The Minnesota Board on Aging
State Plan
2019 – 2022
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**Verification of Intent**

The Minnesota Board on Aging hereby submits its State Plan on Aging for the State of Minnesota October 1, 2018 through September 30, 2022 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 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.

_________________________  _6/26/2018____
Executive Director, Minnesota Board on Aging  Date
Kari Benson

_________________________  _6/26/2018____
Chair, Minnesota Board on Aging  Date
Don Samuelson
Executive Summary

In the spring of 2017, the Minnesota Board on Aging (MBA), in partnership with the Minnesota Department of Human Services (DHS), began a strategic planning effort called MN2030 Looking Forward. The year 2030 is marked as an important milestone because it is the year baby boomers start to turn 85 years old. On average, at about age 85 people start to need more help around the house or with their personal care and many move out of their homes into congregate settings to receive that help. We want to make it possible for each of us as we grow older to age in our community for as long as possible. With that foundation in mind, we are leveraging the State Plan on Aging as a vehicle to refresh the vision and priorities for 2030.

Minnesota has unique opportunities to ensure all older Minnesotans age well and live well. Because we are living longer, healthier and more connected lives there is momentum to take steps to shape our future into one that supports all of us as we age. As a result of the state’s established aging network and committed stakeholders there is also momentum to make necessary changes to help the state prepare for the year 2030.

Minnesota has made substantial progress with the development of a robust long-term services and support (LTSS) system. There is a strong foundation to build and improve LTSS quality and access and to fully prepare other aspects of our communities for the demographic shift. The vision of MN2030 Looking Forward: Minnesota is a great place to grow up and grow old, where all Minnesotans are treated with dignity and respect, regardless of age. The values guiding this vision are ingenuity, equity and justice.

The blueprint to achieve Minnesota’s vision is anchored by five broadly-defined goals:

1. Leverage the experience, expertise and energy of older Minnesotans.
2. Equip older Minnesotans with the tools to take charge of their health and make informed decisions about services when they need them
3. Support families and friends in their caregiving roles
4. Support aging in community with a range of services and housing options
5. Ensure the rights of older people receiving long-term care services.

This State Plan outlines the work the MBA will undertake to achieve these goals and realize the vision of MN2030. Future iterations of the MN2030 plan will articulate the role of DHS in helping older adults age in their community and prepare the state for 2030. It is our intention that other state and local, public and private partners will join us in this effort and commit to their role in realizing the vision of MN2030 (Attachment J).
Trends Shaping the Future of LTSS

As the baby boom population ages, the sheer number of people who will need LTSS when they are older will increase. By 2030, Minnesotans age 60 and older will number nearly 1.6 million and constitute 26 percent of the state’s population. With this demographic shift we will also witness the following trends that by now have become familiar to many of us (See Status Checks-Attachment D).

- More people will need publicly funded services because they will not have the resources to pay for it themselves.
- Fewer family members will be available to provide support, especially intensive personal care, to their loved ones.
- A deepening workforce shortage will continue to strain the formal LTSS system.
- More people will experience behavioral health challenges and social isolation.

If we do not do anything differently in terms of our LTSS policies and programs, we will not meet the level of need projected into 2030. Faced with this challenge, many people can understandably become overwhelmed and feel there is nothing that can be done. But in our MN2030 community conversations we found just the opposite! We heard from people of all ages in communities across the state who are thinking about what they want their future to be when they are older and they are exploring ways to support each other. The energy and enthusiasm from these conversations fueled the development of the MN2030 vision, values and the goals that are outlined in the State Plan. These goals point out ways we can shape the LTSS system, and other aspects of our communities, to prepare for 2030.

At the same time that we are experiencing a demographic shift in the age of our state’s population we will also be experiencing the most significant shift in the race, ethnicity and cultural heritage of our population. Thus, preparing for 2030 must include every cultural and ethnic community determining what their future looks like and how they want to support their older community members. These communities will also help to shape LTSS and other community infrastructure to best meet their needs and preferences. Preparing for 2030 also includes acknowledging and tackling health disparities by building the capacity of culturally-specific providers and meeting the cultural and linguistic needs, values, and preferences of older adults and their caregivers from cultural and ethnic communities (See Policy Briefs-Attachment E). Through the MN2030:Looking Forward efforts there will be a deliberate focus to
make resources available to cultural and ethnic communities to determine how best to meet their LTSS needs.

The Minnesota Board on Aging

The MBA is the designated state agency on aging for Minnesota. It is the doorway to services for older Minnesotans and their families. The first role of the MBA is to administer federal and state funds to deliver a range of in-home and supportive services to older adults and their family caregivers. In addition, the MBA manages two direct service programs: the Office of Ombudsman for Long-Term Care and the Senior LinkAge Line®. In federal fiscal year 2016, the MBA, in partnership with its designated Area Agencies on Aging and their contracted providers, serves 189,000 older adults and caregivers each year including those, who are not yet eligible for the state’s other publicly-funded home and community based service programs.

The second role of the MBA is an advisor to older adults through good information and decision support and to partners through sharing best practices and evidence-based models. The third role of the MBA is an advocate. In this role the Board promotes state and local policies and programs to support older adults to age well to live well at home. It is under this third role the Board develops their legislative priorities and spearheads its strategic planning processes, as evidenced with MN2030 Looking Forward.
MN2030: Introduction

In the spring of 2017, the Minnesota Board on Aging (MBA), in partnership with the Minnesota Department of Human Services (DHS), began a strategic planning effort called MN2030 Looking Forward. The year 2030 is marked as an important milestone because it is the year baby boomers start to turn 85 years old. On average, at about age 85 people start to need more help around the house or with their personal care and many move out of their homes into congregate settings to receive that help. We want to make it possible for each of us as we grow older to age in our community for as long as possible. With that cornerstone in mind, we are leveraging the State Plan on Aging as a vehicle to refresh the vision and priorities for 2030.

We are past the midpoint between our original vision for the long-term services and supports system, crafted by the 2000 legislatively-mandated Long-Term Care Task Force, and the year that baby boomers start turning 85. It is truly a transformative time in our communities. To that end, Minnesota is revisiting its multi-year commitment to prepare for a permanently older society. The MBA and DHS are using this opportunity to engage people across Minnesota communities, sectors and generations with the goal to refresh and refocus our efforts.

Central to the stakeholder engagement that shaped this State Plan on Aging and will continue to guide our efforts into 2030 are the strategies to reframe aging developed by the Frameworks Institute. The Frameworks Institute conducted extensive research to develop messages that were proven to reframe the public conversation around aging and ageism. With the tools and support provided by the Frameworks Institute, our aim is to refocus our conversation about aging to one that involves everyone, of all ages.

The value of justice is a key component of the Frameworks Institute’s reframing approach, and it’s a value that will guide all of the work that we do. Justice requires recognizing that all members of society are equal. Right now, our society is not treating older people as equals. In fact, we are marginalizing their participation and minimizing their contributions. To achieve the future that we want, we must confront the injustice of ageism and work to reshape society so that everyone is fully included in their communities, regardless of their age.

To do so, we have learned from the Frameworks Institute that we want to shift from a moral claim of “doing right” by older adults to emphasizing their participation, contributions, and inclusion. We need to disrupt the Us vs. Them binary that separates the old from the young in the public mind and, thereby, permits a paternalistic stance toward older people (we must do a better job of taking care of them). Within this frame, it is too easy to associate older people with vulnerability—and, thereby, much more difficult to imagine a society in where older adults are full and equal participants. In the development and implementation of the MN2030 plan we want to work across generations, sectors and communities to create a future for all of us that includes all of us.
MN2030 Vision and Values

The culmination of our stakeholder engagement is our renewed vision for Minnesota: *Minnesota is a great place to grow up and grow old, where all Minnesotans are treated with dignity and respect, regardless of age.* The values below will guide our work to achieve this vision and will shape our efforts throughout each goal described below.

*Ingenuity*

As Minnesotans live longer and healthier lives, this presents new opportunities for our communities. We will tap our creativity and resourcefulness to make the most of them. We are problem-solvers. With the assistance of our aging population, when an opportunity presents itself, together we will figure out how to seize it. Alternatively, if we see something that isn’t working, together we can rethink our approach.

*Equity*

We achieve equity when every person in a community has what they need to reach their full potential and if needed, helping each other to increase their social, economic and political assets. We will work with stakeholders to take a systemic approach to promote the physical, mental, social and economic well-being for all people regardless of race, ethnicity, or cultural identification.

*Justice*

Creating a just society includes treating older people as equal members of the community. It also means making sure we are all connected to our communities as we age, so that we can recognize, prevent and address elder abuse. We will confront ageism and work towards a future that values people of all ages and fully includes them in society.
The Minnesota Board on Aging

The MBA is the designated state agency on aging for Minnesota. It is the doorway to services for older Minnesotans and their families. 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 seven AAA leverage additional local dollars and resources and ensure local input and accountability in the delivery of aging services in communities around the state. The Minnesota Indian AAA administers OAA funds to deliver services to Native American elders in the northern half of the state. In federal fiscal year 2016 the MBA, in partnership with its designated AAA and their contracted providers, served 189,000 older adults and caregivers including those, who are not yet eligible for the state’s other publicly-funded home and community based service programs. The administrator role of the MBA and its partners is depicted by figure 1.

In addition, the MBA manages two direct service programs: the Office of Ombudsman for Long-Term Care and the Senior LinkAge Line®. The Office of Ombudsman for Long-Term Care provides direct, one-to-one advocacy and problem-solving for nursing home residents and older persons receiving services in the community. The Senior LinkAge Line®, and the www.minnesotahelp.info website, provides streamlined service information, access assistance, health insurance and long-term care options counseling to older Minnesotans and their families.

The second role of the MBA is an advisor to older adults through good information and decision support and to partners through sharing best practices and evidence-based models. The third role of the MBA is an advocate. In this role the Board promotes state and local policies and programs to support older adults to age well to live well at home. It is under this third role the Board develops their legislative priorities and spearheads its strategic planning processes, as evidenced with MN2030 Looking Forward.
Figure 1

Minnesota’s Aging Network
An infrastructure that annually supports over 189,000 older Minnesotans and caregivers

<table>
<thead>
<tr>
<th>123,897</th>
<th>38,503</th>
<th>10,274</th>
<th>4,060</th>
<th>65,845</th>
<th>22,106</th>
<th>599</th>
<th>2,671</th>
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<tr>
<td>consumers served via the Senior LinkAge Line®</td>
<td>older adults received congregant meals</td>
<td>older adults received home delivered meals</td>
<td>older adults received 100,438 one-way trips</td>
<td>hours of respite provided to 873 caregivers</td>
<td>units of coaching/support/education provided to 2,927 caregivers</td>
<td>older adults participated in Chronic Disease Self Management education programs</td>
<td>older adults participated in Fall Prevention programs</td>
</tr>
</tbody>
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FFY 2016
**World Health Organization Eight Domains of Community Living**

In 2006, the World Health Organization (WHO) launched an effort to prepare the world for the rapidly aging society. The main tenet of the program, *Age-Friendly Cities and Communities program* is to impact the social and economic factors that influence health and aging for older adults. Several factors determine the health and quality of life of people including: environmental, lifestyle, social and economic factors. We maintain this extends to any cultural and ethnic population and any city regardless of population size.

The WHO recognized that to make a community age-friendly was to have active participation by people of all ages, especially older adults. AARP became an affiliate of the WHO program and adopted the eight domains of livability. The eight domains are divided by distinct topics that help a community gauge, organize and prioritize how to become livable community. Below are the eight domains of community living:

1. Outdoor Spaces and Buildings
2. Housing
3. Transportation
4. Social Participation
5. Respect and Inclusion
6. Civic Participation and Employment
7. Communication and Information
8. Community and Health Services

New York State was recognized by WHO and AARP as the first state in the nation to become an age-friendly state. We want Minnesota to be the second!

The first three domains; Outdoor Spaces and Buildings, Housing and Transportation feature the physical environment. The physical surroundings shape if a community is safe, secure, efficient, and if there is mobility. The next three topics; Social Participation, Respect and Inclusion and Civic Participation reflect social engagement for older people. The last two domains, Communication and Information and Community and Health Services address both “social environments and health and social service determinants.”

The eight domains were identified by the WHO in research that show close connections or complementary effect between each domain. Transportation that is accessible and safe is dependent on effective Communication and Information. Housing interacts with Social Participation. When all domains converge an age-friendly community is created. The plan

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within aligns the WHO’s eight domains with its own goals, objectives, and priorities, as noted within that section of the plan.

**Stakeholder Engagement Community Conversations**

The stakeholder engagement process was a multidimensional effort. In the fall of 2017, the MBA and DHS used the eight domains for community living as a framework to create a facilitated process to conduct community conversations throughout the state. The idea was to engage with people of all ages, in particular older adults.

The community conversations engaged attendees to talk about their own aging and what they envision the future could be like for older people in 2030. By June 2018, there were 35 community conversations attended by approximately 800 people hosted primarily by the AAA and other stakeholder organizations. The hosts used a facilitator’s guide to lead groups through the conversation.

With an intentional effort to engage older people across all settings, community conversations were held with residents of nursing homes and assisted living facilities. With help from the Office of Ombudsman for Long Term Care, community conversations were coordinated by the Ombudsman staff with resident councils to gather their perspectives about what is important to them and how they envision services and supports could be shaped into the future. Through the resident council community conversation process there were 12 hosted throughout the state attended by 176 residents.

The MN2030 website featured a survey to gather the input from people all around the state. Over 650 surveys were completed by April 2018. Along with demographic questions, the survey asked people to rank important factors to age in the community and inquired about innovative solutions to prepare for 2030.

Results from the community conversations, resident council community conversations and the survey were categorized using the WHO eight domains for community living.

Given space limitations in the State Plan, only the rankings and general observations for the three input methods are presented below. A report with detailed analysis will be available in summer 2018.
### Table 1

**Stakeholder Engagement Results**

<table>
<thead>
<tr>
<th>Community Conversations</th>
<th>Resident Council Community Conversations</th>
<th>MN2030 Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Housing</td>
<td>2. Community and Healthcare</td>
<td>2. Transportation</td>
</tr>
<tr>
<td>3. Transportation</td>
<td>3. Outdoor Spaces and Building</td>
<td>3. Housing</td>
</tr>
<tr>
<td>5. Communication and Information</td>
<td>5. Social Participation</td>
<td>5. Outdoor Spaces and Building</td>
</tr>
<tr>
<td>7. Outdoor Spaces and Building</td>
<td><em>Civic Participation and Employment and Transportation – Not mentioned</em></td>
<td>7. Civic Participation</td>
</tr>
<tr>
<td>8. Civic Participation and Employment</td>
<td></td>
<td>8. Communications and Information</td>
</tr>
</tbody>
</table>

People who provided their input through the community conversations and MN2030 survey ranked Community and Healthcare as the most important domain. This is the domain that includes LTSS.

Interestingly, Respect and Social Inclusion was identified as the top domain in resident council and number 4 in the community conversations but ranked low within the survey results. This could be because a higher proportion of younger people completed the online survey. Participants in the community conversations highlighted a need to ensure people with dementia as well as people of all cultures, religions and sexual orientations are included and respected. The participants also described an interest in developing, a culture of caring with less isolation and more structured opportunities to get to know diverse people.

Within Respect and Social Inclusion, the resident council participants focused on responsive staffing, which included staff turnover, training and ability for residents to effectively communicate with staff. They also highlighted choices and privacy as high priorities.

People who participated in the statewide community conversations wanted:
• presence of technology as a tool to age well
• better service coordination
• more efficient delivery of services in the community and
• improved access to direct service workers.

Within the same domain – Community and Healthcare – the nursing home and assisted living resident council attendees want to remain close to their family, have adequate food options, private rooms and improved access to physicians and mental health services.

In both the community conversations and MN2030 online survey, housing was an essential domain, ranking #2 and #3 respectively. In the community conversations, participants moved beyond aging in place to having choices to age in community. Specifically, participants want an array of housing options that include:

• Affordable home modifications,
• More affordable housing,
• Single level homes,
• Home sharing,
• Improved zoning regulations to support innovations in housing, and
• Lifetime communities.

**Serving Native American Elders**

There are two distinct tribal nations in Minnesota: Dakota and Ojibwe that include 11 federally recognized tribal governments. Four tribal governments, as part of the MN Chippewa Tribe are designated as MN Indian Area Agencies on Aging (MIAAA), serving the elders living on tribal lands. The following tribal governments are part of the MIAAA’s Program Service Area:


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. 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.

Although the state has been a national leader in developing a system of long-term care that allows older adults and adults with disabilities dignity and choices in how they wish to live, tribes do not feel as though enough has been done to fully address these issues. The need of tribal governments to assure appropriate care for their citizens must be respected, and they
must have access to available resources, as well as information about existing programs for which American Indians are eligible. Additional work needs to be done in LTSS to ensure that the aging Indian population in Minnesota has access to essential services and options when they are needed and that individuals can receive these services in their own communities. Developing strategies for Tribes to provide LTSS will be a priority of both state and tribal government.

Accordingly, this plan will address the need for state and tribal governments to develop strategies for LTSS.

- MBA will convene Title III and Title VI funded providers to strengthen Title III & Title VI services by tracking services provided to at-risk populations.
- Build capacity across tribes through coordination of leader training and education that will increase availability of evidence based interventions for elders.
- Strengthen coordination and input of Title III data through ongoing training technical assistance
- Maintain a list of supportive services needed or requested by the elders. Coordinate services through Title III resources.
- Expand caregiver consultation to Indian Country
- Include urban American Indians elders in programs and services

In addition, specific measures related to the coordination effort are italicized in the strategic priorities (Attachment J).

**Quality Management for Support and Services**

In addition to using the WHO eight domains for community living as a quality framework to gauge and improve the lives of older Minnesotans, there are other distinct initiatives in Minnesota that aim to improve services and supports for people. Starting in March, 2018 DHS began a project called “HCBS Quality Initiatives Inventory.” The “HCBS Quality Initiatives Inventory is an continuing project that identifies DHS quality assurance and improvement initiatives in the systems of services and supports that enable persons to continue living, working and engaging in their community. The purpose of the inventory is to show how these initiatives align with the National Quality Forums (NFQ) HCBS Quality Framework.

Currently there are 45 initiatives included in the inventory with 20 devoted to older Minnesotans. DHS divisions involved with the inventory are Disability Services, Aging and Adult Services Fiscal Analysis and Performance Measurement, Special Needs Purchasing and Mental. Included in the inventory are five quality projects lead by the MBA. Moving into the future, the quality projects below will reflect the goals and objectives articulated in the state
1. OAA Senior Nutrition Program assists older adults to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.

2. The Ombudsman for Long Term Care: Person-Centered Service Delivery is a multi-faceted approach by the Office of Ombudsman for Long-Term Care to promote and support person-centered thinking skills in Minnesota's long-term care service system.

3. The Survey of Older Minnesotans is a statewide survey of persons age 50 and older in Minnesota. The MBA conducts this survey approximately every five to ten years. The purpose of the survey is to monitor the changing needs, assets and expectations of older persons in the state. Findings are used to improve the design and targeting of public programs for older adults and to help researchers and policy makers better understand Minnesota’s older population.

4. The OAA Caregiver Survey is an annual survey of caregivers to obtain demographic and qualitative data about the OAA services they receive. The purpose of the statewide survey is to learn about the availability and capacity of caregiver support services in Minnesota for serving informal and unpaid caregivers. Results are used to inform planning, policy and funding decisions related to developing and strengthening services for informal caregivers across the lifespan.

5. The Live Well At Home (LWAH) Rapid Screen© is a tool to identify personal risk factors related to nursing home admission and/or spend down to Medicaid, or Medical Assistance (MA) in Minnesota. The screen is scored and the person is determined to have a high, moderate, or low level of risk. Identified risk factors become basis for prioritizing and addressing issues so the older adult can sustain community living.

A Strong Foundation of Long Term Services and Supports

LTSS are a spectrum of health and social services that support Minnesotans who need help with daily living tasks (Attachment D-1). LTSS may be provided in institutional settings, such as hospitals and nursing homes, or in people’s homes and other community settings. When provided in a person’s home or other community settings, such as assisted living, the services are referred to as home and community-based services (HCBS).

Federal and state policies, consumer preferences, and other factors have sought to shift the balance of LTSS services toward a greater emphasis on HCBS, with the goal of enabling people to live independently in their own home or in the community as long as possible. In fact,
balancing was a key strategy articulated in 2000 by the legislatively mandated Long-Term Care Task Force. The illustration below (Figure 2) displays the continuum of LTSS programs developed by Minnesota to help older adults with varying levels of need and personal resources. Since 2000, the state has deliberately built the capacity of the system to provide a range of HCBS programs as an alternative to nursing home services.

**Figure 2**

Below are two figures that illustrate trends in Minnesota’s LTSS system. The first figure (Figure 3) compares the percent of MA in Minnesota, LTSS expenditures for people in nursing homes to MA-funded HCBS. Figure 3 shows the state reduced reliance on nursing homes by decreasing the proportion of MA LTSS dollars spent on nursing home services and increasing the proportion spent on HCBS. By 2016, the proportion of public LTSS expenditures was balanced, with 50 percent supporting nursing home services and 50 percent supporting HCBS.
Figure 3

Figure 4 illustrates the number of older Minnesotans receiving MA-funded HCBS compared to people served in a nursing home. The data point to 2005 as a seminal year because it was the first-time Minnesota’s LTSS system was balanced in terms of people served. From that point on Minnesota increased momentum towards providing more HCBS options. By state fiscal year 2014, 70 percent of older adults received HCBS as compared to 30 percent living in nursing homes. This is a dramatic improvement from state fiscal year 2000 when only 40 percent of older adults received HCBS and 60 percent lived in nursing homes.

Figure 4

Source: DHS Data Warehouse
A key factor in the development of the LTSS system is the progress of the Senior LinkAge Line® a direct service program of the MBA. The Senior LinkAge Line® assists individuals to find community resources, including supports for family caregivers, and to create a support plan to remain in the community. This type of assistance, also known as long-term care options counseling, has been used successfully to help older people and their caregivers make informed decisions about their LTSS needs. Figure 5 below illustrates public awareness about the services from the Senior LinkAge Line® and Figure 6 shows the number of people served from 1997 – 2016.

Figure 5

More People Know and Call Senior LinkAge Line

Survey Question: Have you heard of the Senior LinkAge Line? Have you or your spouse or partner ever called the Senior LinkAge Line?
The year 2018 marks another milestone for the MBA and its designated AAA partners. It is the 25th anniversary of the Senior LinkAge Line®, which has done innovative work to enrich and improve the lives of older Minnesotans and their families. The Senior LinkAge Line® works to provide comprehensive services and supports for all Minnesotans. This is a critical time to acknowledge accomplishments, review emerging needs and identify priorities going forward.

MINNESOTA’S FORMAL AND INFORMAL NETWORKS

Minnesota’s LTSS system is large and complex. It is made up of (a) informal services provided by family and friends who are caregiving, (b) formal HCBS delivered by paid staff and volunteers, and (c) nursing home services.

The formal network of Minnesota’s LTSS includes, but is not limited to, the MBA and its seven designated AAA. The mission of the aging services network is to promote, plan, and facilitate the development of a comprehensive and coordinated service delivery system responsive to the needs of older adults age 60+ and family caregivers with OAA funding prior to needing MA-funded HCBS. The system maximizes individual options for high quality, person-centered, and cost-effective services which enables older adults to age well and live well at home.

The continuum of LTSS supports, builds upon, strengthens, and integrates the person’s informal support network. An important part of Minnesota’s strategy is to reach people before they even become eligible for MA. By reaching people early, when their needs are relatively modest,
we can provide less-expensive services, prevent or delay their spenddown to MA, and prevent or delay the use of more expensive services such as nursing home or assisted living services.

**State Plan Goals and Objectives**

The following goals, objectives and strategies outline the steps that the MBA will take to support older adults through the OAA State Plan period and prepare the state for 2030. As the state agency on aging, the MBA will fulfill its mission to advocate, advise and administer to effectively serve older Minnesotans.

The State Plan also articulates the role of the MBA as a partner with other state agencies within the larger, publicly-funded system of services and programs for older persons. The goals, strategies and outcomes in this plan, therefore, represent both the federal expectations for the MBA as well as state priorities and issues identified through the input provided by the AAA, their local partners, older adults, family caregivers and other community members. Future iterations of the MN2030 Plan will include detail regarding the role of DHS to support older adults to age in community and prepare the state for 2030. It is the intention of MBA and DHS that other state and local, public and private partners will join in this effort and commit to their role in preparing for 2030. The Goals are broadly defined and when we work together we will achieve the vision for our state as a great place to grow up and grow old, where all Minnesotans are treated with dignity and respect, regardless of age.

**Goal 1: Leverage the experience, expertise and energy of older Minnesotans**

As with the state’s population overall, the workforce is growing older as the much larger baby boom generation ages. In 2016, 20 percent of the jobs in Minnesota were held by workers age 55 and older. If baby boomers continue to retire near traditional retirement ages there will not be enough replacement workers available to fill all of these openings. This will exacerbate an already significant workforce shortage that is hitting every sector of our economy. But, our future in Minnesota can be very different. We are sitting on a gold mine of people at their prime in thinking, creativity and resourcefulness. And this “gold mine” does not just benefit our economy but can benefit all aspects of our communities.

Standing in the way of these benefits is ageism, discrimination based on prejudices about age. It can be directed at people of any age but when it is directed at older people, it often involves the assumptions that older people are less competent than younger people and need someone else to take care of them. Ageism is largely unconscious. Our exposure to pervasive negative

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messages about older people and their capabilities leave us with a prejudice we may not even be aware of. The negative effects of this bias, however, can be dramatic.

The negative effects can range from workplace discrimination and harassment to social exclusion and neglect to egregious abuse in older adult care settings. Ageism affects the economic security of many older adults who would like to be working. Stress, depression and a higher risk of heart disease result when we internalize negative messages about growing older. Conversely, a Yale study showed that positive attitudes about aging could extend one’s life by more than seven years.³

Minnesotans are ready for change. People participating in the MN2030 community conversations ranked respect and social inclusion high on issues the state should address as we prepare for the year 2030. Results of these conversations show that people want to be connected and to figure out how to support each other. Older adults have come forward in these discussions with ideas for making that happen and with creativity and energy to solve other community problems.

In addition data from 2015 Survey of Older Minnesotans highlights further the social capital potential of Minnesota’s primarily older community members.

- Half of older adults ages 50+ reported volunteering for an individual such as helping others by doing things such as driving them to appointments, church, shopping, doctors; bringing them meals or groceries; helping with house or yard work; visiting; and so on.
- Almost 60 percent of older adults ages 50+ reported they helped organizations such as churches, libraries, hospitals, neighborhood groups or service clubs.
- Overall older adults volunteer at a higher rate of volunteering with an individual or an organization.

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³ *Longevity Increased by Positive Self-Perceptions of Aging*, Becca R. Levy, Martin D. Slade, Suzanne R. Kunkel, & Stanislav V. Kasl, Yale University, January 2002
Researchers have long known about the health benefits of “social capital”; the ties that build trust, connection, and participation. This link may be particularly important for older adults across Minnesota’s rural and urban communities who may also be able to offer more assistance to their peers with routine maintenance tasks, social visits and ultimately shape the landscape to elder abuse including financial, physical and emotional.

**Strategic Priority 1.1**

Facilitate opportunities to connect older people to their communities and engage them in the activities that offer them social connections.

The Minnesota Board on Aging will:

- Advocate for public policies that will create opportunities for low-income older adults to engage in their neighborhoods.
- Build capacity within communities and Senior Corps agencies to harness social capital and take the pledge to be “MN2030 ready”.

*Source: Survey of Older Minnesotans, 2015*
• In partnership with MN Department of Transportation and Commerce, advocate for policies that build capacity for volunteer drivers
• Utilize social capital within the Senior Corps programs to support opioid abuse prevention, awareness and education, reduction of social isolation, through local nonprofits, faith-based community organizations and with Tribal Nation partners across the State.

**Strategic Priority 1.2**

Work with employers to increase the number of older people (those 50+) who are actively recruited and retained as part of an overall workforce strategy.

The Minnesota Board on Aging will:

• Advocate for older people to be an integral part of the state’s workforce; including training for schools/children to work with the older workforce
• Promote flexibility to retain older workers by engaging in a multi-state agency coalition.
• Advise partners on workforce shortage and develop an outreach campaign to utilize older workers.
• Identify and promote incentives for businesses to employ older workers.
• Leverage research relationship with the University of Minnesota to focus on employer and older worker needs and priorities.

**Strategic Priority 1.3**

Leverage advocacy efforts of older people, their families, and all stakeholders to prevent abuse and neglect and support the ability of all people regardless of age to exercise their full rights.

The Minnesota Board on Aging will:

• Work with DHS and MDH to quickly respond to allegations of abuse and neglect of vulnerable adults.
• Partner with DHS to support the role of the country lead investigative agencies through increased regional support, training and technical assistance.
• Partners with DHS to fully develop a person-centered maltreatment reporting and response system to support remediation and prevention activities.
Goal 2: Equip older Minnesotans with the tools to take charge of their health and make informed decisions about services when they need them

Nothing is more central to Minnesotans' quality of life than their health. Creating an infrastructure that supports a system of services and that enables older adults to age with dignity, independence, and choice in the face of increasing health and daily needs is at the core of MBA programs and services. The goal of fulfilling this need will take unprecedented levels of public involvement, including being engaged in our daily lives, our neighborhoods, our communities, and at the state and federal levels. Regular physical activity is one of the most important things an older adult can do to be healthy. Wellness needs to be person-driven in that older adults and people with disabilities experiencing chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life (Attachment E-4).

Two key data points highlight Minnesota’s robust systemic health and individual wellness.

- In 2016, less than 5 percent of Minnesota residents lacked health care coverage. This rate of un-insurance is lower than most States and ensures that health insurance impacts access to health care.
- The prevalence of diagnosed diabetes among Minnesota's adults is consistently lower than the national average, which stood at nearly 11 percent in 2016.

It is estimated that Minnesota has more than 1.1 million adults age 60 and older. When it comes to the current state of healthy aging and nutrition consider the following, of those age 60 and older, it is estimated that 72 percent have at least one chronic health condition (ongoing health issue) and 60 percent have 2 or more. It is also estimated that up to 15 percent experience under nutrition (not consuming enough calories, protein or nutrients). Those at most risk for under nutrition are older women, minorities, and people who are poor or live in rural areas.

