

Long-term Care in Greater Minnesota

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“Between now and 2030, Minnesota will experience the most dramatic population shift in its history. Along with the rest of the nation and the world, we will become older not just as individuals but as a society. By 2030, 1.3 million persons, or one out of every five Minnesotans will be over age 65, compared to one out of every eight today.

Later, in 2050, 324,000 Minnesotans will be over age 85, the largest number ever. These elderly will need health and long-term care services, supportive housing and age-friendly communities. Because of the size of this group, their need could overwhelm the traditional response of family, communities and government.”

Final Report for Project 2030, 1998

When this paragraph was written, the demographic trends described were already a reality in Greater Minnesota. Most Greater Minnesota counties already had the characteristics that the rest of the state would have in 2030. The issues that relate to the aging of the population have been affecting families, communities and government in Greater Minnesota for a decade. Greater Minnesota communities and the organizations that provide long-term care to the elderly there are addressing the issues of long-term care in a variety of ways out of necessity.

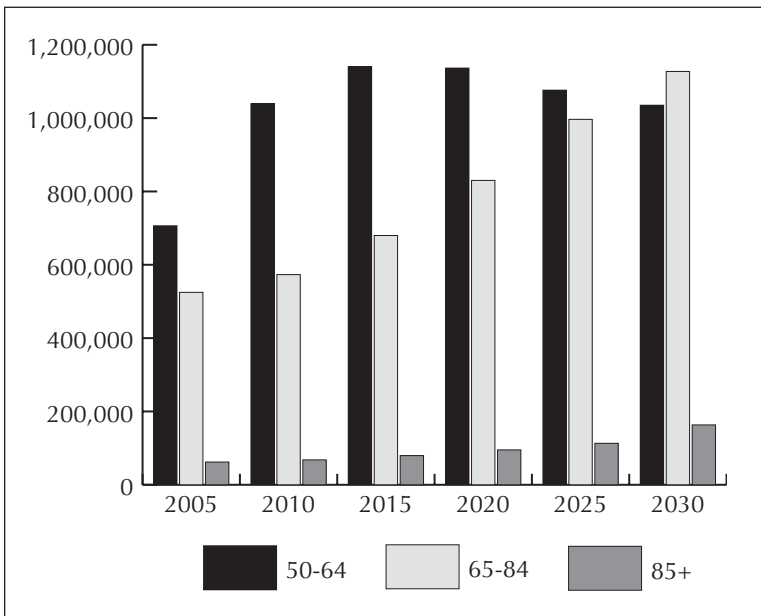
In this article, we will describe some of the key demographic aging trends in Greater Minnesota and how these relate to the need for and issues surrounding long-term care for older persons living in Greater Minnesota. In addition, we will describe some of the responses that state and local organizations are developing to address these changes.

Demographic Aging Trends in Greater Minnesota

For purposes of this discussion, our definition of long-term care is “assistance given over a sustained period of time to people who are experiencing long-term inabilities in functioning because of a disability” (Ladd, Kane, Kane, 1998). The term long-term care as used here refers to care provided in all settings, including homes, apartments, residential settings and nursing homes. While the issues and options analyzed here are from the perspective of the elderly, many of the options may be relevant to younger individuals who need long-term care services. In addition, the definition of Greater Minnesota used here is all those counties outside the seven-county Metro Area. (There are many definitions of Greater Minnesota used by various groups, but this is the author’s definition.)

Greater Minnesota is older than urban Minnesota. Minnesota will experience a permanent shift in the age of its population over the next 25 years, and by 2030, we will have 1.3 million persons over 65, about 20% of the state’s population. In the southwest and west central portions of the state, however, 20% of the population is already over 65. While 30% of the state’s total population lives in

Figure 1: Minnesota’s aging population, ages 50-85+, 2005-2030.



Source: Minnesota State Demographer’s Office, 2004.

Greater Minnesota, 41% of those over 65 lives there. All the counties in which more than 20% of the population is 65+ are in Greater Minnesota.

The numbers of elderly over 85 in Greater Minnesota will rise by 2030. As Minnesota's population ages, the need for long-term care increases. This increase is closely linked to the rise in the 85+ population specifically. In 2000, there were 85,601 persons over age 85. Between 2000 and 2030, the number will double, increasing to 163,310, and then double again by 2050, rising to 323,603.

Overall, the numbers of 85+ in Minnesota will increase 96% between 2000 and 2030. Within various regions of the state, the increase will vary from 30% up to 129%. While all these increases are significant, the percent increases will not be dramatic in most of the Greater Minnesota regions, because the proportion of the total population that is over 85 is *already* so high (see Table 1.)

Dependency ratios will climb. Another measure of aging in Greater Minnesota is the elderly dependency ratio. This is defined as the ratio of the number of persons age 65 and over to every 100 persons age 15 to 64, essentially the working age population. Demographers use this ratio to measure the extent of the growth in the elderly population and compare that to the growth in the

Table 1: Changes in Minnesota's 85+ population by region of the state, 2000 – 2030.

