2016 Legislative Summit
December 6, 2016
8:00 am – 12:15 pm
Eagan Community Center

Objectives: (1) To understand aging policy initiatives underway in Minnesota; (2) To identify actions to move policy forward; and (3) To highlight challenges that will need to be addressed

AGENDA

7:30 Registration & Breakfast

8:00 Welcome
Beth Wiggins, Chair, Minnesota Leadership Council on Aging (MNLCOA)
Meghan Coleman & Sherrie Pugh, Minnesota Board on Aging

8:15 Keynote: Setting the Stage for Aging Issues in MN: Prioritizing Action
Greg Owen, Consulting Scientist, Wilder Research

8:45 Key Policy Topics
Introduction: Paula Hart, Volunteers of America MN/WI
- Workforce: Patti Cullen, Care Providers of Minnesota
- Family/Friend Caregiver Support: Beth Wiggins, FamilyMeans
- Elderly Waiver Program: Kari Thurlow, LeadingAge Minnesota
- Transportation: Dawn Simonson, Metropolitan Area Agency on Aging
- Summary and Other Issues of interest: Paula Hart

10:00 Break

10:15 Responder Panel
Facilitator: Rajean Moone, Executive Director, MNLCOA
Legislative Leaders:
  Rep. Joe Schomacker
  Sen. Jim Abeler
Administrative Officials:
Department of Human Services Assistant Commissioner Loren Colman
Department of Health Assistant Commissioner Gil Acevedo
Department of Employment & Economic Development Deputy Commissioner Jeremy Hanson Willis

11:45 Closing-Action Planning Experience: Beth Wiggins
Attendees will be invited and encouraged to share their thoughts
- What action steps will you take?
- Where is there a potential for collaboration?
- Where /what will you build onto?
- What resources can help?

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Problem Statement
As Baby Boomers age and retire from jobs, employers have a hard time finding younger people to replace them; vacant positions in long term care continue to increase. As the number of people 65 and older grows by 93% by 2035 the workforce will grow by only 0.1%, and the problem may be even more severe in rural areas. The workforce crisis is multi-faceted (demographics, pay & benefits, competition) and the workforce shortage is just beginning—it will continue to get worse in the coming years.
The direct care workforce offers home and community-based services (HCBS) to approximately 90,000 Minnesotans, including vulnerable children and adults with a variety of chronic conditions and challenges with activities of daily living. These workers are in Minnesota’s nursing facilities, assisted living centers, foster care, adult day centers, day training and habilitation centers, treatment clinics, and home care agencies. Most often they work in people’s homes.

Potential Solutions
There is no singular solution nor is there just one state agency or legislative committee that should have the “responsibility” to address the implications of a significant workforce shortage—most significantly being access to services and the inability for older adults to receive care and services they need. Comprehensive solutions need to be developed by multiple stakeholders in key areas such as:
- Improving the public perception of the long-term care workforce so caregiving is an honored profession;
- Increasing wages and benefits to make caregiving a competitive career;
- Removing regulatory and other barriers to workforce recruitment and retention;
- Developing new “pools” of workers focused on high school students, seniors, new Americans;
- Bridging gaps in education to support career ladders and training;
- Developing solutions to expanding the numbers of students being accepted into academic programs in nursing and related professions; and
- A comprehensive commitment by the state to respond to a crisis.

Key Stakeholders
Caregivers, older adults, employers, health care providers, health care systems, academic institutions, insurers, long-term care and community based service providers.

Health Equity Implications
With a growing diversity in our workforce it is critical that we provider culturally sensitive training, resources for employers to fully understand the different approaches and requirements that correspond to various cultures; and opportunities for older adults to gain understanding about the differences that may occur in caregiving by diverse cultures.
Family and Friend Caregiver Support*

Issue Summary
Family, friends, and neighbors often undertake caregiving willingly, and many find it a source of deep satisfaction and meaning. However, caregiving in today’s economic climate amid fragmented systems of health and long-term care can take a significant toll. Those who take on this unpaid role risk the stress, physical strain, competing demands, and financial hardship of caregiving, and thus are vulnerable themselves.

Six in 10 family caregivers are employed. Nearly 1 in 4 (23%) American workers age 25 and older currently provide unpaid care to a relative or friend, most commonly a parent or parent in-law (53%). They often struggle to balance work and caregiving responsibilities with impacts such as:

- One in five family caregivers left the workforce earlier than planned to care for an ill spouse or family member.
- A typical caregiver loses $303,880 in wages, Social Security and retirement savings.
- Women assuming a caregiving role in their working years are 2.5 times more likely to live in poverty in old age.