In addition, falls are the leading cause of injury-related deaths among persons aged 65 and older, and the age-adjusted rate of deaths from falls is increasing. According to the Minnesota Department of Health (MDH), injurious falls and fall related deaths place Minnesota at 3rd in the nation. Minnesota’s fall mortality rate has consistently been calculated to be at least 60% higher than the U.S. rate. Minnesota’s rate continues to increase, moving unintentional injury from the 5th leading cause of death in 2008 to the 3rd leading cause in 2016.

While the above statistic is alarming, Minnesota was ranked as the number 1 healthiest state, in early 2017 by United Health Foundation that released their America’s Health Rankings Senior

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4 Retrieved from MN State Demographic Center, 2018.
5 Retrieved from MN Compass, 2018.
Report. The rankings are based upon analysis of older adult population health on a national and state-by-state basis across 34 measures. Minnesota’s has many strengths including: a high level of volunteerism, decrease in percentage of those in poverty and, nursing home quality (four and five star ratings), prescription drug coverage and a low prevalence of frequent mental distress.

And we know that people can maintain and even improve their health well into their later years, even while living with chronic conditions. Minnesota has made significant progress in making available a range of healthy aging programs that are proven to equip older people with the tools they need to take charge of their health and maintain their wellness. Minnesota also has a strong nutrition services program that reaches 40,000 older people each year. This represents a strong foundation upon which to build our future.

Managing our chronic conditions, living a healthy lifestyle, and addressing our risks for falls can help delay the need for long-term services and supports. But, as we get older, most of us (about 75 percent) will need some help around the house or with our personal care. The MBA, in partnership with the AAA, seeks to make it easy for older people and their families to find this help when they need it.

There are key opportunities to engage in the delivery of a strong system for providing long-term care options counseling through the Senior LinkAge Line® to help older adults and their families make educated decisions about LTSS needs. This coupled with healthy aging initiatives offer self-determination options for older Minnesotans to age in their communities.

**Strategic Priority 2.1**

Achieve statewide availability of a range of healthy aging programs.

The Minnesota Board on Aging will:

- In collaboration with the MN Department of Health, launch a statewide public-private partnership to support health and wellness for all older Minnesotans.
- Increase the support structure for regional and community-wide efforts (such as Juniper, Wisdom Steps), including sustainability and availability, to promote health and wellness.

**Strategic Priority 2.2**

Pursue new opportunities to address disparities and reach currently unserved or underserved populations with healthy aging programs and nutrition services.

The Minnesota Board on Aging will:

- Look toward new and creative partnerships such as with the: Veterans Administration, cultural and ethnic community organizations, community health workers, and healthcare providers.
providers to expand opportunities for all older adults to participate in healthy aging programs.

- Support the dissemination of community level efforts led by older adults (such as Vital Aging Network’s engagement effort, Evolve) to encourage health and wellness.
- Consider other models of healthy aging program delivery such as telehealth, online access or others that meet the standards and outcomes.
- Partner with food shelves to reach high risk older adults with low incomes who are experiencing undernutrition or malnutrition.
- Work with cultural and ethnic communities to train community members as coaches/leaders and increase the availability of culturally tailored programming.
- Advocate for more translations of materials for the healthy aging programs and nutrition.
- Align the work of the MBA Indian Elder Services Coordinator with Wisdom Steps and tribal efforts to support healthy aging for Native American elders.

**Strategic Priority 2.3**

Modernize the nutrition services delivery model to achieve efficiencies, promote sustainability and increase choice.

The Minnesota Board on Aging will:

- Develop and implement a business plan to test and bring to scale one or more new models of nutrition service delivery.
  - Identify and engage non-traditional partners to leverage their areas of expertise.
  - Explore new roles for volunteers to address needs such as social isolation.
  - Explore different infrastructure models for the cooking, packaging, purchasing and delivery of meals.
  - Explore and test the use of new technology to achieve efficiencies in program operation.
  - Maximize the use of participant and population data to drive continuous program improvements.

**Strategic Priority 2.4**

Strengthen the delivery of health insurance counseling, long-term care options counseling, and decision making support, through the Senior LinkAge Line®.

The Minnesota Board on Aging will:

- Develop and implement a robust training plan based on a needs assessment to support Senior LinkAge Line® staff and volunteers in the successful delivery of the full range of Senior LinkAge Line® services.
• Conduct a needs assessment of information technology including research existing options to meet those needs and deploy the preferred solutions statewide.
• Review lessons learned in the delivery of care transition support for people moving into a nursing home, leaving a nursing home, considering a move to assisted living, and being discharged from a hospital. Refine protocols and increase coordination with partners to achieve statewide consistency based on best practices.
• In partnership with DHS, MN Department of Health and external stakeholders, launch an assisted living report card to provide older adults and families with useful quality information.

Goal 3: Support families and friends in their caregiving roles

In 2016, about 5 percent (27,000) of Minnesota’s 585,000 caregivers were served through federal and state funded home and community-based services programs (e.g., federal Title III-E, State respite and MBA dementia grants, Elderly Waiver, Alternative Care) and the Senior LinkAge Line®. Family, friends, and neighbors, provide the vast majority of the support for older people with chronic conditions and functional limitations. The recognition of and support for family and friends who are caregiving matters because it impacts the well-being of the family as well as the individual to continue to age in their communities.

The unpaid help provided by family and friends who are caregiving is valued at $7.9 billion a year and exceeds State Medical Assistance expenditures\(^6\). Aging demographics coupled with longer life expectancies and increased disability rates with age will likely strain our publicly funded LTSS system. Changing family size and composition, and increasing numbers of baby boomers who are divorced or single without children and lack traditional support networks are also factors impacting LTSS for older adults. We have an opportunity to find innovative ways to support family and friends who are vital for supporting older adults, for sustaining public funding for LTSS and lessening the impact of Minnesota’s projected workforce shortage (~59,000 direct care workers by 2020).

\(^6\) Valuing the Invaluable 2015 Update: Undeniable Progress, but Big Gaps Remain. AARP Public Policy Institute.
The presence of a caregiver has been shown to improve medical compliance, reduce hospital re-admissions, prevent or delay premature nursing home placement, and improve quality of life for older adults.

A recent report from the National Academies of Sciences, Engineering and Medicine suggests that society’s reliance on this “work force” — largely taken for granted — is unsustainable. While the demand for caregivers is growing because of longer life expectancies and more complex medical care, the supply is shrinking, a result of declining marriage rates, smaller family sizes and greater geographic separation. In 2015, there were seven potential family caregivers for every person over 80. By 2030, this ratio is expected to be four-to-one, and by 2050, there will be fewer than three potential caregivers for every older American.

This volunteer army is also impacted by a great financial risk. Many reduce the number of hours they work, take a leave of absence or make other career changes, to care for their loved one. Even worse, perhaps, is the physical and emotional toll of extended caregiving. Family caregivers are more likely to experience negative health effects like anxiety, depression and chronic disease.7

An estimated 91,000 Minnesotans over age 65 have Alzheimer’s disease or related disorders (ADRD). ADRD primarily strikes older adults but also significantly affects their families. It poses emotional and medical challenges to family members and affects their finances, living situations, and well-being. Family and friends who are caregiving frequently face fatigue, anxiety, depression, social withdrawal and health problems. They often need education, counseling and support to continue their caregiving role. Nursing facility placement is

7 Families Caring for an Aging America, September 2016. National Academies of Sciences, Engineering and Medicine
frequently the result of persons who are caregiving exceeding their capacity to provide in-home care. Research has found that older adults with ADRD were five times more likely to require nursing facility placement and for longer stays than older adults without dementia.

In the 2017 session, the Legislature authorized the MBA to re-establish an Alzheimer’s Disease Working Group. The Working Group will finalize its recommendations in a report to the Legislature by January 2019. The MBA is committed to working with all partners to support people with ADRD and their families and will incorporate the recommendations of the workgroup into the State Plan on Aging at that time.

**Strategic Priority 3.1**

Enhance the caregiving support infrastructure to provide family caregivers with on-demand access to consultation and resources in person, by phone or online.

The Minnesota Board on Aging will:

- Expand Senior LinkAge Line® hours to include evenings and weekends to accommodate individuals’ caregiving. Enhance services by providing web conferencing, online support and problem solving that meets caregivers at their level of information exchange.
- Increase coordination between Senior LinkAge Line® and OAA-funded caregiver services grantees to maximize support for caregivers.
- Through the MBA dementia grants, strengthen education and resources for caregivers of persons with dementia.
- Increase work with cultural and ethnic communities to develop models that best meet the needs and preferences of those in their community who are providing care as well as the care receivers. Important to recognize the variation in family systems, cultural contexts, and disease trajectories.
- Expand the caregiver consultation service and create regional “hubs” or virtual centers to increase access to a range of support for people who are caregiving.
- Explore/promote market-based solutions for supporting caregivers. Includes vouchers for services and supports and better technology to support older adults and caregivers
- Coordinate the identification and support of family and friend caregivers across the health care and long-term services and supports systems, especially during care transitions

**Strategic Priority 3.2**

Build capacity within informal caregiver networks to enhance caregiving skills.

The Minnesota Board on Aging will:

- Train caregiver consultants to assist family and friends with finding and using various technologies to complement their roles and ease care tasks.
• Continue and increase support for caregivers of older adults during transitions of care, and others who are stressed and at risk of formal placement of older adults. Strengthen partnerships to fully realize the potential of the CARE Act.
• Extend home modification trainings for caregivers by caregiver consultants.
• Disseminate statewide the mobile respite model that taps college-level nursing, occupational therapy and physical therapy students and with high school service learning projects.

**Strategic Priority 3.3**

Support family and friends who are caregiving by building respite options.

The Minnesota Board on Aging will:

• Provide alternatives to one-to-one respite to maximize resources, such as group respite.
• Build a sustainable program and financial infrastructure for family caregivers to include gap filling services for unpaid family caregivers who provide care to individuals across the lifespan.
• Establish a statewide Respite Care Coalition that can, as some of its first objectives, develop and broadcast respite public service announcements and request that the Governor proclaim a state respite day.

**Strategic Priority 3.4**

Strengthen the statewide system for working caregivers to prevent or mitigate caregiver stress and burden.

The Minnesota Board on Aging will:

• Educate and work with employers to develop caregiver flexibility and supports in their policies.
• Conduct educational sessions at workplaces aimed at working caregivers to provide them with strategies and access to resources and services.

**Goal 4: Support aging in community with access to a range of services and housing options**

The MBA supports continued expansion of access to home and community-based service options for older adults, in order to provide meaningful choice for consumers. Minnesota’s Older Americans Act-funded services are targeted to individuals who are at risk for falling into the public safety net, and the demand for services continues to grow.
In Minnesota, nearly 475,000 households (23 percent of Minnesota’s 2.1 million households) included one or more people age 65 or older. As we get older, most of us want to stay living in the single family home that we own. According to an AARP study, 71 percent of people ages 50 to 64 and 87 percent of adults age 65 and older want to stay in their current home and community as they age (Harrell, et al., 2014). And, in fact, that is what the majority of older adults do. In the 2015 Survey of Older Minnesotans, 85 percent of older adults reported living in a single family home, while 13 percent lived in some sort of multi-family dwelling, such as an apartment, high-rise, or duplex. Even among those age 85 and older, 60 percent lived in a single family home.

**Older Adults Live in Single Family Homes**

![Bar chart showing the percentage of older adults living in different types of homes by age group.]

Source: Survey of Older Minnesotans, 2015

**Homeownership and Rental Rates of Minnesotans by Age of Householder**

It must be noted that not all older adults have a home. In fact, according to Wilder Research, there is a growing number of older adults who are homeless. In 2015, a total of 843 people age 55 and older were homeless. This number is expected to continue to grow with the aging of the baby boom generation. The MBA is committed to ending homelessness experienced by older adults.

**Few Older Adults Report Needing Help with Their Homes**
For those who do live in their own home, maintaining them as we get older can be difficult as the need for ongoing maintenance and repair oftentimes increases at the same time as the need for structural upkeep and accessibility modifications. And, as we get older, most of us will need help around the house or with our personal care. The majority of this help is provided to older adults in their own home by family and friends. Additional support is provided through agencies by volunteers or paid staff.

For very low-income older homeowners, meeting these multiple simultaneous needs can be extremely challenging and can often precipitate a move to assisted living or a nursing home. According to a 2015 Wilder study commissioned by the MN Housing Finance Agency, an estimated 16,400 very low-income older homeowners may need to move out of their homes within the next five years if they do not make critical home modifications and repairs. Of these, 74 percent (12,100) will also need home and community-based services (e.g. homemaker and chore). The MBA wants to make it possible for older adults to continue to live in their single family home as long as possible while receiving the help that they need.

However, due to financial or other reasons, for some older people there may come a time when they want or need to seek out other housing options. When contemplating a time when they may not be able to live independently, the proportion of SOM respondents who say they would
stay in their own home decreases with age. This is replaced by a growing proportion who say they will move to assisted living or a nursing home.

**Older Adults Want to Stay in Their Home**

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay in your home, with family/friends providing care</td>
<td>26%</td>
</tr>
<tr>
<td>Move to assisted living</td>
<td>24%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>19%</td>
</tr>
<tr>
<td>Stay in your home, with an agency providing care</td>
<td>18%</td>
</tr>
<tr>
<td>Share a residence with a child or other family</td>
<td>6%</td>
</tr>
<tr>
<td>Something else</td>
<td>3%</td>
</tr>
<tr>
<td>Move to a nursing home</td>
<td>2%</td>
</tr>
<tr>
<td>Share a residence with a friend</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Survey of Older Minnesotans, 2015

When seeking out other options, many older people would like to stay in their community. That is when aging in community becomes very important. The MBA encourages the development of a range of flexible housing and service options within communities across the state.

To ensure older Minnesotans have a range of services and housing options is a vast goal. Through our assessment, this specific goal is linked to five WHO domains; Communication and Information, Housing, Outdoor Spaces and Buildings, Transportation and Community and Health Services. In home services and housing options are interdependent in how they impact successful aging. “Housing” needs cross over into in-home service needs. In many ways an older person that has a secure and accessible physical environment is well-supported to age successfully. It is this “service and housing” interdependence that presents the unique challenge to allow older adults to continue to age well and live well in the home of their choice.
The services that an older adult might need to successfully age in community are not just limited to those that address physical limitations, such as help with personal care or with chores around the house. Service needs might also include those that help an older adult treat or manage behavioral health conditions or substance use disorders. The MBA and DHS, in partnership with the Humphrey Institute of Public Affairs, are currently undertaking an assessment of the mental health needs of the older population and the state’s current service capacity. Strategic priorities identified through this effort will be included in a future iteration of the MN2030 Plan.

**Strategic Priority 4.1**

Assist older low income homeowners to age in community through affordable home maintenance, modifications and in-home services.

The Minnesota Board on Aging will:

- Advocate for the implementation of a state-level multi-agency task force assigned to focus solely on the needs and opportunities related to older adult housing.
- Launch a public-private partnership to complete all home modifications and home maintenance repairs needed by the 16,400 very low-income homeowners at risk of needing to move.
- Request additional state funds for the Minnesota Housing Finance Agency’s (MHFA) Rehabilitation Loan Program to fund home modifications and maintenance for very low-income older home owners.
- Create a strong linkage between the MHFA Rehabilitation Loan Program and the delivery of HCBS, review local building requirements to promote aging in the community.

**Strategic Priority 4.2**

Coordinate funding support of, and service provision in, affordable and subsidized congregate housing options for older adults, ensure Landlord Tenant Law protects older adults

The Minnesota Board on Aging will:

- Explore ways to coordinate funding between Minnesota Housing Finance Agency, DHS and MBA to modernize existing affordable and subsidized congregate housing options with tele-monitoring or other technology and in-home supports.
Strategic Priority 4.3
Assist older adults to age in community through strengthened HCBS; explore options to improve current OAA core services, Elderly Waiver, Alternative Care and Essential Community Supports

The Minnesota Board on Aging will:

- Provide resources to cultural and ethnic communities and work with them to fill gaps in HCBS in ways that they need, prefer, and align with their culture.
- Increase the flexibility of OAA contracting to facilitate the delivery of multiple in-home, supportive and caregivers support services to the same individual or family.
- Pilot models of an OAA-funded “universal worker” or self-directed options that better meet the needs of older people and expand the workforce pool.
- As a member of the MN Council on Transportation Access, advocate for legislative changes to state policies and regulations that limit the availability of volunteer drivers. Advocate for increased capacity to educate, train and support providers and volunteer drivers.
- Advocate for increased reimbursement rates for “critical access” state and MA-funded HCBS that support older people in hard to reach areas, “service desert” areas, or those with complex needs.
- Advocate for a robust, multi-faceted approach to address the direct support workforce shortage that includes the provision of a living wage, benefits such as health insurance coverage, training, and provisions that allow providers to coordinate a 40 hour work week.
- Educate community groups about neighbor-helping-neighbor models such as the Beacon Hill concierge model and service credit banking to reduce or delay the need of participants for formal publicly-funded HCBS.

Strategic Priority 4.4
Assist communities to implement life cycle housing planning and development.

The Minnesota Board on Aging will:

- Provide technical assistance to communities to assess their housing needs holistically and create “communities for a lifetime”, promote “clustered” living model
Strategic Priority 4.5

Through the Heading Home Together Plan, work with others to prevent and end homelessness experienced by older adults.

The Minnesota Board on Aging will:

- Build expertise and capacity to serve older individuals with complex needs in the community through resource development targeted referrals to reduce unnecessary institutionalization.
- Ensure programs for older adults (Senior LinkAge Line®, Caregiver Consultants, and Cultural Consultants) and grantees (Senior Corps, Dementia grantees, Eldercare Development Partnerships and Live Well at Home grantees) make the appropriate referrals if the individual discloses homelessness and is looking for assistance.
- Enhance discharge planning for older adults at risk of homelessness by working with Senior LinkAge® Line and the Office of Ombudsman for Long Term Care.
- Align process to assist with forms completion for economic assistance programs for older adults through Senior LinkAge Line®, DHS grantees and Area Agencies on Aging (Special Access Programs). This includes, but not limited to setting up a bank account, assisting with pensions, entitlement programs (Social Security, Medicare and Medicaid) and other public assistance programs.
- Align the work of the MBA Indian Elder Services Coordinator with the MN Tribal Nations and Urban American Indian Elders to identify and develop protocols for referrals for Native American elders who are homeless.
- Increase the availability of culturally-specific services, programs, and housing opportunities to better reflect preferred options and choices responsive to the needs and interest of people experiencing or at risk of homelessness.
Goal 5: Ensure the rights of older people receiving long-term care services

The mission of the Office of Ombudsman for Long-Term Care (OOLTC) is to enhance the quality of life and the quality of services for consumers of long-term care services (LTSS) by conducting individual complaint investigation, systemic advocacy, and community involvement through advocacy, education, and empowerment.

Ombudsmen envision a time when all consumers will receive high quality health and long-term care services that are free from abuse, honor rights and have built in proper consumer protections. Ombudsmen work to prevent abuse by promoting person-centered planning, and encourage consumer choice by honoring choices in living arrangement and services. The Ombudsmen also ensure the service provider is properly trained to meet individual needs, particularly for those who require dementia care due to a diagnosis of advanced dementia.

People receiving LTSS are not always able to effectively advocate for themselves due to a number of factors. The factors include but are not limited to; diagnosis, age discrimination, fear of retaliation, and a lack of information about their rights. The Older Americans Act enshrines the duties of Ombudsmen staff and volunteers in federal and state law to assist individual consumers with problem-solving through a consistent presence in long-term care settings and responding to calls for assistance. A regular presence by Ombudsmen and Ombudsmen Volunteers is necessary to ensure rights are honored, to provide education, encourage empowerment and bridge collaboration with service providers.

Systemic advocacy aims to create change in laws, regulations, policies and community attitudes by providing a more informed understanding based on the experiences and challenges of seniors and vulnerable adults who receive long-term services and supports. Systemic advocacy occurs as a result of the Ombudsmen and Volunteer work day to day. Knowing the consumer experience through advocacy and educational efforts mobilizes the Ombudsman Office to partner with other consumer groups, public agencies, policy makers, service providers, and citizens to enhance the well-being of older and vulnerable Minnesotans.

The MN Elder Justice Roadmap is a critical component of the MN2030 initiative that, ideally, will convene the OOLTC with partners to identify shared priorities to prevent and end elder abuse, neglect, and exploitation. MBA, OOLTC and DHS Adult Protection will work with the MN Elder Justice Center, and all interested partners, to develop this roadmap and begin a more coordinated and focused approach to elder justice.

Strategic Priority 5.1

Expand and support the capacity of the Ombudsman for Long-Term Care program through paid staff to serve all people who receive LTSS from: nursing homes, board and care homes, home care consumers, and Veterans Homes.
The Office of Ombudsman for Long-Term Care will:

- Review individual complaint investigations.
- Provide information and consultations.
- Offer support to resident and family councils.
- Maintain to provide a statewide presence.

**Strategic Priority 5.2**

Expand the capacity of the Ombudsman for Long-Term Care Program through use of certified Ombudsman volunteers (COVs).

The Office of Ombudsman for Long-Term Care will:

- Establish goals and objectives for the volunteer program based on current need/trends of the LTSS consumer and data analysis of volunteer activities.
- Implement a statewide training curriculum for COVs comparable to the goals and objectives of the volunteer program.

**Strategic Priority 5.3**

Expand outreach and education about resident rights, consumer protections, person-centered planning/care etc. to resident/family/tenant councils, providers of service, legislators, community organizations, and other government agencies at the national, state, and local levels. Expand legal resources for consumers served by OOLTC.

The Office of Ombudsman for Long-Term Care will:

- Offer in-service training on resident rights and other topics of interest related to serving people who receive long-term services and supports.
- Conduct advocacy service outreach to cultural and ethnic communities.
- Conduct advocacy outreach to Legislators.
- Reach out to legal service providers statewide willing to serve consumers of LTSS.

**Strategic Priority 5.4**

As part of the MN2030 strategic planning process the Ombudsman’s Office will work in collaboration to forge dynamic partnerships aimed to promote awareness and prevention of elder abuse.
Work to promote better policy and practice that improves the lives of vulnerable and abused adults

The Office of Ombudsman for Long-Term Care will:

- Elevate public awareness about elder abuse and elder justice
- Provide opportunity for community discussions in policy development.
- Explore systemic barriers to elder abuse prevention and elder justice work with APS, law enforcement, courts, non-profit advocacy groups, state agencies, and others to develop and implement comprehensive solutions.
List of Attachments

A. FFY 2019 - 2022 State Plan Guidance
B. Information Requirements
C. Intrastate Funding Formula
D. Status Check Documents
E. Policy Brief Documents
F. Map of MIAAA Services
G. Healthy Aging in Minnesota: A Priority for Interagency Collaboration
H. Acronyms
I. Public Comment Narrative
J. Goals and Specific Measures
K. MN 2030: The Future of Elderly Waiver
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 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service 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.

(a)(2)(B) The State agency shall 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.

(a)(2)(E) The State agency shall 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;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall 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 and older individuals residing in rural areas.
(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies 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.

States must assure 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 (a), AREA PLANS

(2) Each area agency on aging shall 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 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 who are victims of 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.

(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 subclause (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;
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

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

With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

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

provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

Each area agency on aging shall 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--

older individuals residing in rural areas;

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

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

older individuals with severe disabilities;

older individuals with limited English proficiency;

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

older individuals at risk for institutional placement; and

Each area agency on agency shall provide 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.

Each area agency on aging shall 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.

Each area agency will:

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

(9) Each area agency on aging shall 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 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall 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.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will 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.

(13)(C) Each area agency on aging shall provide assurances that the area agency will 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 non-governmental contracts or such commercial relationships.
(13)(D) Each area agency on aging shall provide assurances that the area agency will 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 non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, 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) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out 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;

(17) 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.

Sec. 307, STATE PLANS

(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.

(7)(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.
(9) The plan shall provide assurances that 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 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance 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)(A) The plan shall provide 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 (A) 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.

(11)(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.

(11)(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;
(11)(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, 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--

(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) 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
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(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.

(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 funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) 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.

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

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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
REQUIRED ACTIVITIES

Sec. 307 (a) STATE PLANS

(1)(A) The State Agency requires 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) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO
STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, 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) has developed a standardized process to determine the extent to which public or private
programs and resources (including Department of Labor Senior Community Service
Employment Program participants, and programs and services of voluntary organizations) have the
capacity and actually meet such need;

(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). Note: “Periodic” (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal
year.

(5) The State agency:

(A) affords an opportunity for a public 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) issues guidelines applicable to grievance procedures required by section 306(a)(10); and (C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a 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 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.

(8)(A) No supportive services, nutrition services, or in-home services are 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.

Kari Benson
Executive Director, Minnesota Board on Aging
Signature and Title of Authorized Official

6/26/2018
Attachment B

Information Requirements

Section 305(a) (2)(E)

*Describe the mechanism 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;

**Minnesota:** 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) (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.

**Minnesota:** 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 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) (Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category of service.

Minnesota:
Access: minimum of 5% of III-B allocation
In-Home: minimum of 5% of III-B allocation
Legal Assistance: minimum of 5% 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 that the State agency will spend for each fiscal year of the plan, 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).
(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year in which such plan applies.

Minnesota:

FFY2019: $10,916,360
FFY2020: $10,916,360
FFY2021: $10,916,360
FFY2022: $10,916,360

In FFY 2017, 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 assurances 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.
Minnesota: 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.

Minnesota: There are 12,219 low-income minority older individuals in Minnesota. An estimated 5,548 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 ten culturally-specific community organizations to serve their elders. Special Access Programs 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. Special Access providers now serve older adults in regions (southwestern and southeastern) outside most densely populated urban area. In at least four service areas outside of the Metropolitan area, nutrition providers offer ethnic meals to different ethnic and cultural groups. Other providers offer evidence-based health promotion interventions to older adults. The Minnesota Indian Area Agency on Aging (MIAAA) 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

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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 (title III), if applicable, and specify the ways in which the State agency intends to implement the activities.

Minnesota: 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 Indian Elders Coordinator staff person coordinates the Wisdom Steps preventive health program that was designed by Native American elders and works with the AAAs to continue to provide more services in their communities.

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) (29)

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.

Minnesota: 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 307(a) (30)

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.

Minnesota: The head of the Minnesota Board on Aging designates staff to be actively involved in the development, revision and implementation of emergency preparedness plans. The MBA Executive Director participates in regular meetings with leadership of the other state agencies to review and update the plans. The MBA Executive Director is briefed on the most current plan by MBA staff and participates in drills to practice the relevant protocols that must be implemented in response to an emergency.

Section 705(a) (7)

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).

Minnesota: 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

INTRASTATE FUNDING FORMULA

(Submitted 7/1/2004)

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.

A. 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;

B. 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 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%).

e. "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:

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

#### 2018 ALLOCATIONS

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

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**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Number of persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>1,307</td>
</tr>
<tr>
<td>Black</td>
<td>1,451</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>468</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>12</td>
</tr>
<tr>
<td>Other race</td>
<td>358</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>794</td>
</tr>
<tr>
<td>Total</td>
<td>4,390</td>
</tr>
</tbody>
</table>

*Source: 2010 U.S. Census*
Status Check
BALANCING THE LONG-TERM SERVICES AND SUPPORTS SYSTEM

MINNESOTA BOARD ON AGING

AUGUST, 2017
REIMAGINING THE FUTURE OF AGING

The Minnesota Board on Aging, in partnership with the Minnesota Department of Human Services, is looking forward to 2030. Today marks the midpoint between our original vision for the long-term services and supports (LTSS) system, and the year that baby boomers start turning 85. It is truly a transformative time in our communities. To that end, we are revisiting our multi-year commitment to prepare for a permanently older society. Across all Minnesota communities, sectors and generations, we aim to refresh and refocus our efforts. In 2000 Minnesota worked with key stakeholders and developed a report called Reshaping Long-Term Care in Minnesota, known as the Long-Term Care Task Force Report. The Long-Term Task Force Report identified six broad goals and 15 strategies to prioritize action.

This Status Check document focuses on progress made on two of the goals from the report: Policy Direction #2: Expand capacity of community long-term care system; and Policy Direction #3: Reduce Minnesota’s reliance on the institutional model of long-term care.

The outcome of efforts under these two goal areas is more currently referred to as “balancing” the LTSS system. That is, balancing the range of services available between home and community-based services (HCBS) and nursing home services. With a balance of services available to us as we get older and need some help we are afforded meaningful choices for how we get that help and where we live.

Why is this important?

As we grow older, most of us live in the home that we own and that’s what we prefer. When we need some help around the house or with our personal care, we want to be able to get that help while we stay at home. Most of the help that is provided to older Minnesotans at this time comes from family, friends and neighbors. However, that is not always possible and in-home services can meet that need.

LTSS refers to on-going supports that an individual needs due to a chronic health condition or disability. These services can be delivered in a person’s home, in another community setting, or in an institutional setting. Currently, LTSS is the nationally recognized term for this range of services and is used by the federal government. The term HCBS refers to LTSS that are delivered in homes or other community-based settings, not in institutional settings.

Historically, in Minnesota we have relied heavily on nursing homes to provide this help. The 2000 Task Force sought creative solutions to reduce our reliance on nursing homes and build our capacity for HCBS, thus “balancing” our system of LTSS. We have made substantial progress in finding resourceful ways to provide HCBS.
Where do we stand today?

Below are two tables that illustrate our progress on the two goals related to “balancing” our state’s LTSS system. When considering the states’ “balancing” effort reviewing the share of expenditures devoted to people in each setting and the number of people served in a setting are central criteria to measure success.

The first table compares the percent of Medical Assistance (MA) LTSS expenditures for people in nursing homes to MA-funded HCBS. In table 1 the state reduced reliance on nursing homes, decreased the proportion of MA LTSS dollars spent on nursing home services and increased the proportion spent on HCBS. With this systematic effort to decrease spending on nursing home services to HCBS expenditures we could say that our system is “balanced.”