Geographic Area	85+ Population			85+ 2000 – 2030 Change	
	2000	2010	2030	Absolute	Percent
East Central	10,880	14,260	24,910	14,030	+129.0
Northeast	7,170	8,744	12,190	5,020	+70.0
Northwest	3,788	4,340	6,150	2,362	+62.4
Southeast	13,221	16,480	23,400	10,179	+77.0
Southwest	9,004	9,920	11,780	2,776	+30.8
Twin Cities Metro	32,870	46,090	75,040	42,170	+128.3
West Central	6,196	6,920	9,860	3,664	+59.1
Total	83,129	106,754	163,330	80,201	+96.5

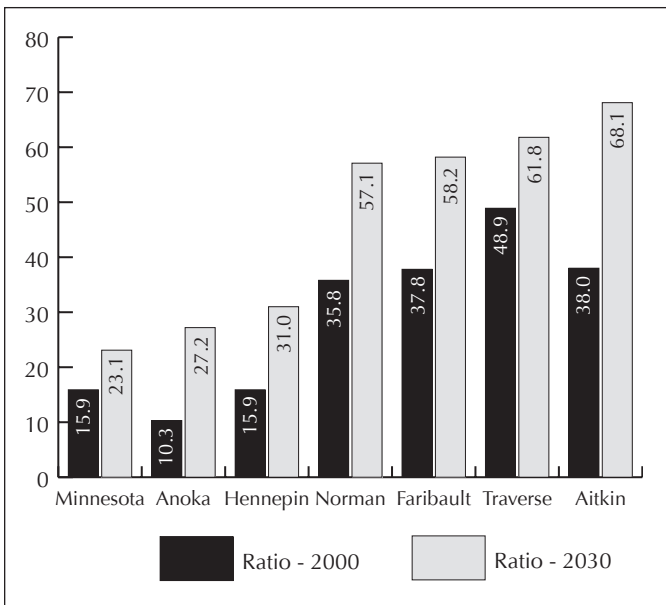
Source: Minnesota State Demographer's Office, 2004, included in LarsonAllen, "Noticeably Different, Minnesota's Changing Long-Term Care Landscape: Implications and Challenges," November 11, 2006.

working age population. This ratio also allows comparison across various locations using a common measure. In Minnesota, the elderly dependency ratio has been fairly stable for many years, hovering at about 18 elderly residents per 100 working-age residents. However, with the increasing number of persons 65 and over, the dependency ratio will skyrocket between now and 2030, rising to about 30.

Once again, Greater Minnesota already has high elderly dependency ratios. In the west central and southwest counties of Minnesota, 32 counties had an elderly dependency ratio of 31 in 1995, and these will grow to extremely high levels by 2030. For example, several Greater Minnesota counties will experience elderly dependency ratios over 60 (see Figure 2).

The status and needs of elderly in Greater Minnesota are somewhat unique. Some recent research on the elderly and their status and needs in Minnesota provide some additional information on how Greater Minnesota elderly compare to urban elderly. The Survey of Older Minnesotans completed by the Minnesota Board on Aging in 2005 contains interesting differences between older persons in Greater Minnesota and the Twin Cities Metro Area (*Survey of Older Minnesotans, 2005*).

Figure 2: Elderly dependency ratio in Minnesota and selected counties, 2000 and 2030.



- Greater Minnesota elderly are more dependent upon Social Security for their income: 26% of Greater Minnesota elderly indicate that Social Security is their major source of income compared to 18% for urban elderly.
- 89% of Greater Minnesota elderly compared to 74% of Metro Area elderly used public transportation in the past year.
- When asked how they would pay for nursing home care, 23% of the Greater Minnesota elderly said they would use a government program, compared to 16% in the urban area.
- Fewer elderly would like to be working for pay in Greater Minnesota (20%) compared to urban elderly (24%).
- More urban elderly consider themselves employed (53%) than the Greater Minnesota elderly (43%).
- In terms of educational status, a greater proportion of urban elderly have postsecondary education of some type (70%) compared to the Greater Minnesota elderly (53%).
- More Greater Minnesota elderly than urban elderly (73% vs. 67%) indicated that they need some assistance to stay in their home, e.g., home repair or renovation, additional accessible features such as ramps or grab bars.
- More urban elderly (14%) vs. Greater Minnesota elderly (9%) were planning to move to another type of housing in the near future.
- More Greater Minnesota elderly (34%) currently live in senior housing than urban elderly (29%).
- A much larger proportion of Greater Minnesota elderly live in single-family homes (77%) than urban elderly (63%), and the urban elderly are more likely to live in apartments (20%) than Greater Minnesota elderly (10%).
- Neither the Greater Minnesota nor urban elderly indicated that they worry about getting good health care (49% vs. 50%).
- Most Greater Minnesota and urban elderly felt that the health care they received in the past year was excellent (52% vs. 50%).