Without family caregivers (both those who are also in the paid workforce and those who are not), the cost of long-term care would be considerably more unmanageable than it already is. The estimated value of family caregiving in Minnesota is $7.8 billion, twice the amount paid for long term care under Medicaid. Family caregivers are essential to helping seniors live independently in their homes and communities and out of more expensive care settings. This saves taxpayer money and is what most people would prefer. But the caregivers themselves are in crisis.

Potential Solutions
- **Extend Family Medical Leave (FMLA) Protections:** Not all employees are protected under FMLA. Extend FMLA to employees of companies with 50 or fewer workers allowing them to take up to 12 weeks unpaid time off for their own or a family member’s serious health condition. Apply the more inclusive definition of family member.
- **Institute a Paid Family Leave Insurance Program:** Paid family medical leave insurance provides economic security during life-changing events. It pays up to 12 weeks of partial wage replacement during a family leave, pregnancy, or medical leave. Employers and employees each contribute a small payroll deduction (.27%) on the first $118,500 of income. This averages $1.75 per week for a Minnesota worker earning a median wage of $32,000 a year. The fund pays partial wage replacement up to a maximum of $1,000 per week.
- **Broaden Sick Leave:** In 2013 Minnesota passed the family caregiver sick leave law allowing employees with earned sick leave to use it for expanded members of their family. But nearly 40% of private workers and 80% of low-wage workers lack access to paid sick days. A statewide sick leave bill requiring all employers to offer paid sick leave using the more inclusive definition of family member would provide all Minnesotans with the security of knowing they can take care of their own health needs and those of their family and not lose their job.
- **Provide financial incentives:** Make available financial incentives such as tax credits, self-directed caregiver grants, social security credits or other financial incentives to help alleviate the financial burden.
many caregivers assume when caring for their aging relatives. Self-directed grants would provide a budget to purchase goods or services, or hire their own workers to address their caregiving needs. Social security credits would allow caregivers to be compensated for periods of time when were not employed or worked reduced hours for caregiving reasons. Many caregivers are spending on average $7,000 per year on out-of-pocket costs related to caregiving in 2016.

- **Improve Training & Support:** The MN Legislature recently enacted the Caregiver, Advise, Record and Enable (CARE) Act. Effective January 2017, it requires hospitals to train caregivers in the medical and nursing tasks expected of them.

**Key Stakeholders**
Caregivers, older adults, employers, health care providers, health care systems, insurers, long-term care and community based service providers.

**Health Equity Implications**
The prevalence of caregiving is higher among Hispanic, African-American, and Asian-American families than in the White population. African-American and Hispanic caregivers experience higher levels of burden and spend more time in the caregiving role than others. LGBT caregivers may have multiple caregiving roles at once in their family of choice and family of origin. They often fear inadequate or insensitive treatment by paid care providers and avoid seeking help, resulting in even more caregiver burden. Developing programs and policies that target the unique needs of caregivers from these populations is essential to increasing accessibility and receptivity.
Elderly Waiver*

**Problem Statement**
The Elderly Waiver (EW) program provides home and community-based services for people who need the level of care provided in a nursing home but who choose to live in the community. Individuals must qualify for Medical Assistance to be eligible for Elderly Waiver services. There is a wide range of services covered under this program such as: adult day services, family caregiver supports (including respite care), chore services, residential services, home delivered meals and transportation. This program has experienced both systemic challenges such as chronic underfunding and administrative complexities; as well as operational issues such as complicated transitions and unrecognized service needs. As a result, seniors in Minnesota are increasingly limited in their choices of what services they can access, whether there are available services at all in their communities, how long they are able to stay in their home, and whether they are able to maintain a quality of life in their home communities. Over 30,000 Minnesotans annually use the services under the EW program to cover the cost of care that helps them stay in the community and reduce state spending on more expensive long-term care settings. With the growing senior population, significant reform is needed to this program to appropriately provide and fund person centered care and services.