![Graph showing percent of LTSS expenditures for Older Adults over years]

### Table 1: Percent of LTSS Expenditures for Older Adults

<table>
<thead>
<tr>
<th>Year</th>
<th>Nursing Home</th>
<th>HCBS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* HCBS programs include the Elderly Waiver, Alternative Care, State Plan Home Care  
Source: DHS Data Warehouse
The second table demonstrates the number of older Minnesotans receiving MA-funded HCBS compared to people served in a nursing home. 2005 was a seminal year because it was the first-time Minnesota’s LTSS system was in alignment. From that point on the Minnesota increased momentum. By state fiscal year 2014, 70 percent of older adults received HCBS as compared to 30 percent living in nursing homes. This is a dramatic improvement from state fiscal year 2000 when only 40 percent of older adults received HCBS and 60 percent lived in nursing homes. As a result of the shift to HCBS, the state also increased capacity of the long-term care system. With the shift to HCBS, community services were expanded to meet needs in the community.

Table 2: Percent of Older Adults using HCBS* vs. Nursing Homes (SFY 2000-2016)

* HCBS programs include the Elderly Waiver, Alternative Care, State Plan Home Care

Source: DHS Data Warehouse

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In-Home HCBS and Residential HCBS

As the previous data illustrates, we can describe our state’s overall system of LTSS as “balanced.” The tables below go a bit deeper to display trends of HCBS by comparing in-home and residential HCBS utilization.

Through the Elderly Waiver (EW) program, older adults are able to receive publicly-funded HCBS in their own home or in a residential setting. Over time, the proportion of older adults receiving MA-funded in-home HCBS has remained steady, as shown in the graph below (table 3). This data shows that some older adults receive a range of help while living in their own home, instead of moving to assisted living or other congregate residential settings. The data not only includes the EW program but also Alternative
Care, Essential Community Supports, Personal Care Assistance, Consumer Support Grant, home care nursing, and home health agencies. The trend is important because HCBS are typically less expensive to provide when people live in their own home.

Table 3: Percent of Older Adults receiving HCBS in their own homes* (SFY 2012-2016)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>70.0%</td>
</tr>
<tr>
<td>2013</td>
<td>69.5%</td>
</tr>
<tr>
<td>2014</td>
<td>69.7%</td>
</tr>
<tr>
<td>2015</td>
<td>69.6%</td>
</tr>
<tr>
<td>2016</td>
<td>71.7%</td>
</tr>
</tbody>
</table>

* This represents people served in the HCBS programs who receive services in their own home rather than in a residential setting, such as customized living or foster care

Source: DHS Warehouse

EW is the only HCBS program serving older adults that offers residential services. The services are Adult Foster Care, Customized Living and Residential Care. The chart below (table 4) shows a steady rise in the number of people on EW that receive the most frequently-used residential service: customized living. In 2000, approximately 3,700 people received customized living services and in 2016 the number increased to 12,600. This trend mirrors the statewide growth in the availability of assisted living for both private pay individuals as well as those on EW.

Table 4: Number of People using Customized Living Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>3,700</td>
</tr>
<tr>
<td>2016</td>
<td>12,600</td>
</tr>
</tbody>
</table>

Residential services are supportive services provided to a person in qualified settings. Customized living is a bundled set of services that include health-related components that may be offered by a home care provider in a registered Housing with Services setting. It is commonly referred to as assisted living.
Use of Nursing Home Services

The number of nursing home beds in Minnesota has decreased consistently over the last 25 years. The projection for the next 16 years continues this trend, with the number of actual beds in 2014 (30,879) decreasing to 22,825 projected beds by 2030. Occupancy in Minnesota’s nursing homes has ranged between a high of 95.4 percent in 1993 to a low of 89.1 percent in 2014. This rather narrow range of occupancy has been maintained in recent years largely by taking beds out of service. Occupancy is important to monitor for two reasons. First, if occupancy were too high, consumers would have difficulty accessing nursing home services and would have limited choice. Second, low occupancy would put a financial strain on facilities and reduce the overall efficiency of the industry.

Looking Forward

Innovation can change the way we age. Minnesota has had an impressive history of developing a range of programs and services to provide LTSS. As a result, we can describe our state’s overall LTSS system as “balanced.” However, there are significant differences in communities across the state in the availability of existing HCBS and nursing home options. And, as we look forward to Minnesota becoming an older society, it is important to compare current capacity to projected future needs – and preferences. The permanent age shift presents an opportunity for us to create the kind of future we all want as we grow older. We can seize this opportunity by reimagining where we live and how we receive the help that we might need as we grow older.

How can I learn more?

Join the conversation! Go to the MN2030: Looking Forward website to find out more about the initiative and how you can get involved. There you will find tools to help you be a part of the conversation to shape our state’s future.
Status Check
DEVELOPING STRATEGIES IN CULTURAL
AND ETHNIC COMMUNITIES

MINNESOTA BOARD ON AGING
SEPTEMBER 2017
REIMAGINING THE FUTURE OF AGING

The Minnesota Board on Aging, in partnership with the Minnesota Department of Human Services, is looking forward to 2030. Today marks the midpoint between our original vision for the long-term services and supports (LTSS) system, and the year that baby boomers start turning 85. It is truly a transformative time in our communities. To that end, we are revisiting our multi-year commitment to prepare for a permanently older society. Across all Minnesota communities, sectors and generations, we aim to refresh and refocus our efforts. In 2000 Minnesota worked with key stakeholders and developed a report called Reshaping Long-Term Care in Minnesota, known as the Long-Term Care Task Force Report. The Long-Term Care Task Force Report identified six broad goals and 15 strategies to prioritize action. This document provides a snapshot of our current status in one of those goal areas, specifically – Developing Strategies in Cultural and Ethnic Communities.

Developing Strategies in Cultural and Ethnic Communities

Why is this important?

The Long-Term Care Task Force identified “Service Gaps in the Community” as a principal theme for all older Minnesotans. The report stated there are gaps, “especially immigrant elders, have difficulty finding and coordinating services.” The report called for specific strategies to assist cultural and ethnic communities. Two such strategies included outreach with useful information for minority communities and to expand capacity of the community long-term care system and “Provide long term care that is responsive to the special needs of elders in ethnic, immigrant and tribal communities.”

While the population of older people of color or American Indian elders remains relatively small, the population is expected to grow and with it, a rise in the number receiving home and community based services (HCBS).

Alley

Aging Data Profiles: Minnesota Population by Race and Ethnicity

<table>
<thead>
<tr>
<th>Year</th>
<th>Total 65+</th>
<th>White non-Hispanic</th>
<th>Black or African American</th>
<th>Asian</th>
<th>Hispanic or Latino</th>
<th>American Indian Alaskan Native</th>
<th>Two or More races</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How are we doing so far?

The state of Minnesota has developed many strategies to reach and provide supports and services to older people of color and American Indian elders. To showcase those efforts this status check is divided into four parts; I. Initiatives that involve outreach efforts; II. Specific projects intended to increase cultural and ethnic community capacity; III. Data on the trends in service use for people of color and American Indian population in Minnesota; IV. Data from the recent National Core Indicators for Aging and Disabilities survey (NCI-AD).

Education and Outreach

Senior LinkAge Line®. The Senior LinkAge Line® is the Minnesota Board on Aging’s free statewide service that provides options counseling. The Senior LinkAge Line® service is provided by six Area Agencies on Aging (AAA) that cover all 87 counties of Minnesota. The Minnesota Board on Aging (MBA) supports these AAA to fulfill a statutory requirement to ensure a Senior LinkAge Line® presence at the neighborhood level. An emphasis is placed on outreach to older people in cultural and ethnic communities. Examples of this outreach to tribal elders include:

- The provision of health insurance counseling for the American Indian tribes, delivered in partnership with Indian Health Services and the Centers for Medicaid and Medicare Services (CMS);
- Senior LinkAge Line® booths at health fairs, pow wow attendance and sponsorships;

In November 2015, the MBA in partnership with the AAAs, ECHO TPT (Emergency Community Health Outreach, Twin Cities Public Television), providers and community members developed a combined media and outreach campaign to offer information and resources for new immigrant caregivers. The initiative included videos titled “Caregiving for Older Adults.” The videos were produced in five languages: Cambodian, English, Hmong, Somali and Spanish.

Cultural Awareness in Dementia Care. The MBA started an initiative in 2016 called “Cultural Awareness in Dementia Care” to assist community organizations with their outreach and service delivery to diverse ethnic and cultural communities. “Cultural Awareness in Dementia Care” promotes principles of health equity and enhances person-centered dementia care for diverse ethnic and cultural communities who most often experience health disparities.
Alzheimer’s disease and related dementias (ADRD) disproportionately affect members of ethnic and cultural communities who also have high rates of diabetes, hypertension and cardiovascular disease - risk factors for Alzheimer’s disease. African Americans are two times and Latinos 1.5 times more likely to develop Alzheimer’s disease than whites. The “Cultural Awareness in Dementia Care” initiative was intended to increase awareness among aging service providers and healthcare personnel about the norms and values of specific ethnic and cultural groups to assist them in providing better service. Individuals from four cultural communities: African American, American Indian, Latino/Hispanic/Chicano, and Somali, were selected to complete on-line and inperson dementia trainings to become consultants as part of this initiative. The cultural consultants are available to provide technical assistance to organizations wishing to provide more culturally competent dementia care.

**MBA Dementia Grants.** The MBA Dementia grants are intended to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, and/or connect caregivers of persons with dementia to education and resources. One area of special focus is projects that originate from culturally focused organizations or serve culturally and racially diverse older adult populations.

**Wisdom Steps.** Wisdom Steps is a partnership among the eleven Minnesota Indian tribes, three urban areas (Minneapolis/St. Paul, Duluth and Bemidji) and the MBA. Wisdom Steps invites Tribal Elders to participate in activities that build their health. Wisdom Steps was created by American Indian elders for American Indian elders to overcome barriers to a healthier life. By 2030, there will be more than 16,000 American Indians over age 55 compared to 5,000 in 1997. Resources and activities help the tribal elders take steps to improve their health. These efforts are recognized and celebrated at an annual Wisdom Steps conference which has an average of 400 attendees each year. The three-day event provides health education, health screenings and healthy living activities for elders in Minnesota’s American Indian communities.

**Community Service Capacity**

Three Live Well at Home (LWAH) grants exemplify development of services by cultural and ethnic communities for their older members. First, in 2008 and 2009 SunLight Investments, Inc. in St. Paul used a LWAH grant to leverage a loan and commence development on their 35-unit assisted living facility. The grantee originally intended to serve Hmong elders and later found a need to serve other Asian elders. Serving an ethnically and culturally diverse population, they made adjustments in staffing, menus, and programming in order to cater to each individual’s needs. Languages spoken by residents include Vietnamese, Lao, Chinese, Hmong and Cambodian.

The next two examples describe how LWAH grantees expanded service capacity to meet the adult day needs of cultural and ethnic communities. Adult day services are beneficial for older adults as well as family caregivers. Participants have an opportunity to socialize with others in a safe environment, get assistance with their activities of daily living, such as bathing, toileting and eating,
while family caregivers can get a break or attend to other responsibilities, knowing their loved one is safe. These services are particularly helpful for working caregivers.

In 2009, Communidades Latinas Unidas En Servicio (CLUES) in Ramsey County, a human service organization that supports the Latino community in Minnesota, opened a licensed adult day service for Latino elders. The organization renovated the space to be used for the program to comply with licensing regulations. This program serves a vulnerable and hard-to-reach population and has grown in the years since it opened.

Third, in 2015 the Minnesota Chippewa Tribe used LWAH grant dollars to build the very first adult day in the nation to serve American Indian elders. The adult day can serve up to 10 people that are both private pay and on public assistance. In addition to the LWAH grant-funded efforts, the AAAs have worked extensively with cultural and ethnic communities as well as the American Indian tribes to build capacity to serve their older community members. The AAAs have worked with their contracted nutrition providers and local community organizations to develop culturally specific congregate dining sites in multiple regions throughout the state. Examples of these programs include those serving Lao, Somali, Hmong, and Hispanic or Latino elders.

The Metropolitan AAA contracts with several cultural and ethnic community organizations to offer Older Americans Act-funded Special Access Programs. These programs provide helpful information and referral, advocacy, translation/interpretation, and short-term case management support for older people of color and non-English-speaking elders to help them access services and connect to community. Contracted organizations include:

- Brian Coyle Center
- Centro
- CLUES
- Division of Indian Work (GMCC)
- Korean Service Center
- Lao Advancement of America
- United Cambodian Association
- Volunteers of America (VOA) Minnesota
- Bhutanese Community Center
- Other AAAs are also funding Special Access Programs in cultural and ethnic communities in order to better reach older people of color

**Use of Home and Community-Based Services by Race and Ethnicity**

The Long Term Care Task Force outlined the need to expand the capacity of the long-term care system and reduce Minnesota’s reliance on the institutional model of long-term care, commonly referred to as “balancing.” Through the efforts described in the previous sections and many others, the state has made strides to help older people of color and American Indian elders receive services in their home and community. Below is a snapshot depicting the use of HCBS for older people of
color and American Indian elders. Since 2012, enrollment for people of color and American Indians into all HCBS programs (figure 4) has increased slightly. Figure 4 represents older people who fit into at least one of the following categories: 1) those who have received Alternative Care (AC) or Elderly Waiver (EW) services, 2) those who are 65 years of age or older and have received home health, personal care assistance (PCA) and home care nursing (HCN) services, or 3) those who are 65 years of age or older and have received services through a consumer supported grant (CSG).

(Figure 4. Data Source: LTC Spending File, 2017. “N” represents total number of people age 65 or older in HCBS programs)

The illustration below (figure 5) shows that since the end of 2014 the percentage of older people of color and American Indian elders receiving state plan home care compared to the white population has increased. State plan home care can offer a range of medical and social services but unlike EW or AC the person does not need to meet the level of care to live in a nursing home. The state plan home care population includes people age 65 and over who received services through the personal care assistance (PCA), home care nursing, and/or home health programs. The data below represents counts of program recipients in January of each year.

This graph also suggests a need for a deeper dive into the many factors that affect how a person enters the LTSS system and begins to use services. It appears older people of color and American Indian elders may first begin receiving state plan home care and later become eligible for EW. These older adults are eligible for Medical Assistance (the name for the Medicaid program in Minnesota) when they enter the system and then eventually navigate to more intense LTSS. Conversely, the white population may have the financial resources to initially pay for LTSS when they first enter the system, and then spend down and become eligible for Medical Assistance.
Older Americans Act (OAA) programs serve people age 60 and older and include home delivered meals, homemaker and chore services, and assisted transportation. Data presented in the table below shows that OAA programs serve a higher percentage of older adults of color and American Indian elders than the percentage in the general population. For example, Black or African American older adults are approximately 3 percent of the OAA service users, but are about 2 percent of the total population of people age 60 and older in Minnesota.

<table>
<thead>
<tr>
<th>OAA Registered Service Use by Race and Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Black/African American</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Two or More</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Percentage of those without missing race and ethnicity data (Registered services include homemaker, chore, home delivered meals, assisted transportation, congregate meals in FFY 2016)
Feedback from Older People who Receive Services

The most important way to measure the effectiveness of Minnesota’s LTSS system is to ask the people who receive the services. The National Core Indicators Survey (NCI-AD survey) is a tool that is used by states to assess their LTSS system. The survey is a 45 minute in-person interview with people who receive publicly-funded LTSS, with a particular emphasis on gathering feedback from older people of color. The people interviewed received services through at least one of these programs: Older American Acts, State Plan home care, AC and EW.

The NCI-AD survey assesses an older adult’s perception about their health, such as self-reported health, feeling in control of their lives, and psychological well-being (how often they feel sad). The survey also looked at their social well-being, such as community enjoyment (being able to do things they enjoy outside of their homes), social relationships (can see or talk to friends and family when they want to), feeling safe at home and service satisfaction. The table below (Figure 1) is a breakdown by race of older Minnesotans that participated in the NCIAD survey.

<table>
<thead>
<tr>
<th>Race</th>
<th>Freq.</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>1,405</td>
<td>72.57</td>
</tr>
<tr>
<td>Black</td>
<td>246</td>
<td>12.71</td>
</tr>
<tr>
<td>Asian</td>
<td>133</td>
<td>6.87</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>38</td>
<td>1.96</td>
</tr>
<tr>
<td>Multiple races</td>
<td>114</td>
<td>5.89</td>
</tr>
</tbody>
</table>

(Figure 1)

Minnesota’s LTSS system strives to support older people in their own home and community for as long as possible and to help them maintain their independence. To that end, the NCI-AD survey data is used to gauge the overall risk of nursing home placement across populations. The data below shows that Black, Asian and Hispanic/Latino older adults indicated significantly higher levels of need with activities of daily living (ADLs) than white older adults, a predictor of nursing home placement. Forgetfulness, an early sign of cognitive impairment, is another predictor of nursing facility placement. More than half of Asian and Hispanic/Latino older adults reported they forget things more often than before during the past 12 months, a significantly higher proportion than in the white population. In contrast, Asian and Hispanic/Latino older adults were significantly less likely to live alone than white older adults. Living alone in your home may lead to social isolation and general decline in overall health, also risk factors for nursing facility placement.
Lives alone (n=1743) Need some or a lot Do not always get Reported they forget History of Frequent falls assistance with self-care enough assistance with things more often than (> 2 falls in a 6-month (n=1962) self-care (n=1071) before during the past period) (n=1899) 12 months (n=1849)

(Figure Table 2. *Indicated having a significant difference compared to white respondents)

The following graph (figure 3) measures the overall service satisfaction across populations. Both the Black and Hispanic/Latino population experienced significantly worse levels of satisfaction with the indicator, “Services meet all their needs and goals.” Additionally, when asked if they “know whom to call if they have a complaint about their services” a significantly lower proportion of the Black, Asian and Hispanic/Latino older adults answered yes. This measurement is important because these data show continued room for improvement with the strategy outlined by the Long-Term Care Task Force Report to increase a presence in communities of color. When asked about provider choice and recommending staff, all populations exhibited a satisfactory experience.

(Figure 3. *Indicated having significant difference compared to white respondents)
Looking Forward

Minnesota has a strong history of developing a range of programs and services to meet the needs of older people of color and American Indian elders, but there is room for improvement. Progress with programs like Wisdom Steps and Cultural Awareness in Dementia Care along with the LWAH grants are positive signs related to goals of the Long-Term Care Task Force. As the NCI-AD data suggests some areas of the LTSS system are strong while other topics show room for improvement.

As indicated in section III there has been a slight increase in the proportion of older people of color using services in their home or community rather than an institution. As a state, the aim is to continue this trend. In the future, a closer analysis of this data and the proportion of older people of color and American Indian elders living in congregate settings compared to the white population is needed. This analysis could help target efforts to improve the experience of older people receiving LTSS across all populations.

How can I learn more?

Join the conversation! Go to the MN2030: Looking Forward website to find out more about the initiative and how you can get involved. There you will find tools to help you be a part of the conversation to shape our state’s future.
Status Check

FLEXIBLE AND SELF DIRECTED SERVICE MODELS

MINNESOTA BOARD ON AGING

SEPTEMBER 2017
REIMAGINING THE FUTURE OF AGING

The Minnesota Board on Aging (MBA), in partnership with the Minnesota Department of Human Services (DHS), is looking forward to 2030. Today marks the midpoint between our original vision for the long-term services and supports (LTSS) system, and the year that baby boomers start turning 85. It is truly a transformative time in our communities. To that end, we are revisiting our multi-year commitment to prepare for a permanently older society. Across all Minnesota communities, sectors and generations, we aim to refresh and refocus our efforts.

In 2000 Minnesota worked with key stakeholders and developed a report called Reshaping Long-Term Care in Minnesota, known as the Long-Term Care Task Force Report. The Long-Term Care Task Force identified six broad goals and 15 strategies to prioritize action. This document provides a snapshot of our current status in one of those goal areas, specifically – Flexible and Self Directed Service Models.

Flexible and Self Directed Service Models

Why is this important?
The 2000 Long-Term Care Task Force outlined six major policy directions which addressed specific themes from the vision statement. Within each of the six major policy directions, the task force recommended strategies to address each major goal. The first major policy direction “Maximize peoples’ ability to meet their own long-term care needs” called to retool the long-term care system and redesign key components through expanding consumer directed care. The report also stated Minnesota must measure the, “proportion of Medicaid longterm care dollars spent on consumer-directed care.” In the spirit of those directives this status check will review important developments in the consumer-directed care since the report.

Consumer-directed or self-directed care allows older people to choose and design their support and services rather than the traditional LTSS model which centers on a provider delivering one or more services from a fixed menu. Consumer-directed care give the person control over who provides the service, when services are provided, and how services are delivered. With this flexibility an older person can hire and fire those people that provide services for them. At the heart of consumer directed care is the person’s expertise about their own needs to maintain community living.

The consumer directed option is available for older Minnesotans across the continuum of care. Specifically the consumer directed option is administered through the Older Americans Act (OAA), Alternative Care (AC), Elderly Waiver (EW) and the Live Well at Home Program.
How are we doing so far?

The self-directed service model was established as a service option for older Minnesotans of various socioeconomic backgrounds and with a broad range of need for assistance. A three year grant from the Robert Wood Johnson Foundation (2004-2007) enabled the state to promote the Consumer Directed Community Services (CDCS) model for older people, and identify best practices throughout the state (Source: Status of Long Term Services in Minnesota Report 2006).

Self-Directed Services – Older Americans Act

The self-directed services (SDS) model funded by Older Americans Act (OAA) is directed by the MBA and administered by the Area Agencies on Aging (AAA). Older people using the self-directed model work with a fiscal support entity (FSE) to manage payments to eligible service providers.

The SDS model under Title III of the OAA is a viable option for a caregiver because it can offer respite and nutritional interventions to individuals at high risk. This model has also worked well for people whose needs are unique and cannot be met through the traditional OAA service delivery network. People with Alzheimer’s disease and related dementias and their family caregivers are an example of a particular population that has benefited from this model.

The AAAs have worked with traditional service providers to offer care consultation and access to a one-time SDS grant. The older adult matches the grant dollar-for-dollar with their own funds, develops an action plan to address issues that might cause them to move, and receives assistance in purchasing services and supports. At the time that their SDS grant runs out, the vast majority of participants continued to use their own dollars to purchase the help that they need and to maintain their community living.

In either model, the core role for the eligible individual is to define and manage individual services and supports including workers. Key responsibilities are:

- Develop a spending plan
- Work with the FSE to hire and manage workers
- Implement and evaluate services
- Manage spending
- Contribute to the cost of services unless exempt
- Consent to use self-directed services in accordance with established policy and other applicable federal and state regulations

Elderly Waiver and Alternative Care - CDCS

In April 2005, CDCS became available to people receiving services through EW and AC (Source: Status of Long
Term Services in Minnesota, 2006) And by April 2009, 44 counties, 7 managed care organizations and one American Indian tribe implemented CDCS for one or more older person. As of 2016, at least one resident in all 87 counties participated in CDCS. Overall the use of the CDCS option has increased starting with 189 people on EW in 2005 to 364 in 2016. For AC in 2005, twenty people chose CDCS as compared to 199 in 2016.

(Source: February 2017 DHS Forecast)

A person on EW or AC that chooses CDCS must develop an individual community support plan that identifies the services that will be provided and how goods and services will be purchased. The community support plan typically has a mix of both paid and non-paid services the person chooses. The plan must also specify the overall outcomes expected by CDCS as well as how services will be monitored. In the spirit of flexibility offered by CDCS, people may choose alternative services that must meet a specific identified need that support their community living goals. Because of CDCS’ flexibility someone may hire a family member to provide them with the help that they need.

**EW and AC CDCS Budget Amounts**

Like all recipients of EW and AC a recipient must stay within a budget based on their most recent assessment of need. The level of need is translated into a case mix. The case mix is linked to a monthly budget amount a person can use under EW and AC. DHS establishes rates for most EW and AC services. Like all EW and AC services, CDCS must stay within the assigned budget cap to purchase services. Uniquely, CDCS budget cap limits are set at a lower rate for each case mix category. As of August 1, 2017, on average a person electing to use CDCS through AC can expect to receive 69% of the monthly budget received by a person not using the CDCS option. For EW, on average someone on CDCS can
expect 55% of the monthly budget compared to someone not using CDCS (Source DHS LTSS Rate Sheet, pages 52 and 53).

Originally, the CDCS budgets for EW and AC were calculated based on the average expenditures for all EW and AC services, excluding the costs for three residential services: adult foster care, residential care and customized living.

**Looking Forward**

Since the Long-Term Care Task Force Report recommended expanding “efforts to test the applicability of consumer-budgeted and directed care,” the state has implemented the consumer directed model for older Minnesotans across payer sources and for people with varying levels of need. The report also recommended that “a proportion of Medicaid long-term care dollars be spent on consumer-directed care.” The state has succeeded in doing this as well. However, it is believed that greater uptake of the consumer directed option across programs would occur if the full case mix budget were available to people using CDCS, as it is with those receiving the traditional model of service delivery. This change would give older Minnesotans more choices to

support themselves in their home. Additionally, increasing the CDCS monthly case mix budget may particularly help in areas of the state where provider supply and worker supply is low. Overall CDCS participation has increased over the years but until the budgets are adjusted it is difficult to compare against traditional AC or EW services.

**How can I learn more?**

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REIMAGINING THE FUTURE OF AGING

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#4: Align systems to support high quality and good outcomes.

Long-term services and supports (LTSS) refers to on-going supports that an individual needs due to a chronic health condition or disability. These services can be delivered in a person’s home, in another community setting, or in an institutional setting. Currently, LTSS is the nationally recognized term for this range of services and is used by the federal government. The term home and community-based services (HCBS) refers to LTSS that are delivered in homes or other community-based settings, not in institutional settings.

Why is this important?

The Long-Term Care Task Force recognized that central to any effort to improve Minnesota’s LTSS system must be a focus on achieving high standards in service quality. The task force recommended measuring the quality of services and quality of life for older Minnesotans across LTSS settings, from HCBS received in one’s own home to services received in a nursing home. The task force emphasized the importance of consumer protection by ensuring adequate capacity for the Office of Ombudsman for Long-Term Care and protection for older adults through the Vulnerable Adults Act.

Where do we stand today?

Since the Long-Term Care Task Force report the state has made considerable progress measuring, improving and assuring the quality of LTSS used by older adults. Minnesota has led the nation in these efforts related to nursing home services. The HCBS sector is learning from this work and developing similar capacity for HCBS quality initiatives.
Nursing Home Quality Initiatives

**Nursing Home Report Card**

In 2006, the Department of Human Services (DHS), Department of Health (MDH), the University of Minnesota and numerous stakeholders worked together to create the Minnesota Nursing Home Report Card. Information included in the online Report Card is designed to provide important information to older Minnesotans and their families before choosing a nursing home. The Nursing Home Report Card has information that includes daily prices, including private pay charges, and allows people to compare facilities on eight quality measures (see measures below). Each facility has a score between 1 and 5 stars (5 being the best) for each quality measure.

- Resident quality of life
- Family satisfaction
- Clinical quality indicators
- State inspection results
- Hours of direct care
- Staff retention
- Use of temporary nursing staff and
- Proportion of beds in single bedrooms.

The Report Card is one of only two state nursing home rating websites to receive an “A” by the Informed Patient Institute (IPI). IPI cites the Minnesota’s Report Card wide range of quality and financial information, its unique function that allows users to prioritize the search based on what’s important to them, and its user-friendly interface. Resident quality of life in particular is information national focus groups prioritize for nursing home rating sites.

**Nursing Home Performance-Based Incentive Program (PIPP)**

Since July 1, 2006, the Nursing Home Performance-Based Incentive Payment Program (PIPP) has allowed nursing homes to apply for a time-limited rate increase in exchange for implementing a project to improve the nursing home’s quality. DHS uses a competitive application process to select which projects will be funded. Individual nursing homes or a collaboration of multiple homes are eligible to apply for PIPP funding. A nursing home may request a performance-based incentive payment of up to 5 percent of their operating payment rate, but providers must achieve measurable program outcomes to retain full funding. The rate add-on amount, duration, and outcomes are negotiated with DHS. DHS has funded projects to improve employee recruitment and retention, reduce the rate of falls among residents, improve clinical care and provide meaningful activities.
Nursing Home Quality Improvement Incentive Programs (QIIP)

The 2013 Legislature directed DHS to develop a Quality Improvement Incentive Program (QIIP) in consultation with stakeholders. The QIIP gives Medicaid (called Medical Assistance in Minnesota) certified nursing homes the opportunity to receive funds if they improve their quality. QIIP went into effect on October 1, 2015. QIIP is a broader quality incentive program than PIPP and is designed to be easier to participate in than PIPP. To participate in QIIP, a nursing home must select one quality measure to improve. Unlike PIPP, there is no competitive application process—to participate a nursing home only needs to select a single quality indicator and work to improve that measure. The amount of a nursing home’s rate increase is based on the amount of improvement in the quality indicator relative to the previous year.

Nursing Home Value-Based Reimbursement

In 2015, the Minnesota legislature enacted major reforms to Medical Assistance nursing home reimbursement. This new system is commonly referred to as “Value-Based Reimbursement” (VBR). Under VBR, the daily per diem rate is a combination of cost-based and price-based rate components. VBR incorporates pay for performance by setting nursing homes’ care-related payment rate limits based on their quality. In doing so, the state pays for higher costs if the services provided are of higher quality. An initial evaluation report of VBR has been published. (Nursing Facility Payment Reform - Report). DHS has recommended an on-going evaluation of VBR to fully understand the impact VBR is having on nursing home quality of care and life and its effectiveness in addressing workforce issues. Nursing homes file a detailed annual cost report which is used to establish payment rates.

Home and Community-Based Services Quality Initiatives

HCBS Performance-Based Incentive Payment Program (HCBS PIPP)

In 2013, the Minnesota Legislature authorized DHS to implement a one-time HCBS Performance-Based Incentive Payment Program (HCBS PIPP). The HCBS PIPP supported provider-initiated projects to improve the quality and efficiency of HCBS delivered to older adults and people with disabilities. The HCBS PIPP program was intended to improve the quality of life of HCBS participants, improve the quality of services and deliver good quality services more effectively. Providers selected through a competitive process to participate in the program were encouraged to identify a problem, take risks and implement innovations, develop goals and show evidence that their plan improved HCBS.

