DRAFT 2028-2031 State Plan goals, objectives and strategies

This is a working draft that includes comments from board member engagement. Additional edits will be made on an ongoing basis.

Updated: October 2026

GOAL 1: Elevate core services

Strengthen and modernize Older Americans Act and Home and Community-Based Services to ensure older adults and caregivers can access high-quality supports.

Why: Core programs support older adults to remain living independently, identified as a key focus area for ACL	**ACL Focus Area:** OAA Core Programs (Title VI), GEN/GSN, Caregiving

OUTCOMES

Short Term: Increased awareness of services, improved identification of support needs, and strengthened connections among providers and systems.	**Mid-Term:** Increased use of caregiver supports, healthy aging programs, nutrition services, and core HCBS services	**Long Term:** Improved health, independence, equitable access, and quality of life for older adults and caregivers across Minnesota.

OBJECTIVE 1

Strengthen caregiver support systems: Strengthen and enhance Minnesota's caregiver support system through improved coordination, data-informed decision-making, and expanded access to caregiver services

1.1	Increase access, awareness and availability of individualized caregiver supports, including caregiver consultation, respite services, adult day programs, in-home respite, companion services, and caregiver support groups, prioritizing caregivers with identified support needs and those at increased risk of caregiver strain and social isolation.
1.2	Leverage Administration for Community Living caregiver discretionary grant funding to develop and implement a coordinated approach to collecting, including through caregiver surveys, integrating, and using caregiver data across Older Americans Act, Medicaid HCBS (aged 65+), and other state-funded caregiver programs to inform care planning, program design and resource allocation.
1.3	Strengthen identification and referral pathways across OAA and HCBS systems by developing coordinated referral protocols among Tribal and County Human Services, Managed Care Organizations (lead agencies), care coordinators, case managers, to identify caregiver support needs and make referrals to caregiver consultants.

1.4 Evaluate and strengthen the use of the Live Well at Home Rapid Screen within intake processes to identify caregivers with priority support needs, establish appropriate referral pathways, and connect eligible caregivers to individualized supports, including Self-Directed Caregiver Grants.
Summarized MBA feedback on Objective 1: • Strategies should reflect that people who are caregiving - often don't see themselves as caregivers. • If we want to expand caregiving support services, we need to ensure that we have enough providers in place – especially those doing caregiving consultation. • What is the role of caregivers and care coordination, and how does that show up here? We should include more information about Medicaid and care coordination services as they have an impact on caregivers also. • In general, ensure that strategies are tied to outcomes, and that strategies are concrete and specific enough to be clear on how they would be undertaken.
OBJECTIVE 2 **Healthy aging efforts:** Advance healthy aging, including falls prevention, brain health awareness, through strategic collaboration with statewide public health and aging partners
2.1 Collaborate with MDH and its Healthy Minnesota Partnership initiatives to align aging and statewide public health strategies.
2.2 Support education and outreach efforts that promote healthy brain aging, early awareness, and dementia-informed practices, including the MDH Healthy Brain initiative.
2.3 Scale up current Title III D evidenced-based interventions, prioritizing healthy brain, falls prevention, Evidence Based medication management, and mental health activities, while exploring use of MAP resource coordinators to identify those at risk
2.4 Expand current partnership with fire departments to explore coordinated lift-assist referral processes to identify individuals at increased risk for falls, hospitalization, or loss of independence.
[Placeholder for potential intersection with recommendations from the Equitable Opportunities for Physical and Mental Health and Well-Being Action Team, part of the Multisector Blueprint for Aging.]

Summary MBA feedback on Objective 2:

- Do we have a role in the issue of falls within assisted living and skilled nursing facilities, where staff often do not/cannot help a resident after a fall, and fire or police need to be called to do a lift assist.
- A lot of alignment exists between MBA work on service access and nutrition with the Healthy Minnesota Partnership.
- More information is needed related to connection to Multisector Blueprint Action Team recommendations and how they show up in the State Plan.

