



# A Blueprint for 2010

*Preparing Minnesota for the*

## *Age Wave*



**Report on Transform 2010**

**Minnesota Department of Human Services  
Minnesota Department of Health  
Minnesota Board on Aging**



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## Background

In less than four years, in 2011, the large baby boom generation—born between 1946 and 1964—will begin to turn 65, and for the next 25 years the aging of the population will dominate the demographic landscape. The number of Minnesotans over age 65 will double, rising to 1.3 million, and by 2030 older people will represent over 20 percent of the state's population. This “age wave” will usher in a permanent shift in the age of our state's population. Such a major shift in the age of our society has never happened before, and policymakers here and around the world are preparing for both the opportunities and the challenges that this dramatic change represents.

In order to prepare Minnesota for this demographic shift, in 2006, the Department of Human Services launched Transform 2010 in partnership with the Minnesota Board on Aging and the Minnesota Department of Health. The purpose of Transform 2010 is to identify the impacts of the aging of our state's population and to transform our policies, infrastructures and services so that Minnesota can survive and even thrive as this permanent shift occurs. The year “2010” was chosen as the target for action because it is the year before the large baby boom generation begins to turn age 65.<sup>1</sup>

## Engaging Minnesotans in Discussions

In 2006, the Minnesota Board on Aging and the Departments of Human Services and Health co-sponsored a series of meetings across the state to discuss the issues of an aging Minnesota with a broad range of citizens. Special meetings were also held with representatives of American Indian Tribal Organizations and other ethnic and immigrant communities to discuss these issues from their perspectives. The Area Agencies on Aging of Minnesota co-sponsored and made local arrangements for these meetings.

Over 1,000 individuals participated in these meetings, including representatives from counties, health and long-term care providers, volunteer organizations, older persons, advocates, citizens, local elected officials and businesses and representatives of ethnic, immigrant and tribal organizations.

The participants were asked to discuss issues related to the aging of the state's population and suggest actions that individuals, communities, businesses and government must take to prepare for 2010 and beyond. Working in small groups, they generated over 1,200 “bullets” about issues, concerns, ideas and specific recommendations for the future. Many of those attending were boomers themselves, and shared thoughts about their own aging and actions they are taking (or should take) to prepare for later life.

During the remainder of 2006, over 100 additional Transform 2010 presentations were completed, during which these issues were discussed with boards of directors, business organizations, counties, cities, health and long-term care providers and advocates.

The Transform 2010 partners also brought together a group of state agency staff in 2006 to begin discussions about the effect of the state's aging on state agencies and what actions are needed to prepare state government for these demographic changes. These agencies continue to meet and work on issues where interdepartmental efforts are beneficial. The group includes representatives from 16 different agencies. (See Appendix A for a list of the agencies and staff participating in this interagency group.)

## What We Learned from Minnesotans

It is clear from all these discussions that the effects of the aging of our state are already visible, especially in the rural portions of our state, where communities have been experiencing the effects of “2030 demographics” for several years. Throughout the state, there are growing worries about labor shortages as large numbers of workers reach retirement age (in 2008, the first baby boomers turn age 62). There are concerns about the solvency of Social Security, Medicare and private pensions. And there are questions about the ability of the health and long-term care systems to meet the challenges posed by an increasingly older population and about the ability of families to continue their high levels of eldercare into the future.

On the more positive side of the ledger, there are exciting new discussions about vital aging and the “third age” of life. Individuals are retiring from career jobs to pursue new businesses, expand their community service or initiate civic engagement projects, and are seen as a valuable resource to their communities. There is a committed cadre of providers and leaders in all sectors of the state who understand the urgency of these issues and are reinventing their services with an eye to the coming age wave. In addition, public awareness of the aging of the baby boom generation and its impact on society is growing as stories about aging regularly appear in the national and local media.

More than this, however, our Transform 2010 discussions reveal broad consensus among citizens about what needs to be done to prepare for the dramatic changes ahead for an aging Minnesota. They understand that individuals must assume personal responsibility to prepare for their later years, but also recognize that significant system transformation is necessary for the state to survive and even thrive during the next 30 years as its age changes dramatically.

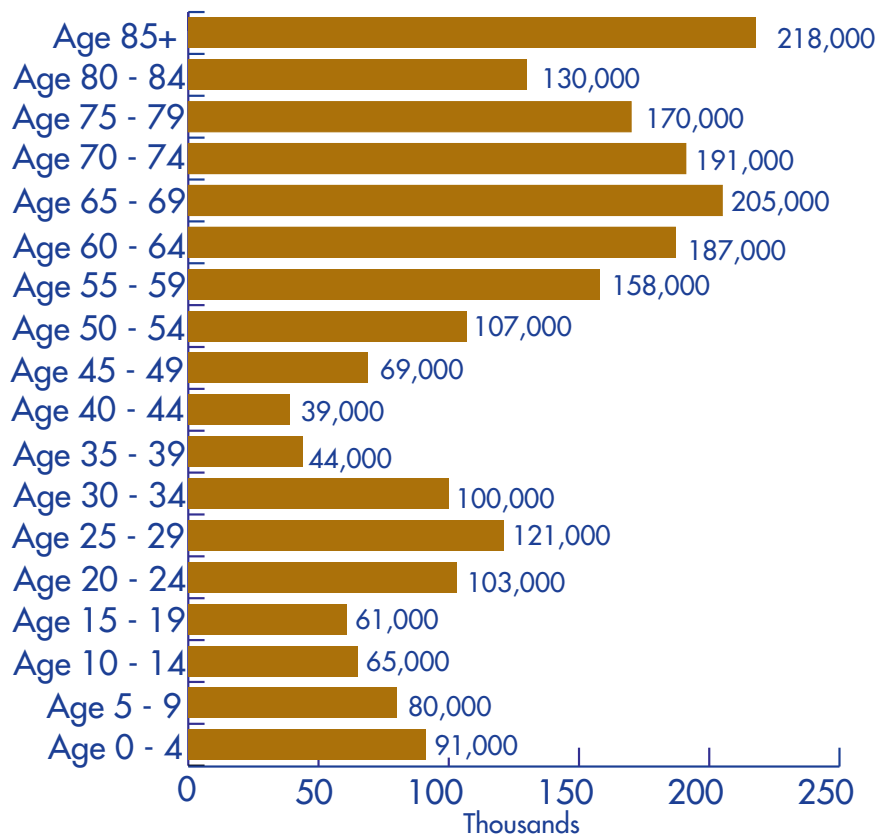


# Demographic Trends and Issues

There are several important trends that provide the context for discussions about the upcoming demographic shifts in our state.

**1. In the next 50 years, most of the growth in Minnesota’s population will occur in persons over 50.** In a dramatic reversal of traditional demographic trends, by 2020 Minnesota will have more retirees than school age children. Figure 1 illustrates the changes we will see in our population between 2000 and 2060. Three-fourths of the population increase between 2030 and 2040 will occur in ages 50 and older. After 2040, this growth stabilizes but the new “gray” landscape will represent a permanent shift in the age of Minnesota’s population.

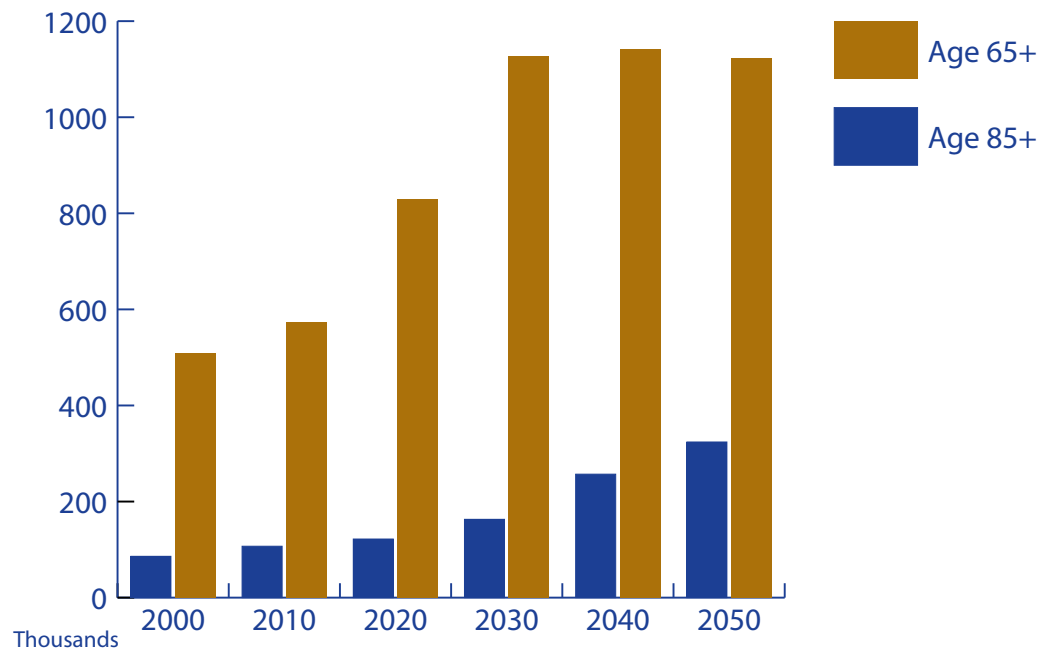
**Figure 1. Growth in Minnesota’s Population 2000 - 2060, by Age Group**



Source: Minnesota State Demographic Center, 2005

**2. Over the next 25 years, the number of older persons will rise dramatically.** Between 2005 and 2030, Minnesota’s population 65+ will rise from 620,000 to 1,300,000, a doubling of this age group. During the same time period, the population 85+ will nearly double, rising to 163,000. By 2050, this number will double again, increasing to 324,000 persons. Once we reach 2050, the major increases will level off but by that time Minnesota will be much older than it is now. (See Figure 2.)

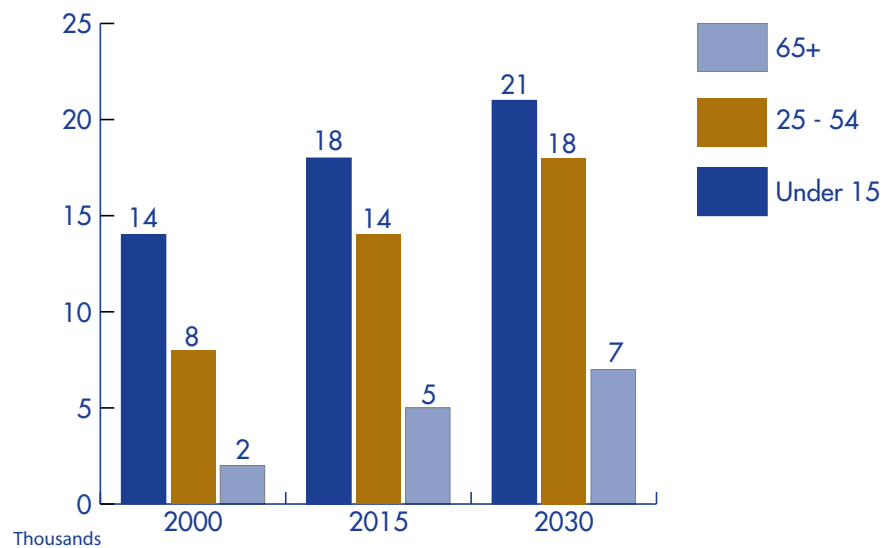
**Figure 2. Minnesota's 65 - 84 and 85+ Population 2000 - 2050**



Source: Minnesota State Demographic Center, 2005

**3. Minnesota's future population will be much more diverse than ever before.** The tremendous growth in the immigrant and ethnic populations in Minnesota during the past 30 years has largely been in the younger ages, with few elders in these populations. While the proportion of elders in Minnesota that are nonwhite will triple by 2030 (2 percent to 7 percent), it will still represent a fairly small portion of the overall elderly population. However, Minnesota's younger population groups will be much more diverse, especially those under 15, where 21 percent will be nonwhite in 2030, compared to 14 percent in 2000. (See Figure 3.)

**Figure 3. Percent of NonWhites by Age Group in Minnesota: 2000 - 2030**

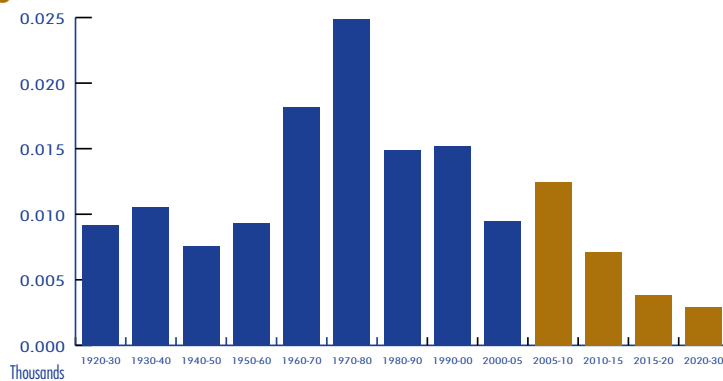


Source: Minnesota State Demographic Center, 2005

**4. Labor shortages are already visible in parts of Minnesota and will become more acute in the future.** Many experts are predicting growing labor shortages as boomers reach normal retirement age. Retirements coupled with employment growth could drive the unemployment rate down to 2 or 3 percent, the levels found during the labor force shortages of the late 1990s.<sup>2</sup>

Projected labor force growth will slow dramatically beginning in 2010 and continue that trend into the foreseeable future. Minnesota’s average annual labor force growth rate hit its all time high between 1970 and 1980 when it reached 2.5 percent, but between 2020 and 2030 the average annual growth rate will be only 0.25 percent. (See Figure 4.)

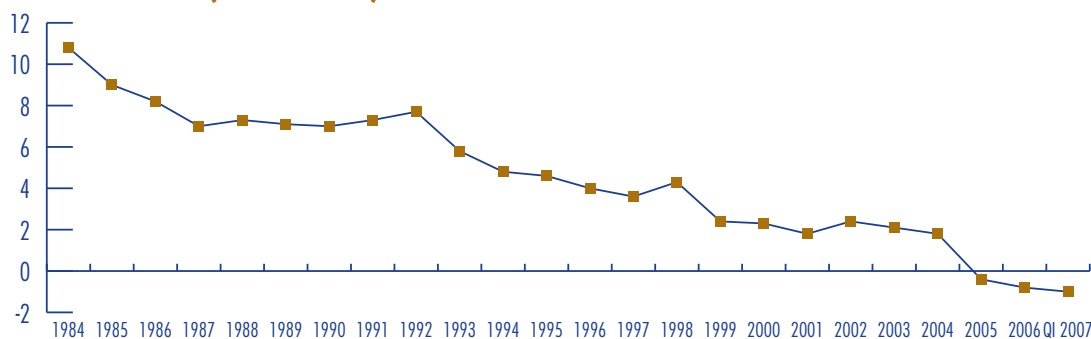
**Figure 4. Minnesota’s Average Annual Labor Force Growth Rate: 1920 - 2030**



Source: 2000 Census, American Community Survey, Minnesota State Demographic Center, 2006

**5. Many Minnesotans are having trouble saving for retirement and old age.** In order to have adequate retirement income that will last for an expected 30 years of later life, individuals need to save and have a plan for how to support their lifestyle into old age. Unfortunately, this is an area where we as a nation are doing poorly. The overall personal savings rate dipped to -0.4 percent in 2005, the first time since the Great Depression that the rate has been a negative number. The low savings rate is illustrative of how difficult it is for us to put money aside for the future.

**Figure 5. Personal Savings as a Percentage of Disposable Personal Income (U.S.) 1984 - 2007 (Quarter 1)**



Source: Bureau of Economic Analysis, National Income and Product Accounts, Table 2.1 Personal Income and Its Disposition

A recent study by the University of Minnesota estimates future retirement income insecurity for Minnesota’s future retirees. Using a national projection model developed by the Employee Benefits Research Institute (EBRI), the study found that a surprising number of Minnesotans are at very high risk of having inadequate income in retirement (533,450 or 29 percent). Another 326,360 or 17 percent were at moderate to high risk of income insecurity in retirement. In total, this means that 860,000 (46 percent) or nearly one-half of future retirees are at risk of having inadequate incomes in retirement. These findings are even more surprising because Minnesota tends to have a higher per capita income than many other states in the country.

