# Legislative Task Force on Aging

# DRAFT Final Report

October 2024

# Executive Summary

The Legislative Task Force on Aging ("Task Force") was established by the Minnesota Legislature during the 2023 Session.[1] The Task Force was charged with reviewing state resources for an aging demographic; identifying necessary support for an aging population through statewide and local endeavors for people to remain in their communities; and ensuring all aging-related state policies are inclusive of race, gender, ethnicity, culture, sexual orientation, abilities, and other characteristics that reflect the full population of the state. From this review, the Task Force is ultimately tasked with identifying the governmental entity to plan, lead, and implement recommended policies and funding for all aging Minnesotans. The Task Force is comprised of 8 members, including 4 legislators and 4 aging professionals to provide a broad range of input and expertise.

From August 2023 through October 2024, the Task Force has heard testimony on diverse sectors that impact healthy aging and aging in community from agencies, researchers, and other stakeholders. This has included presentations on health care, caregiving, transportation services, housing, nutrition programs, care providers, social programs, built environments, financial security and older adults in the workplace, and more. Additionally, the Task Force invited Pennsylvania and Colorado to present on their aging-related government structures and planning processes. Testifiers have been asked to give an overview of information, data, and trends and provide a discussion on their recommendations to the Task Force for promoting a state where all Minnesotans can experience healthy aging in the community of their choice.

The Task Force also received public testimony, both in-person and through an online public testimony submission form on the Task Force's website.

This draft final report covers the Task Force's review of state aging resources and planning, and recommendations from presenters of various aging-related sectors.

[1] See Minnesota Laws 2023 Chapter 62, Article 2, Section 120

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*REPORT LAST UPDATED 10/7/2024*

# Overview of the Task Force

The Legislative Task Force on Aging was established in 2023 to review and develop state resources for Minnesota's aging demographics. Through this review, the Task Force is charged with identifying and prioritizing necessary support for an aging population with both state and local ventures to help older Minnesotans remain in their communities. Resources, programs, and services for older adults span multiple sectors and are often administratively siloed in various departments, agencies, and offices at different levels of government. The Task Force has reviewed aging-related governmental and non-governmental programs and services across state departments and current plans to improve the health and care provider workforces, along with family caregivers. The Task Force has also examined strategies to improve the quality of long-term care and home care, as well as how to sustain neighborhoods and communities for an aging population. Planning efforts across the state were also reviewed, including projected impacts on housing options, land use, transportation, social services and health systems, and access and availability of safe and affordable rental housing options for aging tenants.

From this review, the Task Force on Aging is required to determine the governmental entity to plan, lead, and implement recommended policies and funding for all aging Minnesotans.

The Task Force's review will conclude with a final report to the Legislature, which will include an overview of the various sectors involved with aging in Minnesota, an analysis of current resources and data presented to the Task Force, and the group's recommendations to the Legislature on a proposed entity to plan, lead, and implement all aging-related funding and policies in the state.

It is widely agreed that health outcomes, of which life expectancy and quality of life are often used as a proxy, are not simply a factor of an individual's current physical health. Social determinants of health, defined as the socioenvironmental conditions where people are born, live, work, and age and affect health and quality of life outcomes, are a more holistic view of health and livelihoods. As such, this report will be framed along the social determinants of health, including health care quality and access, neighborhood and built environment, social and community context, and economic stability.

This draft final report represents the Task Force's review of data on Minnesota's older adult population trends, aging-related programs and services, and organizations' current plans and recommendations to prepare for our growing older adult population. For each presentation given to the Task Force, testifiers were asked to present a brief overview of the information they perceived as critical the Task Force should know along with their recommended opportunities to improve healthy aging and aging in community. This information is summarized in the *Overview of Testimony to the Task Force* section beginning on page 8. The Task Force's recommendations will be included when they are finalized.

# Enabling Legislation

2023 Minnesota Session Law, Chapter 62

Sec. 120.

**LEGISLATIVE TASK FORCE ON AGING.**

Subdivision 1.

**Establishment.**

A legislative task force is established to:

(1) review and develop state resources for an aging demographic;

(2) identify and prioritize necessary support for an aging population through statewide and local endeavors for people to remain in their communities; and

(3) ensure all aging-related state policies are inclusive of race, gender, ethnicity, culture, sexual orientation, abilities, and other characteristics that reflect the full population of the state.

Subd. 2.

**Duties.**

The task force shall review:

(1) all current aging-related governmental functions, programs, and services across all state departments;

(2) the current plans to improve health and support services workforce demographics;

(3) current public and private strategies to:

(i) support family caregivers for older adults;

(ii) define and support quality of care and life improvements in long-term care and home care; and

(iii) sustain neighborhoods and communities for an aging population;

(4) the necessity for planning and investment in aging in Minnesota to address:

(i) the longevity economy and the impact it has on the workforce, advancing technology, and innovations;

(ii) housing options, land use, transportation, social services, and the health systems;

(iii) availability of safe, affordable rental housing for aging tenants; and

(iv) coordination between health services and housing supports;

(5) coordination across all state agencies, Tribal Nations, cities, and counties to encourage resolution of aging related concerns; and

(6) from this review, determine the governmental entity to plan, lead, and implement these recommended policies and funding for aging Minnesotans across the state.

Subd. 3.

**Membership.**

(a) The task force shall include the following members:

(1) two members from the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(2) two members from the senate, one appointed by the majority leader and one appointed by the minority leader;

(3) the chair of the Minnesota Board on Aging, or a board member as designee;

(4) the chair of the Minnesota Council on Disability, or an agency employee as designee;

(5) the chair of the Minnesota Indian Affairs Council, or a council member, except the legislative council member, as designee; and

(6) the director of the University of Minnesota Center for Healthy Aging and Innovation, or a University of Minnesota employee as a designee.

(b) The speaker of the house and the senate majority leader shall appoint a chair and a vice-chair for the membership of the task force. The chair and the vice-chair shall rotate after each meeting.

Subd. 4.

**Meetings.**

(a) The task force shall meet at least once per month. The meetings shall take place in person in the Capitol complex, provided that the chair may direct that a meeting be conducted electronically if doing so would facilitate public testimony or would protect the health or safety of members of the task force.

(b) The task force shall invite input from the public, the leadership of advocacy groups, and provider organizations.

(c) The chair designated by the speaker of the house shall convene the first meeting of the task force no later than August 1, 2023.

Subd. 5.

**Expenses; per diem.**

Members serving on the task force shall receive the following per diem:

(1) the Board on Aging task force member who is a volunteer citizen member shall receive the per diem listed in Minnesota Statutes, section 15.059, subdivision 3;

(2) the Council on Disability task force member shall not receive a per diem;

(3) the Indian Affairs Council task force member who is a citizen member shall receive the per diem listed in Minnesota Statutes, section 15.059, subdivision 3;

(4) the University of Minnesota task force member shall not receive a per diem; and

(5) legislative members of the task force shall not receive a per diem.

Subd. 6.

**Report.**

The task force shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy and state government by January 15, 2025.

Subd. 7.

**Expiration.**

The task force expires January 31, 2025.

**EFFECTIVE DATE.**

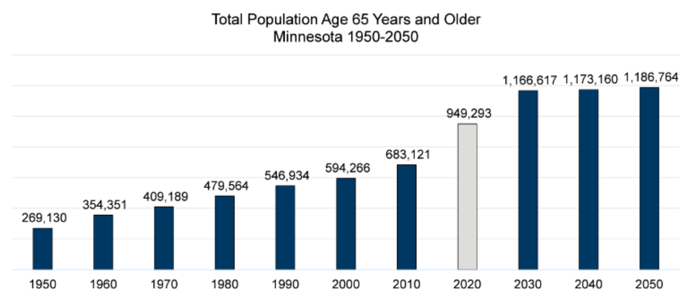
This section is effective July 1, 2023, or when the legislative leaders required to make appointments to the task force name appointees beginning the day after final enactment.

# Overview of Testimony to the Task Force

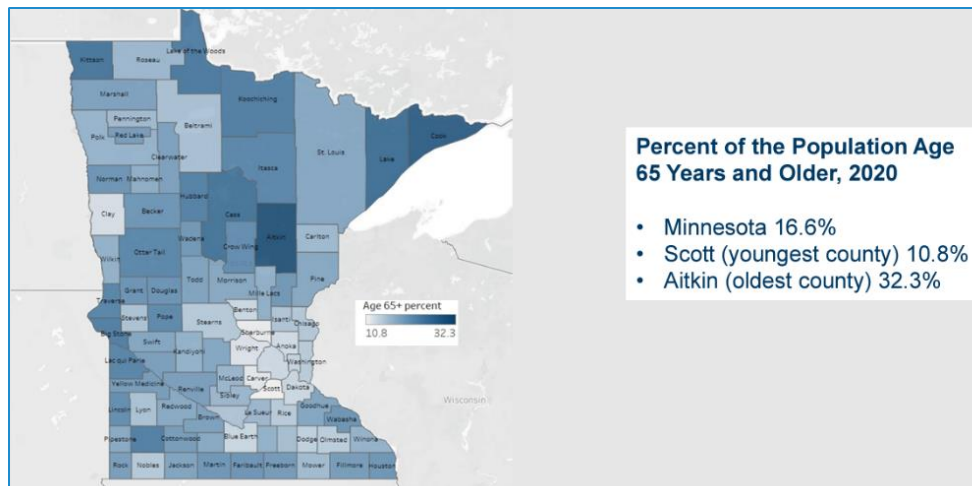
## The State of Aging in Minnesota

### *Aging Demographics*

Minnesota is one of the healthiest states in the country and has high rates of civic engagement, volunteerism, and other metrics that factor into healthy aging. At the same time, these successes, coupled with a falling birth rate, will create a permanent demographic transition to an older state, which requires assessing how our state and its communities plan to address issues associated with growing numbers of adults living longer. The state is now home to over 1 million individuals aged 65 or older, outnumbering the population of school-age children.[2] Around 8% of this older adult population are people of color.[3] By 2030, the number of older adults will reach around 1.16 million and stay near that level through 2050.[4]




There are 25% more women aged 65+ than men, and 78% more women than men over the age of 85.[5] Adults over the age of 85 are the fastest-growing age group in the United States.[6] Nearly 78% of women aged 85+ live alone, and older women rely exclusively on Social Security income at 2 times the rate of older men.[7] Greater Minnesota has a larger share of the state's older adults and is aging at a faster rate than metropolitan areas in part due to outmigration of younger people to urban areas.[8]

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[2] Brower, "Older Adults and the Need for Long Term Services and Supports."
[3] Department of Human Services (DHS), "Overview of Services that Support Aging in Community."
[4] Brower, "Demographic Overview of Minnesota's Older Adults."
[5] Bussey, "Aging in Minnesota Fact Sheet 2022."
[6] Williams, January 9, 2024
[7] Bussey, "Aging in Minnesota Fact Sheet 2022."
[8] Brower, "Demographic Overview of Minnesota's Older Adults."