HCBS Quality Improvement Website

The purpose of the HCBS Quality Improvement website is to share resources and foster a learning community among HCBS providers. The website is a place for providers to connect Status Check with each other, share experiences, and find ideas for future quality improvement projects. The website is
part of a broader set of HCBS quality improvement initiatives which are a collaboration between DHS, providers, stakeholder groups, provider associations, and other state agencies to develop resources and foster learning communities on service quality.

**National Core Indicators for Aging and Disabilities© (NCI-AD)**

The NCI-AD is a standard survey used across participating states that analyzes the quality of life and outcomes of older adults and adults with physical disabilities—including traumatic or acquired brain injury (TBI/ABI). Face-to-face interviews are conducted with individuals who access publicly-funded services through Medical Assistance-funded HCBS programs and nursing home services, state-funded HCBS programs and/or Older Americans Act programs. Indicators are standard questions that review how individuals are doing who receive publicly funded LTSS and are grouped together into 18 broad domains. Domains include employment, respect/rights, service coordination, care coordination, choice, and health and safety. An example of an indicator around service coordination is: “Proportion of people who receive the services that they need.”

**Looking Forward**

The Long-Term Care Task Force prioritized work to “provide more and better information to consumers and their families about assisted living options, and help identify methods to help consumers compare services packages across different assisted living providers.” As recently as the 2017 legislative session, Governor Dayton proposed an assisted living report card, modeled after the highly successful nursing home report card, to provide consumers with more information about their assisted living options. The proposal would have surveyed existing assisted living residents using the NCI-AD survey and combined with other existing data to compare assisted living facilities on quality and other factors important to consumers. Although not passed by the 2017 Legislature, this proposal points to one of many opportunities ahead of us to measure, improve and assure the quality of all types of LTSS. Minnesota has developed a strong approach to measuring, improving and assuring the quality of nursing home services used by older adults. The capacity to undertake quality efforts in HCBS is not as established as those with nursing homes. Current trends show a greater proportion of older adults use and will continue to use HCBS compared to nursing home services. With that there is an opportunity for Minnesota to build and improve how to measure HCBS quality.

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Status Check

TECHNOLOGY AND HOME MODIFICATIONS TO HELP OLDER MINNESOTANS LIVE WELL AT HOME

MINNESOTA BOARD ON AGING

NOVEMBER, 2017
REIMAGINING THE FUTURE OF AGING

The Minnesota Board on Aging, in partnership with the Minnesota Department of Human Services, is looking forward to 2030. Today marks the midpoint between our original vision for the long-term services and supports (LTSS) system, and the year that baby boomers start turning 85. It is truly a transformative time in our communities. To that end, we are revisiting our multi-year commitment to prepare for a permanently older society. Across all Minnesota communities, sectors and generations, we aim to refresh and refocus our efforts. In 2000 Minnesota worked with key stakeholders and developed a report called Reshaping Long-Term Care in Minnesota, known as the Long-Term Care Task Force Report. The Long-Term Care Task Force Report identified six broad goals and 15 strategies to prioritize action.

This Status Check document provides a snapshot of progress made on Technology and Home Modifications to help older Minnesotans Live Well at Home. The 2000 Long-Term Care Task Force envisioned a long-term care system that meets people’s needs and preferences for help when they need it. Critical to attaining this vision is the use of technology. The task force also recommended that individuals are equipped to meet their own needs through several strategies including information and funding for home modifications, energy modifications, general home repairs and personal adaptive equipment. The report also advised greater investment in these technologies through public Home and Community Based Services (HCBS) programs.

Why is this important?

Technology and home modifications offer tools for us to use to help us with our personal care, maintain independence and remain in our homes. A diverse range of technologies are available to help delay — and potentially avoid — the need to move out of our homes in order to receive the help that we need. Technology continues to rapidly evolve to address our shared desire for maintaining self-sufficiency.

Innovative technology via home modifications, remote monitoring and assistive devices is instrumental because technology can reduce a person’s reliance on getting help from other people, help maintain independence and increase cost effectiveness. In addition, with the existing workforce shortage, and the expectation that this challenge will continue, the need to maximize our use of alternatives to help others, such as home modifications and assistive devices, is critical.
Where Do We Stand Today?

As a direct result of initiatives tested and implemented in Minnesota, the following innovative technologies are available to us today.

**Home Modifications**

- Environmental accessibility home modifications: installation of grab bars, fixing broken steps, bathroom adaptations and building ramps
- Home repairs
- Accessibility modifications to vehicles
- Occupational Therapy interventions paired with home safety modifications

**Assistive Devices, Telehealth and Home Monitoring**

- Remote monitoring technology: sensor technology provides health and safety monitoring that sends alert via email or cell to designated responders if a change in routine or movement occurs
- Telehealth for biometrics and vital signs monitoring: technology based monitoring for vital signs and biometrics including motor and cognitive function, glucose monitoring, gait monitoring for prediction and prevention of falls, blood pressure and weight
- Assistive devices: a broad range of devices to support activities of daily living, personal care and home safety such as stove guards and robotics to aid in housekeeping
- Medication monitoring: medication reminder systems include passive and active organizers as well as commercial medication reminders via call or email
- Engagement technology: provides social engagement and interactive therapies at home

Recognizing the importance and outcomes of home modifications and technology, as recently as 2016, DHS amended the elderly waiver (EW) and requested an increase for environmental accessibility adaptations from $10,000 per year for an EW or Alternative Care (AC) enrollee to $20,000. This increase allows people on these programs to cover the market rate cost of the environmental accessibility adaptations they need including home modifications and adaptations to a vehicle.

As proposed by the Long-Term Care Task Force, the [Live Well at Home (LWAH) Grant Program](https://www.dhs.state.mn.us/living-well-at-home-grant-program) has for several years offered resources to communities to stimulate advancements in technology. The impact of these efforts includes the accelerated use of home modifications and technology by older adults throughout the state in order to live well at home. Below are examples of these innovations that demonstrate the important work by LWAH grantees. These examples point to the current best practices in this area as well as opportunities for innovations into the future as we look forward to 2030.
Home Modifications

Below are examples from five LWAH grantees that demonstrate different home modification strategies that assist older adults in Minnesota.

Lakes Area Interfaith Caregivers in Crow Wing County is a Faith in Action program that mobilizes volunteers to assist older adults by building ramps and completing home repairs. Without ramps or other similar modifications, older adults with mobility issues are not able to safely enter and move around in their homes.

MAHUBE-OTWA Community Council, Inc., provides supportive services to older adults in Mahnomen, Hubbard, Becker, Otter Tail and Wadena Counties, including home repair and modifications for older adults living in their own homes. Volunteers work on projects such as installing grab bars in bathrooms, fixing broken steps and building ramps which allow older adults to live safely in their own homes.

A sliding fee scale for both initiatives makes it possible for older adults to contribute toward the cost of the materials based on their ability to pay and volunteers donate their time to complete the work, making the services affordable.

Rebuilding Together Twin Cities makes accessibility modifications to the homes of older adults. They pair occupational therapy interventions with home safety modifications to help older adults live well at home. Occupational Therapists use the Live Well at Home Rapid Screen® that measures the likelihood that an older adult will have to move out of their home to get more help. Before a project with Rebuilding Together Twin Cities, the older homeowners were determined to have considerable risk of having to move. After working with Rebuilding Together, their risk dropped considerably and they were able to live well at home. Remarkably the older adults reported far fewer falls, fewer activities that they needed help with, more support from their caregivers and that their caregivers seemed to be less stressed.

St. Ann’s Senior Residence is a 163 unit subsidized building with services in St. Louis County. In 2006, through the LWAH grant the residence updated the fire alarm and sprinkler systems and refit the building with a modern heating and cooling system. The updates extended the life of the building, improved the health and safety of the residents while making this affordable option available to older adults. Specifically, the residents’ health improved in a temperature controlled environment and, since the upgrade, there have been no hospitalizations for heat related issues. The facility has also seen a steep decrease in the cost of their liability insurance due to having an updated fire alarm and sprinkler system. Crystal Lake Inn, an adult foster care residence in Otter Tail County, installed an elevator in this two-story home. The elevator creates a safer environment and makes it possible for older adults to remain at the residence even when they are having difficulty climbing stairs. As a result of the renovations, the updates allowed people to move out of the nursing homes and into the residence, where they received care and support in a smaller, more home-like environment.
Assistive Devices and Home Monitoring

LWAH grants have been used to invest in technology that helps organizations become more efficient and mobile, which allows them to do business with large systems such as healthcare and government, and helps them to provide better care. Technology is an important part of the way that HCBS are delivered.

In many rural areas of the state the proportion of the population age 65 and older is higher than it is in urban areas. The demand for in-home services is increasing as the total population in rural areas declines. These areas face shortages of nurses, direct support workers and other health care and LTSS professionals. HCBS providers around the state have purchased tele-health and home monitoring equipment in order to address this challenge. The equipment is installed in an older person’s home and is used to monitor vital signs such as blood pressure and weight on a regular basis. The data is then sent to a nurse, who monitors the individual. This equipment can reduce the number of in-home visits required by home care staff, increasing their efficiency and ability to serve more people. Some of the organizations who are using this technology include:

- Worthington Regional Hospital in Nobles County,
- Sioux Valley Canby Campus Home Care in Yellow Medicine County and
- Tri-County Hospital in Wadena County

Many of these organizations have partnered with medical clinics, county human services and HCBS providers to increase their outreach efforts and to implement these home monitoring programs. A staff person from Sioux Valley Home Care said, “We are able to manage complex clients much more cost-effectively through the monitoring system.” After tele-health was implemented in organizations around the state, the University of Minnesota Medical School Duluth completed an evaluation of these projects and provided suggestions to other organizations looking to implement this technology.

How can I learn more?

Join the conversation! Go to the MN2030: Looking Forward website to find out more about the initiative and how you can get involved. There you will find tools to help you be a part of the conversation to shape our state’s future.
Policy Brief: Access

MINNESOTA BOARD ON AGING

OCTOBER 2017
**MN2030 - Access**

**Current Status**
The Senior LinkAge Line® is the Minnesota Board on Aging's free statewide service that provides options counseling. The Senior LinkAge Line® service is provided by six Area Agencies on Aging that cover all 87 counties of Minnesota. The Senior LinkAge Line® staff are trained social workers, nurses and gerontology/human services professionals that have expertise in:

- Prescription Drug Expense assistance for Minnesotans of all ages
- Health Insurance Counseling and benefits such as Medicare and Medical Assistance
- Forms assistance, including help applying for Medical Assistance and enrolling into Medicare plans
- Long-term Care Insurance, including the Long-term Care Partnership
- Caregiver planning and support
- Care Transitions including Pre-Admission Screening, successful discharges back to the community from a nursing home or hospital
- Options to age in place or to make a move, when necessary

The Senior LinkAge Line has seen immense growth over the past roughly two decades (1,156 percent increase).

<table>
<thead>
<tr>
<th>Total Contacts</th>
<th>Total Number of Consumers Assisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997 number of contacts: 21,675</td>
<td>21,675</td>
</tr>
<tr>
<td>2016 number of contacts 272,435</td>
<td>123,868</td>
</tr>
</tbody>
</table>

The service has also gone through significant change with full automation of processes and the addition of significant amounts of in person assistance. This strategic effort was made a priority by the Minnesota Board on Aging (MBA) starting in 2000 and has continued through the current board membership. In addition, the Senior LinkAge Line® has grown substantially in terms of staff and funding, reporting and compliance. Taking on Pre-Admission Screening and the support of high risk individuals through their care transitions – now the number one referral to Senior LinkAge Line® - requires an increased attention to security, detail and risk management.

Senior LinkAge Line® - unlike many government services – is made available to all older Minnesotans who need it. In addition to this foundational service, though, the board has added capacity to target particular populations who are at high risk and are experiencing particular challenges that threaten their ability to live well at home with a focus on the critical pathways to long term services and supports. But the capacity is limited. Meeting with people in their homes and through face to face contact requires more intensive staffing levels and higher credentialing among the staff and this all has an increasing
cost. The current funding for this work can support the delivery of care transition assistance to an estimated 10,000 older adults through phone and in person assistance annually. The Return to Community initiative has been a key part of this and, with the expansion, provides the MBA and AAAs with increased capacity to target high risk populations. Through the implementation, the Return to Community expansion will allow us to partner even more closely with home care and health care providers (including hospitals) to increase coordination, service and follow-up with these individuals to help them live well at home.

Trends and Recommendations for Strategic Priorities
Summarized below are the major trends affecting the Senior LinkAge Line over the next several years. These trends were the most frequently identified by stakeholders to date through the MN2030: Looking Forward process and by MBA staff with expertise in this area.

1. Ending of Minnesota Cost Plans: December 31, 2018

As it stands right now, the Cost plans, which are considered “Other Medicare Plans”, are scheduled to end on December 31, 2018. This means 386,922 current Medicare beneficiaries that are enrolled in a Medicare Cost Plan in Minnesota will have to choose a new plan.

Cost plans are considered almost a "hybrid" plan. The key difference between Medicare Cost plans and other types of Medicare plans is that enrollees are not restricted to the plan’s network of providers. They can go outside the network to receive Medicare-covered services.

The cost plans are reimbursed by Medicare according to the cost of services provided by the health plan instead of receiving a fixed monthly dollar amount to provide all services (as is done with the Medicare Advantage plans).

Overall, Minnesota has the nation’s largest concentration of people with Medicare Cost plans. An estimated 386,000 of the state’s 836,000 Medicare beneficiaries have Medicare Cost plans, The Centers for Medicare & Medicaid Services (CMS) has indicated that cost plan enrollees will most likely be transitioned to Medicare Advantage plans offered by the cost plan companies, if they choose to offer them. This will create many problems for our beneficiaries because they will no longer have “Original Medicare” to revert back to for out of network services. If they go out of network and it is not an emergency, they will be liable for the cost unless they have the Point of Service option (in a Health Maintenance Organization (HMO), this option lets you use doctors and hospitals outside the plan for an additional cost).

Recommendations for Strategic Priorities

- Educating Medicare beneficiaries using a new Health Care Choices tool

Each year, renewal requests for health plans are submitted to CMS for approval. MBA staff receive the list of plan renewals and then builds this into the Health Care Choices Publication for the coming year. This publication is used extensively by professionals, the MBA volunteers and some beneficiaries. The challenge is the short timeframe between when staff receive the information and when the Health Care Choices publication needs to be printed. As a result, the MBA will be developing an online PDF automation strategy which will allow call center staff and volunteers to use the document but print off
specific pages for callers/beneficiaries. This will significantly reduce printing costs and also make the document more accessible to the public.

• Managing the workload

Over the past several years, the Senior LinkAge Line® has moved to paid on call staff to support the higher open enrollment volume. MBA works closely with the AAAs to create a staffing model that supports this approach. In the event that the cost plans end, statewide call routing may be explored and/or a major increase in benefits enrollment sites may be considered along with scheduling callers to receive on site assistance. In addition, the MBA staff unit that oversees the Senior LinkAge Line® will fill in staffing gaps in order for all affected individuals to receive the assistance that they need to make good decisions. Should Congress decide to finally end the cost plans, it will certainly be an all hands on deck scenario.

• Confirmation from ACL and CMS about counseling option for beneficiaries

The MBA (in its role as the designated Minnesota State Health Insurance Assistance Program) needs confirmation from CMS to verify that Medicare Cost plan enrollees will have the option to enroll in a Medicare Supplement (Medigap) or a Medicare SELECT plan option without health screening if they decide they do not want to enroll in a Medicare Advantage plan. Staff will work directly with regional office CMS office staff and the national offices of the Administration for Community Living (ACL) to determine the full list of options.

2. Pre Admission Screening: Challenges in Effectively Serving People with Mental Health Conditions

Federal and state laws require that ALL individuals entering a Medical Assistance (MA)-certified nursing facility (NF), a certified boarding care facility, or a hospital “swing” bed receive a Pre-Admission Screening (PAS) OBRA Level I, regardless of the anticipated length of stay or the payer source for facility services.

PAS is completed to:

• Avoid unnecessary facility admissions by identifying people whose needs might be met in the community and connecting them to home and community-based services;

• Screen people for mental illness or developmental disabilities based on the requirements in the Omnibus Budget Reconciliation Act (OBRA) of 1987, also referred to as OBRA Level I screening. This screening is completed to identify and refer individuals to other professionals for evaluation of the need for specialized mental health or developmental disability services as required under federal law. These activities are referred to as OBRA Level II activities;

• Determine and document the need for NF services for purposes of MA payment for NF services;
• Identify individuals who can benefit from assistance after NF admission to transition back to the community.

The Minnesota Board on Aging, in partnership with the Area Agencies on Aging, has developed an efficient process for receiving Pre-Admission Screening OBRA Level I referrals from health care professionals and processing them within one business day.

OBRA Level II referrals are made to the lead agencies or their contractor and then processed in order to determine if nursing facility placement is appropriate or if the resident needs special services in order to remain successfully in the nursing home with the appropriate level of care. Referrals for OBRA Level II occur when someone currently has, or has a history of, a mental illness or intellectual or developmental disabilities. OBRA Level II screenings review the appropriateness of nursing home placement, as well as determine if the consumer could benefit from additional services that are not offered within the nursing home, called specialized supports and services. These may include counseling, therapy animals or day treatment and habilitation services.

The Senior LinkAge Line® has seen delays in the process once the referral is made for an OBRA Level II. There are communication gaps between lead agencies related to who is responsible for completing the assessment and then further between the lead agency and the nursing home. This can involve lack of correct documentation, and sometimes, an inaccurate conclusion that a person would not benefit from specialized services.

Specific challenges include:

• Lead agencies may not conduct OBRA Level II when appropriate.
• The OBRA Level II process is not automated or tracked within a tool available to lead agencies, Senior LinkAge Line®, MBA or other state agency staff.
• Communication back to the NF with the results of the OBRA Level II assessment can be inconsistent.

Even though dementia is not considered a mental illness diagnosis for purposes of an OBRA Level II referral, there are indicators that with the increasing numbers of people with dementia that the federal government may rethink their approach on this. Also, when one mental illness diagnosis is present there are oftentimes two and that can include dementia as a secondary diagnosis. In an ongoing effort to improve our identification and support of people with Alzheimer’s disease and related dementia it will be important to identify ways to make improvements in the PAS process.

In addition, like much of population, people with developmental disabilities are living longer and possibly aging into Older Americans Act services and other home and community-based service programs designated for older adults. It is important to identify these individuals in order to make sure that they continue to receive the support that they need to successfully age in place.
Recommendations for Strategic Priorities:

- Automation of OBRA Level II screening and referral process

Referrals to lead agencies for OBRA Level II will be automated to reflect that 1) the referral was received by the lead agency; 2) the OBRA Level II screening was completed by the lead agency; and 3) if it was not, the reason it was not conducted. This type of system will allow for data analysis to ensure accurate referrals to lead agencies and that consumers receive timely screenings and appropriate specialized services.

In addition, completed OBRA Level II screenings for mental illness should be automated or tracked electronically allowing Senior LinkAge Line® specialists, lead agencies, MBA and DHS staff, as appropriate, to verify that an OBRA II screening was done for mental illness and the results of that screening. Discussions with the Adult Mental Health division at DHS have already begun and plans are underway to create some automation, although specifics are not known at this time. Currently, OBRA Level II screenings for developmental disabilities are available electronically for viewing by appropriate staff.

- Increase state oversight and support of, including training, entities responsible for implementing the process.

The MBA will assist each Area Agency on Aging with creation of a communications plan outlining meetings with health care providers who complete or receive pre-admission screenings, including providing training on the process. These meetings will also be places on the Extranet Calendar used by Senior LinkAge Line® staff allowing the MBA to review and monitor progress of the plans.

Statewide letters, updates to the mnaging.org and seniorlinkageline.com websites and recorded trainings will be provided by the MBA and appropriate DHS staff outlining the process for Pre-Admission screening, each party’s responsibilities in the process and timelines. An updated bulletin with the most recent Pre-Admission Screening OBRA Level I information is currently being reviewed by the DHS bulletin liaison and will be issued shortly.

- Improve data collection and/or analysis related to individuals with dementia admitting to a nursing facility

Additional analysis will be conducted based on submitted Pre-Admission Screenings to identify the number of individuals identified as having dementia, as well as a co-occurring mental illness. Based on this analysis, data collected upon submission of the Pre-Admission screening may be revised or follow-up protocols updated to ensure those with dementia, regardless of co-occurring conditions, have the supports they need in the nursing facility after admission. This analysis will be shared with a broader planning group developed by the MBA.

- Review Senior LinkAge Line® protocols targeting individuals with mental illness or developmental disabilities who are living longer
As individuals with MI and DD are living longer, it is important that individuals with mental illness and developmental disabilities understand their options regarding housing settings and services available; both in the nursing facility and in the community. This is especially true for those who are not on a public program and therefore do not have a care coordinator or case manager. Analysis will occur to determine if these individuals should receive additional follow-up or be targeted through the Return to Community initiative based on their needs, co-occurring diagnoses and support systems in the community.

3. Changing Workforce Needs as a Result of Increasing Complexity of SLL work

The Senior LinkAge Line is reaching a point where it must rethink how it uses volunteers due to the increasing complexity of Medicare assistance. Historically, volunteers have provided:

- Assistance with enrolling in a Medicare plan through the use of the Medicare plan finder tool
- Screening beneficiaries for programs that can help pay for Medicare related costs
- Conducting Senior Surf Days to help beneficiaries learn how to use a computer to find Medicare related information
- At the metro call center only, a Medicare Volunteer “Hunt Group” was established so calls could be routed
- Help with data entry and administrative tasks

The rate of volunteering with SLL has remained relatively stable, with a slight decrease (6 percent) seen in recent years. SLL currently has 192 volunteers (in kind paid not included) that provided 11,560 hours of assistance for grant period that ended on 3/31/2017. This averages to 60.21 hours of assistance provided by each volunteer in one year. Medicare, long term care insurance and related claims and billing issues are becoming so complex that it is becoming harder to find volunteers that are able to, or perhaps even willing to, provide the type of assistance needed.

Specific challenges include:

- Increased demand for services is expected with the aging of the population.
- There is increased complexity of the issues to be addressed.

Traditionally full retirement age coincided with Medicare eligibility, however; Social Security full retirement is currently age 66 and will eventually rise to age 67, Medicare eligibility remains at age 65. The number of Medicare eligible beneficiaries who continue to work has never been higher, and is projected to grow exponentially as Social Security delays full retirement age even more. Employers provide little to no guidance to employees about the choices that must be made that can lead to a lifetime of premium penalties if the wrong decision is made.

An increasing number of choices and increased use of cost saving measures by both Medicare and the HMOs has increased the complexity and skill level required to assist Medicare beneficiaries with understanding their options to enroll.

In 2018, the Medicare Cost plans will end which will leave more than 386,000 Minnesota
Medicare beneficiaries with the need to change plans. Options counseling provided by the Senior LinkAge Line will be more complex than ever before due to the unfamiliar plan decisions that Minnesota Medicare beneficiaries will have to make.

- There has been an increase in appeals, a trend that is expected to continue.

The number of Medicare appeals increased 267% from FY 2010 to 2015. As more boomers age into Medicare the need for appeals assistance will most certainly grow just as rapidly. Appeals are complex, lengthy legal processes that require a highly skilled person to pursue.

As the complexity of Medicare grows, so does the increasing risk to the program related to incorrect Medicare counseling and assistance services. Health Insurance Counseling remains highly dependent on volunteerism. The risk associated with providing incorrect information or assistance requires extensive training, monitoring and guidance. The rate of volunteerism within Minnesota has dropped about 6% and although the rate among highly educated is quite high so is the demand for their services. In addition, the Department of Labor has recently stepped up enforcement of the rules around stipends and are requiring most organizations to label a volunteer a part time employee.

Recommendations for Strategic Priorities:
While the majority of time, errors are occurring due to lack of knowledge about the Medicare program there are also risks related to the need to:

- Ensure appropriate review of the work of the volunteer as well as mentoring so that the volunteer does not feel that they are going it alone in a complicated environment and building a tracking tool to support the volunteer coordinators in their roles

The Senior LinkAge Line® does not have sufficient tracking and monitoring of the volunteers. Even though volunteers are treated for all intents as the same as a staff by CMS and ACL. This causes challenges with regard to the need for locked bags, encrypted laptop data and ensuring appropriate access to the tools. The MBA will continue to develop an online extranet volunteer tracking tool that can be used to track the work, allow for complaint handling and effective management of the volunteers.

- Maintain clear guidance in a volunteer standards and policies around insurance, transportation, liability and stipends/mileage reimbursement

The MBA has a set of volunteer management standards on the extranet for the Senior LinkAge Line®. This was a requirement of the SMP (Senior Medicare Patrol) and SHIP (State Health Insurance Assistance Program) grants in 2014. MBA staff will maintain this manual and add local Minnesota specific requirements and additional policy guidance to the staff.

- Conduct regular (annually) background checks in alignment with standard security practice to ensure that volunteers are not targeting vulnerable elderly.
Currently background checks are done upon the volunteer starting. Best practices in the industry is starting to be one background check per year. This will result in increased costs but is likely to be a basic security requirement for all organizations going forward.

- Maintain and support the volunteer coordinator position at the Area Agencies on Aging. This will require additional funding and support as the position becomes more complex.

The volunteer coordinator position was funded with the one stop shop funds from Governor Dayton. It is essential to maintain this level of funding to support the coordinators so that they can recruit the best type of volunteer to fit without the work of SMP and SHIP but also so that they can mentor and oversee the existing volunteers and ensure adequate updates and training are provided as changes happen in the world of health insurance and benefits for the elderly.

4. **Senior LinkAge Line® will continue to enhance service delivery to cultural and ethnic communities and older adults living in rural areas.**

The demographics of Minnesota have been changing for some time. With the increasing numbers of refugees and the growing diversity of the older adult population. In addition, rural communities are facing even more challenges as the aging population grows in greater numbers in rural Minnesota.

Senior LinkAge Line® has been actively pursuing strategies to engage diverse populations and increase hiring of people of color and Native Americans:

- Area agencies are monitoring for their diversity hiring strategies and a metric is monitored on the annual dashboard for consumers assistance programs
- Staff have worked hard to engage beneficiaries on reservations or of a Native American background. There are now monthly health insurance counseling sites at tribal locations
- AAA are also attended quarterly meetings that are a part of networks that serve culturally specific community events (Somali, Korean, Hmong etc.)
- The Senior LinkAge Line® has an outreach presence annually to Farm Fest in collaboration with the Department of Human Services
- Numbers of minorities served are reported annually to the Board on Aging on the SLL dashboard
- YouTube video have been produced in multiple languages including a What is Senior LinkAge Line? Video. But they have not had broad dissemination.

**Challenges:**

- MBA staff have noted that SLL staff are often not following the protocol about collecting ethnicity and race data and are instead making assumptions about callers.
• It can be challenging to engage cultural and ethnic communities if the MBA and AAA staff do not represent the face of these cultures. This can come with an expected distrust of staff that requires ongoing reengagement and careful trust building.

• Transportation is an issue for rural communities to get to see a volunteer as it can be a full day trip to get to see a volunteer and they may not have the means to get out and get help.

• The race and ethnicity categories for data collection as issued by the federal government are limiting in terms of meeting person-centered needs since some of these issues are a construct.

Recommendations for Strategic Priorities:
• Utilization of existing tools to do more in person assistance via tele monitoring

The community living specialists have indicated that they feel that there is an opportunity to do more camera based tele monitoring of consumers. The MBA staff will develop a policy for issuing of equipment and criteria to determine those that the fit for this approach. An initial pilot would be done.

• Site visits will include a review of hiring practices

Currently, the Client Services Center is located is one of the most rural towns in Minnesota – Slayton. MNRAA in particular has done an effective job of located staff in home based offices in order to engage more rural workers. These types of promising will be share at site visits and more flexible work arrangements will be reviewed as the SLL is a good service for considered of these practices due to the high level of security of the technology. AAAs are provided with an annual dashboard that includes two metrics measuring minority status of staff hired. The site visit protocol will be modified to include a discussion about outreach strategies and areas where more minority can occur.

• Social media including the MBA’s Facebook page, Twitter and the web page and Minnesotahelp.info will be used more effectively to post materials in a variety of formats and languages

The YouTube videos from ECHO will be more broadly disseminated to the Board’s social media pages but also through hospitals and clinics including conducting an outreach effort to the Federally Qualified Health Care Clinics as there is opportunity to more broadly promote the work of SLL.

• An existing statutorily mandated annual neighborhood level outreach plan will be incorporated into the area plan access section

In the mid to late 2000’s the SLL call centers were mandated to provide outreach plans that place “an emphasis on the metropolitan area and improving outreach and services to seniors and caregivers by establishing annual plans by neighborhood, city and county (See Minn. Stat. 256.975 Subd. 9). This requirement will be added to the annual area plan process and negotiations so that it can be reviewed by the diversity committee and all MBA staff to ensure that a broader review of approaches represents all talents and expertise. In addition, new call monitoring will validate staff are collecting the ethnicity field to ensure adherence to the protocol.
Policy Brief: Caregiving

CAREGIVING

MINNESOTA BOARD ON AGING

OCTOBER 2017
The Minnesota Board on Aging policy briefs offer an opportunity for stakeholders to learn and engage in a planning effort to reform our system and to prepare communities and the state meet the challenges and opportunities associated with an aging population.

**Issue**

Family and friends provide the majority of help needed by older Minnesotans to remain at home. This unpaid help is valued at $7.9 billion a year and exceeds State Medical Assistance expenditures. Aging demographics coupled with longer life expectancies and increased disability rates with age will likely strain our publicly funded long-term services and supports (LTSS) system. Changing family size and composition, and increasing numbers of baby boomers who are divorced or single without children and lack traditional support networks are also factors impacting LTSS for older adults. We have an opportunity to find innovative ways to support family and friends who are vital for supporting older adults, for sustaining public funding for LTSS and lessening the impact of Minnesota’s projected workforce shortage (~59,000 direct care workers by 2020).

**Current Status**

In 2016, about 5 percent (27,000) of Minnesota’s 585,000 caregivers were served through federal and state funded home and community-based services programs (e.g., federal Title III-E, State respite and Minnesota Board on Aging (MBA) dementia grants, Elderly Waiver, Alternative Care) and the Senior LinkAge Line. The focus of this paper is on opportunities and recommendations for improving our state’s identification and support of family and friend caregivers.