OBJECTIVE 3

Strengthen nutrition services: Expand equitable access, modernize service delivery, and foster partnerships that improve health, nutrition, and social connection for older adults

3.1	Strengthen and expand innovative nutrition delivery models by coordinating existing nutrition access points, increasing culturally responsive and flexible meal options (grab and go), prioritizing older adults with the greatest economic and social need.
3.2	Leverage congregate meal programs to integrate healthy aging activities, increase participant engagement, and strengthen social connection.
3.3	Strengthen interagency coordination with MDH to expand knowledge and use of the Commodities Supplemental Food Program.
3.4	Promote increased SNAP use by collaborating with Department of Children Youth and Families (DCYF) and AAAs to educate and inform HCBS providers on SNAP use.
3.5	Advocate for core HCBS services and sustainability of the aging network.

[Placeholder for potential collaboration with recommendations from the Meeting Basic Needs and Beyond Action Team, part of the Multisector Blueprint.]

Summarized comments from the MBA on Objective 3:

- Important to address building capacity, systemic sustainability and specifically how and where we will seek to increase state funds and increase visible advocacy.
- Add more definition and specificity around strategy 3.1.

- Culturally specific meals are really important; interesting models exist, such as a Moorhead cafe that offers shared community meals with a pay-as-you-can approach and is responsive to different cultural preferences. Iowa also has some good examples to consider, featured in a recent ACL webinar.
- Healthcare should be included somewhere here; how can we elevate or partner?

OBJECTIVE 4

Strengthen statewide access to services for older adults in greatest economic need or greatest social need specifically in Tribal, rural, and underserved communities

4.1	On an annual basis, provide Area Agencies on Aging with up-to-date demographic profile data for their Planning and Service Area to identify disparities within GSN and GEN, guide outreach, resource allocation, and service delivery improvements for Older Minnesotans.
4.2	Discuss successful outreach approaches at two MBA/AAA Joint Meetings that support underserved populations
4.3	Support ongoing coordination between Title III and Title VI aging programs through meaningful consultation with Tribal Nations and tribal aging programs, strengthening communication, service access, and alignment of aging network efforts while respecting Tribal sovereignty and self-determination.
4.4	Expand use and knowledge of Minnesota Aging Pathways (MAP) information and assistance services to Tribal communities by coordinating with Indian Health Services to educate Tribal Elders on Medicare options and developing dedicated Tribal Member Resource Coordination within MAP services.
4.5	Increase access to Medicare education, options counseling, and consumer assistance statewide by using demographic and program data to identify underserved older adults, including Statewide Health Improvement Program (SHIP), Senior Medicare Patrol (SMP), and Medicare Improvements for Patients and Providers Act (MIPPA).

Summarized comments from the Minnesota Board on Aging on Objective 4:

- No comments during this round of feedback

GOAL 2: Well-informed communities

Connect Minnesotans with the information, resources, and services we need to navigate aging with confidence and independence.

Why: More effective and coordinated communications will help raise awareness and utilization of the breadth of existing aging-related resources in Minnesota	**ACL Focus Areas:** OAA Core Programs (Assistive Technology, Malnutrition), GEN/GSN

OUTCOMES

Short-Term: Increased awareness, knowledge, partnerships, and capacity.	**Mid-Term (2-4 years):** Increased use of services and stronger coordination.	**Long-Term:** Improved independence, equitable access, and quality of life.

OBJECTIVE 1

Communications and public awareness: Improve how Minnesotans find and access information about aging network resources.

1.1	Improve access to trusted aging information on MBA/DHS websites
1.2	Enhance the usability, accessibility, and engagement of the Minnesota Aging and Disability Resources website
1.3	Digital inclusion efforts to ensure older adults and caregivers can effectively access online services, benefits portals, and care coordination tools
1.4	Include 'social engagement' opportunities into the search option as ways to reduce social isolation
1.5	Improve the clarity, usability, and ongoing maintenance of the Status of Long-Term Services and Supports in Minnesota website
1.6	Engagement of stakeholders (e.g. lead agencies; mental health and health care organization, service providers and community members) thorough focus groups, surveys and/or workgroup
1.7	Develop a plan to enhance usability based on recommendations
1.8	Update the MBA website to enhance visibility of OAA services (Core services, MAP and OOLTC), other efforts such as Dementia Grants, as well connecting other aging network resources
1.9	Enhance the Live Well at Home website to reflect how people "Live, Plan, Act"

1.10 Develop and implement, with applicable partners, statewide outreach initiatives that connect older Minnesotans, family, friends and neighbors' caregiving and communities with information about aging related resources and programs, e.g., Elder Justice, Medicare fraud, Ombudsman Services, caregiving, consumer protection/scam education.