Moreover, 70% of women 65+ live in rural Minnesota.[9] Due to lower population density, it can be more challenging to adequately support health care access, transportation and housing programs, and other resources that promote healthy aging and aging in the community.

While it is necessary to understand the future challenges that this growing older adult population will create, it is also important to acknowledge the contributions that Minnesota's older adults bring to our state. Minnesota's population aged 50 and older is responsible for 57 cents of every dollar spent in the state – this is projected to increase to 62 cents by 2050 – and contribute $154 billion to the state GDP while holding 1.7 million jobs.[10] Older adults have the highest rate of formal volunteering of all population groups and provide the highest rate of childcare.[11]

According to Dr. Susan Brower, the State Demographer, Minnesota's aging demographics will create permanent, wide-ranging impacts across different sectors of society. Minnesota's traditional labor force has already slowed, which may lead to diminished economic growth.[12] Public budgets will see impacts due to differing spending pressures that come with an aging population, including costs for social and health care.[13] As Dr. Brower concluded in her first presentation to the Task Force, "policies put in place to address aging today will position the state to be in better alignment with future populations."

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[9] Bussey, "Aging in Minnesota Fact Sheet 2022."
[10] Ibid.
[11] Grina, "Aging Task Force Testimony."
[12] Brower, "Demographic Overview of Minnesota's Older Adults."
[13] Ibid.

## Health Care Access and Quality – Background Information

### *Older Adult Health in Minnesota*

The Legislative Task Force on Aging heard many agencies and organizations give presentations regarding the health and care of aging Minnesotans. The reality presented to the Task Force is that all will age, and many will age to a point where they require some sort of care for their health needs. While Minnesota consistently ranks among the best states in terms of life expectancy, that alone is not an indicator for healthy aging, nor adequate preparation for our growing aging population. Providing care for those who develop a need for health care and other long-term services and supports (LTSS) will stress the state's health care systems, personal finances, and public budgets, not to mention those that provide the care for this population.

There are 307,000 older adults who live with a disability in Minnesota; about 1/3 of this population lives alone in the community.[14] About 103,000 older adults in the community report having difficulty with living independently, making it hard to run errands or visit a doctor's office, and 54,000 older adults in the community have difficulty with caring for themselves inside their own homes.[15] For the United States as a whole, 70% of adults who survive to age 65 will develop severe LTSS needs before they die, and 48% receive paid care over their lifespans.[16] Many older adults with severe LTSS needs rely solely on family and other unpaid caregivers.[17] 24% of older adult Americans receive more than 2 years of paid LTSS care, and only 15% spend more than 2 years in a nursing home.[18]

The Minnesota Department of Health (MDH) identified the need to reduce dementia risk and promote healthy aging by addressing chronic conditions. Earlier detection and diagnosis of dementia is critical, and Minnesota is not sufficiently screening for cognitive impairment. 40% of Minnesota adults who reported they felt they had trouble with their memory have talked about it with a healthcare provider, and only 30% of Minnesota adults with Medicare had an annual wellness visit in 2019, which included cognitive screening.[19]

| Chronic Disease | % MN Adults 65 and older with the disease |
|---|---|
| Arthritis | 47% |
| Cardiovascular Disease (e.g., heart attack, heart failure) | 19% |
| Diabetes | 20% |
| High Blood Pressure | 56% |
| High Cholesterol | 50% |
| **At Least 1 Listed Chronic Disease** | **84%** |

[14] Brower, "Older Adults and the Need for Long Term Services and Supports."
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] MDH, "Older Adult and Elder Health and Well-being in Minnesota."

In 2020, 99,000 Minnesotans were living with Alzheimer's disease or related dementia (ADRD), and that number is expected to increase by 21.5% by 2025.[20] 95% of people with ADRD have at least one other chronic condition, and ADRD often complicates the management of those conditions, resulting in poorer health quality of life, and care costs.[21] Older Black, American Indian, and Hispanic Americans are more likely to have Alzheimer's or another form of dementia and are more likely to not be diagnosed than older Americans.[22] Medicaid costs for caring for Minnesotans with Alzheimer's in 2020 reached $905 million. That cost is expected to increase by 20.1% in 2025.[23]

Rates of chronic disease for older adults 65+ in Minnesota are high: 84% live with at least 1 chronic disease, such as arthritis, cardiovascular disease, diabetes, high blood pressure, or high cholesterol.[24] Deaths related to chronic diseases impact populations of color in Minnesota at a higher rate and earlier in life.[25] Chronic disease-related spending for adults over the age of 60 is $9.3 billion and is projected to grow 60% by 2028.[26]

Caregiving, in of itself, is a risk factor for various chronic diseases. Caregivers to older adults are more likely to live with chronic diseases than non-caregivers (55% vs 48%).[27] Caregivers also report having worse mental health, and 30% report needing additional support in their caregiving role.[28] Financial costs to caregivers, including value of time spent caregiving and future employability, are estimated at $2.5 billion per year.[29]

Hearing loss is another aspect of the aging experience for many older adults. Nearly 2/3 of Americans older than 70 years old have a clinically significant hearing loss, and those with hearing loss are 24% more likely to experience some cognitive decline.[30]

There are large gaps in resources for aging Minnesotans experiencing age-related hearing loss. Many state resources for older adults do not include or refer viewers to information on age-related hearing loss, and community partners report challenges with supporting seniors in adapting to hearing and communication access technology.[31] Caregivers are often not fluent in American sign language. Additionally, hearing loss is not a part of standard screening protocol and can go undetected. Minnesotans on Medical Assistance (MA)

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[20] MDH, "Older Adult and Elder Health and Well-being in Minnesota."
[21] Alzheimer's Association, "Minnesota Legislative Task Force on Aging."
[22] Ibid.
[23] Ibid.
[24] MDH, "Older Adult and Elder Health and Well-being in Minnesota."
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Minnesota Commission of the Deaf, Deafblind & Hard of Hearing, "Aging in Minnesota: Hearing Loss and Communication Access."
[31] Ibid.

often have difficulty accessing hearing aid services due to reimbursement rates and declining MA coverage.[32]

Eye health and related care will also need to be addressed given Minnesota's aging demographics. Nationally, 1 in 4 older adults have vision impairment, and this is expected to increase 24% per decade over the next 25 years, limiting independence and increasing comorbidities such as depression, risk of falling, and dementia.[33] Moreover, eye care in residential long-term care is insufficient, as the National Nursing Home Survey found that only half of nursing homes contract for vision and hearing services and only 12% have optometric services.[34] Proactive intervention for eye disease is needed to increase the health and independence of older adults – for example, cataract removal has been found to lower the risk of dementia among older adults by nearly 30%, leading to improvement in the quality of life.[35]

Finally, fall prevention strategies will need to be more heavily implemented as the state's population ages. According to 2014 data, the total cost of falls among older Minnesota adults was more than $713 million per year.[36] 29% of adults over the age of 65 have reported a fall in the past year, and more than 48,000 falls-related emergency department visits and hospitalizations occur every year.[37]

*Healthcare and Caregiving Workforce*

The growing number of older adults will strain our health care systems if they do not adapt, as older patients are often more acute and complex, and constitute a majority of adults admitted for hospital care. In Fairview Health System's metro area hospitals, 38% of inpatient discharges are for patients 65+, an increase of 3% in the last 3 years.[38] Comparatively, at Grand Itasca Hospital and Clinic and Hospital in Grand Rapids, 43% of inpatient discharges were for 65+ older adults, highlighting the need for investment in rural care for older adults.[39] Additionally, medications for older adults are more expensive and complex, and there is not enough staff to meet patient needs in community and post-acute settings.[40] Finally, Fairview highlighted that rules and regulations for older adults were designed for the patients of 15-20 years ago, and that transportation, workforce, technology, and discharge to home are challenges that must be addressed to best serve our growing population of older Minnesotans.

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[32] Ibid.
[33] Minnesota Optometrists Association (MOA).
[34] Ibid.
[35] Maltry, "Legislative Task Force on Aging."
[36] Minnesota Department of Health (MDH), "Older Adult and Elder Health and Well-being in Minnesota."
[37] Ibid.
[38] Fairview Health Systems, "Presentation to Legislative Task Force on Aging."
[39] Ibid.
[40] Ibid.

