Central Minnesota Older Adults

Needs Assessment Report 2024

Central MN Council on Aging

cmcoa

Research report prepared by
St. Cloud State University Survey Center

This report was prepared for the Central Minnesota Council on Aging by the
St. Cloud State University Survey Center.

Faculty Directors:

Jim Cottrill, PhD, Professor of Political Science

Amanda Hemmesch, PhD, Professor of Psychology

Ann S. Finan, PhD, Professor of Sociology

Sandrine Zerbib, PhD, Professor of Sociology

Student Directors:

Ben Zabel (Lead Director), Senior, Political Science

Riley Briekos (Lead Director), Junior, Psychology

Gwendolyn Hillger (Assistant Lead Director), Junior, Biological Science

Paige Thisson (Assistant Lead Director), Junior, Mathematics and Statistics

Ben Brecht, Senior, Psychology

Avery Chapp, Junior, Sociology and Criminal Justice

Brittan Peterson, Senior, Psychology

The St. Cloud State University Survey Center is a research institute housed in the College of Liberal Arts at SCSU. The Survey Center's mission is to serve the academic community and public and nonprofit sector community through its commitment to high quality survey research and to provide education and experiential opportunities to researchers and students. The SCSU Survey Center maintains the highest ethical standards in its procedures and methods, and follows the guidelines outlined by AAPOR, the American Association for Public Opinion Research.

Table of Contents

CMCOA 2024 Needs Assessment Executive Summary 2
Part A highlights: Older adult survey 2
Part B highlights: Service provider survey 4
CMCOA 2024 Needs Assessment Methods 6
CMCOA 2024 Needs Assessment Results 10
Part A Results: Older Adults and Older Adult Caregivers 10
Older adult caregivers 14
Bivariate results (crosstabs) 16
Longitudinal comparisons 19
Part B Results: Service Providers 28
Bivariate results (crosstabs) 32
Longitudinal comparisons 33
Comparisons across older adult and service provider responses 36
Conclusions 41
Appendix A: Older Adult Survey Questions 42
Appendix B: Service Provider Survey Questions 45

CMCOA 2024 Needs Assessment Executive Summary

A needs assessment project was completed to better understand the needs of the older adult community (individuals age 60+) in the Central Minnesota Council on Aging (CMCOA) 14-county service area. This 2024 study was a follow up to previous needs assessments conducted in 2012, 1995, and 1985, and included two parts: a survey of older adults and a survey of service providers who work with older adults. The older adult survey was a mixed-methods design that included telephone surveys with a random sample of older adults in Central Minnesota and an online survey with a convenience sample of older adults recruited through service providers. The service provider survey was an online survey that recruited a sample from CMCOA's email distribution list.

Part A highlights: Older adult survey

- 245 older adults completed surveys: 135 respondents completed a survey by telephone, and 110 completed a survey online.
- Respondents represented all 14 counties in the CMCOA service area. This sample was mostly women (64%) and most respondents were white (96%).
- 56% of single adults were below 250% of the poverty line, and 49% of married people were below 250% of the poverty line.
- 17% of older adults in this sample sometimes or often experience food insecurity.
- 91% of respondents have reliable internet at home. Slightly more than half of those respondents use a computer, tablet, or other device to access the internet; slightly less than half rely on only a smartphone. For those without reliable home internet, approximately 37% cannot afford internet, internet services are not provided in their area for 32%, and 26% are not interested in using the internet.
- Approximately 24% of older adults in this sample could be considered lonely according to the three-item UCLA Loneliness scale. This result suggests an increase from prior studies, with only 18% of respondents reporting that "loneliness is a problem" on a similar scale in the 1995 study (no measure of loneliness was included in the 2012 study).
- 60% or more of respondents indicated that they are using or would consider using services related to activities of daily living, housekeeping, chores, transportation, home improvements, health and wellness programs, mental/psychological health, and assistance finding other services; respondents were less interested in services like visiting, home-delivered meals, and congregate meals.

- Lack of information (14%), cost (13%), and lack of transportation (13%) were more commonly reported as barriers to service use; cultural and language issues were a barrier for approximately 1% of this sample which may reflect the demographics of the sample rather than experiences of the older adult population in this service area.
- 76% of respondents indicated that they would be willing to pay for services, which represents a decrease from earlier studies. In 2012, 81% of respondents indicated that they would be willing to pay for services, and in 1985, 75% of respondents were willing to pay (data on this measure was not available in the 1995 report).
- 89% of respondents have someone who can provide care to them if needed. Most respondents identified a spouse/partner as a potential caregiver (62%) or another family member (32%).
- 27% of older adult respondents were providing care to someone else. Their care recipients were most likely to be a spouse/partner (40%) or other family member (43%). (Note that because all respondents were 60 years of age or older, these data are only for older adult caregivers).
    - Most of the older adult caregivers in this sample provided less than 10 hours of care per week (73%). Approximately 60% experienced some caregiving burden; 95% experienced some caregiving reward.
    - 60% or more of caregivers indicated that they are using or would consider using services related to individualized caregiver support/coaching, caregiver consulting, educational classes for caregivers, and services supporting their care recipient; caregivers were slightly less interested in services like caregiver support groups and respite care.
    - Approximately 64% of caregivers would be willing to pay for services to support their caregiving.
- A little over half of respondents (55%) indicated that they were familiar with the Senior LinkAge Line.
- Very few differences were present when comparing CMCOA subregions and demographic groups. Most differences were relatively small.

Part B highlights: Service provider survey

- 426 providers completed this survey, representing all counties of the CMCOA service area. Providers were mostly women (83%) and white (92%), with 3% identifying as "Black/African American," 3% identifying as "Two or More Races," and all other categories each comprising less than 1% of the data.
- Most respondents provided services to just one (33%) or two (10%) counties in the CMCOA service area, but 10% of respondents indicated that they provided services to all 14 counties. 49% of respondents served the Central CMCOA subregion (Benton, Sherburne, Stearns, and Wright counties), 28% served the Eastern CMCOA subregion (Chisago, Isanti, Kanabec, Mille Lacs, and Pine counties), and 31% served the Northern CMCOA subregion (Cass, Crow Wing, Morrison, Todd, and Wadena counties). Multiple providers served counties in more than one subregion. Multiple providers serviced multiple subregions.
- The following barriers were most frequently identified by service providers as 'often' preventing older adults from remaining in their homes:
    - Provider shortages in needed service areas (71%)
    - People wait too long before seeking help (55%)
    - People are reluctant to pay for help (54%)
    - People don't know where to get help (53%)
    - Right types of in-home services are not available (47%)
    - People are unable to identify/find the help they need (44%)
    - Lack of support from family or friends (28%)
- Providers indicated that the availability of the following services was 'inadequate' or 'unavailable' in their service area:
    - Transportation (37%)
    - Heavier chores (32%)
    - Mental health screening or referral (23%)
    - Home modification or repairs for accessibility (22%)
    - Homemaking (21%)
    - Personal care or home health aides (19%)

    - Friendly visiting or telephone reassurance (18%)
    - Legal assistance (14%)
    - Senior centers (10%)
    - Health and wellness programs (7%)
    - Congregate meals (e.g., at a senior center; 7%)
    - Home-delivered meals (e.g., Meals on Wheels; 5%)
    - Information and assistance (e.g., Senior LinkAge Line; 4%)
- When thinking about how to improve conditions and services for older adults in their service area, the following were identified as 'very high priority' by providers:
    - Addressing social isolation and loneliness in older adults and caregivers (48%)
    - Strengthening support for family caregivers (35%)
    - Promoting earlier detection and enhancing supportive services for people with dementia (34%)
    - Building communities that work for all ages (28%)
    - Improving access to information about available resources (26%)
    - Strengthening care management capacity (20%)
    - Creating and promoting service/program flexibility to meet changing consumer expectations for more choice and personalization (20%)
    - Increasing and strengthening culturally responsive services (19%)
    - Providing technical assistance for organizational capacity building and service delivery (15%)
- There was agreement between older adults and providers about the types of services that older adults would consider using and that providers identified as areas for investment (e.g., building toward an adequate supply and as a priority for improving).

CMCOA 2024 Needs Assessment Methods

General information about the SCSU Survey Center

Central Minnesota Council on Aging (CMCOA) collaborated with the St. Cloud State University Survey Center (SCSU Survey) team of principal investigators (Drs. Cottrill, Finan, Hemmesch, and Zerbib) to develop surveys about the needs of older adults and service providers/caregivers to older adults in their service area. This project spanned approximately five months.

The SCSU Survey Center provided consultation for questionnaire development, collected data, and prepared a report outlining the methodology and important findings.

The proposed project consisted of two components. Each set of methods is detailed in the sections below.

Part A involved the collection of needs assessment data via telephone survey interviews with older adults and older adult caregivers using a random-digit-dialing phone number list. A push-to-web method using a QR code was implemented to increase the final number of completed survey interviews.

The second part of the proposed study, Part B, involved an online survey targeted toward service providers using a list of email addresses from CMCOA.

Both parts included mostly closed-ended questions and a few open-ended questions to collect structured qualitative data.

For each study, SCSU survey faculty directors worked closely with Lori Vrolson (CMCOA Executive Director) and Melissa L. Lyon (CMCOA Community Development Specialist) on the research design, the survey instruments, the advertising of the research projects, and the analysis inquiries that were more relevant for CMCOA.

The findings were obtained using SPSS and are available in the results section.

Part A methods: Older adults and older adult caregivers

The older adult population was defined as the population of respondents residing in central Minnesota and who are at least 60 years old. The implied consent of the survey questionnaire served as a screener for their participation. This consent included information about the potential risks and benefits of participating in the study. The survey instrument screened out respondents who were ineligible due to age (i.e., under 60) or not residing within the designated 14 counties in Minnesota.

The older adults survey was designed to fulfill two purposes: assessing the needs of older adults in central Minnesota within the 14 designated counties and exploring further the needs of the subpopulation of older adults who are themselves caregivers to older adults. For caregiver analyses, only respondents who answered "yes" to the screening item about currently providing care to someone else were included; respondents who answered "no," "don't know," "prefer not to answer," or who skipped this item were removed from the analyses for older adult caregivers.

SCSU Survey principal investigators purchased a sample of random-digit-dialing cell and landline phone numbers of Minnesota older adults from Dynata company. Paid student callers dialed those numbers using WinCATI (Computer-Assisted Telephone Interviewing software). The telephone survey data was collected from February 22, 2024, to April 25, 2024.

The sample included both landline phone numbers (approximately 3,000 random numbers) and cell phone numbers (approximately 10,500 random numbers). The cell phone sample included oversamples designed to increase the likelihood of contacting different communities within central Minnesota that are often underrepresented in traditional survey research, including samples targeted toward African American (approximately 2,100 numbers), Hispanic/Latinx (approximately 2,600 numbers), Asian American and Pacific Islander (approximately 500 numbers), and Native American (approximately 580 numbers) respondents.

Student directors and faculty directors conducted a general training session providing student callers with instructions on using the WinCATI software, lab policies and procedures, and best practices for accurate, reliable, and ethical collection of public opinion data. Students were not allowed to collect data until they completed the training and signed a Statement of Professional Ethics affirming that they would adhere to the highest ethical standards when interacting with respondents. Student directors supervised the calling over the survey period to ensure that the data collection was accurate, reliable, and consistent with the norms of professional ethics as outlined by AAPOR (American Association for Public Opinion Research).

The process of collecting telephone surveys from older adults was challenging because of the exceptionally low response rate and the particularly high resistance to perceived non-native student callers. Some potential respondents were concerned about robocalls and scams, so they were hesitant to participate. To address this low response rate, a banner was added to the SCSU Survey Center website confirming that data collection was underway for a study on behalf of the CMCOA, and CMCOA communicated about the study to their clients and providers. Additionally, in collaboration with CMCOA, the research design was modified to include an online survey based on the telephone questionnaire. We used a QR code for potential respondents to access the online survey. The implied consent remained the same except for adjusting the language to an online survey. As done with the already approved online survey of

service providers, we included screening questions and an opt-in yes/no question to voluntarily participate in the online survey. To address potential participants' concerns about scams and 'foreign' accents, we created a new disposition for the telephone survey that put those numbers on hold until the end of data collection, when the most experienced callers followed up with those individuals to invite them to participate again.

Responses from the online survey required cleaning in preparation for data analysis. Fifteen cases were removed from the dataset because they indicated that they were under 60 years of age, six cases were removed because they did not consent to participate, six cases were removed because they were duplicate or incomplete entries from the same IP address, and two cases were removed because they only answered the consent question. Online data collection ran from March 22, 2024, to April 25, 2024.

A total of 135 surveys were collected via telephone interviewing. An additional 110 online surveys were collected via Qualtrics (after cleaning) using the same questionnaire as the telephone survey instrument.

The margin of sampling error for the data is ± 6.2[1] percent at the 95 percent confidence level. The demographic data from respondents closely conformed with the 2023 population estimates for Minnesota from the US Census Bureau, so no weighting of the data was needed. The response rate for the telephone survey of older adults was 2%, and the cooperation rate was 22% (AAPOR IV). We are not able to provide a response rate or cooperation rate for the online survey of older adults, as we did not send an invitation via email but instead relied on CMCOA to publicize the QR code linking to the survey.

Part B methods: Service providers

Service providers were the second population study in this research project for CMCOA. The main research question was, "What types of services do providers give to older adults and how adequate do they feel those services are?"

SCSU Survey collaborated with CMCOA for the design and the survey instrument used for data collection. The survey questionnaire intended for service providers includes questions addressing older adults' service-related needs from the providers' perspective (See questionnaire in Appendix B).

[1] Sampling error for older adults' sample is calculated as: Estimated value ± 1.96 * $\sqrt{.25/245}$ (using P conservatively as .5). Final margin of error was $\pm$ 6.2 %.