1.11 Collaborate quarterly with the MN STAR Program and partners to expand awareness, access, and cross-referrals for assistive technology resources.

Summarized Minnesota Board on Aging comments on Objective 1:

- Communications and public awareness should feed into advocacy efforts; make sure this is reflected in the plan. Also consider how advocacy efforts show up on the website.
- Important to build out our ability to connect with older adults and families.
- Related to HCBS, PCAs are often not included but are important.
- Does simply raising awareness of the MBA help older Minnesotans and improve their lives? We don't just need to know what's available; we need to make sure people know how to make sure of the information they are given.
- The progression from awareness to service use and ultimately to independence and equitable access; objectives should describe changes for Minnesotans.
- Strategy 1.1: What are current data points for the three websites? Should we also be including MAP?
- Strategy 1.2:
    - Elevate in Perham is an interesting model to look at in terms of service access and navigation; may want to consider in relation to this strategy.
    - State websites are important, but who is delivering the message of sending to the website? A champion or charismatic messenger to help drive traffic would really help with visibility. Think outside the box about how we reach audiences.
- More broadly, consider doing a statutory crosswalk showing how the goals and objectives relate to federal requirements, MN law, and MBA's broader authority. What is underrepresented in the plan or not fully reflected? Help us see what we're not doing that we are authorized to do.

OBJECTIVE 2

Strengthen access to information, education, and resources across the aging network: Increase access to trusted information, education, and resources for older adults, families, providers, and aging network partners to support informed decisions, rights, safety, and independence.

2.1	MBA Board members or staff present on applicable topics to MBA external liaison partnerships to increase statewide awareness of the issues impacting older adults and available resources, efforts.
2.2	Increase public awareness of MBA programs and aging resources by partnering on at least three high-impact community outreach events each year (e.g., Senior Day at the Fair, Medicare fraud Prevention panel, legislative engagement) that educate partners, providers and the public and connect them with available resources.
2.3	Strengthen long-term care and assisted living options counseling by expanding outreach, improving counselor training and consistency, and increasing awareness of Home and Community Based Services options for older adults.
2.4	Expand legal kiosks and resource access points within Area Agencies on Aging Planning and Service Area to increase access to affordable legal information and services.
2.5	Advance elder justice capacity across aging network by: • Supporting an Elder Justice Certificate Program that strengthens professionals' ability to recognize concerns, navigate legal and protective systems, and support older adults' rights, choice, safety, and independence. • Develop and offer collaborative training in elder justice issues for Aging Network Partners, including Medicaid partners, MAP resource coordinators and OAA service providers, and other professionals, to increase their knowledge of the legal needs and rights of older adults
2.6	Increase resident, public and provider education and awareness by enhancing understanding of resident rights, OOLTC services, and quality long-term care practices through targeted education, outreach and engagement efforts that empower residents, inform families and support providers in fostering resident-centered care. Efforts may include but are not limited to community meetings, training, webinars and use of local media.

Summarized Minnesota Board on Aging feedback on Objective 2:

- Strategy 2.1:
  - Idea: Create a mailing list of important topics that we're seeing in the field, such as reports that others might want to look at? Could be internal and public, too – or borrow from someone who's already doing it.
  - Very important to have the right person part of each group, in order to maximize what we are contributing to and getting out of these partnerships.
- Strategy 2.2:
  - Idea: Work more closely with AAAs related to the outreach and connections they have with faith communities. Many churches are looking for information and resources to share with their members.
  - Consider compiling a list of all existing partners, including how we currently collaborate with them.