Testimony also highlighted the need for health technology investments to best prepare for Minnesota's growing older adult population. A survey of 2,000 adults 55+ found that 96% that were using a medical alert system responded that it brought relief or assurance and 97% of users' children said it brought them relief.[41] Additionally, 88% responded that assistive or health-related technologies improve their quality of life.[42]

Minnesota has around 640,000 family caregivers, of which most are women, who provide an estimated $8.6 billion a year in care to older adults.[43] An estimated 61% of family caregivers are in the workforce and provide care for an average of 4.5 years.[44] Over 170,000 family caregivers are caring for a relative living with ADRD in MN.[45] In 2022, 163,000 caregivers for individuals with ADRD provided 225 million hours of unpaid care, at a value of $5.25 billion.[46] Nearly 60% of ADRD caregivers rate the emotional stress of caregiving as high or very high.[47] An estimated 40% of family caregivers of people with ADRD suffer from depression, and caregiver burnout is one of the leading risk factors for placement in assisted living or nursing homes.[48] As one respondent to the Task Force's online public testimony form stated, "Family members are carrying much of the burden at a significant financial cost due to working less or not at all to care for family members. The reimbursement rate [for care] is virtually nonexistent unless the family becomes destitute."[49]

There is a noted lack of providers specializing in geriatrics to provide care for Minnesota's growing older adult population, even more so in Greater Minnesota, and aging adults require a disproportionate share of healthcare resources.[50] Geriatric care is often underemphasized in clinical training, with only 5% of social work students, 3% of medical students, and 1% of nursing students specializing in geriatrics at a time when Minnesota's growing older adult population will facilitate a further need for knowledge of aging-related care.[51] Additionally, care coordination is more time intensive for older patients because of a need to coordinate with staff, families, and across medical records.[52]

Public budgets will need to shift to meet the rising costs of health care and LTSS for our aging population.[53] Tax revenues may be impacted by this demographic change, as federal and

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[41] Miller, "Legislative Task Force on Aging: Current Data and Technology Recommendations."
[42] Ibid.
[43] Vrolson, "Roles and Perspectives of Minnesota's Area Agencies on Aging."
[44] Ibid.
[45] Ibid.
[46] DHS, "Overview of Services that Support Aging in Community."
[47] Alzheimer's Association, "Minnesota Legislative Task Force on Aging."
[48] Ibid.
[49] LCC Public Testimony Form, 55372
[50] Minnesota Association of Geriatrics Inspired Clinicians, "Minnesota Legislative Task Force on Aging."
[51] Intergenerational Public Health Interest Group.
[52] Fairview Health Systems, "Presentation to Legislative Task Force on Aging."
[53] Brower, "Demographic Overview of Minnesota's Older Adults."

state tax systems are largely based on income and spending, which often decrease after individuals retire.

*Residential Long-Term Care*

Residential long-term care (RLTC) in nursing homes and assisted living has been declining over the past several decades, due in part to an increase in availability of and preference for services and care received at home and in the community. Only 3%, or around 33,000, of Minnesota's older adults ages 65+ live in RLTC facilities.[54] The rapidly growing group of adults 75+ have an increased need for LTSS, including RLTC, and is projected to increase Medicaid utilization by over 25% by 2035.[55] Quality of care is the top complaint category among individuals who contact the Office of Ombudsman for Long-Term Care.[56] Complaints across all categories, including care, autonomy, admission, facility policies and practices, environment, and abuse, grew 16% from 2021 to 2022, and complaints about care problems rose 30%.[57] Racial differences in nursing home residents' quality of life exist, with minority populations reporting lower quality of life than white residents.[58]

Despite this, access to quality, well-staffed, and compassionate RLTC was identified as an important factor in aging in Minnesota for those that need it. According to the Long-Term Care Imperative, 79% of Minnesotans expect care within 30-40 minutes of their home community, and 80% of Minnesotans believe that people who care for older adults deserve comparable wages to other health care fields.[59]

In Minnesota there are several Green House Homes, which differ from traditional nursing homes and are one of the several 'scalable innovations' highlighted for the Task Force's consideration. These facilities focus on person-centered care, including resident direction, staff empowerment and relationships. Research shows that Green House Homes have fewer hospital readmissions and bedfast, catheter, and low-risk pressure ulcer indicators than traditional nursing homes.[60] Data also show that Green House Homes lower Medicare spending by $7,700, or around 30%, per resident per year.[61] Episcopal Homes, which operates 6 Green House Homes in St. Paul, reports a 98% positivity score for quality for residents' quality of life and dignity and 60% lower rehospitalization rates than the national average.[62]

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[54] Brower, "Older Adults and the Need for Long Term Services and Supports."
[55] Own Your Future, "Legislative Task Force on Aging – Own Your Future Presentation."
[56] Office of Ombudsman for Long-Term Care, "February 9, 2024 Presentation."
[57] DHS, "Overview of Services that Support Aging in Community."
[58] Shippee, "Facility Differences in Nursing Homes Affect Quality of Life for Minnesota Minorities."
[59] Long-Term Care Imperative, "Aging Services in Minnesota."
[60] Zimmerman, "The Green House Model of Nursing Home Care."
[61] Ibid.
[62] Episcopal Homes, "The Greenhouse Model of Care."

Many states have attempted to improve quality of life and care for RLTC recipients, but, according to Elder Voices Advocates, few of these have been adequately implemented.[63] Consistent delivery of quality and compassionate care is required in RLTC, which is supported by adequate staffing levels and investments to improve education, benefits, income, and working conditions for care providers.[64] Elder Voices Advocates highlighted the lack of implemented statewide plans to ensure the LTC system is adequately addressing Minnesota's growing aging population.[65]

*Long-Term Care Workforce*

The LTC workforce is experiencing staffing shortages that threaten the ability of programs to provide adequate care for the older adult population. While vacancy rates for certified nursing assistants and unlicensed personnel positions have been declining, they are still at 15.6% for assisted living facilities and 20.7% for nursing homes.[66] Additionally, 6.3% of assisted living facilities and 9.7% of nursing facilities are considering closure. [67]

Low wages for healthcare support and LTC workers exacerbate workforce shortages, with current median wages for personal care aides at $14.98 per hour, and median wages for nursing assistants at $16.83.[68] One respondent to the Task Force's online testimony form spoke to the shortage of the LTC workforce while also highlighting the need for alternatives to keep aging adults in their homes, stating that "Sufficient workforce should be a priority in order to ensure access to healthcare needs across all of MN, especially in our rural communities. This is a cost saving alternative to bricks and mortar type of residential care- keeping people in their homes to age in place is preferable and most cost effective for our healthcare systems."[69]

[63] Elder Voices Advocates (EVA), "Opportunities and Innovations Through a Department for Community Aging."
[64] Ibid.
[65] Ibid.
[66] Long-Term Care Imperative, "Aging Services in Minnesota."
[67] Ibid.
[68] Brower, "Demographic Overview of Minnesota's Older Adults."
[69] LCC Public Testimony Form, 55422

Table 1: Summary of Testimony on Health Care Quality and Access Resources and Recommendations to the Task Force

| | Current Aging-related Resources | Recommendations to the Task Force |
|---|---|---|
| Long-Term Services and Supports - Department of Human Services (DHS) | • MnCHOICES - helps lead agencies complete LTSS and health risk assessments and eligibility for LTSS<br>• Offers HCBS through Elderly Waiver and Alternative Care<br>• MN Adult Abuse Reporting Center | • Address disparities in services access and outcomes<br>• Increase support for vulnerable adults experiencing self-neglect<br>• Strengthen support for family caregivers<br>• Reach people earlier in their need for services<br>• Reach middle income with financing options |
| Long-Term Services and Supports – Minnesota Board on Aging (MBA) | • Provides services (caregiver supports, meals, transport, falls prevention programs) through Older Americans Act (OAA) funds<br>• Advise on opportunities to meet changing needs of older adult populations<br>• Advocate policies to legislature, governor, and agencies that reflect the needs of older Minnesotans<br>• MBA, along with Area Agencies on Aging, advocate, plan, develop, and deliver LTSS<br>• Manages Senior LinkAge Line<br>• Provides administrative support to Office of Ombudsman for Long-Term Care<br>• Creates State Plan on Aging | • Provide a direct line of communication to the governor and their office to give voice to older persons<br>• Allow for resources to support advocacy, research/analysis, community education and outreach, and cross-agency coordination<br>• Continue the collaboration and support for the Age-Friendly Minnesota Council and its work on the Multisector Blueprint for Aging<br>• Revise MBA's legislative statute to strengthen its authority to work directly with the governor and their office, the legislature directly, state agencies, and Tribal Nations |
| Own Your Future – DHS and Department of Commerce | • Program to educate Minnesotans about future LTC needs and approve insurance products | • Support care navigation and support services to provide awareness and education to older Minnesotans and their caregivers<br>• Increase affordable insurance product options for middle-income Minnesotans |

| | | |
|---|---|---|
| Long-Term Services and Supports/Home and Community Based Services – Area Agencies on Aging | • 7 Area Agencies on Aging statewide, connect people with resources and services, fund community partners, and advocate for resources and systems change<br>• Plan, develop, coordinate, and deliver LTSS | • Strengthen support for family and friend caregivers |
| Falls Prevention – MDH | • Promoting falls prevention programs and supporting walkable communities through Statewide Health Improvement Partnerships (SHIP) | • Expand falls prevention campaign and scale up evidence-based programs identified through chronic disease prevention programs and MDH grants (State Health Improvement Partnerships, Eliminating Health Disparities Initiative (EHDI), Healthy Brain)<br>• Reimburse community-based organizations that offer prevention programs through Medicare, Medicaid, and commercial payors<br>• Address social determinants of health (food security, social isolation, and environmental safety in home and community) |
| Alzheimer's Disease and Related Dementia – MDH | • Preventing, reducing and managing chronic diseases that are risk factors for ADRD through SHIP, EHDI, Healthy Brain grants<br>• Funding community-based organizations (CBOs) to implement culturally competent brain health promotion and clinic-community linkage practices<br>• Planning Alzheimer's Awareness campaign<br>• Supporting primary care organizations to improve screening protocols and developing continuing education for Community Health Workers | • Increase funding to community partners to implement local solutions, and establish regional dementia screening and referral programs<br>• Engage community health workers to train local messengers in communities to promote dementia risk reduction and connect older adults to resources<br>• Follow the Centers for Medicare and Medicaid (CMS) Guiding an Improved Dementia Experience (GUIDE) model to address gaps in primary care and promote provider continuing education |

