Aging in Rural Minnesota

A comparative analysis of data and policy impacting aging in Minnesota rural and urban regions

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Contents

Introduction

The aging population in rural Minnesota faces unique challenges that significantly affect their quality of life and access to essential services. Unlike their urban counterparts, older adults in these areas deal with a scarcity of resources and services tailored to their needs. This includes but is not limited to, limited transportation options, social isolation, and inadequate access to health care. These factors not only exacerbate loneliness but also complicate the delivery of critical support services such as food assistance and caregiver support. Furthermore, the lack of affordable supportive housing and homemaker services further strains the ability of these individuals to live independently and safely in their communities.

This research project aims to conduct a comprehensive analysis of the key aging-related factors affecting older adults in rural Minnesota. By understanding the multi-faceted challenges these individuals face—ranging from transportation difficulties, social isolation, loneliness, and to insufficient food and caregiver support, as well as barriers to accessing affordable supportive housing and health care services—this study seeks to identify gaps in the current support systems. Recognizing these issues is the first step towards developing targeted interventions that can significantly improve the lives of older adults living in rural areas.

The goal of this project is to inform policy recommendations that will enhance the quality of life and support systems for older adults in rural communities. By leveraging the findings from this comprehensive analysis, key collaborative partners can better advocate for and implement solutions that address the critical needs of this vulnerable population. Through targeted policy changes and the development of specialized programs, it is possible to create a more inclusive and supportive environment for older adults in rural Minnesota, ensuring they have access to the resources and services necessary to live fulfilling lives.

Methodology

Rural Health Innovations, LLC (RHI), a subsidiary organization of the National Rural Health Resource Center, partnered with The University of Minnesota Rural Health Research Center to collaboratively produce this report which included data collection and analysis, literature review, policy analysis, and discussion highlighting key insights, identified challenges, and evidence-based recommendations.

Data analysis and literature review included in this report illustrate differences and similarities in challenges for older adults across Minnesota. All comparisons are between the 7-county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties, referred to as metro counties) and Greater Minnesota (the 80 non-metro counties). The analysis population includes individuals age 60+ where possible; otherwise, the population includes individuals ages 55+ and/or 65+, depending on data availability. To ensure the timeliness and cost efficiency of the analyses, data sources used met the following criteria: publicly available at time of analysis (summer 2024); cost free; and with county-level accessible variables. Each variable's respective data source is described in the fourth column of each table, and a detailed data appendix is available at the end of this document. Data was preserved to the first decimal place as data allowed. However, decimal places are inconsistent throughout the document as some data sources did not include decimal places in the original data. Data tables highlight findings in sociodemographic, social well-being, food insecurity, affordable supportive housing, transportation, health care access, aging support services,

and utilization of aging support services. The University of Minnesota Rural Health Research Center conducted a comprehensive literature review to identify best practices and successful interventions across the rural U.S., and relevant policies that have been effective in addressing similar challenges faced by older adults in rural areas. The policy analysis section of this report connects knowledge of existing barriers in supporting rural older adults with potential/existing policies at the local, state, or national level. The policy analysis identifies top areas for intervention and indicates potential policy levers or solutions.

Findings

Sociodemographics

Rural U.S. populations are older than urban populations, on average. As of 2021, older U.S. adults (age 65 and older) make up more than 20% of all rural residents, compared with 16% of urban residents. Further, older adults are the fastest-growing age group in rural areas of the U.S.; between 2010 and 2022 the population of older adults in rural areas grew by 22% compared with a decline of nearly 5% among rural adults ages 18–64.[1]

The demographics of older adults in rural areas of the country differs from that in urban areas in meaningful ways. For example, more than one in five rural older adults is a veteran, which is a significantly higher share than in urban counties.[2] Though both rural and urban older adults are primarily non-Hispanic White, this group comprises almost 90% of older adults in rural counties, compared to just over 75% of older adults in urban counties.[2] There is also a significantly higher percentage of American Indian/Alaskan Native older adults in rural counties, and significantly higher percentages of non-Hispanic Black, Asian, and Hispanic older adults in urban counties.[2] Rural older adults in the U.S. also have significantly higher rates of disability than their urban counterparts.[2,3,4] Finally, rural older adults tend to be less geographically mobile than their urban counterparts, and are much more likely to be living in the state in which they were born than urban older adults.[4]

Demographics for older adults in rural Minnesota mimic many of the rural demographics nationally. Rural Minnesotans are older, have more chronic conditions and report poorer health, and are more likely to be low income compared with urban Minnesotans.[5] Nearly one million older adults (65+), and over half of Minnesota's older adult population, live in non-metro areas.[6] Minnesotans living in rural and small towns are over twice as likely to be 80 years old or older than

[1] Davis JC, Rupasingha A, Cromartie J, Sanders A. Rural America at a Glance: 2022 Edition. Washington, DC; 2022.
[2] Tuttle C, Tanem J, Lahr M, Schroeder J, Tuttle M, Henning-Smith C. Rural-Urban Differences among Older Adults. Minneapolis, MN; 2020. https://rhrc.umn.edu/wp-content/uploads/2020/08/Rural-Urban-Older-Adults_Chartbook_Final_8.25.20.pdf. Accessed September 16, 2020.
[3] Henning-Smith C, Lahr M, Mulcahy J, MacDougall H. Unmet Needs for Help With Mobility Limitations Among Older Adults Aging in Place: The Role of Rurality . J Aging Health. 2023;(10.1177/08982643231151777).
[4] Henning-Smith C, Tuttle M, Swendener A, Lahr M, Yam H. Differences in Residential Stability by Rural/Urban Location and Socio-Demographic Characteristics. Minneapolis, MN; 2023.
[5] Minnesota Department of Health Division of Health Policy. Rural Health Care in Minnesota: Data Highlights. St. Paul, MN; 2021.
[6] Wilder Research. Minnesota Compass: Older Adults Ages 65+. Minnesota Compass. https://www.mncompass.org/older-adults. Published 2024. Accessed August 9, 2024.

urban residents.[7] Older adults in Minnesota (rural and urban) are more likely to be non-Hispanic white than the national average (94% vs. 77%).[8]

Table 1 illustrates the sociodemographics present for the aging population in Minnesota in terms of age, gender, poverty level, race, and ethnicity. Greater Minnesota represents an older population compared to the metro counties for all age groups over 65 years. U.S. Census data does not present a marked difference in the regions (7-county metro compared to Greater Minnesota) in the aging populations of females. Among those 65 years and older, a slightly higher proportion of individuals living below the poverty line live in Greater Minnesota (8.0%) compared to the metro counties (6.8%). Among all age groups, Non-Hispanic Blacks, Blacks or African Americans, and Asians or Native Hawaiian/Pacific Islanders have larger proportions living in the metro counties compared to Greater Minnesota. Among all age groups, American Indians or Alaska Natives and Non-Hispanic Whites have larger proportions living in Greater Minnesota compared to the metro counties. A slightly higher percentage of Hispanic individuals live in the metro counties compared to Greater Minnesota. There is no difference in the proportion of individuals identifying two or more races living in either region. These same trends in race/ethnicity and region are present in adults 65 years and older. In other words, if a race/ethnicity has a larger proportion of its population in the state living in one region, the same trend holds similar for aging adults of that same race/ethnicity.