**Table 1. Estimating Future Retirement Income Insecurity for Minnesotans Born Between 1936 - 1965**

Risk of Retirement Income Insecurity	Number of People in Minnesota (born 1936 – 1965)	Percent of Minnesota Population
Very High Risk	533,450	29%
Moderate to High Risk	326,360	17%
Low to Moderate Risk	1,013,920	54%
Total	1,873,730	100%

Source: State Health Access Data Assistance Center (SHADAC), 2005

**6. The demographic shift means dramatic changes in families in Minnesota.**

Dramatic structural changes are underway in families in Minnesota. Families are becoming smaller: in 1940, the average family had 3.8 members; in 2000 it had 3.1; and by 2040 it is expected to fall to 2.8. Women now have an average of 1.8 children, compared to 3.7 in earlier generations. Increasing numbers of women do not have children at all. In 1980, 9 percent of women were childless; now it has risen to 18 percent. Higher rates of divorce and remarriage are creating many more blended families and challenging traditional patterns of care and affinity.

Growing numbers of adults live alone, and we recently reached a national benchmark of sorts when it was reported that more women are not married than are married (51 percent). Between 2005 and 2030, the number of older Minnesotans living alone will double, and this has major implications for retirement income, housing patterns and service needs. In addition, Minnesota has one of the highest female labor force participation rates in the nation, now at 69 percent.<sup>3</sup> This trend means that more women have their own source of retirement income through pensions and Social Security, but it also means that traditional patterns of caregiving for children and older relatives are affected.

**7. Minnesota has one of the lowest disability rates in the nation but this may change.**

In 2005, about 9 percent of Minnesotans reported being disabled, according to the American Community Survey.<sup>4</sup>

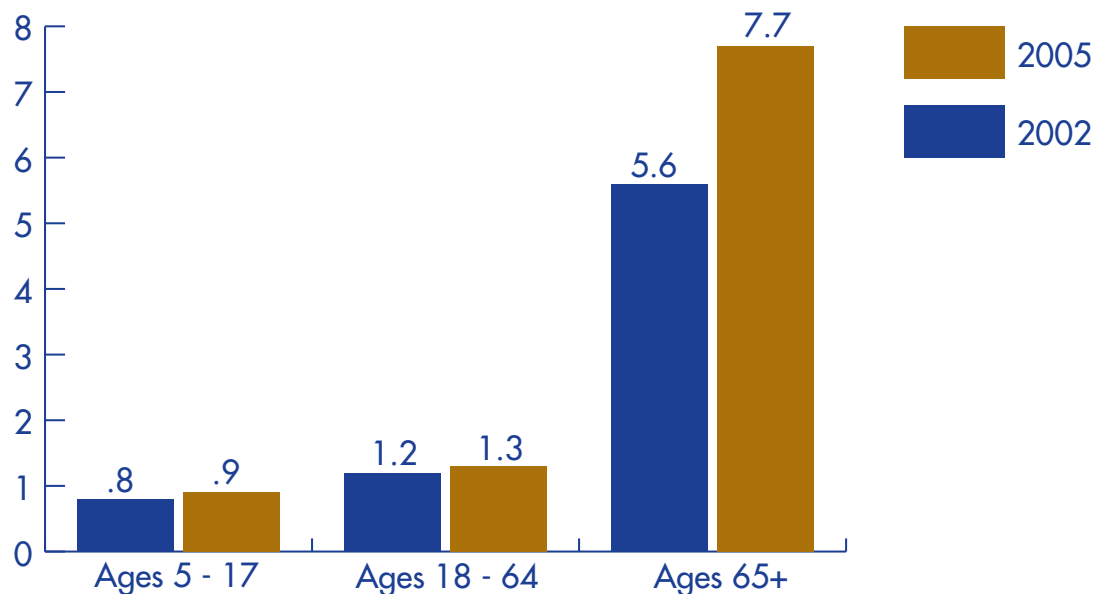
Age-adjusted disability rates have been declining nationally about 1 percent per year for the past 20 years among the older population.<sup>5</sup> Experts say that these declines are the result of advances in health and medical care widely utilized by older people, e.g., hip or knee replacements, prescription drugs that improve functioning and the use of assistive devices and other forms of technology.

It is difficult to predict whether disability rates among the future old will continue to decline. Figure 6 below indicates that Minnesotans 65+ reported a somewhat higher level of self-care disabilities in 2005 than in 2002. However, there is no question that the *number* of older persons with some level of disability will greatly increase in the future solely because of the doubling of the older population that will occur over the next 25 years.

Added to this are troubling signs that disability rates among the nonelderly (those under 65, including children) may begin to rise. According to a 2004 Rand study, disability rates among non-elderly are on the rise, with obesity as the suspected cause of these increases. “If historical obesity trends were to continue through 2020 without other changes in behavior or medical technology, the proportion of individuals reporting fair or poor health would increase by about 12 percent for men and 14 percent for women, compared with 2000. Up to one-fifth of health expenditures would be devoted to treating the consequences of obesity. And rising disability rates could offset past reductions in disability.”<sup>6</sup> (They also expect that the nursing home population would likely grow 10-25 percent more than historical disability trends predict.)

Therefore, rather than continuing to decline, our disability rates may unfortunately begin to rise in the future, putting even more pressure on the state’s health and long-term care system.

**Figure 6. Percent of Minnesotans Who Report Self-Care Difficulty/Disability by Age Group 2002 and 2005**



Source: American Community Survey, US Census, 2002 and 2005

## What's Included in This Blueprint

This Blueprint summarizes the discussions held with Minnesotans during Transform 2010 meetings held in 2006. It includes their suggestions for what needs to be done to address the permanent shift in the age of Minnesota's population. It also includes the results of research and analysis by staff from the sponsoring agencies and specific action steps suggested by Minnesotans across the state to prepare for the age wave under five key themes:

- 1. Redefining work and retirement**
- 2. Supporting caregivers of all ages**
- 3. Fostering communities for a lifetime**
- 4. Improving health and long-term care**
- 5. Maximizing use of technology**

These five themes for 2010 were developed as a framework around which to organize strategies and action steps that respond to the most critical impacts of the age wave. For each of these themes, some facts and figures are provided about "why this is important," the implications of doing nothing are described and broad strategies and examples of suggested action steps are presented. Finally, some benchmarks that can be used to monitor progress over time on the strategies included in the Blueprint are proposed in Appendix B.

It is important to note that this Blueprint is not just about what state government needs to do to prepare for the aging of our population. Rather it includes what needs to be done by all sectors within the state, including individuals and families, communities, businesses, providers, as well as state and local government.

Because a change this dramatic has never happened before, the effects will be felt across all aspects of our lives, and thus there is a role for every one of us as individuals, members of families and residents of communities.



# 1. Redefining Work and Retirement

**Minnesota should encourage individuals to continue working in both paid and nonpaid roles, and prepare for their retirement and old age.**

## Why is this important?

- A number of demographic, economic and social trends are converging to redefine traditional patterns of work and retirement in our society. These trends include longer life expectancies, a shift of the financial risks of later life from employers to individuals, and increased interest by many baby boomers in continued work.
- Retirement no longer means withdrawing from work and other engagements in favor of leisure and related pursuits. It is becoming a time to explore new roles, start new careers, pursue lifelong learning, and engage in volunteer and civic activities for causes that have meaning and value to individuals. Work is becoming less linear, multiple careers are the norm, and individuals are exiting and re-entering the labor force to obtain additional education, volunteer or meet family obligations.
- Minnesota's work force is aging and the number of "mature" workers is increasing. At the same time, the growth of the younger worker pool entering the labor force is slowing. The workplace still includes disincentives for mature workers to continue to work, e.g., early retirement incentives, lack of training and flexible schedules, benefits geared to younger workers.
- Mature workers — Minnesota's baby boom generation — represent a tremendous "human capital" resource to Minnesota, and surveys indicate that these individuals want to stay engaged, either in paid or nonpaid roles. If they do not continue to work, labor shortages will be a growing problem.
- Perhaps one of the most worrisome issues tied to the retirement of the baby boomers is their lack of savings and preparation for their later years. With the continuing increases in life expectancy, individuals need to plan to meet their retirement income, health and other needs for 30 years or more. Both public and private pensions and retiree health benefits are increasingly at risk, making it critical that individuals plan and save on their own, so they have retirement income to cover basic expenses as well as health and long-term care costs.

## What if we do nothing?

- If boomers do not continue to work—leading to a labor shortage in the state — an economic slowdown will collide with a rising elderly dependency ratio. This will strain the economy and the state's standard of living as boomers move from net tax contributors to recipients of public resources.<sup>7</sup>
- If labor shortages occur in the state, this will threaten the state's global competitiveness and the region's quality of life and standard of living.

*"To see older people merely as passengers and not part of the crew is counter-productive to our understanding of aging in America today."*

*--AARP, 2005*

- As baby boomers leave the work force, near zero labor force growth will create a shortage of workers in key sectors.
- If individuals do not save for their later years, the number of individuals with inadequate retirement income will grow dramatically, leading to increased homelessness and hunger among the elderly; they will turn to families and charities for economic support.
- If individuals do not have adequate retirement income, many more older individuals will be forced to turn to public sector programs, straining government safety net programs such as Medicaid, cash assistance programs and food and housing programs.

## What issues need to be addressed to prepare for 2010?

### 1. Transforming public and private retirement and employment policies to better reflect demographic realities and support continued work.

Current policies that govern when people retire and how long they work were developed at a time when our demographics and our labor force looked entirely different than they do now. There has been a gradual increase in life expectancy, and Minnesota now ranks second in the U.S. for life expectancy – 76.5 for men and 81.5 for women. And these additional years are healthier, as evidenced by declines in age-adjusted disability rates.<sup>8</sup>



Jobs are not as physically demanding as they once were. The share of workers in physically demanding jobs has declined from 20.3 percent in 1950 to 7.5 percent in 1996.<sup>9</sup> However, the age of retirement had been declining for the past 20 years, reaching a low of 60 in 1996. It has now begun to rise slightly, up to 62 in 2006. Researchers expect it to continue to rise as more mature workers decide to keep working. The “actual age” of retirement tends to be about five years lower than the “expected age” of retirement, due mainly to factors that workers cannot control, such as disability, layoffs or closures and caregiving responsibilities.<sup>10</sup>

Between 2000 and 2030, the largest growth in the labor force will occur in workers age 65 and older, which will grow by 218 percent. However, during that same time period, the number of workers age 25-44 will increase by only 8 percent.

The recent survey of Minnesota baby boomers completed by Ecumen found that 69 percent of Minnesota’s boomers do not plan to retire until they are 65 or older. Nearly half (46 percent) say they will have a full- or part-time job in retirement, and 73 percent of those who plan to work say their job will be different from their current job.<sup>11</sup> Reasons that boomers give for continuing to work include growing insecurity about their retirement income and the rising costs of health and long-term care. In addition, boomers see the workplace as the place where they can stay connected, be productive and interact with people who have similar interests.

The participants at our 2010 meetings recommended that the basic framework of policies governing work and retirement be redesigned to support a new vision of work and retirement, and eliminate the disincentives for continued work.

They discussed the need for employers to review their employment and retirement policies, complete workforce planning, address knowledge transfer issues and consider phased retirement options and changes in retirement and health benefits. Flexible schedules for where and when work is done were frequently mentioned as important to both younger and older workers. They improve productivity and retain workers for employers that offer them.

There was also discussion about the needs of mature workers. Many could benefit from a more accessible pathway to help them identify their options for continued work and obtain the necessary supports to follow through with their plans.

### **Suggested Action Steps**

1. Encourage development and use of flexible work policies that allow individuals to have more flexibility in how, where and when work is done, and to take care of personal and family needs.
2. Small and mid-size employers may need assistance in reviewing their policies and doing workforce planning.
3. Establish more career “access points” for entry, exit and re-entry into the workforce.
4. Minnesota should establish a Mature Worker Initiative that includes the state’s workforce development centers, to assist mature job seekers and educate employers.
5. Redesign and expand existing job banks, job training and related services to meet the special needs of mature job seekers. Look to Experience Works as a model.
6. Encourage employers to utilize their retired workers when temporary workers are needed.
7. Explore the impact of workplace flexibility policies on the competitive advantage for Minnesota’s businesses in the global economy.
8. The state of Minnesota should be a model employer for 2030 as it reviews its own retirement and employment policies and completes workforce planning to prepare for increasing numbers of retirement-age employees.

## **2. Transforming Minnesota’s post-secondary education system and employer-based training to meet the education and training needs of an aging workforce.**

The changes underway in the economy have affected the labor force participation of mature workers, due to layoffs, downsizing or closings. These mature workers face special problems trying to find new jobs. About 20 percent of workers nationally who were ages 51-61 in 1992 lost their jobs in the next 12 years, and this job loss affected workers at all educational levels.<sup>12</sup> In fact, researchers have found that between 2001 and 2003, workers with a college degree or higher who were laid off suffered an earnings loss of 20 percent, almost twice the loss experienced by workers with less than a high school education.<sup>13</sup>

There are clear economic reasons to focus on upgrading the job skills of mature workers who have been downsized or laid off from their jobs. The most immediate is to help the workers secure a steady and adequate stream of income so that they are not forced to prematurely draw on their retirement income sources to support themselves.

Those who attended the 2010 meetings indicated that Minnesota's post-secondary education system needs to respond to the training needs of mature workers more effectively. As the 18 to 24-year-old group shrinks, educators need to look at nontraditional students, not only those in mid-career but also more mature workers who have been downsized, who want to build their knowledge base for a new career, start a new business or find a nonpaid job within the public or nonprofit sector.

Minnesota's well deserved national reputation for educating younger individuals provides an excellent foundation to focus on older individuals who need or desire to acquire new skills. Participants at the meetings mentioned short courses, workshops, refresher programs and just-in-time training for new types of jobs critical to the state's economy as examples of training that mature workers need in order to reenter the work force.

### **Suggested Action Steps**

1. Provide financial incentives to employers that use training and development resources for their mature workers to maintain and upgrade their skills.
2. Post-secondary education, especially Minnesota State Colleges and Universities, should redesign their education, service and guidance resources to meet the needs of older adults learning new careers, pursuing lifelong learning goals, and those laid off or forced out of jobs. The courses need to be shortened in order to help workers get back into the labor force quickly.
3. Community education departments can provide training and education courses needed by mature workers and older adults in their communities.
4. Set aside some of the available public training funds for mature workers.
5. There should be rewards and scholarships for mature workers to upgrade their skills or change their field to go into an industry where there are shortages.

### **3. Encouraging individuals to plan and "self-invest" in financial planning for a lifetime.**

Many Minnesotans are saving at work. About one-half of Minnesota's employees work for an employer that offers a pension or retirement plan. These workers have the highest participation rate in employer-sponsored plans in the country at 67.6 percent for full-time workers, compared to a national average of 56.6 percent.<sup>14</sup> The median account balance among the workers who regularly contribute to their plans was \$54,591 in 2006.<sup>15</sup>

The other half of Minnesota's workers do not have an employer-sponsored retirement plan available, and these workers are finding it hard to save for future needs. These

workers often work for smaller employers that do not believe they can afford to offer a retirement plan to their employees or pay the administrative costs of setting up such a plan.

Participants at our 2010 meetings stated that, in light of the seriousness of these issues and their implications, we need to make saving as easy and automatic as possible, so that more individuals choose to save. It should not require lots of special knowledge or effort to do so. Those attending the meetings said we should increase the number of employers that offer retirement plans to their employees, especially small employers and nonprofits. We need to encourage (some said we should require) employers to automatically enroll all their employees in retirement plans, and utilize plans that invest in “lifecycle” funds.

The participants talked about the dramatic changes that have occurred in pensions in the past decade, changing from the traditional defined benefit (DB) plan to the defined contribution (DC) plan. The DC plans shift the responsibility of securing an adequate retirement income from the employer to the individual. Nationally, over 60 percent of private pensions are now DC plans, up from 20 percent just 20 years ago.<sup>16</sup>

In addition, an earlier practice of offering health benefits to retirees, especially the retirees of larger companies, has declined markedly. In 1988, 66 percent of retirees in the private sector had some retiree health benefits and, by 2005, that had shrunk to 33 percent.<sup>17</sup>

There was much discussion about the growing need for individuals to plan for their retirement and old age, including financial and other aspects. There was also concern that we must do a better job of educating young people, perhaps in the schools, about money and debt and the importance of saving and preparing for the future.



**Suggested Action Steps**

1. Simplify the types of options available for private retirement savings, increase incentives and make these portable across employers.
2. Focus on educating women about the need to prepare for their retirement and the special issues they face, e.g., widowhood, divorce, caregiving, longer life expectancies.
3. Encourage all employers to automatically enroll all employees in their retirement plans (called “opt-out”), and utilize plans with smart default plans, e.g., plans that offer “lifecycle” investments.
4. Encourage all employers to offer at least some type of payroll savings option to their employees.
5. Provide state tax credits or deductions to employers that offer comprehensive retirement planning and/or related products to their employees.
6. The state of Minnesota should increase the percent of its employees that participate in the deferred compensation plan, and explore an “opt-out” option.
7. Implement a public/private comprehensive public awareness and education campaign on the need to prepare for retirement and old age. Include special outreach efforts to individuals in ethnic, immigrant and tribal communities.
8. Require integration of financial literacy education throughout K-12 and post high school, to educate students about money and debt management, the need to save and the importance of preparing for the future.
9. Explore and identify realistic retirement plan options for small employers.