<table>
<tr><td>Alzheimer’s Disease and Related Dementias – Alzheimer's Association</td><td><ul><li>Cooperates with Volunteers of America, Minnesota, to provide dementia services and caregiver support, including support of African American and East African older adults and caregivers</li><li>Respite Care Grants</li><li>Live Well at Home Grants</li></ul></td><td><ul><li>Create Dementia Services Coordinator within MDH</li><li>Fund Eliminating Health Disparities Initiative and create Healthy Aging and Dementia Health Curricula</li><li>Simplify the Elder Care System</li><li>Educate Minnesotans about AD and other forms of dementia</li><li>Ensure that all health care settings, particularly primary care, are equipped with the tools to recognize the signs of dementia and refer their patients for a cognitive assessment</li><li>Raise awareness about available services and supports for early engagement for people with dementia and caregivers</li><li>Increase alignment between Elderly Waiver, Alternative Care, and OAA service lines.</li><li>Support caregivers w/ respite care grants</li><li>Support HCBS providers with sustained increases to the elder waiver</li><li>Expand access to respite care</li><li>Washington model</li></ul></td></tr>
<tr><td>Chronic Condition Prevention and Management – MDH</td><td><ul><li>Promoting health care system changes to reach vulnerable patients, developing and advancing community-led strategies, and expanding community-clinic links</li></ul></td><td><ul><li>Increase availability and access of prevention/management programs to vulnerable communities, and address barriers to participation</li><li>Create sustainable funding sources and efficient payment systems for chronic disease self-management</li></ul></td></tr>
<tr><td>Caregiver Health and Wellness – MDH</td><td><ul><li>Partnering with community and primary care organizations that connect caregivers with resources</li><li>Collaborate with U of M Center for Healthy Aging and Innovation (CHAI) on caregiver supports</li></ul></td><td><ul><li>Scale culturally responsive community outreach for caregivers with community health workers</li><li>Collaborate with statewide partners to utilize and engage health systems in best practices of caregiver support</li><li>Provide health programming specific to caregivers that address social, emotional, and health needs</li></ul></td></tr>
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| Oral Health – MDH | • Monitoring oral health needs of older adults and tracking ED visits<br>• Starting age-friendly medical-dental integration projects and dental homes in LTC about geriatric oral health<br>• Integrating dementia education in dental training | • Foster cross-agency collaboration to develop age-friendly dental public health system<br>• Train dental students and oral health professionals and community health workers in geriatric oral health |
| Information on Age-Related Hearing Loss – Minnesota Commission of the Deaf, Deafblind, and Hard of Hearing (MNCDHH) | • DHS Deaf and Hard of Hearing Services Division (DHHSD)<br>• Hearing Loss Association of MN, Twin Cities<br>• MN Deaf Senior Citizens | • Have state agencies partner with MNCDHH and DHHSD to update statewide older adult resources (hearing health, communication access, protective measures to mitigate increased risk for cognitive decline associated with hearing loss with information about hearing health and communication access, culturally and linguistically competent information)<br>• Update statewide data collection efforts on seniors to include questions on hearing loss and accommodations needed<br>• Raise awareness of DHHSD's telephone equipment distribution program and include information on hearing access technology in resources offered to Minnesota seniors |
| Health Care and Age-Related Hearing Loss – MNCDHH | • Complete and implement recommendations from MNCDHH Age-related Hearing Loss Task Force | • Screen all adults age 55+ for hearing loss (in accordance with MN St. 256C.233, subd. 3)<br>• Allow ASL-fluent hospice workers and volunteers to work at multiple facilities statewide<br>• MDH collaborate with MNCDHH in their health equity initiatives and continue collaboration between MBA and MNCDHH<br>• Hearing aid access: study hearing aid services reimbursement rates and work with Minnesota congressional delegation to include hearing aids coverage in Medicare |

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| LTC – Episcopal Homes | • Operates and promotes Green House Home model of care | • Financial incentives for culture change and private rooms<br>• Elevate licensed practical nurse (LPN) care to be considered for federal staffing mandate |
| LTC Workforce – Long-Term Care Imperative | • Working to alleviate LTC workforce shortage and access to care through workforce incentives<br>• Commit EW program for community-based services for seniors in assisted living<br>• Incentivize high school students to work in LTC through elective credits<br>• Caring Careers program through grant funds from CDC and MDH | • Aging Services Payment/Reimbursement Policy and ensure EW rates are indexed to current wage data<br>• Continue advocacy for implementation of Program of All-Inclusive Care for the Elderly (PACE)<br>• Nursing Home Worker pay, provide $5/hr average wage increase to NH workers<br>• Expand access to trained Medication Aide training programs, provide language accommodation for CNA applicant written exams, include assisted living settings in state summer health care internship programs, and expand grants to cover full cost of student employment for LTC settings<br>• Allow health care facilities to recover penalties caused by negligent assignment of supplemental nurse staffing agency<br>• Enable LPNs to work in assisted living settings to the same scope as they already do in other health care settings<br>• Reinstate MDH-subsidized background studies |
| LTC Workforce – SEIU Healthcare MN | • SEIU represents over 4,000 nursing home workers in 30 NH - about 30% of the industry is organized | • Home care: workers benefits, retain self-directed PCAs. Interest-based bargaining for 25-27 contract. Secure Choices Retirement Accounts. Health insurance<br>• Nursing homes need to raise wages/census/ NHWSB composition. First Labor Standard<br>• Inflation for Homecare programs. Promote self-direction and nursing home pensions Immigration |

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| Geriatrics Workforce – Minnesota Association of Geriatrics Inspired Clinicians | • Geriatric specialty society that supports multidisciplinary care consistent with older adult values and preferences | • Improve capacity at MDH beyond federal grant initiatives<br>• Coordinate services and care across health care continuum, especially in MN rural areas<br>• Incentivize geriatrics education and careers and promote interest in geriatrics among PCPs<br>• Ensure skilled workforce in geriatrics across the continuum of care<br>• Include clinicians to be at the table with MDH and DHS. Expand medical director role<br>• Innovate in long-term clinical care<br>• Leverage medical directors and geriatric focused primary care providers<br>• Broader use of telemedicine |
| Geriatrics Workforce – Geriatric Workforce Enhancement Program | • Promotes age-friendly primary care, and educates health professionals on geriatric care<br>• Dementia care and support for families and direct care providers | • Increase faculty and professionals specialized in geriatrics<br>• Incentivize and train faculty, students, and health professionals to provide age-friendly care (scholarships, stipends, loan forgiveness)<br>• Implement and incentivize AF and Dementia friendly practices into PC and dental care |
| Community Health - Trellis | • Juniper – a statewide social care network for chronic health conditions, prevent falls, and promote wellness. Bridges gap between social and medical care | • Invest in community care hubs to improve the aging experience, bend the cost curve and secure Minnesota's leadership in addressing health-related social needs<br>• Evaluate recommendations from the Own Your Future study for legislative implementation in the next biennium<br>• Create a cabinet-level position for aging and community living to support aging care innovations and to address service and systems issues that affect older adults |

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| Aging-related Planning, Services and LTC – Elder Voices Advocates | • Supports federal minimum staffing standards and Medicaid institutional payment transparency reporting | • Establish a Department for Community Aging to coordinate and optimize existing age-related programs and services that are currently fragmented across different departments<br>• Develop and sustain a LTC workforce statewide and scale and deliver innovations<br>• Have Department lead a multisector Statewide Plan of Action in collaboration with counties, cities, and private sector to meet economic, health, and social challenges due to aging demographics |
| Home-based services – Community Aging in Place, Advancing Better Living for Elders (CAPABLE) | • 2 CAPABLE sites existed in MN, but have ended due to grant completion | • Cooperate with and build off of existing home-based innovations with AAAs<br>• Expand CAPABLE program (state legislation, required benefit inclusion, or innovation-driven pilot program |
| HealthPartners – Acute Hospital Care at Home | • Care delivery model designed to treat acutely ill patients at home instead of hospital, with outcomes of lower readmissions and costs, and higher patient satisfaction. Has provided care for 800 patients in 2 metro health systems | • Make Acute Hospital Care at Home part of state program benefits<br>• Support strategic use of the healthcare workforce |
| Fairview Health Services/Ebenezer Management Services | • The largest healthcare geographic footprint in Minnesota, serving both urban and rural residents, has a dedicated geriatrics department, providing primary care for 2200 residents living in residential LTC | • Payment/Care Models that incentivize community settings and care coordination (i.e. Fairview Partners, PACE)<br>• Sustainable investment in transportation infrastructure and reimbursement not sufficient for non-emergency medical transportation needs particularly acute in Rural MN<br>• Technology flexibility, including telehealth and remote patient monitoring, and support for technology needs and education for aging adults<br>• Centers of Excellence in post-acute care |