**Background**

Each year the MBA receives approximately $2.1 million through the U.S. Administration on Aging for caregiver support services (Older Americans Act Title III-E funds). This funding is allocated to the Area Agencies on Aging (AAAs) that contract with local providers to deliver a range of flexible services and supports for caregivers of older adults, adults with Alzheimer’s disease and grandparents raising grandchildren. It is also a catalyst for service development. This funding is targeted to caregivers of older adults with the greatest economic and social need, with particular attention to rural, low income caregivers.

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and minority individuals. Title III-E funding supports a regional network of caregiver consultants (CCs) who offer person-centered support to family and friends including one-to-one coaching and consultation, problem solving, expertise in dementia care and family systems. Most offer Powerful Tools for Caregivers, a self-care education program for family caregivers, and REACH (Resources for Enhancing Alzheimer’s Caregiver Health). Most recently REST (Respite Education and Support Tools)® is being implemented in Minnesota. Most of the providers who receive Older Americans Act Title III-E funding also serve caregivers through the other state or federally funded programs.

The MBA, in partnership with the AAAs and Twin Cities Public Television, developed Caregiving: A Part of Our Culture: an online series to raise awareness of caregiving and offer tips and resources for ethnic and new immigrant caregivers. This information is translated into four languages (Somali, Spanish, Hmong and Khmer), and is available in multiple formats to organizations statewide.

In 2016, the MBA conducted a statewide evaluation of the Older Americans Act Title III-E caregiver support program through an independent contractor. This evaluation included a review of Title III-E financial and service data, key stakeholder interviews, a literature review, presentation of results and facilitated discussions. Its goal was to document the current status of the Title III-E program (how funding is being used, patterns and uptake of services to engage caregivers, gaps, successes and challenges) and how funding can be maximized to support Minnesota’s caregivers.

Opportunities

Family and friend who are caregiving are increasingly diverse in terms of needs, stage of caregiving, culture, and informal support networks. Research shows that a “one size fits all” approach is not effective in supporting them. Here are examples of opportunities to support people who are caregiving based on input from key stakeholders in the recent Title III-E program evaluation:

- Addressing the unique needs of family and friends who are caregiving. Each caregiving situation is dynamic and individualistic. There is much variation in care needs, styles of caregiving, cultural norms and practices, whether the caregiver lives with, nearby or far away from the person needing care, the caregiver’s own health, employment and other family roles/obligations. Minnesota’s caregiver consultants are trained to offer person-centered approaches with planning and follow up for supporting the needs of each individual/family. The number of caregivers from Minnesota’s cultural and ethnic communities is growing and efforts are underway to build on current successes, such as outreach partnerships, culturally specific grants and cultural consultants to advise the aging network about culturally responsive services.

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• Reaching caregivers at an earlier point of need, as most seek support during crisis. It is common for family and friends to not fully realize they are “caregivers” until their loved one receives a new diagnosis, there is a change in condition or a recent discharge from a hospital, nursing facility or transitional care unit. However, reaching caregivers earlier can reduce stress and improve confidence and care skills. Examples of earlier intervention include information and education about a disease/condition, skills training to perform care tasks, holding family meetings to plan ahead and support the primary caregiver, and finding respite and other community resources.

• Improving caregiver health by strengthening informal support networks. Caregiving can be rewarding and offer satisfaction, personal growth and increased meaning and purpose in one’s life. However, caregivers may be reluctant to accept support from others (both unpaid and paid) due to a variety of factors and end up “doing it all”, sometimes at a personal cost (physical, emotional and financial). A recent Minnesota study\(^ {12}\) found that family and friend caregivers who have strong informal support networks had better self-reported health and less frequently described their roles as “very stressful”. Another role of Minnesota’s caregiver consultants is to assist family and friends to identify informal support networks to assist them with caregiving and develop a plan for moving forward.

• Replicating best practice models and evidence-based interventions to fill gaps in service. As the demand for unpaid caregivers grows the aging network is seeking innovative ways to support family and friends caregiving. This includes partnerships with health care providers, businesses, and working more closely with other service providers to increase capacity to support caregivers. Other opportunities include leveraging online education resources, chat and market-based solutions to support caregivers.

• Seeking new partnerships and innovations to support caregivers in crisis. There is currently limited capacity for crisis response. The aging network is looking for ways to support those in crisis by exploring ways to increase aging network capacity to respond to crisis, develop referral protocols to agencies and organizations with 24 hour helplines (e.g., Alzheimer’s Association, Suicide Prevention hotline), offer online chat, and developing partnerships around creative solutions.

• The 2017 Minnesota Legislature authorized the MBA to re-establish a time-limited Alzheimer’s Disease Working Group to review and revise the 2011 report, “Preparing Minnesota for Alzheimer’s: the Budgetary, Social and Personal Impacts.” The recommendations from this group, which will be presented to the 2019 Legislature, will guide future efforts to support people with Alzheimer’s disease and related dementias and their family/friend caregivers.

Recommendations for Strategic Priorities

1. Continue/increase support for caregivers of older adults during transitions of care, and others who are stressed and at risk of formal placement of older adults. Increase partnerships with clinics, hospitals and health care homes (HCHs), and coordination with Senior LinkAge Line to identify and support family caregivers. Continue/increase support for family caregivers including those caring for adults with Alzheimer’s disease, rural, low income and culturally diverse caregivers and others as per the Older Americans Act.

2. Increase coordination between Senior LinkAge Line and caregiver services grantees to maximize support for caregivers through calls and Return to Community (RTC) Expansion. Beginning July 2019, a new caregiving service component will be launched that offers self-directed budgets for family and friends of certain individuals enrolled in the RTC program. This is an opportunity to test new ways of supporting family and friend caregivers in a more targeted, flexible and coordinated way.

3. Revamp messaging and service delivery models geared to family and friend caregivers. Take a holistic approach of supporting caregivers and care receivers at the same time. Consider addressing the care receiver’s needs first as families and friends may reach out for help during crisis or transitions of care. For example, caregivers may be more willing to take some help if it is geared towards the care receiver (and also provides them with a break, respite). Create easy and practical service “on ramps” as initial forms of support for caregivers, including transportation, meals, chore services, or housekeeping help. Educate family and friend caregivers about LTSS options in an effort to divert/delay use of assisted living and facility-based care.

4. Increase availability of affordable respite including in-home, out-of-home, self-directed and culturally specific options. Consider offering a range of respite options including volunteer and fee for-service models. Refer to the most recent DHS Gaps Analysis for identified gaps in respite. Think more broadly about services that offer a respite outcome such as adult day services, companion, chore or homemaker.

5. Increase work with cultural and ethnic communities to develop models that best meet the needs and preferences of those in their community who are providing care as well as the care receivers. These efforts must include workforce development (staff training and employing staff from the same cultural or ethnic community), consultation with cultural consultants about policy and service development and making information available in a variety of formats and languages. Build on successes such as ACT on Alzheimer’s dementia friendly communities, REACH (Resources for Enhancing Alzheimer’s Caregiver Health) Community, and Caregiving: A Part of Our Culture.

cultural caregiving awareness and education program developed by the MBA with AAAs and Twin Cities Public Television.

6. Expand the caregiver consultation service and create regional “hubs” or virtual centers to increase access to a range of support for people who are caregiving. Examples might include online education, consultation, finding and using technology, family meetings and chat. Ensure that staff at service hubs is empowered to be early access and referral points for caregivers. Review current state, regional and local policy and guidelines to increase flexibility and accessibility to support and engage more caregivers, including those from cultural and ethnic communities. Streamline contracting and paperwork burden for self-directed services and providers of service.

7. Train caregiver consultants to assist family and friends with finding/using various technologies to complement their roles and ease care tasks. Examples include online calendars, virtual visits, mobile apps and assistive technology.

8. Explore/promote market-based solutions for supporting caregivers. Includes vouchers for services and supports and better technology to support older adults and caregivers. Package services and supports in ways that appeal to caregivers and health care providers.

9. Raise employers’ awareness of caregiving and older workers to promote workplace flexibility through business leaders and key partners as a way to improve workplace environments and lessen workforce shortages. This also makes good business sense as supporting employee caregivers is shown to enhance productivity, lower absenteeism, improve worker retention and provides a competitive edge in recruiting high quality employees.

10. Establish measureable outcomes for the programs seeking to support family caregivers. Explore methods to document return on investment for caregiver support services as a way to generate state funding in order to sustain capacity.
Policy Brief

CULTURAL RESPONSIVENESS

MINNESOTA BOARD ON AGING

OCTOBER 2017
The Minnesota Board on Aging policy briefs offer an opportunity for stakeholders to learn and engage in a planning effort to reform our system and to prepare communities and the state meet the challenges and opportunities associated with an aging population.

Engaging cultural and ethnic communities to better support older people of color and American Indian elders

As the population becomes more diverse, it will be important to have programs and services that are responsive to the needs of different cultures and backgrounds. The Minnesota Board on Aging (MBA) has a number of programs and initiatives underway to be culturally responsive, but there is an opportunity to improve them or add more. This policy brief outlines the demographic landscape, current efforts to reach diverse communities by the MBA and Minnesota Department of Human Services (DHS) and recommendations for the future.

**Current status**

**Demographics/Service Utilization**

Statewide, over five percent of the population age 60 and older is non-white (Aging Integrated Database using 2009-2013 American Community Survey Special Tabulation data). This varies by Area Agency on Aging (AAA) region, with the Metropolitan AAA having the most diverse population at nine percent of people age 60 and older who are non-White and Minnesota River AAA having the least diverse population at two percent.

![Minnesotans (Age 60+) by race, 2014](chart)

Racial and Ethnic Differences from NCI-AD 2015 Survey Data
The Minnesota Department of Human Services partnered with the MBA to conduct the National Core Indicators for Aging and Disabilities (NCI-AD) Survey in 2015 with older adults across all home and community-based service programs, including the Older Americans Act. The survey collects participant feedback regarding their satisfaction with their services as well as other aspects of their daily life and outcomes related to their quality of life. The following highlights are from the 2015 survey results across all programs.

**Demographics:**
- White older adults were older than other groups on average.
- Asian and Hispanic/Latino older adults were less likely to be English speakers.
- Black older adults were less likely to be married.
- Black and Hispanic/Latino older adults were more likely to skip a meal sometimes or often due to financial worries.

**Living Arrangements:**
- White older adults were more likely to live alone or with personal care assistants; Black older adults were more likely to live alone and less likely to live with a spouse or partner; Asian older adults were more likely to live with relatives (not spouse or partner) and friends.
- White older adults were less likely to live in their own or family’s house and more likely to live in an assisted living facility.

**Health and Wellness:**
- Black and Asian older adults had worse self-rated health than White older adults.
- Asian older adults felt less in control of their life than White older adults.
- Black and Hispanic/Latino older adults were less likely to say their services meet all their needs and goals than White older adults.

**Current Programs**

The MBA and the DHS have several existing programs that have a primary goal of engaging cultural and ethnic communities or have prioritized being culturally responsive. They include:

- **Senior LinkAge Line®:** The Senior LinkAge Line® is the Minnesota Board on Aging’s free statewide options counseling service. The Senior LinkAge Line® service is provided by the MBA in partnership with the six geographic Area Agencies on Aging that cover all 87 counties of Minnesota and helps connect people to local services and navigate care transitions.
- **Older Americans Act Special Access Programs:** provide helpful information and referral, advocacy, translation/interpretation, and short-term case management support for minority and non-English-speaking elders to help them access services and connect to community.
- Metropolitan AAA works with
  - Brian Coyle Center
  - Centro
  - CLUES
  - Division of Indian Work (GMCC)
  - Korean Service Center
  - Lao Advancement of America
  - United Cambodian Association
  - VOA MN
  - Bhutanese Community Center

- Older Americans Act Nutrition Programs: the AAAs and Nutrition Providers have worked with cultural and ethnic communities around the state to develop culturally specific meal programs. Examples of these programs include those serving Lao, Somali, Hmong, and Hispanic or Latino elders.

- MBA Dementia Grants: These grants are intended to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, and/or connect caregivers of persons with dementia to education and resources. One area of special focus is projects that originate from culturally focused organizations or serve culturally and racially diverse older adult populations.

- Cultural Consultants: The vision is to create cultural awareness among service providers that will result in culturally responsive service to persons with dementia and their caregivers. Intended outcomes include: 1) Increase awareness among aging service providers and healthcare personnel about the norms and values of specific ethnic and cultural communities, 2) Promote person-centered planning that incorporates cultural norms to address consumer/patient concern about memory loss or an Alzheimer's disease diagnosis, and 3) Spur new initiatives that specifically meet the needs of a cultural or ethnic community.

- Wisdom Steps: Wisdom Steps is a preventive health program developed by Tribal Elders for Tribal Elders in Minnesota in 1999. Wisdom Steps is a partnership among the eleven Minnesota Indian tribes, three urban areas (Minneapolis/St. Paul, Duluth and Bemidji) and the Minnesota Board on Aging. Wisdom Steps encourages elders to take simple steps toward better health. Activities such as participating in health screenings, attending a health education class, or enjoying a healthy living activity are promoted.
Live Well at Home Grants: DHS works with partners statewide to expand the capacity of long-term services and supports to help people age 65 and older stay in their homes and communities of choice. Grant opportunities through this program help Minnesota communities meet the challenges of an aging population and forecasted pressures on Minnesota's long-term support system. One goal of the grants is to improve targeting and management of public funds for culturally and racially diverse older adult populations, older adults in rural areas and those with at-risk needs. Examples include the Lao Advancement Organization of America’s comprehensive licensed adult day service, Korean Service Center Escort Program which provides door-to-door transportation, Northwoods Caregivers Chronic Disease Self-Management classes in partnership with Leech Lake and Minnesota Indian AAA (MIAAA), VINE’s English literacy program for refugees, and CAPI’s Hmong Seniors Program which connects Hmong older adults and their caregivers to support services in the community.

Eldercare Development Partnerships: The goal for these regional staff based in the AAAs is to make strategic changes in the long-term services and supports system for older adults including statewide capacity for local service development and technical assistance, and statewide availability of home and community-based services for older adult services, caregiver support and respite care services, and other supports to create incentives for new and expanded home and community-based services in Minnesota. One example of engaging cultural communities is in developing an East African elders program in St. Peter.

MIAAA: serves tribal elders on the four reservations that are members of the Minnesota Chippewa Tribe (Bois Forte, Grand Portage, Leech Lake, and White Earth) with nutrition, healthy aging, caregiver support and assisted transportation. MIAAA also collaborates with neighboring AAAs to expand services to tribal elders.

Older Americans Act Healthy Aging Programs: Older Americans Act Title III D funds evidence based health promotion (EBHP) programs. These programs encourage participants to make healthy decisions and engage in healthy behaviors. OAA services are targeted to older adults in most need, with a particular focus on reaching people of color and Native Americans. EBHP programs have been expanded by offering programs that maintain fidelity but can be tailored to the needs of a specific community for example: making Tomando Control de su Salud, (Spanish version of Chronic Disease Self Management) available to Hispanic/Latino communities and the Tai Ji Quan Moving for Better Balance can be offered in the language specific to the community being served.

In addition to the current programs, the MBA and DHS have recently undertaken new efforts to engage cultural and ethnic communities and these include:

Somali elders community event: A conversation was held with a group of Somali elders many of whom currently receive publicly funded long term services and supports in their home. The purpose of the engagement was to understand their experience with home and community-
based services and to inform DHS in the development and revision of services and strategies to improve the care experience of Somali elders.

- Caregiving in the African American and Hmong Communities: The MBA, DHS and Wilder Research partnered to learn how to better respond to the increasingly diverse populations of older adults, and the family caregivers. The focus of the study and focus groups was on African American and Hmong communities. MBA and DHS worked with Wilder Research to review concepts, barriers and opportunities to engage caregivers based on a review of current studies and research, combined with information shared by community representatives. The purpose of the roundtable was to get solid ideas (i.e. tangible, accessible and real) for supporting African American and Hmong elders.

**Roles**

The MBA has three roles: Advocate, Advisor and Administrator. Through these different roles, the board works to better engage cultural and ethnic communities as well as better support older people of color and American Indian elders.

**Advocate**

The Board has the opportunity to advocate for certain strategies to improve long-term services and supports and form partnerships to increase the quality of culturally responsive services.

**Advisor**

The Board keeps tabs on demographics of older adults and provides accurate data and resources to those serving older adults.

**Administrator**

As administrator for Older Americans Act programs, including the Senior LinkAge Line®, the Board serves people of many different cultures and has the ability to engage those diverse communities in improving or expanding them.

**Recommendations for Strategic Priorities**

- Refocus our efforts to truly engage cultural and ethnic communities to determine how they would like to support their elders, instead of figuring out ourselves how to deliver services to them. To do so, we can use what we have learned through the development of OAA Special Access Programs, MBA cultural consultants, grant-funded provider efforts and others.

- Since Black and Hispanic/Latino older adults were less likely to say their services meet all of their needs and goals, the MBA could advocate for changes in long-term services and supports that better meet all the needs and goals of people from diverse communities. Since older adults with more assistance with self-care were more likely to report better health the MBA
could work to ensure that people in diverse communities have access to assistance with self-care.
Policy Brief

HEALTHY AGING AND NUTRITION

MINNESOTA BOARD ON AGING

OCTOBER 2017
The Minnesota Board on Aging policy briefs offer an opportunity for stakeholders to learn and engage in a planning effort to reform our system and to prepare communities and the state meet the challenges and opportunities associated with an aging population.

**Current Status**

In 2016 it is estimated that Minnesota has more than 1.1 million adults age 60 and older. When it comes to the current state of healthy aging and nutrition consider the following, of those age 60 and older, it is estimated that 72 percent have at least one chronic health condition (ongoing health issue) and 60 percent have 2 or more. It is also estimated that up to 15 percent experience under nutrition (not consuming enough calories, protein or nutrients). Those at most risk for under nutrition are older women, minorities, and people who are poor or live in rural areas.

![HEALTH AND NUTRITION](chart)

**Nutrition**

The good news is Minnesota Board on Aging (MBA) funds programs that provide better nutrition, help older adults better manage their chronic conditions and reduce falls. Through these programs older Minnesotans have the opportunity to improve their quality of life, and potentially reduce other costs including the cost of healthcare.

The MBA funds nutrition services, including congregate and home delivered meals, under Older Americans Act (OAA) Title III C1 and C2. Additionally, MBA funds Healthy Aging programs, specifically evidence based health promotion, under OAA Title III D.

Nutrition funding represents the largest single amount of OAA funds that MBA receives. In Federal Fiscal Year (FFY) 2016 a total of 38,503 persons were served 1,478,894 meals through congregate dining. For home delivered meals, MBA saw a 14 percent drop in the number of people served for a total of 10,274. However, at the same time the number of meals served in that time period remained
steady at 984,089. This suggests a higher meal per person ratio – people that need the meals and the nutrition they provide are having that need met through more service. Participant data also shows that home delivered meals are reaching those with higher needs (functional limitations and nutrition risk).

The OAA requires that services are targeted to older adults most in need with a particular focus on reaching people of color and Native Americans. The OAA nutrition services, both congregate and home delivered, are in most cases serving the same percentage of participants as identified in the population overall as shown below.

![Nutrition Services](chart.png)

**Healthy Aging**

Title III D, evidence based health promotion (EBHP), which includes strategies to encourage healthy decisions and behaviors, is the smallest amount of funding MBA receives.

Under this funding, a range of EBHP programs, including fall prevention and chronic disease self-management programs, are provided through a variety of organizations and in various settings. In FFY 2016 over 3,600 persons participated in an EBHP program or workshop. As of January 1, 2016 OAA funds can only be used to fund EBHP programs that meet the highest level criteria for evidence based programing.

In the last several years, MBA staff have worked with the Area Agency on Aging (AAAs) and many partners to provide a broader range of evidence based programs that have wider appeal to cultural and ethnic communities. As an example, the Tai Ji Quan Moving for Better Balance (TJQMBB) program, does not require any print materials for participants and leaders, while trained in English, can provide the program in the language that best meets the needs of their community.
Challenges and Opportunities

Nutrition

The challenges to nutrition services, while many, often come down to the needs of the populations that are to be served. Some of the current challenges are:

• The expected growth in the population of those age 60 and older in the context of flat or potentially shrinking federal OAA and related state supplemental funds.
• With increasing diversity, we must continue to work with cultural and ethnic communities to tailor the services to best meet their needs and preferences.
• Systemic issues, such as transportation, must be addressed in order to assure access to congregate meals.
• Reaching an increasingly rural population across large geographic areas around the state, especially with a volunteer-based model.
• Changing expectations and tastes of older adults.
• Other providers, who do not receive OAA funds, competing for funding streams that OAA providers count on.
• Lack of access to healthy food choices in some rural and urban areas (food deserts).
• Aging of the workforce (including volunteers) that serves OAA clients.

Healthy Aging

The area of “healthy aging” includes some similar challenges and some unique to this issue:

• Current number of older adults, in Minnesota, affected by 1 or more chronic conditions is more than 750,000 and this number is expected to grow.
• Geographic challenge of offering older adults the opportunity to participate in a class, workshop or have access to exercise and other healthy activities.
• Currently limited or no access to evidence-based programs that address mental health.
• Limited amount of funding and specific parameters as to what can be funded under the OAA.

In early 2017, United Health Foundation released their America’s Health Rankings Senior Report. Minnesota was ranked as the number 1 healthiest state, up from number 4 in 2016. The rankings are based upon analysis of older adult population health on a national and state-by-state basis across 34 measures. Minnesota’s has many strengths including: a high level of volunteerism, decrease in percentage of those in poverty and, nursing home quality (four and five star ratings), prescription drug coverage and a low prevalence of frequent mental distress.
However, there are also challenges and it is in these areas that Minnesota has the opportunity to continue to lead in creating better lives for older adults:

- Food insecurity: since 2013 food insecurity has risen for Minnesota older adults by 19%; from 8.6% to 10.6%.
- SNAP (Supplemental Nutrition Assistance Program) reach: In Minnesota, 65% of adults age 60 and older, living in poverty are receiving SNAP benefits. While a good percentage, it ranks Minnesota at 27th out of 50 states.
- Obesity: since 2013, obesity in Minnesota has increased 20%; from 23.7% to 28.5% in adults 65+
- Pain management: Arthritis is seen in over 50% of adults 65+ and is a leading cause of disability (limits usual activity). In Minnesota, only 44% of persons those 65+ with arthritis report that they do not experience limits to their usual activity. (MN ranks 37th of 50 states)

**Recommendations for Strategic Priorities**

**Nutrition**

- Expand work with cultural and ethnic community providers to tailor services to their older community members.
- Expand work with providers in rural areas to develop new service delivery models that address the workforce/volunteer shortage, transportation barriers and achieving economies of scale.
- Jointly explore new opportunities and potential partnerships that expand consumer choice and geographic reach for both Congregate and Home Delivered meals while meeting the requirements of the OAA Title III C.
- Work with providers to continue to develop and enhance sustainable sources of revenue for program support.
- Continue to explore options to address anticipated workforce shortage across the state.

**Healthy Aging**

- Develop new opportunities to reach currently unserved populations, particularly in mental health, with evidence based programs.
- Engage community providers to develop sustainable models that provide evidence based programs and services at a reasonable cost for all older adults.
- Look toward new and creative partnerships such as: Veterans Administration, cultural and ethnic community organizations, and healthcare providers to expand opportunities for all older adults to participate in healthy aging programs.
- Consider other models of program delivery such as telehealth, online access or others that meet the standards and outcomes for evidence based programs.
Housing

HELPING OLDER MINNESOTANS AGE IN PLACE

MINNESOTA BOARD ON AGING

MARCH 2018
MN2030 – SUPPORTING THE HOUSING NEEDS OF OLDER ADULTS

The Minnesota Board on Aging (MBA) policy briefs offer an opportunity for stakeholders to learn about and engage in a planning effort to reform our system and to prepare communities and the state to meet the challenges and opportunities associated with an aging population. The housing brief, originally discussed by the MBA in November has updated information and recommendations based on input from stakeholders.

Current Status

The challenge with “housing” for older adults is that having a roof above one’s head is not necessarily “good enough” for older adults who are living with multiple chronic conditions and may need help around the house or with their personal care. “Housing” needs cross over into “healthcare” needs. It is this “health and housing” situation that presents the unique challenge to allow older adults to continue to age well and live well in the housing of their choice.

This updated brief weaves housing for older adults into three categories; first is a review low income older Minnesotans living in single family homes and rental settings; second is a summary of current rental and home ownership programs for older Minnesotans and third a summary of programs related to housing managed by the MBA and Aging and Adult Services Division at the Minnesota Department of Human Services (DHS). The brief does not delve into specifics as it relates to congregate settings like housing with services/assisted living (HWS/AL) or nursing facilities. Finally the brief will review recommendations in the immediate and near future the MBA will consider.

Older adults generally age in place in their single family home through their 70s and early 80s. It is not until age 85 they start to move into some form of rental housing. Currently, the largest group of baby boomers is still under the age of 60, indicating that most of them will remain in their home for another 15 years or more. In 2020, the oldest baby boomers will be turning 74 years old.

To set the stage and understand housing for older Minnesotans, below is the home ownership and rental landscape for Minnesota divided by age group. To support housing needs of older Minnesotans there is a two-fold strategy; support aging in place, a focus on single family homes and second future development of rental housing options for older Minnesotans. With a robust strategy that addresses housing needs of an older person, regardless if they own or rent we can delay a need for long term care services.
Homeownership and Rental Landscape

When considering housing policy and strategies to serve older adults, an important consideration is the number of moderate to low-income older adults that rent or own their own home and future population trends in the state. In fact, by 2035, older adults will account for more than 30 percent of the population in many counties, particularly in north central Minnesota and some of the border counties around the state.

A household is cost-burdened if the homeowner spends 30 percent or more of their income on housing. As reported by the Minnesota Housing Finance Agency (Minnesota Housing), an estimated 26 percent of households age 65 to 74 are cost burdened by home maintenance and 41 percent of people over 85 are burdened by costs to maintain their home (Minnesota Housing, 2018 Affordable Housing Plan, page 7).

Additional metrics to focus on are the number of homeowners and renter households that are low (30% – 50%) and extremely low income (30% or less) levels. These statistics are important because at a time older people encounter rising housing costs, they typically face financial constraints related to medical care and in-home services.
To put a focus on homeowner costs or older people, in 2016, Minnesota Housing contracted with Wilder Research to conduct a study to identify the home improvement needs of extremely low-income older adult homeowners in Minnesota. Wilder Research also estimated the cost of making necessary improvements that would allow low income older adults to continue living in their homes and thereby avoid more costly and restrictive settings such as assisted living or nursing home care. In the study, Wilder estimated based on Integrated Public Use Microdata data from the U.S. Census Bureau’s American Community Survey (2014), there was approximately 51,495 mortgage free, households over 65 that qualify for Minnesota Housing’s Rehabilitation Loan Program and Emergency & Accessibility Loan Program based on income.

The study produced the following additional insights:

- How many extremely low-income older adult homeowner households have home rehabilitation or improvement work that is needed for them to age-in-place appropriately?
  - 16,400 households (32 percent of households with extremely-low-income older adult homeowners) need home rehabilitation or improvement work in order for the older homeowner(s) to remain in their homes for the next five years. This includes 10,400 households in Greater Minnesota and 6,000 households in the 7-county metro area.

- How much will it cost to do this rehabilitation or improvement work?
  - Approximately $15,749 per household or roughly $258 million statewide per 5 years, including $164 million for Greater Minnesota and $94 million for the 7-county metro area.

To illustrate the costs to live in different settings, the 2016 Wilder study evaluated the monthly costs of three types of living arrangements; aging in home, assisted living and skilled nursing facility. Comparing costs for a person to age in their home vs. an assisted living is a complex evaluation. Complex because living arrangements vary and the needs of the person is diverse too.

With that in mind, in the case of aging in home, the study assumed home care services costs at 20 hours per week, monthly costs for home improvement and monthly housing costs including property taxes, insurance and utilities. The person living in their home was assumed to have their
mortgage paid. The monthly cost for a person living in an assisted living was derived from limited services and average monthly rent payment. To round out the assessment, the average monthly costs to live in a private skilled nursing home was also included.

Cost comparison

- Aging in home: $3,346
- Assisted living: $4,357
- Skilled nursing facility: $7,576

**Rental and Housing Supports for Older Minnesotans**

There are many kinds of housing supports within Minnesota whether supported by federal, state, or local funds. Currently, Minnesota Housing has several housing programs that are relevant to older adults. Here are 6 such programs. The appendix provides a more in depth description.

A. Section 8
B. USDA/Rural Development Section 515
C. Public Housing
D. Low Income Housing Tax Credits
E. Minnesota Housing Rehabilitation Loan and Emergency & Accessibility Loan Program
F. Housing Infrastructure Bonds (HIBs).

**A. Section 8**

Section 8 housing serves just over 30,000 households with about 47 percent of these households headed by someone age 62 or older. When compared to the 26 percent share of the general population of low-income renter households in Minnesota who are age 62 or older this issue raises critical concerns. In fact, 10 percent of Section 8 households are headed by someone age 85 or older.

**B. USDA/Rural Development Loans (Section 515 Properties)**

Over 3,800 heads of household who receive USDA/Rural Development Loans are age 62 years or older, or roughly 40 percent of all Rural Development households (9,531). Of those older Rural Development households, 8.1 percent are overburdened. This means those heads of households are paying more than 30 percent of their income on housing.

**C. Public Housing**

Of the 23,000 public housing units in Minnesota about 29 percent are headed by someone age 62 or older. Minnesota Housing helps preserve the physical condition of these units through its programming.
D. Low-Income Housing Tax Credits

Through Low-Income Housing Tax Credits, Minnesota Housing supports rental housing which have income and rent limits to ensure affordability. There are about 33,000 rental units in developments which have been subsidized through a Low-Income Housing Tax Credit. Because Section 8 and Public Housing has served older adults very well, only 16 percent of these units are headed by someone age 65 or older.