**4. Engaging Minnesotans in “vital aging” opportunities as they age.**

Over the next 25 years, the boomers will represent one of the most important sources of human capital in the state. They will be 1.3 million strong, still relatively young and healthy and with the desire to remain engaged either through paid or nonpaid roles.

Recent surveys of Minnesota’s baby boomers have found that 67 percent of boomers plan to volunteer when they retire, and 57 percent expect that they will volunteer more than they do today. About two-thirds report being very optimistic about the impact they can have on community quality of life, and see community groups or individuals doing more to solve Minnesota’s problems (53 percent) than government leaders (11 percent).<sup>18</sup>

Minnesota has a highly regarded record in volunteerism and civic life. We have routinely ranked near the top on almost all indicators used to measure volunteer efforts. Table 2 provides some examples of these ranks. In the proportion of older volunteers (65+), baby boomers and young adults, our volunteer rates are some of the highest in the nation.<sup>19</sup> And all signs indicate that Minnesota boomers will continue this proud tradition.

**Table 2. Ranking of Minnesota on National Volunteer Indicators**

Indicator	Minnesota's Rank	Minnesota's Number
Volunteer Rate (percent of population that volunteers)	#3	40.4%
Volunteer hours per state resident per year	#11	45.2 hours
Retention rate (percent who continue service for more than one year)	#1	76.4%
Civic Life Index (composite of rank on 11 indicators such as voting, volunteering, neighborhood engagement, civic infrastructure)	#6	118.6
Older adult volunteer rate (65+)	#3	40.9%
Baby boomer volunteer rate (those born between 1946 – 1964)	#3	46.0%
Young adult volunteer rate (16 – 24)	#5	33.9%

Source: Corporation for National and Community Service, 2007

Women are more likely to volunteer than men and, if informal volunteer work (helping neighbors and friends) is included, volunteer rates in the African American and Hispanic populations are the same as for the white population. According to those who attended the 2010 meetings held with ethnic and immigrant communities, several of the Asian American groups do not have strong traditions of formal volunteerism, and this is something that is evolving as younger generations born in this country become involved in volunteer work.<sup>20</sup>

Participants at our 2010 meetings had lots of ideas for how to connect and link individuals who want to pursue this type of engagement in later life. Many pointed out that although it is not called volunteering, older people do provide care for their parents, children and grandchildren, and that this is a major benefit to society. Participants emphasized that older persons are the state's greatest resource as it faces the future and the many challenges posed by demographic, economic and social trends.

Minnesota is home to many national models in volunteerism and civic engagement, including the Vital Aging Network, founded in 2000 by a group of older professionals and those working in the aging field. Its purpose is to support involvement with the process of vital aging by linking people to opportunities for productive and meaningful activities that will respond to their individual interests and community needs. Many of those attending the meetings suggested using individuals from the Vital Aging Network and groups such as AARP as role models of engagement to attract and inspire boomers as they begin to search for projects or ideas that interest them.

*“Our whole society benefits when older adults, with their wisdom developed from a lifetime of experience, are given opportunities to further grow and transmit their skills and perspectives through initiatives based on their strengths.”*

*—Jan Hively, Founder, Vital Aging Network*

**Suggested Action Steps**

1. Rethink and redesign volunteer opportunities to attract more boomers, e.g., more short-term commitments, with high touch and high tech, more use of web-based, informal and community networks for recruitment.
2. Encourage more employers to allow flex time for volunteer projects prior to retirement.
3. Provide supplemental health insurance as a benefit to older volunteers who need wrap-around coverage for Medicare.
4. Consider reinstatement of the State Office of Volunteerism to focus on efforts to redesign and refresh volunteerism for all ages, especially strategies that will attract more of the large baby boom generation.
5. Encourage advocacy organizations to train and utilize the new generation of older people to be change agents and advocates within society, using their wisdom as elders to help solve society's problems.
6. Expand models that tap boomers' passions to meet emerging needs in their communities.

**5. Expanding the options available to individuals to pay for long-term care costs.**

One of the biggest risks that individuals face as they age is the prospect of needing long-term care. The latest estimates predict that 69 percent of the elderly population will develop disabilities before they die and 35 percent will eventually need nursing home level care.<sup>21</sup> Close to 20 percent of those age 65+ will need at least three years of long-term care, in their home or a congregate setting.<sup>22</sup>

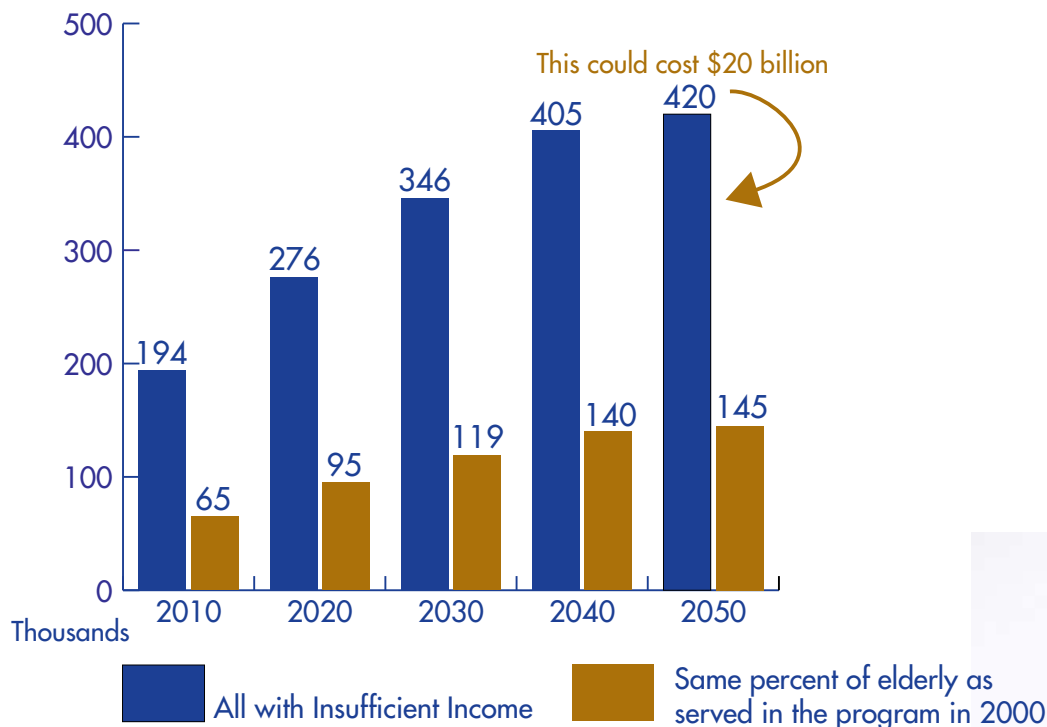
While the vast majority of older people receive long-term care from family members, largely spouses and adult children, the availability of these family members to provide free care will shrink in the future, making frail elderly more dependent on formal long-term care, which can be very expensive. In Minnesota, the most recent cost estimates of a year of formal long-term care are \$48,271 for nursing home care, \$33,994 for assisted living and \$52,728 for home health care.<sup>23</sup>

The 2005 study completed for the state by the University of Minnesota (referenced earlier) found that about 29 percent of Minnesota's future retirees (those born between 1936 and 1964) are at very high risk of having inadequate retirement incomes to pay for their health and long-term care. These figures are very optimistic because the national projection model used to prepare these estimates assumes that individuals will save an additional 5 percent of their income until their retirement. The same study also found that single women are at greatest risk of inadequate retirement income. More than 100,000 of Minnesota's single women or 38 percent of all women born between 1936 and 1965 are projected to have inadequate retirement income to pay for health and long-term care.<sup>24</sup>



If all these individuals turned to the current public programs for assistance, specifically the state’s Medical Assistance (MA) program, the costs of that program would soar.<sup>25</sup> The numbers served would triple from current levels, and could cost the state an estimated \$20 billion (in current dollars) annually in total state and federal dollars by 2050. This compares to about \$1 billion now spent per year to serve older persons in the MA program. (See Figure 7.) This cost would be unsustainable. The issue represents one of the most urgent problems for 2010 and beyond because addressing the problem involves actions individuals must take now to prepare for their long-term care and old age.

**Figure 7. Projected Number of Elderly Served in the Medical Assistance Program in Minnesota: if all at high risk of insufficient income applied for assistance**



Source: Transform 2010, Department of Human Services, SHADAC Report, 2005

Participants at the 2010 meetings suggested that we must take aggressive steps to prevent disability in the first place, support family and informal sources of caregiving to the greatest extent possible and develop communities that provide long-term care supports using volunteers and other affordable options.

Participants also talked about the great need for the state to provide more credible, objective information about available long-term care financing options. At the meetings, many also suggested that the state explore the establishment of a state-level, long-term care savings plan similar to the CarePlus program passed by the Hawaii Legislature in 2002 but not enacted because of a governor’s veto. This plan would have been funded by a \$10 monthly payment by all taxpayers and would have provided one year of



coverage for those who needed long-term care.

Participants also suggested that we spur the development of new products and market them to boomers as they age, especially to the “tweeners,” i.e., individuals who are not eligible for public programs but are not wealthy enough to self-fund their long-term care.

These include products that combine long-term care insurance with health insurance, disability insurance or life insurance and annuities that provide long-term care coverage if needed. True to their interest in value, boomers are looking for products that offer coverage for multiple risks. New names for these products would apparently help in this process. A recent survey found that boomers would be more attracted to products whose names did not include “long-term care” but rather names such as longevity insurance, total living services or life care.<sup>26</sup>

**Suggested Action Steps**

1. Implement Minnesota’s Long-Term Care Partnership program legislation enacted in 2006.
2. Promote a variety of long-term care financing options for individuals that can mesh with overall financial planning for their later years, e.g., long-term care insurance, other insurance or annuity options.
3. Provide incentives to use reverse mortgage funds ONLY for long-term care so older homeowners do not exhaust this funding source before they need long-term care.
4. Explore the establishment of a state-level long-term care savings plan similar to the CarePlus program passed but not enacted in Hawaii in 2002.
5. Encourage development of new and combined insurance products that cover long-term care and other related risks.
6. The state should provide objective, understandable information on long-term care options for consumers, with pros and cons and examples, so people can see how the options work, how much they cost and relate them to their personal situation.

**6. Strengthening federal income and health programs that provide the foundation for individual retirement security.**

Over 97 percent of older Minnesotans receive Social Security and Medicare. Growing numbers of retirees are dependent upon Social Security as the sole source of retirement income. As Figure 8 illustrates, the proportion of retirees that rely on Social Security payments for 90 to 100 percent of their retirement income has risen from 25 percent to 31 percent over the past 18 years. This situation is even more alarming for single women, where 41 percent are totally dependent on Social Security for retirement income.<sup>2</sup> Even though Social Security is intended to be only a portion of overall retirement income, the majority of retirees rely on it for at least 50 percent of their income.<sup>28</sup>

In the case of Medicare, this dependence is also apparent. Medicare now pays less than 50 percent of beneficiaries’ health costs but is considered essential as a source of health insurance coverage for persons 65 and older. Medicaid, the Older Americans

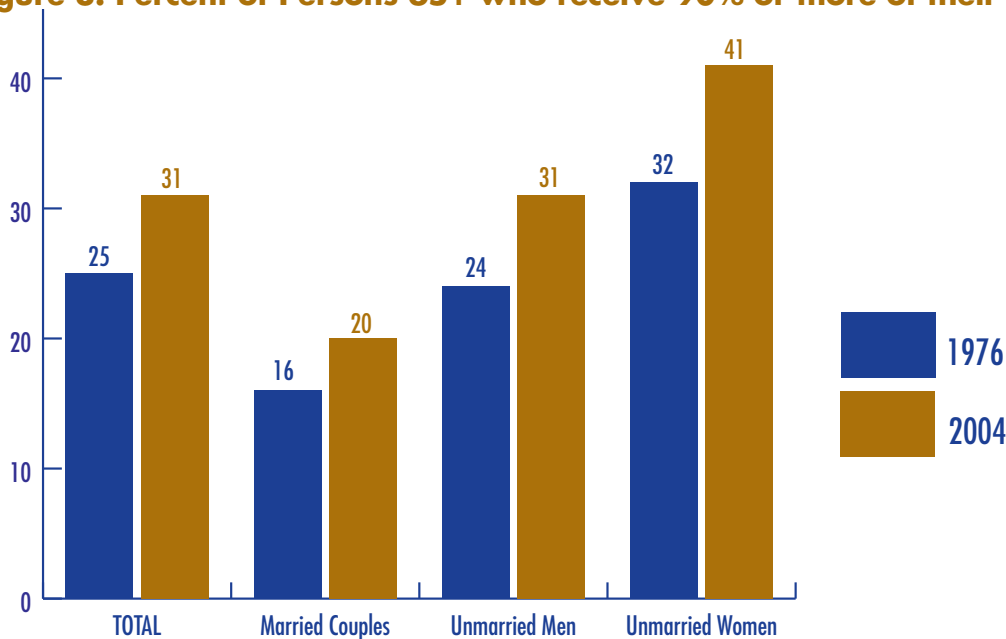
Act and other federal programs also provide essential health and community services to older persons.

Many participants at the 2010 meetings believed that it is in the interest of the state to advocate for strong federal programs to provide retirement income and health care to older people. It is an important strategy for Minnesota, and will reduce the likelihood that the state will need to replace federal dollars in state programs as a result of cuts. Those attending the meetings from ethnic, immigrant and tribal communities underscored the vital importance of these programs for their elders, and 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.

### Suggested Action Steps

1. Advocate for long-term solvency of Social Security.
2. Advocate for long-term strength of Medicare and Medicaid.
3. Advocate for employers to honor their pension and retiree health benefit commitments to workers.
4. Evaluate the impact of the Pension Protection Act of 2006 to determine net effects on employer-sponsored retirement benefits.
5. Evaluate the impact of federal Age Discrimination in Employment regulations on hiring practices, pensions and health benefits.
6. Strengthen the income, health and other foundational programs and systems for all elderly so that they are available and accessible to elders in ethnic, immigrant and tribal communities who are heavily dependent on these programs.

**Figure 8. Percent of Persons 65+ who receive 90% or more of their**



### Income from Social Security 1976 and 2004

Source: US Social Security Administration, 1979 and 2006

## 2. Supporting Caregivers of All Ages

**Minnesota needs to slow the decline of family caregiving by offering eldercare in all workplaces and redesigning services to wrap around family care.**

### Why is this important?

- In Minnesota, the vast majority (92 percent) of long-term care services provided to frail elderly is provided by family members and other informal sources, such as friends and neighbors. This percent has been slowly declining since 1988, when it stood at 97 percent.<sup>29</sup> Research shows that for every 1 percent decline in the percent of eldercare provided by families and friends in Minnesota, it costs the public sector an additional \$30 million per year.<sup>30</sup>
- Because of dramatic changes underway in families, such as reduced numbers of children, longer life expectancy of older members and the high female labor force participation rate in Minnesota, the percent of care provided by families will probably further decline in the future. Since most caregivers in 2010 will be working, this raises the issue of finding ways to support working caregivers.
- The role of the family in eldercare in the rural areas of Minnesota is both critical and challenging. The greater age of the population in many rural counties combined with the relative lack of middle-aged caregivers and the lower supply of other long-term care options mean that family caregivers in the rural communities of our state are stretched quite thin.
- Caregiver ratios measure the number of persons 85+ compared to the number of females ages 45–64 (who are the typical caregivers). These ratios provide a way to compare the availability of caregivers in Minnesota and in each county. In 2000, there were 15 persons 85+ for every 100 caregivers for the state as a whole. By 2030, this ratio will climb to 23 per 100. (See Figure 9.) In the urban/suburban areas with younger populations, caregiver ratios will be lower. But in the more rural counties with fewer younger people and higher proportions of persons 85+, the caregiver ratios will be extremely high. The limited numbers of caregivers mean fewer daughters, daughters-in-law and workers available to fill long-term care jobs.

