the most severe race-based health disparities in the country. Further, older adults who have experienced decades of inequities on many fronts—especially those who are Black, Native American, and members of communities of color, LGBTQ+ individuals, and other marginalized groups — often find themselves in a more vulnerable position in their later

years. **Social determinants of health (SDOH)**[9] define intersections in our overall health and well-being that include circumstances of our lives, including our families, homes, neighborhoods, education, employment, access to healthcare, and natural environment.

Minnesota in 2020:

- ✓ **26%** of older adults 60+ were **living alone**
- ✓ **8%** of older adults 60+ were from **communities of color**
- ✓ **6.8%** of older adults 60+ were **below the poverty level**, with **35%** of older adults 60+ **below 300% of the poverty level**[10]

In addition to advancing equity and addressing disparities across the various groups in Minnesota, the approach to promoting healthier aging is shifting to include more than just healthcare, and now considers the intersectionality of our lives. The SDOH domains has recently expanded to include **digital inclusion**, which encompasses high-speed internet access and the ability to use it, since it is found to be linked closely to the other SDOH[11] such as health care access and social connectedness. While having virtual services has improved access for some, there are still Minnesotans who do not have access.

Digital Access

- ✓ 20% of rural Minnesotans lack internet reliable enough to use for a video visit.[4]
- ✓ Almost 300,000 Minnesotan households do not have access to high-speed internet[12]

COVID-19 underscored the intersectionality of Minnesota's socioeconomic disparities on race, culture, geography, SDOH and other factors, by highlighting and exacerbating health disparities in some communities, leading to higher risk of vulnerabilities and poor health outcomes. Throughout the COVID-19 pandemic, state and local partners worked diligently to modify and adapt service delivery and programs to meet the needs of Minnesotans. While DHS programs and partners were able to effectively pivot services and offer a variety of options allowing services to continue during the pandemic, the emergency highlighted the need to ensure LTSS programs are equitably accessible, inclusive, and responsive to the diversity of Minnesota's population. Although the pandemic provided lessons learned it also provided insight in how to provide services differently and created energy to collaborate and create new partnerships.

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[9] *Social Determinants of Health*, US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/priority-areas/social-determinants-health

[10] *American Community Survey (ACS) Demographic and Household Data*, AGID, Administration for Community Living, 2020. https://agid.acl.gov/.

[11] Sieck, C.J., Sheon, A., Ancker, J.S. *et al.* Digital inclusion as a social determinant of health. *npj Digit. Med.* **4**, 52 (2021). https://doi.org/10.1038/s41746-021-00413-8

[12] *Minnesota Governor's Task Force on Broadband 2022 Annual Report,* Minnesota Department of Employment and Economic Development, 2022. https://mn.gov/deed/assets/2022-broadband-task-force-report_tcm1045-557268.pdf

Advancing Efforts

MBA continues to support and advance efforts around equity; the following includes highlights of work that has been completed.

In 2020, the MBA supported statewide LGBTQ+ Dementia interviews. The interviews revealed that there is room for improvement around aging issues and a lack of an apparent LGBTQ+ safety net for older adults. The interviews illustrated a need for more targeted information to the LGBTQ+ community about signs, symptoms, and strategies related to dementia that is consistently shared as people age.

With the 2020 Dementia interviews and the Minnesota 2022 LGBTQ Aging Needs Assessment Report as a backdrop, the state of Minnesota is working with the aging network to expand services to LGBTQ+ and AIDs/HIV+ older adults:

- Rainbow Health is supporting dementia awareness for LGBTQ+ and HIV-positive Minnesotans. This program has provided awareness training to almost 40 older adults of different genders, races, and geographies and is working to offer a LGBTQ+ Dementia Caregiver Support Group
- Through two recent Live Well at Home® grants, Senior Community Services is conducting outreach efforts to LGBTQ+ older adults in Hennepin County, and Rainbow Health is designing and implementing a comprehensive long-term services plan for LGBTQ+ and HIV-positive older adults in the Twin Cities and Duluth

In 2022, Arrowhead, Central and Trellis Area Agencies on Aging received grant funding from ACL for *Expanding the Public Health Workforce within the Aging Network*[13]. The funds will be used to advance efforts in the Public Health Workforce to alleviate some of the strain our networks have experienced during the pandemic; to respond to the COVID-19 pandemic; and to prepare for future public health challenges. One theme across the three AAAs is to address those disparities by strengthening community connections and outreach to target populations, convening community conversations, and disseminating messages in multiple formats pertaining to: COVID-19 vaccinations and testing, wellness/disease prevention, social isolation, and the benefits of staying socially engaged.

In coordination with the MN DHS led efforts, the MBA has also utilized many tools to ensure equity is in every aspect of our work.

- The Senior LinkAge Line® (SLL) uses an equity assessment tool to analyze new policies and procedures to enhance the equity of our services
- The MBA Dementia Grants RFP and the Live Well at Home® RFP has been reviewed using the DHS Equity Analysis Toolkit
- All MN DHS and MBA leadership have completed the Intercultural Development Inventory (IDI)
- The MN DHS Aging and Disability Services Division Equity Committee will be making recommendations for equity considerations
- Led and participated in a multi-year project in partnership with the University of Minnesota Center on Healthy Aging and the MN Diverse Elders Coalition to understand and help close racial and ethnic disparities in home and community-based services.
- DHS Adult Protection Services (APS) will be using COVID-19 Pandemic funding (CARES Act) funding to train APS staff throughout the state on unconscious bias, and to advance work related to tribal issues and culturally specific service providers.

[13] *ACL begins awarding $150M to expand the aging and disability networks' public health workforce*, Administration for Community Living, 2022. https://acl.gov/news-and-events/announcements/acl-begins-awarding-150m-expand-aging-and-disability-networks-public

Advancements during COVID-19

Although remote services greatly advanced during the COVID-19 pandemic, and were allowed in both HCBS waiver programming, as well as telehealth, and in telephone reassurance with SLL, the state saw continued gaps in internet access, specifically in rural MN. This raised the visibility of social isolation and the impact on older adults, especially those living in rural communities, and uncovered disparities in greater depth. As communities are finding a balance of in-person vs remote services, social isolation continues to rise to the top. Social isolation and loneliness are important, yet neglected, social determinants of the health of older people.[14]

Older Minnesotans are Receiving COVID-19 Vaccines:

- ✓ **94.6%** of Minnesotans 65+ have had at least **one vaccine dose**,
- ✓ **92%** of Minnesotans 65+ have **completed the vaccine series**[15]

- **Digital inclusion**: Multiple AAAs pivoted to provide internet access and devices to help older adults adapt to an abrupt shift to an online world. One AAA supported an affordable housing nonprofit to purchase 50 iPads and 12 internet hotspots so that residents could participate in evidence-based health promotion programs. Another used CARES Act funding to support programs that provided older adults with tablet devices and internet service to allow them to participate in classes and stay socially connected.
- **Repurposing airline meals to meet nutrition needs of older adults**: At the height of the COVID-19 pandemic, many provider agencies closed, including kitchens for the congregate and home delivered meals sites. At the same time, the MBA learned there was a surplus of airline meals through a vendor called AMI. AMI provided a menu of frozen meals that could be loaded onto semi-trucks or airplanes to get to the more remote areas of MN, in particular to the tribal reservations. The goal was for each elder to have a 2-week supply of frozen entrees.
- **Remote Services:** MN DHS implemented permanent options to allow providers to provide a number of HCBS remotely, including adult day and companion services. MN DHS also will continue to allow annual level of care redeterminations for Medicaid HCBS to be conducted remotely, which will help to address workforce shortage and staff capacity issues at the lead agencies.
- **Reducing social isolation**: The SLL will continue working with the MN Disability Hub and the Minnesota Department of Administration's System of Technology to Achieve Results (STAR) program to support and promote the Minnesota Assistive Technology Lending Library. Through this partnership, informational videos, brochures, web copy and more materials are being developed to promote this helpful and important program. In addition to this, the AAAs have distributed over **150 robotic cats and dogs** to combat social isolation.
    - **Khan Bots**: Dr.Arshia Khan at the U of M Duluth designed robots, referred to as "Khan's Bots", to help older adults with dementia in nursing homes. The robots can give reminders for medications, track a patient's movements using sensors placed on their body and in their room, and act as companions to those unable to visit loved ones, administer therapy, entertain, play games, sing dance, help with daily living activities and help improve their mood. The Khan bots are part of a larger project Dr. Khan is working on called the "dementia-friendly living space,"

[14] *Social Isolation and Loneliness*, World Health Organization. https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/social-isolation-and-loneliness

[15] *Statewide COVID-19 Vaccine Data 65+*, Minnesota Department of Health, 2023. https://www.health.state.mn.us/diseases/coronavirus/stats/vaccine.html

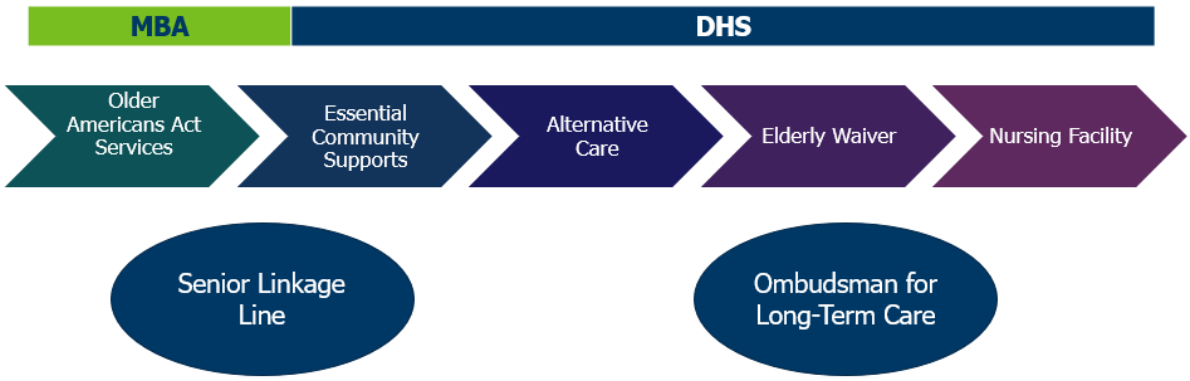
which uses sensors placed around the room to help improve the quality of life for those living with dementia.[16]

Long-Term Services and Supports in Minnesota

Long-term services and supports (LTSS) include the spectrum of health and social services designed to help Minnesotans with daily living tasks - across all funding streams. By providing assistance across various settings, including institutional and community-based settings, LTSS allows individuals to lead meaningful lives based on their personal goals and values. Minnesota is well-known for the quality services and supports it provides to older residents. The latest Long-Term Services and Supports State Scorecard[17] ranks Minnesota number one in the country for creating a high-quality system across five dimensions: Choice of Setting and provider, Quality of Life and Quality of Care, Support for Family Caregivers, Effective Transitions. This speaks to the efforts and importance DHS and the MBA place on supporting our state and ensuring older adults have supports available to lead meaningful lives. Minnesota will continue to build off of this success and lessons learned as we continue to experience demographic shifts that will increase demand for LTSS and require new approaches and strategies.

The range of services provided through the LTSS system in Minnesota is extensive and stretches across several areas within the Department of Human Services and MBA as seen in **Figure 1**. The Status of Long-Term Services and Support Legislative Report[18] provides an overview of collaboration and improvement efforts towards the LTSS system.

Figure 1



[16] *Are robots the solution to understaffed nursing homes?*, NPR, 2022. https://www.npr.org/2022/05/24/1100985010/are-robots-the-solution-to-understaffed-nursing-homes

[17] *The Long-Term Services and Supports State Scorecard 2020 Edition*, AARP Public Policy Institute, The SCAN Foundation, The Commonwealth Fund, and AARP Foundation, 2020. https://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Short%20Report%20PDF%20923.pdf

[18] *The Status of Long-Term Services and Support Legislative Report*, Minnesota Department of Human Services, 2019. https://www.lrl.mn.gov/docs/2020/mandated/200646.pdf

Home and Community Based Services

MBA and DHS oversee the spectrum of services that range from Older Americans Act (OAA) services to the means-tested programs including **Elderly Waiver** (EW), **Alternative Care** (AC) and **Essential Community Supports** (ECS). The EW, AC and ECS programs provide home and community based services for older adults who need a certain level of support so they can remain living in the community and experience a higher quality of life. All of these programs are more cost-effective for individuals and their caregivers, as an alternative to more expensive institutional services, and align with most older adults' preference to remain in their own home for as long as possible.

DHS designs and sets the standards for the HCBS system. Lead agencies, including counties, tribal nations and managed care organizations under contract with DHS, administer the programs on a local level. It is through these partnerships with lead agencies, as well as our quality management oversight that leads us to successful outcomes.

In state fiscal year **2021:**

- ✓ MN DHS served **32,000** individuals on the **Elderly Waiver**
- ✓ MN DHS served **4,000** individuals on the **Alternative Care** program

Minnesota is a managed care state, in which older adults who are dual eligible (Medicaid and Medicare) receive coordinated care through Minnesota Senior Health Options (MSHO) program. Minnesota's MSHO program is recognized nationally for administering one of the most successful and longest standing programs that integrate care. Minnesota's MSHO program is managed by DHS through contracts with managed care organizations to administer MSHO and has a proven track record of improved health outcomes with high satisfaction of individuals enrolled in MSHO.

Minnesota conducted a study to better understand older Minnesotans' long-term care (LTSS) needs, experiences, and decisions leading up to Medical Assistance and Elderly Waiver enrollment. The Elderly Waiver Spenddown Study report describes typical trajectories that enrollees experience prior to enrolling in EW, and suggests opportunities to impact those trajectories through upstream interventions where OAA services may play a key role.

The HCBS programs overseen by MBA and DHS are growing faster than the state's population. Between 2015 and 2019, the state's total population grew by 3%, while the population of persons using HCBS grew by 16%.[18] Unfortunately, rates paid to HCBS providers, who provide EW, AC, and ECS, have not kept up with the increasing cost of delivering services, as indicated in a 2019 legislative report, The Evaluation of Rate Methodology for Services Provided under Elderly Waiver and Related Programs.

DHS and MBA are working collaboratively with other state agencies on elevating and remediating the workforce i shortages. Strategies include:

- Legislative action to ensure adequate rates for services delivered under the HCBS programs
- Continue to build on strategies to tap all potential "workers" to provide HCBS – such as empowering the use of volunteers, utilizing consumer directed community supports, and other avenues so individuals can have choice and options for services

- DHS Grants, Equity, Access, and Research (GEAR) Division is leading a new **Provider Capacity Grants Program** that aims to benefit small providers who want to expand HCBS for older adults and people with disabilities from rural or underserved communities

The Minnesota Board on Aging

The MBA is Minnesota's federally designated State Unit on Aging. The board's 25 members are appointed by the Governor and represent diverse backgrounds, ages, interests and communities across the state. The MBA works to ensure that older Minnesotans and their families are served effectively by state and local policies and programs, so they can age well and live well.

The MBA does this through its **three major roles: administrator, advisor,** and **advocate**. The MBA administers federal and state funds to deliver a range of in-home and supportive services to older adults and their family caregivers.

The Older Americans Act (OAA) instructs the MBA to designate a statewide network of Area Agencies on Aging (AAA). The AAAs leverage additional local dollars and resources to ensure local input and accountability in the delivery of aging services in communities around the state. The MIAAA), currently administered through MBA, administers OAA funds to deliver services to Native American elders in the northern half of the state.

Through its administrator role, the MBA manages two direct service programs: the **Senior LinkAge Line® (SLL)** and **Office of Ombudsmen for Long-Term Care (OOLTC)**.

The Senior LinkAge Line® and its public resource site MinnesotaHelp.info are services of the MBA in partnership with Minnesota's AAAs. These resources provide free, objective information and assistance to help older Minnesotans and their families. The SLL can help with Medicare, health insurance and long-term services and supports options, counseling, care transitions, prescription drug costs and connect Minnesotans to local services. In 2022, the SLL served over 80,000 new clients. Top topics ranged from Medicare to finances to assisting caregivers. The SLL works in tandem with Disability Hub MN and LinkVet to help people navigate to services, find answers and get the help they need. MinnesotaHelp.info provides access to the Nursing Home Report Card, assisted living facility licensure information and the Assisted Living Report Card (official website launching in fall of 2023).

The Office of Ombudsmen for Long-Term Care is responsible for providing advocacy services and interventions for individuals receiving long-term services and supports. The OOLTC is committed to upholding the rights, well-being and empowerment of long-term care recipients, in line with the principles of trauma-informed care.

OOLTC statistics in 2022:

✓ Ombudsmen serve **2,000** licensed assisted living facilities, **345** licensed nursing homes, including **five** Veterans homes

Certified Ombudsman Volunteer program

✓ 247 volunteer hours were donated

✓ Volunteers reached 16 counties and 11 regions

✓ 18 volunteers provided advocacy

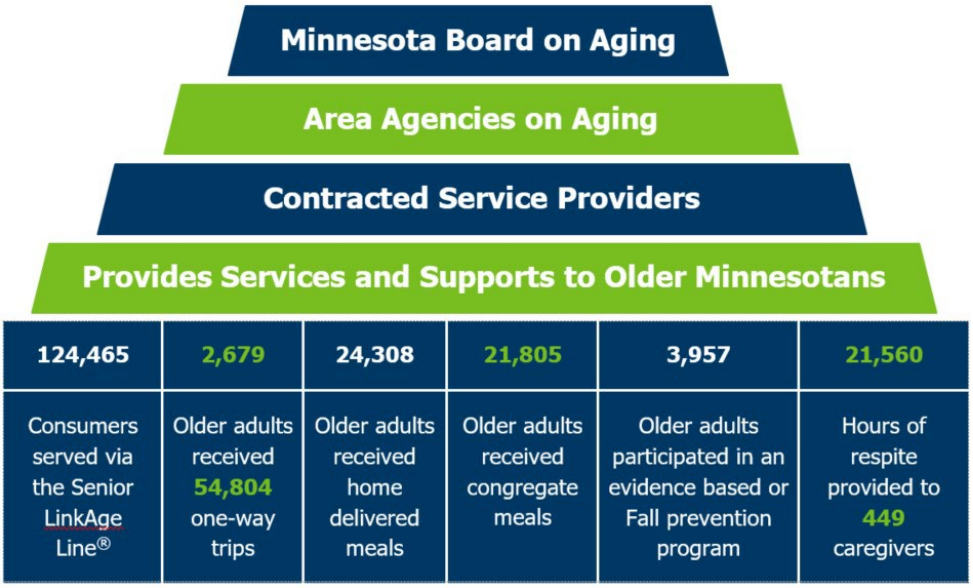
For more information, please refer to the 2022 MN Ombudsman for Long Term Care Annual Report.

Area Agencies on Aging

In Minnesota, the Area Agencies on Aging (AAAs) recruit and partner with local organizations to fill the service needs in their areas. The AAAs leverage additional funds, including participant contributions and cost share, community donations, and actively apply to grants to supplement OAA dollars. As trusted community partners, AAAs play a crucial role in connecting older Minnesotans and their caregivers to local resources and services. By collaborating with a wide range of organizations, AAAs can provide targeted support and information that is tailored to the needs of each service area. This includes essential services such as transportation, homemaker and chore assistance, nutrition programs, and caregiver support services, including respite, support groups and counseling, and information assistance. Together, these programs help ensure that individuals can age well in the community of their choice.

In FFY 2022, the MBA, in partnership with the AAAs and their contracted service providers, served 213,295 older Minnesotans and those caring for them through the SLL and a variety of supports. For a highlight of specific services provided, see **Figure 3**.

Figure 3



Older Americans Act

The Older Americans Act (OAA) of 1965 dedicates federal funding to support older adults across the United States. The MBA works across various Titles within the OAA such as, Title III – Grants for State and Community Programs on Aging; Title VII – Allotments for Vulnerable Elder Rights Protection Activities, as well as coordination with Title VI – Grants for Native Americans.

Title III – Grants for State and Community Programs on Aging
Title III provides services and supports to older adults and their family, friends and neighbors caregiving. Title III consists of five core programs:

- III-B: Supportive services including homemaker, transportation, and chore
- III-C1: Congregate meals (meals provided in congregate settings)
- III-C2: Home Delivered meals (meals delivered to the home, may be hot or frozen)
- III-D: Evidence-based Health Promotion
- III-E: National Family Caregiver Support Program

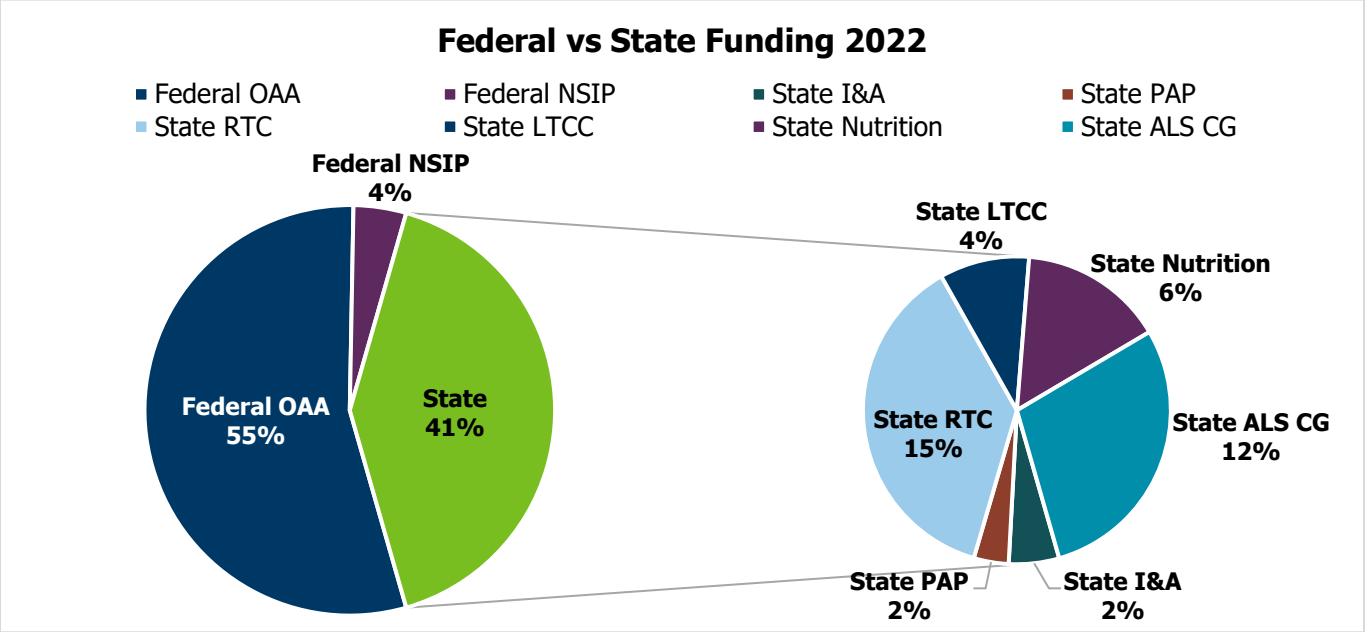
In FFY 2022, the MBA and the aging network awarded over $22 million in Title III funding to support older adults and those caring for them. **Table 2** lists the amount awarded per core program, the units provided, and the number of persons served.

Table 2

Section	Description	Amount Awarded	Units Provided	Persons Served
III-B	Supportive services including homemaker, transportation, and chore	$5,310,526	135,577	8,037
III-C1	Congregate meals	$3,191,404	644,655	20,654
III-C2	Home Delivered meals	$9,629,401	2,455,006	25,189
III-D	Evidence-based Health Promotion	$967,020	N/A	3,957
III-E	Supportive services for those caregiving	$3,462,709	56,235	2,864

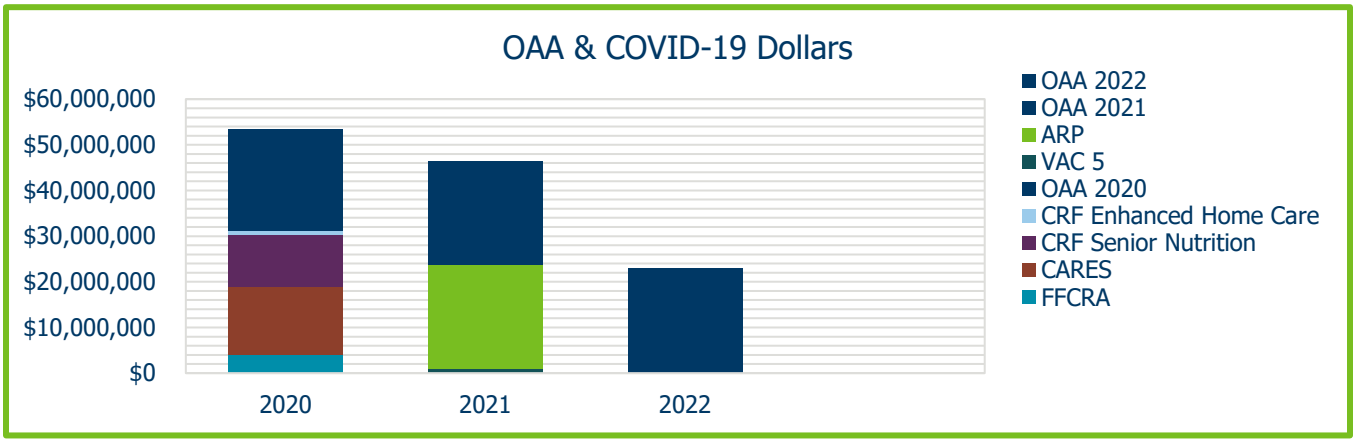
In addition to Title III funding, Minnesota also provides significant State funding to support older adults and those providing care for them. In 2022, MBA also received 1.7 million NSIP (Nutrition Services Incentive Program) dollars for a total of over $24 million in federal funding and over $17 million in State funding including Information and Assistance (I&A), Prescription Assistance Program (PAP), Return to Community (RTC), Long Term Care Consultation (LTCC), State Nutrition, and Amyotrophic Lateral Sclerosis (ALS) Caregiver support. As shown in **Figure 4** state funding amounts to 41% of the funding MBA receives.

Figure 4



As a direct result of the COVID-19 pandemic, Minnesota received significant increases in funding to support older adults and those caregiving for them. As Minnesota looks towards the end of the COVID-19 pandemic and the sun-setting of COVID-19 funding, there is concern about the inevitable decline in services without additional funding. **Figure 5** demonstrates the peak and now decline in available funding.

Figure 5



As the cost of services continue to rise, MBA, AAAs, and partners are working together to explore strategies to fill in the gap left by the loss of additional American Rescue Plan and COVID-19 funding. Strategies include requests to the state legislature, modernizing service delivery to increase efficiencies, increasing the targeting of services, advocating for additional state funding, and finding additional partners.

Nutrition

Nutrition services are one of the most critical programs provided to older adults across Minnesota. Nutrition Services include home-delivered meals, congregate meals, and support of grocery delivery, food shelves, and other services. Having nutritious food is critical to good health, ability to manage or prevent chronic disease, and maintaining a high quality of life.

In FFY **2022**:

- More than **3.5 million meals** were provided through congregate, and home delivered meals programs

Since the COVID-19 pandemic and in-person gathering restrictions, there was a large move from congregate dining to home delivered meals. As the COVID-19 pandemic winds down, there has been a slight shift back to congregate dining, but meals served have yet to reach pre-pandemic levels. In addition to the change in preferred service delivery, there has also been a large increase in nutrition funding available.

Minnesota values providing person-centered care, which includes offering culturally specific meals:

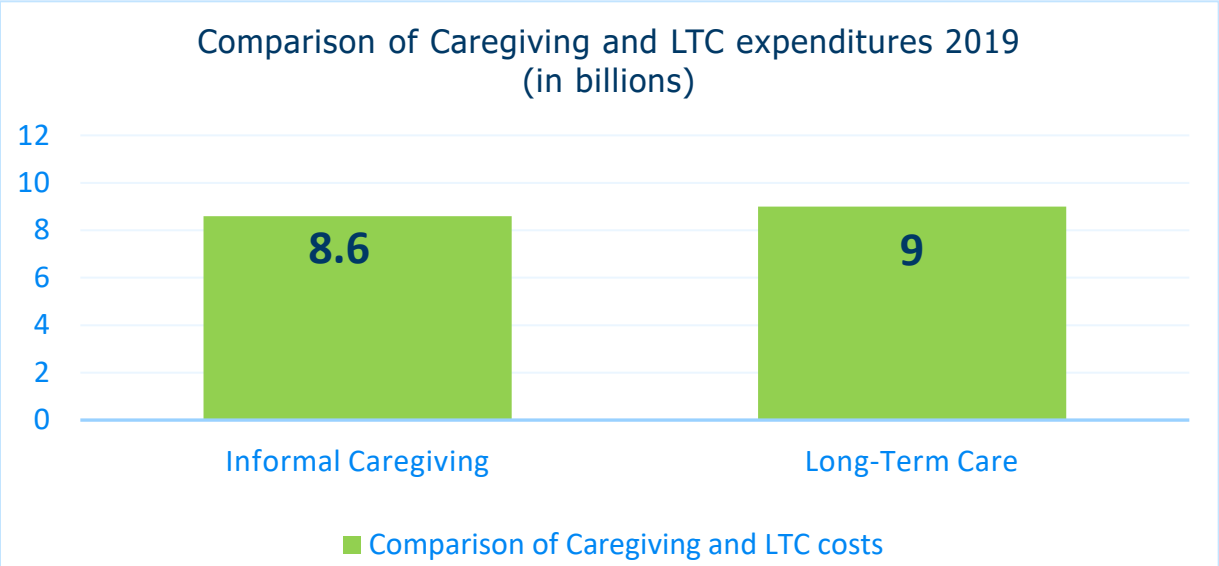
- Metro Meals on Wheels (MMOW), a FFY 2023 Live Well at Home® grantee, has expanded their website to offer meal ordering in English, Spanish, and Somali and a Latino-inspired menu. MMOW has also partnered with a local Halal restaurant and caterer to expand to the East African community
- Area Agencies on Aging (AAAs) partner with providers across Minnesota to provide meals that are Halal, Southeast Asian, Kosher, Hispanic, Laotian, Vietnamese, and Somali

Caregiving

Caregiving, informal (unpaid), is an integral piece of Minnesota's healthcare system. The MBA defines caregiving as a family member, friend or neighbor helping someone who is aging, on a regular basis, and is not paid for it. Caregiving is a journey that's different for everyone. It varies greatly in intensity, from helping to shovel a driveway to assisting with bathing; and in duration, with care lasting from weeks to years. Caregiving is also not a linear process; some weeks may be more intense than others. Caregiving also has

financial impacts on those providing care. **Figure 6** shows the value of family, friends, and neighbors caregiving[19] compared to expenditures of the Long Term Care (LTC) system in Minnesota[20].

Figure 6



As the demographics in Minnesota shift, there is a direct impact on the typical caregiving arrangement. In Minnesota, there is an increasing number of kinship caregivers, older relatives caring for children; and individuals caring for someone with Alzheimer's disease and related dementias (ADRD). Although dementia is not a normal part of aging, it is primarily a disease of age. As we live longer, the number of Minnesotans with dementia continues to rise.