- Fewer Greater Minnesota elderly indicated that their health status was “excellent” and more said it was “fair” (22% and 18%) compared to the urban elderly (27% and 14%).
- A greater proportion (41%) of Greater Minnesota elderly participated in vigorous activities each week than did Metro Area elderly. Interestingly, more older elderly (75+) exercise vigorously than the young old (65 – 75).

Another source of comparative data is a 2005 report on the health status of rural Minnesotans completed jointly by the Office of Rural Health and Primary Care and the Minnesota Center on Health Statistics at the Minnesota Department of Health. This report found that the health status of older people in rural areas is similar to that of urban elders in many areas but different on certain indicators (*“Health and Well-Being of Rural Minnesotans: A Minnesota Rural Health Status Report,”* 2005).

- Greater Minnesota elderly are more likely to be hospitalized from unintentional falls than urban elderly (48.5% vs. 44.4%).
- Compared to Metro Area residents, residents in Greater Minnesota had higher overall mortality rates in all the top five leading causes of death — heart disease, cancer, stroke, unintentional injury and chronic obstructive pulmonary disease (926.2 vs. 633.6 per 100,000).
- Deaths from motor vehicle crashes for people 65 and over were much higher in Greater Minnesota than the Metro Area (25.8 vs. 17.2 per 100,000).
- Elderly adults in Greater Minnesota experience more tooth loss due to decay or gum disease than their Metro counterparts (46% vs. 32.3%).
- The rate of suicide death is slightly higher among residents of Greater Minnesota than among urban elderly (11.3 vs. 10.7 per 100,000).

Long-Term Care Issues Facing Greater Minnesota Seniors

In January 2006, the Minnesota Department of Human Services, the Minnesota Department of Health, and the Minnesota Board on Aging co-sponsored a series of meetings around the state to discuss the impact of the state’s aging population and engage Minnesotans

in a discussion on what needs to happen to prepare for the coming age wave of older people. These meetings were held as a first step in a project called Transform 2010, a project to identify the impacts of the aging of the state and prepare a response to address these issues. Over 1,000 individuals participated in these meetings, and most of the meetings were held in Greater Minnesota. Many of the issues discussed were related to long-term care needs in Greater Minnesota and provide a first-hand account of the current status of long-term care for the elderly across Greater Minnesota.

1. The large population of older persons represents a critical human resource for the state, especially in Greater Minnesota.

Between 2005 and 2025, Minnesota will have the largest group of persons between ages 60 and 80 ever in the state's history. Participants at the meetings spoke of the tremendous resource that this group represents to the state. Because of improvements in health and longer life expectancies, this group at age 65 will have 30 or more years for continued activity and productive pursuits. Older persons represent a major part of the population in most Greater Minnesota communities and their role in work, volunteer, civic engagement, family, and faith communities are crucial to the civic life of their communities.

Many are continuing to work, helping to fill the worker shortage in Greater Minnesota. Others are combining work with leisure, lifelong learning, volunteer efforts, or family, community and civic activities.

2. Our society does not place enough emphasis on preventing health problems and disabilities in the first place.

The importance of healthy living in order to prevent chronic conditions that lead to disability was a big topic of discussion. There is a societal attitude that taking pills to treat health problems is easier than practicing healthy habits and preventing problems in the first place. We need to counteract these messages and motivate individuals to make behavioral changes, not only to prevent disability but to reduce health care costs associated with disability.

3. Changes in families are reducing their ability to provide care for their older relatives.

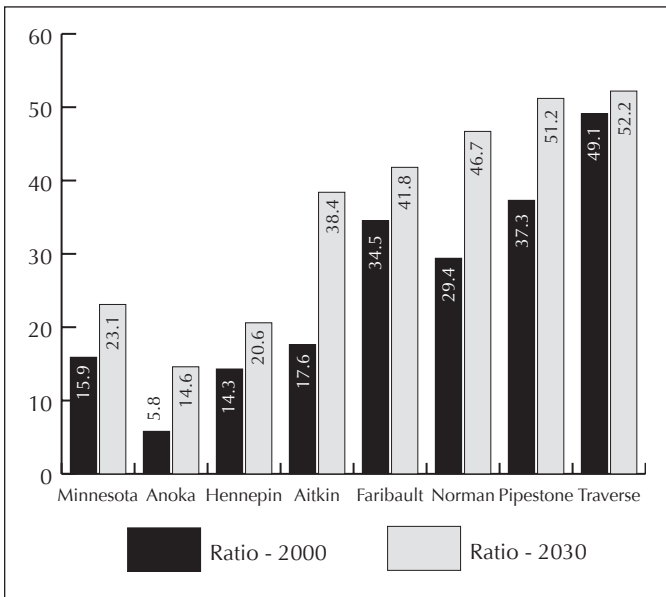
Participants described the changing nature of family life and the pressures that contribute to reduced ability of families to provide care for older relatives. The biggest pressures include smaller family size, increases in the number of older relatives to care for, and the

movement of family members into more urban areas to find better paying jobs. Increased labor force participation of women is also a factor.