    - Much of what is being discussed is very Euro-centric. For many immigrant families, decisions around an older person are a family decision with the best interest of the elder in mind. Current thinking doesn't reflect our changing population. And ensure we are considering mosques in addition to churches.
    - Information on the MBA and its services and programs is not reaching the Black community the way it should; consider how we can better reach and include Black Minnesotans.
    - Think about both written and verbal/non-written communication in reaching various groups.
- Strategy 2.3: It would be helpful if we could have an options counseling system that reflects the reality of timing uncertainties. Look into examples of other places/states for model approaches.

GOAL 3: Healthy people, strong communities

Minnesotans can remain healthy, connected and independent in their communities as we age

Why: Connections with community and access to services play a vital role in health and well-being.	**ACL Focus Area(s):** OAA Core Programs, GEN/ GSN

OUTCOMES

Short-Term: Increased awareness, knowledge, partnerships, and capacity.	**Mid-Term (2-4 years):** Increased use of services and stronger coordination.	**Long-Term: I**mproved independence, equitable access, and quality of life.

OBJECTIVE 1

Expand transportation services and innovative approaches to mobility: Promote flexible, accessible, and sustainable transportation solutions that empower us do the things we want and need to do as we grow older.

1.1 Strengthen and expand partnerships and coordination with MN Council on Transportation Access (MCOTA), Regional Transportation Coordination Councils (RTCCs) in Greater Minnesota, and Transit Coordination Assistance Projects (TCAPs) in the Twin Cities to increase transportation services in each region of the state.

1.2 Expand volunteer driver programs by supporting the expansion of effective volunteer driver programs through existing partnerships with AmeriCorps Seniors RSVP, Senior Companion Programs, and other community-based organizations

1.3 Promote and educate the public about existing transportation services and how they can be accessed, to help meet transportation needs through greater utilization of existing services.

1.4 Assess utilization of assisted transportation services, identify ways to meet increased need and demand, and promote available options so people can easily find and access the support needed. Explore innovative approaches for expanding accessible transportation options.

[Placeholder for potential collaboration related to recommendations from the Multimodal Transportation Action Team, part of the Multisector Blueprint for Aging.]

Summarized feedback from MBA members on Objective 1:

- Transportation is an ever-present concern; it comes up everywhere, all the time.

- Collaboration across counties – or lack thereof – is a big item. Many transportation services are county-operated, and services often won't cross county lines, limiting users' destinations. This is a surmountable policy barrier. Let's learn from counties who are successfully collaborating to get around this.
- May be important to ramp up communications between AAAs related to transportation.
- Related to AAAs:
    - Is there an opportunity for AAAs to be more consistently represented on local/regional transit councils?
    - May be important to ramp up communications between AAAs related to transportation
    - Let's make sure we keep in mind how AAAs reference and use this document
- Volunteer driver programs: Need to understand status of rate and insurance policies as we craft related strategies; important to streamline and simplify processes. Also consider using faith communities as part of these programs.
- Should we consider an advocacy strategy focused on legislative barriers to transportation services?
- Think about how we could partner more closely with MNDOT related to transportation
- The importance is not if the service exists but that it takes me where I need it to. Goal should be that older MNs get to where they need and want to go, not that there is a bus system.

OBJECTIVE 2

Increase opportunities for social connection and prevention of social isolation among older adults: Promote evidence-based programs, volunteer engagement, and community-based approaches that empower us to build connections in the way we value as we age.

2.1 Identify, scale, and activate interventions that reduce social isolation through strong community partnerships. Programs include HCBS Companion, Tribal Nations–Friendly Visiting, Memory Cafés, evidence-based health promotion classes, Trualta virtual support groups, and support groups across caregiver programs.

2.2 Support Senior Volunteer Programs grantee(s) in expanding volunteer recruitment and engagement of the Senior Companion Program, Foster Grandparent, and RSVP to create opportunities that support older adults and reduce social isolation.

2.3 Recruit and train senior volunteer programs to serve as Emergency Preparedness Ambassadors—including retired or current emergency service professionals to co-host sessions with AAA, MBA, or provider staff at community sites.

[Placeholder for potential collaboration related to recommendations from the Digital Engagement Action Team, part of the Multisector Blueprint for Aging.]