Minnesota Caregiving Estimates:

- **In 2021 approximately 530,000 family, friends and neighbors caregiving** for an older adult, estimated to be worth **$10 billion a year**[21]
- **163,000 family, friends and neighbors caregiving** for persons with Alzheimer's disease and related dementias, provided **225,000,000 hours** of unpaid care estimated to be valued at close to $5.25 billion[22]

Caregiving for someone with ADRD is typically more expensive and emotionally, physically and mentally taxing than other caregiving situations. More than 50% of these family/friend dementia caregivers have been providing care for at least two years; nearly one in four provide 20 or more hours of care per week. One in

[19] *Number of Family Caregivers, Hours, and Economic Value of Caregiving by State, 2017.* AARP Public Policy Institute, 2019. https://www.aarp.org/content/dam/aarp/ppi/2019/11/family-caregivers-data-by-state.pdf

[20] *Minnesota Health Care Spending: 2018 and 2019 Estimates and Ten-Year Projections*, Minnesota Department of Health, 2021. https://www.health.state.mn.us/data/economics/docs/2019spendingrpt.pdf

[21] *Valuing the Invaluable: 2023 Update,* AARP Public Policy Institute, 2023. https://www.aarp.org/content/dam/aarp/ppi/2023/3/valuing-state-estimates.doi.10.26419-2Fppi.00082.009.pdf

[22] *Minnesota Alzheimer's Disease Facts and Figures*, Alzheimer's Association, 2023. https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf.

four of those caring for someone with dementia are also part of MN's growing 'sandwich generation'—caring for an older adult and a child or grandchild[23].

As Minnesota's population continues to become more racially and culturally diverse, it will become increasingly important to develop inclusive, equitable services that reflect knowledge of and respect for these cultural differences. The return on investment is multi-faceted—among other things, greater caregiver support relieves pressure on adult protection services, delays or prevents moves into long-term care, and results in better physical and mental health of caregivers, allowing them to provide care longer. Since the last MN State Plan on Aging, improvements to supporting caregivers have expanded:

- Minnesota Caregiving Coalition created in 2019
  - The Minnesota Caregiving Coalition was developed in order to address goal 3 in the 2019-2022 MN State Plan on Aging. The coalition meets monthly and has representatives from over 20 organizations.
- Caregiver Consultation training
  - The MN caregiver consultation training is now available fully online. The training now includes a mechanism for evaluation as well as general updates in content.
- REST (Respite, Education, Support & Training) training and capacity expansion, since 2017:
  - More than 400 REST Companions trained
  - Over 50 Train-the-Trainers
  - 3 Statewide Trainers
  - 1 Regional trainer

- In 2022, the MN Legislature allocated $5 million to support ALS caregiving through the AAAs

Title VI - Serving Indian Country

The MN Indian Area Agency on Aging (MIAAA), currently administered through the MBA, serves the elders of four of the Ojibwe tribal governments: Bois Forte Band of Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe and White Earth Nation.

MBA follows a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and service program activities. Each AAA is required to address their planning and coordination efforts in their Area Plan. The Area Plan instructions have specifically required that one issue area be devoted to the explanation of how services will be provided to American Indian Tribal members and also meet the requirements for coordination between Title III and Title VI under OAA. Some successes from this coordination include:

- In 2022, Prairie Island Indian Community received assistance from Southeastern Minnesota AAA in applying for Title VI funding
- In 2022, the Minnesota River AAA successfully hired a SLL specialist who is housed within the Lower Sioux Indian Community
- In 2021, Trualta, a statewide caregiver education platform was launched, including courses specific to Indigenous Caregiving

[23] *2023 Alzheimer's Disease Facts and Figures*, Alzheimer's Association. 2023. https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf.

Beyond the Older Americans Act

Minnesota has built a robust system that stretches beyond the OAA, which includes different initiatives that support older adults across various funding streams.

Live Well at Home® Grants

Through Live Well at Home®, Minnesota invests in innovative, culturally responsive services that assist older Minnesotans to age in their community of choice. Since 2001 the Minnesota Legislature has committed between $6 million to $8 million each year to DHS for Live Well at Home® grants, which empowers more older adults to remain living at home, delaying or preventing the need for long-term care. A special focus of Live Well at Home® is developing capacity in communities to provide more essential services, particularly in rural areas where access to care in limited.

In 2022, more than $7 million in grants was awarded to 57 organizations across Minnesota. Some of the latest projects include:

- Expanding caregiver support for older individuals and their families to the Red Lake Nation, White Earth Nation, Leech Lake Band of Ojibwe, Bois Forte Band of Chippewa, and Lake of the Woods County
- Funding a raised-bed vegetable and flower garden in McGregor (rural Aitkin County) to allow equal access for people using wheelchairs and walkers
- Providing new services for American Indian elders in their homes in Minneapolis, including homemaker and chore services, home safety assessments and modifications to prevent falls

Eldercare Development Partnership

Since 1992, Minnesota has implemented a unique and innovative grant program, the Eldercare Development Partnership, to support multi-county or statewide efforts to identify and address gaps in HCBS. These grantees bring together stakeholders in the LTSS system to expand home and community-based services (HCBS) for low-income older adults who are at risk of nursing home placement. They work in collaboration with county social service and public health agencies, AAAs, local non-profit and for profit HCBS providers, and other stakeholders in the long-term services and supports system.

Senior Volunteer Program

The AmeriCorps Seniors volunteer program (formerly SeniorCorps) is a network of older adults who are making a difference through the three programs of the Senior Volunteer program: the **senior companion program**, the **RSVP Program** and the **Foster Grandparent program**. The senior volunteer program connects thousands of Minnesotans aged 55 and up with volunteer opportunities each year. In 2021 14,000 volunteers served 1.8 million hours across the state of Minnesota.[24]

Statewide Dementia Efforts

According to data from the Alzheimer's Association (2022), the prevalence of Alzheimer's Disease and Related Dementias (ADRD) in Minnesota is on track to increase from the estimated 99,000 Minnesotans with an ADRD diagnosis in 2020 to 120,000 in 2025. The context becomes even more challenging when considering

[24] Minnesota Senior Corps. http://www.mnseniorcorps.org/

workforce issues, an estimated 221% increase is needed in the number of geriatricians to meet the increased demand in 2050[23].

The State of Minnesota has become a national leader in supporting people with ADRD. The MBA, DHS and Department of Health (MDH) lead much of the State's work related to dementia; other statewide leaders include the Alzheimer's Association of North Dakota and Minnesota, and the University of Minnesota's Center for Healthy Aging and Innovation also are key in leading efforts.

Alzheimer's Disease Working Group

In 2009, the Legislature tasked the MBA with establishing the Alzheimer's Disease Working Group and making recommendations for policies and programs to prepare Minnesota for future increases in dementia. This cross-sector working group produced a 2011 report titled, *Preparing Minnesota for Alzheimer's: The Budgetary, Social, and Personal Impacts*, as well as a review and update to this report—Alzheimer's Disease Working Group, Legislative Report—in 2019.

MBA Dementia Grants

The MBA administers a competitive grant program focused on dementia and its impacts on caregivers. Created by the Minnesota Legislature in 2015, the legislature has appropriated $1.5 million for this program in each biennium since the 2016/2017 biennium. MBA Dementia Grants support regional and local projects focused on 1) increasing awareness of dementia; 2) promoting cognitive testing and early diagnosis; 3) increasing the rate of cognitive testing in the population at risk for dementias; and 4) supporting caregiving by family, friends and neighbors.

Since 2015, MBA Dementia Grantees:

- Delivered general awareness education to **60,748** persons, including community members, healthcare professionals, emergency personnel, and business owners and their employees
- Provided services, supports, and resources to **5,867** persons suspected or diagnosed with Alzheimer's or another dementia
- Supported **6,053** family, friends and neighbors caregiving

ACT on Alzheimer's Initiative

Minnesota's successful ACT on Alzheimer's initiative, launched in 2015, is a public-private effort focused on community-level support for people with dementia. There are also almost 24,000-trained Dementia Friends throughout Minnesota. As a direct result of the availability of MBA Dementia Grants, 22 communities have become Dementia Friendly.

BOLD Initiative

The Minnesota Department of Health received the CDC BOLD Grant (Building our Largest Dementia (BOLD) Infrastructure) to implement Alzheimer's and Related Dementias activities in line with the recommendations in the 2019 Alzheimer's Disease Working Group Legislative Report and the Healthy Brain Initiative Road Map actions[25]. The MBA participates in the BOLD Action Committee, and this State Plan includes strategies that align with and support BOLD goals.

[25] *Alzheimer's Disease and Related Dementias, What is dementia?* Minnesota Department of Health, 2022. https://www.health.state.mn.us/diseases/alzheimers/index.html

BOLD funding and strategies intend to:

1. Support increased communication across the state/tribal/local jurisdiction related to Alzheimer's Disease Related Dementias (ADRD).
2. Analyze and use available data, including BRFSS[26], together with the state/tribal/local strategic dementia plan to set jurisdiction-wide priorities
3. Promote education about the importance of including risk reduction, early diagnosis of ADRD, prevention and management of comorbidities and avoidable hospitalization, and the role of caregiving for persons with dementia.

Dementia-Friendly Airports

The MBA and Age-Friendly Minnesota (AFMN) is developing a new partnership with the Minnesota-Saint Paul International Airport's (MSP) Dementia-Friendly Airports initiative. MSP is one of ten airports part of a Dementia-Friendly Airports Working Group, an international coalition of service professionals, airport staff and travel advocates working to improve air travel for people with dementia. The working group includes numerous representatives from Minnesota.

This builds on other efforts, still ongoing, to make the airport easier to navigate for people with various types of disabilities. In 2014 the MSP Airport created the Travelers with Disabilities Advisory Committee—half airport personnel and half disability advocates—focused on improving equitable access for airport users. In 2020, MSP introduced the Hidden Disabilities Sunflower program, which cues airport staff and personnel to slow down and provide extra support to the person wearing the lanyard.

Cultural Experiences, Activities, and Services

Arts initiatives are proving to be an accessible and non-stigmatizing lens through which to educate community members about dementia and its impact on individuals, families and communities:

- Four Dementia Choruses across Minnesota have been seeded or expanded with Dementia Grants, with two focused on culturally adapted content and approach. The impact of this work was just documented in a peer-reviewed journal article, *Finding Joy and Purpose Through Singing: Giving Voice to People Living with Dementia*
- Statewide tours of *The Remember Project* (supported in part by the Metropolitan Area Agency on Aging DBA Trellis), a theatre-based effort intended to build more dementia-capable communities. Though a portfolio of one-act plays, professional actors bring real issues connected to the care, diagnosis and experience of dementia to life. Audience members take part in a facilitated conversation about the themes, metaphors and impact of memory loss depicted in the plays and often experience life-impacting insights and calls to action.

Cultural services are to key to offering support to all older Minnesotans.

- A Tribal Nation received Live Well at Home® funding to develop the reservation's first housing development for Tribal elders experiencing homelessness. These three, 12-unit village communities will include supportive services from across the reservation.
- A home healthcare agency received grant funding to expand their HCBS services to Hmong, Karen, and Laotian populations through translation and interpretation services.

[26] The Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/index.html

- The Arrowhead AAA is a member of the ARCHS (Arrowhead Region Consortium for Healthcare Staffing). The consortium grew out of a shared interest in working together to meet the staffing crisis in the region has created the Indigenous HealthCare Workforce Career Camps. Scrubs Camp provides students the opportunity to learn about different healthcare professions from healthcare providers and educators.

Rights and Protections for older adults

Minnesota's **Adult Protection Services (APS)** program is responsible for investigating reported allegations of abuse, neglect, or financial exploitation of vulnerable adults referred by the state's centralized reporting system, Minnesota Adult Abuse Reporting Center (MAARC). The APS program is housed in and supervised by the MN Department of Human services and administered by counties and tribal nations. APS exists so that all adults who are vulnerable to abuse, neglect, or exploitation are supported to live in safety and dignity, consistent with their own culture, values, and goals, and so people concerned about them have resources for support. While APS serves adults of all ages, in 2021, there were 14,993 reports of maltreatment to Minnesotans aged 65 or older. These reports represented nearly half of the total 31,403 reports made to APS that year. The Vulnerable Adult Protection Dashboard reflects this data.

The APS 2022 Operational Plan was informed by the Minnesota's Vulnerable Adult Act (VAA) redesign which aims to improve state-wide equity and consistency in the service response provided to adults referred to APS, and to prioritize a person-centered approach that is trauma-informed, culturally responsive, and attuned to changing demographics such as age, race, ethnicity, and culture. These changes are intended to benefit all Minnesotans.

Minnesotans have the right to live with dignity, free from harm, and to receive high-quality, person-centered services in the setting of their choice. The OOLTC Regional Ombudsmen play an integral role in providing this support. Through collaboration with multi-disciplinary adult protection teams, medical discharge planners and county case managers as directed by residents. In 2019 the OOLTC achieved the legislative appropriation of 17 additional staff, greatly improving the staffing ratio of regional ombudsmen to bed capacity in MN. This means more residents have access to advocacy services. At the macro level, OOLTC works collaboratively with the Department of Health, DHS, Adult Protection, Legal Aid and other stakeholders in advocacy efforts. Whether through individual casework or systemic initiatives, OOLTC invests in building relationships that benefit those receiving long-term care services and supports.

DHS has initiatives underway to strengthen efforts that focus on safeguards and informing older adults of their choices:

- Assisted Living Licensure (ALL): As of August 1, 2021, ALL is implemented, which means residents have more rights, including stronger protections against discharge and stronger protections for persons with dementia. It will also provide for stronger oversight of these facilities by the Minnesota Department of Health.
- Medicare Fraud: The Senior LinkAge Line® is Minnesota's federally designated State Health Insurance Program (SHIP) and provides comprehensive, fair and unbiased Medicare counseling. The SLL is also Minnesota's federally designated Senior Medicare Patrol, in which they help people fight fraud, abuse, and scams.

Minnesota State Plan on Aging Goals, Objectives, Strategies and Measures

The following goals, objectives, strategies and measures outline the steps the MBA will take to support older adults through the 2024-2027 State Plan on Aging.

Goal 1: Advance equity and eliminate disparities, while empowering rural and diverse communities and respecting the sovereignty of Tribal Nations
Short Term Outcome: Older adults from Minnesota's diverse communities, including Indian Country, will have greater access to information, resources, and services
Intermediate Outcome: The State will have stronger partnerships with Indian Country and Minnesota's diverse communities
Long-Term Outcome: Older adults from diverse communities and Indian Country will receive services they need and prefer to live well at home
Measures: • % of older adults from diverse communities who report receiving information in the language they prefer • % of older adults who report they know who to call to get the information, resources or services that they need • % of funding to diverse communities and providers • % of diverse individuals served through the Older Americans Act • % of diverse representation on the Minnesota Board on Aging • % of HCBS recipients from diverse communities that express satisfaction with services
Data Sources: Peer Place, Grant Utility, Foundant, State Program Report, Board Member Self Report, National Core Indicator – Aging and Disability
Objective 1.1: Dedicate ongoing resources to advance equity for older adults who experience disparities
a. Review current informational resources, print and web, within the Aging and Adult Services Division (AASD) to analyze if groups experiencing disparities are represented
b. Collaborate with the Older Adults' Equity Collaborative (OAEC), including SAGE, to host two statewide trainings through Odyssey and other avenues focusing on cultural competency and equity

c. Establish protocols/policies to ensure linguistically and culturally appropriate OAA resources are routinely developed, such as web and print accessibility
d. Enhance the targeting of Senior LinkAge Line, Older Americans Act, and Office of Ombudsmen for Long-Term Care services to improve their reach and effectiveness
e. Meet with SAGE on reviewing best practices to create inclusive services on LGBTQ+ and HIV+[27]
f. Promote and expand digital literacy resources for older adults across the state
Objective 1.2 Strengthen advocacy and coordination efforts in Indian Country
a. Create summary report on improving alignment between Title III and Title VI and regulatory barriers to Tribal coordination
b. Complete MBA/DHS Tribal Consultation by 2026 and identify next steps, including addressing regulatory barriers, to implement the resulting work plan
c. Participate in AAA quarterly meetings to check in, share best practices, utilize the MBA Indian Elders Coordinator to provide support and/or strategize on how to include Native representation in all work**
Objective 1.3: Establish and deepen relationships with diverse communities to create reciprocal partnerships
a. Utilize recent Statewide needs assessment and corresponding summary report to create a collaborative workplan to address disparities in Indian Country and other underserved communities
b. Identify strategies and policy opportunities for MBA and the Aging Network to further work with Indian Country and other underserved communities, including ongoing consultation and feedback
c. Conduct an equity review by 2025 of local and regional Aging Grants to inform refinements to RFP to help boost impact in cultural and ethnic communities
Goal 2: Make aging in community truly possible for all Minnesotans
Short Term Outcome: Minnesotans will have greater awareness of community supports
Intermediate Outcome: Minnesotans will have better access to community supports

[27] https://www.lgbtagingcenter.org/resources/pdfs/Sage_GuidebookFINAL1.pdf?_gl=1*1nzlo6u*_ga*MjEyMjkzOTYyOC4xNjYwMjIzOTUy*_ga_YKVT8DY5PC*MTY3ODIwNjQ2OC41LjAuMTY3ODIwNjQ3Ny4wLjAuMA...

Long-Term Outcome: Minnesotans will be able to age in community longer
Measures: • % of older adults who report being able to access the services that they need • % increase in number of older adults served by HCBS providers who pay partially or in full for their service. • % increase in public funds spent on HCBS vs. nursing homes • % increase in persons served in EW in their own home vs. assisted living • Number of individuals RTC helps discharge from a nursing facility • Number of individuals using RTC to remain in their community
Data Sources: National Core Indicator – Aging and Disability, Home and Community Based Services Access Dashboard, Aging Data Profiles Dashboard
Objective 2.1: Support housing and transportation options that promote independence and community connection
a. Strengthen understanding of barriers to creative solutions such as intergenerational housing, cohousing, zoning laws, and accessory dwelling units (ADUs), and advocate for investments in home modifications through all possible funding sources
b. Maximize available resources to decrease older adult homelessness, including active participation in Minnesota Interagency Council on Homelessness (MICH) and MN Olmstead Plan Affordable Housing Work; partnering with Minnesota Housing Finance Agency efforts; and leveraging Live Well at Home grants
c. Support creation of innovative transportation services and models that are responsive to community needs, especially in rural Minnesota—including pilot projects through Live Well at Home grants and advocacy for volunteer driver programs
d. Participate in and advocate through statewide collaboratives to address transportation needs, such as the Minnesota Council on Transportation Access (MCOTA) work group, Regional Transportation Coordinating Councils (RTCCs), and Human Services Transportation Council
e. Invest in and scale up promising models, such as CAPABLE, that take a holistic approach to aging in community
Objective 2.2: Grow and sustain statewide Home and Community Based Service (HCBS) capacity to serve older adults across all funding sources
a. Advocate to the legislature to increase investment in Elderly Waiver, Alternative Care, and Essential Community Supports
b. Identify and address service gaps resulting from loss of American Rescue Plan funding
c. Continue work to address system-wide barriers to access housing, workforce, transportation, and crisis, as identified in DHS' Addressing Gaps ongoing effort
d. Identify partners to address needs related to behavioral health and disparities in access to HCBS
e. Partner to advance statewide volunteer strategies to help recruit, maintain, and support volunteers, including intergenerational approaches, as a way to address workforce issues

Objective 2.3: Catalyze and support efforts to create age-friendly and dementia-friendly communities
a. Active participation in and support for Age-Friendly Minnesota, such as aiding age-friendly communities and development of the Multi Sector Blueprint for an Age-Friendly Minnesota
b. Support Minnesota communities in undertaking dementia-friendly work, including building dementia expertise in professions such as emergency responders, dental care providers, and airport personnel, etc.
c. Empower Minnesotans to support and help each other as we age and recognize family caregivers through innovative community support models such as the Village model, evidence-based health promotion programs, etc.
OBJECTIVE 2.4: Improve and fortify the aging network's ability to respond to emergencies
a. Advocate for universal broadband in Minnesota as critical to preventing and reducing social isolation; emergency preparedness; access to crisis services (such as 988 Suicide and Crisis Lifeline); and rural transit service efficiency, among others, in order to meet goals outlined in the 2022 Governor's Broadband Task Force Final Report
b. Build on policy improvements and innovations learned from COVID-19 that will endure during recovery, such as meal delivery, virtual service delivery, addressing social isolation, and sustaining services during an emergency
c. Collaborate with the Age-Friendly Minnesota Council's efforts to address emergency preparedness
d. Document the expected funding reductions due the loss of American Rescue Plan Act funding. Advocate for additional dollars to offset the estimated decrease of meals and the number of persons served
Goal 3: Support families, friends, and neighbors in sustaining their caregiving roles
Short Term Outcome: Caregivers will recognize the important role they play in our communities and system and the services that are available
Intermediate Outcome: More individuals recognize their caregiving role and access supports
Long-Term Outcome: Individuals who are caregiving are supported in their roles during critical care transitions for their older adult loved one
Measures: • % of caregivers using the Senior Linkage Line • % increase in caregivers served across public programs • % increase in diverse caregivers served across public programs • % increase in caregivers reporting that services helped them maintain their caregiving role and their own health • % increase in older adults screened for dementia through MBA dementia grants

• Number of caregiver consultants
Data Sources: Senior Linkage Line – Client Tracking System, LTSS evaluations, MnCHOICES Support Plans, Peer Place
Objective 3.1: Advance public awareness and recognition of the family, friends, and neighbors caregiving in our communities and their many contributions and challenges
a. Increase access to information and services, including self-service information, in multiple languages and formats with a goal of offering all publications in at least two languages other than English
b. Host a public awareness campaign to showcase caregiving—highlighting new data, findings, and learnings through billboards, social media, etc.—inclusive of all caregiving situations, such as grandfamilies
c. Integrate caregiving into all public outreach, including as part of Older Americans Month
Objective 3.2: Increase the flexibility of caregiving supports to respond to unique and changing needs
a. Create a toolbox with caregiver-centered tools that reduce burden and stress levels across the range of needs and stages of caregiving
b. Strengthen and scale up best practices and promising models currently being used in Minnesota—such as Caregiver Consultants, Trualta, or REST—and identify additional interventions for replication
c. Support the expansion of self-directed services and options for meeting respite needs
d. Enhance the state's capacity to support caregiving situations such as grandfamilies and "sandwich" caregivers by exploring policy flexibilities, maximizing funding, and working with key partners to expand related provider and staff training
Objective 3.3: Expand the existing HCBS direct care workforce
a. Identify strategies for increasing number of professionals focused on older adults, including creating pathways that prepare and encourage high school and college students to enter the aging field
b. Increase Senior Community Service Employment Program (SCSEP) visibility through coordination with OAA programs to support efforts to strengthen the direct care workforce
c. Work on making sure the occupation codes match the standard DOL labels to identify which occupations are related to aging
Objective 3.4: Advocate for policy and investments that center caregiving as essential to broader systems and the economy
a. Implement applicable recommendations within the 2022 National Strategy to Support Family Caregivers, with particular focus on awareness and outreach; advancing partnerships and engagement; and strengthening services and supports, including respite and self-directed services options

b. Collaborate with the aging network on best practices/efforts on caregiver health and well-being through the monthly MBA-AAA Caregiving workgroup and the MN Caregiving Coalition meetings
c. Identify strategies for supporting caregiving related to complex conditions and illnesses, such as amyotrophic lateral sclerosis (ALS), and develop recommendations for continuation, expansion, or duplication
d. Expand strategies with businesses and employers to support their employees who are caregiving, and advocate for policies that allow working caregivers the flexibility they need to provide care
e. Develop support and training for lead agencies and providers on participation (including enrollment, licensing, and billing) in Home and Community Based Services waiver programs (Alternative Care, Essential Community Supports, Elderly Waiver) in order to increase usage of waiver caregiving services
Goal 4: Promote and support healthy aging for all Minnesotans
Short Term Outcome: Minnesotans will recognize the importance of overall health as we age
Intermediate Outcome: Minnesotans will have improved access to healthy aging supports
Long Term Outcome: Minnesota's health and social systems will be better equipped to provide person-centered care for Minnesotans as we grow older
Measures: • % of Broadband service availability, by county • % increase in diverse older adults served through senior nutrition program • % increase in availability of Evidence Based Health Promotion programs, including mental health • % increase in individuals participating in Evidence Based Health Promotion programs, including mental health
Data Sources: State Program Report, Area Plan, Peer Place
Objective 4.1: Promote access to services and programs that support overall health
a. Identify gaps and solutions for collecting data specifically for LGBTQ+ and HIV positive
b. Review data and explore solutions to address food and nutrition security, including malnutrition, through the monthly MBA-AAA work group
c. Review congregate and home delivered meal menus and adapt to address for cultural considerations and preferences and providing medically tailored meals to the maximum extent practicable
d. Explore and document barriers to offering culturally responsive, evidence-based health promotion programs
e. Scale up promising models through the AAA network to support older adults overall health and wellbeing, such as Program to Encourage Active, Rewarding Lives (PEARLs)

f.	Partner with MDH on State Government Actions outlined in the Minnesota Opioid Action Plan
g.	Partner with MDH to advance the Minnesota State Oral Health Plan 2020-2030, with a specific focus on Access to Oral Health Care, Health Systems Integration, and Disability, Special Care Needs, and Inclusion
Objective 4.2: Strategize and develop effective supports for solos	
a.	Explore expanding and creating roles to support solos, such as expansion of Caregiver Consultant and Community Health Worker services, and creation of Personal Health Decisions Assistants, including utilizing AmeriCorps Senior (especially RSVP)
b.	Promote supported decision-making models that prioritize individual choice and autonomy related to issues such as financial decisions, advanced care planning, and family relationships, among others
c.	Expand language (in policies, on forms, etc.) to be inclusive of solos
Objective 4.3: Champion the importance of social connection to overall health	
a.	Leverage recent reports on the issue of social connection, including in long-term care settings, to help quantify the impact and produce recommendations, including related to the (potential) roles of existing programs such as RSVP
b.	Evaluate and raise awareness of innovative social opportunities utilized during the COVID-19 pandemic such as virtual respite, approved virtual EBHP programs, robotic companion pets, and others.
c.	Partner with MDH as a member of the Minnesota Suicide Prevention Taskforce in order to further the MN Suicide Prevention State Plan
Objective 4.4: Strengthen Minnesota's capacity to address Alzheimer's disease and related dementias	
a.	Continue to work with partners to document progress on, promote, and advance recommendations from the Alzheimer's Disease Working Group's 2019 report
b.	Invest in addressing infrastructural barriers to prevention, early detection and diagnosis of Alzheimer's disease and related dementias
c.	Coordinate and meet on a quarterly basis with MDH to advance efforts related to Building our Largest Dementia Infrastructure (BOLD) Grant, including the updated Healthy Brain Initiative Road Map Series
Goal 5: Dismantle ageism and promote older adult rights, autonomy and protection	
Short Term Outcome: Minnesotans, including those from diverse communities and Tribal nations, will have increased awareness of supports for vulnerable adults	
Intermediate Outcome: Minnesotans will have access to person-centered and trauma informed care through multi-disciplinary teams	
Long Term Outcome: Minnesotans have the tools to make their own decisions including access to multi-disciplinary teams	
Measures:	

• An Adult Protective Service public awareness campaign tailored to 1-3 diverse communities is launched • % increase in counties showing increased maltreatment reports accepted for services • % increase in Tribal Nations who report increased capacity for adult protective services. • Satisfaction level individuals have with Office of Ombudsman for Long-Term Care services • Number of trauma-informed care trainings for professionals • Number of Ombudsman volunteers
Data Sources: Minnesota Adult Abuse Reporting Center, OOLTC data sources
Objective 5.1: Elevate aging and work toward greater integration of aging considerations into state policy
a. Advance the priorities and investments of the Age-Friendly MN Council to make Minnesota's communities great places to grow up and grow old
b. Advocate for establishment of, and investments in, financing mechanisms to support Minnesotans with low to middle incomes to plan for their needs as we grow older
c. Expand access to training on working with older adults, including the impacts of ageism, for social workers, dental providers, pharmacists and similar professionals
d. Collaborate with partners to advance evidence-based, high-quality care for older adults through Age-Friendly Health Systems and Age-Friendly Public Health
Objective 5.2: Advance strategies to support individuals receiving long-term services and supports
a. Strengthen and promote the new Assisted Living licensure law through education to providers and partners; systemic advocacy for keeping resident protections in Assisted Living licensure; and pursuit of additional legislative adjustments that support those receiving long-term services and supports
b. Advance trauma-informed care at the individual, facility, and systemic levels through continued staff training on trauma-informed care and individual and systemic advocacy
c. Promote OOLTC services to long term care recipients, providers and the public through social media and other avenues
d. Strengthen advocacy efforts by enhancing partnerships with other entities (OMHDD, case managers etc.)
e. Advocate for increased transparency of facility information and disclosures
f. Increase tribal-state relations and awareness among tribes of OOLTC roles and responsibilities
e. Ensure person-centered services for all Minnesotans receiving LTSS, from home care to nursing homes, through individual and systemic advocacy for person-centered services, provision of trainings, and policy work
g. Advocate for Federal regulations that require nursing home minimum staffing requirements

Objective 5.3: Advance strategies to support vulnerable adults in the community of their choice
a. Establish multi-disciplinary teams in each county to identify and support vulnerable adults and their families, especially those who are experiencing self-neglect or caregiver neglect
b. Increase resources and support to county adult protective services and Tribal nations to build their capacity to identify and support adults who are vulnerable to maltreatment
c. Explore program and policy options for adults who are the subject of reports to the MN Adult Abuse Reporting Center (MAARC) and may benefit from services not currently offered by MN, such as non-Medicaid case management
d. Collaborate with counties, Tribal nations, community organizations and others to address disparities in outcomes for adults referred for adult protective services
e. Launch a public awareness campaign for diverse adults who are vulnerable to maltreatment, that is consistent with culturally appropriate, person-centered messaging (Goal 5.3, APS Operational Plan)
Objective 5.4: Promote and uphold the rights of older adults and empower individual choices and values
a. Expand and promote the use of Supported Decision Making, including in long-term care facilities
b. Provide more education related to legal rights in a variety of circumstances; include linguistically and culturally appropriate education/resources
c. Identify and work with partners, such as Southern Minnesota Legal Services, to expand and promote on-demand legal services such as the Legal Risk Detector, Justice Bus, Legal Kiosks, etc.
d. Leverage caregiver funds and work with partners to update key informational resources and provide the specialized support, including legal assistance, needed by grandfamilies

Quality Management

Minnesota implements a quality assurance system across its home and community-based services for older adults that includes data collection, analysis and continuous improvement.

The Quality assurance system cuts across DHS and the MBA as we work on collaborative performance improvement to support our efforts to achieve better outcomes for people, provide the right services at the same time and sustain the overall system. The data gathered informs our decisions about how to prioritize our efforts and resources.

One of the ways the MBA is addressing quality management is through a close partnership with the AAAs. Currently, there are two ongoing MBA-AAA workgroups to address data collection and process improvement, one focused on nutrition and one focused on caregiving. There are also quarterly meetings between MBA staff and AAAs to discuss data collection and reporting, administrative functions, and other timely topics. Finally, each Area Plan includes a snapshot of services the corresponding AAA provided in the previous calendar year, an estimate for the current calendar year, and a goal for the next calendar year based on trends.

Using Data to Inform Decisions

The Department of Human Services Aging Data Profiles include statewide, regional and county-level demographic and service data. The profiles provide information on the variation and differences about our aging society to inform those developing programs, services and supports that help older adults live, work and engage in their communities. All data is about Minnesotans aged 65 and older. Demographic trends can tell counties and providers about how the population of their community is changing over time and facilitate their development of services to meet those needs. These dashboards provide county level information about the demographics of HCBS programs over time.