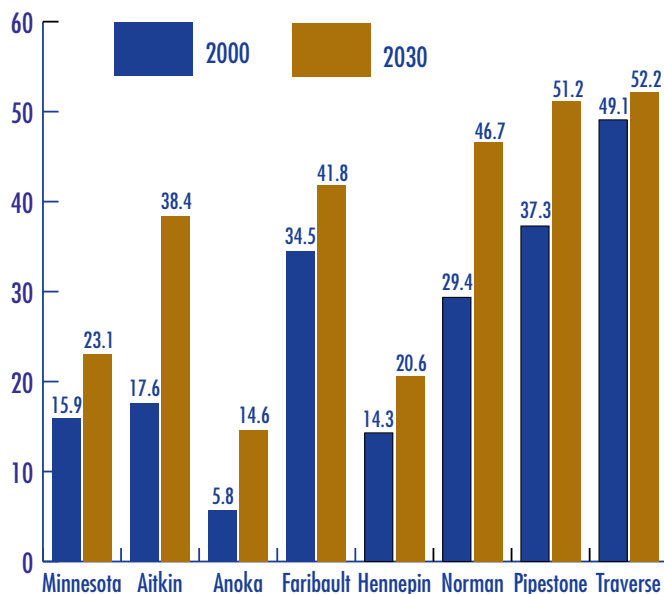
■ Another trend that will affect caregiving in the future is the increase in individuals who do not have the personal and family resources to provide support. In addition, a relatively new caregiving trend that affects many boomers is the increased numbers of grandparents who are raising their grandchildren. They are facing many complex challenges as they try to care for their children's children.

*“There are only four kinds of people in this world: those who have been caregivers, those who currently are caregivers, those who will be caregivers and those who will need caregivers.”*

*--Former First Lady Rosalynn Carter*



**Figure 9. Number of Elderly 85+ per 100 Caregivers in Minnesota and Selected Counties: 2000 and 2030**



Source: US 2000 Census, Minnesota State Demographic Center, 2005

### What if we do nothing?

- The percent of care provided by families will decline faster in the future, and this reduced availability of informal care will increase demand for formal long-term care. This expense will strain the retirement incomes of low- and moderate-income boomers.
- The need to purchase formal long-term care will hasten the dependence of individuals on public programs and the public cost of providing long-term care to frail elderly will rise steeply.
- If working caregivers do not receive eldercare supports, businesses will face the loss of productivity in their workforce, workplace disruptions and replacement costs for employees who must leave the workforce to care for relatives, increasing the cost of doing business.
- If grandparents are not supported in raising their grandchildren, the grandchildren will need to be served in other alternatives such as foster care, a more expensive and less preferred solution.

### What issues need to be addressed to prepare for 2010?

#### 1. Offering eldercare supports in all Minnesota workplaces.

It is estimated that there are approximately 500,000 adults caring for disabled adults and older individuals in Minnesota, or about 21 percent of the households in the state.<sup>31</sup> Most caregivers (60 percent) are working, the majority full-time, and most are caring for a parent or grandparent. About 15 percent of caregivers are providing care to someone who lives over an hour away.

In a 2004 AARP survey, close to 60 percent of the caregivers surveyed reported that

they had to go in late to work, leave work early or take time off to provide needed care. In addition, caregivers often must put their career plans on hold, as well as use their own money to pay for items needed by their older relatives but not covered by any insurance.<sup>32</sup>

Recent studies have documented the costs to business of lost productivity because of eldercare. The annual cost for U.S. businesses is a startling \$17 billion per year and an average of \$2,441 annually per employee who is a full-time employed “intense” caregiver. The most expensive factor is absenteeism estimated at \$3.4 billion per year totally and \$489 per employee per year.<sup>33</sup>

**Table 3. Total Estimated Cost to Employers of Full-Time Employed Intense Caregivers**

<b>Cost Factor</b>	<b>Cost Per Employee</b>	<b>Total Employer Cost</b>
Replacing employees	\$403	<b>\$2,822,461,694</b>
Absenteeism	\$489	<b>\$3,430,263,991</b>
Partial absenteeism	\$118	<b>\$824,512,465</b>
Workday interruptions	\$404	<b>\$2,832,971,162</b>
Eldercare crisis	\$232	<b>\$1,628,347,501</b>
Supervisor time	\$111	<b>\$780,268,472</b>
Unpaid leave	\$206	<b>\$1,447,420,001</b>
Full-time to part-time	\$478	<b>\$3,349,727,407</b>
<b>Total</b>	<b>\$2,441</b>	<b>\$17,115,972,695</b>

Source: The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business, July 2006



When asked what would help them the most and make caregiving easier for them, working caregivers consistently mention flexible schedules and the ability to take time off when needed. Also mentioned is access to “decision support services” that includes help completing insurance paperwork and managing financial matters, elder law services and access to geriatric management services.<sup>34</sup>

Surveys indicate that employers increasingly see the need for eldercare services for their employees because of the importance of these services in maintaining high levels of productivity. Employers who offer eldercare services report decreased absenteeism and turnover and higher job satisfaction and morale. Right now, eldercare services tend to be more available at large employers. However, most Minnesota employees work for mid-size or small employers and do not have these services available.

Those who attended the 2010 meetings recognized that most caregivers now and in the future will be in the labor force and thus will need various types of assistance and services as a supplement to what the caregivers are able to provide. Many said that eldercare resources need to be as available as child care resources.

They suggested that employers need to be as flexible as they can be to allow working caregivers the ability to rearrange their hours to accommodate caregiver needs and ask their caregiving employees about the types of assistance they could use.

### Suggested Action Steps

1. Increase the availability of employer-based eldercare benefits, e.g., lunchtime seminars for caregivers, access to care coordinators and expanding the definition of who can be cared for using personal sick leave.
2. Broaden the Family Medical Leave Act (FMLA) to include more relatives who can be cared for under the law.
3. Publicize Minnesota’s consumer-directed options (similar to the “Vermont” model) that pay families, friends or others to provide care and assistance to frail elderly on publicly funded programs.
4. Provide tax incentives and benefits for working caregivers, e.g., tax credits, use of flexible spending account for caregiving expenses.

## 2. Increasing the supply and the types of caregiver supports and the public awareness of the services.

Services to family caregivers have been available for the past 20 years, including support groups, respite services, adult day care, training and geriatric case management. However, the take-up of these services has been somewhat mixed for a number of reasons. Many caregivers simply do not know that services are available, do not perceive a need for them and are reluctant to accept help.

A new generation of caregiver services is emerging, based upon surveys of past and present caregivers and a growing understanding of what helps caregivers most. These services are more flexible, more tailored to the specific needs of individual caregivers and available when the caregiver needs them, rather than during regular agency hours. An example is the caregiver coach, most often a social worker or a nurse who can be a consistent advisor to caregivers and available whenever they have questions or issues.

Participants at the 2010 meetings 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. Those attending the meetings from ethnic, immigrant and tribal communities spoke of the push and pull of deep-seated traditional and religious family obligations to care for elders versus the need for all family members to work 24/7 to have enough income and get ahead economically. Some groups also said they do not expect their children to care for them when they get old because they do not want to be a burden to them in the future.

One of the suggestions for new ways to reach out to caregivers was to establish very visible, local caregiver resource centers in every community. Another suggestion involved redesigning all caregiver services — those for parents, spouses, siblings or adult children caring for relatives of all ages with a range of disabilities — so that they were integrated into one resource center or



program. Paying family members to be caregivers, rather than paying strangers to provide care, was an important theme for ethnic, immigrant and tribal communities.

### **Suggested Action Steps**

1. Develop one-stop resource centers for caregivers in local communities and use the developing aging and disability resource centers (through the Minnesota Board on Aging) for this effort.
2. Consolidate all caregiver services in each community, to eliminate artificial age or other restrictions.
3. Make all health and aging services more “caregiver-friendly” and encourage service agencies to design their services to “wrap around” family caregivers.
4. Expand the availability of professionals trained as “navigators” or “coaches” who can provide “24/7” advice and counsel to caregivers.
5. Greatly expand community awareness of caregivers and what they do and the type of help they might need from community residents.

### **3. Activating networks of neighbors and faith communities to support individuals who do not have family or other social support.**

Between 2000 and 2030, the number of Minnesotans 65+ living alone will double, from 177,000 in 2000 to 355,000 in 2030. We have already reached the highest figures of one-person households we have ever had in the state (and nation), part of the demographic and social trends that have occurred over the past 30 years. This includes many more persons who have never married and more divorced individuals who have not remarried.

Not only will more persons be alone but the average family size is shrinking and thus these people will have smaller family networks to call upon for support. Research shows that persons who live alone are the ones most likely to use formal sources of support. While the formal service system can provide essential services, it is less able to substitute for other supports families usually provide, e.g., social interaction, emotional support, emergency assistance.

The Minnesotans who attended our 2010 meetings saw an important role for faith communities and similar community institutions to reach out to those who are single without their own networks. (It was recognized that there are many single individuals who do have extensive social networks and do not need the type of assistance envisioned here.)

Many of the programs that now serve older persons provide services to those whose families are not available. There are some programs, such as the Little Brothers Friends of the Elderly, whose primary mission is to provide assistance and social support to those who are alone and do not have family. Their services include hosting the types of events that families would provide such as birthday parties and holiday dinners, as well as transportation, help in emergencies and regular contact.

**Suggested Action Steps**

1. Encourage communities to support models that offer connections between individuals living alone and neighbors, faith communities and community volunteers.
2. Agencies should develop programs that serve older adults who are alone.
3. Encourage new types of housing, e.g., co-housing and home sharing, such as “Golden Girls” homes, which offer a sense of community as well as intergenerational and peer support for single older adults.

**4. Ensuring that grandparents raising grandchildren have access to existing programs intended to help families with children.**

The percent of grandparents raising grandchildren has risen exponentially in the past 10 years. Nationally, the number has increased 66 percent since 1990. A multitude of societal changes contribute to the increasing number of grandchildren living with grandparents, including death of a parent, lack of financial resources, divorce of parents, parents abandoning children, parents with drug and/or alcohol addiction, incarcerated parent(s), teen pregnancy, child abuse or neglect and HIV/AIDS.

According to the 2000 Census, Minnesota has about 34,000 children living in grandparent-headed households and about 18,000 grandparents report they are responsible for the grandchildren living with them. About 10 percent of these are African American, 7 percent are American Indian, 6 percent are Hispanic and 70 percent are White. About 30 percent have taken care of their grandchildren for five or more years, 29 percent have provided care for less than one year. A total of 24 percent of the grandparents are age 60 and over, and 10 percent live in poverty.<sup>35</sup>

While the grandparents provide a stable source of discipline and guidance, the drain on these individuals or couples can be substantial. The average age of these grandparents is mid-50s. They may have quit their jobs to take care of especially young children or are using retirement income to provide for the basic needs of the grandchildren. The availability of health insurance for the children can also be an issue, and certain services or benefits for children that parents can obtain may not be available to grandparents or may be difficult to access.

Participants at the 2010 meetings suggested a number of things to help grandparents raising grandchildren. The present system is difficult to maneuver with its complicated policies and procedures and little coordination between various programs and departments. Those who are raising grandchildren want a more open system of support, not one of hidden benefits that they discover by chance. Also needed is greater community awareness so that communities know about these situations and can provide support to the grandparents. This was a particular topic at meetings with the tribal organizations. It is very common on the reservations for grandparents to be raising their grandchildren, and they face many issues when they try to obtain services and financial assistance.



**Suggested Action Steps**

1. Explore the reimbursement of grandparents as foster care providers in some cases (when the children have disabilities, for example) so that additional financial support is available to grandparents for the care of their grandchildren.
2. Designate or create a place where grandparents can get one-on-one assistance to help them access available supports for their grandchildren.
3. Examine public and private family support programs to identify and remove barriers that grandparents may encounter when seeking services for their grandchildren.



### 3. Fostering Communities for a Lifetime

Minnesota's communities should be good places to grow up and grow old, and offer physical, social and service features for their residents of all ages.

#### Why is this important?

- According to national surveys and the most recent Survey of Older Minnesotans, most boomers and current older people want to remain in their own homes and communities as long as possible and “age in place” there. They are more likely to be able to do so if they live in “communities for a lifetime.”
- Although many names are used, including “age-friendly” communities or “communities for all ages,” they all refer to communities that have the elements needed to provide physical, social and service supports to their residents of all ages and abilities. These communities are good places to grow up and grow old. The elements that make communities good for one group, such as the elderly, also make communities good for children, e.g., safety and security, barrier-free community design and public spaces, health care and transportation. The whole community benefits from participation of older residents in volunteer or paid work and civic activities. And the local economy benefits from the patronage of older consumers, who tend to be more loyal to local businesses than younger residents.<sup>36</sup>
- The key elements of good communities referred to in these discussions include:
  1. **Physical infrastructures or the built environment.** This can include accessible community design and mobility options, such as sidewalks, walking and biking trails, features that support the ability to drive safely longer; and various types of transit or volunteer transportation options. Also included is a mix of housing choices — from home modification services that adapt single family homes to address physical limitations of residents who are elderly or have disabilities — to a range of housing types, sizes, service levels and affordability options.
  2. **Social infrastructures or the opportunities for social connections.** These options foster a sense of responsibility across groups and generations. They can include programs that connect generations; volunteer and civic engagement options; block clubs that help residents get to know and watch out for their neighbors; and community-wide events that build friendships and trust based upon shared experiences.
  3. **Service infrastructures or the offering of an array of products and services to support residents.** The services include access to information, perhaps a community resource center; a range of health care services and facilities, including hospitals, clinics, nursing homes, public health services, wellness programs; a spectrum of home-based services, such as chore and home maintenance, nutrition, caregiver supports; transportation; public safety and emergency services; stores, restaurants, banks, professional services, schools and libraries; sources for education and job training; and parks, recreation and leisure time pursuits. (Small communities will have a smaller array of these services.)

*“Design for the young and you exclude the old; design for the old and you include the young.”*

*Bernard Isaacs,  
founding Director  
of the Birmingham  
Centre for Applied  
Gerontology*

- Communities are an important source of affordable support for persons as they age, especially those whose incomes are too low to afford the full price of services. The numbers of older people with inadequate incomes will grow significantly in the future, and they will, by necessity, turn first to their families and communities for support.
- As the percent of persons 65+ in communities across Minnesota dramatically increases, many communities will need assistance to develop the elements necessary to support their aging residents. There have been many excellent efforts begun over the past 10 years to create communities for a lifetime in various parts of the state. Minnesota has 854 cities, many neighborhoods in larger cities, as well as 1,800 townships and 87 counties. A more coordinated and comprehensive approach is needed to achieve the goal of creating the key elements of communities for a lifetime across the state.

### What if we do nothing?

- If their home communities do not have the support elements they need, older people will be forced to move to other communities, disrupting the patterns of nearby help from their informal network of family, friends and neighbors and requiring substitution with formal, paid help in most cases.
- Because communities are an important source of affordable help for persons as they age, if this were to be reduced or unavailable, low-income persons would be forced to go on publicly funded services more quickly than otherwise.
- There is a growing body of research that documents the ill effects of “non friendly” communities on health, wellness, isolation and depression. One study found that communities that were not walkable had higher rates of social isolation and depression than communities with walking trails and easy ways for residents to connect with one another.<sup>37</sup>

### What issues need to be addressed to prepare for 2010?

#### 1. Supporting assessment and planning efforts to develop healthy communities for a lifetime.

According to the report *Blueprint for Action: Developing a Livable Community for All Ages*, only 46 percent of the communities in the United State have begun planning to meet the need of the “exploding population of aging baby boomers.”<sup>38</sup> In Minnesota, work has started at the neighborhood, city, county and state levels to identify the types of changes needed within communities and to integrate these changes into the planning efforts at the local level.

Between now and 2030, the greatest growth in the 65+ population will occur in suburban areas of the Twin Cities Metro Area, especially Hennepin, Anoka, Dakota, and Washington counties. These counties have been growing rapidly and many middle-aged boomers will age in place in those suburbs over the next 25 years. These suburbs already notice growing demand for the elements of communities for a lifetime. One of these counties—Dakota County—has just completed a comprehensive plan for its aging

# Transform 2010: Preparing Minnesota for the Age Wave Summary of Vision, Themes and Strategies

**Overall vision: Minnesota is a place where people live well and age well, and help others in their community to do the same.**

Strategies will include plans to work with ethnic, immigrant and tribal communities on how to successfully implement these actions.

Strategies will be implemented in ways that provide access to persons with physical, mental and communication disabilities and take urban, suburban and rural perspectives into account.

## Redefining Work and Retirement

Minnesota should encourage individuals to continue working in both paid and nonpaid roles, and prepare for their retirement and old age.