| Minnesota Optometric Association | • Provides medical eye care services, and low vision rehabilitation | • Support health coverage and access for seniors to receive comprehensive in-person medical eye exams once yearly<br>• Encourage access to Low Vision Rehabilitation and make follow-up care a priority<br>• Provide appropriate funding for MN State Services for the Blind and Visually Impaired and other nonprofits such as Vision Loss Resources<br>• Researching and investing in innovations to sustain the engagement of older adults in the community |
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| Minnesota Academy of Ophthalmologists | • Organization of 300 eye physicians and surgeons | • Support preventative care for eye diseases<br>• Insurance coverage for eye drop helpers<br>• Improve transportation options to medical appointments |
| HealtheMed | • Medical technology company | • Support policies to incorporate technology that meets current needs and prepares for future demands of aging population<br>• Assistive technology and technology in the home<br>• Create inclusive approach to technology access for vulnerable individuals<br>• Health management should be proactive and not reactive |
| Intergenerational Public Health Interest Group | • Intergenerational collaborative group between the University of Minnesota Aging Studies Interdisciplinary Group and the Pillars of Prospect Park, an older adult living community | • Incentivizing students to study aging-related topics by expanding loan forgiveness programs<br>• Funding a scholar's program to create cohorts of experts in aging<br>• Ensuring that intergenerational projects are included in grant allocations for initiatives across the life course, not only in aging-related initiatives |

## Neighborhood and Built Environment – Background Information

The built environment in which we live and work, including housing, transportation, urban and regional planning, and land-use, all play a part in our health outcomes and how we interact with our communities as we age. This section will review how transportation and housing, as key components of our built environment, impact older Minnesotans.

*Transportation and Mobility*

Many presentations and testifiers identified transportation as one of the most critical requirements for healthy aging and aging independently in the community – as Director Kate Williams with the Regional Transportation District of Denver stated, "A clinic is no good if you can't get there. A food bank is not good if you can't get there […]. Transportation underlies everything."

Adults 65+ have more trips than any other age group in Minnesota[70], and older adults outlive their ability to drive by 7-10 years.[71] Moreover, 1 in 5 older adults do not drive at all.[72] In the metro area, 8.5% of adults 65+ have no vehicles at home.[73] As one testifier from the Pillars of Prospect Park, a senior living community in Minneapolis stated, "I still want to volunteer and participate in the community, but lack of transportation is a major obstacle…. We need safe, accessible, coordinated options for senior transportation. Please help me be the kind of senior you want me to be, active and serving in the community."[74]

Due to a lower density of destinations and resources, transportation needs will grow for older adults in greater Minnesota, where many will need to rely on a personal vehicle or become dependent on transit services.[75] Adding to this issue, consolidation among healthcare providers creates greater distances between sites, requiring people to travel further for those services.[76] Moreover, physicians cite transportation as a barrier to consistent care. Dr. Amy Maltry of the Minnesota Academy of Ophthalmology testified that "One of the greatest challenges my elderly patients face is transportation…. For those who cannot drive safely, transportation to medical appointments and other essential activities is a significant challenge."[77] Lack of transportation for this demographic also hinders follow up care for older

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[70] Minnesota Department of Transportation (MnDOT), "Legislative Task Force on Aging."
[71] Vrolson, "Roles and Perspectives of Minnesota's Area Agencies on Aging."
[72] Ibid.
[73] Metropolitan Council, "Legislative Task Force on Aging."
[74] Intergenerational Public Health Interest Group
[75] MnDOT, "Legislative Task Force on Aging."
[76] Center for Rural Policy and Development, "Aging Rural Minnesota: The Future of Volunteer Drivers.
[77] Maltry, "Legislative Task Force on Aging."

patients.[78] Public transit is expanding in Greater Minnesota but cannot accommodate all the needs of elderly and disabled transit users.[79]

One solution to rural transit for older adults proposed to the Task Force was volunteer drivers, which, according to the Center for Rural Policy and Development, are the most cost-effective mode of essential rural transit services. While volunteer drivers make up a large portion of transportation services in Greater Minnesota, their numbers are falling.[80] According to a 2019 survey of transit providers around Greater Minnesota, 68% report having trouble recruiting volunteer drivers and 54% have canceled trips due to volunteer driver shortage.[81] There are various causes of this shortage, including low charitable mileage reimbursement rate, no reimbursement for "no-load miles" (miles driven without a passenger), and fear of reduced Social Security benefits.[82]

Regardless of where one lives, Minnesota is a car-centric state which creates barriers to mobility and accessible transportation that older adults may need to rely on for necessary tasks, such as doctor's appointments or grocery shopping.[83] Winter can be a particularly isolating time for Minnesota's older adults, as several testifiers commented on the necessity to improve snow-removal infrastructure, and clear snow and ice off sidewalks and public spaces.

Table 2: Summary of Testimony on Transportation and Mobility Resources and Recommendations to the Task Force

| | Current Aging-related Resources | Recommendations to the Task Force |
|---|---|---|
| Greater Minnesota Transportation Resources – Minnesota Department of Transportation (MnDOT) | • In 2022, Greater MN had 35 public transit systems and 6 tribal transit systems<br>• Developing a Greater Minnesota Transit Plan with Spring 2025 completion<br>• Participates in transportation access coordination with MN Council on Transportation Access<br>• Active transportation and Complete Streets planning | • Continue to be supportive of funding for Greater MN transit and active transportation |

[78] Maltry, "Legislative Task Force on Aging."
[79] Center for Rural Policy and Development, "Aging Rural Minnesota: The Future of Volunteer Drivers.
[80] Ibid.
[81] Ibid.
[82] Ibid.
[83] Minnesota Council on Disability, "Testimony on Transportation for People with Disabilities in Minnesota

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| | • Developing Statewide Bicycle System Plan<br>• Makes investments in accessibility and ADA compliance of pedestrian facilities<br>• Sponsor and facilitate Regional Transportation Coordinating Councils (RTCCS) and Transit Coordination Assistance Projects (TCAPs) to coordinate regional transit services | |
| Greater Minnesota Transportation Resources – Arrowhead Regional Transportation Coordinating Council | • One of 7 RTCCs in MN, which work to improve access to transportation services<br>• Assist and implement priorities in local Human Services Transportation Plans<br>• Formalize coordination plans to engage and work with providers and service agencies | • Provide adequate reimbursement rates for non-emergency medical rides, specialized transportation service rides and other state-supported transportation services<br>• Develop policy directives on how non-emergency medical transportation providers communicate service area changes or discontinuation of service in an area or region<br>• Expand Medicaid Managed Care transportation service contracts<br>• Change MnDOT procurement guidelines to allow for smaller vehicles/minivans<br>• Increase capital investment for vehicles and specify funding for technology needs<br>• Support development and operation of transportation services to events and locations outside of health care and after normal business hours<br>• Support sustainability and/or expansion of public transit<br>• Dedicate appropriation for mobility managers through the Office of Transit for the development of local programs |

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| Volunteer Drivers – Center for Rural Policy and Development, and Volunteer Driver Coalition | • Nonprofits, communities, RTCCs, AAAs and others support advocacy to reduce barriers for volunteer drivers to support older adult mobility | • Support MnDOT's efforts to improve Greater MN's transit systems<br>• Modernize rural transit with cleaner vehicles and seek new innovations and best practices from around the country<br>• Help volunteer driver recruitment through community outreach<br>• Consider reimbursing transit organizations for no load miles |
| Transportation Accessibility – Minnesota Council on Disability | • Extensive network of accessible buses and light rail within urban areas, with audio/visual announcements at stations and priority seating options<br>• Paratransit services exist for door-to-door services<br>• GoMarti pilot program in Grand Rapids | • Remove car-centric policies that create barriers to accessible transportation<br>• Add more trains, busses, and ride-share programs, which create a more pedestrian-friendly environment<br>• Connect paratransit services with mainstream public transit<br>• Increase accessible transit options in Greater MN |
| Transportation Services – Area Agencies on Aging | • Provides transportation services | • Increase services in rural communities<br>• Clarity on requirements for nonprofit providers of volunteer transportation<br>• Designate state funding for community-based transportation solutions<br>• Volunteer mileage tax reform |
| Metropolitan Area Transportation – Metropolitan Council | • Offers Metro Mobility, with a $100 million annual budget and nearly 2 million annual ridership<br>• Older adults 65+ have access to discounted fares on Metro Transit | |
| Transportation Development – Regional Transportation District (RTD) Director Kate Williams | | • Create transit-oriented communities/development |
| Intergenerational Public Health Interest Group | | • Older adults need to be part of the planning, design and construction of the built environment, including housing, streets, and city buildings<br>• Safe, accessible, coordinated options for senior transportation |

| Minnesota Academy of Ophthalmologists | | • State support for a program that provides transportation and aids with companionship after surgery |
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*Housing*

Housing is a key component of aging in the community, affecting mental health, social and civic engagement, and access to care and food, among other aspects of healthy aging. 96% of Minnesotans 65+ live in households outside group quarters such as nursing or assisted living facilities.[84] Of those, 55% live with a spouse or partner and no others, and around 29%, or around 270,000 Minnesotans live alone.[85] 78% of older Minnesotans live in homes they own, and homeownership remains high for all older adult age groups through age 84.[86] Compared to all age groups, 65- to 74-year-olds are the least likely to move.[87] Additionally, 22% of Minnesota's older adults rent their housing.[88]