National Core Indicators-Aging and Disabilities (NCI-AD)[28] initiative measures and tracks the quality of life and outcomes of older adults and adults with physical disabilities – who are accessing Medicaid-funded HCBS. The goal of collecting this data is to understand how people use services and supports to help live, lean, work and enjoy life in their community. The Minnesota Department of Human Services (DHS), in partnership with the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI), implemented the 2018-2019 NCI-AD Adult Consumer Survey in Minnesota. Results will be used to support Minnesota's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life and outcomes of older adults and people with disabilities.

Assisted Living Report Card measures and reports on the quality of individual assisted living settings for housing and services paid for privately and through public programs, is being developed for Minnesota. Once the report card is fully implemented by the DHS Aging and Adult Services Division (AASD) along

[28] *2018-2019 Minnesota Results*, *National Core Indicators Aging and Disabilities Adult Consumer Survey*, National Core Indicators – Aging and Disabilities, 2020. https://nci-ad.org/upload/state-reports/MN_2018-2019_NCI-AD_state_report_FINAL.pdf

with the MBA, results will be shared with the public through a website and will be updated over-time as new data on quality are available.

In 2022, the Ombudsman Office for Long Term Care began collecting additional data, which may lead to greater understanding and analysis of the impact of social determinants on long-term care consumers' needs and service access, as well as equity issues within the OOLTC program. Analysis of race/ethnicity, pay status, language/needs, and gender identity will guide OOLTC to develop an outreach plan to reach underserved populations and identify potential areas of unmet needs.

LTSS Performance Measures demonstrate how well the programs support people in their community while ensuring system sustainability. In general, people report they have a higher quality of life when living in the community. In addition, home and community-based services (HCBS), on average, are also less costly than institutional services.

Analysis and Remediation of Problem Areas

Existing Methods:

- HCBS Lead Agency reviews: DHS designs and sets the standards for the HCBS system. Lead agencies, including counties, tribal nations and managed care organizations under contract with DHS, administer the programs on a local level. DHS initiated the lead agency review of counties and tribes managing and administering HCBS programs in 2006 and has completed three full rounds of reviews for each lead agency. It examines all five Medicaid waiver programs and the Alternative Care program in each lead agency.
- Managed Care Organization care plan audits: The contracts between DHS and managed care organizations require those organizations to audit annually a sample of care plans for all enrollees, including those who receive waiver services. The audits follow established protocols and include review of delegated administrative functions, required waiver case management tasks, and person-centered planning. If managed care organizations use a care system model where entities such as clinics, counties, and tribes provide care coordination for enrollees, DHS requires managed care organizations to audit the care systems that provide contracted services. DHS reviews and approves corrective action plans related to care plan audit findings and care system audit findings.

Establishing Performance Measures

New performance measures are being developed for AAA Area Plans and the State Plan.

- In spring 2022 the MBA contracted with Public Sector Consultants (PSC), utilizing COVID-19 pandemic funds (Consolidation Appropriations Act and VAC5 administrative funding), to establish performance measures for the AAAs based on the Minnesota State Plan goals. This process included several rounds of interviews with stakeholders, data exploration, and an environmental scan of performance measures used in other states. Beginning with the 2025 AAA Area Plans, the MBA will begin to monitor the 10 identified performance measures as identified in the PSC Performance Measures Report.
- New in FFY 2024, the MBA will begin monitoring statewide performance measures, corresponding to each MN State Plan goal.

Continuous Improvement

Satisfaction Surveys

The MBA gathers feedback from the public through two satisfaction surveys:

- The **Senior LinkAge Line® (SLL) offers a post-call survey** to every person who calls into the 1-800 number. The survey allows the person to mark yes or no to the following three questions: 1) if they have received the information needed; 2) whether the staff person was knowledgeable and helpful; and 3) whether they would recommend the SLL. The SLL has received positive feedback with 97% of responses marked yes.

- Since 2005, the MBA in partnership with the AAAs and their providers have administered a survey to caregivers receiving Title III services. The survey collects general demographic information, ratings of the services received, and if the services helped them provide care longer. The Title III Caregiver services consistently receive ratings between four and five, with five being the highest rating possible.

The Minnesota Board on Aging will continue to build upon these initiatives, which will better inform strategies to strengthen our service delivery.

Attachments

- Attachment A: State Plan Guidance
- Attachment B: Information Requirements
- Attachment C: Intrastate Funding Formula (IFF)
- Attachment D: Age-Friendly Minnesota Status Checks
    - Age-Friendly Status Check – Caregiving and Dementia
    - Age-Friendly Status Check – Emergency Preparedness
    - Age-Friendly Status Check – Health & Well-Being
    - Age-Friendly Status Check – Inclusion & Equity
    - Age-Friendly Status Check – Individual Rights & Protections
    - Age-Friendly Status Check – Life At Home and in the Neighborhood
    - Age-Friendly Status Check – Social and Community Connections
- Attachment E: State Plan Needs Assessment Summary
- Attachment F: Why Solos Matter to Minnesota (and Elsewhere…)
- Attachment G: Minnesota Board on Aging Performance Measures Report

Attachment A: State Plan Guidance

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .

(2) The State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)

(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to

low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—…

(5) in the case of a State specified in subsection (b)(5), the State agency;

and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

> (A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)

(i)

(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low income minority individuals, older individuals with limited

English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C) (i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

> (A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
>
> (B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
>
> (C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

> (A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;
>
> (B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b) (1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation;

(L) assistive technology devices and services; and

(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d) (1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f) (1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section,

regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with

the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the

head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8) (A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27) (A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order…

Signature and Title of Authorized Official

6/29/23

Date

Attachment B: Information Requirements

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

RESPONSE: Area Agencies on Aging are required to sign assurances that preference will be given to providing services to older individuals with the characteristics described. In addition, the Area Agencies on Aging must submit, as a component of their annual Area Plan on Aging, a chart that estimates the number of older individuals from each population group that will be served, by section of Title III funding. MBA staff monitor actual participants served and their characteristics throughout the Area Plan year and work with the Area Agencies on Aging to remediate any issues, as needed.

Section 306(a)(6)(I)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE: The Senior LinkAge Line® will continue working with the MN Disability Hub and the Minnesota Department of Administration's System of Technology to Achieve Results (STAR) program to support and promote the Minnesota Assistive Technology Lending Library. Together, we are working to develop informational videos, brochures, web copy and more to promote this helpful and important program that benefits older adults and people with disabilities across the state.

Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

RESPONSE: Area Agencies on Aging are required to sign assurances that they have an emergency preparedness plan in place for the services that are deemed critical. Currently this includes home delivered meals. The assurances include the requirement for the plans to be

coordinated with other efforts and organizations. The MBA reviews the Area Plans and requires modifications before final approval is given to address any gaps in information provided.

Section 307(a)(2)
The plan shall provide that the State agency will —…
(C) *specify a minimum proportion* of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

RESPONSE:
Access: minimum of 5% of III-B allocation
In-Home: minimum of 5% of III-B allocation
Legal Assistance: minimum of 10% of III-B allocation

Together, the expenditure on these three categories of services must be at least 40% of the Area Agencies on Aging's new obligational authority of III-B.

Section 307(a)(3)
The plan shall—
...
(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE:
FFY2023: $10,916,360
FFY2024: $10,916,360
FFY2025: $10,916,360
FFY2026: $10,916,360

In FFY 2023, the Area Agencies on Aging signed assurances that preference will be given to providing services to older individuals in rural areas. In addition, the Area Agencies on Aging submitted, as a component of their annual Area Plan on Aging, a chart that estimated the number of older individuals from each population group that will be served, by section of Title

III funding. MBA staff monitored actual participants served and their characteristics throughout the Area Plan year and worked with the Area Agencies on Aging to remediate any issues, as needed.

Section 307(a)(10)
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

RESPONSE:
Within each of the services funded, the Area Agencies on Aging are required to work with their providers to identify and serve older individuals in need of the service who live in rural areas. As a result, the Area Agencies on Aging have facilitated the development of creative models to reach these older individuals in the most cost effective manner. One example is the delivery of frozen home delivered meals once a week or once every two weeks to older individuals who live in very isolated areas. In addition to the meals, volunteers also bring other items that are needed by the older individuals. Funds are allocated for this purpose according to Minnesota's Intrastate Funding Formula.

Section 307(a)(14)
(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

> *(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and*
>
> (B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

RESPONSE: There are 14,995 low-income minority older individuals in Minnesota. An estimated 5,429 are limited English proficient. The vast majority of the low-income older adult population (including those with limited English proficiency) in Minnesota resides in the Twin Cities metro area. The Metropolitan Area Agency on Aging contracts with thirteen culturally-specific community organizations to serve their elders. Across Minnesota, Area Agencies on Aging contract with 15 agencies to provide Special Access Programs which provide information and referral, outreach, advocacy, translation/interpretation, and short-term case management services to help minority and non-English speaking elders access services they need. Some of the Special Access providers are also receive additional III-B and III-D funds to offer assisted transportation and evidence-based health promotion programs.

Across Minnesota there are at least 4 providers offering culturally specific meals. These meals include Halal, Southeast Asian, Kosher, Hispanic, Laotian, Vietnamese, and Somali. In addition, through various COVID-19 funded partnerships culturally specific food was distributed to Native American communities including frozen soups and smoothies.

The Minnesota Indian Area Agency on Aging (MIAAA), administered by the Minnesota Board on Aging, continues to bring culturally specific assistance to elders on four reservations, including legal services, nutrition services, caregiver services, transportation, information and assistance and access. Other developments include bringing legal services to American Indians who live outside the service area of the one legal services (civil) provider with a contract with MIAAA; forming a relationship between the northwestern AAA, a caregiver provider and a "closed" tribal reservation that is not affiliated with the MIAAA; and other ongoing work to reach other under-represented, hard-to-reach older individuals across the state.

Section 307(a)(21)

The plan shall —

. . .

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and *specify the ways in which the State agency intends to implement the activities.*

RESPONSE: The Minnesota Board on Aging employs a full-time Indian Elders Coordinator staff person to be the liaison for the tribes regarding aging services and to ensure that Native American elders have full access to all programs and services. In addition, the MBA participates in ongoing Tribal Consultation. Since the last State Plan submission, the Senior LinkAge® Line has also hired staff to work directly from Tribal offices. Recently, MBA has revised framework language regarding MBA membership to include Tribal representation. In addition, MBA just completed development of the DEIA Strategic Directive and is now implementing the DEIA Strategic Directive, including additional targeting factors in the Intrastate Funding Formula.

The staff to the Minnesota Board on Aging have attended government-to-government training developed by the 13 tribal governments and the University of Minnesota-Duluth to ground state staff in the principles of sovereignty, ethics, law, management, budget and leadership. The curriculum included information on federal Indian policy and the legal background between the tribes and the states.

Section 307(a)(27)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services

RESPONSE: As part of the Age Friendly MN Council, MBA participated in a statewide needs assessment. This needs assessment directly informed the MN State Plan on Aging. Additionally, in partnership with The SCAN Foundation, West Health, and the May and Stanley Smith Charitable Trust, the Center for Health Care Strategies (CHCS), Age-Friendly MN Council is participating in a multi-state learning collaborative to advance Master Plans for Aging (MPAs).

Section 307(a)(28)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE: The Area Agencies on Aging, as part of their Area Plan submission, each sign an assurance related to emergency preparedness.. The Minnesota Board on Aging is part of the Minnesota Emergency Preparedness Plan in which Home Delivered meals have been classified as a priority 1 service. The Age-Friendly MN Council has adopted Emergency Preparedness as one of its key priorities. An Emergency Planning report will be released soon, highlighting highlight numerous state agencies' immediate priorities and strategies at the outset COVID-19, especially related to older adults. The report will identify common themes and challenges and discuss what the state and Minnesota communities have learned from the pandemic.

Section 307(a)(29)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE: Designated MBA staff participate fully in the development of the state government-wide continuity of operations plan process, ensures the inclusion of older adults in the plan and develops the aging services specific plan. MBA staff work with the Area Agencies on Aging to support their plan development efforts and coordinates regional and local communications between the Area Agencies on Aging and the relevant organizations.

Section 705(a) ELIGIBILITY —
In order to be eligible to receive an allotment under this subtitle, a *State shall include in the State plan submitted under section 307—. . .*

(7) *a description of the manner in which the State agency will carry out this title* in accordance with the assurances described in paragraphs (1) through (6).

(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

RESPONSE: The Minnesota Board on Aging requires, through the annual Area Plans, that Area Agencies on Aging gather public input regarding their programs and services, establish and work through their local advisory boards to make funding decisions on programs and services, ensure access to their programs and benefits, and protect the rights of vulnerable elders through provision of legal education and legal assistance,

The MBA administers the Ombudsman for Long-Term Care Program and, in partnership with the MN Department of Human Services, the Adult Protection Program (which is managed locally by the counties) to protect elders' rights. The staff of the Ombudsman Program are state employees and are located in each region of the state.

Attachment C(a): Intrastate Funding Formula (IFF)

The following Intrastate Funding Formula was approved via the Minnesota State Plan FFY 2019 – 2022 and is effective until 12/31/2024.

Note: June 30, 2023, the Minnesota Board on Aging approved an updated Intrastate Funding Formula (IFF). The updated IFF was reviewed for public comment from April 3, 2023 – May 3, 2023. Many of the comments received identified the need for better targeting on those in rural areas and individuals of color. IFF adjustments were made accordingly and will be incorporated into the IFF that will be effective January 1, 2025. The Minnesota Board on Aging intends to submit a State Plan Amendment reflecting these changes.

The Minnesota Board on Aging shall designate an Area Agency on Aging to serve each designated Planning and Service Area. Older Americans Act and State of Minnesota funds are distributed by means of an allocation formula.

1. Formula Goals and Assumptions
    1. Goals of the intrastate funding formula are to
        - allocate federal and state funds equitably throughout the state;
        - meet the requirements of the Older Americans Act for the allocation of funds;
        - reflect the proportionate distribution of persons age 60 and over in each planning and service area; and
        - give preference to populations over age 60 with greatest social and economic need, as defined in the Older Americans Act, with special attention to low income minority populations.
    2. Assumptions on which the intrastate funding formula is based are that
        - particular attention should be given to the needs of Older Native Americans living on reservations;
        - the distribution of direct service funds should reflect the needs and circumstances unique to providing services to and administering programs for older persons in rural and less populated areas of the state;
        - the distribution of administrative funds should allow designated area agencies on aging to meet the minimum requirements of MBA standards and guidelines;
2. Statement of Funding Formula

1. Area Plan Administration - Title III-3A

After application of amounts used under section 308(b) for state agency administration, the Minnesota Board on Aging shall take 10% of its combined allotments for supportive services, congregate nutrition services, home delivered meal services, disease prevention and health promotion services, and family caregiver funds for Area Plan administration. Funds shall be taken in the same proportion as each fund contributes the total remaining, with the exception of funds for family caregivers and disease prevention and health promotion and set-aside amounts for the Indian Area Agency on Aging. Remaining funds shall be distributed according to the factors of:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

2. Direct Service - Title III-B funds for Supportive Services

After deleting amounts for state agency administration, operation of the long term care ombudsman program, area agency administration and the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance funds according to the factors of:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

Funds available to area agencies on aging for program development and coordination activities shall be taken from the direct service allocation. Area agency on aging requests for specific amounts will be considered as part of the area plan and budget approval process.

3. Direct Service - Titles III-C1 and III-C2 and State of Minnesota funds for Nutrition Services

After deleting amounts for state agency administration, area agency administration and the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance of funds according to the factors of:

a. population 60+ (55%);

b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

4. Direct Service - Title III-D funds for Disease Prevention and Health Promotion Services

After deleting amounts for the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance of funds according to the following factors:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

5. Direct Service - Title III-E funds for Family Caregiver Support Services

After deleting amounts for state agency administration, area agency administration and the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance of funds according to the following factors:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

6. "Set aside amounts" for the Indian Area Agency on Aging utilize the previous year's allocation levels plus or minus a percentage amount equal to changes in statewide totals available for distribution for each fund.

7. No planning and service area shall receive a total allocation of direct service funds that is less than 95% of the previous year's allocation of direct service funds. Should additional funds be necessary to maintain the 95% funding level for any planning and service area, they shall first be taken proportionately from the State of Minnesota direct service funds allocated to other planning and service areas, and then proportionately from federal funds allocated to other

planning and service areas.

8. No planning and service area shall receive an allocation of administrative funds that is less than 95% of the previous year's allocation of administrative funds. Should additional funds be necessary to maintain the 95% funding level for any planning and service area, they shall be taken proportionately from the federal administrative funds allocated to other planning and service areas.

9. Paragraphs 7 and 8 shall not apply beginning in Area Plan Year 2008

10. The Minnesota Board on Aging shall use the data from the most recent Census for the factors of 1) population 60+, 2) low income 65+, 3) minority 60+, 4) population 65+ in non-urbanized areas and 5) density for the 60+ population.

A demonstration of the allocation of funds, pursuant to the proposed funding formula, is as follows:

PSA	60+ POP	% POP	FACTOR	65+ LOW INCOME	% LOW INCOME	FACTOR	60+ MIN	% MIN	FACTOR	65+ NON URBAN	% NON URBAN	FACTOR	SQUARE MILES	DENSITY RATIO	FACTOR	FINAL FACTOR
	WEIGHTED 55%			WEIGHTED 20%			WEIGHTED 10%			WEIGHTED 10%			WEIGHTED 5%			
LDSAAA	90,614	9.41%	5.18%	6,006	11.58%	2.32%	2,984	5.64%	0.56%	72,483	17.55%	1.75%	22,776	3.98	1.55%	11.36%
AAAA	77,703	8.07%	4.44%	3,947	7.61%	1.52%	2,007	3.79%	0.38%	51,282	12.41%	1.24%	18,222	4.26	1.45%	9.03%
CMCOA	131,738	13.68%	7.52%	8,590	16.56%	3.31%	2,912	5.50%	0.55%	85,676	20.74%	2.07%	11,835	11.13	0.57%	14.03%
MNRAAA	114,195	11.86%	6.52%	7,617	14.68%	2.94%	2,069	3.91%	0.39%	106,195	25.71%	2.57%	17,201	6.64	0.94%	13.36%
SEMAAA	98,399	10.22%	5.62%	5,922	11.41%	2.28%	2,888	5.46%	0.55%	68,123	16.49%	1.65%	6,770	14.53	0.45%	10.54%
MAAA	450,247	46.76%	25.72%	19,805	38.17%	7.63%	40,069	75.70%	7.57%	29,349	7.10%	0.71%	2,813	160.06	0.04%	41.67%
TOTALS	962,896	100.00%		51,887	100.00%		52,929	100.00%		413,108	100.00%		79,617	12.0941		100.00%

DATA BY PLANNING AND SERVICE AREA 2018 ALLOCATIONS

FUND	III-3A	III-B	III-C1	III-C2	III-D	III-E	State Nutrition	NSIP	ALLOCATION TOTALS
PSA									
LDSAAA	223,914	486,070	737,370	375,377	44,833	275,455	297,288	289,338	2,729,645
AAAA	178,145	386,715	586,647	298,648	35,669	219,150	236,520	184,898	2,126,392
CMCOA	276,786	600,843	911,480	464,013	55,419	340,496	367,484	306,244	3,322,765
MNRAAA	263,568	572,150	867,952	441,854	52,773	324,236	349,935	328,741	3,201,209
SEMAAA	207,934	451,382	684,747	348,588	41,634	255,797	276,072	168,839	2,434,993
MAAA	822,465	1,785,399	2,708,453	1,378,809	164,678	1,011,781	1,091,977	465,131	9,428,693
MIAAA	59,837	88,576	214,480	68,589	8,109	34,710	75,724	54,161	604,686

In accordance with Section 307 (a) (15) (a) with respect to the fiscal year preceding the fiscal year for which this plan is prepared, the number of low-income minority older individuals in Minnesota is identified below:

Persons Age 60+ below Federal Poverty Guidelines Minnesota 2010

Race/Ethnicity	Number of persons
Asian	1,307
Black	1,451
American Indian/Alaskan Native	468
Native Hawaiian/Pacific Islander	12
Other race	358
Hispanic/Latino	794
Total	4,390

Source: 2010 U.S. Census

AGE FRIENDLY
minnesota

Age-Friendly Status Check

CAREGIVING AND DEMENTIA

SEPTEMBER 2021

AGE-FRIENDLY MINNESOTA

Caregiving and Dementia

We will be prepared to care for each other as we age, and be supported in our roles as caregivers.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website.

Overview

Minnesota has approximately 640,000 family, friends, and neighbors helping to care for an older adult, providing care estimated to be worth $8.6 billion a year,[2] exceeding Minnesota's Medicaid expenditures for nursing homes and long-term services and supports. This informal (or unpaid) caregiving is an integral piece of Minnesota's healthcare system.

Caregiving for someone with dementia is typically more expensive and emotionally, physically and mentally taxing than other caregiving situations. Although dementia is not a normal part of aging, it is primarily a disease of age. As more people live longer lives, the number of Minnesotans with dementia continues to rise. Approximately 100,000 Minnesotans currently have Alzheimer's disease or other dementias, all of which impair brain function; these Minnesotans are cared for by around 170,000 unpaid caregivers, who do work valued at $3.3 billion per year.[3]

Another facet of this work are the varying cultural norms and perceptions related to aging, caring for aging family members, and dementia itself. As Minnesota's population continues to become more racially and culturally diverse, it will become increasingly important to develop inclusive, equitable services that reflect knowledge of and respect for these cultural differences.

The State of Minnesota has become a national leader in supporting people with dementia and their caregivers. In 2009, the Legislature tasked the Minnesota Board on Aging (MBA) with establishing the

[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.
[2] AARP Public Policy Institute, *Valuing the Invaluable* (2019)
[3] Alzheimer's Association of North Dakota and Minnesota

Alzheimer's Disease Working Group (ADWG) and making recommendations for policies and programs to prepare Minnesota for future increases in dementia. This cross-sector working group produced a 2011 report titled, *Preparing Minnesota for Alzheimer's: The Budgetary, Social, and Personal Impacts*, as well as a review and update to this report—*Alzheimer's Disease Working Group, Legislative Report*—in 2019. Within the State of Minnesota, work related to dementia and caregiving is led primarily by the MBA, Department of Human Services (DHS), and Department of Health. Other statewide leaders include the Alzheimer's Association of North Dakota and Minnesota, and the University of Minnesota's Center for Aging.

The aging network has invested in dementia work in a number of key ways:

- Area Agencies on Aging (AAAs), Eldercare Development Partnership, Dementia Grants, and Live Well at Home® all play key roles in strengthening supports for people with dementia and their caregivers.
    - AAAs undertake work such as:
        - Developing caregiver resources, such as caregiver consultation and respite services
        - Expanding available culturally and linguistically appropriate caregiver support for various ethnic and cultural communities
        - Connecting with employers to help them better understand and support working caregivers
        - Partnering with other organizations and sectors to identify collaborative solutions.
    - Senior LinkAge Line (SLL) is a free statewide service of the MBA in partnership with Minnesota's AAAs. The SLL assists older Minnesotans and caregivers by connecting them to local resources. All SLL staff have completed training in caregiving and dementia.
    - Live Well at Home® grants fund projects focused on expanding the capacity of Long-Term Services and Supports (LTSS) to help older Minnesotans remain in their homes and communities of choice. These grants include funding for capital and renovation grants; LTSS development, including community and caregiving support; and core Home and Community-Based Services focused on strengthening and developing alternatives to nursing homes and other residential services.
    - The MBA Dementia grants program was created in 2015 to support regional and local projects focused on: 1) increasing awareness of dementia; 2) promoting cognitive testing and early diagnosis; and 3) supporting caregiving by family, friends and neighbors. The Legislature has appropriated $1.5 million for this program in each biennium since the 2016/2017 biennium.
    - Minnesota's successful ACT on Alzheimer's initiative, which began to be implemented in 2015, was a public-private effort focused on community-level support for people with dementia. ACT on Alzheimer's was used as a model for Dementia Friendly America, a national network of communities, organizations, and individuals seeking to ensure that communities across the U.S. are equipped to support people living with dementia and their caregivers.

Minnesota's investments in caregiving and dementia are significant and commendable, but as the population ages, the scope and acuity of needs will increase and require additional investments from different angles. The return on investment is multi-faceted—among other things, greater caregiver

support relieves pressure on adult protective services, delays or prevents moves into long-term care, and results in better physical and mental health of caregivers, allowing them to provide care longer.

Impact and Examples of Current Work

The following section describes themes that emerged related to the impacts of work focused on Caregiving and Dementia, followed by examples of strategies and grants[4] that help demonstrate how it is being carried out. The work described below is primarily from 2019-2021.

We lead statewide efforts to educate, support, and advance issues related to caregivers.
The Minnesota Caregiving Coalition, coordinated by the MBA, is a statewide coalition of more than 15 unique organizations that meets monthly to share program updates and to discuss best practices for caregiving support services and training or funding opportunities. Caregiving Coalition meetings are an opportunity for providers across the state to discuss services and lessons learned. These discussions have been especially valuable while adjusting services to the COVID-19 pandemic.

As a member of the Center for Health Care Strategies (CHCS) Helping States Support Families Caring for An Aging America, Phase II Initiative, the MBA is enhancing and developing strategies to assist family, friends, and neighbors who are caregiving. This cross-sector partnership includes team members from DHS, the Alzheimer's Association, and Health Partners.

We support and expand the use of effective models for providing caregiver support.
Caregiving is integral to supporting each other as we age. While dementia is primarily a disease of age, other conditions—such as Parkinson's disease, Traumatic Brain Injuries, strokes, and Down syndrome—can cause or increase the risk of dementia.

New models and programs are being developed that both support and empower caregivers, who have a difficult job and often need help to prevent burnout and safeguard their own wellbeing. When compared to caregivers of individuals without dementia, twice as many caregivers of those with dementia indicate substantial emotional, financial, and physical difficulties.[5]

Area Agencies on Aging, Live Well at Home® grants and MBA Dementia grants help extend the reach and impact of caregiver support programs in a number of ways. Namely, they help identify and train individuals to deliver these programs; fund provision of the programs to caregivers who need them; promote and educate partner organizations and service providers about the programs; provide continuing education for those delivering the programs; and form groups or networks where those individuals working with caregivers can learn from and support each other. Below is more information about key models and examples of how they are being employed.

- ***Caregiver Consultants:*** Trained professionals who help caregivers on an individual basis with problem-solving, information, skills, and emotional support. Nearly 80 Caregiver Consultants are available throughout the state, and interested caregivers can learn more through Senior LinkAge Line.

[4] All Live Well at Home® grants referenced in this brief were awarded in State Fiscal years 2018-2021. Numbers shared to illustrate the impact of the most recent grants are likely to increase over the course of the grant cycle.
[5] *Alzheimer's Disease Facts and Figures* report, Alzheimer's Association, 2020.

Caregiver Consultants complete over 30 hours of an MBA-designed, hybrid curriculum, including culturally responsive modules focused on dementia in a variety of communities, including African American, Hmong, Somali, American Indian, and Latino. Some Caregiver Consultants in Minnesota also have received training related to homelessness.

- ***REST (Respite Education and Support Tools):*** An evidence-based respite-training program that is used statewide. There are a variety of trained REST professionals, including more than 400 REST Companions, who provide respite; almost 50 REST Trainers, including two Spanish-speaking trainers (as a result of a Live Well at Home® grant with Centro Tyrone Guzman); four REST Master Trainers; and one of the only nationally trained REST Regional Trainers.
- ***REACH Community* (Resources for Enhancing Alzheimer's Caregivers in the Community):** REACH Community is a dementia caregiving program that empowers caregivers to problem-solve challenges that arise from caregiving. There are more than 125 trained REACH providers in Minnesota.
- ***PEARLS (Program to Encourage Active, Rewarding Lives):*** A program that educates older adults about depression and helps them develop skills for self-sufficiency and more active lives.
- ***Powerful Tools for Caregivers*:** An evidence-based six-week education program focused on supporting caregivers while they provide care.
- ***Trualta:*** An online training platform designed for caregivers. Minnesota's approach uses Caregiver Consultants to help families, friends, and neighbors who are caregiving find appropriate training on Trualta to support them in their caregiver roles, reduce stress, and prevent burnout. The platform consists of curated collections of modules, called badges. The MBA is working closely with Tribal Nations to create the first ever Indigenous Caregiving badge.

We expand availability of respite services.

Opportunities for respite care are of fundamental importance for most caregivers, providing much-needed time to attend to other things or simply do something they enjoy. Respite may be provided by a professional, a volunteer, a family member, friend or may also be provided in a care setting. Approaches to respite include those listed above, among others. Many AAAs helped providers establish virtual respite services during COVID-19 to allow caregiver support to continue during this uniquely difficult period.

Adult Day services are another type of respite care. These services provide activities to meet the health and social needs of a care recipient, while simultaneously providing a break for the caregiver. Activities may include participating in community groups, age-appropriate tasks, and community integration opportunities.

We provide culturally appropriate outreach, support, and information to older adults who are Black, Indigenous, and people of color.
Norms, beliefs, and expectations related to aging can vary considerably across cultures; this is very true as it relates to dementia. Providers must be knowledgeable, respectful, and inclusive. Friendly, caring, and well-intentioned staff are important but not enough; people's use and experience of services are just as informed by cultural traditions, religious practices, and dementia-awareness.[6]

The Alzheimer's Association reports that an overwhelming majority (from 84% to 92%) of Black, Hispanic, Asian, and Native American survey respondents said it was important for Alzheimer's and dementia care providers to understand their ethnic or racial background and experiences. However, most feel that people in their communities do not have access to such providers. In addition, half or more of non-White caregivers say they have experienced discrimination when navigating health care settings for their care recipient.[7]

All AAAs are working to expand and strengthen services to culturally diverse older adults—for example, by working with culturally-specific organizations that provide caregiver support to improve services to caregivers who are members of those communities.

A recent Live Well at Home® grant funded CAPI USA to expand culturally and linguistically appropriate support for low-income Hmong older adults and caregivers in northern Hennepin County. CAPI supported over 60 Hmong caregivers with transportation, grocery shopping, and assistance completing public benefit applications.

A recent MBA Dementia grant supported Volunteers of America Minnesota to increase dementia awareness by promoting and uplifting cultural differences and to respond to community needs in respectful and dignifying ways. This involved training 180 staff from the Minneapolis and Saint Paul Housing Authorities and Volunteers of America Minnesota, and reached nearly 2,000 community members, including African American, Hmong, and East African older adults.

We provide dementia awareness and caregiver support to older people who are LGBTQ.
Older adults who are LGBTQ face particular challenges related to aging. LGBTQ older adults are more likely to be financially insecure and to live alone, less likely to have children to help care for them, and often lack culturally competent healthcare, service providers, and senior housing.[8] Many have faced years of discrimination that can continue into older age. The aging network is working to better understand and build capacity related to serving LGBTQ older adults.

Recent MBA Dementia grants have helped support LGBTQ older adults related to caregiving and dementia.

- Northwoods Caregivers in Bemidji is working to increase awareness and early identification of dementia and to connect caregivers to each other, including outreach to Native American and LGBTQ+ communities. It is building on current partnerships with Red Lake, White Earth, and Leech

[6] "Cultural sensitivity and awareness," Alzheimer's Society United Kingdom
[7] *Special Report: Race, Ethnicity, and Alzheimer's in America*, Alzheimer's Association, 2021.
[8] Williams Institute, UCLA School of Law

Lake Nations as well as Bemidji State University and Northwest Technical College, and a new LGBTQ+ Cultural Consultant.