In Minnesota, about 92% of long-term care needed by older persons in the community is provided by families, but this percent has been gradually declining over the past 20 years (*Survey of Older Minnesotans, 1988 – 2005*). Participants felt that most families want to care for their older relatives as long as they can, and the state needs to support that sense of obligation and help families provide assistance to their relatives. Along with changes in families, those at the meeting also talked about the urgent need for improved systems of community protection for growing numbers of frail elderly, who are living in the community longer rather than moving to nursing facilities, and thus may be vulnerable to abuse, neglect or exploitation.

Despite the lower availability of caregivers in Greater Minnesota communities, the “informal system” of family, friends and neighbors provides the most care for seniors, often for many years. People tend to know their neighbors and have close family and social relationships. Participants at the meetings indicated that in Greater

Figure 3: Number of elderly 85+ per 100 caregivers age 45-64 in Minnesota and selected counties in 2000 and 2030.



Source: Minnesota State Demographers Office, 2004.

Minnesota, frail seniors tend not to “fall through the cracks,” and that their care needs are known and acted upon. In addition to the informal network, non-profit organizations, community organizations and faith communities also provide volunteer-based care such as home delivered meals, transportation and companion services, which are important to maintain seniors in their homes.

“Caregiver ratios” have been used to measure the level of the availability of caregivers now and in the future throughout Minnesota. This ratio compares the number of persons 85+ to the number of females age 45-64 (the most likely caregivers of frail elderly) at the state level and in each county. These ratios are far higher in the Greater Minnesota counties of the state now and are expected to increase even more by 2030. Figure 3 shows what these caregiver ratios look like in some selected counties in Greater Minnesota and urban Minnesota in 2000 and 2030. (For the purpose of this analysis, caregivers are defined as females ages 45-64 because the majority of caregivers are females in this age range. This is gradually shifting somewhat, as men increase their elder caregiving responsibilities. Some experts estimate that 20% of services to older relatives are provided by men.)

4. Most of Minnesota’s communities are not adequately prepared for major increases in their older residents, and more work is needed to make them good places to grow old.

An increasing number of the residents of the state’s communities are over age 65, especially in our small towns. For example, in Fertile, Minn., a small town of 900 in northwestern Minnesota, 50% of the households are over age 65. Participants at the meetings indicated that many communities in the western and southern areas of the state are like Fertile and have a “2030” population right now. As more communities face these demographics, they will need assistance to maintain or develop components that provide support to all residents including their older residents.

The presence of older adults is a tremendous resource for communities, since it provides additional workers, volunteers, leaders to serve in civic positions and caregivers for the more frail elderly. In addition, the goods and services purchased by older persons — groceries, prescription drugs, housing, health services, nursing homes — are critical to the economy and vitality of many communities. Participants described in detail dozens of components of the ideal community that supports its residents, e.g., transportation, housing options and services, volunteer sources of support, ways to connect all generations, community design features

that make the community accessible to those with hearing, visual, or physical disabilities, an array of health and support services, opportunities for volunteering and civic engagement, and more senior-friendly businesses. However, as communities age, it can be more difficult for them to financially support these components.

Current and future housing for the elderly was a big topic. Some commented that the current housing stock is nearly all single-family homes in Greater Minnesota, and much of it is not accessible for persons as they age. Either home modifications need to be more accessible and available from trustworthy sources with the needed expertise, or older people will not be able to remain in their homes as they age.

Many excellent efforts to create age-friendly communities are under way across the state, but the participants felt a more coordinated and comprehensive approach is needed to achieve the goal of livable communities in all parts of the state.

5. The health and long-term care systems in Greater Minnesota are not adequate to provide the type and amount of care needed by a population growing older.

Participants at the meetings identified many problems in the current health and long-term care systems. The use of an acute medical model instead of a chronic care model results in fragmented, episodic care. Continuity of care and access to the range of providers needed is difficult in Greater Minnesota due to population declines, consolidations and closures of hospitals to a certain extent, but more so of nursing homes. These closures have had other effects as well. Longer and more frequent drive times are required to see providers, putting increased pressure on families, volunteer drivers and public transportation programs. In addition, the role that managed care is assuming to serve publicly funded older clients is causing shifts in historical roles of counties, providers and health plans.

6. A significant proportion of the current long-term care work force in Greater Minnesota areas is nearing retirement, and action is needed to recruit and retain their replacements.