1. Transform public and private retirement and employment policies to better reflect demographic realities and support continued work.
2. Transform Minnesota's post-secondary education system and employer-based training to meet the education and training needs of an aging workforce.
3. Encourage individuals to plan and "self-invest" in financial planning for a lifetime.
4. Engage Minnesotans in vital aging opportunities as they age.
5. Expand the options available to individuals to pay for long-term care costs.
6. Strengthen federal income and health programs that provide the foundation for individual retirement security.

## Supporting Caregivers of All Ages

Minnesota needs to slow the decline of family caregiving by offering eldercare in all workplaces and redesigning services to wrap around family care.

1. Offer eldercare supports in all Minnesota workplaces.
2. Increase supply and types of caregiver supports and the public awareness of the services.
3. Activate networks of neighbors and faith communities to support individuals who do not have family or other social support.
4. Ensure that grandparents raising grandchildren have access to existing programs intended to help families with children.

## Fostering Communities for a Lifetime

Minnesota's communities should be good places to grow up and grow old, and offer physical, social and service features for their residents of all ages.

1. Support assessment and planning efforts to develop healthy communities for a lifetime.
2. Transform the physical infrastructures of communities, including housing, mobility options and accessible public space.
3. Foster social connections that build "community" among residents and nurture a sense of responsibility across generations.
4. Expand the range of products and services that help community residents stay independent and engaged as they age.

## Improving Health and Long-Term Care

Minnesota must transform its health care, promote good health for all, improve chronic care and intensify its long-term care reform.

1. Transform health care in Minnesota so that it provides access and quality at an affordable cost for all Minnesotans.
2. Ensure that Minnesotans have access to good chronic care management and receive standards of care known to be most effective.
3. Transform long-term care to increase consumer control over the where, who and how of service provision.
4. Provide individuals with the information they need to make good decisions about lifestyle and health habits.
5. Recruit and retain a stable health and long-term care workforce that has geriatric competence to serve older people.
6. Prepare the mental and chemical health systems for increased demand from aging boomers.

## Maximizing Use of Technology

Minnesota should use technology to maximize the benefits and minimize the hazards that accompany its permanent age shift.

1. Transform health care through use of evidence-based technology, achieving both efficiencies and savings while improving outcomes and quality.
2. Expand use of technology that helps people help themselves, e.g., home modifications, assistive devices and safety systems.
3. Use telehealth and related technology to address worker shortages and distance issues.
4. Utilize the Internet and related technology to expand access to information about resources for consumers and their families.
5. Redesign management information systems to support performance and results measurement.

population over the next 25 years and is preparing for the upcoming changes. Similar efforts are underway in Carver County within the Metro Area, several suburban cities and other counties throughout the state.

Those who attended the 2010 meetings recommended that the state set goals for Minnesota communities to develop the key elements of a community for a lifetime by 2010. They also talked about the need to get information and assistance to communities to help them through the process of planning and determining the most important changes they should make. Many statewide organizations (and their local affiliates) have a stake in these efforts and they all need to be brought to the table to participate and contribute.

<b>Suggested Action Steps</b>
1. Set a goal that 50 percent of Minnesota communities will have the key elements of a community for a lifetime by 2010, and 100 percent by 2015.
2. State agencies should partner with other public and private groups to develop criteria that can be used to measure progress made toward making all Minnesota communities into communities for a lifetime.
3. State agencies should streamline access to state resources available to communities to help them develop the elements of communities for a lifetime.
4. Involve Minnesota League of Cities, Association of Minnesota Counties, Minnesota Area Agencies on Aging, Minnesota Council of Churches, Minnesota Chamber of Commerce and other similar organizations in efforts to develop communities for a lifetime.

**2. Transforming the physical infrastructures of communities, including housing, mobility options, and accessible public space.**

The built environment and other physical infrastructures within a community include housing, schools, highways and roads, parks and general land use. Because older people tend to age in place, they are more sensitive to the availability and extent of these infrastructures. If they are supportive, older people (and residents of all ages) are enabled to age in place and take care of their own needs longer. If they are not supportive, residents face increasing difficulties as they age, needing more support but unable to find it and, as a result, reduce their participation in the activities within the community.

A supportive built environment also encourages active living, which is increasingly important to aging baby boomers. Active living integrates physical activity into daily routines, reduces the costs associated with social services and health care and yields a range of social and economic benefits by extending and expanding older adults' contributions to civic life. These outcomes are important to local governments because instead of seeing their aging residents as a social service issue, they see their older residents as a resource to their community.<sup>39</sup>

## Housing Options

The vast majority of current older persons and aging baby boomers plan to remain in their current home, primarily a single-family home, and age in place. According to the 2005 Survey of Older Minnesotans, 78.8 percent of Minnesotans over 50 are living in a single family home, 7.6 percent are in a multi-family home and 14.3 percent live in an apartment. About 32 percent of Minnesotans over 50 who live in an apartment live in housing planned specifically for seniors. This increases to 47.9 percent for Minnesotans over 65.<sup>40</sup>

Nearly 80 percent of the Minnesotans over 50 surveyed said they had no plans to move, which would indicate that they are planning to age in place and remain in their current housing for some time, until a crisis or major change occurs. A significant proportion of those surveyed indicated that they did need some type of assistance to stay in their home, including ongoing maintenance and repair (23.8 percent), structural upkeep (18.9 percent) and accessible features (6.9 percent).<sup>41</sup>

Current and future housing for boomers was a big topic at the 2010 meetings. Some commented that the state's current housing stock, which is nearly all single family homes, is not accessible for persons as they age, and this will cause problems for boomers as they grow old. Participants spoke of the challenges faced by housing providers as boomers begin to shop for retirement housing. When boomers move, they are not "downsizing" as their parents did. Instead, they are looking for options that relieve them of home maintenance but give them more and different space, often in age-integrated communities. Many participants felt that the current stock of senior-only housing and assisted living options will not meet the needs and wants of boomers as they retire.



## Mobility and Transportation Options

Another component of the built environment in communities is mobility and transportation. Baby boomers consider driving their car a right (not a privilege) and a symbol of independence and freedom. Driving enables individuals to continue to be involved in the community and take care of their own needs within their community. According to the Survey of Older Minnesotans, 92.5 percent of those 50 and over are drivers or a spouse of drivers. About 9 percent of those surveyed indicated that they lacked transportation and were unable to go somewhere during the last month because they could not drive or did not have transportation.<sup>42</sup> It is also significant that many drivers, as they grow older, limit their driving because of concerns about safety. Safety concerns include road signage that can't be read and problems driving at night, in bad weather or during rush hours.

Those who do not drive or are not a spouse of a driver usually depend upon others—family, friends, volunteers—for transportation to get around. Public transportation and special demand-responsive transportation programs (often funded through state and local governments, charitable organizations and/or Title III Older Americans Act funds) provide service to some of those unable to drive. Increasingly, other mobility options are used. For example, good sidewalks and trails encourage community residents to walk to nearby destinations or for exercise. Also important are biking trails and accessibility features that allow rollability on sidewalks and trails for those on bikes, using strollers or walkers or in wheelchairs.

Participants at the 2010 meetings emphasized that, as the proportion of older people doubles across the state in the next 25 years, transportation needs and issues will become critical. Much of the increase in the older population will occur in the suburban and rural portions of the state, where dependence on the car is predominant and public transportation options are scarce. For boomers who age in place in the suburbs, the lack of a car will be even more limiting because it is often difficult or unsafe to walk or bike to destinations, such as grocery stores and other shops. Some suburbs do not have sidewalks and the typical layout of suburbs places stores and facilities far away from residential areas.

The issue of transportation was brought up more than any other community feature at the 2010 meetings. Those attending mentioned the need to make it possible to drive safely longer, have transit options available and to increase the walkability within all communities.

**Suggested Action Steps**

1. Public and private groups should offer grant funds, technical assistance, model comprehensive planning and zoning guidelines to municipalities and counties in their role as planners of the physical infrastructures of communities.
2. Make changes in highway and road systems that help older persons drive safely longer, including redesigned and larger street signs, non-glare traffic signs and assistive devices on cars, such as additional mirrors, swivel seats, warning lights or horns.
3. Support the recent recommendations of the Governor's Commission on Transportation Coordination, which identified ways to more effectively coordinate public and private transportation programs and maximize the use of all resources to meet the needs of our aging population in the future.
4. Identify gaps in transportation programs (counties without minimal coverage) and work with partners to develop options to fill these gaps.
5. Develop a cohesive system for home modification that links the key components — including in-home assessment, builders truly knowledgeable about accessible construction and access to products needed to modify the home — so that each region of the state has a workable system in place before the boomers begin to demand these services.
6. Encourage all communities to develop housing options that offer a mix of types, service levels and affordability for people as they age.
7. Promote the principles of “visitability” and core universal design features in any new housing construction, including features that improve access for those with communication, hearing, visual, physical or mental disabilities.
8. Continue the “Fit City” program, administered by the Department of Health, to encourage cities to support the fitness and wellness of their residents.
9. Encourage cities to use zoning in creative ways to build new housing options for aging boomers, e.g., small homes all on one level, cluster homes that include association fees to handle maintenance and upkeep, co-housing, accessory units.

**3. Fostering social connections that build “community” among residents and nurture a sense of responsibility across generations.**

There are several reasons why social connections and community engagement are particularly important to older persons. They can provide ways to develop new social roles as one ages. Helping at the community level generates a positive outlook. Strong communities have active groups that are working together to improve life in the community. Participating in these groups can result in better physical and mental health for individuals and strengthen communities as well.<sup>43</sup>

A critical component of communities is safety and security, including the need for adult protection services for vulnerable adults. Just as important as the formal protective

services are the “eyes and ears on the street” when neighbors and friends are aware of the daily lives of their elderly neighbors and notice changes in behavior or habits. As older boomers remain in their homes and communities to age in place and do not move to congregate care settings, these elements within communities will be critical to address unfortunate but real increases in the prevalence of abuse, neglect and exploitation of older persons.

Participants at the 2010 meetings generated long lists of social components that good communities should have. There is a need to develop and strengthen intergenerational ties so that the residents of various ages know each other as individuals. It is important for communities to provide ways for neighbors to get to know neighbors, so that residents feel comfortable asking for help and offering help. This support becomes important as people age and need assistance but may not have enough money (or be unwilling to use limited funds in that way) to pay the cost of formal services.

### Suggested Action Steps

1. Increase the opportunities for social connections that community residents have with each other and the civic engagement opportunities available to all residents.
2. Support an adult protection response team in every county. Design and implement a major public education and awareness campaign about the important role of community “eyes and ears on the street” and create a greater sense of responsibility among concerned neighbors and friends for vulnerable adults in local communities.
3. Expand the number of communities that have local Living at Home/Block Nurse programs, parish nurse programs and faith-in-action models that focus community attention and time on older residents who need help and support to stay in their homes.
4. Identify creative ways to invite families of all ages, sizes and types together for social events, e.g., picnics, clean-up days, so that residents can develop social connections.



#### **4. Expanding the range of products and services that help community residents stay independent and engaged as they age.**

The goods and services purchased by older persons—groceries, prescription drugs, housing, health services, nursing home care—are critical to the economy and vitality of many communities. Older residents are loyal to local businesses and stores located in their community. If older people are not able to obtain the services and products they need in their home community, they often must move to another place to get their needs met, even though they may prefer to stay.

Those who attended 2010 meetings pointed to the problems many older residents have accessing senior services when they need them. Senior services are often provided by several different agencies and may be unfamiliar to aging boomers as well as current older people. Redesign of services to introduce the concept of one-stop resource centers and more holistic centers or programs was recommended for the future so that people could access information and services easily and quickly when necessary. Many suggestions were made for how these services could be advertised and marketed to those who may need them.

The participants also discussed the need for businesses in aging communities to think about the changing needs of their customers, and create or repackaging products and services in ways that better meet these needs.

##### **Suggested Action Steps**

1. Businesses in local communities should identify product needs of older households, to develop special service and product offerings such as grocery home delivery, small packages, etc.
2. Educate local public service staff, i.e., fire, police, post office, on ways to support older people in their homes and communities.
3. Encourage product and technology innovations by local businesses and organizations that can enhance the independence and choice of older adults.
4. Create or designate one-stop resource centers for information and access to aging and disability services in every community.
5. Make sure that all communities have the four core support services that help older residents remain independent: nutrition services; affordable chore and home maintenance services; transportation; and caregiver respite services.
6. Maintain or develop a full continuum of health services and facilities to meet the needs of community residents as they age.

## 4. Improving Health and Long-Term Care

**Minnesota must transform its health care, promote good health for all, improve chronic care and intensify its long-term care reform.**

### **Why is this important?**

- One of the greatest challenges of 2010 and beyond will be the increased need for health and long-term care by an aging population. The mortality rate from heart disease and other conditions has dropped substantially over the past 20 years but the prevalence of other chronic conditions, such as diabetes, arthritis and Alzheimers, has gone up. Barring major medical breakthroughs for prevention or treatment of these conditions, we can expect major increases in the future number of older persons with chronic conditions requiring care and treatment.
- However, we have not yet made the transition to “chronic care” in our health system and continue to focus on acute care and long-term care as separate entities. The public sector in Minnesota has developed products for its Medicaid clients that improve chronic care and integrate health and long-term care, e.g., Minnesota Senior Health Options (MSHO) and Minnesota Disability Options (MDO). However, there are few, if any, similar products available for the much larger group of Medicare-only beneficiaries.
- Preventing or delaying disease is still one of the most promising strategies for reducing costs and giving oneself the gift of a healthier life in later years. Promoting good health is becoming an important message, but there are still many individuals who are not making needed lifestyle changes.
- Minnesota continues to have troubling health disparities between its ethnic, immigrant and tribal communities and its white community and, as the presence of these communities grows, it is important to understand and address the underlying causes of these disparities.
- A transformation of long-term care will be needed in time to serve the 85+ population of boomers that will dramatically increase after 2030. Although important reforms have begun, our current system does not provide the degree of control that boomers will demand over where care is provided, who provides the care and how it is provided. In addition, given the projections for growing vacancies in health and long-term care fields, major efforts are also required to recruit and retain the workforce needed by 2030.

*“Chronic conditions are more and more common and yet our health care tends toward acute and episodic care, an expensive misallocation of resources.”*

*—AARP, 2005*

## What if we do nothing?

- If healthy lifestyles do not become the norm, the incidence of chronic conditions and disability rates will rise quickly, as will the cost of treating these conditions.
- If we do not address chronic care management more aggressively, meeting the health care needs of the growing numbers of older people with chronic conditions will overwhelm the existing system, “preventable” hospitalizations will increase, adding stress to the individual (and family), which can lead to quicker decline and death for elderly with multiple chronic conditions.
- If reform of long-term care does not continue, Minnesota will go backwards, increasing its use of institutional care.
- If solutions are not found for health and long-term care labor force shortages, needed services will not be available and the costs of the services that are available will skyrocket. Elderly people will need to make do with ill-trained and overburdened helpers; others who would prefer to live on their own will be forced into congregate settings.
- The health disparities between Minnesota’s ethnic, immigrant and tribal communities and the white community will affect the ability of these communities to remain productive and enjoy the same quality of health and life that other groups in the state have.

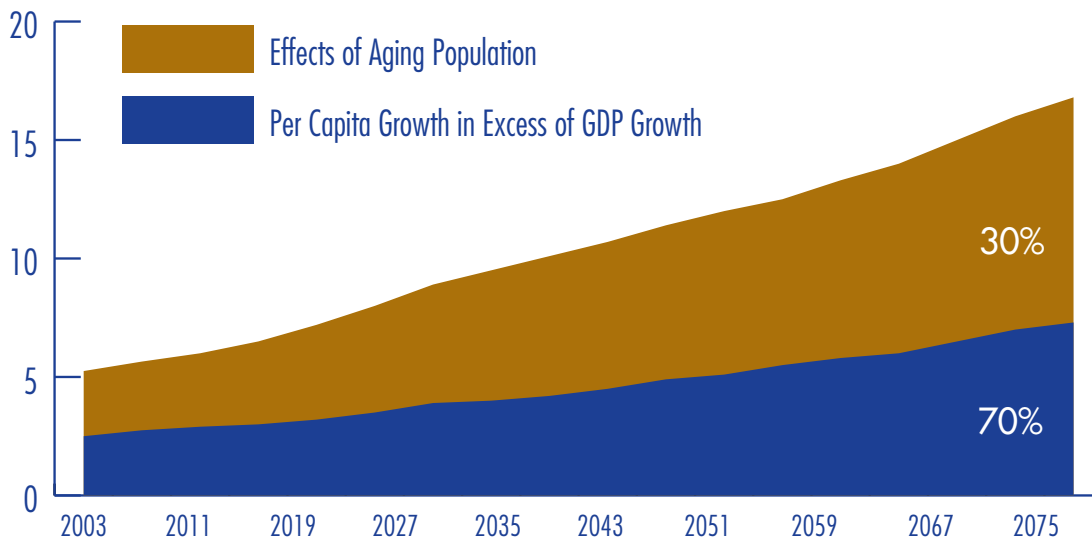
## What issues need to be addressed to prepare for 2010?