- Rainbow Health's (formerly JustUs Health) project, Dementia Awareness for LGBTQ+ and HIV-Positive Minnesotans, has provided awareness training to almost 40 people of different genders, races, and geographies and is working to offer an LGBTQ+ Dementia Caregiver Support Group.

We support and partner with Dementia Friendly Community initiatives.
The State of Minnesota supports dementia friendly communities, which foster the ability of people living with dementia to remain in community and engage and thrive in day-to-day living. Dementia friendly communities respond in part to the fact that dementia is as much a social condition as a medical one. While the ACT on Alzheimer's initiative is no longer active, many communities continue to take up dementia friendly efforts—independent from or in tandem with age-friendly communities work.

AAAs, Live Well at Home® grants, and MBA Dementia grants all support efforts to advance dementia-friendly communities in various ways. For example, in 2020, one AAA successfully reignited collaboration in the region by hosting a virtual regional conversation related to dementia involving Dementia Friends Champions, Memory Café leaders, caregiver consultants, caregivers, and ACT on Alzheimer's leads.

We engage across sectors to build community support and understanding of people with dementia and caregivers.
As part of a community-level approach, we also cultivate active engagement of other sectors that can play important roles in people's daily lives—such as faith communities and local businesses. Some of this work is accomplished through the Dementia Friends program.[9] Minnesota currently has more than 21,000 Dementia Friends.

- Through a Live Well at Home® grant, TRUST, in Minneapolis, is assessing congregations' ability to help older adults and caregivers, offer Dementia Friends training, and provide care coordination. The Gathering, a popular group respite program, was put on hold due to COVID-19. TRUST also offers a durable goods loan program that includes walkers, canes, wheelchairs, etc.,

- With support of a MBA Dementia grant, Barnesville Area HELPERS in Barnesville is expanding community awareness of dementia by providing individualized dementia friendly information sessions to local businesses, banks, students, clergy, and the police, fire, and ambulance crews. Barnesville Area HELPERS staff have also completed the Alzheimer's Group Facilitators training.

We partner with healthcare providers to establish protocols that better help older patients being discharged and their caregivers.
The hospital discharge process presents an opportunity to set the stage for a smooth transition to home and reduce readmissions. This involves the caregiver as well as the patient. Sometimes people become caregivers when a family member or friend is discharged from the hospital, and life will not be returning to normal. Hospital discharge is an opportunity to reach out to a caregiver with information and training about the role they are about to assume—for their own benefit as well as that of the person being discharged.

[9] A Dementia Friend is someone who attends a one-hour session to increase their understanding of dementia and learn how to make a difference for people affected by dementia in their communities.

Some AAAs are working with healthcare providers to establish new procedures in this regard. Among other examples, one has worked with a regional healthcare provider to begin to implement referral protocols—including Senior LinkAge Line, local Caregiver Consultants, and the Alzheimer's Association—upon discharge for people with dementia. Another has worked with a regional foundation on funding opportunities related to improving hospital discharges for tribal elders.

We provide caregiver support as part of an array of home- and community-based services.
Some providers and grantees offer a large menu of services—including caregiver support—focused on helping older people stay well and safe in their homes and communities. An older adult can choose which services they need and may bundle caregiving support with other assistance. This often is referred to as wrap-around services, which support the caregiver in other areas, such as transportation, chore services, or grocery delivery, in order to address the bigger picture of a caregiver's needs. Examples of Live Well at Home® grants that illustrate this include:

- Volunteer Services of Carlton County serves Aitkin and Northern St. Louis counties with one-stop wrap-around services focused on assisted transportation, chore services, in-home and group respite, caregiver support and education, GrandCare and Carlton Wellness Center activities. The organization provided over 700 hours of chore services, almost 900 hours of caregiver respite, more than 15,000 one-way rides, and over 1,400 caregiver counseling sessions.
- ElderCircle in Grand Rapids is enhancing current programing to support aging in place and maximize independent living for older adults and caregivers in Itasca and St. Louis Counties. Throughout the FY 2021 grant period, ElderCircle has implemented an iPad Lending Library, delivered around 500 grocery orders, offered health and wellness sessions to almost 50 participants, and connect with 10 caregivers in support groups.

We use the arts and music to support people with dementia and caregivers.
Music and the arts can transcend some of the loss and challenges that accompany dementia and allow people to connect with each other in a powerful way. We support this approach in a variety of ways.

- One AAA serves on the advisory committee of a local theater, using arts as dementia support. This includes outreach to the Somali community.
- The statewide Trualta platform includes music and playlists with special audio technology to promote relaxation for the care receiver.
- Family Pathways facilitated a Dementia Friends session for Girl Scout Troops, utilizing the book *Grandpa and Lucy* (written by Edie Weinstein, a ninth grader from Saint Paul). Twelve girls from two different troops attended.
- The Alzheimer's Disease and Prevention and Intervention (ADPI) grant includes funding to train Caregiver Consultants in the Music & Memory® intervention. Music & Memory® is an organization that provides personalized music training to help caregivers and care providers create individualized playlists for those living with dementia.

Recent MBA Dementia grants supported the following efforts:

- In Duluth, First Community Health Organization and The Victory Fund will expand the Victory Chorus's educational outreach, providing social connection, musical outreach, and support networks among choir participants.
- A.C.E. of Southwest Minnesota's project, Collaborative Connections for Memory Care Supports and Caregiver Services, provided a variety of virtual training opportunities—such as two showings of The Remember Project, a group of professional theatre artists that uses the arts to build more dementia-capable communities, a Dementia Friends training, and a Senior Life Solutions presentation.

Gaps and Opportunities to Consider

Despite the gains and progress that have been made in the past decade or so, the Alzheimer's Disease Working Group in its 2019 report finds that Minnesota is still not fully prepared to address the impact of dementia on Minnesotans. They recommend a more comprehensive and coordinated—and less fragmented—effort that emphasizes comprehensive accountability for state actions, and prioritizing and investing in health care workforce development. Other areas for improvement include public awareness, consistency of care across residential settings, and cultural responsiveness.

Additional recommendations and opportunities include the following:

American Rescue Plan Act: Federal funding creates new opportunities

As part of the American Rescue Plan Act of 2021, a coronavirus relief bill, MBA received funds via the Administration on Community Living that can be used to invest in Title III[10] program areas, including caregiving. MBA will be working with AAAs to determine how these one-time funds can be most impactfully invested; the work must be implemented over the funding period, which runs through September 2024.

Caregiver Consultants

- Build out Caregiver Consultation services, including virtual services, more broadly and consistently around the state.
- Utilize funding awarded through the Administration on Community Living (ACL) Alzheimer's Disease and Prevention and Intervention (ADPI) grant to expand the current number of Caregiver Consultants; provide iPads/tablets to caregivers receiving Caregiver Consultation services; and train Caregiver Consultants in additional programs, such as Music & Memory®.
- Continue to invest in Trualta—the training platform that helps families build skills to manage care at home for loved ones—which Minnesota families currently can access through their work with a Caregiver Consultant.
- Explore connecting the MBA cultural consultant program to caregiver consulting. This could be a natural extension of the cultural consultants' role and take advantage of their knowledge and existing relationships.

[10] Title III of the Older Americans Act—Grants for States and Community Programs on Aging—funds supportive services (of numerous types), nutrition programs, health promotion and disease prevention services, and caregiver support.

Inclusive and equitable services

In keeping with DHS' goals to reduce disparities and institutionalize equity practices across the agency, increase focus on and investment in the following:

- Culturally competent and respectful caregiver and dementia services for Minnesotans who are Black, Indigenous, and people of color, and that reflect the nuances of different ethnicities. This includes funding and other support of culturally-specific service providers, which are often best positioned to deliver such services.
- Knowledgeable and respectful services to LGBTQ+ individuals and chosen families.

In addition, be responsive to other unique caregiving situations as they evolve, such as millennial and even Generation Z caregiving.

Hospitals and healthcare

- Establish new protocols with healthcare providers across the board to improve the discharge process so that it routinely includes training and the provision of resource information to the person who will be caregiving once home.
- Explore the possibility of rolling out Trualta through hospitals, where families could access Trualta programs before discharge to better prepare for caregiving roles at home.

Elderly Waiver

Opportunities exist to leverage the State of Minnesota's Elderly Waiver (EW) program to maximize informal caregiving. EW provides home and community-based services (HCBS) for people who need the level of care provided in a nursing home but who choose to live in the community. EW participants must be 65 or older and qualify for Medical Assistance.

- *Need for rate increases*: Demand for HCBS services will grow as the population ages, and rates paid to service providers must increase—to allow them to remain in business, pay competitive wages, and provide quality services. EW programs supplement and support the role of family and other unpaid caregivers. In 2017, 44% of EW participants received support from an informal caregiver to address one or more of their care needs. When an EW participant has the benefit of support from family and friends, the services provided through EW supplement what the caregivers can provide, and allow them to provide care longer. The EW program is designed to support the continuation of informal caregiving when possible.

- *New model*: Another model to consider is the consumer-directed community supports (CDCS) option under EW and the Alternative Care (AC) program. AC is a critical model to help address the workforce shortage. The CDCS option allows participants to hire people in their informal networks, such as family and friends, rather than rely upon a shrinking formal workforce to deliver services. It is predicted that Minnesota will be short about 60,000 direct care and support workers in the next few years. The CDCS option provides the greatest degree of flexibility for the person to purchase the services that meet their needs, while maximizing the use of informal supports.

Thank you to Minnesota's seven Area Agencies on Aging, Live Well at Home® grantees, and MBA Dementia grantees for the examples of work highlighted in this brief.

AGE FRIENDLY
minnesota

Age-Friendly Status Check

EMERGENCY PREPAREDNESS

SEPTEMBER 2021

AGE-FRIENDLY MINNESOTA

Emergency Preparedness

We will live in communities that are ready to keep us safe, connected, and autonomous before, during, and after a crisis—be it public health, weather, or other disaster.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website..

Overview

Public emergencies can take many forms. Crises in 2020—especially the COVID-19 pandemic, but also civil unrest in the aftermath of George Floyd's killing—highlighted the importance of emergency preparedness specifically for older adults. The increase in extreme weather events also necessitates better planning. Such hazards disproportionately threaten older adults who need extra care or assistance due to physical, cognitive, or medical issues. Events in 2020 also demonstrated that multiple crises can hit simultaneously, intensifying the overall impacts and vulnerability.

No one state agency is responsible for emergency planning. Homeland Security and Emergency Management analyzes various threats to the state and develops preparedness guidance and response plans to address them. The Minnesota Department of Health Center for Emergency Preparedness and Response leads the state's efforts for integrated preparedness, response, and recovery planning among state, local, and tribal public health and health care partners. However, opportunities and responsibilities to better prepare communities and older Minnesotans abound in many places, including the Minnesota Board on Aging (MBA) and divisions of the Minnesota Department of Human Services (DHS), particularly the Office of Ombudsmen for Long-Term Care (OOLTC).

The Governor's Council on an Age-Friendly Minnesota added emergency preparedness as a ninth domain[2] of focus for the initiative. As the state prepares to undertake a deeper, more concerted

[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.

[2] The AARP age-friendly framework includes eight domains: Outdoor Spaces and Buildings; Housing; Transportation; Social Participation; Respect & Social Inclusion; Communication & Information; Civic Engagement & Employment; and Community Support & Health Services.

emergency preparedness effort as part of Age-Friendly Minnesota, it is worth examining how the aging network, MBA, and DHS responded to changing and, often, urgent needs over the course of 2020 due to COVID-19. The pandemic, unprecedented in this lifetime, taught important lessons about older adult needs in an emergency and how well we are positioned to meet those needs—which include choice and autonomy—in the inevitable event of another crisis, be it weather, public health, or otherwise.

What Was Learned in 2020

This section presents key takeaways from the work of Area Agencies on Aging (AAAs), Office of Ombudsmen for Long-Term Care (OOLTC), and others in the face of COVID-19. We can learn how they mobilized to help grantees, service providers, and communities meet the pandemic challenges they observed among older Minnesotans throughout the state. Consistent, thoughtful planning guides the work of the aging network, yet most plans for 2020 were upended by COVID-19, and work across the board was compelled to shift gears on a dime to address quickly changing needs and circumstances as the pandemic unfolded.

AAAs dealt closely with immediate needs of older residents across the state. The nature of their responses to pandemic challenges can largely be grouped into four categories:

- Redirecting funds to address changing needs
- Supporting and guiding grantees to help them meet changing needs
- Swiftly adapting in-person services, trainings, and classes to online platforms
- Creating forums for service providers to learn from and support each other as they navigated pandemic conditions

More detail on these and other actions is found below, including the most pressing needs observed. Broader themes are noted in bold, followed by examples and descriptions to help illustrate the work.

Basic needs took center stage.

Across the state, agencies and service providers observed basic needs become top priority. Food and social connection were at the top of the list.

Food and nutrition

AAAs and providers across the state saw the need for food surge during the pandemic—especially home-delivered meals. They responded to the need in a variety of ways, such as:

- **Using newly available federal funds to provide meals**
  - *Granting out COVID-19 Relief Nutrition funds to regional organizations*. Often the majority of the funds went to provide home-delivered meals, with a small amount for grocery delivery. In some cases, AAA staff held several calls with stakeholders prior to making the grants in order to plan and foster collaboration.
  - *Awarding COVID-19 Response Funding from the MN Council of Foundations area food shelves*, which had a considerable increase in users from previous years.

- **Amending grantee contracts to redirect dollars to food and nutrition**
  - *Transitioning all Title-III C-1 funds (Older Americans Act Nutrition Program)* to provide home-delivered meals during the period of greatest need.
  - *Helping Title III[3] grantees transition services to new service delivery models and new services* to meet pandemic needs. Partnerships with food shelves, groceries-to-go, and prescription delivery services were encouraged.

- **Providing technical assistance and support to grantees**
  - *Meeting with all nutrition providers* on a weekly basis to provide technical assistance and share updates on service needs, supplies, and transitions.

- **Connecting with new partners and providers**
  - *Working with a regional partner to promote their 7-day meal box program* that operated in partnership with local grocery stores in several counties.
  - *Providing technical assistance and funding* for meal distribution to homeless elders and take-home options for caregivers.

- **Supporting creative and innovative solutions**
  - *Switching to drive-up or take-out meal services* at the onset of the pandemic.
  - *Working with rural bus programs and other transportation services to find creative ways to deliver food* to participants when some drivers were reluctant to continue delivering during the pandemic.
  - *Awarding funding to an organization to provide $200 per month for food* to new immigrants with an elder family member.

- **AAAs were able to provide many meals to American Indian tribal elders.**
  Numerous AAAs worked with tribes and partner organization to fund (with COVID-related dollars in some cases) and coordinate provision of meals to tribal elders, caregivers, and grandkin, amounting to tens of thousands of meals across the state.

Because of the high amount of additional funding that was used during COVID-19, some AAAs' staff are concerned about organizations continuing to meet the high demand for nutrition in 2021 without the supplemental funding that was available during the pandemic.

Social isolation

Social isolation also emerged as a high priority need, especially early on. The OOLTC dealt first-hand with the trauma in long-term care centers caused by COVID-19. It received an unprecedented number of calls regarding loneliness and isolation as residents were confined to their rooms with no visitors allowed or continued restrictions on visitation.

[3] Title III of the Older Americans Act—Grants for States and Community Programs on Aging—funds supportive services (of numerous types), nutrition programs, health promotion and disease prevention services, and caregiver support.

Regional ombudsmen usually visit all 361 licensed nursing homes in person once per quarter, but during COVID-19 they transitioned to telephone and video communication outreach, as well as outreach through written materials—for both staff and residents. This stopgap measure helped the regional ombudsmen maintain some level of contact with people during the pandemic to offer services and supports. OOLTC eventually resumed in-person visitation, first through outdoor and window visitation and later through inside visitation.

As in other areas, AAAs and providers found themselves shifting resources and attention to outreach to ensure that individuals were well and had their basic needs met. AAAs helped their partners learn to identify social isolation, and pivoted Title III funds toward telephone reassurance. Many held frequent, regular calls with grantees to address pandemic concerns and increase provision of telephone reassurance for isolated rural older adults, caregivers, and persons with disabilities.

Several also promoted federal CARES Act grant funding opportunities to organizations in their regions and provided technical assistance and funding ideas. This resulted in numerous organizations being selected to provide services focused on increasing social engagement for older adults during COVID-19. In one region, virtual meetings across three subregions were held to focus specifically on ways that community and residential facilities could help clients and staff maintain social connections.

Supporting caregivers during an emergency

Caregivers faced particular challenges during the pandemic. In some cases, stay-at-home orders and safety concerns deprived caregivers of needed breaks and support. In others, visitor restrictions meant that for long periods, caregivers were unable to see loved ones who live in care facilities.

Moving online: virtual caregiver support

AAAs were able to transfer many caregiver services to virtual platforms as a way to continue supporting caregivers during a difficult period. Caregiver coaching and counseling was offered via online platforms like Zoom, and caregivers who participated reported benefiting from the meetings.

Several AAAs noted providers' creativity and resilience in adapting to online services. Providers conducted virtual respite in many creative forms, such as volunteers watching movies over the phone with a care receiver, virtual group sing-alongs, and activity baskets. One provider offered virtual services for care receivers as well as a separate virtual meeting for the caregiver at the same time. Another established a niche for Caregiver Consulting focused on those caregivers who have a loved one in the nursing home setting and struggled with being unable to see them.

Despite this, some AAAs saw drops in the number of caregivers served during 2020 due to cancellation of in-person services and a lack of technology access and literacy among some caregivers. One AAA noted that providers reported high caregiver stress, rapid decline in care receivers, and technology difficulties.

However, virtual services also made it possible to reach care receivers who usually wouldn't be eligible for group setting respite due to bathroom requirements. Likewise, when one region's caregiver support groups shifted online during the second half of 2020, it enabled them to reach more people by making the support group available in additional areas, including reservations.

Creating opportunities for learning and support

MBA and AAAs provided much-needed opportunities for caregiver service providers to gather (virtually) and learn from and support each other. The statewide MBA Caregiver Coalition became invaluable as a place for providers across the state to gather ideas for service delivery changes or additions during the pandemic. One AAA initiated a regional Caregiver Consultant Network at the beginning of 2020, with most topics centering on providing caregiver support during the COVID-19 crisis. Similarly, another AAA facilitated 10 virtual Title III-E Caring & Sharing meetings to support and generate ideas for meeting the pandemic-related needs of caregivers and care receivers.

Successful shifts to virtual platforms

Across the board, agencies and service providers needed to quickly figure out how to offer services virtually—whether Evidence-Based Health Promotion (EBHP) programs or training for Caregiver Consultants. The majority of classes and services successfully transferred to online formats, with many lessons learned in the process. AAAs undertook this shift internally and helped grantees do the same. The transition required a great deal of time and other resources.

AAAs provided technical assistance to grantees and partners to help establish virtual services. They also found ways to fund programs that include the purchase of devices that participants could use to access services or classes. For example, one AAA amended its Title III award to CommonBond to include purchase of needed devices (50 iPads and 12 internet hotspots) so that older adults could join EBHP programs. Another AAA used CARES Act funding to support programs that provided tablet devices and internet service to older adults to allow them to participate in classes and stay socially connected. A third provided technical assistance to partners, including a church, to help them provide virtual classes, including Aging Mastery, and one provided classes for its class leaders focused on delivering classes on Zoom, who found it critical to success and engagement.

Don't waste a crisis

Amidst the immense challenges and suffering that resulted from COVID-19, some important lessons and opportunities emerged.

New connections and relationships

In some cases, the changing needs driven by COVID-19 opened doors for AAAs and providers to connect with groups that AAAs seek to engage and support but who are sometimes difficult to reach. Examples of new opportunities in various regions include the following:

- Reaching out to low-income senior housing residents related to grocery delivery services, which became especially important and desirable during the pandemic.
- Engaging with tribes and AICHO (American Indian Community Housing Organization) regarding nutrition needs of elders living both on and off of the reservation, and ultimately providing $171,525 of COVID-19 Relief Nutrition funds to these entities to provide home-delivered meals.
- In response to the pandemic, holding weekly/biweekly coordination calls with regional partners, including tribal entities. These calls increased collaboration with tribal entities and led to Older Americans Act service opportunities; in the second half of 2020, two mini-grants were made to a transit service on a reservation for assisted transportation.

- As a result of a referral from MBA staff, one AAA and a senior dining provider connected with the urban Indian office regarding ways to support the nutritional needs of their 120 urban elders. Newly formed relationships with two nations' urban offices are anticipated to continue well into the future.

Smarter, increased use of technology

So many services, trainings, classes, and other aspects of work shifted online under rapid fire. This was a steep but highly instructive learning curve. The experience resulted in discovery of new possibilities that will strengthen and expand the reach of the aging network.

AAAs report that Title III providers are utilizing technology more and more to reach and engage participants and are likely to continue to do so, even as COVID subsides and circumstances no longer necessitate it. In one region, caregiver information sessions, which traditionally target specific locations, now have been made broadly available online. In another, while COVID-19 prevented the AAAs from integrating health promotion programming in congregate dining sites as planned, classes moved to an online format. As a result, hybrid classes—some participants attend in person, some attend online, and others by phone—are being pursued for the future, providing participants with new choices.

Age-friendly communities

Several Minnesota cities that are members of the AARP Network of Age-Friendly States and Communities reported that their age-friendly initiatives put them in a stronger position to respond to COVID-related challenges for several reasons:

- Organizational connections and relationships were already established and aided rapid, coordinated action.
- Greater knowledge of older adults' needs, wishes, and existing resources facilitated more effective responses.
- Strategies and methods were in place to support quick and effective communications of critical information.
- Elevated profile of older residents is established and increasingly "on the radar" of city and community leaders.

This helps speak to the potential and power of community-wide age-friendly initiatives and their ability to help communities be more resilient and better absorb the stressors caused in emergency situations.

Where We Go from Here

A year like no other, 2020 was difficult—an understatement—but a good teacher. Lessons gleaned from what Minnesota's older adults and communities experienced, and how the aging network and other key divisions responded, should be used to inform emergency preparedness work to be undertaken as part of Age-Friendly Minnesota.

Long-term care

Numerous issues related to long-term care emerged during COVID-19. In addition to those mentioned above, there also is a need for the following:

- Better infection control practices in long-term care
- Addressing continued staffing shortages, including new staffing resources to tap in the case of emergency
- Policies that take into account the health and safety effects of isolation—such as ensuring that residents have continued access to family or other informal caregivers even during a pandemic.

Ageism

Ageism is widely regarded as playing an influential part in how COVID-19 impacted older people—such as the nature of public discourse, which devalued older people; the 'protective' policies that can be considered patronizing and that neglected the health consequences of social disconnection; the documentation of deaths of older adults; and the lack of preparation in long-term care homes.[4]

Our attitudes, shaped by media messages and public discourse, show up in our actions, decisions, and policies. Ageism is a common thread in all aspects of age-friendly work, but COVID-19 provides a very immediate example of how it comes to life. Specific attention must be given to how perceptions and attitudes about aging and older people show up in our planning, engagement, and policies.

Utilizing older adults as the rich resource they are

While some older adults are indeed vulnerable and have needs that require deliberate planning for emergency response, it also must be noted that older adults who are not vulnerable can be a tremendous asset in helping those who are. AmeriCorps Senior (formerly SeniorCorps), a program that connects people 55 and older with volunteer opportunities, provided some COVID-19 response, but there is opportunity for them to be better utilized for future emergency responses.

Thank you to Minnesota's seven Area Agencies on Aging and the OOLTC for the examples of work highlighted in this brief.

[4] Fraser, Lagac, Bongué, et al. "Ageism and COVID-19: What does our society's response say about us?" *Age and Ageing,* Vol. 5, Issue 49, Sept. 2020.

AGE FRIENDLY
minnesota

AGE-FRIENDLY STATUS CHECK

HEALTH & WELL-BEING

AUGUST 2021

AGE-FRIENDLY MINNESOTA

Health & Well-Being

We will have convenient, timely, and affordable access to activities we enjoy, and the care and services we need, to optimize our physical health, mental health, and overall well-being.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website.

Overview

Health is far more than medical care. The circumstances of our lives—our families, homes and neighborhoods, our jobs and education, our access to healthcare, and the natural environment—play the largest role in our overall health and well-being. These factors are known as the social determinants of health (SDOH).[2] Digital inclusion, which encompasses high-speed internet access and the ability to use it, recently has been added to this list, and is linked closely to the other SDOH.[3] All of these have particular implications for us as we grow older and are likely to increase our focus on health.

From this angle, virtually all of the work of the aging network, Minnesota Board on Aging (MBA), and Department of Human Services addresses health and well-being. The good news is that because public policy plays a huge role in how we experience aging, Age-Friendly Minnesota is rich with potential to help improve health and later life for older Minnesotans, present and future.

Strategies for healthier aging increasingly are shifting to include not just healthcare but the bigger picture of our lives. This is especially important because many health disparities and inequities are rooted in SDOH. Minnesota, while often recognized for its high quality of life, in fact has some of the worst race-driven health disparities in the country. Further, older adults who have experienced decades of inequities on many fronts—namely Black, Indigenous, and people of color, along with the LGBTQ community and others—enter later life in a more precarious position.

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[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.

[2] Healthy People 2030, US Department of Health and Human Services

[3] Sieck, C.J., Sheon, A., Ancker, J.S. *et al.* Digital inclusion as a social determinant of health. *npj Digit. Med.* 4, 52 (2021).

Affordability and access are two major issues associated with healthcare itself. Even with insurance coverage, healthcare costs, including prescription medications, can become unaffordable to many older adults. Nationally, more than half of people 65 and older report taking four or more prescription drugs, and nearly one in four say it is difficult to afford their prescriptions.[4]

Access to healthcare is of increasing concern in greater Minnesota, where rural hospitals and nursing homes have been closing in the last 10 to 15 years, making it more difficult to access care—an even greater barrier for non-drivers given limited transportation options. Of the hospitals that remain, many offer fewer services than they once did.

As of 2019, the Minnesota Department of Health designated 54 of Minnesota's 87 counties as health professional shortage areas in dental and primary care; all 54 are in rural Minnesota.[5] At the same time, rural Minnesotans are older, more likely to be low income, have more chronic conditions, and report overall poorer health.[6]

As more Minnesotans live longer lives, we need to create conditions that allow all of us to enjoy optimal health as we enter older age and as we move through the various chapters of late life. Investing in better systems and services is good for people and for the system—the two can't be separated.

More of us will seek home or community-based services to support our autonomy and a good quality of life. The State of Minnesota provides a vast array of services to older adults throughout the state—through Area Agencies on Aging, Live Well at Home®, and other means, many of which address various social determinants of health. For the purposes of this document, Health and Well-Being includes physical health, mental health, nutrition, and healthcare.

Impact and Examples of Current Work

The following section describes themes that emerged in the area of Health & Well-Being followed by examples of strategies and grants[7]—primarily drawn from 2019-2021—that help demonstrate how it is being carried out.

We provide evidence-based health promotion and disease management programs and coaching that empower older adults to make informed decisions about their health.
Our work creates opportunities for older adults to access high-quality programs that address common concerns associated with aging—chronic conditions, falls prevention, movement and balance, and others. Program participants learn valuable skills and information, move their bodies, and connect with other people.

This is increasingly important, because while people are living longer, more of us are living with chronic conditions that drive up healthcare costs (for both the individual and the system) and take a toll on our well-being. Many of these conditions—such as diabetes and cardiovascular disease—can be prevented or

[4] Kaiser Family Family Foundation, *Data Note: Prescription Drugs and Older Adults*, 2019.
[5] Rural Health Care in Minnesota: Data Highlights, Minnesota Department of Health, 2019.
[6] *Ibid*
[7] All Live Well at Home® grants referenced in this brief were awarded in State Fiscal Years 2019, 2020, or 2021.

mitigated with physical activity, education, and other preventive measures addressed thorough evidence-based health promotion (EBHP) programs.

Area Agencies on Aging (AAAs) and Live Well at Home® help make EBHP programs possible, by working to raise awareness of the programs, funding providers to offer the classes, and identifying and funding training for new instructors. During the pandemic, AAAs worked with providers to shift their EBHP programs online and had overall encouraging results after a steep learning curve.

AAAs are working to reach more ethnically and culturally diverse residents with these programs by creating partnerships with leaders and organizations from specific cultural communities. They also convene the home- and community-based services (HCBS) providers who offer EBHP programs to discuss regional disparities and how best to reach underserved groups. Some ideas have included vending machines with shelf-stable food and basic supplies for homeless older adults; collaboration with farmers markets and/or Second Harvest food bank to donate food; and mental health program like PEARLS or REACH in Indian country.

Examples of Live Well at Home® grants related to this work include:

- Faith Community Nurse Network in Saint Paul is supporting and training nurses to deliver five distinct evidence-based falls prevention and chronic disease management programs to older adults. Each program improves health outcomes and reduces risks for further injury, illness, or disability.

- Minneapolis Indian Center will deliver an evidence-based falls prevention program model called "Bingocize" online each week by Native staff along with online Native language classes.

AmeriCorps Senior (formerly SeniorCorps) Retired Senior Volunteer Program (RSVP) offers another EBHP program called Stay Active and Independent for Life, or SAIL. SAIL is a strength, balance, and fitness program for people 65 and older. Currently four RSVPs offer SAIL in southwest, central, and northwestern Minnesota. Most classes transitioned to online formats during the pandemic.

We promote and provide effective, respectful services for older adults who are LGBTQ.

Older adults who are LGBTQ face particular challenges related to aging. LGBTQ older adults are more likely to be financially insecure and to live alone, less likely to have children to help care for them, and often lack culturally competent healthcare, service providers, and senior housing. Many have faced years of discrimination that can continue into older age. The aging network and DHS are working to better understand and build capacity related to serving LGBTQ older adults.

The Minnesota Board on Aging requires that Caregiver Consultants[8] be competent and have skills to work with individuals and families from a variety of communities, including the LGBTQ community. AAAs are doing work such as educating communities and providers on developing and offering appropriate

[8] Caregiver Consultants are trained professionals who help caregivers on an individual basis with problem-solving, information, skills and emotional support. See the *Caregiving and Dementia* brief in this series for more information.

services to LGBTQ older adults. One has worked with tribal health leaders to bring a Training to Serve workshop to a reservation to develop greater understanding and improve care for LGBTQ tribal members.

Additionally, recent Live Well at Home® grants have supported the following work:

- Rainbow Health (formerly JustUs) will design and implement a comprehensive long-term services plan for LGBTQ+ and HIV-positive older adults in the Twin Cities and Duluth. The plan will respond to housing, mental health, transportation, and other needs.

- East Side Neighborhood Services in Minneapolis is connecting the east side LGBT communities' older adults to education, resources, and social engagement opportunities that enhance health outcomes and improve quality of life. The organization will partner with other groups, including the East Side's Queer Affinity Group, and use "gerontechnology," including virtual reality and videography, to build intergenerational friendships, support families who care for older adults, and provide an array of programming.

We provide free counseling to help people reduce Medicare costs.

Senior LinkAge Line (SLL) provides free, unbiased counseling to people eligible for Medicare, including all adults 65 and older. Trained specialists talk with SLL callers to answer questions, and also hold free classes for those new to Medicare and during the annual open enrollment people to help people make informed choices. Each year this invaluable service helps 17 percent (or 177,000) of Medicare-eligible Minnesotans navigate what can be a complex and overwhelming—but incredibly important—decision-making process. SLL can also help callers identify programs available to help lower prescription medicine costs. SLL is working to make more culturally diverse older Minnesotans aware of Senior LinkAge Line and the resources it offers.

We advocate for improving and strengthening support service provision to meet growing mental and behavioral health needs of older adults.