Online surveys were conducted through Qualtrics, a cloud-based survey software package that facilitates survey design, distribution, data collection, and secure data storage. Online surveys were collected from March 26, 2024, to April 25, 2024. The first call for participation was sent on March 26 via email to service providers who had provided an email address either to sign up for the CMCOA newsletter or when they worked with CMCOA staff. Reminder emails were sent on April 3 and April 25 to increase the cooperation rate. The final reminder called for participation by April 25 at midnight (end of data collection).

The sample of email addresses was compiled by CMCOA and included emails for subscribers to the CMCOA newsletter, emails for providers who work with CMCOA staff, and community leaders within the 14-county service area. In total, CMCOA provided a list of 5,456 email addresses. The information provided to the Survey Center did not include any information beyond email addresses. A total of 5,455 potential respondents were contacted via email.

No information was collected in the survey questions that would indicate a particular individual's identity. Qualtrics collects IP addresses of the device on which the survey is taken, as well as rough geographic location information. This information, like an email address, could be used to identify an individual respondent. Therefore, the Survey faculty team removed IP addresses and all location data, as well as removing the original contact email address, from the dataset before analysis, leaving only an anonymous dataset. All information is stored on password-protected computers and password-protected institutional cloud storage systems.

In most cases, multiple responses from the same IP address were removed to avoid a respondent submitting more than one completed survey. In instances of identical submissions from the same IP address, the most complete or first submission from an IP address was retained; any other submissions were removed from the dataset. In most cases, duplication was a result of respondents not completing the survey at their first attempt, and then coming back to complete it later.

Because it is possible for multiple respondents to use the same device and, therefore, have the same IP address associated with their submissions, only identical duplicate responses were deleted. When different submissions were collected from the same IP address, all unique submissions were retained.

The dataset was cleaned by removing any data from the testing phase of the project, responses from participants who did not explicitly agree to take the survey (Question 1 – see Appendix A; n = 4), duplicate submissions from the same IP address (n = 1), and participants who only answered the consent item and none of the substantive items from the survey (n = 46). A total sample of 477 surveys were collected via Qualtrics. Of those 477 cases, 51 cases were deleted

based on the cleaning process above. The final sample of completed surveys consists of 426 current service providers.

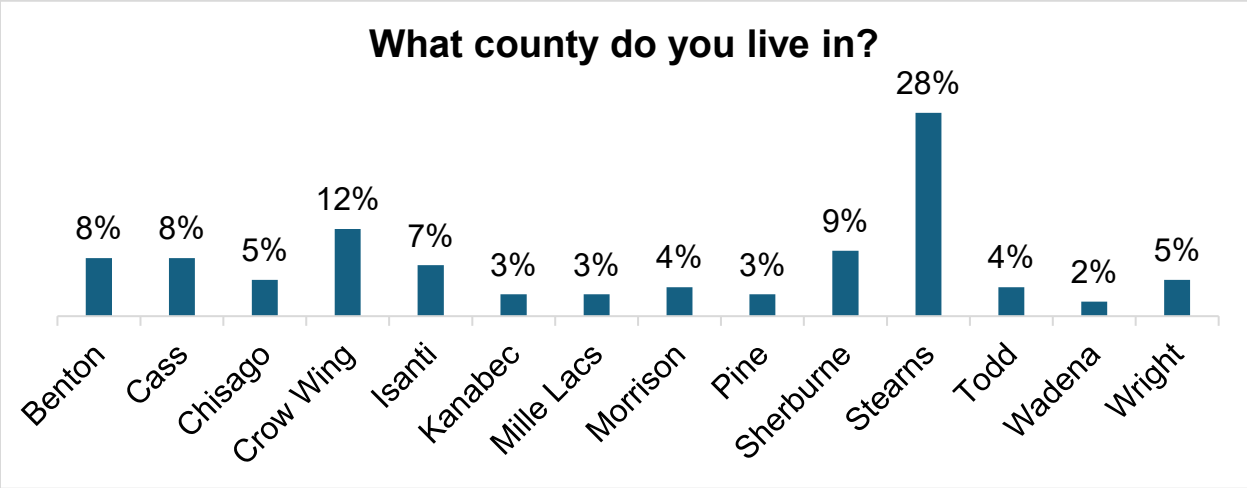
The Qualtrics distribution report for this study indicates an 88% cooperation rate. The margin of error reflects the sample size, i.e. the total number of completed surveys. The margin of sampling error for the complete set of weighted data is ± 4.7 percent at the 95 percent confidence level.[2]

For both the older adult and service provider studies, data was exported as an SPSS file for analysis. Data analysis was conducted using SPSS version 28. The report includes univariate (frequencies) and bivariate (crosstab) results.

CMCOA 2024 Needs Assessment Results

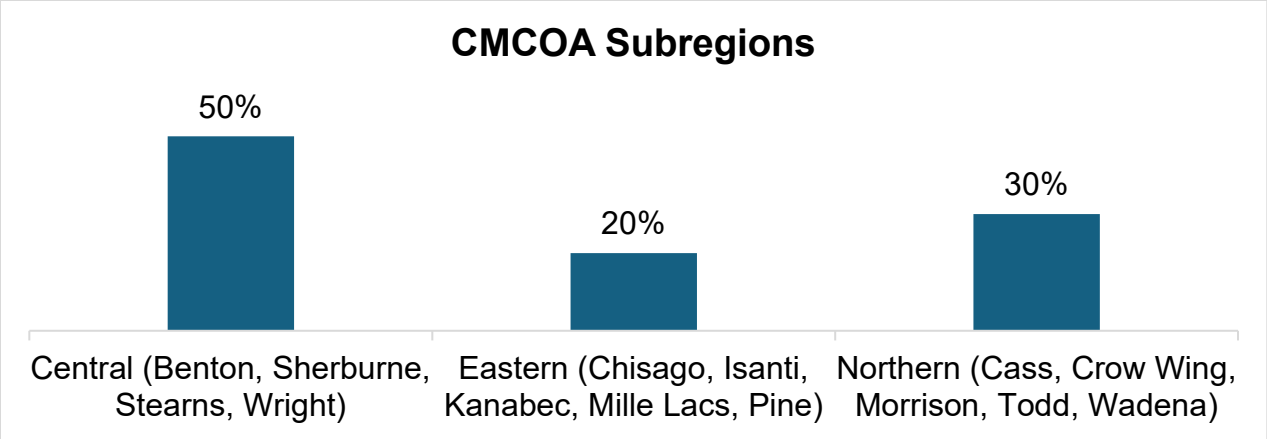
Part A Results: Older Adults and Older Adult Caregivers

The older adult sample included 245 completed surveys: 135 respondents completed a survey by telephone and 110 completed a survey online.



Respondents represented all 14 counties in the CMCOA service area. About half of the respondents were from the Central subregion, 20% were from the Eastern subregion, and 30% were from the Northern subregion.

[2] Sampling error for older adults' sample is calculated as: Estimated value ± 1.96 * $\sqrt{.25/426}$ (using P conservatively as .5). Final margin of error was $\pm$ 4.7 %.



Older adult respondents in this study were mostly white (96%), women (64%), and currently married (61%). Of the people of color, about 1% of the older adult sample identified two or more races, .5% as Native American or Alaska Native, .5% as Asian or Asian American, .5% as Black or African American, and 1% preferred an identifier different than the options provided. Regarding ethnicity, 1% identified as Hispanic/Latinx. Approximately 40% of respondents' monthly income was below 250% of the poverty line. 3% of the sample identified as LGBTQ+.

Internet access

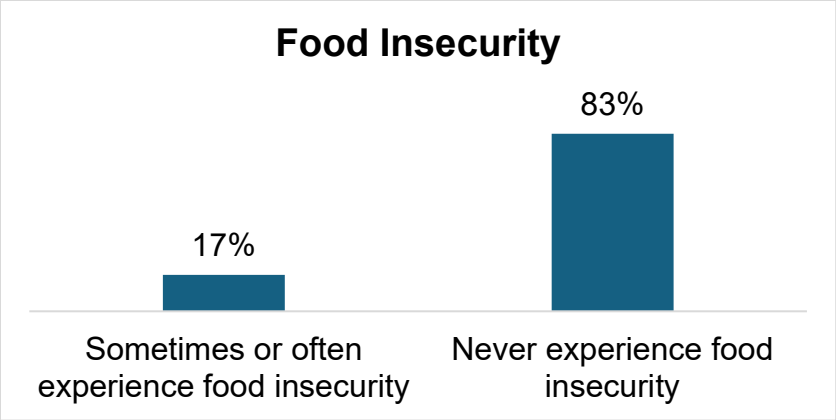
91% of respondents have reliable internet at home. Slightly more than half of those respondents use a computer, tablet, or other device to access the internet; slightly less than half (46%) rely on a smartphone for internet access. For those without reliable home internet, approximately 37% cannot afford internet, internet services are not provided in their area for 32%, and 26% are not interested in using the internet.

Senior LinkAge Line

A little over half of respondents (55%) indicated that they were familiar with the Senior LinkAge Line (SLL). There was a difference in familiarity with the SLL by income, such that respondents who were below 250% poverty level were more likely to be familiar with SLL (71%) than more affluent respondents (53%).

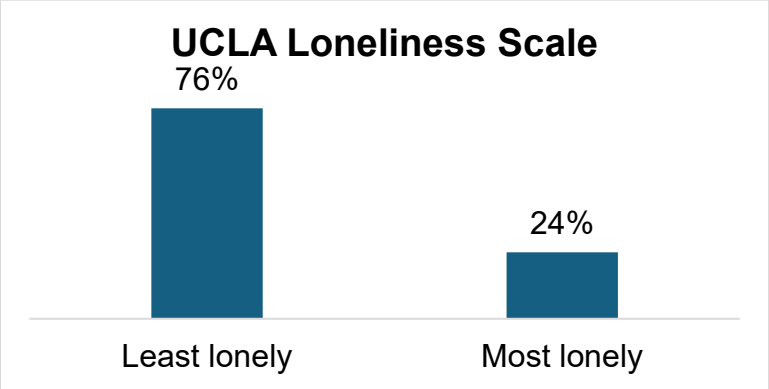
Food insecurity

Although most of this sample of older adults did not struggle with food insecurity, 17% of older adults in this sample sometimes or often experience food insecurity. For the item that asked about worrying if food would run out before respondents got money to buy more, 6% said this was 'often true' and 5% said it was 'sometimes true. For the item that asked about not being able to afford eating balanced meals, 6% said this was 'often true' and 9% said it was 'sometimes true.' This indicates that difficulties with balanced nutrition might be slightly more common among older adults than running out of food.



Loneliness

Approximately 24% of older adults in this sample could be considered lonely according to the three-item UCLA Loneliness scale (i.e., the met the scoring criteria for being considered 'most lonely). This result suggests an increase from prior studies, with only 18% of respondents reporting that "loneliness is a problem" on a similar scale in the 1995 study (no measure of loneliness was included in the 2012 study).



Services and barriers to accessing services

60% or more of respondents indicated that they are using or would consider using services related to activities of daily living, housekeeping, chores, transportation, home improvements, health and wellness programs, mental/psychological health, and assistance finding other services. Respondents were least interested in services like visiting, home-delivered meals, and congregate meals, with most respondents indicating they would not consider those services.

	Using n (%)	Consider n (%)	Not Consider n (%)
Chores	20 (8%)	158 (65%)	45 (1%)
Congregate meals	18 (8%)	82 (37%)	118 (54%)
Education/wellness programs (on health issues)	23 (10%)	129 (58%)	69 (31%)
Home-delivered meals	16 (7%)	84 (39%)	118 (54%)
Homemaker	18 (8%)	128 (57%)	79 (35%)
Home modification/repair	4 (2%)	140 (64%)	76 (35%)
Information & assistance (e.g., Senior LinkAge Line; United Way's 211)	16 (7%)	129 (57%)	81 (36%)
Mental health screening/referral	13 (6%)	125 (57%)	80 (37%)
Personal Care Assistance help (e.g., with eating, dressing, bathing)	12 (5%)	142 (63%)	70 (31%)
Transportation	13 (6%)	124 (55%)	88 (39%)
Visiting	9 (4%)	86 (39%)	126 (57%)

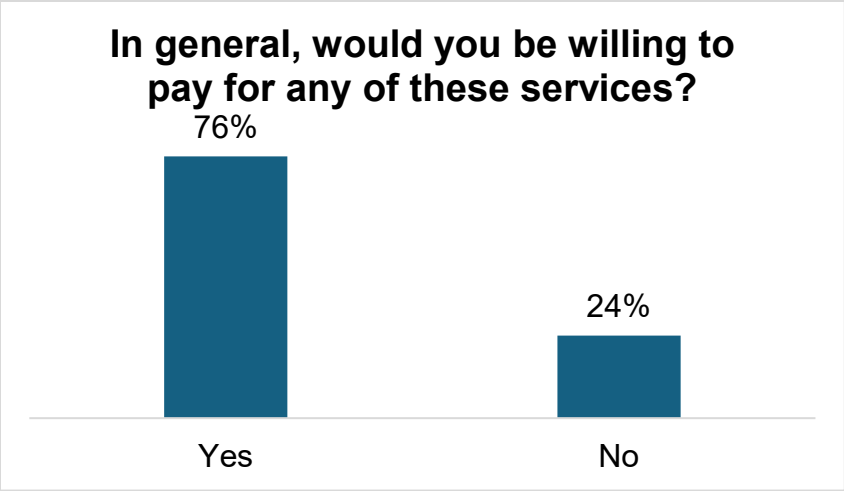
Lack of information (14%), cost (13%), and lack of transportation (13%) were more commonly reported as barriers to service use; cultural and language issues were a barrier for approximately 1% of this sample which may reflect the demographics of the sample rather than experiences of the older adult population in this service area. The other types of barriers submitted by respondents included items like distance, difficulties using benefits like EBT, and provider shortages.