### 1. Transforming health care in Minnesota so that it provides access and quality at an affordable cost for all Minnesotans.

The health care system becomes one of the most important systems in an aging society because older people have more illnesses and use more health care than younger age groups. Experts have been warning for years about the need to reform health care and find a way to control the rising costs before the large baby boom generation turns 65 and ushers in the dramatic age shift in our population.

The Congressional Budget Office (CBO) estimates that Medicare costs will rise from 2.5 percent of Gross Domestic Product (GDP) in 2002 to 9.2 percent in 2075 (see Figure 11). According to the CBO, *approximately 30 percent of that growth is due to society’s aging; the remaining 70 percent is attributable to general growth in health care costs in excess of the rate of GDP growth.*<sup>44</sup> The primary assumptions behind the expected rising health costs are that the organization and delivery of medicine in the future will be the same as they are today. This may not be the case. In fact, “sensible policy changes and structural reforms conceivably could save much more money than the added costs that the aging of the population generates.”<sup>45</sup> Researchers point to the current variations in the amount Medicare spends in different parts of the country (including Minnesota where costs are lower) and the fact that expenditures do not seem to be linked to better or worse outcomes.

**Figure 10. Projected Long-Term Growth of Medicare Spending (as a percentage of GDP)**



Source: Congressional Budget Office, 2003

The participants at the 2010 meetings talked about the need to find a way to reform the state’s health care system and ensure that Minnesotans have health coverage. Because of increasing costs, insurers and employers are shifting more costs to consumers. Sometimes this amount is unaffordable, and consumers then drop the coverage and go without. As more workers (both younger and mature workers) experience transitions in their work life, health coverage during these transitions is either impossible to obtain or extremely expensive. As costs continue to go up and as increasing numbers of our population do not fit neatly into “full-time employment,” the traditional mode for obtaining health coverage, participants said we need to rethink how best to provide this essential coverage. Many said we need to completely redesign the system so that it addresses the problems of access and cost for individuals but also reforms the way that care is delivered.

**Suggested Action Steps**

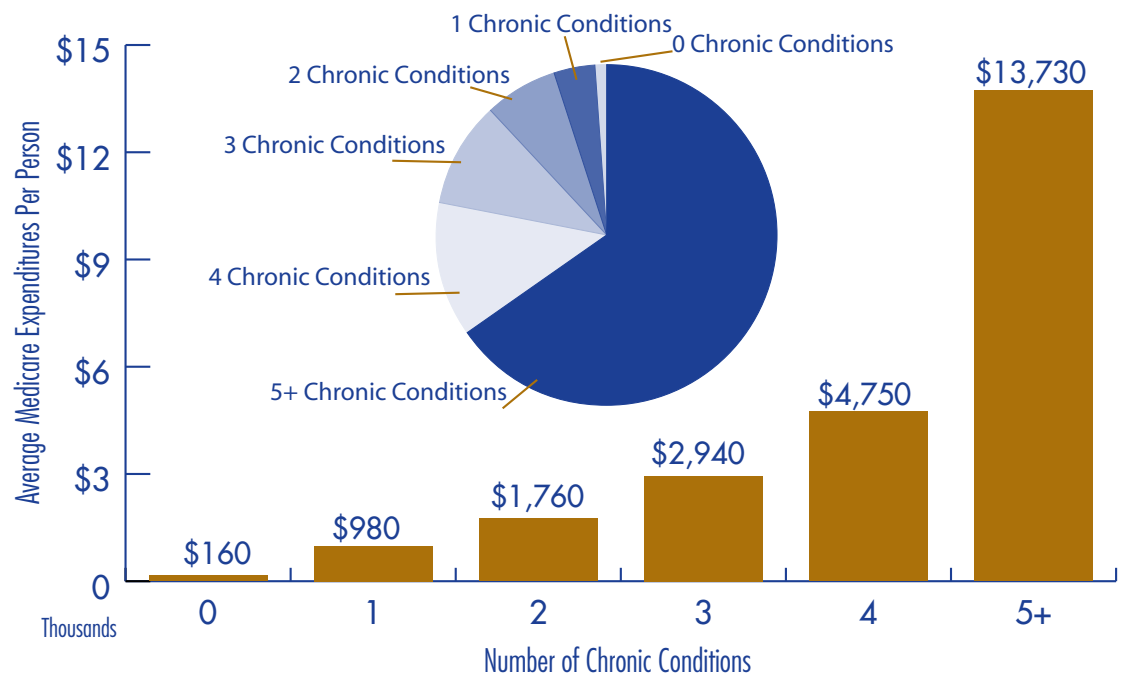
1. Ensure that Minnesotans of all ages can obtain health insurance coverage so they have continuity of care and attention to preventive care.
2. Explore options for health insurance coverage for older adults under age 65 who are uninsured because of job layoffs or career transitions and are unable to find affordable options in the private market.
3. Support the work of the Governor and the Legislature as they develop a new model for health coverage for Minnesota.

**2. Ensuring that Minnesotans have access to good chronic care management and receive standards of care known to be most effective.**

Chronic illness goes hand in hand with an aging population and already we are seeing major increases in many of these conditions within Minnesota’s aging population. Chronic conditions last a year or longer, limit what one can do, and/or may require ongoing medical care.<sup>46</sup> Nearly one-half (48 percent) of individuals with chronic conditions have more than one. For example, an older person may have high blood pressure, diabetes and kidney disease.

Proper care of persons with chronic conditions is critical because of the many interactions that can occur between the specific conditions and the treatments and the expense of providing treatments. Two-thirds of Medicare spending is for people with five or more chronic conditions, but they represent only 20 percent of the Medicare population. (See Figure 11.) Without proper management, these individuals are very likely to experience preventable hospitalizations and these hospital stays can result in further functional decline and increased burden on the family. This, in turn, can increase the risk of institutionalization and medical instability.

**Figure 11. Two-thirds of Medicare Spending is for People With 5+ Chronic Conditions**



Source: Partnership for Solutions, Medicare Standard Analytic file, 1999

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. The acute model treats immediate, single episodes, but does not work well for chronic health conditions. Coordination of all the health care system pieces across specialties and across settings, which is required for good chronic care, is beyond the capability of individuals and their families.

**Suggested Action Steps**

1. Encourage employers and payors to include chronic care management outcomes in all contracts with health plans that serve Minnesotans.
2. Change Medicare reimbursement to pay physicians to integrate and coordinate the care for their patients with multiple chronic conditions.
3. Encourage development of PACE programs and Special Needs Plans to expand integrated care options for older people in Minnesota.
4. Bring together health system and policy experts to explore the development and marketing of new integrated health and long-term care products to Minnesota's Medicare population.
5. Encourage older individuals to involve family members in their health care decision-making. Encourage physicians to include family members in office visits and care planning for their older patients.

**3. Transforming long-term care to increase consumer control over the where, who and how of service provision.**

Minnesota is five years into a comprehensive reform of its long-term care system. It has closed over 10,000 nursing home beds in the past 10 years, and more are likely to close in the future, due to the growing preference among older people for community options that now serve those who used to be placed in nursing homes. The remaining facilities may not always be well located or designed to best serve their future residents who will have much greater medical needs. As beds have closed, the supply of home and community-based services has grown but some parts of the state still need additional options in order to offer the menu of services and settings that the large group of frail boomers will demand. As our system moves to a more decentralized model of service delivery — in homes and communities rather than in institutional settings — the ways in which we measure and assure quality of long-term care also need to change.

According to a recent analysis of the future demand for nursing facilities by the Long-Term Care Imperative, there can be continued decline in the number of skilled care beds in Minnesota if: investments are made in home and community-service spending; acute care utilization per 1,000 population remains constant; an additional 16,649 assisted living units are constructed by 2030; and there is availability of family and community caregivers.<sup>47</sup>

The current and future status of Minnesota's nursing homes was a hot topic at the 2010 meetings. Those within the nursing home industry described major shifts in the numbers and types of individuals served in their facilities: most 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 or end-of-life care.

The nursing homes of the future will look more like “step-down” medical facilities than our current structures. Medicare's role in reimbursing for nursing facility care is increasing as the use of nursing homes for short-term rehab grows. Many commented that the state and all stakeholders need to think through the “nursing home of the future” and the implications of this new vision for how to regulate and finance this new model.

Elderly who need help with their activities of daily living (ADLs) are getting services in their homes or moving to assisted living facilities. Some commented on the important economic role that nursing homes play in their communities, often as the major employer in small communities, and the need to preserve the long-term care expertise of these providers as downsizing of the industry continues.

Participants at the meetings felt that there has been and will continue to be dramatic change in how long-term care is provided. Most boomers want to age in place and remain in their homes and communities as long as possible with the supports they choose provided by whom they choose and where they choose. At the same time, providers face ongoing challenges in providing an adequate array of home care services in all parts of the state. Those at the meetings spoke of the need for new models for delivery of home and community services to the next generation of elders, e.g., membership-based concierge models, models offering new types of group housing, “service bank” models, fee-for-service or sliding fee scale models. There is interest in more consumer-directed options where non-traditional workers are hired and paid directly by older persons, but many consumers and families hesitate to use these models because of legal and financial questions about these arrangements.



**Suggested Action Steps**

1. Continue to downsize the state's nursing facility system, through voluntary planned closures and incentives to offer single rooms.
2. Rethink the role of the nursing facility of the future and encourage development of new facility infrastructure across the state that can better care for future residents. Rethink the design, staffing, distribution of facilities within the regions, outcomes to be achieved and the reimbursement of these facilities.
3. Use consumer-directed models of service delivery that tailor the services to specific individuals and their culture, language and customs to better respond to the special needs of ethnic, immigrant and tribal elders.
4. Ensure that nursing facilities and assisted living residences include access to special services needed by those with communication, visual, sensory, physical or mental disabilities, and those from ethnic, immigrant and tribal communities.
5. Redesign long-term care services so that services are paid regardless of site of care and regardless of provider, to increase consumer control of these decisions.
6. Redesign home care to package the services and make it easier to use.
7. Explore the redesign of the Alternative Care (AC) program, to provide affordable home care service packages to moderate-income older persons, using a sliding fee scale based upon income.
8. The state should use the Community Service/Service Development grant program to support "outside-the-box" ideas and new models of long-term care.
9. Expand the use of volunteer advocates by the Office of Ombudsman for Older Minnesotans for persons in nursing facilities, assisted living facilities and home care programs.

**4. Providing individuals with the information they need to make good decisions about lifestyle and health habits.**

Minnesota is the healthiest state in the nation. According to the United Health Foundation, which ranks states each year, Minnesota has been the healthiest state in 11 out of the past 17 years that the survey has been completed. The factors that contribute to this rank include a low rate of uninsured residents, low percent of children in poverty and low infant mortality rates.<sup>48</sup>

However, if one looks closely at the status of subgroups, differences and disparities emerge. For example, nearly two-thirds of Minnesotans are overweight and, even more troubling, 15 percent of children are obese. This number has tripled since 1980, with children as young as 10 developing Type II (old age) diabetes.<sup>49</sup>

Health disparities between white communities and communities of color in Minnesota are particularly troubling. For example, mortality rates for heart disease and stroke are higher than overall state rates for American Indians, African American females and Asians.<sup>50</sup> Diabetes as an underlying cause of death in Minnesota was between 1.5 and 5 times more common among African Americans, Hispanics/Latinos and American

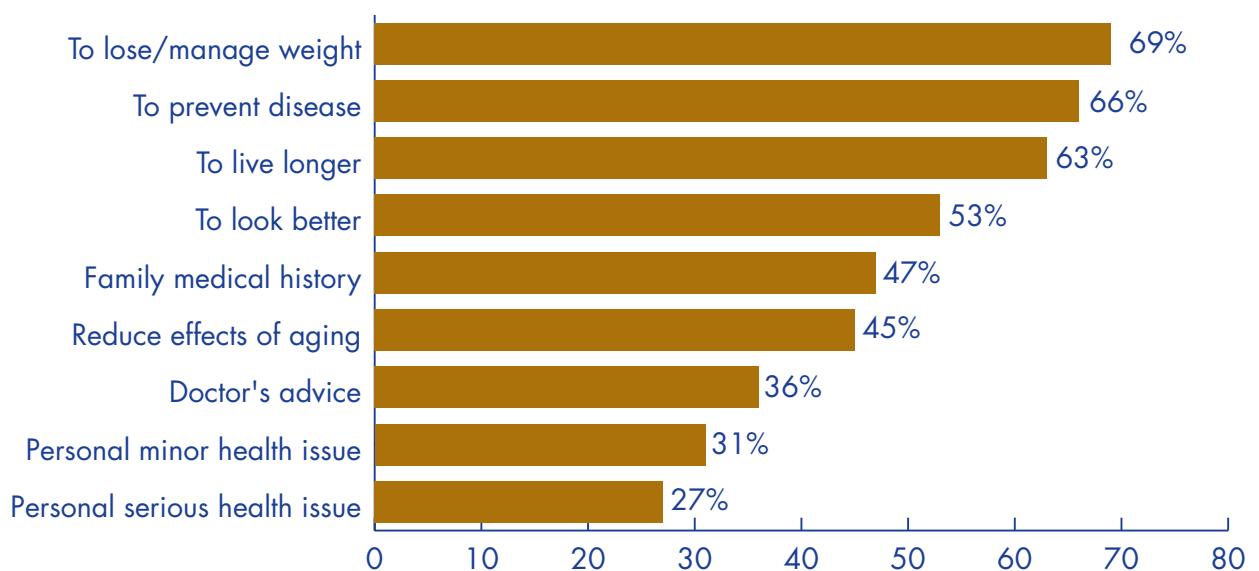
Indians than whites. Death from diabetes is increasing faster among African Americans than any other racial or ethnic group. Among people with diabetes, kidney failure is up to six times greater in populations of color; lower limb amputations are four times greater in American Indians; and eye disease is two times greater in Hispanics/Latinos, and 40-50 percent greater in African Americans.<sup>51</sup> The representatives of ethnic, immigrant and tribal communities emphasized the need for ongoing effective health promotion activities in their communities.

### Health Status of Boomers

Boomers are very concerned about maintaining their health as they age. The reasons boomers give for changing to a healthier lifestyle are primarily to lose weight, prevent disease, live longer or look better. (See Figure 12.) Almost one-third of boomers indicate that they are less healthy than they expected to be at their current age.<sup>52</sup> Boomers are assuming that advances in medical science will allow them to live a longer healthier life than their parents (85 percent), and that advances in health care are going to cure diseases they may get (68 percent).<sup>53</sup>

However, recent studies indicate that boomers are not as healthy as their parents were at the same age. Analysis of the results from the Health and Retirement Study, completed by the University of Pennsylvania, found that the first wave of boomers to enter the study reported poorer health than groups born in their parent's generation. They were less likely than earlier generations to describe their health as excellent or very good, and were more likely to report having difficulty with routine activities, such as walking several blocks or lifting 10 pounds. They were also more likely to report pain, drinking and psychiatric problems and chronic problems such as high blood pressure, high cholesterol and diabetes.<sup>54</sup>

**Figure 12. Reasons Boomers Give for Thinking Seriously about Healthier Lifestyles**



Source: NMI Healthy Aging/Boomer Database, Natural Marketing Institute, 2005

The importance of healthy living in order to prevent chronic conditions that lead to disability was a big topic of discussion at the 2010 meetings. There needs to be much more emphasis on early health promotion and disease prevention instead of focus on treatment of diseases once they appear. The common perception is that healthy living almost always involves doing things people do not want to do (sweating or exercising) or giving up things that people do not want to give up (favorite foods, smoking, drugs or alcohol). Participants at the meetings said 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.

**Suggested Action Steps**

1. Provide web-based and other tools that help individuals make healthy lifestyle choices.
2. Support local public health infrastructures and their role in community-wide health promotion and disease prevention for all ages.
3. Incorporate incentives for healthy behaviors and use of evidence-based protocols for chronic care management in all contracts with health plans.
4. Advocate for inclusion of more evidence-based measures for chronic care in the Community Measurement Project, sponsored by the Minnesota Council of Health Plans.
5. Provide information and education on benefits of healthy living to all age groups, starting with children, using the most effective, proven messages and tactics. Model these efforts after the successful no-smoking campaign.
6. Increase financial and other incentives for healthy living, e.g., reduced health premiums, individualized health assessments with specific plans for changing behaviors and use of local schools, community centers, malls and walking and biking trails for exercise and education.
7. Support and continue the Department of Health’s “Eliminate Health Disparities Initiative,” which provides grants to groups in communities of color to address health disparities.
8. Require physical education in schools and make school lunches healthier.