Mental health is health. Generally, about one in 10 older adults experience depression or anxiety, and this jumped to one in four during the COVID-19 pandemic.[9] While these conditions are typically treatable, they often are under-recognized and untreated in older adults. Further, most areas of Minnesota do not have sufficient services to meet mental health needs.

Substance abuse is a growing but under-recognized problem among older people, as well, for a variety of reasons. Older adults are prescribed more medications than other age groups, including potentially addictive pain management medications. Decreased social connections may contribute to, as well as make it easier to hide, a problem. Healthcare practitioners may under-diagnose the issue in older people, and older people may be less likely to recognize a problem or seek help.[10]

AAAs around the state either lead or participate in collaborative mental health initiatives related to topics that include mental health and aging, and needs and barriers related to mental health services. AAAs also develop and share resource lists related to mental health services.

[9] Kaiser Family Foundation, October 2020.
[10] NIDA. "Substance Use in Older Adults DrugFacts." *National Institute on Drug Abuse*, 9 Jul. 2020, https://www.drugabuse.gov/publications/substance-use-in-older-adults-drugfacts.

Live Well at Home® grants also support efforts to address mental health among other older adults. One example is a grant to Touchstone Mental Health in Minneapolis to provide access to housing, and coordination of services and long-terms supports for older people who have been homeless and have multiple barriers to housing, including many people of color and veterans. Live Well at Home® grants also support the offering and expansion of PEARLS, a national evidence-based program for late-life depression discussed later in this brief.

We expand access to nutritious food as a foundation of overall health and well-being.

Food is one of the most needed and important things we work to provide. This includes home-delivered meals, congregate meals, and support of grocery delivery, food shelves, and other services. Nutritious food can become a challenge in older age—due to things like limited transportation and greater difficulty cooking or preparing food—yet it is critical to good health, ability to manage or prevent chronic disease, and maintaining a high quality of life.

When COVID-19 hit, the need for food quickly emerged as the most urgent. Examples of notable initiatives related to food included:

- One AAA gathered and compiled data on grocery stores that provide home delivery and that accept EBT payments; it explored partnership with grocery stores to facilitate both services as a way to provide greater access to fresh foods.

- Through a Live Well at Home® grant in Rushford, Semcac Community Action Agency bought five used delivery vehicles to replace three aging vehicles and to add two home-delivered meal routes to their service area. SEMCAC serves 11 southeastern Minnesota counties via their senior nutrition programs.

We invest in and expand promising models.

The aging network provides opportunities to test promising new approaches to building capacity of older adults and communities. Two such programs—CAPABLE and PEARLS—are being used in both rural and urban parts of the state and are demonstrating good results in both contexts.

Community Aging in Place – Advancing Better Living for Elders (or, CAPABLE) is a low-cost, person-centered model that helps low-income older adults remain at home by addressing the home environment and using the strengths of the client themselves. Developed at the John Hopkins School of Nursing, CAPABLE provides in-home support by an occupational therapist, registered nurse, and handy worker over the course of five months.

- Through a Live Well at Home® grant, Twin Cities Habitat for Humanity, the first known CAPABLE provider in Minnesota, served 46 older adults in 2019, its first full year of operations. While slowed by COVID, Twin Cities Habitat still served 32 homeowners in 2020, and is working on a pilot to serve households at slightly higher incomes with a fee-for-service model. A major accomplishment was becoming a waivered service provider, which makes Habitat eligible to serve UCare, Blue Cross and Blue Shield, and Medica's Medicaid and dual-eligible clients. In the future, Habitat will also be eligible for reimbursement for projects through the Medicare Advantage plans that these insurers provide.

- Live Well at Home® also funded Habitat Douglas County to implement CAPABLE in a rural setting, one of few rural sites in the nation. Around a dozen older adults will complete CAPABLE, and more than 15 home modifications will be completed. Habitat Douglas hopes to expand its service area for the program.

- One AAA, also through a Live Well at Home® grant, assisted a coalition in implementing the CAPABLE program in three rural counties to decrease hospitalizations and nursing home stays by improving medication management, problem-solving ability, strength, balance, mobility, nutrition and home safety.

Program to Encourage Active, Rewarding Lives (or, PEARLS) is a short-term, evidence-based, chronic condition management intervention for older adults with depressive symptoms. It teaches problem-solving and behavior skills and engages participants in activities designed to help them deal with depression. PEARLS is being implemented through two Live Well at Home® grants—one in the Twin Cities metro, one in greater Minnesota:

- VINE Faith in Action in Mankato is implementing PEARLS in Blue Earth, Nicollet and Le Sueur counties, with all materials being translated into Spanish, Somali, and Arabic.

- Jewish Family Service of St. Paul is extending the reach of PEARLS in Blue Earth, Hennepin and Ramsey counties. This expansion includes a collaboration with Jewish Family and Children's Service of Minneapolis, providing a refresher series to individuals who have completed the initial PEARLS program and extending the program's reach to a more diverse population.

Finally, Keystone Community Services is using a Live Well at Home® grant to pilot two new food program options designed to improve low-income older adults' access to high-quality, nutritious food. Keystone will form new partnerships and deploy its wheelchair lift-equipped food mobiles, which are food shelves on wheels. The programs operate in seven neighborhoods in St. Paul and northern Ramsey County suburbs.

Gaps and Opportunities to Consider

The following items present key points related to addressing health and wellness as part of Age-Friendly Minnesota. This list is not comprehensive, but an important starting point.

American Rescue Plan Act: Federal funding creates new opportunities

As part of the American Rescue Plan Act of 2021, a coronavirus relief bill, MBA received funds via the Administration for Community Living that can be used to invest in Title III[11] program areas, including those related to healthy aging. MBA will be working with AAAs to determine how these one-time funds can be most impactfully invested; the work must be implemented over the funding period, which runs through September 2024.

[11] Title III of the Older Americans Act—Grants for States and Community Programs on Aging—funds supportive services (of numerous types), nutrition programs, health promotion and disease prevention services, and caregiver support.

Healthy aging: systems and vision

- Apply an age-friendly lens to the public health system using recommendations from the emerging Age-Friendly Public Health Systems model being led by the Trust for America's Health. A core tenet of this work is cross-sector coordination and collaboration.
- Create a new healthy aging vision as part of Age-Friendly Minnesota.
- Identify and maximize opportunities to align with, contribute to, and leverage the Healthy Minnesota Partnership, which brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota. The *Healthy Minnesota 2022: Statewide health improvement framework* advances health equity that focuses on improving the conditions that create health.

More and better services for the full range of Minnesota's residents

- Continue and increase investment in building capacity to more effectively serve older adults who are Black, Indigenous, and people of color and older members of the LGBTQ community
- Recognize the consequences of the loss of rural hospitals and healthcare, the limited availability of home- and community-based services in many rural communities, and incorporate these issues into planning and decision-making.

Programs and models

- Consider shifting investments away from EBHP programs—now well-established through Juniper—and toward promising models like CAPABLE, which is being successfully applied in both urban and rural contexts.
- Continue to expand PEARLS and similar programs that have demonstrated success in addressing mental health for older adults.
- Consider implementation of other complementary programs that would leverage existing provider partnerships—for example, programs that could be offered at a dining site or faith-based organization, such as Eat for Life or Eating for a Healthy Life.

Links to social connection and inclusion

- Recognize the fundamental importance of social connectedness to the area of health and well-being, and identify new ways to bring social connections into this work.

Thank you to Minnesota's seven Area Agencies on Aging, Live Well at Home® grantees, and MBA Dementia grantees for the examples of work highlighted in this brief.

AGE FRIENDLY
minnesota

Age-Friendly Status Check

INCLUSION & EQUITY

SEPTEMBER 2021

AGE-FRIENDLY MINNESOTA

Inclusion and Equity

We will be valued, respected, and free from discrimination, and will have access to services that are appropriate for us, regardless of age, income, physical or cognitive ability, sexual orientation, gender identity, religion, geography, race, ethnicity, or culture.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website.

Overview

The Governor's Council on an Age-Friendly Minnesota championed diversity, equity, and inclusion as one of its top recommendations and one that underlies each thread of the work. The Minnesota Board on Aging (MBA) and Department of Human Services (DHS) have embedded practices and are undertaking work across their divisions designed to reduce disparities experienced by Black, Indigenous and people of color and to ensure that *all* older adults are intentionally included and well-served in their work. These efforts to be more inclusive and equitable will continue to evolve as more is learned from ongoing education and research; concerted and genuine commitment to learn and grow; successes and challenges gleaned from various strategies; and capacity being developed in communities over time.

As is true in many places, Minnesota is becoming more racially and ethnically diverse. About 950,000 (or 17%) of Minnesotans are aged 65 or older. Of those, 66,000 (or about 7%) are people of color.[2] Younger generations are more diverse at present—about 32% of Minnesota youth ages 0-19 are children of color—but older adults also are becoming more diverse, and that will become increasingly true over time as younger generations age.

[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.
[2] 2020 US Census, via Minnesota Compass.

Age-Friendly Minnesota is working alongside the eleven American Indian tribal nations whose geography overlap with the State of Minnesota in this work. The state's American Indian population is about 60,251, and about 5,888 of them are 65 and older.

Inclusion and equity also refer to age itself. While older people are, of course, the focus of this work, there remains a need to update our thinking, and help others update their thinking, about the inherent value of a person at all ages, what it means to grow older, and the importance of appreciating the possibilities in older age and the contributions that we, as older people, make to our communities. Ageism—stereotypes, prejudice and discrimination towards people based solely on their age—has very real consequences. It is linked to maltreatment of vulnerable older adults, poorer health outcomes, and even shorter life spans.

For the purposes of this document, Inclusion & Equity includes discussions of various ways that the aging network, MBA, and DHS are working to learn about the lived experiences of older Minnesotans, and the disparities that exist as a result of our current systems, with a goal of helping *all* older Minnesotans live full and rewarding lives.

Impact and Examples of Current Work

The following section describes current themes in our work as it relates to Inclusion and Equity, followed by examples of strategies, projects, and grants that help demonstrate how it is being carried out. They primarily draw from work undertaken in 2019-2021. These are but a few examples of work of this nature. Additional examples can be found in the other documents in this series.

Commitment to and investment in greater equity in the aging network, MBA, and DHS

Throughout the aging network and beyond in DHS and State of Minnesota, work is underway to better include and serve our state's increasingly diverse population. Among other things, we are undertaking extensive efforts to engage and learn from historically excluded groups, gather and analyze data, build relationships, and train and educate staff to make important changes to a system that is well-established but does not function well for all people.

Some examples of this work include:

- DHS has been leading an effort to understand and help close racial and ethnic disparities in home and community-based services. This multi-year project, a partnership with the University of Minnesota Center on Healthy Aging and the MN Diverse Elders Coalition, runs from late 2019 through 2022 and has been identified by the Blue Ribbon Commission[3] as a key strategy to advance equity in state services for Minnesota's older adults and individuals living with disabilities. While not focused exclusively on older adults, people ages 65 and older are a major piece of the work. Findings and recommendations that emerge from the research will be important to integrate into Age-Friendly Minnesota's planning and strategies.

[3] The Blue Ribbon Commission on Health and Human Services was created by the Minnesota Legislature and Governor Tim Walz in 2019 to develop an action plan, "to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans."

- With around 80% of its current users being White, Senior LinkAge Line (SLL) is focusing on more effective outreach to diverse populations. Barriers are both cultural and practical. SLL is working to partner with culturally-specific community organizations as well as publishing materials in additional languages, among other strategies. It also has developed a productive relationship with the state's tribal nations.

- DHS Adult Protective Services (APS), whose work includes adults of all ages but impacts many older people, is conducting a study related to equity and outcomes. It has previously identified racism in its screening processes and outcomes, and will be using CARES Act funding (federal dollars tied to COVID-19) to train APS staff throughout the state on unconscious bias, and to advance work related to tribal issues and culturally-specific service providers.

  APS also is leading a multi-year effort called the Vulnerable Adults Act (VAA) Redesign, a substantial review of the VAA, which establishes state policy for the protection of vulnerable adults and Minnesota's adult protection system. The VAA Redesign was inspired in part by a recognition that the current system does not serve people equitably and was not built to support Minnesota's increasingly diverse population. The Redesign also aims to make services consistently equitable across Minnesota's 87 counties, which administer APS under state oversight.

- Annual area plans developed by each of state's seven Area Agencies on Aging (AAAs) specify goals related to addressing disparities in their regions. AAAs also are working to ensure that their regional Boards of Directors include individuals who represent a broad spectrum of the community.

- MBA is working to strengthen relationships with Minnesota's tribal nations—specifically, working to develop government to government tribal consultation policies.

- Live Well at Home® grants support provider efforts to develop and offer culturally appropriate services for a range of historically underserved groups. This includes grants that support culturally specific providers to serve members of their own communities.

- The DHS Gaps Analysis[4] process is using data to better understand disparities in accessing services and utilization by Minnesotans who are Black, Indigenous and people of color.

Connecting older adults with broadband and technology

Access to broadband service has become as necessary as basic utilities. A recent study also identified digital inclusion as a social determinant of health.[5] The COVID-19 pandemic made this crystal clear when it relegated much of society to the internet in order to access everything from work and school to medical appointments to visits with friends and family to grocery delivery.

[4] The DHS Gaps Analysis is an ongoing process to understand and improve access to services systems for older adults, people with disabilities and children, and youth and adults living with mental health conditions in Minnesota. It is a collaboration between DHS, lead agencies (counties, tribal nations and managed care organizations), service providers, consumers and local community members.

[5] Sieck, C.J., Sheon, A., Ancker, J.S. *et al.* Digital inclusion as a social determinant of health. *npj Digit. Med.* 4, 52 (2021). https://doi.org/10.1038/s41746-021-00413-8

The aging network helped older adults use technology to take classes, access services, and connect with family and friends by providing devices, WiFi service, and online programs and services. However, this does not substitute for reliable, universal internet access that residents of all ages can count on during emergency situations as well as more ordinary times.

Broadband is not only for the young. The Governor's Council for an Age-Friendly Minnesota included affordable broadband access in its recommendations as a way to achieve fundamental equity across geography, race, and income, as well as age. Broadband unlocks doors to information, telemedicine, opportunities to maintain social ties, and vital services such as transportation. The aging network will continue to prioritize broadband access and associated resources (devices, training, tech support, etc.) into its work, and will actively support the Minnesota Office of Broadband Development's goal to provide all Minnesota homes and businesses with high-speed internet by 2022.

During the pandemic, multiple AAAs pivoted to provide internet access and devices to help older adults adapt to an abrupt shift to an online world. One AAA amended a funding award to affordable housing nonprofit CommonBond to include purchase of 50 iPads and 12 internet hotspots so that older adults could join Evidence-Based Health Promotion programs. Another used CARES Act funding to support programs that provided tablet devices and internet service to older adults to allow them to participate in classes and stay socially connected.

Numerous Live Well at Home® grants[6] also have supported access to WiFi, devices, and technical knowledge.

- In Minneapolis, the Lyndale Neighborhood Association worked with Minneapolis Public Housing Authority to provide digital access and inclusion services with a special focus on serving older Somali residents of Charles Horn Towers. Personal electronic devices were given to 30 households, free wireless hotspots were available in community spaces of Horn Towers, and part-time tech support was provided.

- Lighthouse Center for Vision Loss in Duluth is delivering technology services to older adults with disabilities and chronic health conditions. The project includes a statewide resource center as well as outreach and public education in several regions, including Native American communities.

- In Itasca and St. Louis counties, ElderCircle is implementing a program that includes new technologies to combat isolation and loneliness, and virtual Adult Day Stay for those confined to their homes. This includes the purchase of 30 iPads that older adults and caregivers can check out and use to attend virtual support groups, health and wellness sessions, and community education.

- Faith in Action for Cass County is recruiting and training volunteers, providing resources, and giving virtual support to people living in remote rural areas, including online Memory Cafés and caregiver support groups. This includes the purchase of six GrandPads to loan to isolated older adults without internet service.

[6] All Live Well at Home grants referenced in this brief were made in State Fiscal Years 2019, 2020, or 2021.

We build capacity of culturally-specific organizations to better support their older community members.
Organizations rooted in a particular cultural or ethnic group often are best positioned to serve members of that community. Along with a shared language and culture, they serve as trusted partners and a bridge between their traditional culture and the culture and systems of this country. We help those organizations expand their reach and their services.

Below are two examples of Live Well at Home® grants that are building capacity in cultural communities.

- The Minneapolis American Indian Center is providing in-home services such as meal delivery, weekly check-ins, and technology support for educational, social, and wellness resources to American Indian elders. Further, an evidence-based falls prevention program model called "Bingocize" is being delivered online each week by Native staff along with online Native language classes.
- In Saint Paul, Vietnamese Social Services of MN is providing interpretation and application assistance that helps refugees/immigrant elders access resources available to them.

In addition, during the pandemic, one AAA provided technical assistance to the executive director of an African organization for home-delivered meals to Somali elders. With the in-person dining site on hold, the organization partnered with a Somali restaurant to provide biweekly meal delivery to Somali elders.

We build other providers' capacity to improve and expand effective services to older members of Minnesota's ethnic and cultural communities.
As Minnesota's population diversifies, service providers will need training and education to help them understand and support people from a wide range of backgrounds. Norms and expectations related to aging can vary considerably across cultural groups. Without an understanding of and respect for these differences, providers will struggle both to connect with members of these groups and to serve them effectively and equitably. Both AAAs and Live Well at Home® grants are investing in efforts to educate providers about cross-cultural work and ensure that older Minnesotans from all backgrounds can receive effective, knowledgeable, and respectful services. Examples of this work include the following:

- One AAA is working with new and continuing culturally-specific organizations that provide caregiver support services to improve services to low-income caregivers from those cultural communities. Another, understanding that Asian- and African-Americans are served more frequently once in the system, is helping providers more effectively market services to these groups.

- Through a Live Well at Home® grant, Lutheran Social Service of Minnesota in Kandiyohi County is partnering with immigrant communities to identify community ambassadors, learn more about community needs, culturally appropriate service delivery, and culturally specific meal offerings. Another Live Well at Home® grantee, Pelican Rapids OAKS Living at Home Network, is working to strengthen relationships with diverse older adults in Pelican Rapids.

We support and cultivate connections between LGBTQ older adults.
LBGTQ[7] older adults face a unique set of challenges. Rather than relying on adult children or other relatives for care and support as they age—the common arrangement in the United States—many have "chosen families" made up of close friends and others who care for each other. They are more likely than non-LGBTQ older adults to have ruptured or complicated biological family relationships, face ongoing discrimination, have higher risks of mental health issues, and face barriers to getting health and social support. A report from The Williams Institute at the UCLA School of Law recommends that LGBT older adults be recognized by the Older Americans Act as a "greatest social need" group, which would open up funding to prioritize services and research related to LGBT aging.[8]

Minnesota DHS' and MBA's efforts to better include and serve diverse older adults includes LGBTQ individuals.

- Through two recent Live Well at Home® grants, Senior Community Services is conducting outreach efforts to LGBTQ older adults in Hennepin County, and Rainbow Health (formerly JustUs Health) in Saint Paul is designing and implementing a comprehensive long-term services plan for LGBTQ+ and HIV-positive older adults in the Twin Cities and Duluth.
- Rainbow Health is also using an MBA Dementia grant to support dementia awareness for LGBTQ+ and HIV-positive Minnesotans. That program has provided awareness training to almost 40 older adults of different genders, races, and geographies and is working to offer a LGBTQ+ Dementia Caregiver Support Group.
- Through another recent MBA Dementia grant, Northwoods Caregivers in Bemidji is working to increase awareness and early identification of dementia and to connect caregivers, including outreach to Native American and LGBTQ+ communities. Northwoods Caregivers will be building upon current partnerships with three tribal nations as well as a new LGBTQ+ Cultural Consultant.

We work to strengthen and sustain rural communities' capacity to provide the services and options older residents desire.
Greater Minnesota is collectively older than the Twin Cities metro. Residents of rural and small-town Minnesota are more than twice as likely to be age 80 or older than residents in urban parts of the state.[9] Rural older adults, however, often lack ready access to important services, such as caregiver support and transportation assistance. Further, rural hospitals and nursing homes have been closing, creating even bigger barriers to accessing care or being able to remain in one's community.

The Rural Health Research Center at the University of Minnesota notes that because many aging-related resources and services originate at the state level—such as Medicaid funding for long-term care, Area Agencies on Aging, and other state agencies—states play a particularly important role in helping older rural residents age in place and allocating resources to rural communities.[10] Indeed, AAAs as well as Live

[7] We recognize that some older adults in this community prefer LGBT to LGBTQ.
[8] Choi and Meyer, *LGBT Aging: A Review of Research Findings, Needs, and Policy Implications*, The Williams Institute, UCLA School of Law. 2016.
[9] *Greater Minnesota: Refined and Revisited*, Minnesota State Demographic Center, 2017.
[10] "Aging in Place in Rural America: What Does It Look Like and How Can It Be Supported?" Rural Health Research Center, University of Minnesota, 2021.

Well at Home® grants and MBA Dementia grants work throughout the state to build up service capacity, test innovative approaches, and provide choices for older residents in communities in rural Minnesota.

While many examples exist, one notable example is the CAPABLE program (Community Aging in Place – Advancing Better Living for Elders), a low-cost, person-centered model that helps low-income older adults remain at home by addressing the home environment and using the strengths of the client themselves. Developed at the John Hopkins School of Nursing, CAPABLE provides in-home support by an occupational therapist, registered nurse, and handy worker over the course of five months. The State of Minnesota is helping to pilot this promising model in various places across the state, including several rural counties.

We dismantle ageism through education and communications.
Age-related stereotypes often are perpetuated with humor or offhand condescension, but ageism is real and its consequences are serious. Ageism—negative stereotypes, prejudice, and discrimination towards others or ourselves based on age— influences how policies related to older adults are developed, adversely impacts health, contributes to maltreatment of vulnerable older adults, and was widely noted as a factor in how systems and society treated older people in relation to COVID-19. As we internalize society's negative messages about aging, it also impacts our health and well-being on an individual level and can even shorten life expectancy. This is a widespread issue that will require consistent work to begin to change. It is an important piece of age-friendly communities work.

All AAAs are working to address ageism in how they think about, communicate about, and approach their work. Several AAAs are using the Frameworks Institute's "Reframing Aging" tools and recommendations to train staff and audit their own marketing and communications materials. Staff learn about language and themes to avoid as well as preferred alternatives shown to more effectively influence public policy and change the public's thinking about aging.

Gaps, Considerations, and Opportunities

The following items present key points related to advancing Inclusion & Equity as part of Age-Friendly Minnesota. This is not an exhaustive list, but an important starting point.

- State-level and other government task forces, working groups, and other efforts to formulate and influence plans, policies, and funding decisions must include members whose race, ethnicity, culture, and other characteristics reflect the full population of the state of Minnesota.
- Efforts to uncover institutional biases and adopt practices that address disparities must be deliberate and ongoing. As part of this work, seek out and raise up the voices of older adults who experience disparities to share their lived experience, and use that input to directly inform the policies and programs seeking to serve them.
- Continue to train and educate staff and providers to understand, respect, and knowledgeably serve people from historically underserved groups. Training should include diversity, equity, inclusion, and access (DEIA) but also go beyond it to include cultural competency, which helps develop knowledge of and sensitivity to cultural issues and their many implications in planning and delivering services. This includes a recognition that people of color differ considerably from culture to culture. Further,

even those under one umbrella, such as Asian, includes older adults from Laos, Pacific Islands, and Korea, among others, each of which represents a distinct culture with different needs.

- Recognize the value and importance of existing and new community-based, culturally-specific organizations that are seeking to serve members of their communities. Increase support (financial and otherwise) of these organizations to increase their capacity to serve their community.
- The complexity of the current system is a barrier—even more so for people with limited English proficiency and/or those who, for any reason, have a limited ability to read.
- Continue partnership with the Minnesota Leadership Council on Aging, Minnesota Diverse Elders Coalition, and other key partners to work towards ending institutional barriers and race-based disparities facing Minnesota's older adults.
- Strengthen connections between and actively learn from existing and new efforts that focus on people who experience disparities and advance equity for all older adults.

  Examples of internal efforts include 1) the VAA Redesign and 2) DHS research project to examine racial and ethnic disparities in home and community-based services, both discussed earlier, as well as:

  - Healthy Minnesota Partnership,[11] whose charge is to develop an approach for statewide health improvement that engages multiple sectors and communities across the state and assures that every person in every community can be healthy. The Partnership has a particular focus on equity, inclusion, and understands the degree to which systems and places influence our health.

  Among others, additional research and efforts include:

  - A recent report developed for Trellis (formerly Metropolitan Area Agency on Aging) includes important insights and recommendations related to barriers that influence the ability of older adults of color to access and benefit from Title III services. *Equity Assessment on Access to Title III Services for Native Americans and Minority Older Adult Populations* presents a community-centered view on racial equity and aging in the Twin Cities, with a special focus on both the common and unique needs of older adults in the Black, Latinx, and American Indian communities.[12]
  - *50+ LGBTQ Needs Assessment Study* being conducted by Rainbow Health and University of Minnesota to provide actionable insight into the health needs of aging LGBTQ Minnesotans.
  - *Immigrant Memory Collaborative* hosted by ACER (African Education, Career and Resource) and the University of Minnesota School of Public Health to learn about dementia caregiving strengths and needs in the African immigrant community.

Thank you to Minnesota's seven Area Agencies on Aging, Live Well at Home® grantees, and MBA Dementia grantees for the examples of work highlighted in this brief.

[11] Health Minnesota Partnership brings community partners and the Minnesota Department of Health together to improve the health and quality of life for individuals, families, and communities in Minnesota.
[12] *Equity Assessment on Access to Title III Services for Native Americans and Minority Older Adult Populations*, SDK Communications + Consulting, June 2021.

AGE FRIENDLY
minnesota

Age-Friendly Status Check

INDIVIDUAL RIGHTS & PROTECTIONS

SEPTEMBER 2021

AGE-FRIENDLY MINNESOTA

Individual Rights & Protections

We have the right to be educated and empowered to promote our rights, and to have our rights respected.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website.

Overview

Among the roles of the Minnesota Department of Human Services (DHS) and Board on Aging (MBA) is work to not only protect older Minnesotans from abuse, neglect, and exploitation, but to help respect and maximize each person's autonomy and choices about their own lives. The Office of Ombudsmen for Long-Term Care (OOLTC) and Adult Protective Services (APS) are the divisions most directly involved in this work, though the state's Area Agencies on Aging (AAAs) and Live Well at Home® grants also address these topics.

The reach of the OOLTC is extensive. It helps residents of licensed nursing homes, assisted living facilities, Minnesota Veterans Homes, adult care homes (such as adult foster care), and adults who receive licensed home-care services in their own homes. It also advocates for people on hospice and people experiencing premature discharge from hospitals. Ombudsmen handle complaints and problems from individuals related to a range of issues—from quality of care or services to rights violations to discharge or eviction. They also advocate for reform in long-term care. All services are free to residents. OOLTC advocates on behalf of recipients of long-term care services and helps to resolve resident concerns and promote resident rights.

In Federal Fiscal Year 2020, OOLTC resolved 5,830 complaints and closed 2,556 cases. OOLTC also engaged in many other activities, including consultations to residents, families, and providers on resident rights; educational sessions; and resident and family council activities, among others. Importantly, OOLTC is and must be an independent entity, according to the federal Older Americans Act.

[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.

Adult Protective Services (APS) is an essential human service program administered by counties and tribes responsible for service response in appropriate cases for vulnerable adults who are reported to the Minnesota Adult Abuse Reporting Center (MAARC). APS is also responsible for investigating reported allegations when the person or agency alleged responsible is not licensed by DHS or the Minnesota Department of Health. In 2020, more than 24,500 reports of Minnesotans 65 or older being maltreated were made to the Minnesota Adult Abuse Reporting Center (MAARC), representing nearly half of the total reports made that year.

APS and OOLTC will be critical to Age-Friendly Minnesota. The scope and impact of their work related to older adults intersects with many issues—such as caregiving, the need for preventive and upstream services and support, ageism, resident rights, and social connections, among many others.

Some parts of the aging network deal with these rights and protections, as well. AAAs contract with five separate legal service providers to ensure that older Minnesotans can have basic civic legal needs met.

Impact and Examples of Current Work

The following section describes themes and impacts tied to this work, followed by examples of strategies and recent efforts that help demonstrate how it is being carried out.

We are reviewing and improving foundational policies to make them more effective and responsive to Minnesota's aging and changing population.

MN DHS Aging and Adult Services Division is leading a multi-year project to redesign Minnesota's Vulnerable Adult Act (VAA), which establishes the state's response to maltreatment of vulnerable adults. The VAA Redesign[2] aims to develop a more person-centered approach that ensures adults who are vulnerable to abuse, neglect, and financial exploitation experience equity, dignity, and consistent outcomes from APS—regardless of which county they live in. Until the Redesign, the VAA hadn't been substantially reviewed in 40 years. The Redesign will help the system be more responsive, effective, and inclusive given changing demographics—age, race, ethnicity, and culture—as well as address weaknesses in the current statute.

The VAA Redesign focused on APS, which receives the majority of reports about alleged maltreatment of vulnerable adults. This project will have significant implications for older adults, who tend to represent about half of all reports of maltreatment. The VAA Redesign process involved extensive stakeholder engagement, including that of older adults and people with disabilities, to identify both problems and solutions as well as policy and budget implications for the solutions.

We empower and advocate for older adults through policy changes related to assisted living and long-term care.

OOLTC worked closely on the development of legislation that mandates for the first time that assisted living facilities in the state be licensed. This new licensure program, which took effect August 1, 2021, aims to improve the safety and quality of care in assisted living facilities. It will substantially improve resident rights—including in the areas of discharge and contract termination, a focus of many complaints to

[2] More information on the VAA Redesign can be found here.

OOLTC. Related to this, OOLTC also is looking to improve protections in HUD properties that are exempt from assisted living licensure.

OOLTC dealt first-hand with the trauma in long-term centers caused by COVID-19. It received an unprecedented number of calls regarding loneliness and isolation from residents who were confined to their rooms with no visitors allowed and residents unable to leave their facilities. As a result of this experience, OOLTC is working to improve protections to ensure people have better access to family and friends during future pandemics. It also is identifying other important lessons from the pandemic in order to capture and apply learnings.

We advance older adult autonomy, choice, and well-being through efforts to strengthen and expand Supported Decision-Making.

The MBA, Live Well at Home® grantees, and legal services providers all work to advance Supported Decision Making (SDM). SDM provides an alternative to guardianship, a court process that takes away a person's legal ability to make decisions about their life. Instead, SDM works by empowering individuals—such as those with intellectual disabilities and some older adults—to make decisions about their lives with the help of their "supporters," who often include family and friends along with professionals such as health care agents and attorneys. SDM is increasingly recognized as a best practice to support adults who are not able to be fully independent.

SDM has broad application and benefits. It helps older people remain at home longer because they are working with social workers or care teams comprised of a social worker, attorney, caregiver, or others who can help identify suitable alternatives to guardianship through individual assessment, development of power of attorney forms, health care directives, and SDM agreements.

A series of statutory changes in recent years have prioritized an individual's autonomy and self-determination by requiring courts to evaluate whether less restrictive alternatives can be used as proper protections for a person, rather than the process of guardianship or conservatorship.

SDM also crosses over different areas. For example, a key takeaway from the VAA Redesign stakeholder engagement process (referenced earlier) was the need to balance a vulnerable person's safety and protection with their right to self-determination. OOLTC highlighted the need for a similar balance between keeping long-term care residents safe from infectious diseases and recognizing the safety risks of isolation as well as resident rights, including choice and autonomy, such as during COVID-19.