---

* NOTE: There was an issue with the script that prevented "lack of transportation" from being displayed for part of the duration of data collection for the telephone survey, so these results may underestimate transportation as a barrier to accessing services.

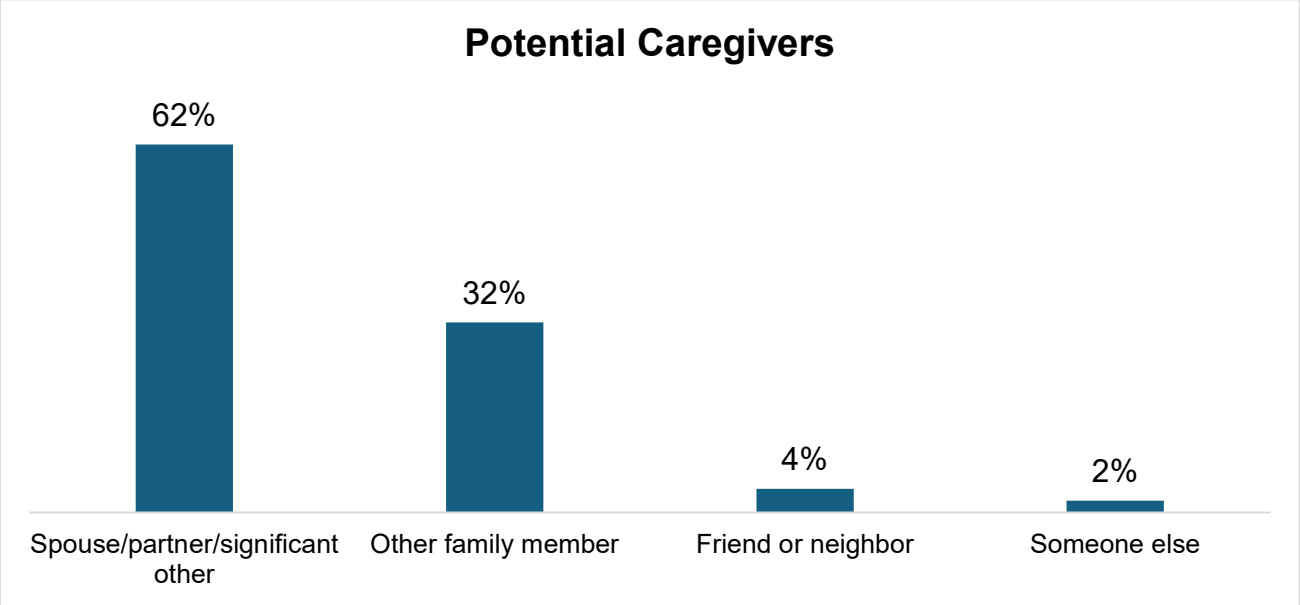
	Yes n (%)	No n (%)
Lack of information	30 (14%)	193 (86%)
Cost or copays	28 (13%)	196 (87%)
Lack of transportation*	12 (13%)	82 (87%)
Culture or language issues	3 (1%)	231 (99%)
Other	21 (10%)	201 (90%)

76% of respondents indicated that they would be willing to pay for services, which represents a decrease from earlier studies. In 2012, 81% of respondents indicated that they would be willing to pay for services, and in 1985, 75% of respondents were willing to pay (data on this measure was not available in the 1995 report).



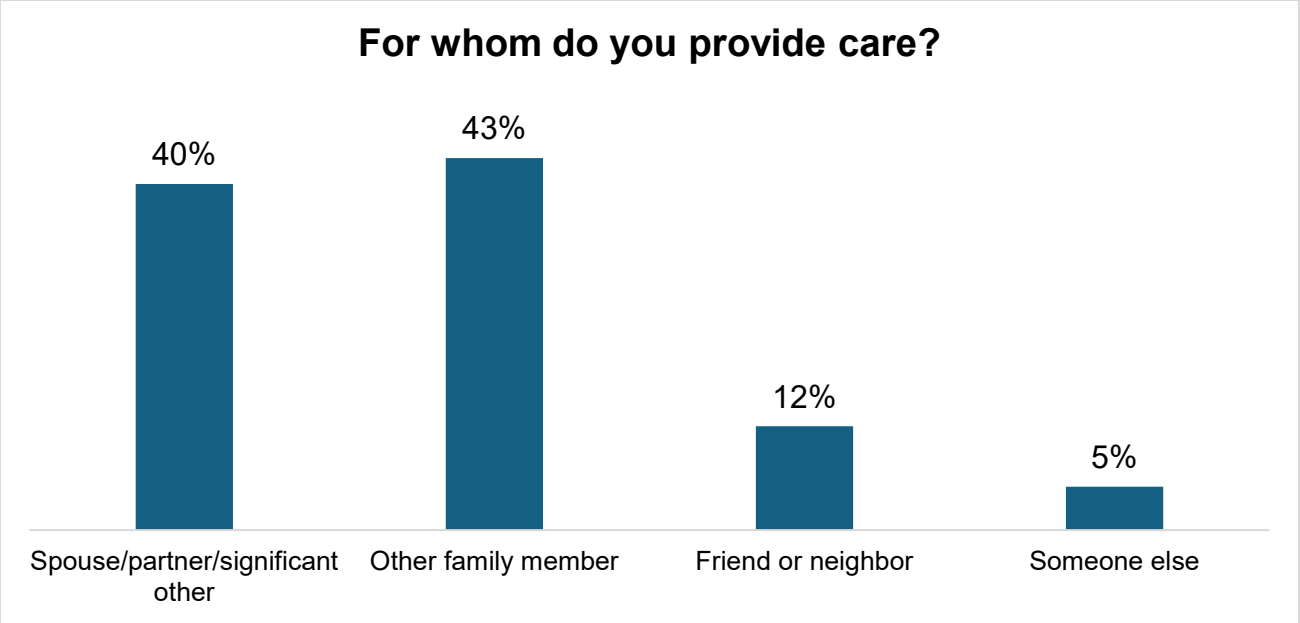
Access to a caregiver

89% of respondents have someone who can provide care to them if needed. Most respondents identified a spouse/partner as a potential caregiver (62%) or another family member (32%).

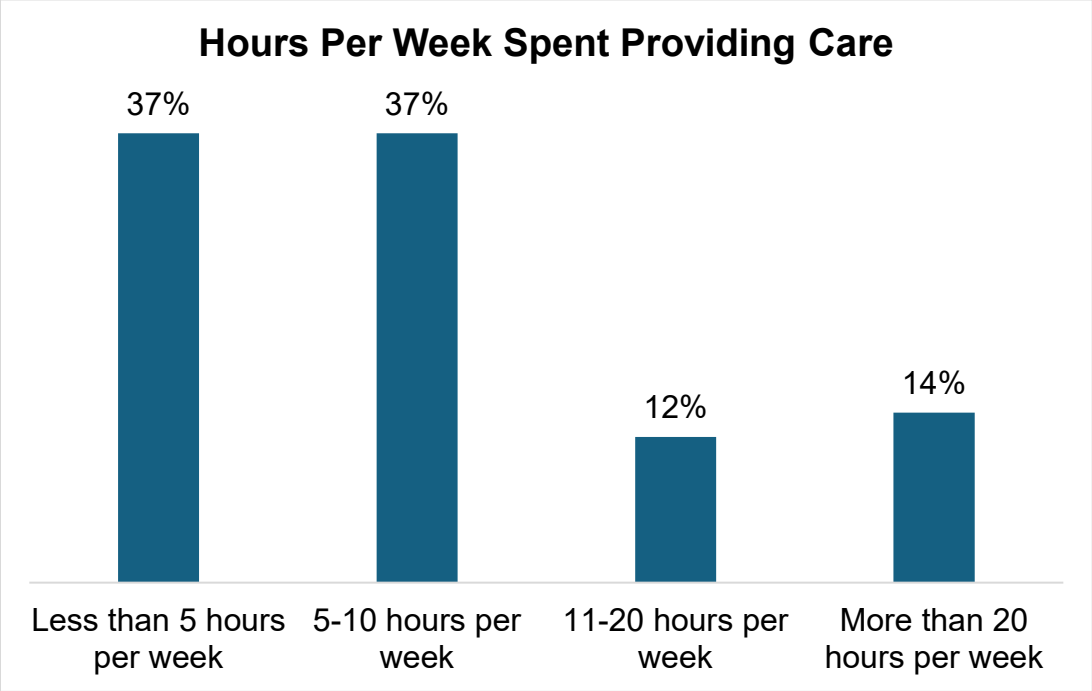


Older adult caregivers

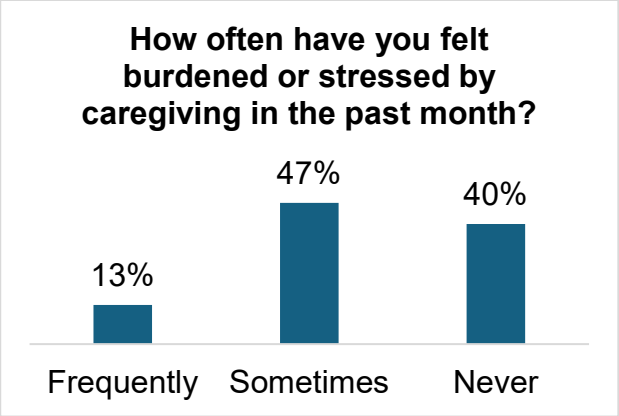
27% of respondents were providing care to someone else. Their care recipients were most likely to be a spouse/partner (40%) or other family member (43%).

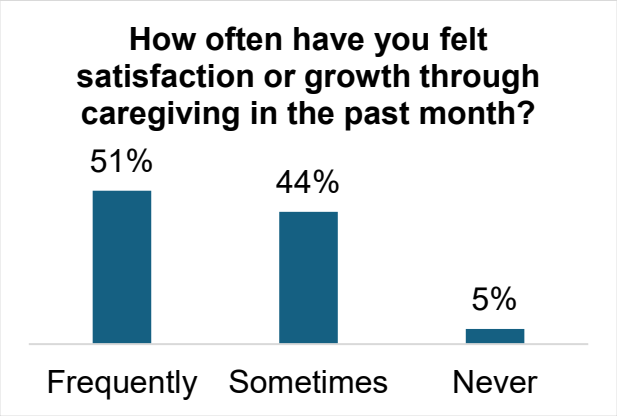


The majority of older adult caregivers in this sample (73%) provided 10 hours or less of care per week. Only 14% provided more than 20 hours per week.



For older adults providing care to someone, most reported that they sometimes feel burdened or stressed by their caregiving, and most felt some level of satisfaction or growth through caregiving.





Approximately 60% experienced some caregiving burden; 95% experienced some caregiving reward. These results suggest that caregivers experience both burden and potential reward from providing care.

A substantial majority of older adult caregivers (60% or more) indicated that they are using or would consider using services related to individualized caregiver support/coaching, caregiver consulting, and services supporting their care recipient; caregivers were slightly less interested in services like caregiver support groups, educational classes for caregivers, and respite care.

	Using n (%)	Consider n (%)	Not Consider n (%)
Individualized support	6 (11%)	33 (61%)	15 (28%)
Caregiver consultant	5 (8%)	34 (58%)	20 (34%)
Support groups	4 (7%)	21 (40%)	28 (53%)
Educational classes	5 (9%)	23 (43%)	25 (47%)
Respite support	0 (0%)	29 (53%)	26 (47%)
Services to help care recipient	4 (7%)	35 (58%)	21 (35%)

Approximately 64% of caregivers would be willing to pay for services to support their caregiving.

Bivariate results (crosstabs)

CMCOA staff requested comparisons across subregions and demographic groups (e.g., age, gender, income, marital status, LGBTQ+ status). Statistically significant results are described below; differences that did not reach statistical significance are not included, nor are results from analyses that resulted in crosstab cells too small to generalize.

Demographic differences by subregion

There was a difference in LGBTQ+ representation, such that there were more LGBTQ+ respondents from the Eastern (9%) and Northern (5%) subregions than the Central subregion (0%). The only other marginally significant difference is that the sample from the Central subregion (66%) was more likely to include married respondents than the other subregions (Eastern: 53%; Northern: 57%).

Internet access and Senior LinkAge Line awareness by subregions and demographics

There were no differences in the internet access variables across subregions or demographic groups. There was a difference in familiarity with Senior LinkAge Line (SLL) by income, such that respondents who were below 250% poverty level were more likely to be familiar with SLL (71%) than more affluent respondents (53%).

Food insecurity by subregions and demographics

There was no difference in food insecurity by subregions. As expected, lower-income respondents were more likely to sometimes or often experience food insecurity (27%) than higher-income respondents (7%).

Loneliness by subregions and demographics

There were differences in loneliness by subregion: Respondents in the Northern (32%) and Eastern (29%) subregions were more likely to be lonely than those in the Central subregion (16%). As expected, single/divorced (35%) and widowed (38%) respondents were more likely to be lonely than married ones (13%).

Service use/consideration by subregions and demographics

These comparisons could not be conducted because some of the groups were too small for analysis (e.g., only one or two people per group who were ‘currently using’ or ‘would not consider using’ a service).

Willingness to pay for services by subregions and demographics

No statistically significant differences existed between subregions or demographic groups in the willingness to pay for services. This included comparisons of respondents with monthly income below 250% of the poverty line (78% were willing to pay for services) and those with income at or above 250% of the poverty line (88% were willing to pay for services).

Barriers to accessing services by subregions and demographics

Lack of information: The only difference identified was for marital status: single/divorced (20%) and widowed (33%) respondents were more likely to experience this barrier than married respondents (6%).