[7] Minnesota State Demographic Center. Greater Minnesota Refined & Revisited. St. Paul, MN; 2017. https://mn.gov/admin/assets/greater-mn-refined-and-revisited-msdc-jan2017_tcm36-273216.pdf. Accessed August 9, 2024.
[8] Brower S. Minnesota's Aging Population and Disability Communities. St. Paul, MN; 2022. https://mn4a.org/wp-content/uploads/2022/03/Minnesotas-Aging-Population-and-Disability-Communities-SBrower2022.pdf. Accessed August 9, 2024.

Table 1: Sociodemographics, percent of the total population for the region

Age	Metro Counties	Greater Minnesota	Data source
65+	15.3%	20.7%	U.S. Census
60 – 69	11.6%	14.1%	Census Reporter
70 – 79	6.8%	8.7%	Census Reporter
80+	3.6%	5.6%	Census Reporter
Among 60+, female	53.3%	52.3%	U.S. Census
Among 65+, female	54.2%	53.1%	U.S. Census
Among 65+, below poverty line	6.8%	8.0%	Aging Data Profiles MN
Race/Ethnicity			
Non-Hispanic Black (Total population)	8.5%	1.7%	County Health Rankings
Black or African American (65+ population)	4.5%	0.6%	Aging Data Profiles MN
American Indian or Alaska Native (Total population)	0.8%	2.6%	County Health Rankings
American Indian or Alaska Native (65+ population)	0.3%	0.9%	Aging Data Profiles MN
Asian or Native Hawaiian/Pacific Islander (Total population)	7.8%	1.5%	County Health Rankings
Asian or Pacific Islander (65+ population)	3.6%	0.8%	Aging Data Profiles MN
Hispanic (Total population)	6.3%	5.4%	County Health Rankings
Hispanic (65+ population)	2.0%	1.1%	Aging Data Profiles MN
Non-Hispanic White (Total population)	74.4%	87.5%	County Health Rankings
Non-Hispanic White (65+ population)	89.2%	96.2%	Aging Data Profiles MN
Two or more races (65+ population)	0.5%	0.5%	Aging Data Profiles MN

Affordable Supportive Housing

The majority of older U.S. adults (over 60% in rural and urban) believe that the home is the optimal setting to receive long-term care; still, one-third would prefer an institutional setting.[9] As such, policies and programs need to support older adults aging in place, but also ensure a range of housing and long-term care options are available to meet a range of preferences and needs. Yet, rural areas face unique challenges to supporting older adults in aging in place. In a recent survey of State Offices of Rural Health (SORHs), more than one-third (35%) identified transportation as the largest barrier to older adults successfully aging in place in rural communities, followed by barriers related to accessing health care (22%), workforce (16%), and home health care (14%).[10] Rural older adults are more likely than urban older adults to own their homes, which may provide economic stability, but also leaves them responsible for maintenance and upkeep.[2,4,11] Rural older adults aging in place also have greater unmet needs for help with mobility limitations and are more likely to live in homes with stairs at the entrance.[4] Overall, not all housing is of adequate quality or accessibility to support aging in place for rural older adults in the U.S. and greater investments are needed to ensure that rural housing stock is able to support the needs of an aging population.[4,12,13,14]

In Minnesota, roughly 80% of older adults (both rural and urban) own their home,[6] which may help to foster aging in place, but which may also require interventions to support maintenance, upkeep, and accessibility modifications when appropriate. Homelessness among older adults is also growing among older adults in Minnesota. Between 2015-2018, homelessness among people ages 55-plus increased by 25%, while homelessness overall grew by 10% during the same period.[15] Lack of affordable housing in Minnesota was cited as the primary reason.[15]

Table 2 explores affordable housing impacts on aging adults. The median value of all owner-occupied housing units is considerably higher in the metro counties ($372,000) compared to Greater Minnesota ($196,764). Among all housing units in a region, there is almost twice as many multi-family housing units in the metro counties (29.1%) compared to Greater Minnesota (15.7%). Similar to median value, housing costs per month are almost double in the metro counties ($1,545) compared to Greater Minnesota ($873). A slightly greater prevalence of housing units with zero-step entrance exisits in Greater Minnesota (53.2%) compared to the metro counties (45.4%). The housing cost burden is somewhat higher in the metro counties (15.7%) compared to Greater Minnesota (12.5%). The availability of subsidized housing per

[9] Henning-Smith C, Mulcahy J, Lahr M, Tanem J. Preferences for Long-Term Care Arrangements among Rural and Urban Older Adults. Minneapolis, MN; 2021. https://rhrc.umn.edu/publication/preferences-for-long-term-care-arrangements-among-rural-and-urban-older-adults/. Accessed May 21, 2021.
[10] Lahr M, Henning-Smith C. Barriers to Aging in Place in Rural Communities: Perspectives from State Offices of Rural Health. Minneapolis, MN; 2021.
[11] Henning-Smith C, Swendener A, Rydberg K, Lahr M, Yam H. Rural/urban differences in receipt of governmental rental assistance: Relationship to health and disability. J Rural Heal. 2024;40(2). doi:10.1111/jrh.12800
[12] Yam H, Swendener A, Tuttle M, Pick M, Henning-Smith C. Rural/Urban Differences in Housing Quality and Adequacy: Findings from the American Housing Survey, 2019. Minneapolis, MN; 2024.
[13] Swendener A, Pick M, Lahr M, Yam H, Henning-Smith C. Housing Quality by Disability, Race, Ethnicity, and Rural-Urban Location: Findings from the American Community Survey. Minneapolis, MN; 2023.
[14] Swendener A, Rydberg K, Tuttle M, Yam H, Henning-Smith C. Crowded Housing and Housing Cost Burden by Disability, Race, Ethnicity, and Rural-Urban Location. Minneapolis; 2023.
[15] Lindberg C, Ulstad K, Owen G, Gerrard M. Older Adults Experiencing Homelessness in Minnesota. St. Paul, MN; 2020. https://www.wilder.org/sites/default/files/imports/2018_HomelessOlderAdultsInMinnesota_4-20.pdf. Accessed August 9, 2024.

10,000 residents is slightly higher in Greater Minnesota, while the prevalence of housing units with severe housing programs is similar across regions.