Trends are in place that will shrink the long-term care work force at the very time that the need for long-term care will be increasing. Participants spoke of a number of social and economic factors that contribute to the continuing shortage of workers: low wages and lack of affordable retirement and health insurance benefits, physical stress and strain, emphasis by schools on computer or business careers rather than health and long-term care occupations, and lack of status

associated with these types of jobs. Given these factors, the industry is not attracting the number of young or new workers needed to replace those who will begin retiring soon.

These labor force issues are clearly more acute in Greater Minnesota areas. The population base in Greater Minnesota areas is declining and is not expected to grow in the future. Many experts cite low wages as the most significant factor in the continuing out migration of younger persons. As a result, Greater Minnesota communities have fewer professionals available to provide care for older residents.

7. Minnesota's long-term care reform efforts must be intensified so that a broader menu of long-term care options is available in Greater Minnesota.

Participants at the meetings agreed that there has been and will continue to be dramatic change in how long-term care is provided. The vast majority of elderly want to age in place and remain in their homes and communities as long as possible with the supports they choose to help them stay there. At the same time, providers face ongoing challenges in providing an adequate array of home care services. While the supply of services is growing, many communities still do not have enough affordable services to meet current needs, much less meet the increased demand as the older population increases.

The long-term care system in Greater Minnesota areas often includes few choices in home and community-based services including home care, affordable assisted living, and basic supports such as transportation, chore services and respite. Participants at the meetings reported that the number of home care agencies continues to shrink and there are counties with no private home care providers. In these situations county public health agencies find that they are needed to deliver home care services directly rather than performing their strategic roles in education and prevention. Many of the long-term care service gaps in Greater Minnesota areas stem from the expense of delivering services across long distances and the inability to capture economies of scale.

Transportation is universally noted as a service gap in Greater Minnesota areas and one that often needs to be addressed through multi-county, regional efforts. The issues in transportation include availability, access, fragmentation, geographic boundaries, need for an escort component, and Greater Minnesota residents needing to get "to town" to catch the bus. Volunteer driver programs are available, but they are often unable to meet all the need and also face

liability issues. The informal network of family and friends — often seniors themselves — is the primary foundation for meeting seniors' transportation needs in Greater Minnesota areas.

The current and future status of Minnesota's nursing homes was a hot topic at the meetings. Those within the nursing home industry described major shifts in the numbers and types of individuals served in their facilities: many of those now served need post-acute rehab, complex medical management that used to be provided in hospitals, or have severe dementia requiring close supervision and care. Less disabled elderly are staying in their homes or moving to assisted living facilities. In the past ten years, nearly 10,000 beds have closed statewide, and predictions were made at the meetings that more would close. Many participants commented on the important economic role that nursing homes play in their small communities, often as a major employer, and the importance of keeping the long-term care expertise of these local providers, even as downsizing of the industry continues.

Due to the lack of in-home services, and because of long-standing community practices, nursing homes in some Greater Minnesota communities are sometimes used as housing options. Greater Minnesota residents are concerned about intentionally decreasing the supply of nursing home beds, fearing that these actions will harm their community's economic vitality or that there will not be a nursing home bed available for them if they need one in the future. There is agreement that there may be excess nursing home beds, but there are not enough home and community-based services to replace the care provided by these nursing home beds and facilities.

8. The older population within ethnic, immigrant and tribal communities is growing in Greater Minnesota, and the long-term care systems are not prepared to meet their special needs.

Meetings with representatives from the state's American Indian tribal organizations identified the many challenges that American Indian elders have in their lives, their families and their communities, ranging from poverty to health concerns, to concerns about the youth in their communities. The gaps in service that exist in Greater Minnesota areas are even larger on many reservations, especially those in the northern areas of the state. Participants also mentioned the effects of major cutbacks in federal Indian Health Services funds. A very high number of American Indian children are being raised by their grandparents because their parents are unable to do so. With all of the critical issues facing their communities now,

it is difficult for the elders to have a normal retirement.

The representatives attending the meetings to discuss the needs and issues of ethnic and immigrant elders spoke of the challenges facing their communities, also. Younger members of these groups experience the tension between obligations to care for elders and the reality of getting ahead in our society, which requires many hours of work and leaves little time for eldercare. Social isolation is a reality for many immigrant elders and leads to physical and mental health issues. Because of the lack of services, family members are called upon to be interpreters, caregivers, and transportation providers, as well as providers of social support.

Participants drew a distinction between the assistance that immigrant elders need as they arrive in this country, and retirement income, health care, housing and other supports that *all* elders need. They stressed the need to emphasize the similarities rather than the differences among elders and advocate for strong income, health and housing programs for *all* older people.

Long-Term Care Reform in Greater Minnesota

In 2001, the recommendations of a state legislative task force on long-term care were enacted, resulting in the most comprehensive long-term care reform in Minnesota in many years. The reform called for policy action in six areas intended to beef up the state's long-term care system and reduce our reliance on the institutional model of care, a model that is growing less attractive to new generations of older persons and is also the most expensive form of care. These policy directions provide a framework to assess how these reform efforts have worked and how they have affected long-term care in Greater Minnesota.