A recent Live Well at Home® grant to Volunteers of America in Minneapolis is being used to promote and expand use of Supported Decision-Making in an effort to disrupt over-reliance on guardianship for older adults. This project provides professional and community education and outreach, caregiver support, direct legal and social work services, and collaboration with partners.

We help older adults access free and low-cost legal services.

AAAs and Live Well at Home® grants both help older adults access legal services, education, and protection in various ways. In general, each year civil legal service attorneys receive funding through the AAAs to provide advice and direct services to older Minnesotans to prevent homelessness, ensure access

to health care and government benefits, obtain protective orders and develop safety plans for vulnerable adults, address family law matters, and provide information about alternatives to guardianship.

Several years ago, a Live Well at Home® grant supported the creation of the first legal kiosk in the state—a remote location where older adults could go to access computers, printing, and other resources needed to deal with legal issues. This model proved so successful that there are now 278 kiosks in high-need areas throughout the state. Some include video cameras and other equipment needed to have virtual meetings with attorneys or attend court. Kiosks are available to adults of all ages, but the idea originated as a service for older people.

Federal funds available in response to COVID-19 were used to expand these services. During the pandemic, one AAA provided carryover Title III funding to Legal Aid Services to create two remote kiosks in the region where older adults can access computers and print legal paperwork.

Gaps, Opportunities and Considerations

This section identifies considerations and opportunities for how Individual Rights & Protections might be woven into planning for Age-Friendly Minnesota. It focuses on issues related to APS and OOLTC and while not comprehensive, it is an important starting point.

Adult Protective Services

While the VAA Redesign is addressing critical issues, additional concerns exist that are beyond the scope of the Redesign but still warrant attention. It should also be noted that catching people farther upstream can help prevent or mitigate some of these issues.

- The current APS system is not culturally appropriate or responsive. Instead, it is one standardized process—similar to a criminal justice model—imposed on vulnerable adult services. (This concern is being addressed as part of the VAA Redesign.)

- *Time-limited services*: People who receive adult protective services do get help—but only for so long. The program is time-limited. Many individuals need ongoing or indefinite support, but no resources are available that allow for monitoring on a long-term basis.

- *Unmet need for case management*: Individuals in Medical Assistance (MA)[3] or who receive Elderly Waiver services[4] have case managers who help prevent maltreatment. However, many older adults who are not eligible for MA or Waiver programs also may need case management services, but they don't qualify. Families—if available, willing, and able—are then left to handle various issues. Most people are not willing or able to pay for services themselves, and may not even know that is an option.

[3] Medical Assistance is Minnesota's Medicaid program for people with low income.

[4] The Elderly Waiver program provides home and community-based services for people who need the level of care provided in a nursing home but who choose to live in the community. A person must qualify for Medical Assistance to be eligible for Elderly Waiver services.

- *Cracks in the system*: Eighty percent of people who are reported through MAARC as being maltreated are screened out of receiving services because they or their situations do not meet the statutory definitions of vulnerable adults or maltreatment. However, many of those people still need help. In the current system, APS has no way to serve or support those individuals.

- *Dementia and cognitive impairment*: In some cases, older adults have dementia or age-related cognitive impairment and may end up in the APS system because of diminished judgement and reasoning. In the current system, there is no good way to support individuals in this situation.

- *Is the front door in the right place?* There may be a gap in services for people who need help navigating more complicated situations. Senior LinkAge Line provides connections to resources, but it is not designed to help talk people through the practical ways they could support an older family member—how to create a balance between respect for the person's autonomy along with the help they require. In situations involving long-term care, OOLTC provides consultation services as well as full service supports to people who are struggling with certain issues, which include helping an older family member.

- *Financial management*: Vulnerable older adults sometimes have trouble paying their bills and may end up in the courts system or guardianship unnecessarily. Rather, they simply need assistance to manage their finances. Counties once provided such services but have largely stopped doing so.

As part of the outcomes of the VAA Redesign, APS is pursuing policy and legislative changes related to:
  - Improvements for family caregivers, by connecting individuals to services rather than investigations
  - Balancing privacy rights of vulnerable adults with need for information-sharing for protection during an investigation
  - Improving person-centered practices by the Lead Investigative Agency (LIA) by requiring that information on the VAA process be provided as well as that the vulnerable adult themselves be interviewed by the LIA during the investigation
  - Alignment of state policy supporting family caregivers and unpaid informal supports for vulnerable adults.

- The initial report[5] produced as part of the VAA Redesign noted several evidence-based and emerging models being used to prevent and counter abuse of vulnerable adults. APS is working towards the following:
  - Balancing the need to protect vulnerable adults with respect to their right to self-determination
  - Promoting a culture of safety: improving safety through systems reform and root cause analysis as opposed to individual blame
  - Multidisciplinary teams: providing additional resources for coordination and community involvement

[5] *The Vulnerable Adult Act and Adult Protective Services in Minnesota: A Review of National Models, Best Practices, and Stakeholder Insights* (June 2019)

- Structured Decision Making® Model: improving equity and outcomes for vulnerable adults by helping them remain autonomous with support from key people, rather than other tactics, such as guardianship, that limits a person's control of their life and future
- Community engagement: engaging social supports in prevention and response to maltreatment of vulnerable adults.

Office of Ombudsmen for Long-Term Care

- The right of older people to live in the least restrictive environment often is barely acknowledged. Most people want to remain living in their own home, yet this can be very difficult to actually achieve.

- Ongoing barriers that prevent older adults from remaining at home include:
  - *Lack of proper care coordination* as people try to navigate a complex system.
  - *Inefficient systems*. Siloed government agencies and health care entities, as well as inadequate communication among providers, result in health care delays to vulnerable people that diminish the chance for a positive outcome.
  - *Limitations to available services*. Some communities have few or no services available, and home care agencies cannot pay to cover employees' mileage to and from work locations. Low wages and mileage reimbursement are two workforce-related gaps that could be addressed to make services more widely and consistently available.

- Expanded opportunities for patient and family engagement in health care planning at the earliest point is essential for improving people's ability to manage their conditions and adhere to treatment plans following a medical event—with the goal of getting back home.

  - OOLTC works to properly inform people at the point of entry into the health care system, and increase individual and family engagement and participation in care planning. Consistent use of transitional care coordination (often by a nurse or social worker, but potentially by OOLTC staff) that uses a holistic, person-centered approach, with a goal of returning a person home, is critical to achieving this.

- Better public education is needed related to:

  - *Our rights in older age*. We have the right to remain in our homes and to access home care services and formal and informal supports that can help us do so.

    In most circumstances, we get to choose where we live. There are common misunderstandings, for example, related to what authority is conferred to someone with Power of Attorney. More readily available information is needed about supported decision making, especially as an alternative to surrogate decision making.

    People, including adults who live in LTC facilities, have the right to take risks. Law enforcement and the broader community have limited understanding of LTC residents' rights and often believe

that LTC facilities are responsible for removing all risks—such as, for example, a LTC resident driving a motorized wheelchair to the store. There is an opportunity to educate LTC residents about their rights as well as the general public.

- *How long-term care is paid for*. Misinformation and misperceptions are widespread. Many people have no idea how expensive care is and believe that Medicare pays for services and that Medicaid will pay for care, regardless of assets or income. Own Your Future is a public awareness initiative, supported by MBA, DHS, and other state agencies, that helps provide information about their risk for long-term needs, how to hold conversations with family members and others about who will care for you, how to decide where to live, and how to pay for long-term care costs. The work of Own Your Future should be incorporated and coordinated with the work of Age-Friendly Minnesota.

- Legislative opportunities:

  - *More notice upon termination of home care services*. Under current statute, home care providers are required to give only 10-days' notice to an individual prior to terminating services. This is inadequate and insufficient to arrange for a new provider to conduct a screening at home and assess and schedule care. Legislative reforms are needed to require more advance notice—a minimum of 30 days, and ideally 60 days. Contact information for the OOLTC also should be provided at the time of termination.
  - *Back-up plans when staff are absent*. Home care services are required to develop a back-up plan for care in the absence of staff (due to sick days, snowstorms, etc.). The responsibility for back-up care is almost always assigned to family or neighbors, who may not be reasonably accessible and who often aren't aware that they are written into the plan. OOLTC could help push for legislative changes in requirements related to how these plans are developed.

- People entering or living in long-term care facilities need more information and knowledge about their rights related to:
  - What questions to ask and information to gather when seeking services—especially related to limitations of services. Up-front conversations about what happens if the facility can no longer meet a person's needs can prevent rights violations later.
  - Resident and family councils, and how they can help to resolve issues
  - Access to information about staffing levels and the skill sets of staff caring for them
  - Voting in long-term care facilities and access to information—such as from TV and printed materials—to make informed decisions
  - Grievance policies, which every facility or provider of home care services is required to have.

AGE FRIENDLY
minnesota

Age-Friendly Status Check

LIFE AT HOME AND IN THE NEIGHBORHOOD

SEPTEMBER 2021

AGE-FRIENDLY MINNESOTA

Life at Home and in the Neighborhood

We will live in the homes and communities that we desire, and have access to the quality services and housing we need to do so—safely, comfortably, and affordably.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network,[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website.

Overview

Our homes and neighborhoods are always important, and they become even more so in older age. Does where we live—both our dwelling and our immediate community—enable us to live safely, comfortably, and affordably, and to remain connected to the people and things we care about?

Minnesota Board on Aging (MBA) and Department of Human Services (DHS) provide a wide range of services and supports that help older adults live with autonomy, dignity, and maximal independence. This support, continuously evolving to meet changing needs and test new strategies, includes an array of services that help people be safe and well in day-to-day life and remain living at home. Minnesota consistently ranks as one of the top states for providing services and supports to older adults and people with disabilities, according to a national scorecard by AARP and others.[2]

Minnesota's aging network, overseen by MBA, annually supports over 189,000 older Minnesotans and caregivers, providing services and supports to one in six older Minnesotans. As such, each year it provides funding to around 100 organizations and providers throughout the state who deliver a wide range of quality, affordable services—such as caregiver supports, respite, adult day, indoor and seasonal chore services, transportation, home modification, nutrition, and supports for people with vision loss.

[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.

[2] Long-Term Services & Supports Scorecard, developed by AARP, The Commonwealth Fund, and The Scan Foundation.

MBA, in partnership with Minnesota's seven Area Agencies on Aging (AAAs), also operates the Senior LinkAge Line, a free statewide service that assists older Minnesotans and caregivers by connecting them to local services.

Since 2001 the Minnesota Legislature has committed funding to DHS focused on helping more people remain living at home rather than relocate to long-term care facilities. This funding, known as Live Well at Home® grants, is awarded to organizations that work to develop and provide services that help older adults live at home in their communities. Each year between $6 million to $8 million dollars is awarded to Live Well at Home® grantees throughout the state. Live Well at Home® includes a focus on developing capacity in communities to be able to provide needed services to older residents. This is especially critical in rural areas where fewer services are available.

The demographic shift to an older population will drive demand for even more services at home. Age-friendly communities should include the services people want at the time that they need them. Services must be affordable to those receiving them, and wages paid to those providing them must be enough to attract and keep workers in these jobs.

A major piece of this work involves not only age demographics, but demographic shifts related to race, ethnicity, and culture. Minnesota's population, including older adults, is becoming more diverse in these ways and others, which has very significant implications for service planning and delivery. Rural residents also face scant options for housing, transportation, and services. Service access and equity are fundamentally important and must be at the center of this work.

For the purposes of this document, *Life at Home and in the Neighborhood* includes topics related to housing, transportation, community design features, and home- and community-based services (HCBS) in a broad sense. We understand "home" to mean where a person lives—whether it be the house where you raised your family, a condo or apartment, an assisted living community, care facility, or somewhere else.

While it is difficult to capture the scope of such services provided through MBA and the aging network, the following section highlights some of the key ways that we are building capacity in communities around the state.

Impact and Examples of Current Work

This section describes themes that emerged related to our impact in areas related to Life at Home and in the Neighborhood. Each theme is followed by examples of strategies, actions, and grants that help demonstrate how it is being carried out.[3]

We promote and provide an array of culturally-specific services to Minnesotans who are Black, Indigenous, and people of color.

Minnesota's population is becoming more diverse—particularly in race, ethnicity, and culture, but also in terms of religious beliefs, sexual orientation, and physical and cognitive abilities, among other things. The aging network and DHS are working to better understand and develop capacity for providing services that

[3] All Live Well at Home® grants referenced in this brief were awarded in State Fiscal Years 2019, 2020, or 2021.

meet the needs of various groups effectively and respectfully. An important part of this work is building capacity for culturally-specific providers to support older residents of their own communities, as they are usually best positioned to do.

Recent Live Well at Home® grants have helped both urban and rural providers develop and deliver culturally-appropriate services for Minnesotans from a range of backgrounds:

- African Community Senior Services in Minneapolis is developing, expanding, and sustaining services to African older adults. This work includes assessing the needs of and eligibility for supports/services of 1,000 people, providing community support referrals to 500 people, and providing transportation services to 200 people.

- Lutheran Social Service of Minnesota in Kandiyohi County is partnering with immigrant communities to identify community ambassadors; holding focus groups on community needs and culturally appropriate service delivery; developing culturally appropriate caregiver and companion programming and training; developing culturally appropriate Friends in the Kitchen events; and expanding culturally specific offerings of LSS meals for distribution.

- SEWA-AIFW, Inc. which assists South Asian older adults in the Minneapolis-St. Paul metro area, is helping provide in-home respite (including a pilot of technology-based remote respite), develop a group respite program, engage older adults in activities that reduce isolation and support management of chronic disease, buy an accessible van, and develop a South Asian food pantry.

- CAPI USA, which provides community-based services to help low-income Hmong elders in Northwest Hennepin County, is providing case management, adult caregiver support services, benefits enrollment assistance, transportation, and companionship with the help of volunteers.

- Vietnamese Social Services (VSS) is helping Vietnamese and Karen immigrants in the Twin Cities metro fight depression and isolation, challenges that are particularly pronounced for refugees and immigrants.

Additionally, one AAA has held conversations with two community advocates for Hispanic/Latino families to increase access to HCBS by encouraging providers to recruit bilingual workers and/or translate materials into Spanish.

We support older adult independence, safety, and community living through home modifications. Many homes—especially houses and buildings constructed during particular eras—offer few if any design features that accommodate mobility challenges. Home modifications targeted to a person's needs can make it possible for them to remain living safely in their home, and can be a relatively inexpensive way to overcome a significant housing barrier.

Some AAAs are addressing this issue by partnering with their regional Habitat for Humanity organizations. In one region, the AAA helped Habitat for Humanity develop its Age in Place program. In another, the AAA connected contractors who were willing to volunteer their services with Twin Cities Habitat for Humanity and Sustainable Resources, Inc. in order to reduce wait times for people who needed modifications to their homes.

Live Well at Home® grants also support this work. Two examples include:

- Rebuilding Together Twin Cities increased capacity to modify low-income older adults' houses within the seven-county Twin Cities metro area by enhancing accessibility, fully deploying a second ramp team, strengthening the financial stability of the program, and continuing to partner with St. Catherine University.

- Northwest Community Action in Badger is providing home modification services for older adults and volunteer management in Roseau, Kittson, Lake of the Woods, and Marshall counties.

We educate stakeholders and advocate for affordable housing and lifecycle housing.
Housing is increasingly expensive, and most homes still are not constructed with a full lifespan in mind. However, few things in life are as fundamental as housing. Our work in housing includes efforts to educate and encourage leaders and key decision-makers about the importance of affordable and lifecycle housing.

AAAs are working on this issue across sectors. One leveraged its relationship with a regional planning body to disseminate information on life cycle housing, planning, and development to representatives of cities, townships, counties, and tribal governments. Another participated in planning with a city's Housing and Redevelopment Authority (HRA) Board related to affordable senior housing. A third partnered with AARP to coordinate a training on lifelong homes by a Certified Aging in Place Specialist (CAPS) and architect with expertise in Universal Design.

We help create new transportation options and alternatives to driving.
Our automobile-focused culture makes getting around a challenge for those who do not or cannot drive. We all need convenient, affordable, appropriate transportation for everything from medical appointments to errands, to social gatherings and community events—to simply be who we are and do the things that matter to us. As we think about an older society, lack of transportation options is a major barrier to connected, autonomous living in later life.

Numerous providers in the aging network offer transportation assistance among their available services. However, the below examples highlight two notable transportation-specific efforts funded by recent Live Well at Home® grants.

- Newtrax is expanding current service of circulator bus loops for older adults in five Ramsey County communities, and launch loops in additional locations. This includes providing connections to affordable food options.

- SmartLink, the coordinator of non-emergency medical transportation for Scott and Carver counties, is creating an innovative transportation option for rural residents. The project includes education for residents about all available transportation options via a Travel Trainer and the addition of three accessible passenger vans that are available via a kiosk using enhanced technology for requesting, scheduling, providing, tracking and billing rides.

We contribute to more inclusive design of outdoor spaces and the built environment.
When we step out our front doors into our neighborhoods and communities, the design of those spaces can determine how well we can safely and comfortably move around and participate in our communities.

AAAs are working to bring a lifespan approach to how outdoor spaces and buildings are being planned and designed. One AAA participates in a regional collaborative bike-friendly planning initiative. Another has partnered with a regional foundation to advise on age-friendly grants to improve basic infrastructure in several small communities—such as the addition of a sidewalk outside a local swimming pool, and the installation of handicap accessible doors and bathrooms at community centers.

Live Well at Home® grants have also supported improvements to the built environment. A recent grant to the Lao Advancement Organization of America in Minneapolis supported the resurfacing of the parking lot of the Lao Cultural Center, an important institution in the Lao community, and the creation of a safe and welcoming presence in the neighborhood through landscaping and outreach.

We provide opportunities to innovate.
Seed-type funding usually is needed to give promising ideas a real shot. The aging network helps provide this funding to test new approaches to meet changing needs. Below are two such examples from recent Live Well at Home® grants.

- Prairie Five Community Action Agency in Montevideo purchased and outfitted a vehicle to serve as a Mobile Senior Center that can bring community-based services to residents in more than 30 rural communities. Services offered include blood pressure and blood sugar checks, foot clinics, mobile food shelf, application and information assistance, support groups, access to a computer, and welcome to Medicare classes.

- Episcopal Home Care and Services in St. Paul piloted an innovative home care delivery model—which uses a team rather than a single caregiver—to serve racially and economically diverse elders.

We expand promising models.
New approaches that are both effective *and* cost-effective will be needed to help us thrive in an older Minnesota. Our work includes investing in models that show promise for addressing complex issues.

One AAA is exploring Mobility Management software that has the capability to process payments, schedule rides and coordinate services. This innovative model would help meet transportation needs in rural communities.

A Live Well at Home® grant to Mobility 4 All has allowed this organization to adapt its Twin Cities personalized ride service program to meet the unique needs of two cities outside the metro, beginning with Rochester, then Winona. Mobility 4 All is extending ride service to low-income, older adults in single-family homes by collaborating with senior centers, veterans' organizations and home care providers. It also will develop an online "CareDriver Portal" for recruiting, vetting, training and coaching of Mobility 4 All CareDrivers and volunteer drivers.

Rebuilding Together Twin Cities' recent Live Well at Home® grant will allow the organization to expand services to rural southwestern Minnesota, specifically in Jackson, Cottonwood, and Nobles counties. This includes accessibility modifications for 25 homeowners; expanding existing partnerships; and developing new partnerships with strategic organizations that work on aging-in-place issues. The project also includes hiring a program manager for southwestern Minnesota.

We help prevent homelessness among older adults.
Homelessness among older people is rising faster than other age groups. Wilder Research's 2018 Minnesota homeless study[4] found homelessness among people ages 55-plus increased by 25% from 2015 to 2018, while homelessness overall grew by 10% during the same period. Lack of affordable housing was cited as the primary reason.

AAAs work to prevent and address homelessness in a variety of ways. Homelessness resources are included in MNHelp.info so that Senior LinkAge Link staff can refer to them, and Senior LinkAge Line staff receive training and education related to helping people who are homeless or at risk of homelessness. Some AAAs partner with other organizations to train homelessness service providers on issues specific to older adults, including cognitive decline. AAAs also work with other partners like police departments and emergency management staff to make them aware of how Senior LinkAge Line can assist people who are homeless or at risk of homelessness.

Staff and volunteers from several AAAs participated in Heading Home Together training, which helped them identify people at risk of homelessness. This new knowledge has helped staff connect older adults in danger of becoming homeless with the supports and services they needed.

Live Well at Home® grants also address homelessness. One example includes a grant to Mahube-Otwa Community Action Partnership, Inc., in Park Rapids, which is helping older adults who are homeless, or at risk of becoming homeless, find and keep safe rental housing in Becker, Hubbard, Mahnomen, Otter Tail and Wadena counties.

We advocate for practices and policies that support home care workers.
In an older society, more home care workers will be needed to provide services. These critical jobs, which thousands of older Minnesotans rely on to help them stay at home and out of care facilities, are among the fastest-growing occupations in Minnesota.[5] However, they also pay little and often don't include benefits or opportunities for full-time work.

AAAs are working to cultivate a strong workforce able to provide high-quality services and earn better wages. One AAA is supporting a regional service provider to work with a consultant on multiple issues related to staffing: improving staff retention rates; developing a more positive work culture; attracting talent of all ages (including older adults); and communicating more effectively with staff.

During COVID-19, another AAA connected with the Legislature in support of temporary pay increases for personal care assistants (PCAs), who were leaving their jobs in order to collect unemployment insurance that had been increased during the pandemic and now exceeded their wages.

[4] "Older Adults Experiencing Homelessness in Minnesota," Minnesota Homeless Study 2018. Wilder Research.
[5] "Growing Demand for Caregivers," MN Department of Employment and Economic Development, 2016.

Gaps and Opportunities to Consider

The following items present key points related to addressing Life at Home and in the Neighborhood as part of Age-Friendly Minnesota. This list is not comprehensive, but an important starting point on which more will be built.

American Rescue Plan Act: Federal funding creates new opportunities

As part of the American Rescue Plan Act of 2021, a coronavirus relief bill, MBA received funds via the Administration for Community Living that can be used to invest in Title III[6] program areas, including those that fall into this category. MBA will be working with AAAs to determine how these one-time funds can be most impactfully invested; the work must be implemented over the funding period, which runs through September 2024.

Inclusive and equitable services

- Broadly speaking, there is a fair distance to travel concerning diversity and equity. While Minnesota is among the very top states in the long-term services and supports it provides for older residents, we know that people of color and other groups fare significantly worse in our current system.

- DHS has been leading a multi-year effort to understand and help close racial and ethnic disparities in home and community-based services. The project, a partnership with the University of Minnesota Center on Healthy Aging and the MN Diverse Elders Coalition, runs from late 2019 through 2022 and has been identified by the Blue Ribbon Commission[7] as a key strategy to advance equity in state services for Minnesota's older adults and individuals living with disabilities. While not focused exclusively on older adults, people ages 65 and older are a major piece of the work. Age-Friendly Minnesota has been somewhat connected to this effort and should remain so. Findings and recommendations that emerge from the research should be coordinated with and integrated into Age-Friendly Minnesota's planning and strategies.

- A recent report undertaken for Trellis (formerly Metropolitan Area Agency on Aging) includes important insights and recommendations related to barriers that influence the ability of older adults of color to access and benefit from Title III services. *Equity Assessment on Access to Title III Services for Native Americans and Minority Older Adult Populations* presents a community-centered view on racial equity and aging in the Twin Cities, with a special focus on both the common and unique needs of older adults in the Black, Latinx, and American Indian communities.[8]

- Progress has been made and continues to be. Concentrated efforts of time, resources, and planning are being committed across the board—from Senior LinkAge Line to AAAs to Adult Protective Services—to better understand the specific gaps and inequities and determine ways to evolve in order

[6] Title III of the Older Americans Act—Grants for States and Community Programs on Aging—funds supportive services (of numerous types), nutrition programs, health promotion and disease prevention services, and caregiver support.

[7] The Blue Ribbon Commission on Health and Human Services was created by the Minnesota Legislature and Governor Tim Walz in 2019 to develop an action plan "to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans."

[8] *Equity Assessment on Access to Title III Services for Native Americans and Minority Older Adult Populations*, SDK Communications + Consulting, June 2021.

to meet those needs. This will require continued dedication, humility, and openness to finding and undertaking new ways of working.

Rural challenges

- Gaps and disparities exist in rural communities, including tribal communities. Rural hospitals and clinics are closing, making it difficult for those residents to access care, particularly given a shortage of transportation options. Rural residents also often have few available HCBS. There may be an opportunity to identify critical HCBS to ensure that all communities have access to the most-needed services that allow people to remain living safely at home as independently as possible and delaying or preventing the need to move to a care facility. This approach would be similar to Critical Access Hospitals, a federal designation given to eligible rural hospitals in order to help keep essential services in rural areas.

Greater attention to the built environment

- Given the importance of the design and availability of green and outdoor spaces to all ages, the Governor's Council on an Age-Friendly Minnesota should consider adding a representative from the MN Department of Natural Resources to the Council. Active participation from the Department of Transportation, already represented on the Council, will be critical to sustain.

A missing layer?

- A gap was noted between Senior LinkAge Line and case management. While Senior LinkAge Line provides a wealth of information, some individuals need more in-depth help navigating services, resources, and personal situations. This level of support currently isn't available, although Caregiver Counseling, a service provided by MBA, offers something similar in the context of caregiving. Consider whether this type of service is important and feasible to develop and provide.

Thank you to Minnesota's seven Area Agencies on Aging and Live Well at Home® grantees for the examples of work highlighted in this brief.

AGE FRIENDLY
minnesota

Age-Friendly Status Check

SOCIAL AND COMMUNITY CONNECTIONS

SEPTEMBER 2021

AGE-FRIENDLY MINNESOTA

Social and Community Connections

We will be connected to the people and things that matter to us and have lifelong opportunities to participate in and contribute to our communities.

Background

This document is one of eight briefs that explore current approaches and impact of the Minnesota Board on Aging, Minnesota's aging network[1] and Department of Human Services. A better understanding of the foundation provided by our existing work will guide us as we develop strategies for Age-Friendly Minnesota. We aim to stretch our thinking about what aging can and should mean for all Minnesotans—creating policies, communities, and services that see age in everything and empower us with what we need to live with dignity and autonomy at every stage.

The briefs are not exhaustive but aim to capture major ideas, prompt needed questions and discussions, and help us identify priority opportunities for greater impact and better outcomes. All briefs are available at the Age-Friendly Minnesota website.

Overview

Human beings are wired to connect with other people. That doesn't change with age. For various reasons, older adults commonly find themselves with too few connections with other people. It may stem from retirement, loss of the ability to drive or get around, family members moving away, death of a partner or spouse, having fewer occasions to meet new people, managing a chronic health condition, or other reasons.

Our relationships and interactions with others greatly impact our overall wellbeing. Social isolation and loneliness have very real consequences. They take a measurable toll on physical and mental health, make us more vulnerable to abuse and maltreatment, and put us at risk of getting too little or suboptimal care.

The need for active strategies that bolster our social and community connections are becoming increasingly important as a growing number of older people are living and aging alone. About 30% of Minnesotans ages 65 and older live alone, and more than one-quarter of boomers are divorced or never married.

As the Citizens' League points out in its report *A Backup Plan for Solos,* it is not that "solo" agers lack family or friends, but that they may not have the types of support they need when facing issues related to health, functioning, and end-of-life decisions. Public policy makers, medical professionals, and others who work with older adults do not recognize or understand "solo-ness," but it is an issue that requires specific and active attention.[2]

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[1] The Older Americans Act of 1965 established a national network of federal, state, and local agencies to plan and provide services that help older adults, including American Indian and Alaska Native elders, to live independently in their homes and communities. This interconnected structure of agencies is known as the aging network.

[2] Citizens League, *A Backup Plan for Solos: Health Care Decision Making for People Aging Alone*, 2019.

Older adults play critical roles as volunteers and in the workforce, making social and economic contributions on which we all depend. One-quarter of Minnesotans ages 65-74 are currently working,[3] and 45% volunteer, compared to 30% in the U.S.[4] Work and volunteering benefit our communities, and they also provide important interpersonal connections for people engaged in those activities. And, of course, connecting with family, friends, and neighbors for its own sake is important at every stage of life.

The AmeriCorps Seniors volunteer program (formerly SeniorCorps) connects thousands of Minnesotans ages 55 and up with volunteer opportunities each year.[5] Area Agencies on Aging (AAAs), Live Well at Home® grants, and Minnesota Board on Aging (MBA) Dementia grants all also help older adults stay or become socially connected in ways that are meaningful to them, while at the same time filling important community needs.

The State of Minnesota recognizes the reality and risks of social disconnection, isolation, and of aging without a reliable network of family or comparable support. This issue is being addressed in a variety of ways and will be incorporated into the work of Age-Friendly Minnesota.

For the purposes of this document, Social and Community Connections include issues related to social connectedness, volunteering, and employment.

Impact and Examples of Current Work

The following section describes themes that have emerged related to our impact on Social and Community Connections, followed by examples of strategies and grants that help demonstrate how it is being carried out. These examples are drawn primarily from work planned for and undertaken during 2019-2021.

We connect people to each other and reduce social isolation.
Many Live Well at Home® grants support providers who offer an array of services that, collectively, address an older person's overall well-being and ability to live at home. This can include social connections in a variety of forms. Culturally-specific organizations provide opportunities for older adults with similar customs, language, background, and experiences to gather and socialize. Some providers work specifically with caregivers to reduce the social isolation that can come with that role. Others test new approaches to the very important work of ensuring that people are connected to other people.

Two recent Live Well at Home® grants supported the following efforts:

- Little Brothers-Friends of the Elderly in Minneapolis piloted an innovative "warm line" program targeted at isolated older adults throughout the state. Specially-trained volunteers staffed this inbound phone line.

[3] U.S. Census Bureau, Decennial Census and American Community Survey (2019), via Minnesota Compass
[4] 2021 Senior Report, America's Health Rankings,
[5] AmeriCorps Senior includes three main programs: Foster Grandparent, where volunteers work with kids across the state; Senior Companion, where volunteers help older adults who need help with daily tasks; and RSVP, where volunteers can provide a wide range of support.

- Ecumen is testing a new approach to the mitigation of social isolation and depression among older adults through a partnership with Intuition Robotics, the inventors of ElliQ, a robotic companion with artificial intelligence.

MBA's Dementia grants also include social support for people with dementia and caregivers. A recent grant funded First Community Health Organization/The Victory Fund in Duluth to increase awareness of dementia and connection through expansion of the Victory Chorus's educational outreach, providing social connection, musical outreach, and support networks among choir participants.

During COVID-19, AAAs worked with providers to find other ways to facilitate social connections—such as phone-based visiting with isolated people; helping community and residential facilities maintain social connections for their residents, who were unable to receive visitors during the pandemic; and establish virtual opportunities to socialize.

The extreme social isolation experienced by residents of long-term care facilities during COVID-19, due to visiting restrictions and quarantine requirements, was emotionally devastating and also posed significant health and safety risks for those individuals. Office of Ombudsmen for Long-Term Care (OOLTC) experienced an unprecedented number of calls and issues related to the serious social and emotional consequences of imposed, pandemic-driven isolation.

We improve capacity and expand reach of volunteer programs.
All AAAs are working in different ways to strengthen the capacity and reach of AmeriCorps Seniors, which seeks to increase the number of new volunteers and boost the impact and value of volunteer service. As COVID-19 curtailed opportunities for in-person volunteering, however, AAAs generally shifted focus to finding other ways to provide social connections.