**Potential Solutions**
- For Customized Living, re-design the workbook to align with client needs for nursing and behavioral services;
- Reform the assessment and communication processes to ensure a person-centered approach with transparency, timeliness and collaboration between client, family, assessors, case manager, and provider of services;
- Performance measures and accountabilities are needed to improve overall health and satisfaction of the senior population, starting with customer satisfaction surveys and workforce retention metrics;
- For services identified “at risk” due to funding and workforce shortage, establish a critical access program to ensure seniors can stay in their home communities as long as possible.
- Create service rates and categories based on a logical methodology. For example, utilize the personnel employed using annual labor market information from the Minnesota Department of Employment and Economic Development (DEED).
- Examine alternatives to or uniformity of the waiver obligation collection policy and process.
- Increase the Medical Assistance spenddown for Elderly Waiver to align with Medicaid Expansion eligibility.

**Key Stakeholders**
Consumers, health plans, health care systems, community based providers, Department of Human Services, long-term care providers, and counties.

**Health Equity Implications**
Older adults of color have been placed in nursing homes instead of community-based alternatives at a greater rate than their white peers. Between 1999 and 2008, the number of older Latinos and Asian Americans living in U.S. nursing homes grew by 54.9% and 54.1%, respectively. While the number of older African American residents increased by 10.8%. During the same period, the number of white nursing home residents declined by 10.2%. This rapid uptick in number of people of color placed in nursing homes, outpaced their overall population growth.
Transportation*

Problem Statement
Lack of appropriate and adequate transportation for older adults who do not drive has been a serious issue for several years and the urgency to create solutions is accelerating. The complexities involved with providing transportation of all types, such as inconsistent insurance practices, differing rural and urban geographic requirements, restrictive city ordinances and restrictions from third party payers are causing existing nonprofit and community providers to reconsider their willingness to provide transportation services. Access to transportation for transit dependent adults of all ages improves their economic prospects and provides critical independence to older adults. Keeping older adults connected to community is essential to their physical and emotional well-being. They in turn support local businesses, volunteer and stay engaged in community. Transportation services of all types are the essential link to meet basic needs of healthcare, food, and other essential goods and services. Transportation coordination is necessary to eliminate barriers to necessary travel destinations, and to encourage public utility of publicly funded/subsidized vehicles.

Potential Solutions
Over the last decade, some human services transportation programs have closed, primarily due to lack of funding. Volunteer driver programs end services in the face of additional challenges inherent in their service model. Strategies to reverse these trends and put Minnesota on the road to solution include:

- Designate state funding for community-based transportation solutions state-wide and ensure those dollars cover the true costs, including assisted rides
- Work to remove barriers, such as reimbursement restrictions for volunteer drivers
- Continue efforts to clarify the transportation network companies Uber/Lyft statute MS 65B.472 to ensure volunteer drivers are a viable resource options for ride-on-demand programs
- Support state-wide transportation resource sharing and coordination

Key Stakeholders
Consumers, healthcare organizations, community-based providers, counties, state agencies, federal government.

Health Equity Implications
Access to healthcare is a key for older adults to live their best lives at home. Older adults who have lived in or near poverty are more likely to be transit dependent, have greater incidence of multiple chronic conditions, and are a racial minority. Lack of transportation to healthcare services and limited access to healthy foods and lifestyles over their lifetimes are contributing factors to ill health and loss of independence in older age.
Long-Term Care Financing Reform
Problem Statement:
Sixty thousand Minnesotans turn 65 each year and will continue to do every year for approximately the next 14 years in our state. Recent national data indicates that about half of this growing senior demographic will need a high level of assistance, care and support for a prolonged period of time. Given that most seniors lack long-term care (LTC) insurance of any kind, and that many lack retirement savings that could cover the estimated lifetime financial risk that long-term services and supports (LTSS) represents -- approximately $182,000 for women and slightly lower for men -- many will turn to Medical Assistance to cover the costs of care and support, creating an unsustainable rate of growth in this publicly funded program. Minnesota has taken the first steps to begin to address this issue with the Own Your Future Initiative and its focus on a public/private solution to this challenge. Promising work has also been done on a bi-partisan basis at the national level. Still, we need to move farther, faster to meet the challenge that lies just a few years ahead.

Possible Solutions:
1. Stimulate and re-vitalize the private insurance marketplace to introduce new and innovative insurance products focused on lower priced policies with a defined set of benefits e.g. front end coverage for LTSS tied to a health episode.
2. Fund state-level simulation of the possible insurance solutions that would reduce further reliance on Medical Assistance.
3. Engage the employer community in efforts to educate younger individuals on the lifetime risk of LTSS and to encourage saving for future LTSS needs.
4. Advance coverage for “wrap around” services for seniors to support individualized LTSS in their homes.