E. Rehabilitation Loan Program

The Rehabilitation Loan Program is a federally funded program that provides either secured or unsecured loans to homeowners who qualify for the program through income eligibility guidelines. The program can be used to repair, improve, or modernize homes (e.g. repair or replace roof, winterizing, purchase or repair of heating system, structural repair, and water and sewage connect fees, and similar uses). In federal fiscal year 2016, just over $640,000 was spent to complete 107 single family home repair projects. Based on the study conducted by Wilder Research, Minnesota Housing estimates that over 51,000 older adult households are eligible for, and could benefit from, this resource if more funding were available.

F. Housing Infrastructure Bonds (HIBs)

HIBs proceeds are intended to address affordable housing infrastructure needs. The Minnesota Housing Finance Agency allocates HIBs through an RFP process. When a loan is awarded the money goes to development or rehabilitation of affordable housing units. In 2017, the legislature allocated $55 million in HIB proceeds. As of 2017, $13.5 of the HIB was awarded, leaving $41.5 for 2018.

MBA and DHS Supports for Housing

Older Americans Act Funds

The Older Americans Act (OAA) funds administered by MBA can support “home modification” for the minor modification of homes that is necessary to facilitate the ability of older individuals to remain at home. Currently, the amount of OAA funding allocated to home modifications is quite low with an estimated 40 individuals to be served this calendar year. These limited funds must also support equally critical in-home and supportive services such as chore, homemaker and transportation.

Live Well at Home – Capital and Renovation Grants

Applications may be made for Live Well at Home (LWAH) grants, administered by DHS, to cover the capital costs of new construction, renovation, retrofitting, or remodeling of existing buildings or accessibility modifications in individuals’ homes. The goal of the renovation and remodeling efforts is the delivery of unique approaches to housing and services, affordable housing units suitable for in-home services or combinations of services, to residents age 65 and older with low and moderate incomes and persons with a variety of chronic health conditions. Retrofitting produces savings for older adults as it reduces costs of medical care and other services. It should focus on homes that lack the necessary structural features and support systems to make aging in place viable. Renovation, retrofitting and home
modification includes making existing housing units accessible and/or incorporating elements of universal design.

Three examples of the capital and renovation projects funded by LWAH grants in the past include:

- In 2014, Dellwood Gardens, a culturally specific residence was awarded a LWAH grant to cover capital costs to develop rental housing. The project included several capital improvements such as:
  - Americans with Disability Act (ADA) compliant walkways and ramps
  - Updated electrical and plumbing work on residential and common spaces
  - Improved fire prevention updates
  - An updated exercise room for the residents.

- Alliance Housing was awarded a grant to provide 42 units of housing support to older adults who are homeless. This project received tax credits from Minnesota Housing and began breaking ground on the project.

- In 2015 Mahube-Otwa (in Mahnomen, Hubbard, Becker, Otter Tail, and Wadena counties) was awarded a grant to provide ongoing homemaking/chore or one-time home repair/remodel assistance to low-income older adults living in rural Minnesota.

**Environmental Accessibility Adaptations – DHS HCBS Programs**

Unlike rehabilitation projects that modernize or improve the home structure of an older person’s home, a recipient on one of the home and community-based services (HCBS) programs administered by DHS, the Elderly Waiver (EW) or Alternative Care (AC) programs, are eligible for environmental accessibility adaptations (EAA) for their home or vehicle. An EAA is portable or permanent equipment, materials, devices and systems that is a direct benefit of the person. The EAA must be linked to an assessed need and ensure the health and safety or help the person function with greater independence. As of 2016 a person on EW or AC is now eligible for $20,000 EAA adaptations per year up from $10,000. This increase allows people on these programs to cover the market rate cost of the environmental accessibility adaptations they need including home modifications and adaptations to a vehicle.

**Recommendations for Strategic Priorities**

MBA, DHS and Minnesota Housing are committed to addressing the affordable housing needs of older adults in preparation for 2030. Closely coordinated with this effort is the provision of services to older adults who need help around the house or with their personal care.

As Americans live longer, healthier and connected lives, access to home rehabilitation opportunities combined with accessible services is key to living in the community. As such, **home rehabilitation will be a primary strategy for at least the next 10 years because most Baby Boomers are under age 65 and will continue to live in their own single family homes for the next 15-plus years.** When Minnesotans choose to live in their updated home this creates an opportunity to preserve connections to their community, friends and family.
The provision of affordable older adult housing with services is a longer term need and requires new thinking. Through the use of “gap financing”, which is zero-interest, deferred loans, rather than regular interest-bearing amortizing debt, the property owner does not pay any interest on this debt, and only pays off the principal 30 or more years down the road. With no debt costs, they can charge lower rent. Housing is made more affordable and serves even lower income households by increasing the share of the financing coming from zero-interest, deferred loans. Minnesota Housing in collaboration with DHS and MBA, is exploring the use of “gap financing” as a way to support the development of affordable rental housing for older adults. A senior housing pilot is underway with two developments, one in Mora and one in Woodbury. As the housing is being developed, work is also underway to determine the service availability for residents and ways to support aging in place.

A priority across all of these efforts is to work with cultural and ethnic communities to develop models that best support their older community members. These efforts can build on the successful models that have been supported, in part, through the LWAH grant program. These models have combined congregate housing with supportive services in ways that have fostered social connections and facilitated healthy aging for the older residents.

Below are more housing strategies to consider.

- Advocate for the implementation of a multi-agency task force assigned to focus solely on needs and opportunities related to older adult housing.
- Request additional state funds for the Rehabilitation Loan Program to fund home modifications and maintenance for very low-income home owners.
- Create a strong linkage between the Rehabilitation Loan Program and the delivery of HCBS
- Build provider capacity, especially in rural areas, to effectively administer these programs to help very low-income older homeowners to age in place.
- Prioritize projects that address the needs of low income home owners and development/rehabilitation of affordable rental housing in the LWAH Request for Proposals.
- Explore ways to coordinate funding between Minnesota Housing and DHS to modernize existing affordable/subsidized rental housing developments with tele-monitoring or other technology and in-home supports.
- Provide technical assistance to communities to assess their housing needs holistically and create “communities for a lifetime”. Encourage the development of housing plans that balance the housing needs across generations, increase flexibility in allowed housing types and otherwise encourage fluid use of housing across generations as needs change.
- Support the development of new smaller-scale housing options that provide meaningful alternatives to assisted living for low income older adults and encourage family and informal help around the house or with personal care.
Appendix

Minnesota Housing Finance Agency Housing Programs  Section 8

The housing choice voucher program, or Section 8 as it is commonly referred to, is the federal government's program for assisting very low-income families, the elderly, and the disabled to afford housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

USDA/Rural Development Loans (Section 515 Properties)

Similarly, the U.S. Department of Agriculture (USDA) oversees the rural development housing loans program, known as Section 515. It is primarily a direct housing mortgage program where loans are direct, competitive mortgage loans made to provide affordable multifamily rental housing for very low-, low-, and moderate-income families, elderly persons, and persons with disabilities. Many Section 515 properties also provide project-based rent assistance similar to Section 8. A current priority of Minnesota Housing is to preserve the affordability and physical condition of both Section 8 and 515 properties and units.

Public Housing

Public housing provides rental housing for eligible low-income families, the elderly, and persons with disabilities. It comes in all sizes and types, from scattered single family houses to high-rise apartments for elderly families. The U.S. Department of Housing and Urban Development (HUD) administers Federal aid to local housing agencies (HAs) like Minnesota Housing to achieve its mission.

Low-Income Housing Tax Credits

The Low-Income Housing Tax Credit (LIHTC) is the federal government’s primary program for encouraging the investment of private equity in the development of affordable rental housing for low income households. It is an indirect federal subsidy that finances low-income housing allowing investors to claim tax credits on their federal income tax returns.

Rehabilitation Loan Program

The Rehabilitation Loan Program is not age related and provides either secured or unsecured loans to homeowners who qualify for the program. Minnesota Housing’s estimation is that roughly 51,000 older adult households are eligible for this programming.
Attachment F

CY 2017 Annual Title III FEDR C1, FEDR C2, State & NSIP / FY 2017 Annual Title VI Part A/B, Part C, and NSIP

<table>
<thead>
<tr>
<th>Congregate</th>
<th>FEDR C1</th>
<th>FEDR C2</th>
<th>State &amp; NSIP</th>
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<tbody>
<tr>
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<td>34,650</td>
<td>-</td>
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</tr>
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<td>White Earth</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Leech Lake</td>
<td>72,500</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HDM</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bois Forte</td>
<td>-</td>
<td>18,285</td>
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<td>Leech Lake</td>
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<td>46,135</td>
<td>68,345</td>
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<table>
<thead>
<tr>
<th>Grantee Name</th>
<th>Title VI A/B</th>
<th>Title VI C</th>
<th>NSIP (Cash)</th>
</tr>
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<tbody>
<tr>
<td>Bois Forte Band of Chippewa</td>
<td>$83,960</td>
<td>$20,730</td>
<td>$11,200</td>
</tr>
<tr>
<td>Fond du Lac Band of Lake Superior Chippewa</td>
<td>$137,640</td>
<td>$48,380</td>
<td>$42,236</td>
</tr>
<tr>
<td>Leech Lake Band of Ojibwe</td>
<td>$137,640</td>
<td>$48,380</td>
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<tr>
<td>Red Lake Nation</td>
<td>$137,640</td>
<td>$0</td>
<td>$55,728</td>
</tr>
<tr>
<td>White Earth Nation</td>
<td>$137,640</td>
<td>$48,380</td>
<td>$12,158</td>
</tr>
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<td>Grand Portage Band of Lake Superior Chippewa</td>
<td>$73,990</td>
<td>$13,820</td>
<td>$4,760</td>
</tr>
<tr>
<td>Mille Lacs Band of Ojibwe</td>
<td>$83,960</td>
<td>$20,730</td>
<td>$25,940</td>
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<tr>
<td>Lower Sioux Indian Community</td>
<td>$73,990</td>
<td>$13,820</td>
<td>$4,730</td>
</tr>
</tbody>
</table>
The Older Americans Act (OAA) Congress passed the Older Americans Act (OAA) in 1965 in response to concern by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law also established the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the federal focal point on matters concerning older persons. Administration for Community Living (ACL) established on April 18, 2012, bringing together the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities.

Although older individuals may receive services under many other federal programs, today the OAA is considered to be a major vehicle for the organization and delivery of social and nutrition services to this group and their caregivers. It authorizes a wide array of service programs through a national network of 56 state agencies on aging, 629 area agencies on aging, nearly 20,000 service providers, 244 Tribal organizations, and 2 Native Hawaiian organizations representing 400 Tribes. The OAA also includes community service employment for low-income older Americans; training, research, and demonstration activities in the field of aging; and vulnerable elder rights protection activities.

OAA Title III C1: Congregate meals
OAA Title III C2: Home delivered meals
OAA Title VI Part A: Grants for Native Americans
OAA Title VI Part B: Grants for Native Hawaiian program
OAA Title VI Part C: Grants for the Native American caregiver support program
OAA NSIP: Nutrition services incentive program
Healthy Aging in Minnesota: A Priority for Interagency Collaboration

Minnesota communities are transforming, spurred by the aging of the baby boomer generation. In 2030 our society will be permanently older and we have a unique opportunity now to think about and plan for thriving in this new reality. Key to this effort is the development of strategies that support older adults’ opportunities to age and live well in their communities. Several state agencies have expertise and experience in this regard, although it remains unclear how their collective impact can be optimized. This brief report highlights areas of apparent common interest and/or complementary skills and expertise across the Department of Human Services-Aging and Adult Services Division (DHS), the Minnesota Board on Aging (MBA), and the Department of Health (MDH) that can be used to inform future collaboration and/or legislative proposals.

Key Synergies:

Synergy 1: DHS, MBA, and MDH have similar population focuses, providing opportunities for collaborative plans/initiatives to support culturally sensitive healthy aging for people >60.

- DHS provides support to older recipients of state-sponsored services, including long-term services and supports through medical assistance and elderly waiver programs
- MBA distributes Older Americans Act funds to support healthy aging to Minnesotans age 60 or older (chore, homemaker, Congregate and home-delivered meals, evidence-based programs, caregiver)
- MDH compels each State Health Improvement Program grantee to include a plan for the >65 population (plan varies by grantee)
- Both MBA and MDH have explicit priorities to be culturally sensitive and to address the needs of at risk and minority communities through an equity lens

Synergy 2: MDH and MBA both support the implementation of evidence-based programs for healthy aging and have drafted recommendations to support their scale

- MBA distributes Older American Act funds to support evidence-based program implementation across the state
- MDH operates a diabetes group that oversees technical support and the development of a state-wide system for Diabetes Prevention Program implementation
• The Rural Health Advisory Committee Senior Wellness Work Group of MDH has drafted recommendations for sustainable implementation of these programs
• Topical focus of programming is broad and could be used to target many priorities (e.g. chronic disease self-management, physical activity, falls prevention, pain management, mental health, caregiver support, medication management, Alzheimer’s support, ethnic/racially targeted interventions, etc.)

Synergy 3: DHS, MDH, and MBA have complementary experience and interest in engaging healthcare and facilitating linkages that promote healthy aging

• DHS and MDH’ Healthcare Homes Division both have expertise in coordinating services around high need older adults and connecting them to community resources
• MDH’ State Health Improvement Program healthcare strategies often promote clinical integration of and education about several evidence-based programs
• MDH’ Rural Health Advisory Committee Senior Wellness Workgroup highlights the importance of engaging healthcare and community health workers in connecting people to resources and programs for healthy aging
• MDH’ Office of Health Information Technology has interest in translating public health practices into electronic data that could conceivably facilitate clinical referrals
• MBA, through the Area Agencies on Aging, coordinates many services that could be integrated into care transitions plans for older adults leaving the hospital
• MDH’ epidemiologic capacity can be used to catalog, map, and connect people to available community-based supports while also targeting their development

One potential area of focus:

DHS, MBA, and MDH should partner together to build capacity for and operationalize a state-wide system of healthy aging resources in Minnesota, potentially through legislative action. This system should be used to create new partnerships, reach currently underserved populations, and engage community providers in developing sustainable funding models that support healthy aging.

1. This effort should be overseen by an interagency coordinating group (or equivalent) as recommended in MDH’ recently submitted budgetary request, potentially with inclusion of broader stakeholders to extend value and impact.
2. This effort should include the development of a technology infrastructure capable of cataloging and connecting people to useful and diverse resources for healthy aging
a. It should include integration of evidence-based programs implementation efforts currently ongoing across agencies (DPP in MDH, others in MBA, for example)
b. It should include space for inclusion of social supports critical to successful aging (housing, nutrition, home and community-based supports)
c. It should be generic and flexible enough to adapt to needs over time and serve as a framework for addressing problems together (e.g. opioid crisis)

3. The effort should be promoted and prioritized to the greatest extent possible within existing statewide networks (AAAs, local public health departments, healthcare homes, managed care organizations).

4. This effort should be accessible to all, especially to those at highest risk and in greatest need
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAAA</td>
<td>Arrowhead Area Agency on Aging</td>
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<tr>
<td>AAA</td>
<td>Area Agency on Aging</td>
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<tr>
<td>AASD</td>
<td>Aging and Adult Services Division</td>
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<tr>
<td>AC</td>
<td>Alternative Care</td>
</tr>
<tr>
<td>ACL</td>
<td>Administration for Community Living</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ADRD</td>
<td>Alzheimer’s Disease or Related Disorders</td>
</tr>
<tr>
<td>AL</td>
<td>Assisted Living</td>
</tr>
<tr>
<td>CC</td>
<td>Caregiver Consultant</td>
</tr>
<tr>
<td>CDCS</td>
<td>Consumer Directed Community Services</td>
</tr>
<tr>
<td>COV</td>
<td>Certified Ombudsman Volunteer</td>
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<tr>
<td>CMCOA</td>
<td>Central Minnesota Council on Aging</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicaid and Medicare Services</td>
</tr>
<tr>
<td>CSG</td>
<td>Consumer Supported Grant</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>EB</td>
<td>Evidence-Based</td>
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<tr>
<td>EBHP</td>
<td>Evidence-Based Health Promotion</td>
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<tr>
<td>ECHO</td>
<td>Emergency Community Health Outreach</td>
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<tr>
<td>EW</td>
<td>Elderly Waiver</td>
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<tr>
<td>FFY</td>
<td>Federal Fiscal Year</td>
</tr>
<tr>
<td>FSE</td>
<td>Fiscal Support Entity</td>
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<tr>
<td>HCBS</td>
<td>Home and Community Based Services</td>
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<tr>
<td>HCN</td>
<td>Home Care Nursing</td>
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<tr>
<td>HDM</td>
<td>Home Delivered Meals</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>IPI</td>
<td>Informed Patient Institute</td>
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<tr>
<td>LDSAAA</td>
<td>Land of the Dancing Sky Area Agency on Aging</td>
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<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>MAA</td>
<td>Metropolitan Area Agency on Aging</td>
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<tr>
<td>MBA</td>
<td>Minnesota Board on Aging</td>
</tr>
<tr>
<td>MCOTA</td>
<td>Minnesota Council on Transportation Access</td>
</tr>
<tr>
<td>MDH</td>
<td>Minnesota Department of Health</td>
</tr>
<tr>
<td>MHFA</td>
<td>Minnesota Housing Finance Agency</td>
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<tr>
<td>MIAAA</td>
<td>Minnesota Indian Area Agency on Aging</td>
</tr>
<tr>
<td>MNRAA</td>
<td>Minnesota River Area Agency on Aging</td>
</tr>
<tr>
<td>NCI-AD</td>
<td>National Core Indicators for Aging and Disabilities survey</td>
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<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>NH</td>
<td>Nursing Home</td>
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<tr>
<td>OAA</td>
<td>Older Americans Act</td>
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<tr>
<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act (1987)</td>
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<tr>
<td>OOLTC</td>
<td>The Office of Ombudsman for Long-Term Care</td>
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<tr>
<td>PAS</td>
<td>Pre-Admission Screening</td>
</tr>
<tr>
<td>PCA</td>
<td>Personal Care Assistant</td>
</tr>
<tr>
<td>PIPP</td>
<td>Performance-Based Incentive Program</td>
</tr>
<tr>
<td>QIIP</td>
<td>Quality Improvement Incentive Program</td>
</tr>
<tr>
<td>REACH</td>
<td>Resources for Enhancing Alzheimer’s Caregiver Health</td>
</tr>
<tr>
<td>REST</td>
<td>Respite Education and Support Tools</td>
</tr>
<tr>
<td>RTC</td>
<td>Return To Community</td>
</tr>
<tr>
<td>SDS</td>
<td>Self-Directed Services</td>
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<tr>
<td>SEMAAA</td>
<td>South-Eastern Minnesota Area Agency on Aging</td>
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<tr>
<td>SHIP</td>
<td>State Health Insurance assistance Program</td>
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<tr>
<td>SLL</td>
<td>Senior LinkAge Line®</td>
</tr>
<tr>
<td>SMP</td>
<td>Senior Medicare Patrol</td>
</tr>
<tr>
<td>SNAP</td>
<td>Supplemental Nutrition Assistance Program</td>
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<td>SOM</td>
<td>Survey of Older Minnesotans</td>
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<tr>
<td>T/ABI</td>
<td>Traumatic/Acquired Brain Injury</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
<td>--------------------------------------</td>
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<tr>
<td>LTSS</td>
<td>Long-Term Services and Supports</td>
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<tr>
<td>LWAH</td>
<td>Live Well At Home</td>
</tr>
<tr>
<td>MA</td>
<td>Medical Assistance</td>
</tr>
</tbody>
</table>
In addition to public engagement from the online survey, community conversations and resident council community conversations, the State Plan had an official 30-day public comment period.

Through the public comment period there were individual comments from a range of stakeholders. The input included issues around direct care employment that included ensuring benefits for employees in skilled nursing facilities, to the role of community health workers. Comments also suggested the need to provide support for caregivers especially in communities of color.

Other comments included reminders to avoid the binary “Us vs. Them” language. Even more comments encouraged us to review ageist language to create a more inclusive State Plan. More comments had positive feedback for the goals and objectives and support using the WHO eight domains for community living as a framework. There was also support for the thoughtfulness of the State Plan.

Comments identifying ways to include Community Health Workers may be adapted under leveraging older adults to engage in their communities. This was further emphasized by MBA Board members who discussed empowering neighborhoods so older adults can assist one another and their communities. This avenue of sharing information through “trusted messengers” has a lot of value.

Comments on increased funding for skilled nursing facilities (for physical improvements and maintenance) was exemplified along with improving wages for workers and boosting their benefits (health insurance and pension).

Comments to serve diverse communities by being intentional and more exploration into the MN2030 value of ingenuity was highlighted. In addition, comments to review how assessment tools apply to diverse communities and clients with no or limited English skills. Having a person centered care that provides services based on diverse needs will need to be considered as we look to develop LTSS for the future.

It is important to highlight when the public comment State Plan was issued, Community and Healthcare was the number one issue between the online survey, community conversations and resident council community conversations. After further input from our stakeholder engagement, the rankings changed. For the resident council community conversations Respect and Social Inclusion was the most important issue. Community and Healthcare remained number for the online survey and community conversations. To visually illustrate the community conversations and resident council community conversations below is a map that shows the reach throughout the state.
## Goal 1: Leverage the experience, expertise and energy of older Minnesotans

### Strategic Priority 1.1: Facilitate opportunities to connect older people to their communities and engage them in the activities that offer them social connections.

- Advocate for public policies that will create opportunities for low-income older adults to engage in their neighborhoods.
- Build capacity within communities and Senior Corps agencies to harness social capital and take the pledge to be “MN2030 ready”.
- In partnership with MN Department of Transportation and Commerce, advocate for policies that build capacity for volunteer drivers.
- Utilize social capital within the Senior Corps programs to support opioid abuse prevention, awareness and education, reduction of social isolation, through local nonprofits, faith-based community organizations and with Tribal Nation partners across the State.

### Specific Measures:

- Establish a baseline assessment on the current patterns of volunteer engagement.
- Assess range of HCBS options that offer meaningful engagement opportunities for older adults.
- Convene Funders Network (philanthropies – private and public) to support the development of volunteer engagement in grant funding.
- Engage 50% of senior Corp programs to be part of the MN2030 effort by strengthening HCBS efforts within their network of community organizations.
- Develop legislative proposal to exempt volunteer drivers from livery laws and provide protection from liability and insurance rates.
- **Disseminate information related to community involvement, intergenerational programs, and volunteerism to AAAs, state agencies, tribal organizations and other stakeholders.**

**Target Time: June 2021**
### Strategic Priority 1.2: Work with employers to increase the number of older people (those 50+) who are actively recruited and retained as part of an overall workforce strategy

**Specific Measures:**

- Increase awareness for workplace flexibility for service and professional industry to phase/delay retirement.
- Re-develop the Transform 2010 policy brief based Minnesota’s New Pathways for Older Workers with MN2030 themes and initiatives.
- Increase number of older adults working from home
- Increase number of trainings for lower income older people close to retirement
- Increase access to technology for lower income older people close to retirement
- Increase number of employers utilizing “phased” retirement options
  
  **Target Time:** December 2019 and ongoing

- Advocate for older people to be an integral part of the state’s workforce; including training for schools/children to work with the older workforce
- Promote flexibility to retain older workers by engaging in a multi-state agency coalition.
- Advise partners on workforce shortage and develop an outreach campaign to utilize older workers.
- Identify and promote incentives for businesses to employ older workers.
- Leverage research relationship with the University of Minnesota to focus on employer and older worker needs and priorities.

### Strategic Priority 1.3: Leverage advocacy efforts of older people, their families, and all stakeholders to prevent abuse and neglect and support the ability of all people regardless of age to exercise their full rights

**Specific Measures:**

- Prepare training curriculum for community volunteers on how older adults and families can help reduce the incidence of abuse and neglect.
- Convene quarterly meetings with Tribal Health and Human Services and MN Department of Health- American Indian Liaison to support elders by increasing capacity of tribal communities in identifying and working through issues of

- Work with DHS and MDH to quickly respond to allegations of abuse and neglect of vulnerable adults.
- Partner with DHS to support the role of the county lead investigative agencies through increased regional support, training and technical assistance.
- Partners with DHS to fully develop a person-centered maltreatment reporting and response system to support remediation and prevention activities.
• Increase awareness of and promote antibiotic stewardship by providing information and consultation to individuals and presentations at facility resident and family councils.
• Develop materials and conduct outreach so older volunteers may understand rights and respects so they can advocate against abuse and neglect.
• Create awareness and develop materials on prevention and reporting of educational materials on abuse and neglect for non-English speaking communities.

Target Time: June 2020 and ongoing

Goal 2: Equip older Minnesotans with the tools to take charge of their health and make informed decisions about services when they need them

Strategic Priority 2.1: Achieve statewide availability of a range of healthy aging programs.

Specific Measures:
• Convene quarterly Healthy Aging meetings with MN Department of Health for interagency collaboration on complimentary priorities.
• Continue to build sustainable local/regional infrastructure to deliver evidence-based health promotion (Title IIIID) programs.
• Continue to provide technical assistance to licensed organizations and AAA.
• Target special populations with health disparities including Native Americans.

• In collaboration with the MN Department of Health, launch a statewide public-private partnership to support health and wellness for all older Minnesotans.

• Increase the support structure for regional and community-wide efforts (such as Juniper, Wisdom Steps), including sustainability and availability, to promote health and wellness.
Strategic Priority 2.2: Pursue new opportunities to address disparities and reach currently unserved or underserved populations with healthy aging programs and nutrition services.

- Look toward new and creative partnerships such as with the: Veterans Administration, cultural and ethnic community organizations, community health workers, and healthcare providers to expand opportunities for all older adults to participate in healthy aging programs.

- Support the dissemination of community level efforts led by older adults (such as Vital Aging Network’s engagement effort, Evolve) to encourage health and wellness.

- Consider other models of healthy aging program delivery such as telehealth, online access or others that meet the standards and outcomes.

- Partner with food shelves to reach high risk older adults with low incomes who are experiencing undernutrition or malnutrition.

- Work with cultural and ethnic communities to train community members as coaches/leaders and increase the availability of culturally tailored programming.

- Advocate for more translations of materials for the healthy aging programs and nutrition.

- Align the work of the MBA Indian Elders Coordinator with Wisdom Steps and tribal efforts to support healthy aging for Native American elders.

Target Time: June 2022.

Strategic Priority 2.3: Modernize the nutrition services delivery model to achieve efficiencies, promote sustainability and increase choice.

Specific Measures:

- Implement the Veterans Directed-HCBS program in at least three AAA

- Strengthen Peerplace data for sites supported by Title III Funds

- Quarterly review of Peerplace data by race/ethnicity by AAA region

- Compile gaps analysis of the Title IIIC Home Delivered Meals (HDM) nutrition risk assessment for dissemination to AAA.

- Establish a new partnership with at least one non-OAA funded agency to collaborate on identifying and implementing strategies to improve food security within cultural and ethnic communities and tribal nations.

Target Time: June 2022.
• Develop and implement a business plan to test and bring to scale one or more new models of nutrition service delivery.
  o Identify and engage non-traditional partners to leverage their areas of expertise.
  o Explore new roles for volunteers to address needs such as social isolation.
  o Explore different infrastructure models for the cooking, packaging, purchasing and delivery of meals.
  o Explore and test the use of new technology to achieve efficiencies in program operation.
  o Maximize the use of participant and population data to drive continuous program improvements.

• Convene quarterly meetings with nutrition providers and AAA to explore nutrition models.
• Pilot and evaluate a new volunteer engagement strategy at one nutrition site
• Quarterly meetings with providers to assure data integrity
Target Time: March 2022.

**Strategic Priority 2.4: Strengthen the delivery of health insurance counseling and long-term care options counseling, through the Senior LinkAge Line®.**

<table>
<thead>
<tr>
<th>Specific Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop and implement a robust training plan based on a needs assessment to support Senior LinkAge Line® staff and volunteers in the successful delivery of the full range of Senior LinkAge Line® services.</td>
</tr>
<tr>
<td>• Conduct a needs assessment of information technology including research existing options to meet those needs and deploy the preferred solutions statewide.</td>
</tr>
<tr>
<td>• Review lessons learned in the delivery of care transition support for people moving into a nursing home, leaving a nursing home, considering a move to assisted living, and being discharged from a hospital. Refine protocols and increase coordination with partners to achieve statewide consistency based on best practices.</td>
</tr>
<tr>
<td>• In partnership with DHS, MN Department of Health and external stakeholders, launch an assisted living report card to provide older adults and families with useful quality information.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Time: June 2022.</th>
</tr>
</thead>
</table>
### Goal 2: Equip older Minnesotans with the tools to take charge of their health and make informed decisions about services when they need them

#### Strategic Priority 2.1: Achieve statewide availability of a range of healthy aging programs.

<table>
<thead>
<tr>
<th>Specific Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Convene quarterly Healthy Aging meetings with MN Department of Health for interagency collaboration on complimentary priorities.</td>
</tr>
<tr>
<td>• Continue to build sustainable local/regional infrastructure to deliver evidence-based health promotion (Title IIID) programs.</td>
</tr>
<tr>
<td>• Continue to provide technical assistance to licensed organizations and AAA.</td>
</tr>
<tr>
<td>• Target special populations with health disparities including Native Americans and cultural and ethnic communities specific to needs.</td>
</tr>
<tr>
<td>• Partner with Wisdom Steps and share information about evidence-based disease prevention programs with tribal organizations and members to promote opportunities for collaboration and coordination.</td>
</tr>
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**Target Time:** March 2020

<table>
<thead>
<tr>
<th>Specific Measures:</th>
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<tbody>
<tr>
<td>• In collaboration with the MN Department of Health, launch a statewide public-private partnership to support health and wellness for all older Minnesotans.</td>
</tr>
<tr>
<td>• Increase the support structure for regional and community-wide efforts (such as Juniper, Wisdom Steps), including sustainability and availability, to promote health and wellness.</td>
</tr>
</tbody>
</table>

#### Strategic Priority 2.2: Pursue new opportunities to address disparities and reach currently unserved or underserved populations with healthy aging programs and nutrition services.