Table 2: Affordable Supportive Housing

	Metro Counties	Greater Minnesota	Data source
Median value of owner-occupied housing units	$372,000	$196,764	Census Reporter
Units that are multi-family housing*	29.1%	15.7%	AARP Livability Index
Housing units with zero-step entrance	45.4%	53.2%	AARP Livability Index
Housing costs per month	$1,545	$873	AARP Livability Index
Housing cost burden**	15.7%	12.5%	AARP Livability Index
Availability of subsidized housing (units/10,000 people)	160.5	172.0	AARP Livability Index
Units with severe housing problems***	12%	11%	County Health Rankings

**Out of total housing units in region*

***Percent of income devoted to monthly housing costs*

****From source: "the percentage of households with one or more of the following housing problems: housing unit lacks complete kitchen facilities; housing unit lacks complete plumbing facilities; household is overcrowded; or household is severely cost burdened."*

Food Insecurity

The U.S. Department of Agriculture defines food insecurity as "the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways."[16] Food security may be influenced by many factors including poverty or low fixed income and access to foods including proximity to a source of food, reliable transportation or access to transportation including public transportation or ride sharing, physical mobility to acquire foods, availability of food delivery services, and social isolation. In 2022, 9.1% of U.S. households with adults 65 years and older were food insecure at some time during the year.[17] Table 3 describes access to grocery stores, healthier foods, and participation in food assistance programs. Low access to grocery stores measures adults living in urban areas who are living more than one mile from a supermarket or large grocery store, or in rural areas living more than 10 miles from a from a supermarket or large grocery store. A greater proportion of adults 65 years and older living in Greater Minnesota have low access to grocery stores (4.3%) compared to the metro counties (2.7%). The food environment index measures income and proximity to healthy foods. The weighted index measures include distance to a grocery store or supermarket, locations for health good purchases in the community, percent of the population that is low income, and food insecurity. A higher food environment index indicates a healthier food environment.[18] Individuals living in the metro counties have a higher food environment index (9.4) compared to Greater Minnesota (8.6). Supplemental Nutrition Assistance Program (SNAP) provides food benefits to low-income families.[19]

[16] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/measurement
[17] https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=108066
[18] https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/diet-and-exercise/food-environment-index?year=2024
[19] https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program

There is minimal regional difference in Minnesota in the proportion of households with adults 60 years and older who receive SNAP benefits.

Table 3: Food Insecurity

	Metro Counties	Greater Minnesota	Data source
Among 65+, with low access to grocery stores*	2.7%	4.3%	Food Access Dashboard
Food Environment Index**	9.4	8.6	County Health Rankings
Households 60+ with SNAP***	6.0%	5.8%	Food Research & Action Center

**Percentage of older adults (age > 64) in a county living more than one mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area*
***From 0 to 10, higher values indicate healthier food environments*
****From source: "the share of all households with older adults (60+) that participate in SNAP in each county"*

Transportation

All adults require access to various methods of transport to not only meet basic living needs, but to also support purpose, engagement, fulfillment, and health. Table 4 describes the transportation data for the metro counties and Greater Minnesota regions. Greater Minnesota residents are more likely to drive alone to work, while those in the metro counties are more likely to have a commute over 30-minutes spent alone. Household transportation costs per year are similar among both regions. Transit system data was only available for the Greater Minnesota counties. In that region, half the transit systems operate past 6:00 p.m. on weekdays, almost three-fourths operate on Saturdays, and less than half operate on Sundays (all metro transit systems operate during these times). The majority of transit stations and vehicles in the metro counties (90.1%) and Greater Minnesota (83.0%) are wheelchair accessible according to the requirements of the Americans with Disabilities Act (ADA).

Table 4: Transportation

	Metro Counties	Greater Minnesota	Data source
Driving alone to work*	71%	77%	County Health Rankings
Long commute alone (over 30 minutes)**	35%	28%	County Health Rankings
Household transportation costs/year	$16,547	$17,357	AARP Livability Index
Greater MN transit systems operating past 6:00 p.m. on weekdays		50%	MNDOT 2023 Transit Report***
Greater MN transit systems operating on Saturdays		71%	MNDOT 2023 Transit Report***
Greater MN transit systems operating on Sundays		44%	MNDOT 2023 Transit Report***
Stations and vehicles ADA-accessible (wheelchair accessible)	90.1%	83.0%	AARP Livability Index

**Out of the total workforce*

***Out of the workforce that drives alone to work*

****The transit report used only provided data for Greater Minnesota; data is included transit systems with both fixed route and/or dial-a-ride services in our analysis, and calculated data based off of the percentage of all 34 transit systems operating in Greater Minnesota*

Social Well-Being

Social well-being is foundational to good health for older adults and rural areas have historically been known for stronger social cohesion than urban areas.[20,21] A 2019 study found that older adults in rural areas of the U.S. have larger social networks (both friends and family) than urban older adults, but that they were also more likely to report symptoms of loneliness, especially feelings of being left out.[22] This suggests a structural barrier to connection in rural areas, such as transportation, technology, or access to social infrastructure.[21,23] However, rural adults aging in place are still significantly more likely to say that people in their community know each other well, compared to urban adults aging in place.[24]

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[20] Henning-Smith C. The Unique Impact of COVID-19 on Older Adults in Rural Areas. J Aging Soc Policy. June 2020:1-7. doi:10.1080/08959420.2020.1770036

[21] Henning-Smith C. Meeting the Social Needs of Older Adults in Rural Areas. JAMA Heal Forum. 2020;1(11):e201411. doi:10.1001/jamahealthforum.2020.1411

[22] Henning-Smith C, Moscovice I, Kozhimannil K. Differences in Social Isolation and Its Relationship to Health by Rurality. J Rural Heal. January 2019. doi:10.1111/jrh.12344

[23] Henning-Smith C, Ecklund A, Lahr M, Evenson A, Moscovice I, Kozhimannil KB. Key Informant Perspectives on Rural Social Isolation. Minneapolis, MN; 2019. https://rhrc.umn.edu/publication/key-informant-perspectives-on-rural-social-isolation-and-loneliness/.

[24] Henning-Smith C, Lahr M, MacDougall H, Mulcahy J. Social Cohesion and Social Engagement among Older Adults Aging in Place: Rural/Urban Differences. Minneapolis; 2022. https://rhrc.umn.edu/publication/social-cohesion-and-social-engagement-among-older-adults-aging-in-place-rural-urban-differences/. Accessed February 14, 2022.

Social isolation and loneliness are more common among people living alone, and more than one in four older adults in both rural and urban counties live alone, but this rate is significantly higher among rural older adults.[2,25] Rural adults with disabilities in the U.S. are also more likely to live alone; indeed, age, disability, and rural residence are compounding factors in the likelihood of living alone.[23] In Minnesota, rates of living alone are similar between rural and urban older adults, with more than one-quarter living alone total (25.0% non-metro; 25.7% metro).[26]

Table 5 explores those social connections, as well as social isolation. Greater Minnesota has twice as many social associations (17.9) per 10,000 people compared to the metro counties (8.8). The social involvement index measures belonging to groups, organizations, or associations, how often one sees or hears from friends and family, does favors for their neighbors, or does something positive for their community.[27] A higher value indicates more social involvement. There is minimal difference in the social involvement index comparing the two regions. About one-fourth of Minnesota adults 65 years and older live alone, with slightly more living alone in the metro counties (26.4%) compared to Greater Minnesota (25.0%).

Table 5: Social Well-Being

	Metro Counties	Greater Minnesota	Data source
Social associations/10,000 people	8.8	17.9	County Health Rankings
Social involvement index*	1.2	1.1	American Association of Retired Persons (AARP) Livability Index
Among 65+, living alone	26.4%	25.0%	Aging Data Profiles MN

**From 0 to 2.5, higher values indicate more social involvement*

Health Care Access

Nationally, access to care is a constant issue for many older adults living in rural communities.[28] For example, a significantly higher share of urban older adults saw their regular doctor within the past year compared to rural older adults.[2] Access to specialty care can be particularly challenging for rural older adults, especially mental health providers.[29] In a 2019 study, rural Medicare beneficiaries were more likely than their urban counterparts to have delayed care due to cost and they had longer travel times to see their usual provider.[30] Compared with urban Medicare

[25] Schroeder J, Henning-Smith C, Tuttle M. Demographics and Disability Status of Adults Living Alone in Rural Areas . Minneapolis, MN; 2021. https://rhrc.umn.edu/publication/demographics-and-disability-status-of-adults-living-alone-in-rural-areas/. Accessed May 19, 2021.
[26] Minnesota Department of Human Services. Aging Data Profiles. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/aging/aging-2030/data-profiles/. Published September 8, 2017. Accessed August 9, 2024.
[27] https://livabilityindex.aarp.org/methods-sources#categories
[28] Probst J, Eberth JM, Crouch E. Structural urbanism contributes to poorer health outcomes for rural America. Health Aff. 2019;38(12):1976-1984. doi:10.1377/HLTHAFF.2019.00914/ASSET/IMAGES/LARGE/FIGUREEX2.JPEG
[29] Lahr M, Neprash H, Henning-Smith C, Tuttle M, Hernandez A. Access to Specialty Care for Medicare Beneficiaries in Rural Communities. Minneapolis, MN; 2019.
[30] Henning-Smith C, Hernandez A, Lahr M. Rural-Urban Differences in Access to and Attitudes Toward Care for Medicare Beneficiaries. Minneapolis, MN; 2019. https://rhrc.umn.edu/publication/rural-urban-differences-in-access-to-and-attitudes-toward-care-for-medicare-beneficiaries/. Accessed December 13, 2019.

beneficiaries, rural Medicare beneficiaries were much more likely to avoid going to the doctor and to not tell anyone if they were feeling sick.[28]

There are many reasons that access to care is challenging for older adults in rural areas, including geographic isolation, transportation barriers, workforce shortages, and facility availability.[31,32,33,34,35,36] Nationally, rural areas are much more likely to be health professional workforce shortage areas than urban areas[37] and rural areas have a lower ratio of direct care workers (home health aides and nursing assistants) to older adults compared to urban areas.[38] Since 2005, over 192 rural hospitals have closed or converted to provide a lower level of care.[39] Nursing homes have also been closing at an alarming rate, with 472 nursing homes in non-metropolitan areas closing between 2008-2018.[40] These nursing home closures resulted in longer distances for rural residents to access home health agencies, other nursing homes, and hospitals with swing beds.[41] Rural nursing homes have capacity constraints owing to lower population density, limited financial resources, and unique workforce recruitment and retention challenges.[42,43,44]

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[31] Turrini G, Branham DK, Chen L, et al. Access to Affordable Care in Rural America: Current Trends and Key Challenges (Research Report No. HP-2021-16). Washington, DC; 2021.
[32] Martino SC, Elliott MN, Hambarsoomian K, et al. Disparities in Care Experienced by Older Hispanic Medicare Beneficiaries in Urban and Rural Areas. Med Care. 2022;60(1). doi:10.1097/MLR.0000000000001667
[33] Lahr M, Henning-Smith C, Rahman A, Hernandez A. Barriers to Health Care Access for Rural Medicare Beneficiaries: Recommendations from Rural Health Clinics. Minneapolis, MN; 2021.
[34] Johnston KJ, Wen H, Joynt Maddox KE. Lack Of Access To Specialists Associated With Mortality And Preventable Hospitalizations Of Rural Medicare Beneficiaries. Health Aff (Millwood). 2019;38(12):1993-2002. doi:10.1377/hlthaff.2019.00838
[35] McCarthy S, Moore D, Smedley WA, et al. Impact of Rural Hospital Closures on Health-Care Access. J Surg Res. 2021;258. doi:10.1016/j.jss.2020.08.055
[36] MacDowell M, Glasser M, Fitts M, Nielsen K, Hunsaker M. A national view of rural health workforce issues in the USA. Rural Remote Health. 2010;10(3):1531. doi:1531 [pii]
[37] Health Resources & Services Administration (HRSA) Bureau of Health Workforce. Health Professional Shortage Areas (HPSAs) . https://bhw.hrsa.gov/shortage-designation/hpsas. Accessed August 7, 2024.
[38] Dill J, Henning-Smith C, Zhu R, Vomacka E. Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas. J Appl Gerontol. 2023;Epub ahead of print.
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[42] Henning-Smith C, Cross D, Rahman A. Challenges to Admitting Residents: Perspectives from Rural Nursing Home Administrators and Staff. Inq (United States). 2021;58. doi:10.1177/00469580211005191
[43] Henning-Smith C, Kozhimannil K, Prasad S. Barriers to Nursing Home Care for Nonelderly Rural Residents. J Appl Gerontol. December 2017:073346481774677. doi:10.1177/0733464817746772
[44] Henning-Smith C, Casey M, Prasad S, Kozhimannil K. Medical Barriers to Nursing Home Care for Rural Residents | The University of Minnesota Rural Health Research Center. Minneapolis; 2017.

Many national challenges in access to care for rural older adults are present in Minnesota, too. Minnesota has long-standing health professional workforce shortages, including in specialty care,[45,46] and there is a growing need for direct care workers in Minnesota to support the aging population.[47] Minnesota currently has 76 Critical Access Hospitals,[48] many throughout rural communities. Though the last rural hospital to close in Minnesota was in 2015, 27 facilities have made other adjustments based on ability to remain viable. For example, a Critical Access Hospital in Mahnomen transitioned to a Rural Emergency Hospital, and no longer provides inpatient care.[49] While such conversions may help to sustain health care in rural communities – rather than losing it entirely – they may also limit access to a full continuum of services required by older adults living in rural Minnesota.

Overall, the healthcare professional shortage area index is seven times higher in Greater Minnesota (9.2) compared to the metro counties (1.3) (Table 6). Data was explored on the ratios of the number of residents per region to a provider type. The ratios of provider to residents were higher in Greater Minnesota compared to the metro counties for all provider types (primary care physician, dentist, mental health provider), indicating reduced access to providers in Greater Minnesota. Notably, access to a mental health provider is almost three times more severe in Greater Minnesota (1,250 residents to 1 provider) compared to the metro counties (401). All seven metro counties have assisted living facilities, home care providers, hospitals, and nursing homes. In Greater Minnesota, 99% have nursing homes, 94% have assisted living facilities, 93% have hospitals, and 76% have home care providers. A greater proportion of the metro counties compared to Greater Minnesota counties have hospice programs (71%, 56%) and rehabilitation facilities (86%, 15%).

[45] Fritsma T, Henning-Smith C, Gauer JL, Khan F, Rosenberg ME, Clark K, Sopdie E, Sechler A, Sundberg MA, Olson AP. Factors Associated with Health Care Professionals' Choice to Practice in Rural Minnesota. JAMA Network Open. 2023 May 1;6(5):e2310332. doi: 10.1001/jamanetworkopen.2023.10332

[46] Henning-Smith C, Fritsma T, Olson A, Woldegerima S, MacDougall H. Decisions to Practice in Rural Areas Among Mental Health Care Professionals. JAMA Netw Open. 2024;7(6). doi:10.1001/jamanetworkopen.2024.21285

[47] Campbell C. Growing Demand for Caregivers.; 2016. https://mn.gov/deed/assets/caregivers_tcm1045-270160.pdf. Accessed August 9, 2024.

[48] Flex Monitoring Team. Historical CAH Data. Flex Monitoring Team. https://www.flexmonitoring.org/historical-cah-data-0. Published 2024. Accessed August 9, 2024.

[49] Mahnomen Health. Mahnomen Health's Transition to a Rural Emergency Hospital. https://mahnomenhealth.org/mahnomen-healths-transition-to-a-rural-emergency-hospital/. Published 2024. Accessed August 9, 2024.

Table 6: Health Care Access

	Metro Counties	Greater Minnesota	Data source
Healthcare professional shortage area index*	1.3	9.2	AARP Livability Index
Primary care physician ratio**	1,386	2,288	County Health Rankings
Dentist ratio**	1,464	2,158	County Health Rankings
Mental health provider ratio**	401	1,250	County Health Rankings
Counties with any assisted living facilities	100%	94%	MN DHS Provider Files***
Counties with any home care providers	100%	76%	MN DHS Provider Files***
Counties with any hospice programs	71%	56%	MN DHS Provider Files***
Counties with any hospitals	100%	93%	MN DHS Provider Files***
Counties with any nursing homes	100%	99%	MN DHS Provider Files***
Counties with any rehabilitation facilities	86%	15%	MN DHS Provider Files***

**From 0 to 25, higher scores indicate higher levels of shortage*

***Ratio indicates number of people per 1 clinician*

****Data shows county in which address for provider organization/facility is located and does not necessarily reflect the full service area*

Aging Support Services and Caregiving

Across the U.S., the vast majority (80-90%) of all long-term care is provided by informal/unpaid caregivers. These individuals are usually family members, and more than 53 million Americans are currently providing unpaid care to a loved one, with the majority of care recipients being older adults.[50,51,52] With rural populations being older and having higher rates of chronic conditions and disability, caregiving needs can be more pronounced, and are complicated by the aforementioned barriers to accessing resources, transportation, and formal supports.[53] Rural caregivers are less likely to have access to supportive programs through their workplaces, and rural employed adults overall are less likely to have access to paid sick leave,[54,55] all of which may compound the economic challenges associated with providing care to a loved one.

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[50] Trivedi R, Beaver K, Bouldin ED, et al. Characteristics and well-being of informal caregivers: Results from a nationally-representative US survey. Chronic Illn. 2014;10(3):167-179. doi:10.1177/1742395313506947

[51] AARP. Caregiving in the U.S.: 2020 Report.; 2020. https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf. Accessed August 9, 2024.

[52] Kaye HS, Harrington C, LaPlante MP. Long-term care: who gets it, who provides it, who pays, and how much? Health Aff (Millwood). 2010;29(1):11-21. doi:10.1377/hlthaff.2009.0535 [doi]

[53] Henning-Smith C, Lahr M. Perspectives on Rural Caregiving Challenges and Interventions. Minneapolis, MN; 2018. http://rhrc.umn.edu/wp-content/files_mf/1535633283UMNpolicybriefcaregivingchallenges.pdf. Accessed October 29, 2018.

[54] Henning-Smith C, Lahr M. Rural-Urban Difference in Workplace Supports and Impacts for Employed Caregivers. J Rural Heal. June 2018. doi:10.1111/jrh.12309

[55] Henning-Smith C, Dill J, Baldomero A, Backes Kozhimannil K. Rural/urban differences in access to paid sick leave among full-time workers. J Rural Heal. 2022. doi:10.1111/jrh.12703

Minnesota has approximately 640,000 caregivers across rural and urban areas.[56] In Minnesota, the family caregiver ratio, defined as the number of adults age 85+ per 100 women ages 45-64, is 17 adults age 85+ to every 1 caregiver overall (17:1). However, it is 14:1 in metro areas and 20.5:1 in non-metro areas, indicating a higher caregiving burden in areas that already have fewer other resources and supports.[26]

As seen in Table 7, a larger proportion of adults 65 years and older living in the metro counties are receiving home and community-based services (HCBS) instead of institutional services (84.5%) compared to Greater Minnesota residents (66.6%). Greater Minnesota residents have increased ratios for the proportion of older adults dependent on care from family and younger generations. Among those who are eligible for Alternative Care and Elderly Waiver and with higher needs (ongoing behavioral or cognitive support, help with four or more activities of daily living, or frequent clinical monitoring), a larger proportion are being served in the metro counties (75.6%) compared to Greater Minnesota (65.1%).

Table 7: Aging Support Services

	Metro Counties	Greater Minnesota	Data source
People receiving HCBS instead of institutional services (out of all older adults ages 65+)	84.5%	66.6%	LTSS Demographic Dashboard
Family caregiver ratio (number of people ages 85+ per 100 women ages 45-64)	14	21	Aging Data Profiles MN
Old-age dependency ratio (number of people ages 65+ per 100 people ages 15-64)	24	32	Aging Data Profiles MN
Eligible people with higher needs being served*	75.6%	65.1%	Aging Data Profiles MN

**Eligible people with higher needs are defined by the source as "the percentage of persons eligible for Alternative Care and Elderly Waiver with higher needs for the selected region," where higher needs is defined as "a need for either ongoing behavioral or cognitive support, help with four or more activities of daily living, or frequent clinical monitoring."*

Utilization of Aging Support Services

All metro area counties have residents using adult day services, case management services, chore services/homemaker services, environmental adaptations, home care nursing/extended home care nursing, home health aide/extended home health aide, home delivered meals, personal care assistance/extended personal care assistance, skilled nursing, and transportation assistance (Table 8). Similarly, all counties in Greater Minnesota have residents using case management

[56] Reinhard SC, Feinberg LF, Houser A, Choula R, Evans M. Valuing the Invaluable: 2019 Update. Washington, DC; 2019. https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf. Accessed August 9, 2024.

services, and 96-99% of the counties have residents using chore services/homemaker services, home health aide/extended home health aide, and home delivered meals. Slightly less than half of the Greater Minnesota counties have adult day services being used (49%) and less than a third (31%) have respite services being used. Just 18% of the Greater Minnesota counties have home care nursing/extended home care nursing being used by residents and 9% have caregiver training/ education being used.

Table 8: Utilization of Aging Support Services**

	Metro Counties	Greater Minnesota	Data source
Counties with any adult day services used	100%	49%	MN DHS Data
Counties with any caregiver training/ education used	86%	9%	MN DHS Data
Counties with any case management services used	100%	100%	MN DHS Data
Counties with any chore services/homemaker services used	100%	96%	MN DHS Data
Counties with any environmental adaptations used	100%	76%	MN DHS Data
Counties with any home care nursing/extended home care nursing used	100%	18%	MN DHS Data
Counties with any home health aide/extended home health aide used	100%	99%	MN DHS Data
Counties with any home-delivered meals delivered	100%	99%	MN DHS Data
Counties with any personal care assistance/extended personal care assistance used	100%	89%	MN DHS Data
Counties with any respite care services used	71%	31%	MN DHS Data
Counties with any skilled nursing used	100%	98%	MN DHS Data
Counties with any transportation assistance used	100%	73%	MN DHS Data

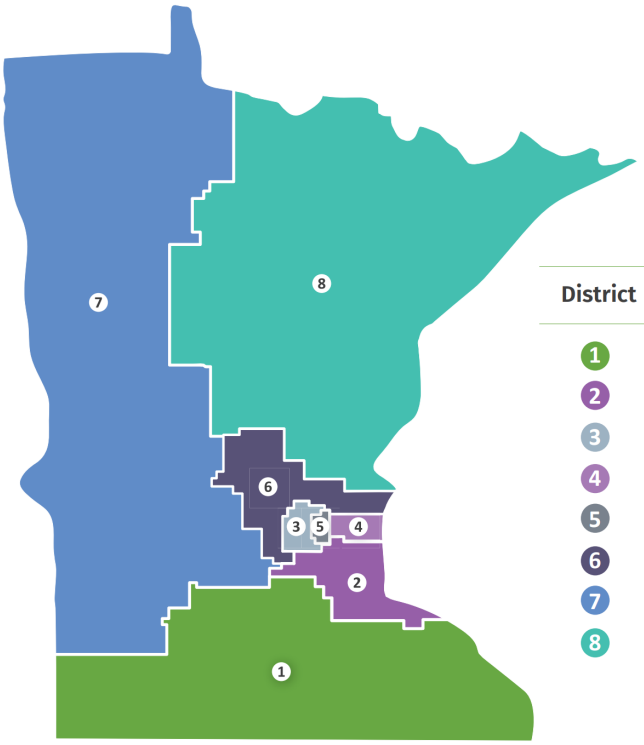
***Data include individuals receiving services; data show the county of financial responsibility for recipient, so individuals who utilized services in these counties may reside in a different county.*

Minnesota-Based Grantmaking

Per the Minnesota Council of Foundations, the majority of grantees receiving funding from Minnesota-based foundations are located in the US outside of Minnesota (48.3%) or in the Twin Cities metro (42.1%). A small portion of the grantees are based in Greater Minnesota (8.4%) or internationally (1.1%). Among Minnesota-based foundations

supporting grantees in Greater Minnesota a larger proportion are community/public foundation (19.6%) compared to private foundations (7.0%) or corporate foundations and giving programs (2.9%).

Figure A. Location of Minnesota Grantmakers by Congressional District and Grants Paid, 2019



District	#of Grantmakers	Grants Paid
1	59	$62 Million
2	46	$10 Million
3	268	$320 Million
4	142	$531 Million
5	258	$997 Million
6	25	$10 Million
7	36	$9 Million
8	84	$168 Million

Source: Minnesota Council on Foundations

The map in Figure A. illustrates the number of grantmakers by Minnesota Congressional District and the total grant dollars paid in 2019. A total of $638.2 million was awarded in 2021 for human services and $527.6 million for health. This was an increase from the 2019 funding allocations to the subject areas by +81.7% and +73.6%, respectively. The 2021 foundation funding portfolios in the combined subject areas of human services and health ranges from 40.4% of private foundations' portfolios, 52.4% of community and public foundation's funding portfolios, and 69.4% of corporate foundation and corporate giving programs funding portfolios.

Policy Analysis

Within the topics investigated, the most distinct difference between the 7-county metro area (metro counties) compared to Greater Minnesota (remaining 80 counties) were within the Health Care Access and Aging Support Services domains, which cover the topics of health care access as well as aging in place, caregiving, and additional home and community based services (HCBS) for older adults.

Health Care Access

Provider ratios are much higher (worse) in Greater Minnesota compared to the metro counties, especially with mental health providers where the ratio is three times higher in Greater Minnesota. Strategies to address provider shortages are among some of the most well-known, and often include federal and/or state programs to provide loan forgiveness for health care providers who practice in areas with the greatest need, often including rural.[57,58,59,60] Some states have advanced policies that address scope of practice issues that may prevent some provider types (e.g., nurse practitioners, physician assistants, and others) from working to the full extent of their ability. For example, states have expanded policies to allow broader scopes of practice or relaxed regulations for providers including respiratory therapists (Hawaii), nurse midwives (California), and physician assistants (Illinois).[61,62,63] Other workforce strategies include the use of innovative provider types, such as community paramedics, community health workers, or dental therapists, to fill gaps in rural communities where there are specific health needs among community members that cannot be met with current providers in the community.[64,65,66]

Other longer term strategies include programs that will increase the number of physicians working in rural areas, often through providing learning or training experiences in rural communities. This is particularly important given that the most consistent factor related to providers choosing to work in rural areas is whether they have lived in rural areas;[45,46] in

[57] Health Resources and Services Administration. NHSC Loan Repayment Program. https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program. Accessed August 4, 2024.
[58] Health Resources and Services Administration. Apply to the Nurse Corps Loan Repayment Program. https://bhw.hrsa.gov/funding/apply-loan-repayment/nurse-corps. Accessed August 4, 2024.
[59] Indian Health Service. Loan Repayment Program. https://www.ihs.gov/loanrepayment/. Accessed August 4, 2024.
[60] Federal Student Aid. Public Service Loan Forgiveness (PSLF). https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service. Accessed August 4, 2024.
[61] State of Hawaii. S.B. No.599. https://www.capitol.hawaii.gov/sessions/session2023/bills/SB599_CD1_.pdf. Accessed August 10, 2024.
[62] California State Legislature. SB-667 Healing arts: pregnancy and childbirth. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB667. Accessed August 10, 2024.
[63] Illinois General Assembly. Full Text of SB0218. https://www.ilga.gov/legislation/fulltext.asp?DocName=&SessionId=112&GA=103&DocTypeId=SB&DocNum=218&GAID=17&LegID=&SpecSess=&Session=. Accessed August 10, 2024.
[64] State of Maine. H.P. 1026 – L.D. 1581. https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP1026&item=3&snum=131. Accessed August 10, 2024.
[65] North Dakota Legislative Assembly. Senate Bill No. 2133. https://ndlegis.gov/assembly/67-2021/documents/21-0560-03000.pdf. Accessed August 10, 2024.
[66] Minnesota Department of Health. Dental Therapist (DT) and Advanced Dental Therapist (ADT). https://www.health.state.mn.us/facilities/ruralhealth/emerging/dt/index.html. Accessed August 10, 2024.

other words, "grow your own" pathway programs and programs to provide training experiences in rural areas are essential to successful recruitment efforts. One example is the University of Minnesota Medical School CentraCare Regional Campus in St. Cloud,[67] which hopes to increase primary care and rural providers through its medical school and increase in residency slots. Additionally, increasing residency slots in rural communities[68] (opportunities for young doctors to complete their training in a non-metropolitan community), is another strategy for increasing rural physician workforce. Other promising strategies include a focus on introducing rural K-12 students to rural health care careers,[69] as well as partnerships with rural technical colleges and universities to train students in health care careers.[70,71]

While the proportion of facilities located in the metro counties compared to Greater Minnesota counties varied by facility and service type, the starkest disparities were with home care providers, hospice providers, and rehabilitation facilities. Only 76% of Greater Minnesota counties have home care providers in their county, compared to 100% of metro counties; 56% of Greater Minnesota counties have hospice programs compared to 71% of metro counties; and only 15% of Greater Minnesota counties have rehabilitation providers compared to 85% of metro counties. These metrics depict where facilities/providers are based (or physically located), so it is an imperfect indicator of access in Greater Minnesota, though it is the closest information available to describing how much (or little) access older adults in Greater Minnesota might have to certain facilities or provider organizations.

Access to nursing homes and assisted living facilities seems to be somewhat well placed across the state (with 99% of counties having at least one nursing home, and 94% having at least one assisted living facility), but the mere existence of one facility does not mean that access is available due to the large proportion of older adults in many communities across Greater Minnesota. Further, having only one facility in a county may not meet the diverse care needs and preferences across all rural older adults, especially if HCBS are also challenging to access (see Aging Support Services below). Staffing for these types of facilities in rural areas is often the most common reason for closure;[72] as such, more needs to be done to ensure health care workforce are available for these and other facilities in Greater Minnesota. Health care professional shortages are much more common in Greater Minnesota compared to metro counties (index value of 9.2 vs. 1.3), indicating an overall broader need for health care workforce in Greater Minnesota. Alongside ongoing efforts to address workforce shortages in Minnesota, there needs to be a continued emphasis on rural communities to ensure access to care for older adults. Some examples of state-level interventions to improve health care workforce in rural areas include scholarships for providers who will practice in rural or underserved areas,[73] grants to

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[67] University of Minnesota Medical School. CentraCare Regional Campus St. Cloud. https://med.umn.edu/CentraCare-Regional-Campus. Accessed August 4, 2024.
[68] Health Resources and Services Administration. Rural Residency Planning and Development (RRPD) Program. https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd. Accessed August 4, 2024.
[69] Thill N, Fortune M, Radcliffe A. Addressing the National Rural Health Care Worker Shortage with a Focus on Kindergarten through 12th Grade Educational Strategies. National Rural Health Association Policy Brief. 2024. https://www.ruralhealth.us/getmedia/47a40e1e-e08a-46b8-a0a3-00037dd998f9/2024-NRHA-Rural-Workforce-Pathway-Programs-policy-brief.pdf.
[70] Center on Rural Innovation. Rural America's Tech Employment Landscape: How to Increase Tech Talent and Tech Employment. http://ruralinnovation.us/wp-content/uploads/2022/06/CORI_Rural_Tech_Landscape.pdf
[71] Washington State Department of Health. Grow Your Own Toolkit. https://doh.wa.gov/sites/default/files/2024-03/609027-GrowYourOwnToolkit-RuralHealth.pdf
[72] National Rural Health Association. Comments Submitted to the Centers for Medicare and Medicaid Services on November 6, 2023. https://www.ruralhealth.us/getmedia/2952f25b-13a0-440e-bd7e-059a5e9c1d62/NRHA-Minimum-Staffing-Standards-comment-11-6-23.pdf
[73] California Department of Health Care Access and Information. Advanced Practice Healthcare Scholarship Program (APHSP). https://hcai.ca.gov/workforce/financial-assistance/scholarships/aphsp/. Accessed August 4, 2024

create local training programs,[74] or other funding related to service in health professional shortage areas.[75] Beyond state initiatives, there are many other examples of rural health care workforce initiatives that can be replicated to improve availability of those providing services to older adults.[76]

Aging Support Services

The data regarding aging support services and utilization of these services provides an in-depth look at how services may be received by older adults living in Greater Minnesota. There is a much lower proportion of older adults in Greater Minnesota receiving HCBS compared to institutional services compared to the metro counties (66.6% vs. 84.5%). This value, paired with differences between the percentage of eligible people with higher needs being served of 65.1% in Greater Minnesota and 75.6% in metro counties, seems to indicate that older adults in Greater Minnesota may have a harder time accessing needed services compared to those living in the metro counties.

Overall, states vary in how they provide services to rural older adults, particularly when viewed through the lens of their state plans on aging, as indicated by how "rural" is defined for allocating Older American Act funds[77] as well as how few states explicitly mention rural communities in statewide aging in place or age-friendly initiatives.[78] Minnesota's statewide policy to promote healthy aging, Age Friendly Minnesota, does identify rural communities as one of several underserved groups to address,[79] and they also provide grants to communities across the state that are looking to become more age-friendly.[80] Successes from grants like these can provide a model for other communities across Greater Minnesota to be able to focus on being more age-friendly, and begin to address challenges for older adults aging in place across Minnesota.[81]

Specifically looking at utilization of aging support services by county, several disparities between metro counties and Greater Minnesota exist. While most metro counties had at least one older adult using services for each category (except for caregiver training/education and respite care), four types of services had fewer than half of Greater Minnesota counties with older adults receiving services. These included adult day services (49%), caregiver training/education (9%), home care nursing/extended home care nursing (18%), and respite care services (31%). Again,