1. Maximize peoples' ability to meet their own long-term care needs. *This policy direction emphasizes the importance of the role of information and assistance to increasing awareness about what services are available to meet long-term care needs, the need to expand the private financing options available to individuals to pay for long-term care, and the use of technology to meet long-term care needs.*

Since 2001, much effort has gone into expanding and improving the Minnesota Board on Aging Senior LinkAge Line, a telephone information and assistance service operated by the regional Area Agencies on Aging around the state. Specially trained staff is now available in each of these offices, and expanded visibility is increasing the number of calls each year. In terms of technology, a growing number of providers are using telehealth to connect

rural elders with health services. These projects have been readily accepted by seniors and make best use of limited health and long-term care staff resources in Greater Minnesota by reducing time that used to be used for travel. Health monitoring services, which check vital signs and provide a daily reassurance for elders with chronic conditions, are being provided to a growing number of seniors in Greater Minnesota with excellent results. Increasing use of video and web-based technology could play a major role in meeting the future health and long-term care needs in Greater Minnesota.

2. Expand the capacity of community long-term care system. *To be able to reduce the state's reliance on the institutional model of long-term care, the supply of community based services needs to be expanded in all parts of the state so options are truly available to all elderly. Communities also need to be more age-friendly so they can support their older residents as they age in place.*

One of the major provisions passed in 2001 to address this policy direction was the Community Service/Service Development Grant program (CS/SD). This state grant program, administered by the Minnesota Department of Human Services, has been used to implement strategies for long-term care reform by providing seed money to develop new capacity within the home and community-based service system and to help "redesign" existing services to make them more cost-effective and fiscally sustainable into the future. Over \$27 million in grant funds have been awarded to more than 200 CS/SD projects in 82 counties across Minnesota in the past five years. The grant staff estimates that two-thirds of these funds have been awarded to projects serving Greater Minnesota. These projects have:

- Expanded home and community-based services to over 90,000 persons.
- Increased the number of volunteers providing services by more than 18,000 (with significant growth occurring in community support, transportation and caregiver support services, areas identified as gaps through a statewide "service gaps analysis" completed by counties in 2001, 2003, and 2005).
- Helped to build or renovate over 890 units of affordable senior housing.

CS/SD funds have also increased program sustainability. Over 91% of funded projects continued to provide services after the grant

ended; 7,000 additional older persons eligible for public long-term care services have been served in the community; 8,239 persons have paid for services based on a sliding fee scale; and 18,000 persons have paid for services on a private pay basis or through third-party payers.

3. Reduce our reliance on the institutional model of long-term care.

This policy direction focused not only on reducing nursing home capacity but also transforming and strengthening the remaining nursing homes to better serve those consumers who need more rehab, medical management or long-term dementia care.

Since 2001, when the state enacted major long-term care reform, the number of nursing home beds throughout the state has declined steeply. The number of beds has actually been declining since 1987, when the state had 48,307 beds, an all-time high. Since then, 57 facilities and 9,538 beds have been closed, with an additional 1,587 beds taken out of active status and put in layaway status. As of 2005, Minnesota had 411 facilities with a total of 37,182 beds in active service. Most of this reduction was completed under the voluntary planned closure provision included in the comprehensive long-term care reform legislation in 2001. An estimated 4,500 of the beds closed were located in Greater Minnesota. However, most of these closures have been partial closures, where beds have been reduced but the facilities have remained open.

The ratio of nursing home beds per 1,000 elderly persons is generally higher in Greater Minnesota counties than in urban counties. Figure 4 illustrates the wide variation in this ratio across selected counties in various parts of Greater Minnesota compared to urban counties. There are several possible explanations for these higher ratios.

First, many feel that the limited availability of a broad range of home and community-based options for older persons in Greater Minnesota forces a greater use of nursing homes for care that could be provided in the home if services were available. Even with the expansion that has occurred in the past five years, the most recent county level “gaps analysis” completed by county staff working in aging services indicated that many counties still reported significant gaps in home and community-based services for the frail elderly (*Transform 2010 regional profiles, 2006*).