Summarized feedback from MBA members on Objective 2:

- Include special emphasis on rural communities and challenges.
- Consider the importance of a personal approach for social connection for caregivers – such as one-on-one outreach in key situations.
- Regarding the Multisector Blueprint placeholder, make sure we are making use of existing recommendations.

OBJECTIVE 3

Strengthen service navigation and care transitions: Improve connections to services and supports at key points of transition so older adults can address needs earlier and remain safely in their homes and communities.

3.1 Strengthen care transitions support through MAP Resource Coordination and help people return or remain in their communities through assessment, support planning and long-term follow-up.

- Continue coordination between MAP and MDH to develop and increase referrals from hospitals, nursing homes and primary care to MAP Resource Coordinators for care transitions.
- Explore incorporating evidenced based models.

Summarized MBA member feedback on Objective 3:

- Learn more about what tools are being used by families, services, etc. that artificial intelligence (AI) can help with. The phone alone seems outdated.

GOAL 4: Sustain and expand Long-Term Services and Supports (LTSS)

Create a more sustainable and responsive long-term services and supports system that expands access, improves coordination, and responds to the changing needs of Minnesota's aging population.

Why: Shifting demographics, lack of providers, additional barriers to effective service delivery	**ACL Focus Area(s):** OAA Core Programs, Expand access to HCBS

OUTCOMES

Short-Term: Improved information data, partnerships, and system capacity to identify needs and connect Minnesotans to LTSS.	**Mid-Term:** Enhanced service navigation, reduced barriers and stronger coordination across LTSS programs and systems.	**Long-Term:** More equitable access to person-centered LTSS that supports independence, choice and quality of life.

OBJECTIVE 1

Improve access and coordination across LTSS systems: Address barriers, service gaps, and system challenges to improve access to benefits, services, and supports for older adults, and individuals' caregiving.

1.1	Improve Medicare Savings Program applications by reviewing the online application to synthesize and streamline. Additionally, partner with DHS Health Care Administration to remove barriers improving eligibility requirements to provide coverage for more Minnesotans.
1.2	Address Elderly Waiver service gaps for those with high needs beyond what current care covers by conducting a needs evaluation to understand the necessary expansion of Elderly Waiver budgets for individuals who have high needs access (i.e., services beyond what current case mix caps/budget allows)
1.3	LTSS Mapping Project: Improve access to long-term services and supports (LTSS) for older adults, individuals with disabilities, and caregivers by identifying, documenting, and mapping connections between programs, referral pathways, and service systems across MBA, Aging and Adult Services Division (AASD), Health Care, Disability Services Division (DSD) and other relevant divisions within DHS.
1.4	Develop an inter-agency site (DHS, DCYF, DCT, MDH) that provides information, resources and referrals to improve client navigation and service access for the public and resource navigators. This site will also strengthen coordination between state departments, MAP, healthcare providers, community-based organizations, and LTSS providers (including OAA).

1.5 Explore and advocate for an increase in state resources and capacity for individuals who do not qualify for Medicaid programs, including ongoing case management (AAA/APS Pilot)
Summarized MBA member feedback on Objective 1: • What about the issues of ownership transparent of assisted living and skilled nursing facilities? Private equity firms have been purchasing facilities and raising rents and costs of services. • What are the safeguards that we are putting in place to minimize fraud and what we will need to do so (administrative support, etc.) • More broadly, should some of the work, especially some of which lives under this goal, be used in the new Stewardship and Oversight section? That might help keep the goals section more focused on what we want to change for older Minnesotans and the strategies that will produce that change.
OBJECTIVE 2 **Advance LTSS data, monitoring and accountability:** Use data and system monitoring to identify gaps, assess performance and inform LTSS planning, funding and advocacy efforts.
2.1 Integrate and synthesize data across the Client Tracking System (CTS) within Minnesota Aging Pathways (MAP), and the Minnesota Aging and Disability Resources (MADR) website to identify service utilization patterns and unmet needs. Report annually to MBA members on findings and recommendations.
2.2 Integrate Older Americans Act data into the LTSS Dashboard to provide a comprehensive view of older Minnesotans receiving upstream services to inform funding decisions, advocacy and long-term planning
2.3 Analyze population-level trends, access barriers, geographic or demographic service gaps, and develop a recommendation report to inform equitable resource allocation for program planning, funding and service expansion.(Adult Protection)
2.4 Build upon existing internal controls, reporting and monitoring processes, to ensure accountability across funded programs to meet requirements set through program integrity, access rule, final rule implementation and other required efforts.
Summarized MBA member feedback on Objective 2: • Do not see benefits for older adults in this section; let's back up and think about what we are ultimately trying to accomplish • Strategy 2.1: Let's look at how ownership impacts access to primary care, specialties, etc.