**5. Recruiting and retaining a stable health and long-term care workforce that has geriatric competence to serve older people.**

Labor shortages already exist in Minnesota’s health and long-term care sectors, within both professional and paraprofessional positions. And yet, we will need more doctors, nurses, nursing assistants, home care workers, social workers and allied professionals to meet the health and long-term care needs of an older population that will double in size by 2030.

RNs, LPNs, and direct care workers (nurse’s aides, orderlies and attendants) constituted the largest group of health services workers in the U.S. in 2000, at nearly 31 percent of the health services workforce. In Minnesota, for these three fields, more than 2,800 positions are currently open, at a combined job vacancy rate of 5.7 percent.<sup>55</sup> By 2014,

*“We’re facing a historic demographic change, and we do not have an adequate, well-trained work force from doctors down to basic in-home caregivers who know the details of aging.”--Dr. Robert Butler, President, International Longevity Center-USA*

these three fields are projected to have net replacement openings for 18,160 workers (above and beyond the labor pool that is already expected to fill these jobs). If these projections hold true, a full 47 percent of positions for these three fields alone could go unfilled in 2014.

Similarly, as more people choose to age in place and receive care in their homes, the demand for home health aides is growing. Currently, more than 800 positions are unfilled in the state, at a job vacancy rate of 13.3 percent. This field is expected to see a nearly 52 percent increase in employment needs by 2014, with more than 20 percent of these positions projected to go unfilled.<sup>56</sup>

There are trends in place that could shrink the state’s long-term care work force even more at the very time that the need for long-term care will be increasing. Retirements of current baby boomer workers will take a large number of workers out of the field. Other social and economic factors contribute to the continuing shortage of workers: low wages and lack of 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 to replace those who will begin retiring soon.

Participants at the 2010 meetings talked about the inadequate supply of health professionals with geriatric training and expertise right now; filling this void will take years. While competitive wages and benefits are a key issue in recruitment and retention of workers in these jobs, many believe that changes in the nature of the work itself and how health and long-term care is practiced are just as central to solving this problem. The workers need the geriatric and cultural competence to provide appropriate and high quality care to an older population including an increasing number of elders from ethnic, immigrant and tribal communities.



**Suggested Action Steps**

1. Increase the supply of qualified faculty in Minnesota’s post-secondary nurse training programs so that all those who want nurses training can be served.
2. Expand tuition credits, loan forgiveness and scholarship programs available for health and long-term care workers.
3. Improve training, certification process and career ladders/lattices for workers, especially immigrant workers.
4. Encourage greater use of universal and nontraditional workers and consumer-directed options, where clients pay family, friends or neighbors to provide personal services.
5. Recruit retiring baby boomers who want more flexible hours and a chance to “give back” at this stage of their life to take long-term care jobs in their communities.
6. Create strong intergenerational programs that increase interaction between young and old and expand volunteer and internship programs for young people in health and long-term care settings.
7. Make sure local schools have strong math and science programs, to encourage students to pursue these studies and related health and science fields.
8. Integrate geriatric training into the core curricula for all professional schools in the state, especially for nurses, physicians and social workers so that all future workers receive some exposure and training in geriatrics.
9. Provide competitive wages and benefits for workers in health and long-term care.

**6. Preparing the mental and chemical health systems for increased demand from aging boomers.**

Many experts predict the aging baby boom generation will usher in a major increase in the demand for mental and chemical health services. The boomer generation will include those who have had these problems earlier in life and are now aging and those who will experience problems for the first time as they age. These co-occurring problems will strain the mental and chemical health systems as well as the health and long-term care systems that provide most services to older people. Part of the concern is that boomers are less likely to feel any stigma regarding mental and chemical health issues compared to earlier generations and thus will expect more treatment for their problems.

At the focus groups held on mental health and aging as part of Transform 2010, the discussion centered on how the needs of boomers are different than current elderly, and how to meet the growing needs. Because boomers are so youth-oriented, they will have more trouble accepting their aging and this will cause more mental health issues. Anxiety disorders are more prevalent than depression among boomers. There is some difference between older and younger boomers in that the older group tends to have some remaining negative stigma about mental health needs while younger boomers want therapy and are familiar with use of medications to address mental health needs.

There is a growing shortage of psychiatrists in the state and this is especially true in rural Minnesota. There are even fewer psychiatrists with experience working with older

persons. The capacity of the mental and chemical health systems to meet the challenge of boomer mental health varies across the state but is generally very weak. Regardless, boomers will expect that the services they need will be there, as they always have. Boomers with already existing mental or chemical health issues have fewer close family members available to help meet needs for support so other networks will need to replace families.

### **Suggested Action Steps**

1. Educate health, home care and aging workers on how to identify early signs of mental and chemical health problems and talk to their clients so they accept help.
2. Integrate health, aging and mental health services into a special service delivery module with specially trained professionals easily accessible when needed.
3. Increase and improve the ability of primary care providers to identify and manage mental illness in their patients.
4. Include mental health services as reimbursable services in Medicare, Medicaid and other long-term care funding.
5. Prepare for growing numbers of elders from ethnic, immigrant and tribal communities in need of mental and chemical health services.
6. Improve recognition, assessment and treatment of mental illness and depression among older persons in nursing facilities.
7. Support the integration of older adult mental and chemical health services into primary health care, long-term care and community-based services.
8. We cannot dismantle the current mental health system that serves the serious and persistently mentally ill in order to serve boomers who are not as ill. We need to add to the overall system to serve more who are in need.
9. Use boomers to help others with mental and chemical health problems as peer counselors, volunteers, etc.



## 5. Maximizing Use of Technology

Minnesota should use technology to maximize the benefits and minimize the hazards that accompany its permanent age shift.

### Why is this important?

- Given the increases in the older population in the future, there will be a great need for new and innovative ways to meet the pressures and demands for additional services and products. Technology will be the key to addressing these demands. It can also help take advantage of the opportunities presented by the aging of our population.
- The baby boom generation has a fascination with technology. They have lived during a time of huge advances in technology and believe that, eventually, technology will solve most human problems and maladies. They will take their optimism as well as their expectations into their later years.
- While technology holds great promise in solving problems related to an aging population, it also has a downside. Experts who have closely studied the role of technology in health care have concluded that while technology can offer treatments and procedures to improve quality of life and reduce costs, the existence of these procedures will increase consumer demand, which will also fuel the rising cost of health care.
- Technology plays many roles in addressing the issues faced by an aging population, including: 1) transforming the health care system; 2) helping people help themselves; 3) addressing worker shortages and distance issues, especially in rural Minnesota; 4) expanding access to an unlimited array of resources and networks; and 5) supporting information systems that collect and analyze large datasets to support performance and results measurement.

### What if we do nothing?

- If technology is not utilized to replace workers in health and long-term care, the provision of these services to an older population, especially in the rural areas, will become impossible.
- Without expanded use of technology, people with disabilities will not be able to do as much for themselves and they will need to depend more on other people for help, which increases costs, limits access and reduces independence of individuals.

### What issues need to be addressed to prepare for 2010?

#### 1. Transforming health care through use of evidence-based technology, achieving both efficiencies and savings while improving outcomes and quality.

Medical technology is advancing to the point where it is continuously transforming health care in ways that increase productivity and improve patient outcomes. For

*“The number one benefit of information technology is that it empowers people to do what they want to do. It lets people be creative. It lets people be productive. It lets people learn things they didn’t think they could learn before, and so in a sense it is all about potential.”*

*--Steve Ballmer*

example, in cardiac care, mortality has dropped 40 percent since 1980 as a result of new technologies used to intervene in coronary heart and stroke diseases. Shorter hospital stays are a result of newer procedures that have replaced traditional surgeries, such as gall bladder removal or angioplasty with stent implantation.

Even the decline in disability rates over the past decade among the elderly can be traced to technology. Such procedures as hip and knee replacements have meant that elderly are not as disabled, more able to take care of themselves and more independent. According to Manton, whose research documented the declines in elderly disability, “if disability rates decline 1.5 percent annually, the resulting Medicare savings could completely offset the impact of the influx of new beneficiaries over the next several decades.”<sup>57</sup>

Minnesota has made great strides in the areas of information technology through its public/private e-health initiative, staffed by the Minnesota Department of Health. While overall implementation of electronic health records is still several years away, steps are being taken to make “interoperable” health records a reality throughout Minnesota by 2015.

Participants at the 2010 meetings returned many times to the potential of technology as a major part of the solution to many of the issues we face as an aging society. There seems to be unlimited potential for technology to improve access and quality of health and long-term care in the future.

**Suggested Action Steps**

1. Implement interoperable electronic health records to improve continuity of care, better coordinate the management of medical and community care components and save administrative dollars.
2. Develop and implement uniform information systems and use of common forms across all health providers and payers in Minnesota.
3. Support continued advances in medical and health technology, especially those that address major chronic conditions, such as arthritis, diabetes and Alzheimers disease.

**2. Expanding use of technology that helps people help themselves, e.g., home modifications, assistive devices and safety systems.**

Technology is a type of equalizer for persons with disabilities, because it can remove traditional barriers within physical and social environments. As the population ages and experiences more disabilities and as the younger population with disabilities ages, the use of technology to help individuals help themselves can increase the ability to be independent and thereby reduce the cost of formal services.

Because the workforce is aging and the growth of the labor force in general is slowing dramatically, employers are expected to turn to groups whose labor force participation rates are still low. Minnesota’s current labor participation rate for persons with disabilities was 64 percent in 2000, the highest in the country. Minnesota also has an extremely high rate for women and youth. The only group that had slower growth in its labor force participation rate between 1970 and 2000 was workers over 65: our rate ranks us 16th in the nation, at about 17.5 percent.<sup>58</sup> In order to accommodate more mature workers (as

well as younger workers with disabilities), employers will need to put in place additional accommodations, ergonomics and assistive technology in the workplace.<sup>59</sup>

Another example of technology that can help an individual help themselves is home modification. Because the vast majority of boomers plan to age in place in their home, many of them may find that they need some level of modification within that home in order to age in place, especially as disabilities begin to appear. These modifications can range from grab bars in the bathroom or a ramp on the outside of the house to more extensive remodeling to widen doorways or build a bathroom on the first floor. Studies have shown that many of these modifications are cost-effective because they delay a move to a more expensive setting for at least several months, and allow elderly who prefer to stay in their home to do so.

Those attending the 2010 meetings shared many examples of how technology was being used to allow older persons to remain independent in ways that could not have been possible a few years ago. The invention of systems that help older people remember to take their pills means that older people can now manage this task independently. Participants were confident from the progress made just in the past 10 years that technology to help people stay in their homes and meet their own care needs would become widely available and also be quite affordable.

Several housing and service providers are already demonstrating the value and the effectiveness of a variety of sensors placed within a senior’s home or apartment as a means to alert family or staff to emergencies or unusual behavior that might signal a health problem. Contrary to earlier assumptions, installation of these devices appears to be affordable and effective.

**Suggested Action Steps**

1. Increase availability of reimbursement, insurance coverage or tax credits for home sensors, home modifications and assistive devices for individuals who are able to remain independent in their homes with the help of this technology.
2. Expand access to communications devices for the deaf, hearing impaired and vision impaired, and other individuals needing special communication assistance, e.g., interpreter services, to provide better access to health and long-term care services for these target groups.
3. Create or designate one-stop centers for assistance with housing-related needs, e.g., home modifications and new technologies that increase access for those with physical or hearing and visual disabilities, so individuals can more easily make their homes accessible and supportive.
4. Increase the knowledge and use by caregivers of home modification, assistive devices and technology, e.g., medication management tools, personal emergency response systems, sensors and video cams, to help them in their caregiving role.

**3. Using telehealth and related technology to address worker shortages and distance issues.**

Telehealth technology includes computer-based telephone-linked devices between a patient’s home and a health care professional or organization to provide access to information on the patients’ health status. Many of these models also include a

videoconferencing element as well since that is a requirement for Medicaid funding in Minnesota. In this case, the patient and health professional can see each other and the professional can not only monitor the patients' vital signs transmitted over the phone lines, but also visually observe the patient for signs of improving or declining health.

Just in the past five years, the use of telehealth has grown exponentially across Minnesota, especially in rural Minnesota. Early funding by the Bush Foundation, the Department of Health, USDA, and subsequent grants awarded through the state Community Service/Community Development (CS/SD) grant program, administered by the Department of Human Services, has provided information on the benefits and costs of this model of care for use with older patients.

In an evaluation of telehomecare completed for the CS/SD grant program, researchers documented that without the use of telehomecare services, 94 percent of the patients served traveled more than 70 miles in order to receive medical care. In addition, 84 percent would miss a day of work in order to participate in face-to-face care and 74 percent would incur additional expenses of \$75-150 per visit. When telehomecare was used, 92 percent of patients saved \$32 in fuel, 84 percent saved \$100 in wages, and 74 percent saved between \$75 – \$150 in family expenses compared to the cost of one face-to-face trip.<sup>60</sup>

Participants in the 2010 meetings talked about telehealth as a great example of technology that saves money and time on both the patient side and the worker side. Other examples include equipment used to check continence in residents of care facilities and robots that provide simple services to persons in their homes or care settings. These types of labor-saving devices and more will be needed to address worker shortages in the future.

#### **Suggested Action Steps**

1. Expand the applications and the system of telehealth service models in order to maximize use of the available workforce and improve quality of care, especially in the rural areas.
2. Expand the reimbursement for telehealth services so that workers other than nurses can provide the service and receive reimbursement.

#### **4. Utilizing the Internet and related technology to expand access to information about resources for consumers and their families.**

According to a recent survey of boomers in Minnesota, 85 percent of them currently use the Internet. Nearly one-half (46 percent) use it for e-mail, 29 percent use it for research and 11 percent get their news from it.<sup>61</sup> As they began to seek more information about aging-related issues for their own situations, it will be natural for them to turn to the web for information on resources, including resources that are available locally.

Through the Minnesota Board on Aging, the state has a well-respected and comprehensive website called [www.minnesotahelp.info](http://www.minnesotahelp.info) that provides information on thousands of services and programs available across Minnesota that help older people,

persons with disabilities and children and families get connected to the assistance they need. As the use of the Internet grows, more ways of using the web to help with life's questions and problems are being developed daily.

Participants at the 2010 meetings shared thoughts about how the Internet could be used to improve data storage, connect family members and friends scattered around the world, and connect people with other people or with information needed to make decisions. Ideas include storage of useful personal health information, transmittal of up-to date information on older relatives for family and caregivers spread around the state or world and storage of legal and health documents so that they can be accessed quickly. Of course, websites that specialize in information and resources for boomers or older people are growing as well. Those at the meetings said we need to keep improving upon and adding to the web-based information for older people in Minnesota, in order to serve the growing number of Internet users of the future.

### **Suggested Action Steps**

1. Design web-based tools that help individuals assess their needs and preferences, identify realistic options and choose a course of action or a resource that best fits their situation. These tools should cover financial literacy, retirement planning, caregiving options, long-term care decision-making tools, planning for the future, etc.
2. Continue to improve Minnesota's major website for resources for older persons and others called [www.minnesotahelp.info](http://www.minnesotahelp.info). This website, operated through the Minnesota Board on Aging, is the main portal into a large directory of resources of interest to individuals and families of all ages, including older persons.
3. Encourage individuals to undertake "proactive health" activities, e.g., use of interactive technology and web-based tools to monitor their health and lifestyle behaviors.

## **5. Redesigning management information systems to support performance and results measurement.**

Information sharing technology is transforming how governments and businesses work. It is allowing groups to get rid of paper-based systems and documentation that were cumbersome, imprecise and sometimes incomplete or inaccurate.

One example of this change is a transformation in how the Department of Human Services collects and processes cost reports from nursing facilities in order to pay reimbursement rates. The department recently released a secure, password protected web-based provider portal for use by all Medicaid-certified nursing facilities. Beginning with the report year ending September 30, 2006, all facilities must file their cost report using this web-based application.

The positive features of the web-based application include pre-filled information based on the previous year's report, interactive editing features that will highlight potential reporting errors and immediate feedback on costs per resident day and performance on quality measures. Users of the application will be able to enter information, quit, and then resume completing the cost report at any time. The application will also include a batch upload feature useful to large chain organizations or accounting firms submitting multiple cost reports.