Cost/copays: Differences were identified for income, gender, and marital status. Respondents with a monthly income below the 250% poverty line were more likely to experience this barrier (20%) than respondents with a monthly income at or above the 250% poverty line (10%). Women were more likely to experience this barrier (16%) than men (5%). Single/divorced (28%) and widowed (20%) respondents were more likely to experience cost as a barrier than married respondents (5%).

Lack of transportation: Comparisons could not be conducted because some of the groups were too small for analysis. However, trends suggest that transportation may be a more significant barrier for the Northern subregion (31%) than the other subregions (Central: 4%; Eastern: 9%). The differences across subregions should be interpreted cautiously, though, due to the small sample sizes for respondents reporting transportation as a barrier in Central and Eastern regions.

Providers not understanding of culture/language: Comparisons could not be conducted because some of the groups were too small for analysis.

Access to a caregiver by subregions and demographics

Older adults' access to a potential caregiver varied by income, gender, and marital status. Lower-income respondents (80%) were less likely to have a potential caregiver than higher-income respondents (94%). Women (86%) were less likely to have a potential caregiver than men (95%). Single/divorced (69%) and widowed respondents (77%) were less likely to have a potential caregiver than married respondents (99%).

Older adult caregivers by subregions and demographics

Younger respondents were more likely to be providing care to someone than older respondents: 33% of respondents between 60-74 years old were providing care, compared to 16% of respondents between 75-84 years old and 21% of respondents aged 85 or older. Married respondents were marginally more likely to be providing care (33%) than single/divorced (18%) or widowed respondents (19%). There were no significant differences between groups of older adult caregivers in willingness to pay for services.

Longitudinal comparisons

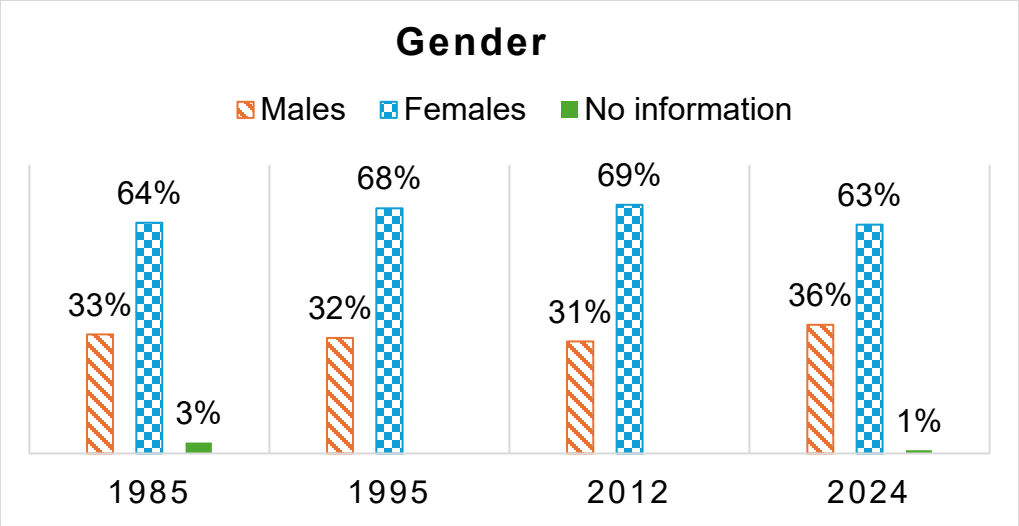
The Central Minnesota Council on Aging (CMCOA) has commissioned four studies over the last 40 years, in 1985, 1995, 2012, and now, 2024. In 2005, the CMCOA's designated planning and service area expanded from four counties (Stearns, Sherburn, Benton, and Wright) to its current 14-county central Minnesota territory. Although the demographic makeup of the population has remained quite similar even after 2005, readers should keep in mind that the data from 2012 and 2024 includes respondents from 10 more counties than in 1985 and 1995.

It is also the case that many of the questions and response options have changed over the years, making comparisons difficult or impossible in some cases. However, there are several survey items that are the same or similar enough to enable longitudinal comparisons to identify trends in the Central Minnesota older adult population. First, we will examine demographic changes over the four studies, and then compare changing patterns of service needs and caregiver concerns. Note that respondents who chose 'Don't know' or 'Prefer not to say' were included in these analyses to make them comparable to previous reports.

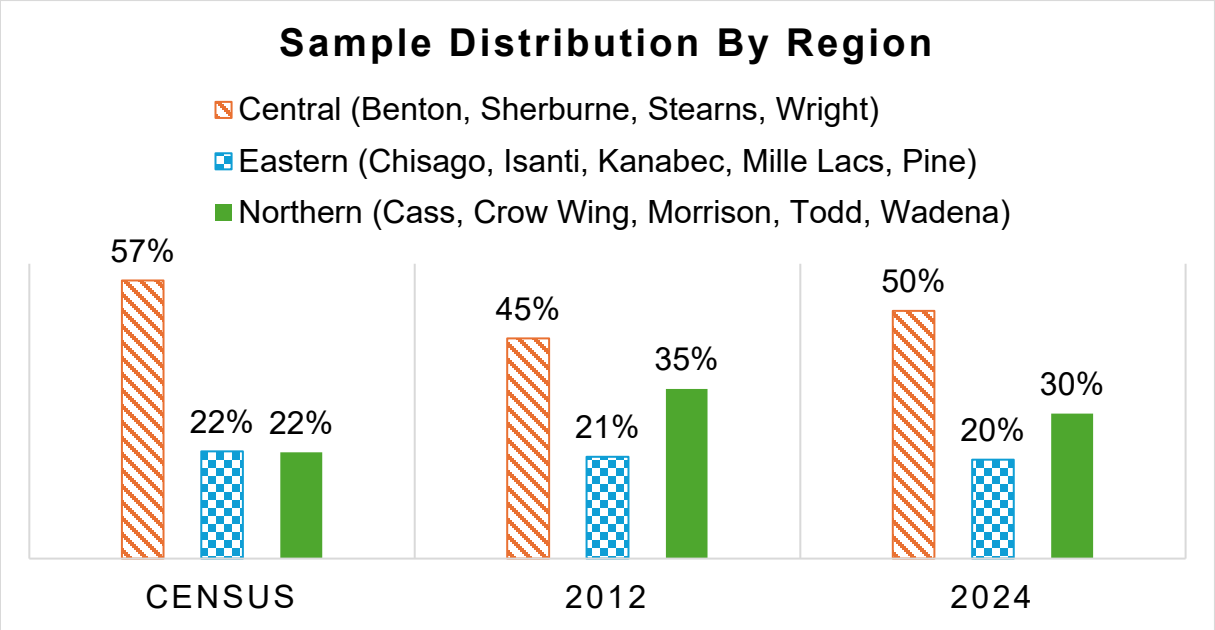
Demographic trends

Age: Demographic differences across the different studies are very minor. The percentage of respondents in each of the age groups has remained remarkably consistent over the last 40 years, with most respondents (64-69%) coming from the 60-74 group and the fewest (6-9%) in the 85+ group.

Gender: Between 2012 and 2024, there is a small increase in the percentage of male respondents (31% to 36%) and a decrease in the percentage of female respondents (69% to 63%), which likely reflects changing response rates to telephone surveys due to the cultural shift from landline usage (in which women were more likely to answer the phone) to cell phone usage (in which women are more likely to screen their calls and not pick up if they do not recognize the number).



Race: The percentage of respondents who identify as Black, Indigenous, or People of Color (BIPOC) increased since 2012, from about 1% to a little over 7%, reflecting a methodological decision to purchase an oversample of people of color in this year's phone sample. While these numbers still do not permit a statistical analysis of the BIPOC subsamples, they do suggest a better, more complete estimation of the target population.

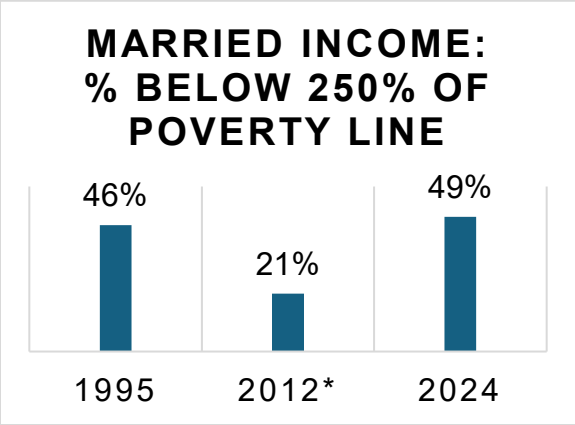


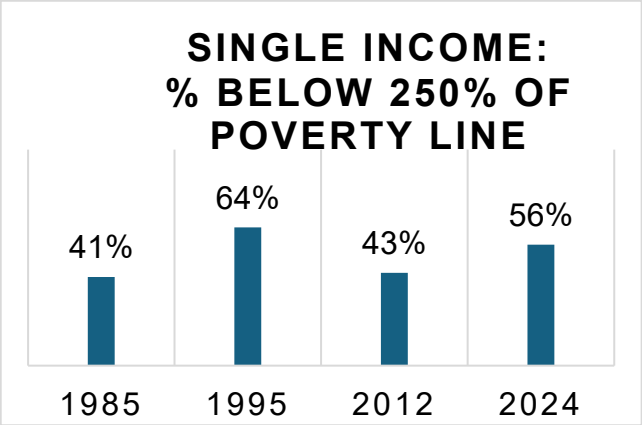
County and region: Comparing the regional distribution of respondents in the 2012 and 2024 studies with actual population estimates from the US Census (above) suggests that the sample from this year's study is a closer approximation of the true population than earlier studies. From 1985 to 2024, Stearns County has consistently been the largest percentage of the sample, just as it is the largest county in the study (NOTE: In 1985 and 1995, the CMCOA coverage area

only covered the four counties in the Central region). However, response rates in some of the other counties (e.g., Wright, Sherburne) have not reflected the rate of population growth relative to Stearns. Organizing the sample by region instead (Central, Eastern, and Northern) provides a more representative distribution of the data, one that is a substantial improvement over the 2012 sample.

The increase of 5% from 2012 to 2024 in the Central region, along with the decrease in the percentage of respondents from the Northern region, makes the 2024 sample a better approximation of the actual population of those regions. (2022 Census estimates are from the Minnesota Demographer's Office at https://mn.gov/admin/assets/mn-county-edr-historical-estimates-sdc-1990-2022_tcm36-586680.xlsx)

Income: Income levels have fluctuated significantly from decade to decade, with representation of lower-income respondents being higher in 1995 and 2024. Single-income respondents reporting their monthly income below 250% of the poverty line ranged between 41% and 43% in 1985 and 2012, but in 1995, it spiked to 64%, and it is at 56% for the current year.



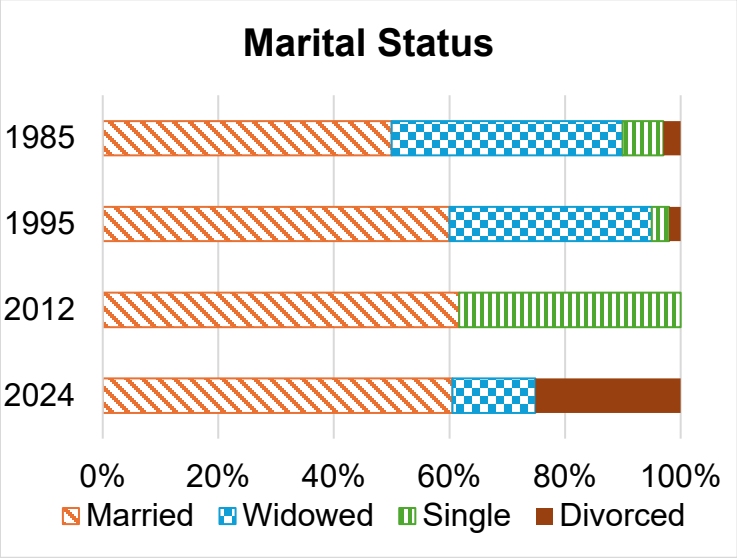


NOTE: *2012 totals and percentages are corrected from the original report, which cited 719 as the total N for both Single and Married Income and resulted in calculation errors for the percentages.

Married couples consistently do better on income measures in every period studied. The percentage of respondents reporting married income below 250% of the poverty line declined from 46% in 1995 to 21% in 2012 and has since risen to 49% in the current study (married income was not measured in 1985). While the data for married people trends in the same general direction as with single respondents, married couples are generally less likely to fall into

the lowest income category over the periods studied. Note that "Unknown," "Don't Know," and "Refused" are excluded from the above figures to facilitate comparisons to 1985 and 1995.

Marital Status: Respondents' marital status has remained stable for the last three decades, with only very minor variations in the percentage of respondents who were married. Variations in how "Single" status was specified in the questionnaire make inter-year comparisons of Divorced and Single (not widowed or divorced) impossible, but the data on Widowed collected for 1985, 1995, and 2024 show a dramatic drop in the number of respondents reporting that they have been widowed (from 40% to 14%). This result may reflect improvements in health care and increases in life expectancy since 1985.