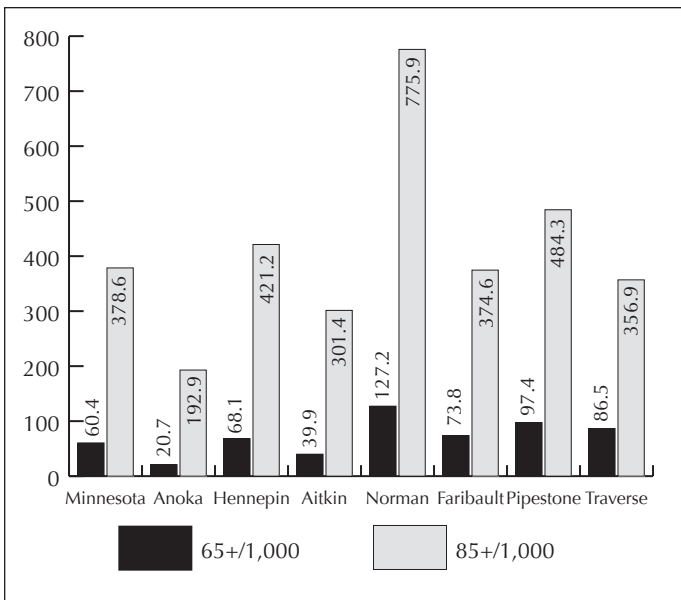
Second, the informal network plays a critical role in the use of congregate settings by the elderly in Greater Minnesota areas. Because of gaps in formal services, families and friends are called upon to fill more of the care needs themselves and at some point

cannot continue this role. Once they can no longer provide the increasing amounts of care needed, the older person cannot remain in their home, and a move to a congregate setting becomes the only care option available. Thus, the use of senior housing, assisted living and nursing homes — in other words, all current versions of congregate settings for elderly — tends to be high in Greater Minnesota.

Third, the long distances that must be traveled by family members or staff from provider agencies limits the efficiency of the home care model for elderly who need multiple services. Many providers and families also point out the social isolation that can occur when frail elderly are “independent” in their homes but unable to get out socially and do not have lots of visitors or contacts within their home or community. Many feel that a congregate setting fills the need for a more packaged set of services and reduces the social isolation factors.

Another provision in the 2001 legislation that has affected the nursing home industry both in urban and Greater Minnesota has been the effort to improve the reimbursement system for nursing homes. A number of options have been studied since 2001 to find a better method for setting rates and paying for nursing home care. In

Figure 4: Nursing facility beds per 1,000 65+ and 85+ persons in Minnesota and selected counties, 2005.



2005, the legislature enacted a first step in “Pay For Performance” for nursing homes. This effort provides a quality add-on to the payment rate. Based on quality scores, facilities will receive increases as large as 2.4% of their operating payment rates effective October 1, 2006. The quality score is based upon measures included in the nursing home report card (see section 4 below). This will affect individual facilities throughout the state.

4. Align systems to support high quality and good outcomes. *The focus of this policy direction is to ensure that adequate quality information is collected and available to help consumers make decisions on specific care settings or facilities.*

After a number of years of development, in early 2006, the Minnesota departments of Health and Human Services published the first nursing home report card. It is web-based and allows the user to select the quality measure they consider most important, providing scores on eight quality measures using a five star rating. All nursing facilities throughout the state (except for veterans and state-operated homes) are included in this report card.

5. Support the informal network of families, friends and neighbors. *The emphasis of this policy direction is on widening and strengthening the supports available to informal caregivers who provide the vast majority of assistance to the frail elderly in the state.*

The 2001 long-term care legislation called for expanding the menu of respite and other support services in all parts of the state and making these services more affordable to caregivers. Since that time, counties have expanded the caregiver services they provide within their Elderly Waiver and Alternative Care programs. More services for caregivers are also now available through the state’s Area Agencies on Aging. They have used their available federal Older Americans Act fund to provide additional caregiver services. In addition, the CS/SD grant program described earlier is funding 30 projects serving nearly 7,000 persons with caregiver support, caregiver coach and respite services. A total of 24 of these projects have been funded within Greater Minnesota.

6. Recruit and retain a stable long-term care work force. *It is essential that steps are taken to recruit, retain and support an adequate work force for health and long-term care services.*

The 2001 long-term care reform legislation emphasized a number of actions that were necessary to attract and retain long-term care workers. The legislation called for adding a cost of living adjustment

to the rates of all long-term care providers reimbursed through state-funded programs and studying ways to cover more direct-care workers with health insurance.

Also included was expansion of tuition credits, loan forgiveness options, and additional efforts through MnSCU and the Healthcare Education - Industry Partnership (HEIP) to improve and expand training for direct-care workers. Internship programs for middle and high school students to work in health and long-term care settings were also expanded through this legislation. These additional efforts joined an already wide array of loan forgiveness programs available through the Department of Health to provide incentives for health and long-term care workers to work in underserved areas of the state.

Who is Working to Improve Rural Long-Term Care?

A number of agencies and organizations are working with local communities and groups to further develop the long-term care system for older persons in Greater Minnesota.

Minnesota Department of Health (MDH). The Office of Rural Health and Primary Care within the Minnesota Department of Health has as one of its priorities the special needs of the elderly in Greater Minnesota. It began a major initiative in 2005 to identify the needs of Greater Minnesota elders and define the elements of healthy communities where older residents can successfully age in their home communities. This work is summarized in a number of reports and documents available on the Health Department website at www.health.state.mn.us.