• Strategy 2.2: How do we know we'll be able to keep up to date with data collection amidst shifting priorities? We should know we can be consistent.
OBJECTIVE 3 **Improve HCBS access and outcomes through strategic grant investments, technical assistance and data:** Align grants, technical assistance, and data-informed initiatives with community priorities to address service gaps, improve support for older adults and caregivers, and promote the ability to live safely and independently in the community
3.1 Partner with MDH on a marketing plan to expand strategic use of the Customized Living Improvement Grant to improve housing stability, safety, and quality for individuals receiving HCBS services.
3.2 Use findings from the Comprehensive Aging Survey to inform Eldercare Development Partnership (EDP) and Live Well at Home grant priorities, ensuring future investments respond to identified service gaps, emerging needs, and opportunities to strengthen community-based services across Minnesota.
3.3 Partner with DHS HIV Division to coordinate the development and delivery of technical assistance to providers to help older adults with HIV connect to services for older adults and individual caregiving.
3.4 Through MBA Regional and local Dementia and Self-Directed grants, identify family, friends and neighbors' caregiving, provide flexible self-directed grants tailored to their most critical needs, provide technical assistance and measure whether the support reduces caregiver strain.
3.5 Develop a dementia dashboard that shows caregiving capacity and measures crisis respite, to enable older adults/caregivers to remain safely at home longer.
OBJECTIVE 4 **Strengthen Long-Term Care Ombudsman advocacy and system capacity:** Protect the rights, choices, and well-being of older adults in long-term care through effective advocacy, quality improvement, and a responsive Ombudsman system.
4.1 Support enhanced staffing models, workload assessment and resource allocation strategies that enable Office of Long-Term Care Ombudsman (OOLTC) staff to effectively respond to increasing case complexity, resident acuity and service demand.
4.2 Leverage complaint data, demographic trends, service utilization patterns, and workforce metrics to identify emerging issues, disparities, and areas requiring additional OOLTC resources or policy attention.

4.3 Promote transparency and accountability in long-term care by supporting efforts that increase transparency regarding ownership structures and assess their impact on resident quality of life, care outcomes and consumer protections.
4.4 Support and advocate for federal, state, and local investments that strengthen OOLTC infrastructure, expand service capacity and ensure residents have timely access to independent advocacy and quality assurance protections
4.5 Promote recruitment, retention, succession planning and specialized training opportunities that equip OOLTC staff, including volunteers, to address emerging long-term care issues, such as behavioral health, dementia care, guardianship, housing instability and resident rights
Summarized MBA member comments on Objective 4: • No comments during this round of feedback

GOAL 5: Planning for longevity

Advance strategies that improve financial security, housing stability, and long-term planning so people can prepare for and afford longer lives.

Why: Shifting demographics, lack of providers, additional barriers to effective service delivery	**ACL focus area(s):** OAA Core Programs, expand access to HCBS

OUTCOMES

Short-term: Older adults and caregivers have greater awareness of resources and opportunities that can support financial security, employment, housing and planning for the future.	**Mid-term:** Older adults and caregivers are better connected to employment opportunities, financial and legal support, stable housing, and planning resources.	**Long-term:** More Minnesotans are financially secure, safely housed, and better prepared for the realities of longer lives.

OBJECTIVE 1

Support workforce and economic stability for older adults and caregivers: Strengthen connections between aging and workforce systems to increase access to employment, training, and supports that promote economic stability for older adults and caregivers.

1.1 Collaborate with Senior Community Service Employment Program (SCSEP) and workforce partners to use program data and identify opportunities to better connect older Minnesotans with employment, training, volunteer and community opportunities.