Many Live Well at Home® grants[6] also include support for strengthening the role of volunteers in providing services to older adults who need assistance. This includes support for numerous Block Nurse Programs in Minneapolis and Saint Paul neighborhoods as well as in rural communities, which count on volunteers to provide crucial services like transportation and chore service. Recent Live Well at Home® grants have supported the following efforts:

- The Argyle Living at Home Block Nurse Program will maintain and expand volunteer services for older adults and its own role as the primary in-home services resource in northwestern Minnesota.

- START Senior Solutions in Eden Prairie will support an innovative Dementia Visitor program that empowers faith community volunteers to provide companionship and welfare check-ins for isolated older adults in Hennepin County and expanding into Carver and McLeod counties.

We advocate for older workers and support local economies.
Employment, whether full- or part-time, is a critical source of income, purpose, and social connections for adults of all ages, including many older people. AAAs are helping employers better understand the value

[6] All Live Well at Home® grants referenced in this brief were awarded in State Fiscal Years 2019, 2020, or 2021.

of older workers and their potential for filling workforce gaps. AAAs also are educating employers about age-friendly policies, including how to support the growing number of working caregivers.

AAA staff meet with employers directly and participate in workforce development initiatives in their regions. Some AAAs are meeting with Chambers of Commerce to cultivate interest in collaboration related to older workers. Several are developing educational materials and presentations for employers related to retaining employees who are engaged in family caregiving.

In one region, the AAA human resource director met with numerous human resource officers and business leaders to better understand what businesses are doing to support, retain, and recruit older workers. Another developed an employer survey regarding working caregivers; the survey was administered internally and may be rolled out to external organizations post-COVID.

We pursue promising models.
Grants, technical assistance, and other resources provided by the aging network and DHS help make it possible to explore new ways to help people function well at home and remain engaged in their communities. One such model is Villages. Through this approach, which often is initiated at the neighborhood level, Village members pay dues (which may be subsidized) to gain access to a network of trained volunteers, paid staff, and vetted local businesses for needed services. Villages often organize social events, as well, and members also volunteer to help each other.

One AAA is working with existing and potential Villages in hopes of expanding the model to additional communities. Two AAAs are teaming up to use the work of a Village in Minneapolis to guide development of a potential Village in rural Minnesota. Another AAA is exploring the possibility of assisting a local agency in developing a Village, which, among other benefits, has potential to address rural transportation challenges.

We build intergenerational connections.
Live Well at Home® grants provide opportunities to connect people across generations—something that doesn't often happen in modern day-to-day life but benefits people of all ages. Recent grants of this nature include:

- Something Cool in Aitkin and Carlton counties is helping teenage youth gain work skills by providing chore services for veterans, American Indian elders, and adults with disabilities.

- Centro Tyrone Guzman in Minneapolis is promoting intergenerational relationship-building by coordinating activities with children from the Siembra Montessori early learning program.

We advocate for policies and funding that support social connections and older workers.
AAAs, often as leaders or members of coalitions or other collaborative efforts, advocate for legislative changes on priority issues.

One AAA created the Volunteer Driver Coalition to protect the viability of volunteer driver programs in Minnesota, which are vital to older adult transportation. The AAA serves as the backbone organization for

the Coalition, which has 81 members, including other AAAs. The Coalition advocated with the Legislature to support policies that protect volunteer driver programs.

Another AAA advocated to policymakers to begin exploring and researching incentives regarding hiring and/or retaining older workers, and for increased funding to expand AmeriCorps Senior. Yet another is an active part of establishing the Minnesota Area Agencies on Aging (M4A) legislative priorities for the next two years, as it will be critical to expand the capacity of the Elderly Waiver program to ensure that older adults have the financial resources necessary to stay at home.

Gaps and Opportunities to Consider

While much good work is being done related to social inclusion and connection, major needs and opportunities exist given the fundamental importance of social connection to other areas of our lives.

Gaps and opportunities include those discussed below; this list is not comprehensive, but an important starting point.

American Rescue Plan Act: Federal funding creates new opportunities

As part of the American Rescue Plan Act of 2021, a coronavirus relief bill, MBA received funds via the Administration for Community Living that can be used to invest in Title III[7] program areas, including social supports. MBA will be working with AAAs to determine how these one-time funds can be most impactfully invested; the work must be implemented over the funding period, which runs through September 2024.

Quantify the impact

Consider undertaking a return on investment study to help build the case for increased investment in this area. On the federal level, we already know that a lack of social contacts among Medicare recipients is associated with about $6.7 billion in additional funding each year.[8]

"Solo" aging

- The Citizens League's 2019 report *A Backup Plan for Solos* was developed to recognize health care decision making by and for "solos"—those aging alone—as an important public policy issue that is currently not recognized or understood by policymakers and other key professionals, such as those in the medical, legal, and aging services fields. The report includes a set of recommendations that should be considered as part of the development of Age-Friendly Minnesota's priorities, goals, and strategies. While many recommendations apply to the work of DHS and the MBA, two note the State of Minnesota specifically:
    - Key agencies, including the Departments of Human Services; Health; Workforce Development; and Employment and Economic Development, should collaborate to

[7] Title III of the Older Americans Act—Grants for States and Community Programs on Aging—funds supportive services (of numerous types), nutrition programs, health promotion and disease prevention services, and caregiver support.

[8] AARP Public Policy Institute, Stanford University, Harvard University. "Medicare Spends More on Socially Isolated Older Adults," 2017.

address the emerging and critical need for credentialed professionals to serve in Personal Health Decision[9] support and health care agent roles.
    - State agencies serving older adults should identify and implement policies, standards, and procedures to better address solos and solo-ness.

- *A Backup Plan for Solos* also recommends that organizations who identify, train, and provide volunteers to support older adults should expand their scope of services to include health decision assistants.[10] Given its reach, scope, and well-established structure, AmeriCorps Senior should consider whether health decision assistance is something that could be incorporated into its programs.

Ensuring choice and connection for long-term care residents

- For many residents of long-term care facilities, the responses to COVID-19—which focused narrowly on prevention of infectious disease and involved severe visitor restrictions and quarantine requirements—resulted in extreme isolation, emotional distress, and overall decline. This was especially difficult for people with dementia.

  Looking ahead to future pandemics or crises, OOLTC is working on policies that balance disease prevention with 1) the rights of people (including those who live in state-regulated assisted living facilities) to remain connected even during emergencies, and 2) older adults' overall well-being, autonomy, and the health impacts of social isolation. This may involve exploring legal rights and protections of older adults, including the right to essential caregivers who could always visit, even during a pandemic. Such measures could be implemented at the state level for assisted living and settings; it is also being considered at the federal level for federal settings.

Intersection with Adult Protective Services

- Socially isolated older adults are at greater risk of maltreatment, such as abuse, neglect, or financial exploitation. This reality intersects with the work of Adult Protective Services (APS), an essential human service program that is administered by counties and tribes responsible for service response in appropriate cases for vulnerable adults who are reported to the Minnesota Adult Abuse Reporting Center (MAARC). In 2020, more than 24,500 reports of Minnesotans 65 or older being maltreated were made to MAARC, representing nearly half of the total reports made that year. Social supports can be used in both prevention and response to maltreatment of older adults.

Thank you to Minnesota's seven Area Agencies on Aging, Live Well at Home® grantees, and MBA Dementia grantees for the examples of work highlighted in this brief.

[9] A Personal Health Decision Assistant is at least one individual who has the appropriate skills and is available to whom a solo can turn for help in the face of a health care change or health event. The person may be a paid professional or a volunteer.
[10] *Ibid*

Why Solos Matter to Minnesota (and Elsewhere…)

A White Paper By Linda J. Camp*
January, 2023

In 2014, Minnesota Compass described Minnesota's aging population as "a jet airplane that has just lifted off." [1] Today, nearly a decade later, the wisdom of that statement is abundantly clear. According to the 2021 American Community Survey some 17% of Minnesota's people are age 65 or older, with another 13% ages 55 to 64 following quickly behind. [2] The Minnesota Demographics Center projects that by 2030, more than 1 in 5 Minnesotans will be an older adult, including all Baby Boomers. As policy makers and stakeholders plan for the continuing demographic shift, it is important to look beyond the overall numbers. This age cohort is not a homogenous group, and it is critically important to consider the large number of older adults who can be considered "solos."

Solos and Solo-ness

In 2017, the Bush Foundation awarded a Community Innovations grant to the Citizens League to investigate issues surrounding solos--people who, by choice or circumstance, are aging without the benefit of support historically provided by family. In the popular press, it is common to define solos in demographic terms—as individuals without children or partners because of downward trends in fertility and family size. The project task force, however, found there were other relevant factors with the potential to contribute to "solo-ness." People can be "functionally solo" if appropriate support is not available when it is needed—even those with children.[3] Figure 1 provides examples of relevant risk factors.

Figure 1. Risk Factors Contributing to Solo-ness

Demographic	Relational	Behavioral	Other
•No Children or Disabled Child •No Spouse or Partner •Friend/Spouse/Partner is Same age or Older •No Living Blood Relatives	•Live Alone •Children/Family Live at a Distance •Friends/Family Unreliable, Unable, Unwilling •Dysfunctional Family •Estranged From Family	•Extreme Independence or Reclusiveness •Lack of Social and or Self Management Skills •Personality Diisorder •Choose Not to Involve Family or Friends •Substance abuse •Past Trauma	•Where Solo Lives •Lack Relevant and Culturally Appropriate Support Resources and Services •Homelessness •Vsion, hearing and mobility issues

[1] Citizens League. (2019) *A Backup Plan for Solos: Health Care Decision Making for People Aging Alone.* Phase 1 Final Report. Sant Paul, Minnesota.
[2] US Census 2021 American Community Survey; One-year Estimates by Age and Sex in Minnesota.
[3] Citizens League repor. Page 16.

Because of the scope and complexity of these risk factors, it is difficult to determine the total number of solos in Minnesota—and elsewhere—at any given time. However, recent research offers clues about the potential size of the solo population.

- Carney *et al* were among the first to attempt to quantify the number of solo older adults. In 2016, using data from the University of Michigan Health and Retirement study, she estimated that **22.6%** of older adults were at risk for becoming solos. (Estimate based on marital status, number, proximity of children and siblings and degree of contact.) [4]

- A 2016 Associated Press-NORC study found that **30%** of those surveyed ***would choose*** non-family to provide care as they age. [5]

- A 2020 Cornell University study of family estrangement found that **27%** of those surveyed were estranged from at least one family member. [6]

- The 2019 US Census indicated that some **38.2%** of those 55 and over were widowed, divorced, separated or never married. [7]

- Other research has found that **6.6%** of those age 50 and over are kinless (without any blood relatives)[8] and that **62%** of Boomers worry they will be a "burden" to their family.[9]

Minnesota Solos

While there is no estimate of solo older adults in Minnesota, the US Census does, however,

[4] Maria T. Carney et al. Elder Orphans Hiding in Plain Sight: A Growing Vulnerable Population. *Current Gerontology and Geriatrics Research*. Volume 2016 (2016).
[5] The Associated Press-NORC Center For Public Affairs Research. University of Chicago. *Long Term Care in America: Expectations and Preferences for Care and Caregiving*. (2016 poll).
[6] Pillemer, Karl. *Fault Lines: Fractured Families and How to Mend Them*. (Avery 2020).
[7] U.S. Census Bureau. Households By Type and Age of Householder: 2019. Retrieved from https://www.census.gov/data/tables/2019/demo/families/cps-2019.html
[8] Rachel Margolis and Ashton M. Verdery. *Older Adults Without Close Kin in the United States*. Brief Report. The Gerontological Society of America. Oxford University Press. 2017)
[9] AARP Research. *Long Term Care Readiness*. June 2022. Doi: https://doi.org/1026419/res/00555.001.

offer one reliable and meaningful yardstick with which to gage solo-ness throughout the state. That is the number of older adults living alone. Table 1 offers a summary of findings from the 2021 American Community Survey for Minnesota counties. Table 2 is based on 2023 population estimates from the Minnesota Demographic Center and the 2021 ACS data on those 65+ living alone. Results are grouped in three categories:

- Metro area counties
- Greater Minnesota counties with populations of more than 25,000 people
- Greater Minnesota counties with populations of 25,000 or fewer people

The detailed analysis is contained in Appendix A.

Table 1. Older Adults (Age 65+) Living Alone In Minnesota

Geographic Area	ACS 2021 Population (Number)	1-Person Household 65 & Older (Number)	65+ Living Alone as % of the Area Population
Metro Area	3,585,144	144,821	4
Greater MN – Most Populated Counties	1,566,869	76,698	4.9
Greater MN – Least Populated Counties	590,023	34,499	5.4

Table 2. Estimated Portion of Those Age 65+ Living Alone in Minnesota, 2023

Geographic Area	Estimated 2023 Population	Estimated 2023 65+ Population	Age 65+ As Percent of 2023 Population	Estimated Percent of 65+ Living Alone
Metro Area	3,663,685	593,526	16	24
Greater MN – Most Populated Counties	1,567,759	308,857	19	25
Greater MN – Least Populated Counties	578,672	135,669	23	26

Though the percentages in Table 1 are small, they are noteworthy because they show that the proportion of older adults living alone increases as the population in the associated counties decreases. This is also reflected in Table 2. The Table 2 percentages also help to underscore the magnitude of solo older adults in Minnesota as the percentage is calculated on just one risk factor.

Care and Support

A long standing goal for the state is to assure that Minnesotans can continue to live well and thrive as they age. Thus, at the top of the agenda is providing effective care and support for older adults. Historically most such support has been unpaid and has come from family members. A 2019 report from the AARP Public Policy Institute calculated the value of unpaid care in 2017. In Minnesota an estimated 540,000 care hours were provided at a value of $8,600,000.[10]

While these data help to highlight the important role family members play, the report does not answer the question of who is providing support to older adults who cannot or choose not to rely on family. Additionally, the report does not fully examine the future consequences of many more solos, as the number of available unpaid family hours will likely decline. There are unspoken public policy and service delivery implications surrounding the AARP data. Consider a scenario that assumes there is a one-to-one relationship between support hours and dollar value. Using the AARP numbers for Minnesota, a **10% decrease** in available unpaid support hours would translate to an annual support gap valued at **$860,000.** (This is in addition to current support gap estimates for long term care.) What if the decrease is 30% to match the estimated number of solos? How will Minnesota make up the gap?

Personal Support

It is easy to assume that solos can reach out to friends and neighbors to step in when family members are not in the picture. But will such acquaintances have the right temperament, skills and be ready, willing, and available to respond with whatever is required? In a 2017 Joint Economic Committee hearing, Harvard Professor Robert Putnam testified that those in the Boomer cohort "are entering retirement with one third less social support than their parents had at the same stage of life."[11] Friends may be able to assist in small ways but are unlikely to become the same kind of safety net historically provided by an available and committed family.

Financial Dimensions

The situation is equally problematic when exploring whether solos will be able to purchase the services they need. On the one hand there are questions about affordability. Minnesota's "Own Your Future" project suggests the following Long Term Care costs in the state:

- $60,000 for an average of 44 hours a week of care in an individual's home;
- $48,000 in annual costs in an assisted living facility (not counting services and additional fees);

[10] S.C. Reinhard, L.F. Feinburg, A. Houser, R. Choula, & M. Evans *Valuing the Invaluable 2019 Update: Charting a Path Forward.* AARP Public Policy Institute. (November 2019).

[11] United States Congress. Joint Economic Committee. Social Capital Project. SCP Brief: *A Future Without Kin?* Washington, D.C. (2018).

- $90,000+ for care in a nursing home.

The Genworth 2022 Annual Cost of Care Survey offers another perspective, finding that Minnesota's median annual costs were approximately:

- $80,000 for in-home care;
- $54,000 for assisted living (private, one-bedroom)
- $139,000 for nursing home (semi-private room)[12]

Compare these costs with the 2021 American Community Survey of income data in Minnesota.[13]

Annual Income	Share of Those Age 65+
Under $25,000	21%
$25,000 to $74,999	45%
$75,000 and Over	33%

Most of those age 65 and older fall into the middle, low, and poverty income levels. These figures help illustrate the disconnect between costs and available financial resources of older adults. Those with family support often find this situation challenging, but it is even more so for solos.

Services

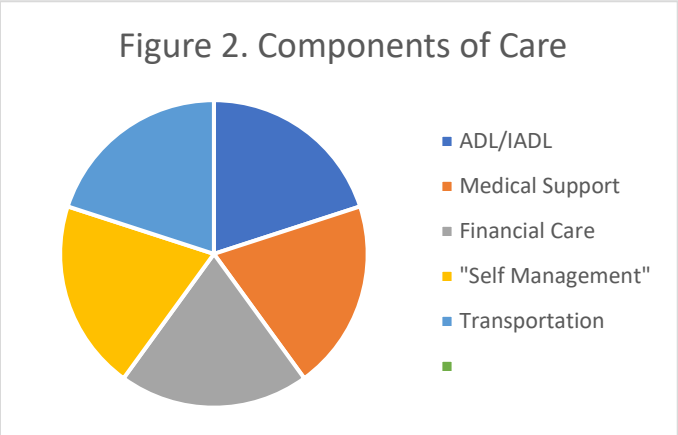
A second dilemma is the availability of services, whether offered by the private sector or non-profit organizations. Almost every day there are stories in the media about health and personal care workforce shortages along with the closing of health facilities in rural areas. The impact of these shortages can be felt across all demographic groups. The resource void is even greater when other kinds of support are factored in. Time use studies from the Bureau of Labor Statistics and AARP of those who provide unpaid care tell us that caregivers routinely handle tasks beyond activities of daily living and medical management. Many log hours on planning and coordinating support, advocating on behalf of the care recipient, paying bills, and providing transportation, to name just a few. Furthermore, these kinds of "management" activities take place all across the second half of life, not just in late life. Solos, however, cannot rely on family to address such needs. If friends and neighbors aren't available to fill in, paid options are scarce, costly, and often difficult to locate, especially in greater Minnesota.

[12] *Genworth Cost of Care Survey* (Median Data Tables). Genworth Financial Inc. (January 31 2022).
[13] 2021 American Community Survey Household Income for Minnesota Householders Age 65 and Over

What Constitutes Care?

A final troublesome dimension of care and support is the narrow focus of both scope and time. There is no question that health and care needs tend to increase for most people as they age. Thus, it makes sense that services and associated funding sources revolve around "long term care." There is, however a good reason to reframe our thinking here, to come up with a more comprehensive definition of what constitutes care and the time period when it is required.

Figure 2 reflects what shows up in the time use studies. As Minnesota plans for the future, it will be important to focus on all of the segments of the pie, not just the two most associated with late life.



Again, it is important to recognize that care and support are essential all across the second half of life, not just in late life. Even "small" and/or intermittent events, such as cataract surgery and colonoscopies matter and failure to act can be consequential. In concert with an expanded definition and timeline, financial tools, such as long term care insurance, should be applicable to all of components reflected in Figure 2. Currently that is not the case. Using the inability to perform Activities of Daily Living as a primary trigger to access funding leaves out individuals who may have capability but still lack the resources to pay for necessary things such as non-emergency medical transportation.

Moving Forward

So what is the path forward to assure that both people with and people without family support are recognized in the landscape of older adults? Here are a few ideas about how to paint a more complete picture and to begin generating solutions.

1. Recognize that solos are not a special interest group and solo-ness is not about bad choices but, rather, another dimension of diversity. In addition to focusing on older adults of different cultures, incomes, and educational levels, etc., it is important to recognize that solo-ness may be a part of all of these. Reflect such recognition in informational materials, web sites, and planning documents by specifically referencing solos as part of the older adult audience ("we serve those with and without family support").

2. Among the top issues for solos is a lack of affordable, relevant, and accessible resources that fill in the gaps where friends and family are missing, not able, or not available.

Common examples identified by solos include:

- People who can transport solos to medical appointments/procedures and stay with them afterwards;
- Personal representatives to administer their estates after they pass or serve as representative payees, or serve as health care agents;
- Individuals or organizations to serve as emergency contacts;
- Individuals who can advocate on behalf of solos with service providers and help resolve problems.

Here is a place where the State of Minnesota may be able to use its grant making authority to stimulate solutions. Requests for proposals could identify these and other needs and, ideally, give some priority to responses that address these gaps in the award process.

In addition, when the Older Americans Act (OAA) comes up for renewal in 2024, the state of Minnesota will likely have the opportunity to recommend changes. Such changes could include adding solo older adults as an important target for OAA funding, along with suggestions about specific resource and service gaps.

3. Factor in the needs of solos when addressing workforce issues to include workers associated with an expanded definition of care as reflected in Figure 2. Look beyond the positions associated with long term care, such as medical professionals and personal care assistants. Highlight workers who have the skills and ability to provide the kinds of decisional, advocacy, and "self management" support to assure overall well being.

   One good example of professional with the desired skill set is the growing number of people who serve as independent health advocates. Many participate in the Alliance of Professional Health Advocates (APHA),[14] a national professional association that helps link members to relevant training and ongoing peer support. A separate certification board helps to oversee and maintain professional standards for those in this occupation[15]. Given that the training and credentialling infrastructure already exists, this may be an avenue worth further exploration as part of Minnesota workforce initiatives.

4. One very important resource for older adults in Minnesota is the Senior Linkage Line. The service could be even better if those who staff the line had the opportunity to learn

[14] Alliance of Professional Health Advocates (APHA). https://a[jaadvpcates.org
[15] Patient Advocate Certification Board. www.pacboard.org

about Minnesota's solos and be able to direct them to specific resources that meet their needs.

5. The number of solo older adults is likely to continue growing in the future so it will be important to develop strategies for monitoring the size and composition of this group. One way to accumulate information is to look toward the places where data about older adults is already collected as part of existing services. For example, the Long Term Care Ombudsman's office might be able to identify calls from solos or on behalf of solos along with the regular information. Similarly, Senior Linkage Line staff might be able to document calls from solos with a simple notation. And, when special surveys are conducted, it might be possible to add a question to the demographic section to provide another element of analysis to data.

Final Thoughts

We often talk about well being support in retirement as a three-legged stool, with Social Security, Medicare, and personal savings/investments being the three legs. In reality, there are four legs, with the family as the overlooked element. For thousands of older adults, however, that fourth leg is either missing or very weak. We need to broaden the older adult framework to include solos so there will be a level playing field for all people as they age. An expanded approach should not necessarily result in a competition for resources between those who lack family support and those who do not. When we fill in the resource gaps for solos, we will also be offering resources that can help reduce the stress on family caregivers.

Linda J. Camp is an independent researcher, writer, and consultant in St. Paul, MN, focusing on solo older adults from a systems perspective. From 2017 to 2019 she coordinated the Citizens League Task Force project. She is the creator of "The Backup Plan," a new planning model and tool designed for solos. She can be reached at: thebackupplan2@gmail.com

Appendix A – Minnesota Detail by County

Table 1. Older Adults (Age 65+) Living Alone, by County

METRO AREA	ACS 2021 Population	One-Person HH Age 65+	% of 2021 Population
Anoka	366,888	12,863	3.5
Carver	108,891	3,060	2.8
Chisago	57,291	2,199	3.8
Dakota	443,692	17,407	3.9
Hennepin	1,289,645	57,174	4.4
Isanti	41,878	1,797	4.3
Le Sueur	28,945	1,222	4.2
Mille Lacs	26,809	1,310	4.8
Ramsey	553,229	26,689	4.8
Scott	153,199	3,852	2.5
Sherburne	98,924	2,923	2.9
Washington	270,805	9,712	3.6
Wright	144,948	4,613	5.1
Totals	3,585,144	144,821	4

Greater MN – Most Populated	ACS 2021 Population	One-Person HH Age 65+	% of 2021 Population
Becker	35,307	1,875	5.3
Beltrami	46,358	1,997	4.3
Benton	41,204	1,396	3,4
Blue Earth	69,264	2,367	3.4
Carlton	36,529	1,599	4.4
Cass	30,784	1,743	5.7
Clay	65,512	3,015	4.6
Crow Wing	67,887	3,685	5.4
Douglas	39,578	2,124	5.3
Freeborn	30,647	1,955	6.3
Goodhue	47,819	2,768	5.7
Itasca	45,193	2,909	6.4
Kandiyohi	43,809	2,020	4.6
Lyon	25,184	1,247	5
McCleod	36,958	1,917	5.2
Morrison	34,041	1,815	5.3
Mower	40,356	1,871	4.6
Nicollet	34,706	1,639	4.7
Olmstead	164,196	6,079	3.7
Otter Tail	60,194	3,434	5.7
Pine	29,108	1,694	5.8
Polk	30,835	1,618	5.2
Rice	66,964	3,092	4.6

St Louis	198,559	12,046	6
Stearns	159,301	6,407	4
Steel	37,559	1,993	5.3
Winona	49,017	2,393	4.8
Totals	1,566,869	76,698	4.9
Greater MN – Least Populated	**ACS 2021 Population**	**One-Person HH Age 65+**	**% of 2021 Population**
Aitkin	16,002	1,283	8
Big Stone	5,233	418	8
Brown	25,790	1,526	6
Chippewa	12,498	731	6
Clearwater	8,616	476	5.5
Cook	5,629	370	6.6
Cottonwood	11,685	753	6.4
Dodge	20,959	676	3.2
Faribault	13,765	997	7.2
Fillmore	21.405	1,131	5.3
Grant	6,152	380	6.1
Houston	18,832	1,042	5.5
Hubbard	21,909	1,142	5.2
Jackson	9,998	636	6.4
Kanabec	16,295	864	5.3
Kittson	4,157	255	6.1
Koochiching	11,946	927	7.7
Lac Qui Parle	6,679	469	7
Lake	11,016	745	6.7
Lake of the Woods	3,828	233	6
Lincoln	5,568	405	7.2
Mahnomen	5,404	262	4.8
Marshall	9,012	552	6.1
Martin	19,896	1,384	6.9
Meeker	23,499	1.180	5
Murray	8,094	587	7.2
Nobles	22,145	1,020	4.6
Norman	6,386	403	6.3
Pennington	13,757	835	6
Pipestone	9,278	653	7
Pope	11,396	803	7
Red Lake	3,944	260	6.6
Redwood	15,313	892	5.8
Renville	14,608	887	6
Rock	9,662	602	6.2
Roseau	15,268	666	4.4
Sibley	14,986	791	5.3
Stevens	9,355	430	4.6
Swift	9,972	747	7.5

Todd	25,263	1,174	4.6
Traverse	3,305	266	8
Wabasha	21,645	1,090	5
Wadena	14,081	807	5.7
Waseca	18,985	980	5.1
Watonwan	11,165	705	6.3
Wilkin	6,337	502	8
Yellow Medicine	9,305	562	6
Totals	590,023	34,499	5.4

Table 2. Estimated Portion of Those Age 65+ Living Alone by County in 2023

METRO AREA	**Estimated 2023 Population**	**Estimated 2023 65+**	**% 65+ of 2023 Population**	**Estimated % of 65+ Living Alone**
Anoka	367,961	61,713	17	20
Carver	112,000	16,805	15	18
Chisago	56,525	10,211	18	21
Dakota	442,029	75,063	17	23
Hennepin	1,332,323	212,898	16	27
Isanti	46,678	7,656	16	23
Le Sueur	28,481	5,515	19	21
Mille Lacs	25,749	5,185	20	25
Ramsey	578,579	93,299	16	28
Scott	159,303	21,213	13	18
Sherburne	99,885	14,413	14	20
Washington	271,293	48,518	18	20
Wright	142,879	21,037	15	22
Totals	3,663,685	593,526	16	**24**

Greater MN – Most Populated	**Estimated 2023 Population**	**Estimated 2023 65+**	**% 65+ of 2023 Population**	**Estimated % of 65+ Living Alone**
Becker	35,364	8,030	23	23
Beltrami	47,980	8,662	18	23
Benton	41,592	6,418	15	22
Blue Earth	69,161	10,674	15	22
Carlton	35,787	6,789	19	23
Cass	29,926	8,515	32	20
Clay	67,379	9,389	14	32
Crow Wing	65,763	16,457	25	22
Douglas	38,939	9,813	25	21
Freeborn	29,770	7,070	24	27
Goodhue	46,401	10,268	22	27
Itasca	45,167	12,053	26	24
Kandiyohi	43,031	9,171	21	22
Lyon	25,757	4,726	18	26

McCleod	35,160	7,364	21	26
Morrison	32,802	7,498	23	24
Mower	40,146	7,702	19	24
Nicollet	35,034	6,497	18	25
Olmstead	163,634	29,198	18	21
Otter Tail	59,248	7,490	12	45
Pine	28,774	7,018	24	24
Polk	31,657	6,258	20	26
Rice	67,862	12,103	18	25
St Louis	199,162	44,156	22	27
Stearns	164,931	28,376	17	22
Steel	36,999	7,309	20	27
Winona	50,333	9,853	19	24
Totals	1,567,759	308,857	19	25

Greater MN – Least Populated	**Estimated 2023 Population**	**Estimated 2023 65+**	**% 65+ of 2023 Population**	**Estimated % of 65+ Living Alone**
Aitkin	15,481	5,557	36	23
Big Stone	4,765	1.345	28	31
Brown	24,618	5,648	23	27
Chippewa	11,576	2,654	23	27
Clearwater	8,936	1,926	21	24
Cook	5,506	1,785	32	20
Cottonwood	10,925	2,620	24	28
Dodge	21,198	3,590	17	19
Faribault	13,999	3,311	23	30
Fillmore	21,847	4,780	22	23
Grant	5,919	1,549	26	24
Houston	18,325	4,538	25	23
Hubbard	21,547	5,768	26	19
Jackson	9,676	2,476	25	25
Kanabec	15,911	3,775	23	23
Kittson	4,035	1,055	26	24
Koochiching	11,818	3,645	31	25
Lac Qui Parle	6,218	1,911	31	24
Lake	10,307	3,050	29	24
Lake of the Woods	3,527	980	27	23
Lincoln	5,527	1,413	25	28
Mahnomen	5,574	1,000	18	26
Marshall	9,295	2,207	23	25
Martin	19,027	4,981	26	27
Meeker	22,048	5,198	23	22
Murray	7,971	2,195	27	26
Nobles	22,109	3,889	17	26
Norman	6,277	1,354	21	29

Pennington	14,323	2,983	21	28
Pipestone	8,691	1,937	22	33
Pope	11,079	2,997	27	26
Red Lake	3,928	501	13	52
Redwood	14,485	3,223	22	27
Renville	13,743	3,121	20	28
Rock	9,202	1,935	21	31
Roseau	19,150	3,137	16	21
Sibley	14,636	3,004	21	26
Stevens	9,799	1,789	18	24
Swift	9,035	2,135	23	35
Todd	24,088	5,872	24	20
Traverse	3,130	839	27	31
Wabasha	21,437	5,403	25	20
Wadena	13,606	2,956	21	27
Waseca	18,313	3,841	21	25
Watonwan	10,739	2,342	22	30
Wilkin	6,001	1,345	22	37
Yellow Medicine	9,325	2,109	22	26
Totals	578,672	135,699	23	26

Needs Assessment Activities and What Was Learned

Minnesota's State Plan goals grew out of needs and opportunities identified in several ways. We both gathered our own data and consulted findings from our core partners' work. This section provides an overview of those efforts and highlights some key findings.

Statewide Needs Assessment on Aging

DHS, MBA, AFMN Council

Beginning in 2021 Minnesota conducted a multi-stage needs assessment focused on the state's older residents. The assessment was to inform plans and priorities of DHS, MBA, and the Age-Friendly Minnesota Council. It also represented a key step in the AARP Network of Age-Friendly States and Communities, which Minnesota joined in January 2022. Network members commit to following a five-year process that begins with identifying community needs.

Status Check Briefs

MN DHS engaged a consultant to develop a set of "status check" briefs exploring the approaches and impact of the aging network over the previous one to two years. The briefs served as a basis for a series of structured discussions with AAAs and MBA staff over the course of several months to elicit priority needs and opportunities related to the development of this State Plan.

Priority concerns that emerged from this process included:

- Need for more equitable and culturally-responsive services
- Quality, caring workforce to serve older residents and support caregivers
- More transportation options and affordable, equitable, appropriate housing
- Recognition and treatment of social connection as essential
- Increased access to broadband and technology

Targeted Phone Interviews

MN DHS contracted with Rainbow Research to develop an interview guide and conduct phone interviews with older adults from historically underserved groups, such as BIPOC (Black, Indigenous, and People of Color), LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Queer), low-income, rural, veterans, or who have a disability, among others.

Interviews were conducted with 95 individuals ages 60 and over; 62 of whom were Black, Native American, Asian American and Latiné/Hispanic; 34 of whom identified as having a disability; and 10 identified as veterans.

Priority concerns that emerged from these interviews included:

- Social isolation
- Awareness and use of services was low (e.g., 46% were not aware of Senior LinkAge Line)
- Affordable housing, employment opportunities, and mental health services were the least available things overall, and they were least available to BIPOC communities.
- White respondents reported the highest community satisfaction and degree to which essential needs are being met.

While the sample size was relatively small, important knowledge was gained related to key gaps and needs, particularly among older adults from communities of color and other underserved groups.

Statewide Survey and Focus Groups
DHS built on Rainbow Research's work and developed a longer survey organized into ten sections. For several months in 2021, this survey was promoted broadly throughout the state, primarily online. Rainbow Research and two cultural navigators were contracted to boost participation among groups whose voices are often missed during such engagement.

The survey received 913 responses, of which 741 were 55 years old or older. Seventy-seven percent were women, and 6% identified as part of the LGBTQ+ community. Three percent were Black, 4% were African (such as Somali or Ethiopian), 2% were Asian American, 1% were Latine/Hispanic, 1% were Native American, and 82% were White.

In addition, DHS contracted with the National Resource Center on Native American Aging (NRCNAA) to engage American Indian Tribal and urban Elders in the survey to ensure their voices were heard and included. During spring 2022, this effort resulted in 301 survey responses from adults ages 55 and above. Seventy-seven percent were women, and 10% identified as members of the LGBTQ community.

With strong support from the state's six regional Area Agencies on Aging and other partners, the State also conducted forty-eight focus groups throughout the state using questions organized by the same domains used in the survey.

Key survey findings are discussed below and tie to the goals, objectives and strategies at the center of this State Plan. However, in-depth analysis of this data is forthcoming over the course of the plan and also will be tied to work happening as part of the Multi-Sector Blueprint for an Age-Friendly Minnesota.

Key Survey Findings

Initial analysis of survey data reveals numerous commonalities as well as some striking differences between statewide and Tribal respondents.

- Statewide survey respondents generally reported more concern about **social isolation**, whereas Tribal survey respondents generally reported more concern about **transportation**.
- The greatest difference in the responses between the two sets of respondents was as follows that 38% of statewide survey respondents said they have enough family, friends or neighbors nearby to help care for them if their needs change, compared to 72% of Tribal survey respondents.

The following table presents additional highlight from the two surveys. Respondents for both datasets were 55 years old or older.

Key Survey Findings by Domain	Statewide Survey	American Indian & Urban Tribal Elder Survey
DEMOGRAPHICS		
• Have children under 18 living in their household	9%	37%
• Regularly help an aging family member or friend take care of themselves	35%	48%

BUILT ENVIRONMENT: HOUSING AND OUTDOOR SPACES AND BUILDINGS		
• Need modifications or significant repairs to their current residence to remain safely living at home	49%	53%
• Say their community does not have appropriate, affordable housing options should they need to move out of their current residence	32%	23%
• Say they have enough family, friends or neighbors nearby to help care for them if their needs change	38%	72%
TRANSPORTATION		
• Say lack of transportation "negatively impacts my life"	20%	36%
COMMUNITY SUPPORT & HEALTH SERVICES		
• Reported fair or poor availability of mental health services	32%	30%
• Reported poor availability of affordable home care services	19%	14%
• Don't know who or where to call for assistance with finding or accessing services	20%	20%
COMMUNICATION AND INFORMATION		
The sources most respondents would turn to for information:		
• Family and friends	87%	90%
• The internet	82%	80%
• Doctor/health care professional	80%	81%
• Senior LinkAge Line	67%	61%
• Say it is extremely important or very important to have broadband service at home	93%	79%
SOCIAL PARTICIPATION AND INCLUSION		
Respondents said they often or sometimes:		
• Lack companionship	44%	36%
• Feel left out	38%	26%
• Feel isolated in their community	35%	29%
SAFETY, BASIC NEEDS, AND AFFORDING AGING		
Respondents often or sometimes go without:		
• Food	3%	15%
• Mental health care	15%	19%
• Legal assistance	18%	27%
• Of those who go without needed services, financial challenges are the most common barrier.	21%	30%

WORK & CIVIC ENGAGEMENT:		
• Are or have been employed while also doing significant caregiving for an aging family member or friend	58%	31%
• Say their community has very good or good availability of volunteering opportunities	74%	45%
EMERGENCY PREPAREDNESS		
• Do not have friends or family who could help them at any time of the day or night	17%	9%
• Rely on friends and/or family to help with daily tasks	18%	48%
• Are very concerned about a public health emergency affecting their home or community	22%	31%

Regional Comparison
Some notable differences—discussed below--stood out across the state's six Area Agency on Aging geographic regions: Central (Central MN Council on Aging), Metro (Trellis), Northeast (Arrowhead AAA), Northwest (Dancing Sky AAA), Southeast (Southeast AAA), and Southwest (Minnesota River AAA).

- **Built Environment: Housing and Outdoor Spaces & Buildings**
  - The fewest Metro respondents (79%) say their housing is "affordable or appropriate for my needs," compared to in 95% in the Southwest and 86% overall.
  - 33% of Central respondents said they have enough family and friends nearby to help care for them should their needs change, compared to 42% in the Southwest and 38% overall.
  - The highest proportion of Northeast (58%) and Southwest (60%) respondents say their homes need major repairs to enable them to stay there long as possible, compared to 41% in Southeast and 49% overall.
- **Transportation:**
  - Transportation is most problematic for Metro respondents and least so for respondents in the Southwest and Southeast regions. For example, 24% of Metro respondents say lack of transportation negatively impacts my life, compared to less than 10% among Southeast respondents.
- **Community Support & Health Services**
  - Access to low-cost yardwork or home repair services is highest in the Southeast (23% say good or very good), and least available in Central (4.2% say good or very good).
  - Northeast (18%) and Northwest (16%) regions reported poor access to healthcare within 15 minutes of home, compared to 9% overall.
- **Communication & Information:**

- 25% of Metro respondents do not know who or where to call to find or access services, compared to 12% in Southwest Minnesota, and 20% overall.
- More than 10% of Northwest respondents do not feel safe using the internet, compared to 6% overall.

- **Social Participation and Inclusion:**
  - Metro and Central regions had the highest percentages of respondents who answered that they often lack companionship, feel left out, and feel isolated in their communities. For example, 67% of Northwest respondents said they never lack companionship, compared to 51% in the metro region and 56% overall.
- **Work & Civic Engagement:**
  - Northwest has the highest percentage of respondents (71%) who are, or have been, employed while also doing significant caregiving for an aging family member or friend, compared to 58% overall.
  - 95% of Southeast respondents say their communities have good or very good volunteer opportunities, compared to 74% overall.
- **Safety, Basic Needs and Affording Aging:**
  - Metro respondents are most likely to go without needs such as health care, mental health care, transportation, and social connection. For example, 16% often or sometimes go without needed health care, compared to 4% in Southeast and 11% overall.
  - Barriers to meeting these needs vary across regions: in the Northeast, the most common challenge is lack of internet access; in Northwest, services or staff are not culturally appropriate; in Central, the most common challenge is financial; in Metro, it is language; and in Southwest and Southeast, it is lack of technological devices.
- **Emergency Preparedness:**
  - Northeast respondents report the lowest rates of having broadband service at home (74%), compared to 85% overall.
  - Metro respondents are least likely (78%) to have friends or family who can help them at any time of the day or night, compared to 91% in Southeast and 83% overall.

Minnesota Board on Aging Performance Measures Report

A Performance Measure Development Framework

January 31, 2023

PSC

PUBLIC SECTOR
CONSULTANTS

Prepared by

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Prepared for

Minnesota Board on Aging
Aging and Adult Services Division
Department of Human Services
https://mn.gov/board-on-aging/

Table of Contents

Executive Summary

Background

The Minnesota Board on Aging (MBA) engaged Public Sector Consultants (PSC) to review the current data reporting environment in the state's aging network, investigate the use of national performance measures, and use that knowledge to develop performance measures to include in the MBA's upcoming Federal Fiscal Year (FFY) 2024–2027 State Plan on Aging. The MBA plans to use this information to support its staff and members in gaining a comprehensive view of information that is currently gathered and identifying how it can be used to measure the performance of the state's Area Agencies on Aging (AAAs) and the services they provide.

PSC's process involved:

- Reviewing Minnesota's aging network
- Scanning measures used in other states and at the federal level
- Conducting focused conversations with groups of key partners in the effort
- Identifying and mapping existing data sources within the network.

These activities provided a strong foundation and detailed information that helped to generate a set of performance measures, descriptions, and calculations.

Performance Measures Development and Methodology

Based on the information gathered from the focused conversations and MBA interviews, PSC mapped existing data to provide a foundation for developing Minnesota-specific performance measures. PSC created an extensive list of potential data elements and their respective sources that could be used to support performance measures based on state plan goals. PSC utilized the SMARTIE Method, making sure goals were specific, measurable, attainable, realistic, timely, inclusive, and equitable, to incorporate equity and inclusion.

State Plan Goals

- **Goal one:** Advance equity and address disparities, through empowering cultural and ethnic communities, and respecting the sovereignty of Tribal Nations
- **Goal two:** Make aging in community truly possible for more Minnesotans

- **Goal three:** Support families, friends, and neighbors in sustaining their caregiving roles
- **Goal four:** Promote and support healthy aging for all Minnesotans
- **Goal five:** Dismantle ageism and promote older adult rights, autonomy, and protection

Performance Measures

Ten performance measures align to four of the State Plan's five stated goals. No measures are recommended for goal five due to a lack of currently existing data.

Exhibit 1. MBA Performance Measures

State Plan Goal	Measure Name	Unit of Measure
Goal one	1A. Individuals served in targeted populations	Percentage
Goal one	1B. AAA Advisory Committee representation	Count
Goal two	2A. Return to Community referrals that accept services	Percentage
Goal two	2B. Return to Community from a nursing facility	Count
Goal two	2C. Return to Community to remain in their community	Count
Goal three	3A. Caregivers served by Title III-E services	Count
Goal three	3B. Satisfaction of caregivers with caregiving services	Percentage
Goal three	3C. Outcomes of caregivers who complete caregiver survey	Percentage
Goal four	4A. Number of meals per person per month	Average
Goal four	4B. Persons served who are at high nutritional risk	Percentage

Performance Measure Specification Manual

PSC developed a measure specification manual during the performance measure development process. The measure specification manual provides the technical components of each measure for MBA staff to be able to generate the developed performance measures.

- Performance measure name
- Performance measure description
- Data source and elements
- Processes for measure construction
- Data quality considerations
- Targets and baseline
- Reporting frequency
- File date

Roadmap to Performance Measure Implementation

The recommendations provided are laid out as a roadmap to enable the MBA to continue working on the performance measures and take them from their current state to full implementation.

- **Step one:** Quality assurance and quality control
- **Step two:** Measure specification refinement
- **Step three:** Measure reporting
- **Step four:** Adoption and implementation
- **Step five:** Data warehousing

Introduction and Background

In January 2022, the Minnesota Board on Aging engaged Public Sector Consultants to review the current data reporting environment in the state's aging network, investigate the use of national performance measures, and use that knowledge to develop performance measures to include in the MBA's upcoming Federal Fiscal Year (FFY) 2024–2027 State Plan on Aging. The MBA plans to use this information to support its staff and members in gaining a comprehensive view of information that is currently gathered and identifying how it can be used to measure the performance of the state's Area Agencies on Aging and the services they provide.

Performance measures can support resource allocation and other policy decisions to improve service delivery, program effectiveness, accountability, and equity of public services based on quantifiable data and empirical evidence. Performance measures can also help identify processes that are or are not working.

PSC's process involved reviewing Minnesota's aging network, scanning measures used in other states and at the federal level, speaking with groups of key partners in the effort, and identifying and mapping existing data sources within the network. These activities provided a foundation for developing an initial set of performance measures, which were then vetted and revised as needed.

In addition, PSC worked to adopt a common definition for performance measures to ensure a mutual understanding among partners involved in the measure development process. The MBA used the following definition of performance measurement from the Administration for Community Living (ACL):

> Performance measurement is the systematic measuring of a program's activities, outputs, and outcomes and their relationship to the agency's or program's objectives. (ACL 2020)

MBA staff and the AAAs collaborated for the performance measure development process. PSC and MBA staff met regularly through biweekly project management meetings and monthly team meetings. During the monthly team meetings, MBA staff provided direction and feedback on the requirements and considerations for performance measures as they were created. Discussions regarding specific data elements and sources used in the development and application of performance measures gave MBA staff an opportunity to provide feedback on the proposed data

elements and sources, identify specific challenges or limitations with the data as it is currently collected, and offer alternative data elements if needed. These conversations also provided PSC with detailed information that helped to generate and clarify performance measure names, descriptions, and calculations so that every component of the performance measure appropriately matched the data being used.

Once the measures were developed, PSC prepared specifications for each performance measure, generated the performance measures using real data, and held a final presentation webinar. The specification document is a companion to this report that the MBA can to operationalize and expand on each performance measure. The webinar clarified measure specifications and allowed partners an opportunity to ask questions.

This report concludes with recommendations made by the AAAs and MBA staff, for future measure development and enhancements.

The Aging Network in Minnesota

A fundamental understanding of the regulatory and funding structures that govern service provision is key to developing effective performance measures. The framework for the oversight and provision of aging services nationwide begins with the Older Americans Act (OAA)—the sentinel legislation providing for the needs of older adults. The provisions of that legislation are handled by several federal and state agencies, including the U.S. Department of Health and Human Services and the ACL, state units on aging, Area Agencies on Aging, and local aging services providers. It is helpful to understand how these various elements interact to appreciate the value of well-crafted performance measurements.

The Older Americans Act

The OAA was signed into law in 1965 to provide comprehensive support services to older adults. It established authority for grants to states to deliver social and nutritional care to this population and their family caregivers through a national network of state agencies on aging, local AAAs, and tribal organizations. Subsequent reauthorizations of the act have promoted specific operational priorities aimed at improving the experience of participants and the effectiveness of service delivery (ACL 2021).

As a primary source of funding for these vital services, the act provides a central source of guidance and regulation. It sets many of the governing rules with which the delivery

of OAA Title III services must comply. OAA Title III services account for the largest portion of OAA funding, supporting a comprehensive national network of federal, state, and local agencies (ACL 2021).

Administration for Community Living

ACL was established in 2012 within the U.S. Department of Health and Human Services to promote the principle that older adults and people with disabilities should be able to live where they choose and be able to participate fully in their communities. By funding services and supports and providing resources and guidance to agencies that provide these services, ACL is a primary source of information in the field.

Minnesota Board on Aging

The MBA oversees over $25 million in funding allocated through the OAA, which is distributed among seven AAAs throughout the state to provide services to older Minnesotans. Every four years, the MBA submits a State Plan on Aging to ACL that outlines how it will spend the OAA and related funding it receives to support older adults and caregiving family and friends. The State Plan on Aging provides the priorities and parameters for the Area Plans on Aging that are submitted by the AAAs to the MBA each calendar year. The Area Plans are discussed in greater detail further in this report. The MBA, which serves as administrator, adviser, and advocate, then administers the state plan, setting out goals and objectives for the aging network statewide.

Minnesota Area Agencies on Aging

There are seven AAAs, six of which serve geographical regions of the state and one, the Minnesota Indian Area Agency on Aging, which serves four tribal reservations in the northern half of the state. The AAAs are sources of services and information to older adults, their families and communities, and caregivers. The seven AAAs are:

- Arrowhead Area Agency on Aging
- Central Minnesota Council on Aging
- Dancing Sky Area Agency on Aging
- Metropolitan Area Agency on Aging (dba Trellis)
- Minnesota Indian Area Agency on Aging
- Minnesota River Area Agency on Aging
- Southeastern Minnesota Area Agency on Aging

AAAs create and submit annual Area Plans on Aging to the MBA describing how they will use their funds to perform their roles in administration, access, development, and advocacy. Each agency submits utilization reports about their services throughout the year through multiple data reporting vehicles. MBA staff then analyze the information based on program and service requirements as part of their process to align the regional reports to the state report.

National Practices on Performance Measures

Lessons from Federal and National Partners

To understand how performance measures are developed and used, the project began by investigating materials already tested and available from many national and state partners. Notable among these sources is ACL's Performance Measure Guidance published by their Office of Performance Evaluation in September 2020. This guidance provides valuable information on the elements and benefits of good performance evaluation, instructions on how to develop and evaluate effective measures, and resources and templates to accomplish the task.

PSC also looked to many of the materials made available by ADvancing States. This national association supports system innovation and national policies that support long-term services and supports for older adults and people with disabilities. Many of their papers, publications, conference presentations and materials, and other resources have been pertinent to the work of this project. Additionally, their National Core Indicators—Aging and Disabilities initiative is a unique effort to develop standardized data to assess the outcomes of services in a host of states.

In July 2022, the Centers for Medicare and Medicaid Services released their first set of quality measures for home- and community-based services (HCBS). This standardized set of quality measures for Medicaid-funded HCBS is intended to promote common and consistent measures, create opportunities for comparing data across states, improve quality of care and outcomes for persons receiving services, and support state efforts to promote equity within HCBS programs. The HCBS Quality Measure Set was reviewed for its possible applicability to the measures needed in Minnesota.

Lessons from Other States

In addition to the national sources of information on quality and performance measurement, PSC interviewed staff from selected states, that were recommended based on their work at the state level. Given the limited time frame of this project, it was not feasible to attempt a comprehensive state-by-state review, so focus was given to Ohio and Michigan, two states with demonstrated success.

States vary widely in how aging services are organized, funded, and delivered. Approaches that are highly successful in another state do not necessarily translate well to Minnesotan circumstances and expectations. Therefore, the most important lessons gleaned in this research were from the conversations and materials obtained from Minnesota staff and organizations.

Ohio

In May 2022, representatives from the MBA and PSC met with staff from the Ohio Department of Aging to learn of their experience in developing and applying measures designed to evaluate their aging programs. The discussion provided insights into the process Ohio used to construct their Strategic Action Plan, which helped define the measurability of their State Plan. Topics included how to adequately define outputs and provide working definitions, special challenges the department faced in their process for developing performance measures, and their strategies to address equity considerations. Additionally, they mentioned an inclusive advisory committee was crucial to their work to garner necessary input and feedback on their measures.

Michigan

PSC reviewed the Michigan State Plan on Aging for Federal Fiscal Years 2021–2023, which is notable for the extensive efforts of the Aging and Adult Services Agency and Commission on Services to the Aging, to define and prioritize a succinct set of performance measures aimed at the agency's and commission's four articulated goals. PSC's review found that the plan demonstrates the value of stakeholder input into the development process and proves the value of simplicity. Crafting measures that are on target and straightforward can greatly increase the chances that they will be successfully implemented.

Focused Conversations

An initial step in the process to develop measures was a set of focused conversations held with key partners. These sessions included meetings with representatives from the AAAs and MBA staff. Prior to the focused conversations, PSC worked with the lead MBA project staff to identify factors that should be considered during the measure creation process. One theme that emerged from MBA staff was the desire for performance measures to help program staff determine how well services are being provided. They noted that performance is currently measured anecdotally and, at this time, it is not possible to gain a consistent understanding of service delivery models, outputs, and effective practices at the AAA level.

Generally, among focused conversation participants, there was strong consensus on the importance of developing performance measures with a specific goal. Staff did note that the development of robust performance measures over time would allow them to identify gaps in services and how well services are being delivered to older adults. Conversation participants noted that most of the data currently collected represents inputs and outputs (e.g., number of clients served, number of volunteers, etc.), rather than demonstrating outcomes or impacts. For example, some staff mentioned wanting measures that focused on the cost per unit of services, but others suggested that measures related to the cost of services may have unintended consequences on service delivery and quality. On the whole, participants shared the desire to generate performance measures that would inform them of the impact of their work.

Data Mapping

MBA Staff Interviews

PSC met with MBA staff responsible for the data sources PSC reviewed. During these conversations, MBA staff provided PSC with demonstrations of existing data collection platforms and repositories, including PeerPlace, Grant Utility, Senior LinkAge Line's (SLL) client tracking system, and ACL's State Program Report.

The demonstrations allowed PSC to better understand the data MBA currently uses, from data collection through reporting, and created a visual, interactive learning opportunity that provided a complete overview of each data source. The demonstrations also helped:

- Identify and understand the full breadth of the data being collected, including data not in reports
- Identify potential data elements for performance measures
- Clearly define what each data point measures and its parameters
- Highlight potential data limitations
- Answer any questions about the data

Based on the information gathered from the focused conversations and MBA interviews, PSC mapped existing data to provide a foundation for developing Minnesota-specific performance measures. PSC reviewed data and collection methods from AAAs, and MBA staff to identify alignment between data that is currently being collected and the Minnesota State Plan on Aging goals. PSC used this information to develop a methodology for assessing each group's data and collection methods to provide a systematic review and identify and organize relevant information.

MBA staff supported this effort by providing a data resource spreadsheet that cataloged relevant data by:

- Program
- Platform where data is collected
- Data collected
- How data is reported
- Frequency of collection
- Staff who oversee data collection and reporting

MBA staff also provided PSC examples of data spreadsheets and relevant reports for each piece of data to better understand data collection and utilization.

AAA Area Plans

PSC also reviewed each of the 2022 AAA Area Plans on Aging to understand the roles of the AAAs, the services they provide, and the data they collect and report to the MBA. The plans relay a wide variety of information, including:

- Information on program development and coordination
- Population profiles and demographics, including targeted populations and services provided
- A summary of all services provided by or through the AAA, including indirectly through contracts with community partners

- Specific metrics identified by the AAA that relate to state plan goals and objectives and how they relate to each of the AAAs' service roles (i.e., administration, advocacy, access, and development)

An overview of the sources reviewed during the data mapping exercise is outlined in the table below.

Exhibit 2. Data Sources Reviewed

Data Source	Description	Data Owners
Area plans	Annual workplan and budget submitted by the AAAs to the MBA that describe the agency's priorities and plans for their service area for the following calendar year	AAAs and MBA
Caregiver survey	Survey conducted annually for family, friend, and neighbors' caregiving that gathers information, including demographics, satisfaction with services and supports, and caregiver outcomes	Resource Development (RD) team
Client Tracking System	Data reporting system that tracks client-level data for anyone seeking or receiving information and assistance from the SLL	SLL
Grant Utility	Data reporting system that tracks funding expenditures for Title III programs and services	RD team
Peer Place	Data reporting system that tracks client-level data for those receiving services under Title III programming	RD team
State Program Report	Report ACL uses to monitor performance on OAA programs. Report provides annual data on program participants, services, and expenditures for Title III, VI, and VII programs	RD team
Trualta	Online platform that provides information, training, and resources for family and friend caregivers	RD team

With this catalog of data, PSC was able to create an extensive list of potential data elements and their respective sources that could be used to support performance measures based on state plan goals and objectives.

Performance Measures Development and Methodology

Performance measures are a concrete way to drive results, but without an explicit equity and inclusion component, measures will not produce better outcomes for marginalized communities or address disparities. By incorporating equity and inclusion into the SMARTIE methodology, the MBA's commitment to equity and inclusion is anchored by tangible and actionable steps.

This acronym was used as a checklist for each measure:

- **S**pecific—linked to a specific goal, e.g., the state plan goals
- **M**easurable—a quantifiable way to track progress or success
- **A**ttainable—action oriented
- **R**ealistic—benchmarks must be achievable
- **T**imely—appropriate deadline for achieving goal
- **I**nclusive—incorporates traditionally marginalized communities by stratifying measures
- **E**quitable—includes elements of fairness or justice that seek to address systematic justice, equity, and oppression

Performance measures developed during the initial phase will not meet all components of SMARTIE objectives; however, the checklist should be used as a final validity check for the performance measures in the future.

Alignment with State Plan Goals and AAA Roles

The process for developing performance measures was not a linear one. It required multiple strategies and iterations to develop the final framework and measures. One consistent aspect of measure development was the requirement to link the measures to the state plan goals. The MBA also sought measures to monitor AAAs' success in carrying out their primary roles of administration, advocacy, access, and development.

State Plan Goals

The MBA is currently in the process of finalizing their goals for the FFY 2024–2027 State Plan on Aging. At the time this report was written, the state plan goals were not yet finalized. Below are the drafted goals expected to be finalized in February 2023.

- **Goal one:** Advance equity and address disparities, through empowering cultural and ethnic communities, and respecting the sovereignty of Tribal Nations
- **Goal two:** Make aging in community truly possible for more Minnesotans
- **Goal three:** Support families, friends, and neighbors in sustaining their caregiving roles
- **Goal four:** Promote and support healthy aging for all Minnesotans
- **Goal five:** Dismantle ageism and promote older adult rights, autonomy, and protection

AAA Roles

The AAAs have four roles. Though it was not feasible during this initial phase to develop measures that would cover each of the roles, measures were developed for outputs from teams that work toward filling these AAA roles.

- **Administration:** Maximize quality and effectiveness AAAs create and maintain high-quality internal processes, standards, and systems. AAAs achieve this through effective fiscal management, well-qualified staff, building strong partnerships, using data to strengthen services, and understanding the resources and needs in their planning and service areas.
- **Advocacy:** Promote policies that reflect the needs and interests of older Minnesotans AAAs advocate for policies that fairly reflect the needs and interests of older Minnesotans to ensure that older people and their families are well served. AAAs provide one-to-one advocacy, systems advocacy, and policy advocacy. They engage in the legislative process, provide information and assistance to individuals, and draw attention to critical issues, especially by providing data on key trends.
- **Access:** Link people to information from AAAs to provide access to high-quality assistance for older adults, their families and caregivers, the organizations serving them, and their communities. This includes directly providing older adults and their families with the resources they need to make informed choices.

- **Service development:** Promote statewide availability of key community-level supports. AAAs promote local availability of core home and community-based services and supports. AAAs form partnerships and work to create sustainable, person-centered, and evidence-based systems and services to pursue these goals. Promote local availability of core HCBS.

Recommended Performance Measures

PSC developed the following performance measures to measure outcomes of the drafted state plan goals and meet components of the SMARTIE criteria above. PSC also created specifications, which include data sources, data elements, etc., to operationalize the performance measures developed.

Specifications for each of the performance measures are in Appendix A.

Exhibit 3. Recommended Performance Measures by State Plan Goal

Goal one: Advance equity and address disparities, through empowering cultural and ethnic communities, and respecting the sovereignty of Tribal Nations

Measure Name	Measure Definition
1A. Individuals served in targeted populations	Percentage of individuals served in targeted populations as defined by OAA Section 206 compared to percent of total population
1B. AAA Advisory Committee representation	Individuals serving on the AAA Advisory Committee reflect the communities they serve

Goal two: Make aging in community truly possible for more Minnesotans

Measure Name	Measure Definition
2A. Return to Community referrals that accept services	Percentage of referrals to Return to Community that accept services
2B. Return to Community from a nursing facility	Number of persons Return to Community helps discharge from a nursing facility
2C. Return to Community to remain in their community	Number of persons currently living in the community and using Return to Community to remain in their community

Goal three: Support families, friends, and neighbors in sustaining their caregiving roles

Measure Name	Measure Definition
3A. Caregivers served by Title III-E services	Total number of caregivers served by Title III-E services
3B. Satisfaction of caregivers with caregiving services	The level of satisfaction of caregivers with caregiving supportive services that they have received
3C. Outcomes of caregivers who complete caregiver survey	Self-reported outcomes of caregivers who have received caregiving supportive services

Goal four: Promote and support healthy aging for all Minnesotans

Measure Name	Measure Definition
4A. Number of meals per person per month	Number of meals per person per month
4B. Persons served who are at high nutritional risk	Percentage of persons served who are at high nutritional risk

Key Staff Feedback

In November 2022, PSC presented the newly developed performance measures to MBA staff and the AAAs to offer them the opportunity to provide feedback. MBA staff prepared an FAQ to respond to questions AAA staff asked during the second round of focused conversations. The Feedback document is included in Appendix C.

Recommended Next Steps

This report provides an overview of the process the MBA and PSC took to develop the initial set of performance measures. The recommendations provided are laid out as a roadmap to enable the MBA to continue working on the performance measures and take them from their current state to full implementation. Implementation of additional performance measures will provide the MBA the ability to assess and evaluate their programs' performance. Additionally, fully implemented performance measures can be used to support the MBA in decision making.

Roadmap to Performance Measure Implementation

- **Step one:** Quality assurance and quality control
- **Step two:** Measure specification refinement
- **Step three:** Measure reporting
- **Step four:** Adoption and implementation
- **Step five:** Data warehousing

Step One: Quality Assurance and Quality Control

The MBA should establish a performance measure workgroup or leverage existing spaces to continue the work to strengthen and develop new performance measures.

Step Two: Measure Specification Refinement

The measure specifications must be recognized as a living document. As quality assurance and control get underway, the performance measures must be updated according to findings.

Staff should utilize the SMARTIE checklist to support the creation of inclusive and equitable measures while keeping measures relevant, applicable, focused, and quantifiable.

PSC provided a master specification template to support this process and recommends that MBA staff develop standard operating procedures and document how and when to update measure specifications.

Step Three: Measure Reporting

As measures are refined and finalized, MBA leadership must determine the best way to regularly report performance measures. For example, staff can generate a performance monitoring report or dashboard to share outcomes. A dashboard would require the MBA to develop and maintain a user interface, while reports can be distributed through email and via the website. Both are appropriate means for reporting measure results. The benefits of the dashboards over reports are that they tend to have more capabilities in displaying, filtering, and sharing data. MBA should examine its capacity and determine which reporting method meets their needs. Once a reporting mechanism has been determined, staff training on system programming to generate and stratify measures will be essential.

Step Four: Adoption and Implementation

Once performance measures have been vetted, refined, and operationalized, MBA can utilize performance measure results to assist in decision-making processes. The performance measures will become a tool to help inform whether program objectives are being met and identify areas needing additional work. The measures will have limitations, as they are only able to provide information about certain components of the program and therefore should be applied with other information to make strategic decisions. Nonetheless, evaluating measure results in regularly scheduled decision-making meetings will support program goals and objectives.

Step Five: Data Warehousing

MBA staff will need to develop a plan to strengthen data collection processes and systems for generating current and future measures. This planning includes building a data warehouse, which would integrate data from different systems into a single source, thus accelerating the process of generating measures by enabling the user to query any data needed. It also streamlines data availability through automated live feeds and can help decrease user error by reducing the need to manually transfer and use the data.

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