The health department is also partnering with the Minnesota Department of Human Services and the Minnesota Board on Aging on a major project called Transform 2010, which is identifying the impact of the permanent shift in the age of the state's population and developing a strategic plan for what needs to be done to prepare Minnesota for the "age wave."

The Minnesota Board on Aging (MBA). The MBA is another agency whose priorities include efforts to address the needs of the elderly in Greater Minnesota. It is a governor-appointed board, designated as the "State Unit on Aging" under the federal Older Americans Act. As the State Unit on Aging, the Board has the federal mandate to develop a comprehensive, coordinated system of services for persons 60 and over within Minnesota. The federal legislation includes a long list of mandated activities such as providing

information and assistance, operating an ombudsman service for older Minnesotans, and administering about \$21 million in federal Older Americans Act funds available to fund supportive services at the community level, e.g., chore, transportation, caregiver respite, nutrition services, etc.

Area Agencies on Aging and Eldercare Development

Partnerships. The MBA funds and oversees a network of regional Area Agencies on Aging (AAAs) and Eldercare Development Partnerships (EDPs) that provide system and service development in their regions. (All but one of the seven EDPs are organizationally part of AAAs.) Because they are organized at the regional level, six of the seven Area Agencies and EDPs serve Greater Minnesota. Hence, their service development and funding efforts focus on developing or expanding services to meet the long-term care needs of older persons in rural areas.

Minnesota's network of AAAs is mandated to develop home and community services, including senior nutrition programs, senior centers, transportation, chore, respite, information and advocacy, and health promotion programs. Each office also operates the Senior LinkAge Line, a telephone information and assistance service backed up with an extensive web-based database of programs and resources available to older persons and their families. Currently, one of their main priorities (within their contracts with MBA) is the development of local linkages between acute care providers and community-based supports in an effort to improve chronic care management and reduce preventable use of hospitals by frail elderly.

The EDPs provide targeted technical assistance to counties, local communities and service providers, with a focus on creating new services and redesigning existing services to improve quality and sustainability. Most of their technical assistance occurs in two areas: 1) best practices for use of public and private resources to meet new needs and priorities; and 2) assistance in making needed changes, e.g., providing business plan expertise, convening and developing new partnerships, and technical assistance to those seeking state grant sources. Filling gaps in local long-term care systems is a major role in the work of EDPs as well as AAAs.

Minnesota Department of Human Services (DHS). DHS administers a number of programs that benefit older persons in Greater Minnesota. Through its Health Care Administration, it contracts with nine health plans to provide an integrated package of acute, primary and long-term care services to elderly who are

eligible for Medical Assistance because of their low income and need help paying for their health and long-term care. Currently, over 30,000 seniors are served in this program, most through a program called Minnesota Senior Health Options. Other health care programs available to older persons throughout the state include Medicare-related services, such as assistance with Medicare premiums, deductibles, coinsurance and copays for certain Medicare enrollees.

DHS also supervises the provision of long-term care services through counties, including Long-Term Care Consultation services that help elderly of any income with assessing their needs for long-term care and developing plans for how to meet their needs; the Elderly Waiver services for low-income elderly eligible for Medical Assistance and at risk of nursing home placement but not served through health plans; the Alternative Care programs for elderly who are at risk of nursing home placement but are not eligible for Medical Assistance; and adult protective services for vulnerable adults including the elderly. (More detail on these programs can be found on the DHS website at www.dhs.state.mn.us/aging, and click on “reports and publications” and then “fact sheets.”)

DHS is a leader in the Transform 2010 effort. Along with MDH and MBA, DHS is working on a number of steps including completion of a strategic vision for the state on what needs to happen to prepare all sectors for a permanent shift in the age of our state’s population.

Counties. Counties provide critical services and functions that support long-term care systems in Greater Minnesota. Through their public health and social service departments, counties provide health promotion and education, home care, adult protection services, long-term care consultation and related assessment, care planning and monitoring, although some of these functions are changing as the EW services are transferred to the health plans and Alternative Care services. Some counties continue to provide some EW and related services under contract with local health plans. Many counties have developed and continue to fund other essential services such as transportation, volunteer services, chore or housing related services, affordable senior housing through county housing redevelopment authorities, and a variety of health and social supportive services. Some counties are also working with local communities to make them more age-friendly for their older residents.

Counties will continue to be a key local resource in the development and provision of services to their older residents as the older population grows and changes over the next 25 years.

Local communities and service providers. Local communities and health, housing, aging and long-term care providers in those communities are playing a key role in developing responses to the growing elderly populations in their areas. The long list of CS/SD projects developed by local providers and funded in Greater Minnesota is testimony to the creative and innovative models being developed by local organizations to better serve their frail elderly population.

Conclusion

Long-term care for the elderly is a critical issue in Greater Minnesota and its importance will grow as the population continues to age. State and local groups are working together to develop and test new approaches to address these needs. The results of their efforts will help all of Minnesota face the long-term care challenges of the future.

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