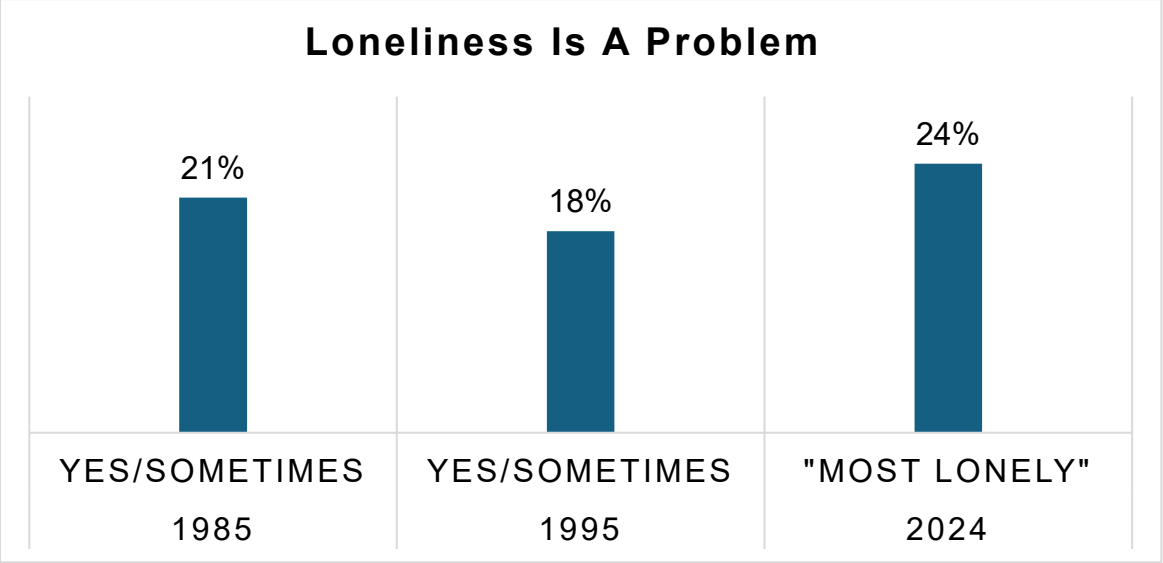
NOTE: In 2024, "Single" and "Divorced" were combined as a single measure. In 2012, neither Widowed nor Divorced were offered as response options; "Single" captures those categories for 2012.

Trends in feelings of loneliness

Measures of loneliness and depression have changed over the four studies, with no data collected in 2012 and a new, composite index measure of loneliness (from UCLA) used in the 2024 study. In 1985 and 1995, respondents were asked "Is loneliness a problem for you?" The percentage of respondents reporting that "Loneliness is a problem" at least some of the time dropped from 21% in 1985 to 18% in 1995. The 2024 study employed a new index of loneliness based on three separate questions, with results ranging from low risk of loneliness ("least lonely") to the greatest risk of loneliness ("most lonely"). The results suggest an increase in

feelings of loneliness in the older population based on nearly 24% of respondents scoring on the “Most lonely” end of the scale.

While the two measures are not directly comparable, they do suggest that older adults in the 14-county service area are at greater risk for feelings of loneliness and isolation than they were in 1995. This result, which comes on the heels of the global pandemic, may reflect some lingering isolation that many experienced during that time.

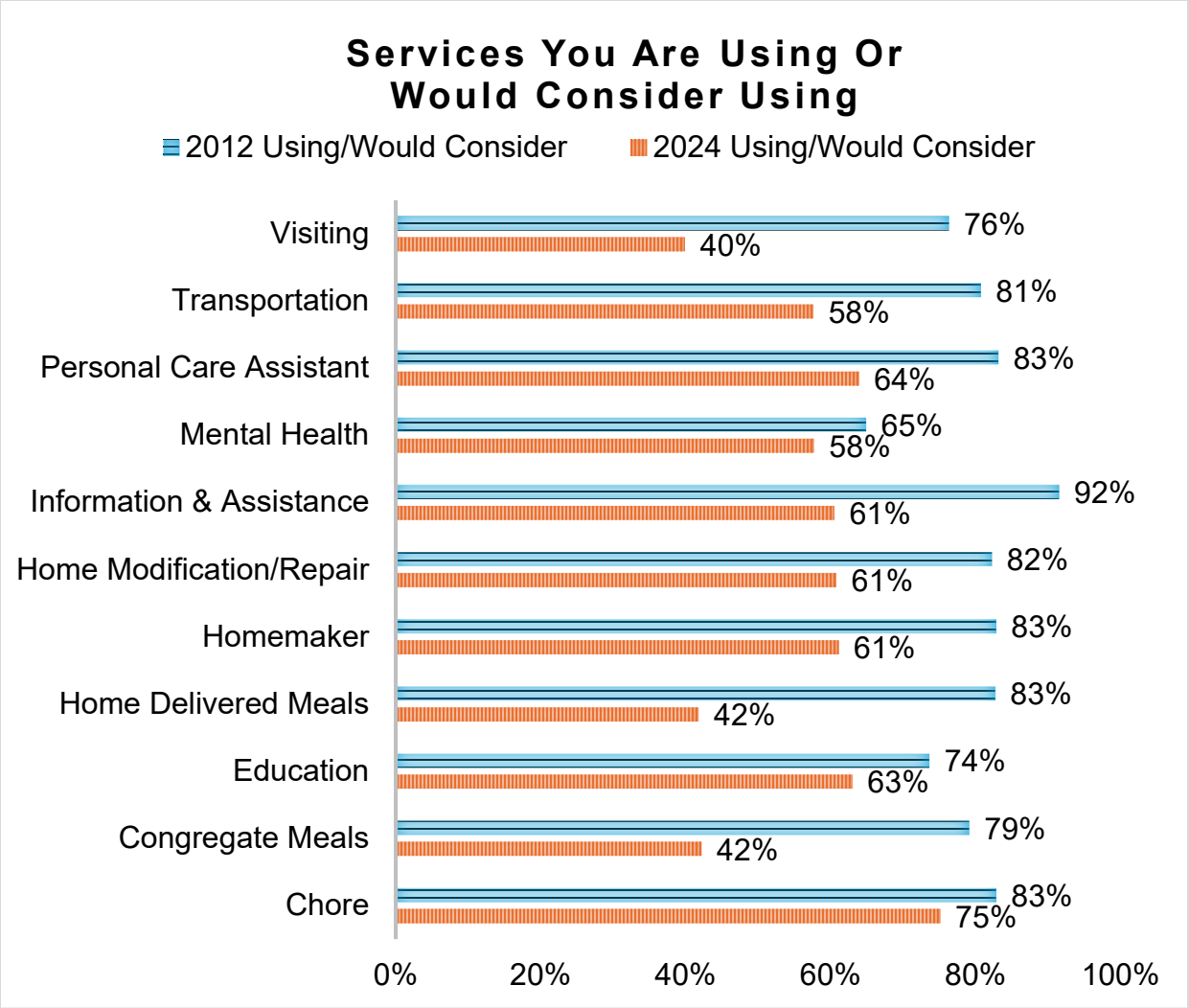


The upward trend in loneliness over the period studied may be expected to impact the services sought by the older adult population. In the next section, we examine trends in the types of services that respondents would use or consider using.

Changing demand for services among older adults

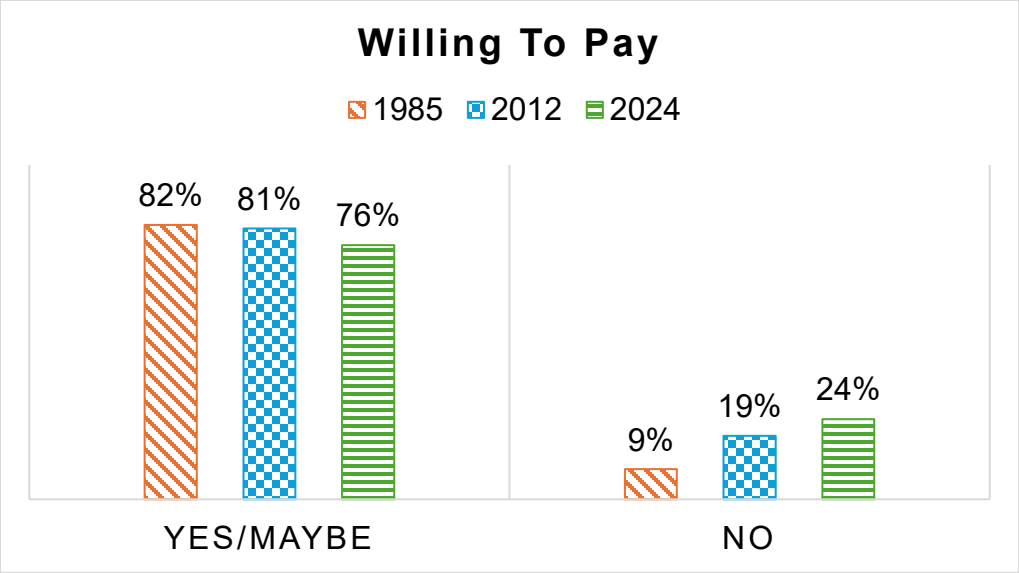
Demand for services: Data from 2012 and 2024 shows some changes in the types of services older adults in the central Minnesota area are using or would consider using, and many of these changes are consistent with our finding of increased feelings of loneliness.

While demand for services in general dropped across all of the services measured, it appears there has been a larger decrease in demand for services that involve face-to-face, direct social interaction. For example, between 2012 and 2024 there has been a dramatic decline in the percentage of respondents reporting using or considering services for “congregate meals” (79% to 42%), home-delivered meals (83% to 42%), and “visiting” services (76% to 40%). Mental health services (65% to 58%) and help with chores (83% to 75%) were the only services measured that did not suffer a double-digit decline.



NOTE: The 2012 survey explicitly asked respondents if they would like a Personal Care Assistant (PCA), whereas the 2024 study specified if the respondent would like someone to "help with things like eating, dressing, bathing, or walking."

Willingness to pay: In addition to respondents expressing less desire for services, they also expressed a lower willingness to pay for the services that they want, even if payment is on a sliding scale or based on ability to pay. In 2012, 81% of respondents indicated they would be willing to pay for services, but by 2024 that percentage had dropped to 68%. This year's study also produced the largest percentage of respondents (22%) who said "no" they would not be willing to pay for services. These results are consistent with the general decrease in demand for services overall. (NOTE: 1985 was the only year that included "maybe" as a response option).

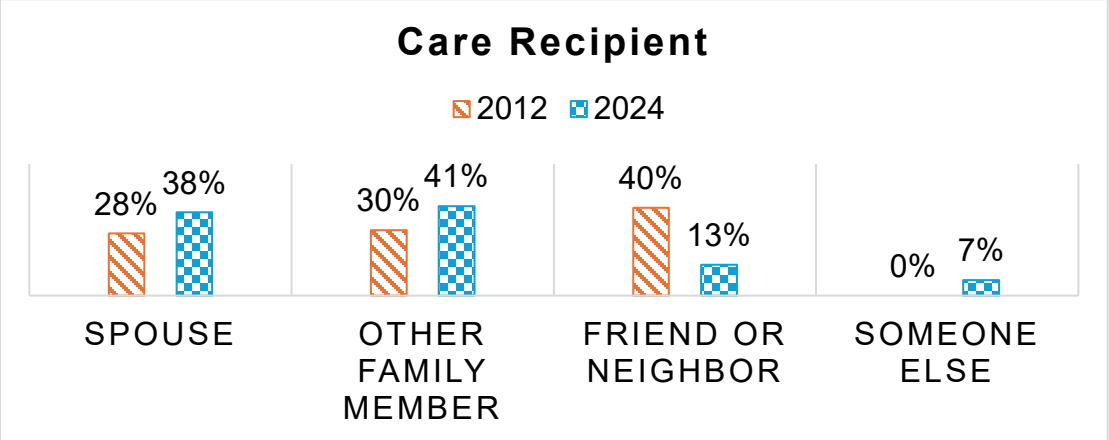


Trends in older adult caregiving behavior

A significant subset of questions in the 2012 and 2024 study relate to older adults who are also caregivers to others. In both studies, a significant percentage of respondents reported that they engage in caregiving to someone else. This section reviews the trends in caregiving since the 2012 study.

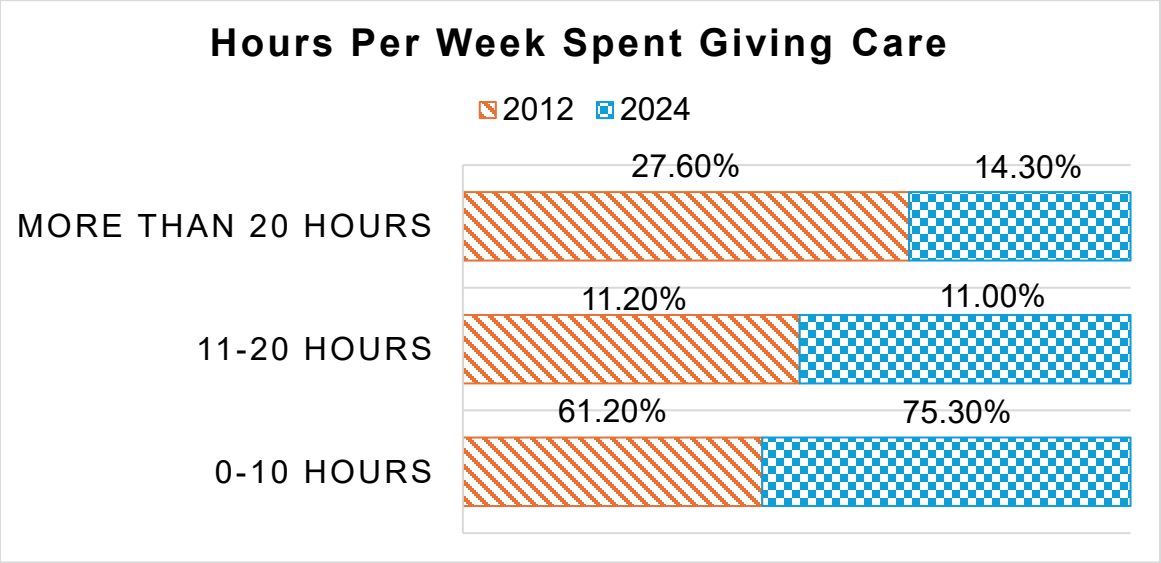
Caregiving among older adults: Slightly fewer respondents in 2024 reported that they were providing care to someone, with 30% in 2012 reporting caregiving compared with 27% in 2024. This decline is relatively small, however, and within the margin of error for this year's study. The biggest change has been in who receives care.