According to 2016 data, 16,400 homeowner households of extremely low-income older adults in Minnesota must have home rehabilitation needs met in order to remain in their homes.[89] On average, rehabilitation costs are nearly $16,000 per home, creating $250 million of rehab needs from 2016 to 2021.[90] 52% of the Minnesota Housing Finance Agency rehabilitation loan program are older adults, though this program has constraints as local administrators run the programs and local contractors do the work.[91]

Housing is often developed for older adults rather than with them.[92] Factors that should be considered that impact the quality and accessibility of housing include finances, maintenance, and mobility.[93] One public testifier added to this, stating that "Properties that rent to seniors need to recognize that many of their residents have mobility and other issues that require some level of safety. This will require regulatory oversight to make sure that basic safety is met. They aren't renting to 20-year-olds."[94] Housing developers will need to start incorporating universal design principles, such as no-step entries, wider doors and hallways, and lever handles, to adequately conform to the current and future needs of Minnesota's aging population that want to age in their homes.[95]

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[84] Brower, "Older Adults and the Need for Long Term Services and Supports."
[85] Ibid.
[86] Minnesota Housing, "Legislative Task Force on Aging: Housing for Older Adults."
[87] Ibid.
[88] Brower, "Demographic Overview of Minnesota's Older Adults."
[89] Minnesota Housing, "Legislative Task Force on Aging: Housing for Older Adults."
[90] Ibid.
[91] Minnesota Housing, "Legislative Task Force on Aging: Housing for Older Adults."
[92] Ramsey County Public Health, "Healthy Aging and Housing."
[93] Ibid.
[94] LCC Public Testimony Form, 56301
[95] Johnson-Reiland Builders and Remodelers, "January 9, 2024 Presentation."

Furthermore, there are large housing needs for older adults in Greater Minnesota. In Olmsted County, for example, housing units for older adults that has been delivered compared to what was in demand is insufficient.[96]

Table 3: Summary of Testimony on Housing Resources and Recommendations to the Task Force

| | Current Aging-related Resources | Recommendations to the Task Force |
|---|---|---|
| Housing Choices and Affordability – MHFA and John Patterson, Age-Friendly Minnesota Council | • Section 202 Housing with Rental Assistance Contract<br>• Project-Based Section 8 Rental Assistance and Preservation Affordable Rental Investment Fund<br>• Public Housing<br>• Housing Infrastructure Resources | • Support diverse housing choices and rehab and retrofit existing housing, both rental and owner-occupied<br>• Develop new housing that is age-friendly with universal design<br>• Develop age-restricted senior housing<br>• Support funding for: Housing Infrastructure Resources; Economic Development and Housing Challenge; Rehabilitation Loan Program; Preservation Affordable Investment Rental Fund; Rental Rehabilitation Deferred Loans; Publicly Owned Housing Program<br>• Support age-friendly housing efforts (connect housing with services and transportation, CAPABLE)<br>• Promote alternative age-friendly housing (Accessory dwelling units, shared housing, intergenerational home sharing, cohousing communities, multigenerational housing, missing middle housing)<br>• Promote age-friendly communities (holistic planning with housing, transit, outdoor spaces, social life, work, and community health services)<br>• Make the Governor's Council for Age-Friendly MN a permanent entity |

[96] Olmsted County, "Greater Minnesota Housing for Older Adults."

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| Greater Minnesota Housing – Olmsted County Housing | • Priority to enhance housing options for seniors<br>• Co-designing and planning senior housing with community partners of Coalition for Rochester Area Housing<br>  ○ Work to create and raise awareness of diverse housing options<br>  ○ Understand role of transportation with housing for aging in community<br>  ○ Simplify programs | • Fund housing rehabilitation programs<br>• Implement statewide rental assistance program and modify Housing Support Program<br>• Construct new multifamily and single-family housing (older adult housing currently not prioritized in the state Qualified Allocation Plan), and modify housing infrastructure bonds to include senior housing<br>• Support local housing options (flexible funds to assist counties)<br>• Tax policies that allow seniors to age in place<br>• Reduce administrative burden |
| County Housing – Ramsey County Public Health | • Heading Home Ramsey for homeless older adults<br>• Living at Home/Block Nurse programs provide options to have care and support at older adults' own homes | • Create older adults as a category of long-term homelessness to be eligible for state rapid rehousing services and change the prioritization based on high need and add 65+ as one criterion<br>• Increase meal delivery, safe transportation and infrastructure and in-home services to age at home<br>• Uptake universal design principles and improve affordability of ADA compliant housing<br>• Have housing developers talk to older adults |
| Universal Design – Johnson-Reiland Builders | • Develops housing that satisfies universal design standards | • Improve education on reverse mortgages<br>• Finance missing middle housing<br>• Standardize zoning techniques<br>• Educate on benefits of universal design |
| Housing Development – RTD Director Kate Williams | | • Promote and develop multigenerational and multicultural housing communities |

## Economic Stability – Background Information

Economic stability impacts access to many aspects that affect healthy aging in the community of one's choice, including care, nutrition, housing, transportation, and more. This is particularly important, considering incomes generally decrease as we age past retirement. While the poverty rate for older adults has consistently dropped since 1960 due to the enactment of programs such as Medicare, it significantly increased between 2020-2021 due to the COVID-19 pandemic.[97] According to 2021 data, around 110,000 Minnesotans who live alone had a total household income of less than $25,000.[98] According to Elder Index, a tool that calculates how much income older adults require to meet basic needs, a single older adult in Minnesota needs around $24,000 to meet their costs.[99] In the Twin Cities metropolitan area, 18% of older adults age 65+ have an income less than 185% of the federal poverty threshold, and 31.5% live in households whose housing costs exceed 30% of total income.[100]

### *Older Adults in the Workforce*

The reality of an aging state demographic means that Minnesota's workforce is also growing older. Nationally, from 1997 – 2022 the number of workers ages 50 and older increased 89% and accounted for 93% of total labor force growth, while the number of workers younger than 50 increased only 2%.[101] The fastest growing segment of the workforce is workers aged 75+, which is expected to grow by 96.5% by 2030.[102] In 2020, 23.8% of Minnesota jobs were held by workers aged 55+.[103]

Ageism is also prevalent in the workforce and the hiring process. According to a survey of employers conducted by the Transamerica Institute, when asked "What is the age that is too old for you to consider somebody for a position?" the average answer was 60.[104] Additionally, two-thirds of workers 45+ have reported seeing or experiencing age discrimination in the workplace.[105] Older workers who are laid off often have a difficult time getting rehired, and face financial hardships of lost wages, earning power, and savings.[106] A 2018 Urban Institute study found that 90% of older workers who lost their jobs involuntarily end up in positions that pay less than they had made previously, "fracturing the foundation they have created for their

[97] Brower, "Demographic Overview of Minnesota's Older Adults."
[98] Ibid.
[99] Ibid.
[100] Metropolitan Council, ""Legislative Task Force on Aging."
[101] Kaskie, "Age-Inclusive Management Strategies."
[102] Schaefers, "Older Workers in Minnesota: An Important and Growing Resource."
[103] Ibid.
[104] Kaskie, "Age-Inclusive Management Strategies."
[105] Schaefers
[106] Ibid.

retirement."[107] Ageism in the workplace has led to older workers often being seen as a liability for hiring managers and financial spreadsheets. In actuality, older workers generally use fewer sick days than younger workers, and tend to have lower health care costs, as most do not have children as dependents on their health care plans and qualify for Medicare if they are over the age of 65.[108]

The traditional idea of 'retirement age' is changing, with many older workers staying in the workplace because they want meaningful work, a sense of purpose, and to stay socially connected. Despite this, as Dr. Kate Schaefers of the University of Minnesota testified, "for an increasing number of older adults, they work because they need to earn an income."[109] According to a 2024 AARP survey, 20% of workers age 50+ have no retirement savings, and for 12% of men and 15% of women aged 65+, Social Security benefits constitute 90% of their income.[110] Barriers to continued employment are broad, and physically demanding jobs, health issues, or caregiving responsibilities may keep older adults from staying in the workforce despite their desire to keep working. These barriers disproportionately effect BIPOC communities and contribute to racial disparities in older adult poverty rates.[111] The average Social Security monthly benefit is modest; at $1,915.26 per month as of April 2024.[112]

Despite these barriers to employment for older workers and their impacts on a secure retirement, research shows that older workers exhibit concrete advantages when compared to their younger counterparts. For example, older workers tend to show gains in accumulated job skills and wisdom and are oftentimes more intrinsically motivated.[113]

Additionally, the gender wage gap across the lifespan results in older women making less lifetime earnings than men while at the same time living longer than them.[114] This trend negatively impacts the lifetime earnings of women of color at an even higher rate. In 2022, Minnesota women made 81 cents to every dollar paid to men.[115] As a result of the gender wage gap, Black, Latina, and Native American women lose $1,000,000, Asian women lost $741,000, and white women lose $483,000 over their lifetimes, harming secure retirement planning and effecting the affordability of care and living as they age[116]. Women 65+ live below the poverty line at a rate 4% more than men and have an average Social Security income nearly $4,000 less than men.[117] With the reality of women living longer than men, more older women live alone

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[107] Schaefers, "Older Workers in Minnesota: An Important and Growing Resource."; Kaskie, "It's Time to Fix Our Foundation: How Can We Best Address the Challenges and Opportunities Presented by an Aging Workforce?"
[108] Kaskie, "Age-Inclusive Management Strategies."
[109] Ibid.
[110] Ibid.
[111] Ibid.
[112] Schaefers, "Older Workers in Minnesota: An Important and Growing Resource."
[113] Cadiz, Brady, & Truxillo, "Workability: A Metric to Inform Policy for an Aging Workforce."
[114] Heyer, "More Women and Fewer Resources: How a Lifetime of Inequality adds up for women in Minnesota."
[115] Ibid.
[116] Ibid.
[117] Ibid.