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[74] Wisconsin Department of Health Services. Primary Care Program: Advanced Practice Clinician (APC) Training Grant. https://www.dhs.wisconsin.gov/primarycare/apc-grant.htm. Accessed August 4, 2024.
[75] Colorado Department of Public Health and Environment. Colorado Health Service Corps. https://cdphe.colorado.gov/colorado-health-service-corps. Accessed August 4, 2024.
[76] Rural Health Information Hub. Education and Training of the Rural Healthcare Workforce – Models and Innovations. https://www.ruralhealthinfo.org/topics/workforce-education-and-training/project-examples. Accessed August 4, 2024.
[77] Henning-Smith C, Powell MA, Lahr M. Approaches to Serving Rural Older Adults in State Plans on Aging: A Policy Content Evaluation. Journal of Applied Gerontology. 2022 Oct;41(10):2132-9. https://doi.org/10.1177/07334648221104085
[78] Tanem J, Henning-Smith C, Lahr M. Statewide Age-Friendly Initiatives: An Environmental Scan. University of Minnesota Rural Health Research Center Policy Brief. 2021. https://rhrc.umn.edu/wp-content/uploads/2021/10/UMN-Statewide-Age-Friendly-Initiatives_10.04.21_508.pdf
[79] Tanem J, Henning-Smith C, Lahr M. Examples of Statewide Age-Friendly Initiatives. University of Minnesota Rural Health Research Center Policy Brief. 2021. https://rhrc.umn.edu/wp-content/uploads/2021/10/Aging-Initiative-Guide_10.04.21_508.pdf
[80] Age-Friendly Minnesota. Multisector Blueprint for an Age-Friendly Minnesota. https://mn.gov/dhs/age-friendly-mn/. Accessed August 4, 2024.
[81] City of Northfield. Age-friendly Northfield. https://www.northfieldmn.gov/1547/Age-friendly-Northfield. Accessed August 4, 2024.

while the need (based on population sizes) may not be the same when comparing the metro counties to Greater Minnesota, these numbers still likely indicate a lack of access to important services for older adults. Efforts to improve access, beginning with awareness for services, access to facilitators to educate older adults and their families about resources they may be eligible for, and improvements in services being provided in Greater Minnesota communities would help to improve availability and access to aging support services in Greater Minnesota.

Conclusion

The aging population in rural Minnesota faces unique challenges that significantly affect their quality of life and access to essential services. Unlike their urban counterparts, older adults in these areas deal with a scarcity of resources and services tailored to their needs. As nearly one million adults aged 65 years and older call rural Minnesota home, it is important to reflect on their needs, access to care, and access to needed services and persons that support health and well-being. This report provides an in-depth analysis of the factors affecting the aging population in Greater Minnesota in comparison to the seven-county metro region.

A focus of policy and systems changes is recommended related to access to care and aging support services. Access to health care is a constant issue for many older adults living in rural communities. Access issues relate to costs, delaying care, transportation, and workforce shortages among other issues. Evidence-based recommendations include scope of practice policies, use of innovative provider types, provision of rural physician learning or training experiences and rural residency slots, and early introduction in K-12 for health care careers that can aid in building and sustaining a rural health care workforce.

Access challenges are not solely related to primary or specialty care, but also related to aging support services. Alongside ongoing efforts to address health care workforce shortages in Minnesota, there needs to be a continued emphasis on rural communities to ensure access to care for older adults in settings such as nursing homes, assisted living facilities, and home care providers. Evidence-based recommendations include scholarships for practicing in rural or underserved areas, local training program grants, and funding to support services in health progressional shortage areas. It is recommended to expand Age Friendly Minnesota into additional sites in rural Minnesota.

Caregiving needs can be more pronounced in rural populations and are complicated by the aforementioned barriers to accessing resources, transportation, and formal supports. Recommendations include increasing awareness of available services, access to facilitators to educate older adults and their families on resources and eligibility, and improvement in availability of and access to services being provided to older adults residing in Greater Minnesota.

Appendix

Data Sources

U.S. Census, 2022
https://data.census.gov/
The official data exploration tool of the U.S. Census.

Census Reporter, 2022
https://censusreporter.org/
A data exploration tool from Northwestern University that allows for easier location, visualization, and comparison of American Community Survey (U.S. Census Bureau) data.

Aging Data Profiles MN, 2020
https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/aging/aging-2030/data-profiles/
A data visualization tool from the Minnesota Department of Human Services including state-, regional-, and county-level demographic and service data on Minnesotans age 65+.

County Health Rankings, 2024
https://www.countyhealthrankings.org/health-data/minnesota?year=2024
A data visualization and tabular comparison project funded by the Robert Wood Johnson Foundation and compiled by the University of Wisconsin Population Health Institute that describes various state- and county-level socioeconomic and health metrics.

Food Access Dashboard, 2015
https://www.fns.usda.gov/data-research/data-visualization/nutrition-education-and-local-food-access-dashboard
A data visualization tool from the Food and Nutrition Service, USDA.

Food Research & Action Center, 2017
https://frac.org/maps/snap-county-seniors/tables/tab-seniors-snap-county.html
A data visualization tool from the Food Research & Action Center, produced in collaboration with the AARP Foundation, which tracks the share of all households with any adults 60+ that participate in a SNAP program.

AARP Livability Index, 2023
https://livabilityindex.aarp.org/
A data exploration tool from the AARP Public Policy Institute that scores communities across seven livability categories to determine how "livable" each U.S. community is. Includes state-, city-, zip code-, and address-level data.

MNDOT Transit Report, 2023
https://www.lrl.mn.gov/docs/2024/mandated/240355.pdf
An annual report from the Minnesota Department of Transportation describing Greater MN's public transit systems. For the purpose of our analysis, we combined fixed route and dial-a-ride branches of the same city (e.g., Rochester Public Transit: Fixed Route and Rochester Public Transit: Dial-a-Ride) into one transit system.

LTSS Demographic Dashboard, 2022
https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/public-planning-performance-reporting/performance-reports/performance-measures-dashboard/
An interactive dashboard from the Minnesota Department of Human Services describing the populations served by various health and social services programs compared to the overall Minnesota population.
Note: "Older Adults" includes age groups "65-84" and "85+"; the "% Receiving HCBS" data for both age groups was averaged to create a single value for each county.

MN DHS Provider Files, 2023
https://www.health.state.mn.us/facilities/regulation/directory/providerselect.html
Data on health care provider service/facility locations by MN county are from the MN Health Care Provider Directory managed by the Minnesota Department of Health. The location data indicate where the facility or provider organization are located, and do not necessarily indicate the complete service area for these providers/facilities.

MN DHS Data, 2023
Data from the Minnesota Medicaid Management Information System (MMIS) shows the number of people in select LTSS programs: Elderly Waiver (EW), both FFS and MCO); Alternative Care (AC, FFS); and Essential Community Supports (ECS), FFS who had the selected services delivered in FY 2023. Data was provided by the Fiscal Analysis, Research, and Evaluation (FARE) Team, Fiscal Analysis & Results Management (FARM) Division, Aging and Disability and Services Administration, Minnesota Department of Human Services.