Care recipients: The 2012 study indicated that the largest percentage of respondents (40%) who were caring for someone were caring for a friend or neighbor. The results for 2024 show a dramatic decline in this percentage (13%), with most respondents reporting that they care for a spouse (40%) or a family member (43%).

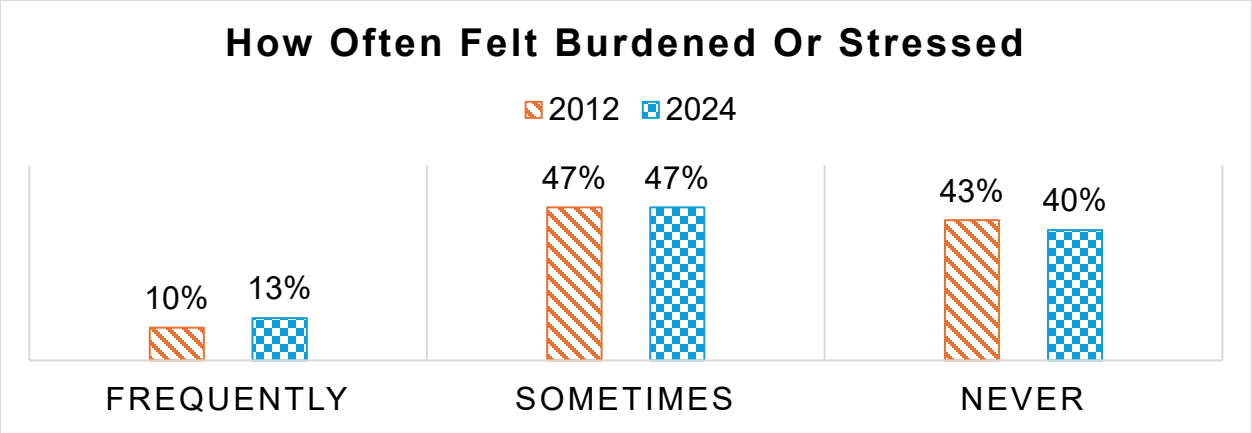


The reasons for this change are not clear, but it is worth noting that there were some discrepancies in the figures in the 2012 report, with the N of the reported cells adding up to 326, not the reported 257, and the reported percentages adding up to 126.9% (which is likely due to the incorrect figure of 257 being used as the denominator for the calculation of the percentages, or to respondents providing care to more than one person).

Hours spent giving care: Between 2012 and 2024, the number of hours caregivers spent every week on caregiving decreased. The percentage of respondents providing 0-10 hours of care per week increased by 14% since 2012, and the percentage who devoted more than 20 hours per week to providing care showed an equal decline from about 28% to 14%. These data show that while there has not been a significant decline in the percentage of caregivers, there has been a decline in the amount of time spent caregiving.



Burdens and stress of caregiving: The decline in the number of hours spent providing care may have helped to reduce stress among respondents. The percentage of respondents who reported feeling "burdened" or "stressed" by their efforts to provide care remained relatively constant, though a slightly higher percent of older adult caregivers reported feeling "frequently" burdened or stressed in 2024 (13% vs 10% in 2012). An item asking about caregiving growth and satisfaction was added for the 2024 survey; 95% of respondents reported "sometimes" or "frequently" experiencing these positive aspects of caregiving.



Services for caregivers: Longitudinal comparisons of caregiver services is complicated by changes to the methodology from 2012 to 2024. In 2012, a single, open-ended question asked respondents to indicate what "would be most helpful to you as a caregiver?" In 2024, a series of questions asked respondents which services they "would consider using" as a caregiver. Because these measures are not directly comparable, they are ranked in terms of which services had the most support expressed by respondents to provide a rough indicator of the relative importance of each service to care providers.

	2012	2024
Ranking	**Open-ended, single item**	**"Would you consider using?" multiple items**
(1)	Time off, respite (N=38)	Personal Care Assistant * (N=39)
(2)	Personal Care Assistant * (N=11)	Caregiver coaching (N=39)
(3)	General support /Support groups (N=11)	Time off, respite (N=29)
(4)	Caregiver coaching (N=8)	Education classes (N=28)
(5)	--	Support groups (N=25)

* The 2012 study explicitly asked respondents if they would like a Personal Care Assistant, whereas the 2024 study specified if the respondents would like someone to "Help with things like eating, dressing, bathing, or walking." Totals for 2024 include respondents who indicated they were currently using or would consider using each service.

This ranking suggests some interesting changes in preferences since 2012, with services of the kind provided by a Personal Care Assistant ("help with things like eating, dressing, bathing, or walking") and individualized caregiver coaching topping the list in 2024, whereas most respondents in 2012 cited a need for "time off, respite" as the thing that would be most

helpful. In 2012, the least cited of the services included in both studies was “caregiver coaching” (measured in 2024 as “A caregiver consultant service that helps on an individual basis with problem-solving, information, skills, and emotional support. A consultant can help develop strategies to achieve a balanced lifestyle to provide good care and protect your health”), but this service was tied for the most popular option in 2024.

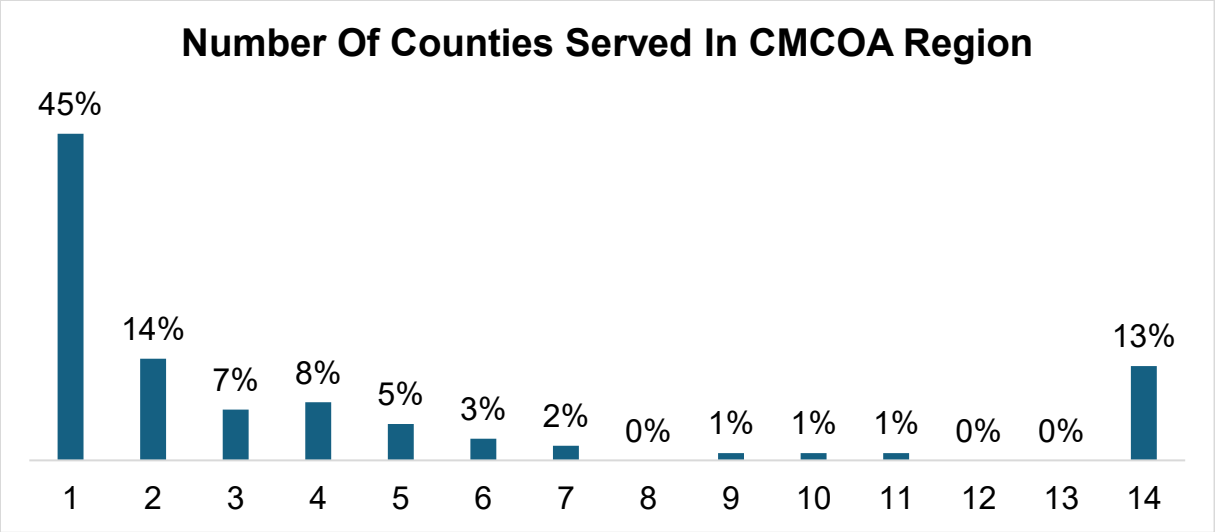
Part B Results: Service Providers

426 providers completed this survey, representing all counties of the CMCOA service area. Providers were mostly women (83%) and white (85%). For providers of color, 3% identified as Black or African American, 3% identified as two or more races, and all other categories each comprised less than 1% of the data. Most respondents provided services to just one (33%) or two (10%) counties in the CMCOA service area, but 10% of respondents indicated that they provided services to all 14 counties. 49% of respondents served the Central CMCOA subregion (Benton, Sherburne, Stearns, and Wright counties), 28% served the Eastern CMCOA subregion (Chisago, Isanti, Kanabec, Mille Lacs, and Pine counties), and 31% served the Northern CMCOA subregion (Cass, Crow Wing, Morrison, Todd, and Wadena counties). Multiple providers served counties in more than one subregion.

In which of the following counties do you provide services? *

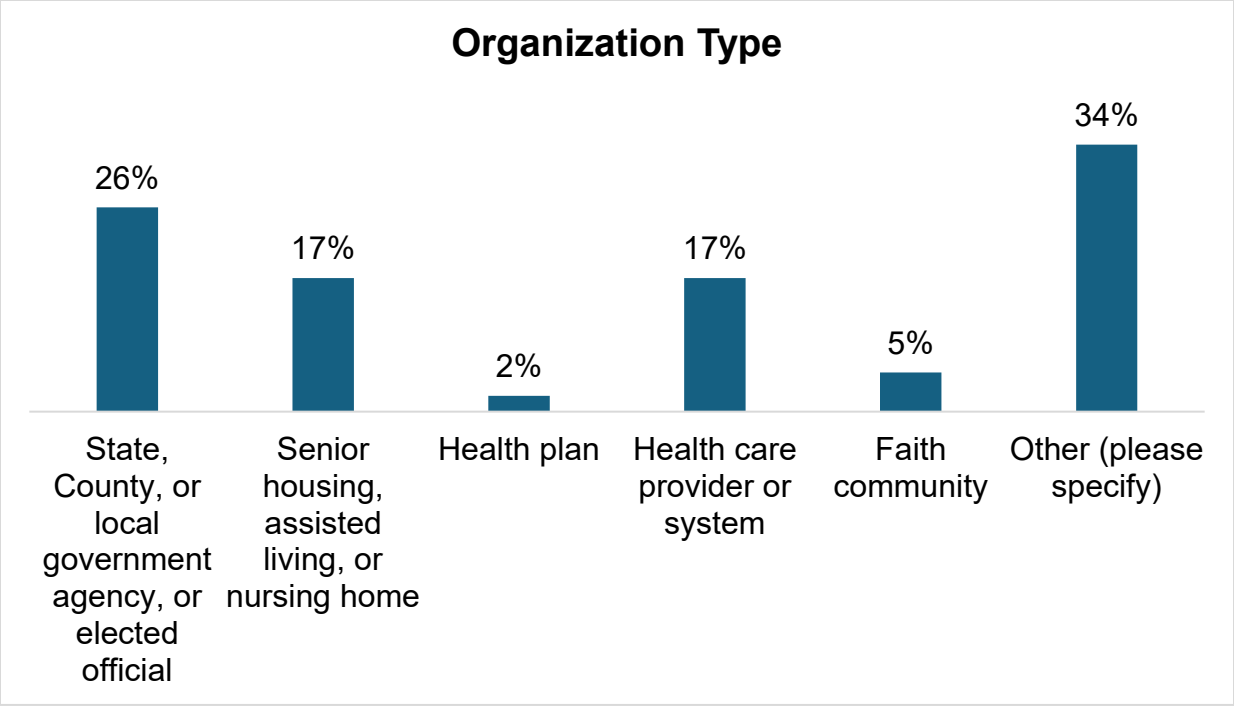
	n (%)		**n (%)**
Benton	111 (26%)	**Morrison**	82 (19%)
Cass	64 (15%)	**Pine**	72 (17%)
Chisago	70 (17%)	**Sherburne**	133 (31%)
Crow Wing	79 (19%)	**Stearns**	147 (35%)
Isanti	73 (17%)	**Todd**	81 (19%)
Kanabec	71 (17%)	**Wadena**	62 (15%)
Mille Lacs	86 (20%)	**Wright**	98 (23%)

*Please note that the total adds to more than 100%, as many respondents indicated that they serve more than one county.



Service provider respondents were mostly white (92%), women (86%), and middle aged (ages 45-64; 60%). 1% identified as Hispanic/Latinx and 1% identified as East African or Somali. 3% identified as part of the LGBTQ+ community. Respondents represented a variety of organization types, the most common being government agencies (26%), senior housing (17%), and health care providers or systems (17%). Approximately 34% responded 'other,' which included organizations such as non-profits and home health agencies.

Organization type	**n (%)**
State, county, or local government agency, or elected official	79 (26%)
Senior housing, assisted living, or nursing home	51 (17%)
Health plan	7 (2%)
Health care provider or system	51 (17%)
Faith community	14 (4%)
Other (e.g., nonprofit, home health agency)	103 (34%%



Organizations had a variety of fee structures, and many respondents indicated that their organization used more than one type of fee.

Fee type	n (%)
Fee for services (self-pay)	91 (21%)
Sliding fee based on ability to pay	42 (10%)
Donation requests only	27 (6%)
Waiver or medical assistance	121 (29%)
Health plan	87 (21%)
No cost	103 (24%)

Provider perceptions of barriers to older adults accessing services

Providers were asked to consider which barriers 'often' prevent older adults from remaining in their homes. The most frequently endorsed barrier was provider shortages in needed service areas (71%). Over half of providers also identified people waiting too long before seeking help (55%), people being reluctant to pay for help (54%), and people not knowing where to get help (53%) as barriers to accessing services.

	Often n (%)	Sometimes n (%)	Never n (%)
Provider shortages in needed service areas	137 (71%)	55 (28%)	2 (1%)
People wait too long before seeking help	111 (55%)	91 (45%)	0 (0%)
People are reluctant to pay for help	108 (54%)	90 (45%)	3 (1%)
People don't know where to get help	107 (53%)	96 (47%)	0 (0%)
Right types of in-home services are not available	96 (47%)	104 (51%)	3 (2%)
People are unable to identify/find the help they need	113 (43%)	142 (55%)	5 (2%)
Lack of support from family and friends	55 (28%)	143 (71%)	2 (1%)

Provider perceptions of the availability of existing services

60% or more of providers indicated that the availability of the following services was 'somewhat inadequate,' 'inadequate,' or 'unavailable' in their service area: help with chores, transportation, mental health, and home modifications for accessibility. Not all respondents answered every question in this section, which is why the counts below are associated with different percentages.