and on one household income[118]. As well, more women live in residential long-term care communities than men, making up 68% of RLTC nursing home residents.[119] 60% of caregivers aged 60+ are women, which increases the need to take time off work to provide care, further reducing income.[120]

*Housing Costs*

Housing affordability is intertwined with older adults' ability to age in the community of their choice. Many older adults would like to downsize but cannot afford to do so.[121] Single-level ranch-style homes have become one of the highest priced types of homes in all parts of the United States, partly because people are thinking ahead about where they would like to live when they get older.[122] Most government entities are not offering benefits that lead to downsizing, such as property tax exemptions. Around 31% of older adult households are housing cost burdened,[123] and oftentimes there is no weight given to age for affordable housing eligibility.[124]

Testimony to the Task Force also highlighted several gaps in affordability and housing types for older adults. As one respondent to the Task Force's online testimony form stated, "Affordable housing for [the] elderly isn't affordable if you are single. You cannot pay over $1000 when you make $1300."[125] Another member of the public responded they "would like to move out of the large house that I raised my family in, but my community, Virginia, MN lacks options for active elders that are affordable. In addition, my house needs work in order to sell it for [its] real value."[126]

*Nutritional Security*

2023 was Minnesota's hungriest year on record, with a record number of visits to food banks.[127] According to 2021 estimates, 3.8%, or over 47,000, of adults 60+ were food insecure.[128] Food insecurity for older adults is intensified for historically marginalized populations. Nationally, senior food insecurity is worse for seniors and older adults who are

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[118] Heyer, "More Women and Fewer Resources: How a Lifetime of Inequality adds up for women in Minnesota."
[119] Ibid.
[120] Ibid.
[121] Williams, "January 9, 2024 Testimony"
[122] Ibid.
[123] Brower, "Demographic Overview of Minnesota's Older Adults."
[124] Williams, "January 9, 2024 Testimony."
[125] LCC Public Testimony Form, 55372
[126] LCC Public Testimony Form, 55792
[127] Second Harvest Heartland, "Senior Hunger in Minnesota Current State & Policy Priorities."
[128] Ibid.

Black, Latino, or have a disability.[129] Food insecure seniors are more likely to have chronic health conditions and limitations in daily activity, and multigenerational households experience elevated rates of food insecurity. The food insecurity rate is rising as pandemic-related aid and funding is ending.[130]

Various programs assist older adults with access to food, including food banks, Meals on Wheels, Supplemental Nutrition Assistance Program (SNAP), and Commodity Supplemental Food Program (CSFP).[131] The current minimum SNAP benefit level is $23 per month, which fell to this level after the loss of SNAP emergency allotments.[132] CSFP has seen a decrease in the number of users, possibly due to the difficulty of outreach and the lack of culturally relevant foods.[133]

*Transportation Costs*

Affording transportation can be an issue, particularly for older adults on a fixed income – the average cost to own and operate a vehicle is $11,000 per year.[134] Public transportation can be a lower-cost option for older adults, as transit service providers often offer rides at a lower rate.[135] However, local governments' share of the cost to serve older riders is expected to double from 2020 to 2030.[136]

*Costs of Care*

According to the State Demographer, many older adults report difficulty in affording LTC and services and supports. 43% of American adults nationally say they are not confident they will have the financial resources to access the care they may need as they age.[137] Of those nearing retirement aged 50-64, only 28% say they have enough money saved that could be used to pay for future living assistance expenses.[138] Nationally, 90% of adults report that it would be very difficult or impossible to pay the estimated $100,000 per year at a nursing home, and 83% report this difficulty or impossibility to pay for a year of care from a paid nurse or aide.[139] Nursing homes are exceptionally expensive for the vast majority of older adults; only 14% of adults 65+ could finance living in a nursing home with their monthly income, and only

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[129] Ibid.
[130] Second Harvest Heartland, "Senior Hunger in Minnesota Current State & Policy Priorities."
[131] Ibid.
[132] Ibid.
[133] Ibid.
[134] MnDOT, "Legislative Task Force on Aging."
[135] Ibid.
[136] Ibid.
[137] Brower, "Older Adults and the Need for Long Term Services and Supports."
[138] Brower, "Older Adults and the Need for Long Term Services and Supports."
[139] Ibid.

5% of those with severe LTSS needs could finance it.[140] Around 74,000 Minnesotans over 65 live in the community with a disability and make an income of below $14,580.[141] As one respondent who testified to the Task Force's online form stated, it is "very hard to find support without paying a lot out of pocket."[142]

Caregiving for a friend or family member is an expensive prospect. On average, 26% of caregivers in the U.S. spend a quarter of their income on caregiving expenses, and African American, Hispanic, and Asian Americans spend more than white caregivers.[143] Most caregivers are women, exacerbating gender wealth gaps.[144] 64% of solo agers, those who by choice or by situation live without support traditionally provided by family, receive only unpaid care, and only 22% of solos pay for care.[145] According to 2023 data, the welfare cost to Minnesota caregivers, in terms of value of time and future employability, is $2.5 billion per year, and caregivers' out-of-pocket expenses is $3 billion every year, not to mention incalculable costs to loss of wisdom and community interactions, and workforce contributions.[146]

Table 4: Summary of Testimony on Economic Security Resources and Recommendations to the Task Force

| | Current Aging-related Resources | Recommendations to the Task Force |
|---|---|---|
| Housing Availability and Affordability – Ramsey County Public Health and RTD Director Kate Williams | • Housing Stability Department works to reduce barriers and racial disparities, and key housing functions that create pathways to affordable housing<br>• Healthy Aging Coordinator promoting housing affordability | • Promote the Silvernest program, which encourages older adults to make roommate arrangements with other older adults<br>• Give weight to age when considering eligibility for housing affordability programs |

[140] Ibid.
[141] Brower, "Older Adults and the Need for Long Term Services and Supports."
[142] LCC Public Testimony Form, 55446
[143] MDH, "Older Adult and Elder Health and Well-Being in Minnesota."
[144] Vrolson, "Roles and Perspectives of Minnesota's Area Agencies on Aging."
[145] Camp, "Why Solos Matter."
[146] MDH, "Older Adult and Elder Health and Well-Being in Minnesota."

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|---|---|---|
| Nutritional Insecurity – Second Harvest Heartland and Hunger Solutions | • Provided 128 million meals in 2023 – along with meals provided through 5 other MN food banks<br>• Older adult food support provided through Meals on Wheels, SNAP, and CSFP | • Increase SNAP minimum benefits to $50 for older adults<br>• Support access to food in rural communities<br>• Fund food delivery, especially to older adults with disabilities<br>• Increase access to culturally relevant food, including in CSFP<br>• Increase support for prepared food |
| Nutritional Security – Area Agencies on Aging | • Partner with community organizations to provide meals to older adults | • Strengthen reliable sources of nutrition for frail and food-insecure seniors |
| Affording Care - DHS | • Funds for Home and Community-Based Services through Older Americans Act Federal funds and Elderly Waiver/Alternative Care | • LTSS financing options and public-private program integration |
| Transportation – Metropolitan Council | • Older adults 65+ have access to discount fares | |
| Older Adults in the Workforce – Age-Inclusive Management Strategies | • Consultation program for employment leaders and HR directors | • Utilize the AIMS program to create more age-inclusive work environments |
| Older Workers in Minnesota – Dr. Kate Schaefers | • Secure Choice – takes effect in Jan. 2025<br>• Paid Leave Act – takes effect in 2026 | • Support working caregivers through paid leave, financial assistance and employer education<br>• Expand support for alternative work options, including phased retirements, downshifts in roles, and restructure work. Support self-employment options and sustainable work<br>• Expand access to retraining and skill building, offer career change assistance, and expand apprenticeships and ‘returnships’ for older adults |

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|---|---|---|
| Minnesota Chamber of Commerce Foundation | | • Employers can get creative to structure job descriptions, scheduling, and benefits in a way that responds to changing age demographics<br>• Local and state policies should provide autonomy for employers to innovate and find ways to attract/retain workers across the age spectrum<br>• Self-employment opportunities should be maintained and expanded for older adults who want to earn income as they blend work and retirement. |
| Department of Employment and Economic Development | • Senior Community Service Employment Program, a federal job training program for low-income older adults | |

## Social and Community Environment – Background Information

Social and community contexts of living involve interactions with friends, family, and the community, and significantly impact on quality of life and aging. Many aging adults, however, live without the support of a beneficial social environment. Solo agers make up around 30% of the older adult population, and 62% of baby boomers worry they will be a burden to children or other family members.[147] In a nationwide survey of solo agers, 67% of respondents had no help with household activities, 71% had no one to help with finances, and 51% said they had no planning for health needs.[148] Current aging-related systems and infrastructure are mostly aimed towards those with traditional family support, and with Minnesota's increasing aging population, there will be an increasing number of solos across all future generations.[149]

Broadband access is critical when providing services and offering some of the social aspects of living and aging in the community. According to the Surgeon General, loneliness and isolation are at epidemic levels, especially among older adults.[150] Prioritizing broadband access, especially for older adults, is vital.

Table 5: Summary of Testimony on Social and Community Environment Resources and Recommendations

| | Current Aging-related Resources | Recommendations to the Task Force |
|---|---|---|
| Social Connection & Housing – Ramsey County Public Health & RTD Director Kate Williams | • Living at Home/Block Nurse Programs that provide social connection visits | • Promote Silvernest older adult roommate finder |
| Solo Agers – Linda Camp | • Development of Backup Plan Model & Tool<br>• Launch of 8 Solos Groups, with 3 more in 2024<br>• CLE Training on Solos for 130 Elder Law and Estate Planning attorneys<br>• Inclusion of Solo Agers as target population in MBA State Plan on Aging | • Identify and prioritize solos in aging initiatives, including work plans, age-friendly plans, and outreach<br>• Prioritize resource gaps impacting solo agers in allocating state funds for aging services<br>• Include needs of solos in addressing workforce issues to include decisional support workers<br>• Incorporate solo agers in existing data gathering |

[147] Camp, "Why Solos Matter."
[148] Ibid.
[149] Ibid.
[150] Rose, "Testimony at February 9, 2024 meeting of State of Minnesota Legislative Task Force on Aging."

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|---|---|---|
| Broadband infrastructure – All Elders United for Justice | | • Categorize broadband as a necessary utility, and affirm taxpayer ownership in broadband infrastructure<br>• Regulate services so high costs are not passed down to older adults |
| Intergenerational Public Health Interest Group | | • Develop a Senior Volunteer Corp modeled after VISTA and the Peace Corps |

## Testimony on Aging-related Planning and Coordination Bodies

The Legislative Task Force on Aging was charged with recommending the governmental entity best suited with planning, leading, and implementing aging-related planning, policies and funding. As such, the Task Force heard presentations from other states about how their government entities that lead on statewide aging-related planning are structured. Pennsylvania and Colorado were invited to present to the Task Force, as well as the Governor's Council for an Age-Friendly Minnesota.

### *Pennsylvania*

The Pennsylvania Department of Aging was the first agency invited to testify to the Task Force. The Pennsylvania Department of Aging was created in 1978 by Governor Milton Shapp, with the mission of promoting independence, purpose, and well-being in the lives of older adults through advocacy, protection and service.[151] This differs from the "sister agencies" of the Pennsylvania Departments of Human Services and Health, with the Department of Aging's specific charge to advocate for older Pennsylvanians.[152] Governor Shapp also created the Pennsylvania Lottery and directed that lottery revenue be used for older adult programs and services, which provides 80% of the budget for the Pennsylvania Department of Aging, with the other 20% being federal funds through the Older Americans Act.[153] Pennsylvania currently has the fifth highest population of older adults in the United States, and it is projected that 1 in 3 Pennsylvanians will be over the age of 60 by 2030.[154] Moreover, Pennsylvania has the third highest population of adults 85+ nationwide.[155]

The Pennsylvania Department of Aging highlighted several benefits to their current structure. Firstly, given that the Commissioner of Aging sits on the Governor's Cabinet, there is an established pathway for communication to the Governor's office, helping to elevate older adult issues in the state.[156] As the Department stated to the Task Force, "Having that relationship [with the Governor] is so vitally important to make sure … that older adults are not left behind."[157] Additionally, with the Pennsylvania Department of Aging's primary funding coming from the PA Lottery, there is specified funding for all older adults, regardless of Medicaid eligibility.[158] The Department of Aging also highlighted their structure allows for the

[151] Pennsylvania Department of Aging (PDA).
[152] Ibid.
[153] Ibid.
[154] Ibid.
[155] Ibid.
[156] Ibid.
[157] Ibid.
[158] Ibid.

opportunity to advocate for supplemental funding specifically for the aging services network.[159] Finally, the Department of Aging spoke to the importance of having legislative power to help set an agenda that prioritizes older Pennsylvanians.[160]

At the same time, the Department of Aging brought forward several challenges to their structure. One of these challenges includes streamlining overlapping efforts between the Department of Aging, and the Departments of Health and Human Services.[161] Additionally, the Department of Aging is one of the smallest agencies in the state, limiting their relative legislative and financial influence. Lastly, the commonwealth is unique in its aging network structure, with 52 separate Area Agencies on Aging, compared to Minnesota's 7.[162]

Along with many other states, Pennsylvania has undertaken an intensive planning process to create a Multisector Plan on Aging, titled *Aging Our Way, PA*. The inception of the plan was created through Executive Order 2023-09 by Governor Josh Shapiro on May 25th, 2023.[163] The Executive Order directed the Pennsylvania Department of Aging to lead the development of Pennsylvania's Master Plan for older adults. The final plan, *Aging Our Way, PA,* is a 10-year strategic plan designed through collaborative stakeholder engagement to help transform the infrastructure and coordination of services for Pennsylvania's older adults.[164] The development of this plan has involved over 200 listening sessions and received thousands of public comments.[165] *Aging Our Way, PA*, was ultimately structured around 5 priorities: Unlocking Access, Aging in Community, Gateways to Independence, Caregiver Supports, and Education and Navigation.[166] After public comment, the final *Aging Our Way, PA* Plan was released in May 2024 and is currently being implemented by the Department of Aging.

### *Colorado*

The Task Force also invited the planning and aging-service agencies of Colorado, the second fastest aging state in the country, to present on the work of the Colorado Department of Human Services and the Colorado Commission on Aging.[167] Colorado, according to the most recent budget estimate, has an aging-related budget over around $1.9 billion in FY17-18. In 2015, the Colorado Legislature passed HB-15-1033, which established the Governor-appointed Strategic Action Planning Group on Aging (SAPGA), and tasked it with developing a strategic

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[159] Ibid.
[160] Ibid.
[161] Pennsylvania Department of Aging (PDA).
[162] Ibid.
[163] Ibid.
[164] Ibid.
[165] Ibid.
[166] Ibid.
[167] Burrows, "Colorado Aging Structure."

plan on aging.[168] One of the outcomes of SAPGA was HB-22-1035 in 2022, which strengthened the Colorado Commission on Aging (CCOA) and positioned the group to be the primary advisory body to the Colorado Department of Human Services (CDHS) on behalf of Older Adults.[169] This bill also gave CDHS the authority to be the state agency responsible for the welfare and planning for older Coloradans, and developed an intra-agency advisory committee (Technical Advisory Committee - TAC) to collaborate and promote older adult services, policies, and funding.[170] CDHS identified several challenges with the TAC, including a lack of decision makers with aging expertise and separate agency budgets.[171] HB-22-1035 also created the Lifelong Colorado Initiative planning process within CDHS to implement strategies proposed by the CCOA, TAC, SAPGA, and CDHS.[172] Additionally, the Lifelong Colorado Initiative has around $200 million in FY24-25 to support age-friendly in communities throughout Colorado.[173]

Several challenges were noted for Colorado's aging structure, including that the CCOA is a Type II advisory board, advising the Governor and CDHS, but not the legislature, as well as that it lacks a budget. While the CCOA has the authority to propose legislation, it must align with the priorities of the CDHS commissioner and Governor's office.

*Governor's Council for an Age-Friendly Minnesota*

Finally, the Governor's Council for an Age-Friendly Minnesota (AFMN) was also invited to present its planning work to the Task Force. AFMN was established through Executive Order 19-38 by Governor Walz in 2019 to create a statewide effort to make the state more inclusive of older adults.[174] Council membership includes nine state agencies, tribal government, and community representatives, and is administratively supported by DHS. The Legislature passed bills extending the work of AFMN and launching the AFMN Grants Program, which started in 2023 and have funded 90 community grants.[175]

AFMN and consultants have also been developing Minnesota's Multisector Blueprint for Aging, which intends to build on existing coordination of state agencies through the AFMN. The Blueprint's domains include Connected Communities, Emergency Preparedness, Individual Rights and Safety, Optimized Health and Longevity, and Economic Security and Vitality.[176] The development of the Blueprint has included community input from stakeholders and members

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[168] Burrows, "Colorado Aging Structure.".
[169] Ibid.
[170] Ibid.
[171] Ibid.
[172] Ibid.
[173] Ibid.
[174] Pugh, Shetty, & Olson, "Presentation to the Legislative Task Force on Aging."
[175] Ibid.
[176] Ibid.

of the public.[177] The Blueprint is intended to be a 10-year roadmap for coordinating state planning for Minnesota's growing older adult population.[178]

*Testimony on a Department of Community Aging*

Lastly, testimony from a group of advocates recommended the creation of a Cabinet-level Department of Community Aging to prioritize the needs of and necessary planning for Minnesota's growing older adult population. These testifiers highlighted the State's inadequate structures and ability as they currently are to support this permanent demographic shift and ensure that all older Minnesotans, regardless of where they live, can age with dignity, support, and vibrancy. Testimony asserted that a new Department of Community Aging could work to fill these gaps and would "be dedicated to planning and coordinating efforts across the state to ensure that our elders can live their later years in safety, health, and with the respect they deserve."[179] Additionally argued was that many of the above recommendations by presenters focused on "deficits and challenges ahead," and that "A collection of these recommendations will result in a flurry of legislative proposals that would serve as band-aids but not form a coherent actual plan of action."[180] Finally, testimony stated that the new Department of Community Aging should lead and be accountable for implementing an state-led multi-sector planning process.[181]

[177] Ibid.
[178] Ibid.
[179] Sundberg, "Legislative Task Force on Aging Comments."
[180] Kelso, "Legislative Task Force on Aging."
[181] Ibid.

## Task Force Recommendations

***RECOMMENDATIONS TO BE ADDED WHEN FINALIZED***

## Appendices

***ALL PRESENTATIONS AND TESTIMONY TO THE TASK FORCE TO BE ADDED (AVAILABLE ON TASK FORCE WEBSITE)***