1.2 Build partnerships with employers, workforce organizations, and the aging network to increase working caregivers' access to information, resources, and supports that help them remain engaged in the workforce while providing care. This may include promoting employer practices that support working caregivers, including providing aging resources, Medicare and planning presentations.

[Placeholder for potential collaboration related to recommendations from the Vital Contributors to the Workforce Action Team, part of the Multisector Blueprint for Aging.]

Summarized feedback from MBA members on Objective 1:

- Strategy 1.1: Add some language around reducing stigma associated with employing older adults. There is good information and presentations part of the Legislative Task Force on Aging from June 2024.
- Strategy 1.2:
    - Revise the language to shift the responsibility from the caregiver and to the employer/workforce
    - Ageism and employment is a big issue.
- Does SCSEP have a role in engaging employers to reduce age discrimination?

OBJECTIVE 2

Advance financial, housing, and legal stability and protect rights: Strengthen systems, partnerships, and policies that help older adults and caregivers remain financially secure, safely housed, and safe from exploitation.

2.1	Increase access to benefits counseling, resource navigation, and financial support programs to ensure that older adults and caregivers can meet basic needs and remain stable in the community.
2.2	Prepare and review summary report from the Legal Needs survey with board members and AAAs and determine steps to incorporate findings.
2.3	Expand housing stability by strengthening partnerships, resources, and interventions that help older adults remain safely and affordably housed and reduce housing related barriers to aging in the community.
2.4	Reach more Minnesotans with legal, decision-support, fraud prevention, and consumer protection resources that help older adults protect their assets, housing, rights, and ability to make decisions about their lives.
2.5	Collaborate with community partners and public agencies to identify and address financial barriers to aging safely in the community, including advocating sustainable funding for home and community-based services

[Placeholder for potential collaboration related to recommendations from the Affordable Housing Action Team, part of the Multisector Blueprint]

Summarized feedback from MBA members on Objective 2:

- Strategy 2.1: How do we include people 55+ in independent living buildings as they transition to other living situations and need care?
- Strategy 2.2: How does some of this work overlap with Own Your Future? Funding for OYF is not available right now.
- Strategy 2.3: Could the housing strategy be more specific about the outcome we want? For example, affordable, accessible/adaptable, and well-locate housing choices that continue to work as people's circumstances change – not simply remaining housed.
- Strategy 2.5: Glad to see advocacy explicitly named here. Could we make the intended policy outcomes clearer? For example, sustainable financing so people are not prevented from aging in the community because needed supports are too expensive?

OBJECTIVE 3

Promote planning and preparation for longer lives

Increase access to trusted information, resources, and planning supports that help Minnesotans prepare for the financial, health, housing, caregiving and long-term care needs associated with longer lives.

3.1	Increase access to trusted information and resources that help Minnesotans understand prepare for the financial and practical implications of longer lives, including future long-term care needs and available public and private options.
3.2	Promote and empower more Minnesotans to undertake earlier planning for the future – for housing, caregiving, and health care needs—before a sudden change in circumstances occurs. Develop or promote tools and information that help Minnesotans assess and prepare for the financial and practical implications of longer lives.
3.3	Strengthen partnerships across the aging network and other trusted community systems to reach more Minnesotans with planning resources, with particular attention to people and communities who are less likely to be reached through traditional approaches. The work may include AAAs, community organizations, employers, health care providers, financial professionals, faith communities, and other points of contact.

Summarized feedback from MBA members on Objective 3:

- Caution with how we approach "planning ahead." Avoid suggesting that people can individually plan their way around structural problems such as inadequate housing choices, unaffordable care, or limited HCBS. Could these objectives reflect both individual preparation and creating conditions that give people realistic choices?
- We need to be clear on where the MBA has the structure, staffing, and resources to do these things and which we are asking or looking for the AAAs to accomplish.

- Strategy 3.1:
    - How will we make this happen? What is the workflow and ability to support this? If it is AAAs, can we state that?
- Strategy 3.3: There are similarities between these strategies and the Healthy Minnesota Partnership's three priorities for 2025-2029.