Inadequate/somewhat inadequate availability	n (%)
Chores	179 (71%)
Transportation	189 (69%)
Mental health screening or referral	144 (63%)
Home modification or repairs for accessibility	149 (62%)
Homemaker	151 (59%)
Friendly visiting or telephone reassurance	129 (57%)
Legal assistance	109 (52%)
Personal care or home health aide services	131 (51%)
Health and wellness programs	86 (35%)
Senior centers	85 (32%)
Availability of congregate meals	79 (32%)
Information and assistance	62 (25%)
Home-delivered meals	57 (22%)

Priorities for improving conditions for older adults

When thinking about how to improve conditions and services for older adults in their service area, addressing social isolation, strengthening support for family caregivers, and providing

earlier detection and better support for dementia/neurocognitive disorders were rated as the highest priorities by providers (rating as a 4 or 5 on a 5-point Likert scale).

High/very high priority need	n (%)
Addressing social isolation and loneliness in older adults and caregivers	192 (80%)
Strengthening support for family caregivers	177 (74%)
Promote earlier detection and enhance supportive services for individuals living with dementia	172 (72%)
Build communities that work for all ages	148 (61%)
Access to information about available resources	144 (60%)
Create and promote service/program flexibility to meet changing consumer expectations	136 (60%)
Provide technical assistance for organizational capacity building and service delivery	103 (46%)
Care management capacity	99 (44%)
Increase and strengthen culturally responsive services	97 (42%)

Bivariate results (crosstabs)

For most outcomes, comparisons across organizations' types and fee structures were not possible due to small group sizes, which make it difficult to generalize findings. Only statistically significant differences are highlighted below.

Provider perceptions of barriers to older adults remaining in their own homes

Provider perceptions of the inability of older adults to find needed help differed across CMCOA subregions: Respondents from the Northern (49%) and Eastern (46%) subregions were more likely to identify this as 'often' a barrier than respondents from the Central subregion (34%). Respondents from the Northern (77%) and Eastern (74%) were also marginally more likely than respondents from the Central region (59%) to identify provider shortages as a barrier.

There were no differences across subregions for the right types of services not being available, not knowing where to get help, reluctance to pay, waiting too long to seek help, or lack of support from family/friends.

Availability of services

Respondents serving the Eastern (20%) and Northern (26%) subregions were more likely than those serving the Central region (14%) to say that there was inadequate/lack of availability for homemaker services. Availability of transportation services also differed by subregion such that respondents from Eastern (51%) and Northern (43%) were more likely to say that transportation was inadequate/unavailable than respondents from the Central region (23%).

Respondents from the Eastern region (21%) were more likely to identify the availability of senior centers as inadequate than respondents from the Northern (8%) and Central regions (5%).

There were no differences across subregions in respondents' perceptions of the adequacy of services related to personal care or home health aide services, chores, legal assistance, information and assistance finding other services, home modification for improved mobility, friendly visiting or telephone reassurance, health and wellness programs, mental health screening and referral, home-delivered meals, and congregate meals.

Priorities for improving conditions and services for older adults

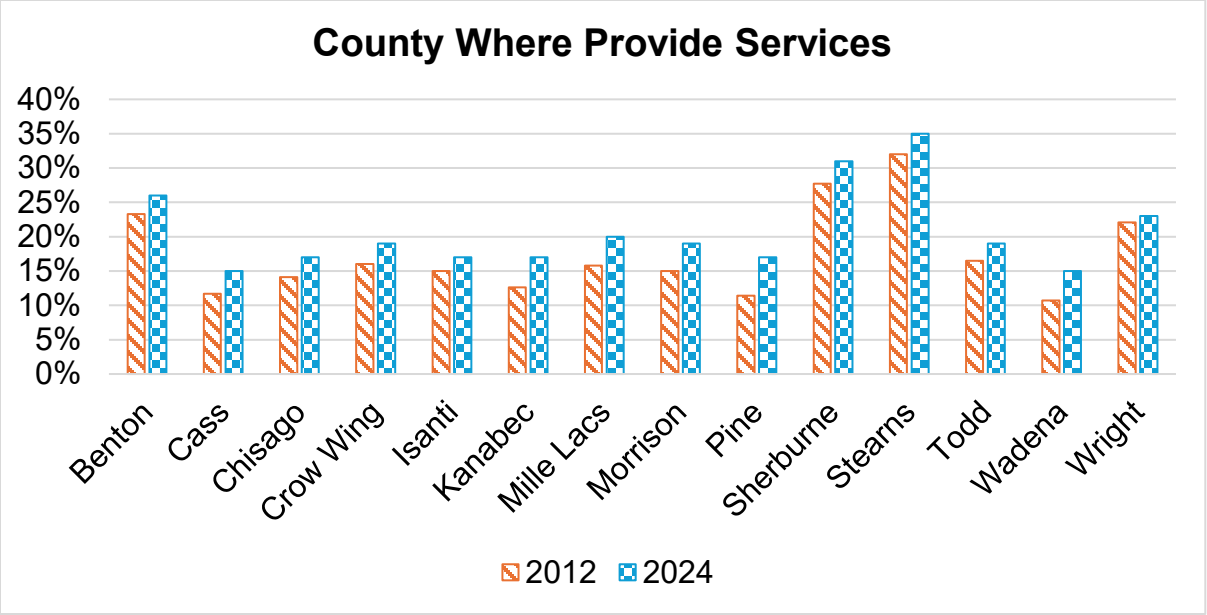
The only marginally significant difference that was identified across service subregions was that respondents who served the Northern subregion (42%) were more likely to identify strengthening support for family caregivers as a 'very high priority' than respondents who served the Eastern (32%) or Central (26%) subregions.

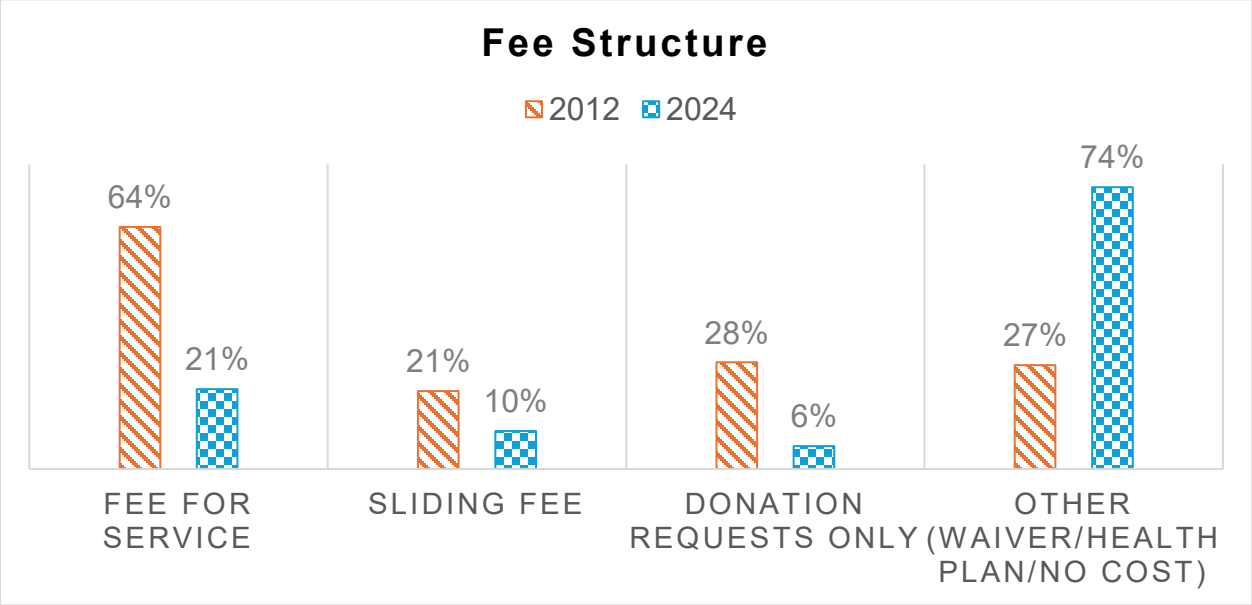
There were no differences across subregions for identifying the following as a priority: strengthening care management capacity, improving access to information about available resources, building communities that work for all ages, promoting earlier detection, and enhancing supportive services for individuals living with dementia/neurocognitive disorders, providing technical assistance for organizational capacity building and service delivery, creating and promoting service/program flexibility to meet changing expectations for more choice and personalization, addressing social isolation and loneliness in older adults and caregivers, or increasing and strengthening culturally responsive services.

Longitudinal comparisons

Sample comparisons

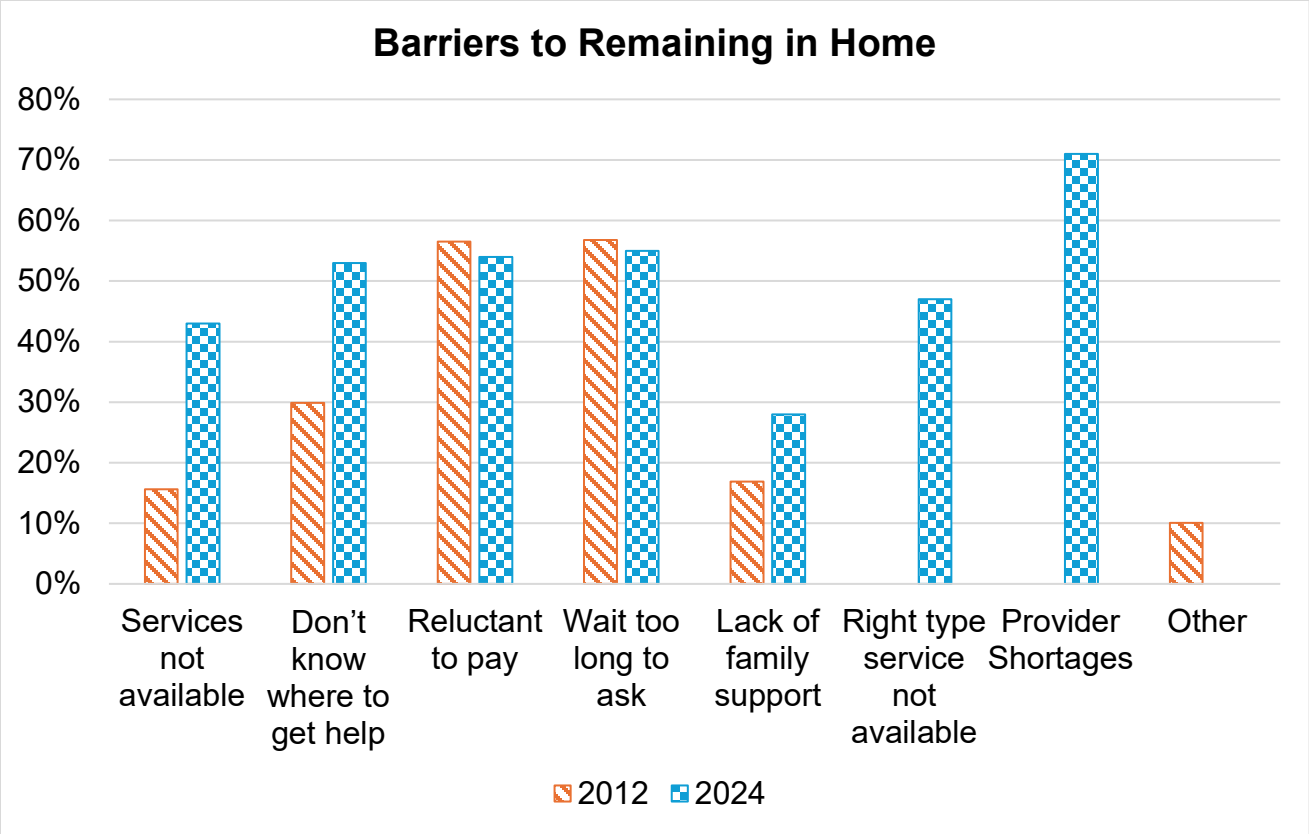
Compared to the 2012 needs assessment study, there is an increased representation of providers from each of the counties in the CMCOA service area. The 2024 provider sample included more providers whose fee structure includes waivers, health plans, and no cost to clients. For both of these provider characteristics, percentages can add up to more than 100% because some providers serve multiple counties and have different fee options.