<table>
<thead>
<tr>
<th>Specific Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implement the Veterans Directed-HCBS program in at least three AAA.</td>
</tr>
<tr>
<td>• Strengthen Peerplace data for sites supported by Title III Funds.</td>
</tr>
<tr>
<td>• Quarterly review of Peerplace data by race/ethnicity by AAA region.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific Measures:</th>
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</thead>
<tbody>
<tr>
<td>• Look toward new and creative partnerships such as with the: Veterans Administration, cultural and ethnic community organizations, community health workers, and healthcare providers to expand opportunities for all older adults to participate in healthy aging programs.</td>
</tr>
<tr>
<td>• Support the dissemination of community level efforts led by older adults (such as Vital Aging Network’s engagement effort, Evolve) to encourage health and wellness.</td>
</tr>
</tbody>
</table>
- Consider other models of healthy aging program delivery such as telehealth, online access or others that meet the standards and outcomes.

- Partner with food shelves to reach high risk older adults with low incomes who are experiencing undernutrition or malnutrition.

- Work with cultural and ethnic communities to train community members as coaches/leaders and increase the availability of culturally tailored programming.

- Advocate for more translations of materials for the healthy aging programs and nutrition.

- Align the work of the MBA Indian Elders Coordinator with Wisdom Steps and tribal efforts to support healthy aging for Native American elders.

- Compile gaps analysis of the Title IIIC Home Delivered Meals (HDM) nutrition risk assessment for dissemination to AAA.

- Establish a new partnership with at least one non-OAA funded agency to collaborate on identifying and implementing strategies to improve food security within cultural and ethnic communities and tribal nations.

  Target Time: June 2022.

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**Strategic Priority 2.3: Modernize the nutrition services delivery model to achieve efficiencies, promote sustainability and increase choice.**

- Develop and implement a business plan to test and bring to scale one or more new models of nutrition service delivery.
  - Identify and engage non-traditional partners to leverage their areas of expertise.
  - Explore new roles for volunteers to address needs such as social isolation.
  - Explore different infrastructure models for the cooking, packaging, purchasing and delivery of meals.
  - Explore and test the use of new technology to achieve efficiencies in program operation.
  - Maximize the use of participant and population data to drive continuous program improvements.

**Specific Measures:**
- Convene quarterly meetings with nutrition providers and AAA to explore nutrition models.
- Pilot and evaluate a new volunteer engagement strategy at one nutrition site
- Quarterly meetings with providers to assure data integrity

  Target Time: March 2022.

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**Strategic Priority 2.4: Strengthen the delivery of health insurance counseling and long-term care options counseling, through the Senior LinkAge Line®.**

- Develop and implement a robust training plan based on a needs assessment to support Senior LinkAge Line® staff and volunteers in the successful delivery of the full range of Senior LinkAge Line® services.

**Specific Measures:**
- Conduct surveys with Senior LinkAge Line® staff and volunteers to determine confidence providing options counseling

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- Conduct a needs assessment of information technology including research existing options to meet those needs and deploy the preferred solutions statewide.

- Conduct surveys with consumers to determine high satisfaction (90% or better) of service delivery
- Implement new client tracking tool and VoIP option
- Increase care transition referrals by 10%
- Completion of assisted living report card for distribution to stakeholders
- Increase use of assisted living report card by 10% within first 3 months after launch
- Increase statewide healthcare directives by 10%

Target Time: June 2022.

- Review lessons learned in the delivery of care transition support for people moving into a nursing home, leaving a nursing home, considering a move to assisted living, and being discharged from a hospital. Refine protocols and increase coordination with partners to achieve statewide consistency based on best practices.

- In partnership with DHS, MN Department of Health and external stakeholders, launch an assisted living report card to provide older adults and families with useful quality information.
<table>
<thead>
<tr>
<th>Goal 3: Support families and friends in their caregiving roles</th>
</tr>
</thead>
</table>
| **Priority 3.1: Enhance the caregiving support**  
infrastructure to provide family caregivers with on-demand access to consultation and resources in person, by phone or online.  

- Expand Senior LinkAge Line® hours to include evenings and weekends to accommodate individuals’ caregiving. Enhance services by providing web conferencing, online support and problem solving that meets caregivers at their level of information exchange.  
- Increase coordination between Senior LinkAge Line® and OAA-funded caregiver services grantees to maximize support for caregivers.  
- Through the MBA dementia grants, strengthen education and resources for caregivers of persons with dementia.  
- Increase work with cultural and ethnic communities to develop models that best meet the needs and preferences of those in their community who are providing care as well as the care receivers. Important to recognize the variation in family systems, cultural contexts, and disease trajectories.  
- Expand the caregiver consultation service and create regional “hubs” or virtual centers to increase access to a range of support for people who are caregiving.  
- Explore/promote market-based solutions for supporting caregivers. Includes vouchers for services and supports and better technology to support older adults and caregivers  
- Coordinate the identification and support of family and friend caregivers across the health care and long-term services and supports systems, especially during care transitions.  

**Specific Measures:**  
- Caregivers report satisfaction with availability and information of services provided 90% of the time.  
- Increase Senior LinkAge® Line staff awareness of OAA caregiver services  
- Increase referrals to OAA caregiver services by 10%  
- Enhance protocols for Community Living Specialists to offer resources to caregivers  
- Ensure [www.minnesotahelp.info](http://www.minnesotahelp.info) data includes OAA and community caregiver resources  
- Increase dementia training opportunities for a diverse range of partners and communities.  
- Increase access to caregivers on a range of evidence-based training opportunities that help them be better equipped to provide emotional and physical support to their loved one.  
- Increase access to at-risk family caregivers with information about services that will assist them in their caregiving role.  
- Increase awareness to tribal members on caregiver resources for grandparents raising grandchildren  
- Increase caregiver services to tribal members by 5% annually.  

**Target Time:** Annually & ongoing
<table>
<thead>
<tr>
<th>Priority 3.2: Build capacity within informal caregiver networks to enhance caregiving skills</th>
<th>Specific Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Train caregiver consultants to assist family and friends with finding and using various technologies to complement their roles and ease care tasks.</td>
<td>• Refresh MBA caregiver web page to be more user friendly and to connect with other relevant websites and caregiver resources.</td>
</tr>
<tr>
<td>• Continue and increase support for caregivers of older adults during transitions of care, and others who are stressed and at risk of formal placement of older adults. Strengthen partnerships to fully realize the potential of the MN CARE Act.</td>
<td>• Increase the percentage of caregivers supported in the Family Caregiver Support Program.</td>
</tr>
<tr>
<td>• Extend home modification trainings for caregivers by caregiver consultants.</td>
<td>• Build sustainability in Respite Education and Support Tools (REST) by training 4 Master Trainers in the State to offer annual statewide REST companion trainings.</td>
</tr>
<tr>
<td>• Disseminate statewide the mobile respite model that taps college-level nursing, occupational therapy and physical therapy students and with high school service learning projects.</td>
<td>• Increase funding of respite to approved respite or licensed adult day provider licensed by State as enhancements to the CARE Act.</td>
</tr>
<tr>
<td></td>
<td>Target Time: November 2020 and ongoing</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority 3.3: Support family and friends who are caregiving by building respite options</th>
<th>Specific Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide alternatives for one-to-one respite to maximize resources, such as group respite.</td>
<td>• Increase respite awareness, access and utilization by 25%.</td>
</tr>
<tr>
<td>• Build a sustainable program and financial infrastructure for family caregivers to include gap filling services for unpaid family caregivers who provide care to individuals across the lifespan.</td>
<td>• Offer one free emergency respite to any individual that identifies as a caregiver.</td>
</tr>
<tr>
<td>• Establish a statewide Respite Care Coalition that can, as some of its first objectives, develop and broadcast respite public service announcements and request that the Governor proclaim a state respite day.</td>
<td>• Increase the availability of affordable respite including in-home, out-of-home, weekend, evening, overnight, self-directed and culturally specific options by 10%.</td>
</tr>
<tr>
<td></td>
<td>• Highlight Family Caregiver Month (November 2019 and onwards) to bring greater awareness to the critical service unpaid caregivers who are family, friends and neighbors caregivers provide in our state by including a press release and Governor’s Proclamation.</td>
</tr>
<tr>
<td></td>
<td>Target Time: November 2019 and ongoing</td>
</tr>
<tr>
<td>Priority 3.4: Strengthen the statewide system for working caregivers to prevent or mitigate caregiver stress and burden.</td>
<td>Specific Measures:</td>
</tr>
<tr>
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</tr>
<tr>
<td>• Educate and work with employers to develop caregiver flexibility and supports in their policies.</td>
<td>• Partner with AAA to Reach 10% of MN 500+ employers educate employers on caregiving stress and burden</td>
</tr>
<tr>
<td>• Conduct educational sessions at workplaces aimed at working caregivers to provide them with strategies and access to resources and services.</td>
<td>• Distribute “Beyond the Workday” Resource Guide for Employers to at least 50% of the top 30 employers in the State</td>
</tr>
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<td></td>
<td>• Develop presentation/resource kit for outreach to employers</td>
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<td></td>
<td>• Increase education on health care directives in all REST trainings by 90%.</td>
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<td></td>
<td>• Assess current caregivers needs by utilizing the caregiver assessment tool and disseminate to AAAs</td>
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<tr>
<td></td>
<td>• Pilot a caregiver support option offered by an employer to mitigate stress of employees.</td>
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<td></td>
<td>• Ensure that at least 10% of caregivers have completed a caregiving plan that includes respite, health care directives, and includes REST training</td>
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<tr>
<td></td>
<td>• Gather aggregate data on Family Medical Leave Act utilization in Minnesota to further develop resources for employers.</td>
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<tr>
<td>Target Time: December 2021</td>
<td></td>
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</tbody>
</table>
### Goal 4: Support aging in community with access to a range of services and housing options

#### Strategic Priority 4.1: Assist older low income homeowners to age in community through affordable home maintenance, modifications and in-home services.

- Advocate for the implementation of a state-level multi-agency task force assigned to focus solely on the needs and opportunities related to older adult housing.

- Launch a public-private partnership to complete home modifications and home maintenance repairs needed by the 16,400 very low-income homeowners at risk of needing to move.

- Request additional state funds for the MHFA Rehabilitation Loan Program to fund home modifications and maintenance for very low-income older home owners.

- Create a strong linkage between the MHFA Rehabilitation Loan Program and the delivery of HCBS, review local building requirements to promote aging in the community

#### Specific Measures:

- Percent increase in number of home modifications and home maintenance repairs
- Increase additional state funds to fund home modifications and maintenance for very low-income older home owners
- Develop 2019 legislative proposal (with budget) in coordination with MHFA and other stakeholders

**Target Time: December 2021**

#### Strategic Priority 4.2: Coordinate funding support of, and service provision in, affordable and subsidized congregate housing options for older adults, ensure Landlord Tenant Law protects older adults

- Explore ways to coordinate funding between MHFA, DHS and MBA to modernize existing affordable and subsidized congregate housing options with tele-monitoring or other technology and in-home supports.

- Convene stakeholders to review local building requirements to promote aging in the community

- Increase outreach to access funding

- Increase communication in subsidized housing on Tenant Laws that protect older adults

**Target Time: June 2021**
<table>
<thead>
<tr>
<th>Strategic Priority 4.3: Assist older adults to age in community through strengthened HCBS; explore options to improve current OAA core services, Elderly Waiver, Alternative Care and Essential Community Supports</th>
<th>Specific Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide resources to cultural and ethnic communities and work with them to fill gaps in HCBS in ways that they need, prefer, and align with their culture.</td>
<td>• Improve/increase HCBS for older people of color pursuant gaps identified in National Core Indicators – Aging and Disability 2017 survey data</td>
</tr>
<tr>
<td>• Increase the flexibility of OAA contracting to facilitate the delivery of multiple in-home, supportive and caregivers support services to the same individual or family.</td>
<td>• Increase the number of providers/trips for older Minnesotans with limited access to transportation</td>
</tr>
<tr>
<td>• Pilot models of an OAA-funded “universal worker” or self-directed options that better meet the needs of older people and expand the workforce pool.</td>
<td>• Assemble/develop background materials to promote direct care workforce. This include information about loan forgiveness programs and other incentive program for potential works</td>
</tr>
<tr>
<td>• As a member of the MN Council on Transportation Access, advocate for legislative changes to state policies and regulations that limit the availability of volunteer drivers. Advocate for increased capacity to educate, train and support providers and volunteer drivers.</td>
<td>• Increase number of social workers</td>
</tr>
<tr>
<td>• Advocate for increased reimbursement rates for “critical access” state and MA-funded HCBS that support older people in hard to reach areas, “service desert” areas, or those with complex needs.</td>
<td>• Public Health model</td>
</tr>
<tr>
<td>• Advocate for a robust, multi-faceted approach to address the direct support workforce shortage that includes the provision of a living wage, benefits such as health insurance coverage, training, and provisions that allow providers to coordinate a 40 hour work week.</td>
<td>Target Time: December 2021</td>
</tr>
<tr>
<td>• Educate community groups about neighbor-helping-neighbor models such as the Beacon Hill concierge model and service credit banking to reduce or delay the need of participants for formal publicly-funded HCBS.</td>
<td>• Advocate for increased reimbursement rates for “critical access” state and MA-funded HCBS that support older people in hard to reach areas, “service desert” areas, or those with complex needs.</td>
</tr>
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<thead>
<tr>
<th>Strategic Priority 4.4: Assist communities to implement life cycle housing planning and development.</th>
<th>Specific Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide technical assistance to communities to assess their housing needs holistically and create “communities for a lifetime”, promote “clustered” living model.</td>
<td>• Increase the development of housing plans and zoning policies that balance the housing needs across generations, increase flexibility in housing types and otherwise encourage fluid</td>
</tr>
<tr>
<td><strong>Strategic Priority 4.5:</strong> Through the Heading Home Together Plan, work with others to prevent and end homelessness experienced by older adults.</td>
<td><strong>Specific Measures:</strong></td>
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<tr>
<td>• Build expertise and capacity to serve older individuals with complex needs in the community through resource development and targeted referrals to reduce unnecessary institutionalization.</td>
<td>• Develop a training plan to identify and respond to unique needs of older adults who are homeless or at-risk of homelessness</td>
</tr>
<tr>
<td>• Ensure programs for older adults (Senior LinkAge Line®, Caregiver Consultants, and Cultural Consultants) and grantees (Senior Corps, Dementia grantees, Eldercare Development Partnerships and Live Well at Home grantees) make the appropriate referrals if the individual discloses homelessness and is looking for assistance.</td>
<td>• Through the Senior LinkAge Line®, identify the number of older adults homeless or at-risk of homelessness in nursing homes and hospitals.</td>
</tr>
<tr>
<td>• Enhance discharge planning for older adults at risk of homelessness by working with Senior LinkAge Line® and the Office of Ombudsman for Long Term Care.</td>
<td>• Develop referral protocols to service providers, medication management, access to transportation and mental health services</td>
</tr>
<tr>
<td>• Align process to assist with forms completion for economic assistance programs for older adults through Senior Linkage Line®, DHS grantees and AAA (Special Access Programs). This includes, but not limited to setting up a bank account, assisting with pensions, entitlement programs (Social Security, Medicare and MA) and other public assistance programs.</td>
<td>• Develop partnerships with hospitals and nursing homes to enhance knowledge and resources to inform the discharge process for older adults who are homeless or at-risk of homelessness</td>
</tr>
<tr>
<td>• Align the work of the MBA Indian Elder Services Coordinator with the MN Tribal Nations and Urban American Indian Elders to identify and develop protocols for referrals for Native American elders who are homeless.</td>
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</tr>
<tr>
<td>Increase the availability of culturally-specific services, programs, and housing opportunities to better reflect preferred options and choices responsive to the needs and interest of people experiencing or at risk of homelessness.</td>
<td>MBA staff will attend 2 tribal events and cultural outreach activities to inform and educate older adults on resources related to affordable housing.</td>
</tr>
</tbody>
</table>
### Goal 5: Ensure the rights of older people receiving long-term care services

#### Strategic Priority 5.1: Expand and support the capacity of the Ombudsman for Long-Term Care program through paid staff to serve all people who receive LTSS from: nursing homes, board and care homes, home care consumers, and Veterans Homes.

- **Specific Measures:**
  - Reduce number of active beds per regional staff member. Current ratio is 1/9000, national average is 1/2000. Work to reduce the disparity by adding full-time regional staff.
  - Increase number of individual resident complaints investigated per month, at 25 complaints per month.
  - Increase number of individual cases investigations closed per month, at least 85% of all cases will be closed annually.
  - Number of information and consultations; increase to approximately 3,000 consumers and families receive information and consultations in addition to the complaints investigated per month.
  - Increase number of information and consultations to others such as providers to approximately 2,500 annually.
  - Increase number of systemic advocacy cases closed to approximately 15 cases annually.

**Target Time:** June 2020 and ongoing

- **Specific Measures:**
  - Review individual complaint investigations.
  - Provide information and consultations.
  - Offer support to resident and family councils.
  - Maintain to provide a statewide presence.

#### Strategic Priority 5.2: Expand the capacity of the Ombudsman for Long-Term Care Program through use of certified Ombudsman volunteers (COVs).

- **Specific Measures:**
  - Increase the number of volunteers assigned to regional ombudsman, should the Office receive additional full-time regional ombudsman, by 50 percent through local and statewide recruitment efforts.
  - Hire a full-time Volunteer Coordinator.

- **Specific Measures:**
  - Establish goals and objectives for the volunteer program based on current need/trends of the LTSS consumer and data analysis of volunteer activities.
  - Implement a statewide training curriculum for COVs comparable to the goals and objectives of the volunteer program.
### Strategic Priority 5.3: Expand outreach and education about resident rights, consumer protections, person-centered planning/care etc. to resident/family/tenant councils, providers of service, legislators, community organizations, and other government agencies at the national, state, and local levels. Expand legal resources for consumers served by OOLTC.

- Offer in-service training on resident rights and other topics of interest related to serving people who receive long-term services and supports.
- Conduct advocacy service outreach to cultural and ethnic communities.
- Conduct advocacy outreach to Legislators.
- Elevate public awareness about elder abuse and elder justice
- Provide opportunity for community discussions in policy development.
- Explore systemic barriers to elder abuse prevention and elder justice work with APS, law enforcement, courts, non-profit advocacy groups, state agencies, and others to develop and implement comprehensive solutions.
- Reach out to legal service providers statewide willing to serve consumers of LTSS.

### Specific Measures:
- Increase number of educational sessions about person-centered planning, resident rights, abuse, etc. annually
- Increase number of in-service presentations about role and responsibilities of the Ombudsman Office to minority groups
- Provide annual report to state legislators and other government agencies to educate on improved areas of service and to identify systemic concerns and make recommendations.
- Provide in-service session to legal resource providers, contact at a minimum 5 different legal providers.
- Hold at least 2 meetings annually with Minnesota legal aid agencies statewide.
- Sponsor at least one forum discussion to include diverse group of invested stakeholders and identify multidisciplinary responses to elder abuse and elder justice. Forum discussions to include: elders, caregivers, non-profit advocacy groups, law enforcement, civil and legal partners, domestic violence and sexual assault professionals, mental health professionals, etc.
- Collect information from stakeholders to create a strategy to raise public awareness about elder abuse and decide on goals for a public awareness campaign including who to target. Define what messages will most effectively reach the public.
- Co-sponsor cross-training events.
Target Time: June 2020 and ongoing
THE FUTURE OF ELDERLY WAIVER

MINNESOTA DEPARTMENT OF HUMAN SERVICES

JULY, 2018
Executive Summary

Minnesota’s Elderly Waiver (EW) program was developed in the 1980s as an alternative to nursing home services. The program serves people age 65 and older who are financially eligible for Medical Assistance, who need the level of care provided in a nursing home, but who choose to receive services in the community. In fiscal year 2017, the program served 29,329 older adults, at a cost of $343 million dollars (state and federal funds).

EW participants are able to choose the services that best meet their needs from the EW service menu. The service menu includes a wide range of offerings, including in-home services such as homemaker and home-delivered meals, group day services such as adult day service, and residential services such as customized living (a service frequently delivered in assisted living settings). In 2017, roughly 42 percent of EW participants received customized living services, and customized living represented 62 percent of overall EW program spending. EW participants who receive customized living are generally older than participants who receive other waiver services, and are more likely to need behavioral support.

Participants report high levels of satisfaction with the EW program. The majority report that their services meet their needs and goals, that they would recommend the people who are paid to help them, that their paid support staff treat them with respect, and that they know who to call if their needs change or if they have a complaint.

Minnesota has put a number of strategies in place to meet the needs of older adults through the EW program, while managing growth in the program. An important strategy has been reaching people early, before they even become eligible for EW, in order to prevent or delay their spenddown to MA, and prevent or delay the use of more expensive services such as nursing home or assisted living services. These strategies include upstream programs such as Alternative Care (AC) and Essential Community Supports (ECS); the Return to Community Initiative to assist private paying nursing home residents to return to the community early in their stays; and Long Term Care Options Counseling to ensure people have information about a full range of options before making a decision to move to assisted living. Supporting family caregivers is another important strategy. The EW program is designed to support the continuation of informal caregiving, by supplementing what family caregivers can provide, and by providing services specifically aimed at providing respite and other types of support to caregivers.

The EW program has a number of specific design features that are intended to manage growth and spending. EW services and budgets and tailored to individual needs. The state has taken significant steps to manage costs, ensure consistency, and enforce policies for the customized living service. And finally, the state implemented changes to the nursing facility level of care (NF LOC), which governs eligibility for HCBS programs including EW.

Despite the significant progress Minnesota has made to effectively serve older adults in their homes and communities, Minnesota faces challenges in maintaining and continuing that momentum. These challenges include lack of availability of in-home services; workforce shortages that impact all service
delivery models; continued growth in the assisted living market, which drives increased use of this service within EW; and the increasing complexity of needs of EW participants.

Minnesota has a history of successes upon which to build. Minnesota’s publicly-funded long-term services and supports for older adults can not only be maintained but strengthened, in order to serve older adults now and into the future. Minnesota can do this by: ensuring that considerations of equity are embedded in all decisions related to the EW program; addressing service rates, in order to ensure that services are available for public program participants into the future; developing and promoting cost-effective services, including Consumer Directed Community Supports (CDCS) options; evaluating incentives for the Alternative Care (AC) program and potential cost savings to the state; understanding the spenddown trajectory for people prior to becoming eligible for EW in order to develop data-driven strategies to prevent or delay spending down; and paying for quality in assisted living.

The state is faced with demographic realities and must respond. The state can build on a strong foundation to ensure this program continues to meet the needs of older adults for many years to come.

**Elderly Waiver Background**

Minnesota has a long history of innovation in serving older adults. In 1982, Minnesota created the state’s first Medicaid waiver, called the Elderly Waiver. Prior to this time, Medicaid was only available to pay for long-term services and supports (LTSS) provided in nursing homes. Under a plan approved through a federal authority, called a 1915(c) waiver, the state was able for the first time to use Medicaid to pay for LTSS provided in the community. Like all Medicaid-covered services, Elderly Waiver services are paid through a combination of federal and state dollars.

Minnesota’s Elderly Waiver (EW) has been in continuous operation since 1982. The waiver serves people age 65 and older who are financially eligible for Medical Assistance (Minnesota’s name for its Medicaid program), who need the level of care provided in a nursing home, but who choose to receive services in the community. Services provided in the community are known as home and community-based services (HCBS). Most of us, as we get older, prefer to remain in our own home for as long as possible. The EW program supports that goal for individual participants. It’s also more cost-effective for individuals and for the state to serve people in their homes and communities, rather than in an institution. The program has been a critical component of the state’s efforts to “balance” its LTSS system, in order to rely less on nursing facility services, support more individuals in the community, and ensure that older adults have meaningful choice about where to live and receive services. 14

Minnesota has chosen to include a broad range of services in its EW service menu. EW participants are able to choose services from this service menu to meet their particular needs, goals, and preferences. The EW service menu includes such services as:

- Adult day services
- Case management
- Chore services

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• Companion services
• Family caregiver support services, including respite
• Home health aides
• Home-delivered meals
• Homemaker services
• Home and vehicle modifications
• Individual community living support
• Non-medical transportation
• Personal emergency response systems
• Personal care assistance
• Residential services, such as assisted living or foster care
• Skilled nurse visits
• Specialized equipment and supplies

EW participants also have the option to hire their own workers and direct their own services, through the Consumer Directed Community Support (CDCS) option.

Who Are We Serving?

Demographics

The age of Elderly Waiver program participants is distributed quite evenly, with roughly a third age 65 to 74, 75 to 84, and 85 and older (see the graph below). Nearly three quarters of EW participants in 2017 were female (72%).

![Percent of Elderly Waiver Participants by Age in 2017](image)

Source: DHS Data Warehouse, State Fiscal Year 2017

While the majority of EW participants are white, a growing number of participants are people of color. The number of Asian, Black, and Latino participants grew between 20 and 37 percent between 2013 and 2017 (see the table below).
# Race / Ethnicity

<table>
<thead>
<tr>
<th>Race / Ethnicity</th>
<th>2013 EW</th>
<th>2017 EW</th>
<th>% Change 2013-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Pacific Islander/Native Hawaii</td>
<td>10.2%</td>
<td>11.5%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>10.6%</td>
<td>13.7%</td>
<td>37.3%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>1.4%</td>
<td>1.4%</td>
<td>3.1%</td>
</tr>
<tr>
<td>White</td>
<td>74.3%</td>
<td>68.9%</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>1.7%</td>
<td>2.1%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Other or Unable to determine</td>
<td>1.7%</td>
<td>2.4%</td>
<td>48.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: DHS Data Warehouse, State Fiscal Years 2013 and 2017

The graph below compares the race and ethnicity of EW participants with people in the general population age 60 and older who are in poverty. According to this comparison, the EW program serves a slightly smaller proportion of white people and a slightly larger proportion of black/African Americans and Asian/Asian Americans.

A small majority of EW participants live in the 7-county Twin Cities metropolitan area (52%).
In 2017, more than a third of EW participants were living alone (38%), and another 7 percent would have likely been living alone, or even homeless, without the housing planned for in their long term care services assessment. Fifty five percent of participants were living with a spouse, other family or friends, or in a congregate setting. Less than one percent of EW participants were homeless at the time of their last assessment.

Source: DHS Data Warehouse, State Fiscal Years 2013-2017

**Level of Need in the EW Program Population**
Minnesota has a 12-level Case Mix Classification system to describe the level of care needs each individual has at the time of their assessment. Case Mix L is the lowest level of care needs, and Case Mix K is the highest level. In 2017, the most common Case Mix levels were L, B, E, and D.

<table>
<thead>
<tr>
<th>Case Mix</th>
<th>Case Mix Description</th>
<th>2013</th>
<th>% Case Mix in 2013</th>
<th>2017</th>
<th>% Case Mix in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>Very Low ADL</td>
<td>6,486</td>
<td>23%</td>
<td>7,366</td>
<td>24%</td>
</tr>
<tr>
<td>A</td>
<td>Low ADL</td>
<td>4,851</td>
<td>17%</td>
<td>2,630</td>
<td>9%</td>
</tr>
<tr>
<td>B</td>
<td>Low ADL + Behavior</td>
<td>4,671</td>
<td>16%</td>
<td>5,772</td>
<td>19%</td>
</tr>
<tr>
<td>C</td>
<td>Low ADL + Special Nursing</td>
<td>230</td>
<td>1%</td>
<td>243</td>
<td>1%</td>
</tr>
<tr>
<td>D</td>
<td>Medium ADL</td>
<td>3,547</td>
<td>12%</td>
<td>4,094</td>
<td>13%</td>
</tr>
<tr>
<td>E</td>
<td>Medium ADL + Behavior</td>
<td>3,716</td>
<td>13%</td>
<td>4,151</td>
<td>14%</td>
</tr>
<tr>
<td>F</td>
<td>Medium ADL + Special Nursing</td>
<td>213</td>
<td>1%</td>
<td>259</td>
<td>1%</td>
</tr>
<tr>
<td>G</td>
<td>High ADL</td>
<td>1,097</td>
<td>4%</td>
<td>1,513</td>
<td>5%</td>
</tr>
<tr>
<td>H</td>
<td>High ADL + Behavior</td>
<td>1,533</td>
<td>5%</td>
<td>1,852</td>
<td>6%</td>
</tr>
<tr>
<td>I</td>
<td>Very High ADL + Feeding</td>
<td>899</td>
<td>3%</td>
<td>1,130</td>
<td>4%</td>
</tr>
<tr>
<td>J</td>
<td>High ADL + Severe Neurological Impairment/Behavior</td>
<td>1,012</td>
<td>4%</td>
<td>1,026</td>
<td>3%</td>
</tr>
<tr>
<td>K</td>
<td>High ADL + Special Nursing</td>
<td>511</td>
<td>2%</td>
<td>470</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>28,766</td>
<td>100%</td>
<td>30,506</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: DHS Data Warehouse, State Fiscal Years 2013-2017

Whereas Case Mix classifications are largely determined by Activities of Daily Living, activities related to caring for oneself, Instrumental Activities of Daily Living (or IADLs) are more about taking care of personal business. A person’s ability to perform ADLs and IADLs, or to access needed support, helps them remain as independent as possible as they age.

The graph below shows the IADLs that EW participants needed substantial or total assistance with in 2017, in rank order.
The next few figures have to do with the health of EW participants. First, in terms of overall health, more than a third of EW participants reported that they are in fair health (41%). Nearly the same proportion of participants described their health as good or excellent (39%). Thirteen percent described their overall health as poor, and 7 percent did not respond.

In long-term care consultation (LTCC) assessments, which are used to determine program eligibility,
participants are asked if they have a diagnosis of a mental illness from a qualified professional. In 2017, well more than a third of EW participants reported having a mental illness (43%).

![Elderly Waiver Participant History of Mental Illness in 2017](image)

Source: DHS Data Warehouse, State Fiscal Years 2013-2017

In terms of mental orientation, more than two thirds (69%) of EW participants were assessed to be fully oriented or have minor forgetfulness. The remaining 31 percent show noticeable disorientation.

![Elderly Waiver Participant Level of Mental Orientation at the time Assessment, 2017](image)

Source: DHS Data Warehouse, State Fiscal Years 2017
In terms of behavioral needs, the majority of EW participants require little or no support (55%), with 38 percent requiring no support at all. However, more than a third require regular support with behavioral concerns (36%), and 9 percent of participants are either verbally or physically abusive.

Who Are We Serving through Customized Living?

Customized living is one of the services available to EW participants. Customized living is a package of regularly scheduled health-related and supportive services provided to a person who lives in a registered housing with services establishment\textsuperscript{15}. Many of these settings meet the definition of assisted living\textsuperscript{16}.

In 2017, roughly 42 percent of EW participants received customized living services, and customized living represented approximately 62 percent of overall EW program spending. More information about the use of customized living is provided in the “Trends in Service Utilization and Spending” section of this report.

EW participants who received customized living were generally older than participants who received other waiver services. In 2017, a full 50 percent of customized living recipients were 85 or older, whereas just 19 percent of recipients of other waiver services were 85 or older.

\textsuperscript{15} “Housing with services establishment” is defined in Minnesota Statute, Chapter 144D

\textsuperscript{16} “Assisted living” is defined in Minnesota Statute, Chapter 144G
The Case Mix Classifications vary substantially among EW participants who do and do not receive customized living services. Perhaps the most striking difference is that participants receiving customized living are more likely to need behavioral support (see Case Mix B, E, H, and J below). Special nursing needs are also more common among customized living recipients.

<table>
<thead>
<tr>
<th>Case Mix</th>
<th>Case Mix Description</th>
<th>Not Receiving Customized Living</th>
<th>Receiving Customized Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>Very Low ADL</td>
<td>33.6%</td>
<td>8.5%</td>
</tr>
<tr>
<td>A</td>
<td>Low ADL</td>
<td>10.6%</td>
<td>5.6%</td>
</tr>
<tr>
<td>B</td>
<td>Low ADL + Behavior</td>
<td>13.7%</td>
<td>26.4%</td>
</tr>
<tr>
<td>C</td>
<td>Low ADL + Special Nursing</td>
<td>0.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>D</td>
<td>Medium ADL</td>
<td>16.6%</td>
<td>9.0%</td>
</tr>
<tr>
<td>E</td>
<td>Medium ADL + Behavior</td>
<td>7.6%</td>
<td>22.9%</td>
</tr>
<tr>
<td>F</td>
<td>Medium ADL + Special Nursing</td>
<td>0.3%</td>
<td>1.6%</td>
</tr>
<tr>
<td>G</td>
<td>High ADL</td>
<td>6.2%</td>
<td>3.4%</td>
</tr>
<tr>
<td>H</td>
<td>High ADL + Behavior</td>
<td>4.0%</td>
<td>9.4%</td>
</tr>
<tr>
<td>I</td>
<td>Very High ADL + Feeding</td>
<td>3.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>J</td>
<td>High ADL + Severe Neurological Impairment/Behavior</td>
<td>2.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>K</td>
<td>High ADL + Special Nursing</td>
<td>1.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: DHS Data Warehouse, State Fiscal Years 2013-2017

What Are Participants Telling Us?
In the past several years, DHS has been participating in the National Core Indicators Aging and Disabilities Adult Consumer Survey (NCI-AD). The NCI-AD is one way that DHS measures quality and uses the results to improve services and supports. The NCI-AD survey was developed by the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI) as a validated tool to assess states’ publicly funded Long Term Services and Supports. The NCI-AD is how DHS hears directly from people about how well their services and supports help them to live, work, and engage in their community.

According to the 2015-2016 NCI-AD survey results, three quarters of EW participants reported that the services they receive through the program allow them to completely meet their goals. Another 20 percent of respondents said that the services helped them mostly or somewhat meet their goals. Just 3 percent reported that the services are not helping them meet their goals.

EW participants also report favorable experiences with their paid care providers. Well more than a third (43%) of respondents reported that their paid care providers exceeded their expectations. Another 49 percent reported that their expectations are being met, with only 4 percent of respondents saying that their experience is worse than they expected.
The vast majority of EW participants would recommend their paid care providers to others (87%). Only 4 percent reported that they would not recommend their paid care givers to someone else.

Ninety-six percent of respondents reported that their paid care providers treat them with respect. Only 1% said that they are not treated with respect by their care staff.
A strong majority of EW participants know who to call if something is not right about their care, or something needs to change (74 to 79%). However, 13 to 17 percent did not know who to contact, and additional respondents were unsure.

The vast majority of EW participants are receiving the help they need with personal care and other daily activities (85 to 87%). However, about 1 out of 7 respondents reported that sometimes they could use more assistance than they currently receive.
In the NCI-AD survey, EW participants were asked what additional services might help them meet their goals, if their goals were not yet fully met. More than a third of respondents (35%) indicated that chore or homemaker services would be useful. Transportation and additional personal care assistance were named next, followed by companion and home delivered meal services.

**Trends in Service Utilization and Spending**

Elderly Waiver participants are served through two purchasing models: through a fee-for-service arrangement, or through a capitation arrangement coordinated by health plans. The vast majority of EW
participants receive services coordinated by health plans. In 2017, 92 percent of EW participants were served in the Managed Care environment.

Under the managed care purchase model, a health plan receives a per-member per-month capitation payment and arranges and pays for EW services for all EW enrollees in the health plan. Under the fee-for-service purchase model, counties and tribes arrange for and authorize payments for EW services through the state’s Medicaid Management Information System (MMIS). The graphs in this section combine these types of EW payments.

In the past five years, the number of older Minnesotans served through EW has grown year by year. In 2017, nearly 30,000 people participated in the program; this is an increase of 6 percent over the number of people served in 2013. The graph below shows program participant numbers for the past five fiscal years.

Looking forward, participation in the EW program is expected to grow. The graph below shows average monthly participant counts through 2021.
In the past five years, overall program spending has increased. In 2017, Minnesota spent nearly $350 million dollars on EW services. Between 2013 and 2017, overall program spending has increased between 3.5 and 6 percent per year. The graph below reports the number of dollars spent on EW services in the past five years.

Between now and 2021, total spending for the EW program is expected to increase year by year, growing at an average rate of 10 percent per year.
Overall program spending is increasing because of increased enrollment, but also because the average spending per participant is increasing. In 2017, the average cost per EW participant was $11,689 per year, or $974 per month. Between 2016 and 2017, the cost per participant increased by 2.4 percent. Between 2013 and 2016, the cost per participant went up between about 2 and 5 percent per year.

Participation and spending are growing in some EW services more than others. The three services with the greatest growth in participation are customized living, waiver transportation, and adult day services. The graph below shows the rising participant numbers for these services.
As the graph above shows, utilization of customized living is not only growing, a larger number and percentage of EW participants receive this service. In fact, more EW participants receive customized living than any other service. In 2017, 42 percent of EW participants received this service.

More dollars are spent on customized living than any other service as well, and spending for that service is increasing year by year. In 2017, more than $213 million was spent on customized living, which represents 62 percent of total EW program spending for that year. Between 2016 and 2017, spending for customized living services increased nearly 6 percent. Year by year, spending on customized living services is growing between 3 and 6 percent.

While spending for customized living services is the most significant factor in the growth in overall program spending, spending is increasing for other waiver services as well. After customized living, the three top waiver services in terms of dollars spent are adult day services, homemaking, and adult foster care. Of these four services, however, spending is only increasing for adult day and case management. The graph below shows spending trends for these four services.

Source: Elderly Waiver Payment Summary Reports, State Fiscal Years 2013-2017
The graph below shows the percentage change in utilization for several services that have been heavily utilized historically. In addition to customized living, transportation, and adult day, which were discussed above, the utilization of homemaking, personal emergency response systems (or PERS), and supplies are increasing, but more modestly. Use of home delivered meals decreased between 2013 and 2017.
Meeting the needs of older Minnesotans while managing growth

The EW program has been extremely effective in meeting the needs of participants, in order to support them to remain living in their homes and communities, engage with their communities, and have the highest possible quality of life. At the same time, demand for these services continues to grow as our population ages and as more people choose HCBS over nursing facility services. Minnesota has implemented several strategies to meet the need for LTSS among older Minnesotans, as well many innovate and creative strategies to effectively manage growth in the EW program.

Reaching people early

An important part of Minnesota’s strategy to meet the needs of older Minnesotans as well as manage the growth in EW is to reach people before they even become eligible for EW. By reaching people early, when their needs are relatively modest, we can provide less-expensive services, prevent or delay their spenddown to MA, and prevent or delay the use of more expensive services such as nursing home or assisted living services. Minnesota has multiple strategies in place to reach people early.

Alternative Care

The Alternative Care (AC) program has been available in Minnesota since the early 1980’s. AC provides HCBS to older adults who have modest income and assets but are not yet eligible for MA. AC serves people who are 65 or older, who need the level of care provided in a nursing home, but who choose to receive services in the community. In order to qualify financially for AC, a person must not have enough income and assets to pay for 135 days of nursing facility services. AC provides most of the services that are available on the EW service menu. The primary difference is that AC does not pay for residential services, such as assisted living or foster care.

Through the AC program, Minnesota is able to serve older adults before they spend their resources and become eligible for MA. The program connects older adults with cost-effective community services that allow them to remain living in their own homes. The program helps participants avoid or delay nursing facilities and/or spending down to MA eligibility. The program also encourages the continued use of these cost-effective, non-residential services after a person becomes eligible for MA and EW.

Enrollment in AC has declined over the past five years; however, participation rose slightly between 2016 and 2017.
While enrollment has been declining, the average cost per participant has been growing steadily in the last five years. Between 2013 and 2017, the average per-person spending increased 21 percent.

**Essential Community Supports**

The Essential Community Supports (ECS) program is a new program, implemented in 2015, that serves people with modest needs who want to remain living in their community. ECS provides HCBS to people who are 65 or older, who are not eligible for MA, who do not need the level of care provided in the nursing home, and who need some support to remain living in the community. ECS participants must meet the same financial eligibility criteria as AC participants.

ECS provides a limited benefit set: chore services, homemaking, personal emergency response systems (PERS), support for caregivers, help with household management, adult day service, home-delivered...
meals, and case management. The amount available to pay for services is very modest, at a little over $400 per month.

ECS was developed in response to changes in the state’s nursing facility level of care (NF LOC), which governs eligibility for EW and AC, as well as MA payment of nursing facility services. People who do not meet the NF LOC criteria can be served with ECS program, which allows Minnesota to reach people before their needs increase, helping them to remain in their own home for a longer period of time.

ECS has served a small number of participants in its first three years, and numbers were lower in 2015 as the program was getting started.

The average annual cost for each participant has grown in the program’s first three years, but the cost per participant is considerably lower than AC and EW due to the smaller menu of services and the lower monthly spending limits.
Return to Community Initiative

The Return to Community Initiative (RTCI), implemented in 2010, is a state-wide initiative to assist private paying nursing home residents to return to the community early in their stays, e.g., 60-90 days after admission. The goals of the RTCI are to facilitate consumer choice in care setting and to achieve cost savings for the consumer and the Medicaid program. The RTCI is administered by the Minnesota Board on Aging (MBA) and it operates within the framework of the Older Americans Act and Area Agencies on Aging (AAA). The RTCI’s focus on privately paying nursing home residents is unique nationally; most states have not delved into transitions for the privately paying NH residents. By supporting private pay residents who would otherwise remain in the nursing home to return to the community, the program helps extend person’s private resources, therefore preventing or delaying the person’s spenddown to Medical Assistance and achieving cost savings for the state.

A subset of non-Medicaid residents is targeted for the RTCI intervention using a profile score based on their desire to return to the community, health and functional status, and length of stay in the nursing home. Community Living Specialists provide individual support, including in-person visits, to residents who have consented to receive the support. Since April 2010, Community Living Specialists have assisted with over 5,800 discharges from Minnesota nursing homes.

Long Term Care Options Counseling

In 2011, the Minnesota Legislature passed a law that required all prospective residents, with the exception of individuals seeking a lease-only arrangement with a subsidized housing provider, to be offered long-term care options counseling and verification of consultation, prior to executing a lease or contract with any registered Housing with Services provider. (Housing with Services is the type of setting where assisted living services are delivered). This requirement is part of a strategy to ensure that people have information about a full range of options before making a decision to move to assisted living. If a person’s needs can be met in their own home, the person’s private resources will be extended, therefore preventing or delaying the person’s spenddown to Medical Assistance.

Senior LinkAge Line® options counselors assist consumers calling for this service by doing the following:

- Review the consumer’s current situation based on their values and preferences
- Connect consumers to services that are available and can meet the consumers’ needs
- Compare financing options that may be available to help pay for their long-term care services
- Provide a verification number to be provided to the Registered Housing with Services setting
- Follow-up with the consumer to ensure their needs have been met

Supporting caregivers

Family and friends provide the majority of help needed by older adults to remain at home. In Minnesota, this unpaid help is valued at $7.9 billion a year.¹⁷ Those family and friend caregivers continue to be involved when a person becomes eligible for EW. In 2017, 44 percent of EW participants received

¹⁷ https://mn.gov/dhs/assets/Caregiving_tcm1053-315631.pdf
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. According to the most recent NCI-AD survey results for MN, 23 percent of EW participants report receiving most of the help they need from a spouse, partner, or other family member (25% for AC). An additional 14 percent report paying a friends or family member to provide most of the help they need (12% for AC). This demonstrates that EW participant needs are being met by a variety of formal and informal supports. This varied and wider network of support is critical, because just 19 percent of EW participants reported being married, and 38 percent of EW participants were living alone (2017).

The EW program is designed to support the continuation of informal caregiving when possible. One strategy to achieve this is through services and supports specifically aimed at supporting informal caregivers. These services include respite, training and education, and caregiver coaching and counseling. Adult day services are also used by caregivers, allowing a caregiver to attend to other responsibilities during the day, such as employment, while continuing to provide support to an older adult. Of these services, the most frequently-used are adult day service and respite. In 2017, 4,561 EW participants received adult day services, which represents nearly 16 percent of all EW participants. Another 102 participants received formal respite services.

The Consumer Directed Community Support (CDCS) option under EW is another way the program can enhance the role of informal caregivers. Through CDCS, an EW participant can choose to use their EW budget to hire family and friends to provide support. This may allow a caregiver to forego other employment and provide more support to the older adult. Participants may also appreciate receiving support from a person of their choice, who they know and trust. The caregiving experience may also be more stable and enduring, because of the personal relationship between the older adult and caregiver. The wider home and community based services system benefits, too. Paying informal caregivers through CDCS augments the long term care workforce, which is experiencing a workforce shortage. In 2017, 395 EW participants elected to use the CDCS option, which represents just over 1 percent of all EW participants that year. Another 215 people participated in CDCS through the Alternative Care program. This represents 6 percent of the program population that year.

**Services tailored to individual needs**

Minnesota has implemented a number of strategies within the EW program, to serve people with the right amount of services, tailored to their needs. By not over-serving people with more services than they need, the state can effectively manage spending in the EW program.

**Individual budgets and service limits**
A long-standing feature of the EW program is individual budgets. EW participants are assigned an individual budget amount based on their case mix classification, or level of need. Higher-need people have higher budgets, and lower-need people have lower budgets. Participants can choose the services, and the amount of services, that best meet their needs while staying within their assigned budget.

In 2009, the state created a new case mix classification (Case Mix L) for very low-need individuals who otherwise would have met criteria for Case Mix A (the lowest-need classification at the time). Participants in the Case Mix L classification have a smaller budget than Case Mix A.

In addition to individual budgets, the EW program also has limits on the amount that can be spent for some services. For example, there are limits on the amounts that can be spent on customized living and 24-hour customized living, based on a person’s case mix.

**24-hour customized living eligibility**

24-hour customized living is a service that provides all of the components of customized living. In addition, it offers 24-hour supervision. Therefore, it is a more expensive service than customized living. In 2009 the state implemented new eligibility criteria that a person must meet in order to access 24-hour customized living. These eligibility criteria are beyond what is required to enter the EW program. This allows the state to reserve the 24-hour customized living service for people with greater needs.

**Individual community living support (ICLS)**

In 2013, the legislature authorized a new service under EW and AC, called individual community living support (ICLS). The service was launched in 2017. The service was developed as an alternative to more expensive residential services. ICLS allows participants to access a wide range of services and support in their own home, under a single service, without needing to move to a new setting to access those supports or use multiple providers. The service was first available to participants on April 1, 2017. Between that date and May 31, 2018, 80 participants utilized the service, in eleven counties.

**Managing costs within customized living**

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18 Laws of Minnesota, 2009, Chapter 79, Art. 8, Sec. 45
19 Laws of Minnesota, 2009, Chapter 79, Art. 8, Sec. 46, 47 & 49.
As noted previously in this report, customized living is a highly-utilized and relatively expensive service within the EW program. Minnesota has taken significant steps to manage costs, ensure consistency, and enforce policies for the customized living service.

In 2010, Minnesota launched the EW customized living tool. The tool is completed by case managers for all EW participants who receive customized living services (including 24-hour customized living). With the launch of the tool, the state established standard service components and component rates for customized living services. For example, the state established a standard rate for every hour of assistance provided to participants, such as assistance with homemaking, or assistance with personal cares. Through the tool, the case manager develops an individualized service delivery plan for the person. The tool also generates an individual rate for the person, based on the amount of component services the provider will deliver.

There are a number of features within the tool that support effective management of customized living services:

- The person’s assessed needs are recorded within the tool. The case manager can only add time for a provider to assist with a need if the person’s assessment indicates that need. For example, the case manager can only add time for a provider to assist with bathing if the person’s assessment shows they need help with bathing.

- For each need, the case manager must also indicate within the tool that the person’s preference is to have the customized living provider meet that need, rather than have the need met another way. For example, if a person has a need for medication set-up, they may choose to have a family member set up medications, rather than the provider. In this situation, the case manager cannot add time for the provider to set up medications.

- The tool gives case managers feedback when they are planning above the average amount of time that other case managers are planning for people with similar needs. This functionality helps case managers know how their service authorizations compare to other authorizations across the state.

Minnesota has been very successful in managing costs, ensuring statewide consistency, and developing service plans that meet the individual needs of each participant.

**Change in nursing facility level of care (NF LOC)**

In 2009, the legislature approved changes to the state’s nursing facility level of care (NF LOC). A person must meet the NF LOC in order to be eligible for payment for long-term care services under Medical Assistance (MA), including payment for nursing facility services and home and community-based service (HCBS) programs. The nursing facility level of care (NF LOC) initiative was intended to:

- Contribute to sustainability in MA-funded long-term care programs by providing lower cost alternatives to individuals with lower needs;
- Standardize NF LOC criteria used statewide for both HCBS and NF populations; and

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• Create objective NF LOC criteria to support equity in access to HCBS and NF services.

While the revised criteria were adopted by the Legislature in 2009, Minnesota could not implement this change until January 1, 2014 for individuals age 21 and older, and until October 1, 2019 for individuals under the age of 21 due to federal requirements included under the Affordable Care Act enacted in March 2010. Implementation was further delayed until January 1, 2015 by executive order to allow additional time for systems changes needed to fully implement transition services intended to support potentially affected populations.

DHS issued a legislative report in February 2016, summarizing the impact of implementing this change. The report showed that the initial impact of the change was small. Approximately 1.2% of people age 21 and older who were reassessed during 2015 were no longer eligible for their HCBS program due to the change in NF LOC. The majority of people affected were age 65 and older.

**Challenges**

Despite the significant progress Minnesota has made to effectively serve older adults in their homes and communities, Minnesota faces challenges in maintaining and continuing that momentum.

**Availability of in-home services**

As noted previously in this report, a key strategy to meet the needs of older adults is through in-home services, rather than serving people through nursing homes or through residential services such as assisted living. In-home services are less expensive, both for individuals who are using their own resources to pay for services, and for the state when people are on public programs. The state’s goal is to serve people in their own homes for as long as possible. However, there are gaps in the availability of these important services.

The Gaps Analysis study gathers local information about the capacity of Minnesota’s publicly funded home and community-based services (HCBS) system and continuum of mental health (MH) services and supports to meet the needs of all persons who need services. The Gaps Analysis is conducted every other year. Findings are reported in a biannual legislative report, “Status of Long-Term Services and Supports.” The 2017 report found that, as in previous years, the most frequently-cited service gaps for older adults were for in-home services, such as transportation, companion, homemaker, personal care assistance, and chore services.

**Workforce shortage**

The 2017 “Status of Long-Term Services and Supports” report, mentioned above, also noted the pervasive impact of the workforce shortage across all populations and services. The shortage of available workers to deliver services impacts the availability of home and community-based services across the state. DHS convened a Direct Care/Support Workforce Summit in July 2016, and has since compiled a Directory of Leaders to help connect people and organizations who want to work together on similar efforts to address the direct care/support workforce shortage with those willing to lead these

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21 [https://mn.gov/dhs/assets/2017-08-long-term-services-supports_tcm1053-309107.pdf](https://mn.gov/dhs/assets/2017-08-long-term-services-supports_tcm1053-309107.pdf)
efforts. The consumer-directed community supports (CDCS) option under EW and AC is a critical model to help address this 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.

**Growth in assisted living**

Minnesota has seen significant growth in assisted living settings. Assisted living settings are a subset of housing with services (HWS) settings. These settings must register annually with the Department of Health. The chart below shows the growth in assisted living settings since 2007.

![Growth in the Number of Assisted Living Settings](chart)

Source: Minnesota Department of Health

A significant number of EW participants who receive customized living services were living in an assisted living setting prior to becoming eligible for EW. In 2017, there were 1,089 EW participants who initiated customized living services and appeared to live in assisted living prior to services being initiated. In other words, participants spend their private assets on assisted living services until such point that they become eligible for EW and their services are paid through public resources.

The state lacks reliable data about the trajectory of private resource spend-down in these settings. For instance, the state does not have information about the average number of months a person pays privately for assisted living services before becoming eligible for EW. The state does have information about nursing home rates and length of stay in a nursing home, which has allowed the state to design strategies targeted at reducing nursing home stays. The state would benefit from this type of

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23 According to claims data for State Fiscal Year 2017, 1,089 unique participants had their first Long Term Care Consultation (LTCC) assessment, qualified for MA that month or 3 months prior, and had a Customized Living claim in the month of their LTCC assessment.
information related to assisted living, in order to inform strategic planning for future growth and expenditures within the EW program.

Serving people with complex needs

Older adults who seek long-term services and supports may have complex needs, meaning that their needs cannot be easily met with the traditional long-term service and support system. One example of complexity is HCBS participants who also have mental health concerns. The chart below shows the proportion of older adults using HCBS and mental health services (MH) through public programs.

This may mean that participants have mental health needs, in addition to LTSS needs. [insert a description of data, and data itself]

<table>
<thead>
<tr>
<th>Proportion of Older Adults Using Home and Community-Based Services (HCBS) and Mental Health Services (MH) through Public Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
</tr>
<tr>
<td>75-84</td>
</tr>
<tr>
<td>85+</td>
</tr>
</tbody>
</table>

Source: Minnesota Department of Human Services MMIS, State Fiscal Year 2016

This may also mean that participants are experiencing homelessness, or are at risk of homelessness. Older adults are one of the fastest-growing groups of people experiencing homelessness. According to a study of homeless older adults conducted by Wilder Research, the number of homeless older adults age 55 and older increased 8 percent from 2012 to 2015. An increasing number of homeless older adults report one or more chronic health conditions. Health-related problems for homeless older adults are both more common and more complicated than for those of similar ages who have the advantage of permanent housing.24

<table>
<thead>
<tr>
<th>Chronic health conditions for homeless adults age 55 and older</th>
<th>2009</th>
<th>2012</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adults with a chronic physical health condition</td>
<td>66%</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>Older adults with a serious mental illness*</td>
<td>37%</td>
<td>41%</td>
<td>49%</td>
</tr>
</tbody>
</table>

In some cases, people with these complex needs are requesting long term services and supports for the first time when they are over the age of 65. The EW program must evolve as the older adult population changes. The state must evaluate whether the long-term service and support needs of certain populations are different than the needs of people who have traditionally been served with the EW program. Then the state must make changes to better meet the needs of this population, by updating LTSS service and program design, and by improving coordination and integration with the systems that serve people with mental illness and people experiencing homelessness.

Where do we go from here?

Minnesota has a history of successes upon which to build. Minnesota’s publicly-funded long-term services and supports for older adults can be not only maintained, but strengthened, in order to serve older adults now and into the future. We must take steps now to ensure this happens.

Ensure equity

Minnesota has built a strong program that provides high quality services to a broad population. But there are populations for which we need to improve. As noted earlier in this report, the EW population is becoming more diverse, as the state’s overall older adult population becomes more diverse. Service systems have traditionally been developed with the majority white population in mind. The state must continue to evaluate the extent to which service systems and service design is meeting the needs of communities who experience inequities, including communities of color and American Indians. Considerations of equity must be embedded in all decisions regarding operations, programming, investments, and policy development.

Address service rates

In order to ensure that services are available for public program participants into the future, it’s critical that Minnesota maintain service rates that are sufficient and reasonable. In 2017, the Minnesota Legislature authorized a new rate-setting methodology for a number of services covered under Elderly Waiver, Alternative Care, and Essential Community Supports:

- Adult day (EW, AC, ECS)
- Chore (EW, AC, ECS)
- Companion (EW, AC)
- Customized living (EW)

*The diagnosis of “anxiety or panic disorder” was added in 2015.

^Serious or chronic disability includes mental illness, substance abuse disorder, or other conditions that limit work or activities of daily living.

Source: 2015 Minnesota Homeless Study, Wilder Research
• Foster care (EW)
• Residential care (EW)
• Home delivered meals (EW, AC, ECS)
• Homemaker (EW, AC, ECS)
• Respite (EW, AC)
• Individual community living support (EW, AC)

The legislation provides specific direction and formulas for how rates should be calculated with the new methodology. Rates will be built by calculating a “base wage” for each rate, then applying certain factors.\(^{25}\) The legislation states that the new methodology will be partially implemented. On January 1, 2019, the rates for affected services shall be the sum of:

• 10% of the rates calculated with the new methodology
• 90% of the rates calculated using the methodology in effect as of June 30, 2017

Further implementation of the new methodology (i.e. 20% new methodology/80% previous methodology) will require legislative action.

The Legislature also directed DHS to conduct an evaluation of the new rate methodology, in consultation with stakeholders, to determine if the assumptions within the methodology are appropriate and reasonable.\(^{26}\) DHS must submit a report to the legislature by January 1, 2019 that includes any recommended changes to the rate methodology.

Through the evaluation, DHS will be able to determine not only the appropriateness of the rates established with the new methodology, but also the degree to which current rates support reasonable costs for providers to deliver services. DHS may recommend a faster implementation of new rates for services where the historic rates have been especially low compared to reasonable costs.

### Develop and promote cost-effective services

The state must continue to promote and enhance cost-effective, in-home services that are tailored specifically to the needs and preferences of the person being served. The state must continually evaluate and address barriers to delivering those in-home services. The state must ensure that the regulatory and administrative requirements for those services is appropriate and manageable, in order to ensure providers’ interest and ability to deliver those services. The state should also consider whether to develop new purchasing strategies that would support and expand in-home services, in order to address critical gaps in service availability.

The Consumer Directed Community Supports (CDCS) option provides the greatest degree of flexibility for the person to purchase the services the supports that meet their needs, while maximizing the use of informal supports. Unfortunately, some EW and AC participants determine that CDCS is not a viable option because the budget for services is less than what is available when they select traditional EW/AC

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\(^{25}\) Minnesota Statutes, 256B.0915, Subd. 11-14

\(^{26}\) Minnesota Statute, 256B.0915, Subd. 17
services. The state should create parity between budgets available for CDCS participants and non-CDCS
participants, in order to ensure that CDCS is a viable option for more people.

Evaluate incentives for Alternative Care

As described above, the Alternative Care (AC) program provides home and community-based services to
older adults who have modest income and assets but are not yet eligible for MA. The program reached a
peak annual enrollment of 12,193 in fiscal year 2002. The legislature approved changes to the program
in order to address budget constraints.

- In 2005, the legislature removed residential services, such as assisted living, from the AC benefit
set. Residential services are now only available through the EW program.
- In 2003, the legislature approved lien and estate recovery requirements for AC participants. The
legislature repealed the lien requirements in 2005. The state continues to recover the cost of
providing AC services to participants from their estates following their death.

The above changes coincided with a sharp drop in AC enrollment. Currently, Minnesota serves
approximately 3,600 participants per year. Enrollment in AC is relatively stable, despite the increased
number of older adults in Minnesota. The state should evaluate whether eligibility, programmatic, or
other changes to the AC program would incentivize more people to participate in the AC program, and
whether that increased participation would result in cost savings to the state.

Understand the spenddown trajectory

People become eligible for the EW program after spending their private resources on LTSS. People
choose to pay privately for both in-home services as well as assisted living services. This is known as
“spending down” to MA eligibility. However, the state lacks meaningful data about this spenddown
trajectory from private pay to public pay status. For example, how much money do people spend on
services before applying for EW? How long do they pay privately for services? What services do they
buy? What is the difference in spenddown trajectory for people who pay for in-home services vs. people
who pay for assisted living? Answering these questions would help the state develop smarter, data-
driven strategies to delay or prevent spending down to MA.

Pay for quality in assisted living

As noted throughout this report, the growth of assisted living is one of the most significant features of
the LTSS landscape in Minnesota. The cost of assisted living (or customized living) drives a large share of
the spending in the EW program. The state’s goal is to promote and ensure high-quality, cost-effective
services that meet the needs of participants and allow participants to remain living in and connected to
their communities. To that end, the state is exploring ways to promote quality services through value-
based purchasing strategies for assisted living.

Minnesota is currently participating in CMS initiative, through the Medicaid Innovation Accelerator
Program (IAP), that will support the state to develop this value-based purchasing strategy. The Medicaid
IAP is offering a new technical support opportunity that is intended to build the knowledge base and
capacity of states to adopt strategies that tie together quality, cost, and outcomes for community-based
LTSS. Minnesota is seeking technical assistance specifically to design a value-based purchasing strategy for customized living services paid by Elderly Waiver, including for services provided to people with dementia. Through this 1-year technical assistance opportunity, Minnesota will develop a roadmap for design and implementation of this strategy.

**Conclusion**

Minnesota can be proud of its EW program. The program is undeniably achieving the state’s goal to serve MA-eligible older adults in their homes and communities, rather than in institutions. Participants report high levels of satisfaction with the program, and that the program is meeting their needs. The state is now faced with a new demographic reality and must respond. The state can build on a strong foundation to ensure this program continues to meet the needs of older adults for many years to come.