Now, instead of taking four months to obtain completed reports from the facilities and enter them into the department's information system, staff has the data available one day after the report deadline.

This is just one example of what information technology allows us to do: to sift and analyze large amounts of data quickly, administer programs more efficiently and monitor performance, quality, cost or services provided to clients.

Participants at the 2010 meetings saw the role that technology could play in making it much easier to collect and analyze data and use this to inform planning and policy development. In addition, some suggested that quality assurance efforts could be greatly improved through increases in the ability to obtain fast and accurate data from clients on how programs and services have affected them.

### **Suggested Action Steps**

1. There should be report cards on the quality of all services for older people on the web, similar to the Nursing Home Report Card, using new technologies to collect and summarize data for these reports.
2. Providers should have small grants available to help them develop better information and management systems.

## Conclusion

The aging of the baby boom generation and the permanent age shift ushered in by this age wave is the most significant demographic trend we will experience over the next 50 to 100 years and is a major achievement of modern society.

Living longer and healthier lives brings with it tremendous potential and economic and social opportunity for both individuals and society. Many of the European countries have populations older than ours and they appear to be responding to and accommodating the demographic shifts within their populations. The key is to ensure the active participation and integration of older people in the ongoing economic and social life of their communities. Seen through this lens, the age wave of baby boomers is not a problem but rather an opportunity to extend economic growth and productivity into more years, and spur us to make needed changes in our retirement and health systems, in the workplace and in our communities.

Of course, this permanent age shift also brings with it significant challenges. Pressures on pension systems, health and long-term care services and family caregivers all require systemic policy responses. Also required is significant individual action to prepare for one's own later years, through continued work, active engagement, "self-investment" and healthy lifestyles.

Transform 2010 has given Minnesotans a chance to look at the demographic realities of Minnesota's age wave and suggest strategies and action steps. Taking actions outlined in the Blueprint for 2010 will help ensure continued economic vitality and quality of life for all Minnesotans as we age. Minnesotans believe that we can meet both the opportunities and the challenges presented to us by the age wave, but doing so requires that we start now.

## Next Steps

The state agencies involved in Transform 2010 are committed to a leadership role in moving the Blueprint forward by:

- Keeping these issues in the public eye and on the policy agenda.
- Disseminating the Blueprint to all those who participated in the earlier discussions, as well as the change agents who can influence action.
- Rethinking and transforming the programs and services the state administers in order to accommodate and respond to an aging Minnesota.
- Monitoring progress toward meeting the challenges outlined in this Blueprint, using benchmarks to measure our progress.
- Completing additional work on key issue areas that require immediate attention and monitoring emerging trends and issues related to the aging of Minnesota.
- Developing an implementation plan for this Blueprint that establishes goals and timelines, and identifies the change agents that need to be involved in order to accomplish the changes needed by 2010.

*"The art of prophecy is very difficult, especially with respect to the future."*

*--Mark Twain*

# Appendix A

## Transform 2010 State Agency Work Group

### Members

#### June 2007

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## Appendix B

### Benchmarks for the Blueprint

#### How do we measure progress?

(Source of data for benchmarks noted in parentheses)

#### Redefining work and retirement

1. Percent of Minnesota employees participating in employer-sponsored retirement plans. (Minnesota Department of Employment and Economic Development and Employee Benefits Research Institute)
2. Percent of Minnesota employers that offer retirement plans and automatically enroll all employees in their plans. (Minnesota Department of Employment and Economic Development and Employee Benefits Research Institute)
3. Labor force participation rates for men and women 65+ in Minnesota. (Minnesota Department of Employment and Economic Development)
4. Volunteerism rates for Minnesotans at various ages. (Corporation for National and Community Service)
5. Percent of adult Minnesotans who have purchased a product that covers long-term care expenses. (Survey of Older Minnesotans)
6. Percent of beneficiaries in Minnesota who rely on Social Security for less than 90 percent of their retirement income. (Social Security Administration)

#### Supporting caregivers of all ages

1. Percent of services needed by older Minnesotans living in the community that are provided by families and informal sources. (Survey of Older Minnesotans)
2. Number of Minnesota employers rated as good employers for persons 50+ because of their supportive environment for working caregivers. (AARP)
3. Percent of Minnesota's population that has caregiver support services available in their community. (DHS Gaps Analysis)
4. Percent of grandparents raising grandchildren who report they are receiving the assistance they need. (Survey of Older Minnesotans)

## Fostering communities for a lifetime

1. Percent of Minnesota’s communities that meet the criteria for a “community for a lifetime.” (These criteria would be developed by a joint public/private group to measure the existence of physical, social and service infrastructures in communities throughout the state.)
2. Percent of Minnesotans 50+ who say their community is getting better and is more supportive than before. (Survey of Older Minnesotans)

## Improving health and long-term care

1. Rates of disability among adults in Minnesota, by age, sex and minority status. (American Community Survey and MDH Reports)
2. Percent of older adults in Minnesota served by integrated health care products, e.g., PACE, MSHO-like products. (DHS and MDH Reports)
3. Percent of persons served in community long-term care programs who have higher care needs. (DHS Performance Measurement System)

## Maximizing use of technology

1. Progress toward completion of system of interoperable health records. (MDH Reports)
2. Percent of Minnesotans 50+ who have modified their home or installed assistive or security devices. (Survey of Older Minnesotans)
3. Percent of Minnesotans who have telehealth options available in their community. (DHS Gaps Analysis)
4. Level of readiness within the communications infrastructures (fiber optics, cable, telephone) in all parts of Minnesota. (Office of Technology)



## Endnotes

<sup>1</sup>An earlier effort, Project 2030, began in 1997. A partnership between the Minnesota Board on Aging and the Department of Human Services, it took its name from the year before the baby boom generation begins to turn age 85 in 2031. It raised awareness of the issues surrounding the aging of the state's population and generated more than 20 publications analyzing various issues and components of the impact of the state's aging population on all sectors of the state.

<sup>2</sup>Minnesota Department of Employment and Economic Development. (April 2006). The Age Divide: Generations in the Workplace. *Minnesota Economic Trends*. Accessed online May 18, 2007, from <http://www.deed.state.mn.us/lmi/publications/trends/0406/age.htm>

<sup>3</sup>Minnesota Department of Employment and Economic Development. (February 2007). *Minnesota Workforce Facts*. Accessed online May 18, 2007, from [http://www.deed.state.mn.us/lmi/\\_shared/assets/MN\\_Workforce\\_FACTS16494.pdf](http://www.deed.state.mn.us/lmi/_shared/assets/MN_Workforce_FACTS16494.pdf)

<sup>4</sup>U.S. Census Bureau. (2005). American Community Survey Tables on Self-Care Disability by Age. Accessed online May 18, 2007, from [http://www.pascenter.org/state\\_based\\_stats/state\\_statistics\\_2005.php?state=minnesota](http://www.pascenter.org/state_based_stats/state_statistics_2005.php?state=minnesota)

<sup>5</sup>Spellman, Brenda C. (2004). Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost. *The Milbank Quarterly*, Vol. 82, No.1.

<sup>6</sup>Rand Corporation. (2007). Obesity and Disability: The Shape of Things to Come. *Research Highlights*, 3.

<sup>7</sup>Citizens League. (1998). *Help Wanted: More Opportunities Than People: Final Report on Labor Shortages in the Twin Cities*. Minneapolis: Author, 13.

<sup>8</sup>Minnesota State Demographic Center. (2002). Minnesota Life Expectancy in 2000. *Population Notes*. p. 1. Accessed online May 18, 2007, from <http://www.demography.state.mn.us/PopNotes/LifeExpectancy/MNLifeExpectancy.pdf>

<sup>9</sup>Urban Institute. (January 2007). Retirement Policy by the Numbers: Older Americans in the Labor Force. *Figure 9: Share of US Workers in Physically Demanding Jobs*.

<sup>10</sup>Employee Benefits Research Institute. (May 1, 2007). When Do Workers Plan to Retire, vs. Actually Doing so? *Fast Facts from EBRI*. Accessed online May 18, 2007, from <http://www.ebri.org/pdf/publications/facts/fastfacts/fastfact050107.pdf>

<sup>11</sup>Ecumen. (2007). The Ecumen "Age Wave" Study. St. Paul, MN. Accessed online May 18, 2007 from <http://www.ecumen.org>

<sup>12</sup>Urban Institute, Figure 14.

<sup>13</sup>Hacker, Jacob. (2006). *The Great Risk Shift: The Assault on American Jobs, Families, Health Care, and Retirement—and How You Can Fight Back*. New York: Oxford University Press, 72.

<sup>14</sup>Employer Benefits Research Institute. (November 2006). Employment-Based Retirement Plan Participation: Geographic Differences and Trends, 2005. *Issue Brief No. 299*, 19.

<sup>15</sup>Employer Benefits Research Institute. (August 2006). 401(k) Plan Asset Allocation, Account Balances, and Loan Activity in 2005. *Issue Brief No. 296*, 4.

<sup>16</sup>Munnell, Alicia H. and Annika Sunden. (2004). *Coming Up Short: The Challenge of 401(k) Plans*. Washington DC: Brookings Institution Press, 3.

<sup>17</sup>Center for Retirement Research at Boston College. (February 2007). What Happens to Health Benefits After Retirement? *An Issue in Brief, Series 7*, 4.

<sup>18</sup>Ecumen, Age Wave Study, 8.

<sup>19</sup>Corporation for National and Community Services, Office of Research and Policy Development. (2007). *Volunteering in America: 2007 State Trends and Rankings on Civic Life*. Washington, DC: Author, 22-25.

<sup>20</sup>Minnesota Department of Human Services. (March 2006). Summary of Meetings with Ethnic and Immigrant Communities. Accessed online May 18, 2007, from [http://www.dhs.state.mn.us/main/dhs\\_id\\_057948.doc](http://www.dhs.state.mn.us/main/dhs_id_057948.doc)

<sup>21</sup>Kemper, Peter, Komisar, Harriet L., and Alecxih, Lisa. (2005/2006). Long-Term Care over an Uncertain Future. What Can Current Retirees Expect? *Inquiry*, 42:335-50.

<sup>22</sup>Ibid.

<sup>23</sup>Genworth Financial. (March 2007). Cost of Care Survey: Home Care Providers, Assisted Living Facilities and Nursing Homes. Wellesley, MA: CareScout.

<sup>24</sup>State Health Access Data Assistance Center (SHADAC). (March 2005). Retirement Security and Minnesota's Elderly Population. *Issue Brief #1*. University of Minnesota, 13. Accessed online May 18, 2007 from [http://www.dhs.state.mn.us/main/dhs\\_id\\_049723](http://www.dhs.state.mn.us/main/dhs_id_049723)

<sup>25</sup>Minnesota Department of Human Services estimate, 2006. The Medical Assistance (MA) program, the name that Minnesota uses for the Medicaid program, is the federal/state program that provides health and long-term care assistance to individuals who have exhausted their own resources.

<sup>26</sup>Ecumen, 5 – 6.

<sup>27</sup>National Academy of Social Insurance. (May 2007). Social Security and Retirement Income Adequacy. *Social Security Brief. No. 25*, 6.

<sup>28</sup>Ibid.

<sup>29</sup>Minnesota Department of Human Services. (2005). *Financing Long-Term Care for Minnesota's Baby Boomers: Report to the Legislature*. St. Paul: Author, 4. Accessed online May 18, 2007 from <http://edocs.dhs.state.mn.us/lfsrserver/Legacy/DHS-4393-ENG>

<sup>30</sup>Ibid, 25.

<sup>31</sup>National Alliance for Caregiving/AARP. (April 2004). *Caregiving in the U.S.* Bethesda, MD: Author, 32-44. Accessed online May 18, 2007 from <http://www.caregiving.org/data/04finalreport.pdf>

<sup>32</sup>Ibid, 66.

<sup>33</sup>Metlife Mature Market Institute/National Alliance for Caregiving. (July 2006). *The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business*. Westport, CT: Author, 11.

<sup>34</sup>Wagner, Donna L. (2006). Families, Work, and an Aging Population: Developing a Formula that Works for the Workers. *Journal of Aging & Social Policy*, 18, 3/4, 117.

- <sup>35</sup>AARP. (July 2006). *Minnesota: A State Fact Sheet for Grandparents and Other Relatives Raising Children*. Washington, DC: Author, 1.
- <sup>36</sup>Judith Marshik, consultant, personal communication regarding surveys of older suburban residents in Twin Cities Metro Area, 2000.
- <sup>37</sup>AARP. (2005). *Beyond 50.05: A Report to the Nation on Livable Communities: Creating Environments for Successful Aging*. Washington, DC: Author, 27.
- <sup>38</sup>n4a. (2006). *The Maturing of America: Getting Communities on Track for an Aging Population*. Washington. DC: Author, 5.
- <sup>39</sup> International City/County Management Association. (September 2003). *Active Living for Older Adults: Management Strategies for Healthy and Livable Communities*. Washington DC: Author, 3.
- <sup>40</sup>Minnesota Board on Aging. (2005). *Survey of Older Minnesotans*. St. Paul: Author, 60-62. Accessed online May 18, 2007 from <http://www.mnaging.org/advisor/survey/SOM2005Tables.pdf>
- <sup>41</sup>Ibid, 66.
- <sup>42</sup>Ibid.
- <sup>43</sup> AARP. (2005). *Beyond 50.05*, 44.
- <sup>44</sup>The Century Foundation. (2006). *Public Policy in an Older America*. New York City: The Century Foundation Press, 36.
- <sup>45</sup> Ibid.
- <sup>46</sup>Johns Hopkins University. (2002). *Partnership for Solutions*. Baltimore, MD: Author.
- <sup>47</sup>The Long-Term Care Imperative. (March 2007). *Mapping the Future of Older Adult Services: Estimating the Need*. St. Paul and Bloomington, MN: Author, 3.
- <sup>48</sup>MSNBC. (December 5, 2006). Report: *And the healthiest state in the U.S. is...* Accessed online May 18, 2007 from <http://www.msnbc.msn.com/id/16054213/>
- <sup>49</sup>Minnesota Medical Association. *Obesity Rounds*. St. Paul, MN: Author. Accessed online May 17, 2007 from <http://www.mmaonline.net/obesity/childhoodfactsheet.cfm>
- <sup>50</sup>Minnesota Department of Health. (2007). *Eliminating Health Disparities Initiative*. Accessed online May 18, 2007 from <http://www.health.state.mn.us/ommh/priority.html>
- <sup>51</sup>Ibid.
- <sup>52</sup>Natural Marketing Institute. (March 9, 2005). *New Consumer Research: Boomer Trends and Insights into Healthy Aging*. Presented at the What's Next Boomer Business Summit. Harleysville, PA: Author, 12.
- <sup>53</sup>Natural Marketing Institute. (March 7, 2007). *Highlights from What's Next Boomer Business Summit: Excerpts from the Healthy Aging Boomer Database*. Harleysville, PA: Author, 13.
- <sup>54</sup>Stein, Rob. (April 20, 2007). Baby Boomers Appear to Be Less Healthy Than Parents. *Washington Post*. Accessed online May 18, 2007 from <http://www.washingtonpost.com/wp-dyn/content/article/2007/04/19/AR2007041902458.html>
- <sup>55</sup>Minnesota Department of Human Services. (June 1, 2007). Report on the Transform 2010 Agency Subgroup: Examining the Health Care Workforce Needs for the Future. St. Paul: Author, 2-3.

<sup>56</sup>Minnesota Department of Employment and Economic Development. (2007). *Employment Outlook Tool: 2004 - 2014*. St. Paul: Author.

<sup>57</sup>AdvaMed. (2006). *The Value of Medical Technology: The Turning Point to a New Health Economy*. Washington DC: Author, 8.

<sup>58</sup>Minnesota Department of Employment and Economic Development. (April 2006). *The Age Divide: Generations in the Workplace*. Accessed online May 18, 2007 from <http://www.deed.state.mn.us/lmi/publications/trends/0406/age.htm#sidebar2>

<sup>59</sup>Mosner, Ellen, Spiezle, Craig and Emerman, Jim. (July 2003). *The Convergence of the Aging Workforce and Accessible Technology: The Implications for Commerce, Business and Policy*. Seattle: Microsoft Corporation, 16.

<sup>60</sup>University of Minnesota Medical School Duluth. (March 21, 2005). *An Evaluation of Technical and Implementation Questions in Selected Telehomecare Projects Funded by the Minnesota Department of Human Services*. Duluth, MN: Author, 8.

<sup>61</sup>Ecumen. (2007). 19.

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