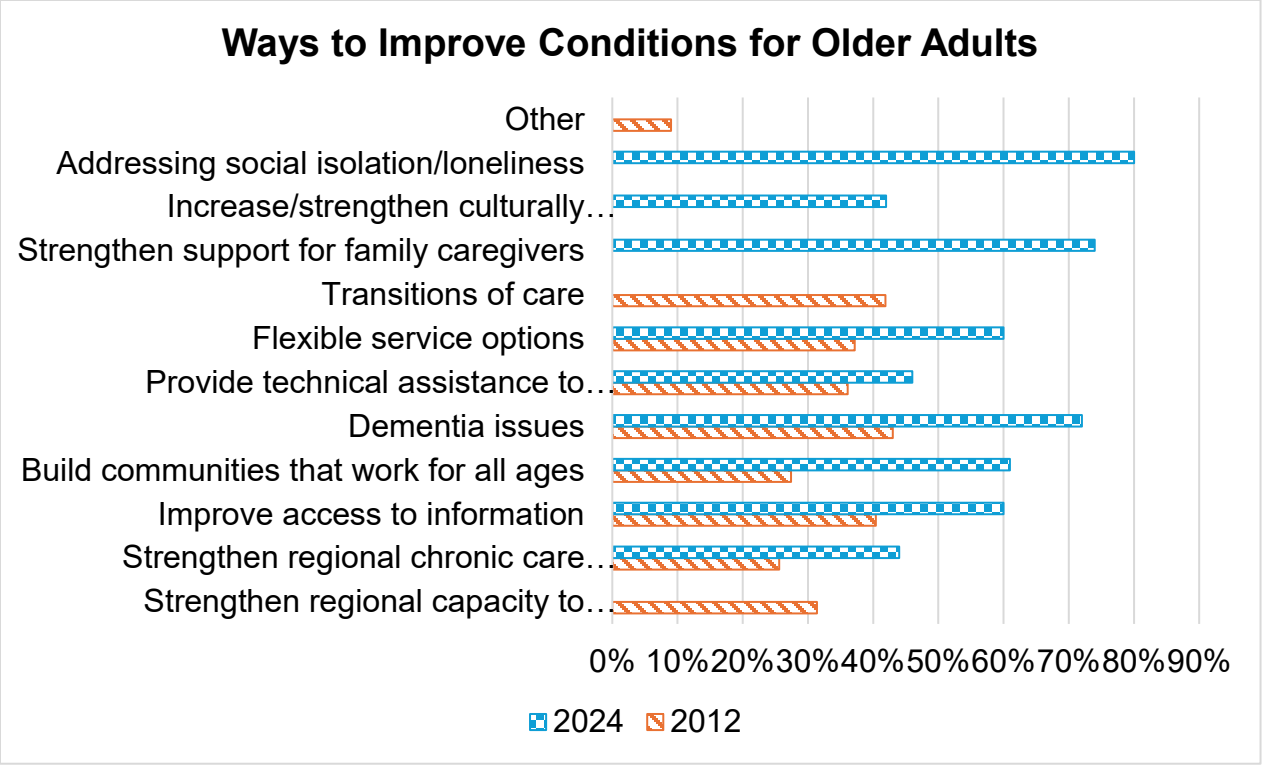
Provider perceptions of barriers to older adults remaining in their homes

There was an increase in providers' perceptions that lack of availability of services, older adults not knowing where to get help, lack of family support, and provider shortages prevented older adults from remaining in their homes as they need more help when comparing this year's data to the results of the 2012 needs assessment. A change in methodology may have contributed to these differences, such that in 2012, providers selected the top two barriers they perceived, but in 2024, providers selected whether they believed each potential barrier was present for the older adults they served.



Priorities for improving conditions for older adults

Providers ranked each area as a higher priority in 2024 than in 2012. This may reflect a change in methodology: in 2012, providers were asked to pick their top three priorities from a list of items, whereas, in 2024, providers were asked to rank the priority level for each individual item.



NOTE: A missing bar indicates a response option that was not available in that year's study.

Comparisons across older adult and service provider responses

Services

Older adult responses to items about services were compared to service providers' responses about the perceived adequacy of existing services. Typically, responses were aligned such that older adults' willingness to use services mapped onto service providers' impressions of perceived adequacy/availability of those services: services in highest demand from older adults were often perceived by providers as having an inadequate supply.

Help with things like eating, dressing, bathing, or walking

Older Adults	
Use or will use	69%
Will not use	31%

Service Providers	
Adequate	49%
Inadequate	51%

Help preparing meals, shopping, paying bills, or housekeeping

Older Adults	
Use or will use	65%
Will not use	35%

Service Providers	
Adequate	41%
Inadequate	59%

Help with chores like yard work, cleaning windows, or snow removal

Older Adults	
Use or will use	80%
Will not use	20%

Service Providers	
Adequate	29%
Inadequate	71%

Help with transportation

Older Adults	
Use or will use	61%
Will not use	39%

Service Providers	
Adequate	31%
Inadequate	69%

Help to make home improvements to make it easier to get around

Older Adults	
Use or will use	66%
Will not use	33%

Service Providers	
Adequate	38%
Inadequate	62%

Having someone visit or give you a call to check in

Older Adults	
Use or will use	43%
Will not use	57%

Service Providers	
Adequate	43%
Inadequate	57%

Home-delivered meals, such as Meals on Wheels

Older Adults	
Use or will use	46%
Will not use	54%

Service Providers	
Adequate	78%
Inadequate	22%

Meals with a group, in locations such as a community or senior center

Older Adults	
Use or will use	45%
Will not use	55%

Service Providers	
Adequate	69%
Inadequate	31%

Barriers to accessing services

CMCOA also requested comparisons across the older adult and provider surveys to see if there is an alignment between older adults' experiences with barriers to accessing services and providers' perceptions of barriers. Providers were asked how often people are unable to identify the help they need, whereas older adults were asked if a lack of information about where to get help prevented them from seeking or using services. Providers were more likely to identify the inability to identify help/resources as a barrier than older adults.

Inability to identify help/resources

Older Adults	
Yes	14%
Never	87%

Service Providers		
Often	44%	99%
Sometimes	55%	
No	2%	

Providers were also asked how often people don't know where to get help. This was compared to older adults' responses to the item 'has a lack of information about where to get help prevented you from seeking or using services?' Again, providers were more likely to identify this as a potential barrier than older adults

Lack of information about where to get help

Older Adults	
Yes	14%
Never	87%

Service Providers		
Often	53%	100%
Sometimes	47%	
No	0%	

Providers were asked how often they thought people are reluctant to pay for help, whereas older adults were asked if they were willing to pay for services. Providers underestimated older adults' willingness to pay for services.

Willing to pay for services

Older Adults	
Yes	24%
Never	76%

Service Providers		
Often	54%	99%
Sometimes	45%	
No	2%	

Providers underestimated support from family and friends relative to older adults' self-report that they have someone who would care for them if they were sick or unable to care for themselves.

Support from family or friends

Older Adults	
Yes	11%
Never	89%

Service Providers		
Often	28%	99%
Sometimes	72%	
No	1%	

Priorities for improving conditions for older adults

Providers identified priorities for future investments by ranking them on a one (not a priority) to five (very high priority) scale. Note that the value 'three' was assumed to mean 'neither a priority or not a priority' and was therefore not matched with older adults' responses.

Providers were asked about how much of a priority it was to improve access to information about available resources. This was compared to older adults' responses to an item about if a lack of information about where to get help prevented them from seeking or using services. Providers identified addressing lack of information as a priority, but only a small subset of older adult respondents identified this as a barrier.

Lack of information

Older Adults	
Yes	45%
No	55%

Service Providers	
Not a priority	69%
Priority	31%

Service providers were asked about addressing social isolation and loneliness in older adults and caregivers. When compared to older adults' self-reported loneliness, it seems that providers are aware of increasing feelings of loneliness among older adults in central Minnesota.

Loneliness

Older Adults	
Least lonely	76%
Most lonely	24%

Service Providers	
Not a priority	3%
Priority	80%

Providers were also asked about increasing and strengthening culturally responsive services, whereas older adults were asked about if provider's lack of understanding of their culture or language prevented them from using services. Very few respondents in the older adult sample identified this as a barrier to accessing services. Providers' identification of this as a priority area may reflect their experience working with more diverse groups of older adults than those represented in this sample of older adults.

Lack of understanding of their culture or language

Older Adults	
No	99%
Yes	1%

Service Providers	
Not a priority	23%
Priority	42%

Conclusions

The 2024 needs assessment provides updated data from older adults and service providers in the CMCOA service area that can be used to guide delivery and growth of services for older adults in central Minnesota. The majority of older adults in this sample had reliable internet access at home, but nearly half of respondents relied exclusively on a smartphone for accessing the internet, which should be taken into consideration when developing materials targeted toward older adults. Many older adults in this sample expressed interest in using different services, if needed. Increasing experiences of loneliness among older adults relative to previous needs assessment reports may reflect ongoing aftereffects of the COVID-19 pandemic. Provider perceptions of the adequacy of available services and priorities for future investment could help guide future investments to support aging in place in central Minnesota.

Appendix A: Older Adult Survey Questions

1. What county do you live in?
2. What is your age?
3. Do you have reliable access to the internet in your home?
4. What type of device do you typically use to access the internet?
5. Why is it that you do not have reliable internet access at home?
6. Are you familiar with the Senior LinkAge Line?
7. Was this statement often, sometimes, or never true for you in the last 12 months: "We worried whether our food would run out before we got money to buy more"?
8. Was this statement often, sometimes, or never true for you in the last 12 months: "We couldn't afford to eat balanced meals"?
9. How often would you say that you feel a lack of companionship?
10. How often do you feel left out?
11. How often do you feel isolated from others?

I would consider using a service for . . .

12. Help with things like eating, dressing, bathing, or walking
13. Help preparing meals, shopping, paying bills, or housekeeping
14. Help with chores like yard work, cleaning windows, or snow removal
15. Help with transportation
16. Help to make home improvements to make it easier to get around
17. Having someone visit or give you a call to check in
18. Home-delivered meals, such as Meals on Wheels
19. Meals with a group, in locations such as a community or senior center
20. Health and wellness programs that educate older adults about health issues such as osteoporosis, cardiovascular disease, alcohol and substance use reduction, weight loss and control
21. Mental health or psychological services, such as screening for the prevention of depression and referral to psychiatric or psychological services
22. Assistance finding services in your community by phone or in person, such as services through Senior LinkAge or United Way's 211, housing, health insurance, community support
23. In general, would you be willing to pay for any of these services?

24. In the past 12 months, has a lack of information about where to get help prevented you from seeking or using services?
25. In the past 12 months, has cost of services or copays prevented you from using any of these services?
26. In the past 12 months, has a lack of transportation prevented you from using any of these services?
27. In the past 12 months, has a provider's lack of understanding of your culture or language prevented you from using services?
28. In the past 12 months, has anything else prevented you from seeking or using services?
29. Do you have someone who would care for you if you were sick or unable to care for yourself?
30. If yes, who would that be?
31. Caregiving can include doing or organizing a wide range of services – things like grocery shopping, preparing meals, regularly driving someone to appointments, doing chores around the house, helping with medications, helping organize bills, or providing personal care for someone who is unable to do these things for themselves. And the person you are caring for could be living with you, they could live near you, and sometimes they could live a long distance away.
    Given this definition, would you say that you are currently providing care to someone?
32. For whom do you provide care?
33. In general, about how many hours per week do you spend providing care or help for this person(s)?
34. How often have you felt burdened or stressed by your caregiving in the past month?
35. How often have you felt growth or satisfaction through your caregiving in the past month?

    As a caregiver, would consider using specific services.

36. An individualized support service that helps caregivers gain knowledge, develop skills, learn resources, and set goals to continue to care for their loved one
37. A caregiver consultant service that helps on an individual basis with problem-solving, information, skills, and emotional support. A consultant can help develop strategies to achieve a balanced lifestyle to provide good care and protect your health
38. Support groups for caregivers
39. Educational classes for caregivers
40. Respite support to give you a break, for example in-home or adult daycare

41. Services to help your care recipient, like home-delivered meals, personal care, housekeeping, transportation, chores, home modification, or social visits
42. In general, as a caregiver, would you be willing to pay for any of these services?
43. What is your sex/gender?
44. Which one or more of the following would you say best describes your race/ethnicity?
45. Do you identify as Hispanic/Latino?
46. Were you or one of your parents born in Eastern Africa or Somalia?
47. What is your marital status?
48. If single, what is your monthly household income?
49. If married, what is your monthly household income?
50. Do you identify as LGBTQ+?

Appendix B: Service Provider Survey Questions

1. Are you currently in a paid or volunteer position serving older adults in Central Minnesota?
2. Which of the following counties do you provide services to older adults or family caregivers?
3. Which of the following best describes your organization?

How frequently do the following issues prevent people in your service area to remain in their own homes as they age and start to need help?

4. People are unable to identify/find the help they need
5. The right types of in-home services are not available
6. Provider shortages in needed service areas
7. People don't know where to get help
8. People are reluctant to pay for help
9. People wait too long before seeking help
10. Lack of support from family or friends
11. Other (Please specify)

How would you describe the existing service area's availability of home and community-based services?

12. Personal care or home health aide services (help with things like eating, dressing, bathing, walking)
13. Homemaker (help preparing meals, shopping, paying bills, or housekeeping)
14. Chores (help with things like snow shoveling, lawn mowing, or cleaning windows)
15. Transportation
16. Legal Assistance (legal counseling and representation)
17. Information and assistance (finding services in the community, by phone or in-person, like
18. Senior LinkAge or 211 through United Way)
19. Home modification or repairs for accessibility (home improvements to make it easier to get around the home)
20. Friendly visiting or telephone reassurance (having someone visit or call to check in)
21. Senior Centers
22. Health and wellness programs (programs that educate older adults about health issues such as osteoporosis, cardiovascular disease, alcohol and substance abuse, healthy weight, etc.)

23. Mental health screening or referral (screening for the prevention of depression and referral to psychiatric or psychological services)
24. Home-delivered meals (like Meals on Wheels)
25. Congregate meals (meals with a group, in locations such as community or senior centers)
26. Does your organization charge for the services you provide?

The following have been identified as important ways to improve conditions and services for older adults. Which of the following are most urgently in need of attention in your service area?

27. Strengthen care management capacity.
28. Improve access to information about available resources.
29. Build communities that work for all ages.
30. Promote earlier detection and enhance supportive services for individuals living with dementia.
31. Provide technical assistance for organizational capacity building and service delivery.
32. Create and promote service/program flexibility to meet changing consumer expectations for more choice and personalization.
33. Addressing social isolation and loneliness in older adults and caregivers.
34. Increase and strengthen culturally responsive services.
35. Strengthening support for family caregivers.
36. Other priority issue?
37. Please help us identify opportunities for enhancing services to diverse populations, for example, older adults who are new immigrants, limited English speakers, Black/Indigenous/People of Color, and/or LGBTQ+.
38. As you think about the work you do to support older adults and their caregivers, what other comments or concerns would you like to share with CMCOA?
39. What is your sex/gender?
40. What was your age at your last birthday?
41. Which one or more of the following would you say best describes your race/ethnicity?
42. Do you identify as Hispanic/Latino?
43. Were you or one of your parents born in Eastern Africa or Somalia?
44. Do you identify as LGBTQ+?

Central Minnesota Council on Aging
3333 West Division Street
Suite 217
St. Cloud, MN 56301
320.253.9349