Mental Health Services for Older Minnesotans
Problem Statement:
It is estimated that 20% of people age 55 or older experience some type of mental health concern. The most common conditions include anxiety and mood disorders such as depression or bipolar disorder. Depression, in particularly, can impair an older person’s ability to function independently and lead to poor health outcomes. Researchers confirm that older adults with evidence of mental disorder are less likely than younger and middle aged adults to receive mental health services and that when they do, they are less likely to receive care from a mental health specialist (Karel, Gatz & Smyer, 2012). Older Americans underutilize mental health services for a variety of reasons, including:
- stigma surrounding mental health and its treatment
- inadequate insurance coverage and reimbursement for mental health treatment
- a shortage of trained geriatric mental health providers across settings
- lack of coordination among primary care, mental health, health care and aging service providers
• access barriers such as transportation

Potential Solutions:
1. Modify current Elderly Waiver program to reflect additional service and staff needs of recipients with chemical and mental health needs.
2. Coordinate and engage stakeholders in an ongoing discussion to share knowledge and expertise as it relates to coordination of care and best practices for meeting the mental health needs of older Minnesotans.
3. Make tele-health services available using psychiatrists/behavioral health specialists.
4. Strengthen the discharge planning process so mental and chemical health needs are clearly identified prior to discharge into the community.

Case Management & Discharge Planning

Problem Statement:
Older adults with complex, chronic conditions consume a significant and growing share of medical resources. Trends suggest that the number of high-cost, high-need older adults will grow while public and private resources will not. Our complex care systems often require multiple transitions within and between providers. Critical to successful transition is case management and planning for transitions and discharges. An older adult being discharged from the hospital can have multiple people designated to help navigate systems. These can include a case manager from the county, a service coordinator through a health plan, a social worker in transitional care, a discharge planner from the hospital, a social worker with a community-based organization, etc. each with a separate assessment, care plan and scope of practice. This provider or system centric model can lead to frustration and confusion of older adults and caregivers.

Potential Solutions:
• Re-engage the Department of Human Services (DHS) case management redesign process;
• Learn from the Personal Health Record for LTSS (TEFT) planning and demonstration grant at DHS regarding sharing of information across systems;
• Communicate across sectors. Look to community based agencies to supply cross-system navigators as part of an integrated approach. Train non-clinical support to make systematic observations of their clients and to communicate changes in status to clinicians and encourage clinicians to take action on even vague descriptions. Share records among medical and social care systems.
• Employ a single care coordinator/navigator that is empowered and has authority. Provide navigator/care manager services to all older adults at critical target points in transitions.

HCBS Transition Plan

Problem Statement:
The federal Centers for Medicare & Medicaid Services (CMS) published a Final Rule defining what constitutes home and community based services (HCBS) settings for purposes of Medicaid payment under the waiver programs. Originally published in March of 2014, states have 5 years to come into compliance with these rules. Minnesota submitted an initial plan in January 2015 to CMS to which CMS responded asking for more details. A revised draft Statewide Transition Plan (STP) was posted on October 4th, with a 30-day public comment period. Within this plan DHS has concluded that Minnesota
statutes, chapters 144D (HWS), 144G (Assisted Living Services) and 144A (Home Care) need to have changes to them to ensure that people are supported to fully access and engage in the community. We will be actively reviewing and participating in these proposed changes to ensure that persons served under the Elderly Waiver program are not negatively impacted when implemented.

**Electronic Monitoring**

**Problem Statement**

During the 2016 legislative session, a work group was established to develop recommendations for legislation to authorize the use of voluntary electronic monitoring to protect vulnerable adults. The workgroup, convened by the Minnesota Elder Justice Center, has been meeting since mid-summer with plans to come up with recommendations for legislation to authorize the use of voluntary electronic monitoring to protect vulnerable adults and hold accountable perpetrators of abuse in residential care settings. The work group will report its recommendations to the legislature by January 15, 2017.

*Content and solutions are designed to comprehensively highlight initiatives underway for the 2017 session and are not necessarily endorsed by individual MNLCOA members, MN Board on Aging, or Summit sponsors.*
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Check all that apply:

☐ Elderly Waiver          ☐ Transportation
☐ Family/Friend caregiving ☐ Workforce
☐ General MNLCOA list      ☐ General aging policy

I have the following ideas/thoughts about aging policy in Minnesota: