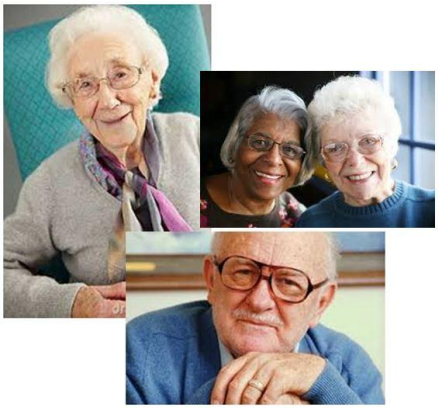

Sustaining Services for the Silver Tsunami

A Report on Findings and Proposed Solution Options for the Minnesota State Services for the Blind Senior Services Unit

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Executive Summary

Minnesota will almost double its population aged 65 years and older by the year 2030. This population trend has been referred to as the "silver tsunami" and it will redistribute our population toward the older end, where one in five Minnesotans will be over age sixty-five by 2030. An aging population brings both depth and wisdom to a community but it also requires attention from the community to the myriad changes that come with the aging process. With aging come changes in physical and mental capabilities, including impairments such as vision loss. The Senior Services Unit (SSU) of the Minnesota State Services for the Blind (SSB) provides services and aids/devices to older individuals with vision loss transition needs to help them remain living independently in their homes, avoiding a more costly and disruptive move to nursing or assisted living facilities.

Leadership at SSB and other key stakeholders in the vision loss field recognize that the growing elderly population will have impacts on SSU, placing new and more demands that will likely exceed their staff and budget capacity. This has left them with concerns about their agency's ability to meet the needs of future clients.

Findings point to five key themes that impacting considerations for redesign solution options:

- There is a growing client population with unique and changing needs
- SSU provides quality services, but its current service structure does not provide services to all eligible clients
- There is no "perfect model" of service delivery
- There are currently few sources of income beyond federal and state funding, which is projected to either remain at the same level or decrease into the future
- The future of technological and medical advances will affect this population and its services

The recommendations for redesign solution options reflect the opportunity for SSB to creatively rethink how they can contribute to achieving the desired outcome that all elderly individuals with transition needs in response to loss of vision have quality services, devices, and support that are locally accessible and utilized. Four broad solution categories offer opportunities for SSU to increase capacity with:

- More funding sources to pay for additional service providers and devices
- More opportunities to serve more individuals with the same number of providers
- More providers within the existing budget
- A network of trained providers

SSB has the opportunity to move closer to this desired outcome by implementing redesign solutions that range from system-wide change down to specific processes and practices within SSB. Every option will have near-, mid-, and long-term strategies and tactics. There is tremendous opportunity for SSB to harness and engage with existing and new networks to achieve a desired outcome that is broadly shared.

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Introduction

Minnesota will almost double its population aged 65 years and older by the year 2030. This population trend has been referred to as the "silver tsunami" and it will redistribute our population toward the older end, where one in five Minnesotans will be over age sixty-five by 2030[1]. An aging population brings both depth and wisdom to a community but it also requires attention from the community to the myriad changes that come with the aging process. With aging come changes in physical and mental capabilities, including impairments such as vision loss. Vision loss among older adults is most often due to Age-related Macular Degeneration (AMD), Cataracts, Diabetic Retinopathy, and Glaucoma. When older individuals develop vision loss or blindness they are often in need of help to transition to a new way of living their lives, lives that up until this point have been led without significant vision problems. The Senior Services Unit (SSU) of the Minnesota State Services for the Blind (SSB) provides services and aids/devices to older individuals with vision loss transition needs and contracts with other individuals and organizations to provide additional training. The primary purpose of these services and aids/devices is to help older individuals remain living independently in their homes, avoiding a more costly and disruptive move to nursing or assisted living facilities.

Leadership at SSB recognizes that the growing elderly population will have impacts on their agency, placing new and more demands that will likely exceed their staff and budget capacity. This has left them with concerns about their agency's ability to meet the needs of future clients. SSB approached the Public and Nonprofit Leadership Center (PNLC) of the University of Minnesota's Hubert H. Humphrey School of Public Affairs to conduct a study that would offer future service delivery redesign options for their Senior Services Unit. This report shares the findings from the PNLC study and presents a range of service delivery redesign options with corresponding analyses and considerations for implementation. The following problem statement was developed and refined by key stakeholders and serves as the basis for this study:

Problem Statement Basis for Redesign Project

The anticipated continued growth of elderly individuals in Minnesota with vision loss will exceed the current capacity of SSB's Senior Services Unit (SSU) to serve their needs.

[1] These data come from the U.S. Census Bureau (http://www.census.gov/population/age/) and Minnesota Compass (http://www.mncompass.org/), projections are compiled by the Minnesota State Demographic Center (http://www.demography.state.mn.us/)

The following report is organized into five sections: The first section provides context to the problem statement and background information on the fields of service with which the aging population in Minnesota frequently interacts. The second describes the study's methodology, including the methods used in data collection and analysis. The third summarizes findings from the study, which informs the fourth section that provides solution options and analysis of the options to achieve a desired outcome for older individuals experiencing vision loss. The report concludes in the fifth section by summarizing the findings and solution options and addresses considerations for implementation.

Background and Context

Minnesota State Services for the Blind (SSB) is a state agency whose mission is to facilitate the achievement of vocational and personal independence by Minnesotans who are blind, visually impaired or DeafBlind. SSB is situated within the Minnesota Department of Employment and Economic Development (DEED), as a significant portion of its services are for individuals seeking to gain or retain employment. SSB also operates a Communications Center that offers reading and transcription services. The 1973 Federal Rehabilitation Act was amended in 1978 to include Title VII, Chapter 2 that authorizes service delivery to older individuals who are blind (OIB). Federal OIB funding is administered by the U.S. Department of Education's Rehabilitation Services Administration. SSB manages the federal OIB funding for the state. Minnesota Statute 248 authorizes DEED to create a division that develops and administers programs serving the needs of the blind and visually impaired to which Minnesota Rule 3325 establishes the procedures and standards for the provision of these services. SSB is advised by the State Rehabilitation Council for the Blind (SRC-B), comprised of members appointed by the Governor. SRC-B council members help set agency priorities and provide advice and recommendations on services.

As a unit of SSB, the Senior Services Unit (SSU) primarily serves individuals aged 55 and older in pursuing personal independence by offering counseling, training, devices and referrals to help seniors find ways to adapt to changes in their vision. While the typical SSU client is a woman in her early to mid-eighties who lives alone, SSU will serve anyone at any age who does not want to, or is incapable of, actively pursuing employment. Over the past decade, SSU has served an average of 2,900 clients across the state of Minnesota and in the past three years they have averaged over 3,000 clients. They have fifteen direct service staff across nine regions in Minnesota with an annual operating budget of just over two million dollars.

In addition to SSB, there are other providers across Minnesota who offer rehabilitation services to the blind and visually impaired. Minnesota is home to three private, non-profit organizations whose mission is to serve the blind and visually impaired. Two are located in the Twin Cities metropolitan area: Blindness: Learning in New Dimensions (Blind, Inc.) and Vision Loss Resources (VLR). The third, Lighthouse Center for Vision Loss (formerly Lighthouse for the Blind), is located in Duluth and serves residents in the Duluth region. SSB maintains a contractual relationship with each of these organizations as they are qualified to provide adjustment to blindness training to individuals of all ages. SSB also maintains contracts with

private, individual contractors who can provide itinerant rehabilitation teaching (IRT) services which include instruction in the use of alternative techniques.

There is a range of services and providers in Minnesota who also strive to help older individuals remain living independently in their homes. The Minnesota Department of Human Services administers federal and state programs that serve older individuals, including the administration of the federal Older Americans Act through the Minnesota Board on Aging (MBA). MBA provides a gateway to services for older individuals along with its regional Area Agencies on Aging located throughout Minnesota. MBA and the Area Agencies on Aging operate the Senior LinkAge Line, a phone service that connects individuals with local services. In addition, they maintain an online database of service providers. Beyond these specific agencies on aging, there are a myriad of other providers interacting with older Minnesotans at organizations like the Centers for Independent Living and other professional home care agencies as well as health and social welfare providers like county public health nurses, parish nurses, and personal care assistants, to name just a few.

Methods

The research team utilized participatory methods to engage a diverse set of voices and perspectives throughout the study period. Methods included conducting individual and group interviews, site visit observations, and creating and convening a redesign team to serve as study advisors. The research team also reviewed agency documents and other documentation on the vision loss and aging service fields.

The research team worked in close consultation with the leadership staff at SSB throughout the study sharing initial ideas and drafts with staff and maintaining frequent communication for assistance in understanding the nuances of the vision loss field and in providing entrée and access to the many individuals, including SSU clients, interviewed throughout the study.

The research team utilized interpretive methods to analyze the project data. This included using NVivo, a computer assisted qualitative data analysis software that allows the researcher to create connections and draw out findings from a substantial amount of qualitative data, including interview transcripts and other documents.

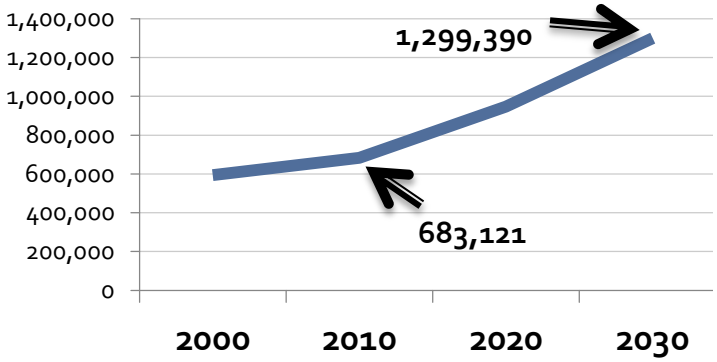
The report appendix provides additional information on the study's methods, including interviewee characteristics and information on the redesign team, including its members, purpose and activities.

Findings

1. There is a growing client population with unique and changing needs.

Figure 1 shows that based on population trends, by 2030 the population of Minnesotans 65 years and older is projected to increase by 90%. As someone grows older, so does the chance of experiencing a medical condition that causes vision loss. Vision loss occurs in this population for several reasons; the most common are due to medical conditions like Age-related Macular Degeneration (AMD), Cataracts, Diabetic Retinopathy, and Glaucoma. Risk of vision-related complication increases with smoking, obesity, race (whites are much more likely than African Americans), family history, gender (women are at a higher risk), smoking/alcohol use, and those with high exposure to ultraviolet sunlight (National Eye Institute 2003). Therefore, most clients coming to SSU are experiencing vision loss for the first time after spending a lifetime with vision. This often causes depression, anxiety, and other emotional issues for this population[2].

Figure 1. Minnesota Population Estimates Age 65 and Older 2000-2030



Current research shows a range of estimates on the magnitude of older individuals with vision loss. This is due to different measures of current prevalence and projected incidence rates for vision loss among the elderly due to differences in the criteria used to determine vision loss and in the distribution of rates across different age categories. For example, according to the National Institutes of Health, 1.2% of individuals aged 60-69 years have vision loss, including blindness[3], 3.8% aged 70-79, and 23.7% aged 80 and above. Additionally, according to the National Health Interview Survey, approximately 12.2% of individuals aged 65-74 years old report vision loss[4] and 16.1% of individuals aged 75 and older report vision loss. Arguments have been made that incidence rates are projected to increase given the connection between vision loss

[2] Centers for Disease Control and Prevention. 2009. *Vision Loss and Comorbid Conditions*

[3] In this case, blindness is defined as the best-corrected visual acuity of 6/60 or worse (=20/200) in the better-seeing eye; low vision is defined as the best-corrected visual acuity less than 6/12 (<20/40) in the better-seeing eye (excluding those who were categorized as being blind.)

[4] In this case, the term vision loss refers to individuals who reported that they have trouble seeing, even when wearing glasses or contact lenses, as well as to individuals who reported that they are blind or unable to see at all.

and a growing number of older individuals suffering from obesity and diabetes[5]. The uncertainty in future incidence levels of vision loss presents additional challenges for preparing to serve a changing population of clients.

Findings from our interviews reflect – albeit anecdotal –that, in general, the aging baby boom generation holds an attitude of entitlement toward the availability and accessibility of public services for their needs. Additionally, interviewees commented that these future clients will also be far more technologically "savvy" than today's clients. Therefore they will not only expect vision loss services but they will expect to have access to the latest technological methods and devices for their adjustment to vision loss.

2. SSU provides quality services, but its current service structure does not provide services to all eligible clients.

There are over three hundred combined years of experience serving individuals with vision loss among SSU staff, which come from a variety of training backgrounds. All are considered low vision specialists. All SSB direct service staff receives in-house training in a low vision training program that teaches the basic concepts of low vision and how to perform a low vision assessment. Additionally, direct service staff undergoes six weeks of under-the-blindfold blindness skills training, and one week of training using various levels of partial vision.

The fifteen direct service staff are dispersed throughout the state among nine regions. Annually, each staff member will serve a range of 100-350 clients each. It became very clear from our interviews with SSU staff and clients that the focus of services is on spending quality time to provide individualized attention to clients, ideally in their own homes. Each SSU direct service provider maintains autonomy in their methods for organizing and delivering their services. However, from our interviews, we heard similar practices resulting in the following portrayal of service delivery: Each client is seen by a staff member at least once for an initial assessment, while receiving a follow-up telephone call or visit. Staff will most often meet with clients in their own homes where they can conduct an assessment of the client's needs based on their living situation. Some clients come into SSU offices, but transportation is often difficult for clients to get to the office, and in some cases, the office location is difficult to access for an older person with vision loss (for example, one regional office is inconspicuously located on the second floor of a building making it difficult for clients to access).

The typical client is most interested in regaining some ability to read. SSU staff will bring to their visit a suitcase filled with various magnifying devices that help leverage residual vision for reading. Staff will work with the client to find and fit the best device for their needs. Staff may also assist clients with marking appliances to keep them with cooking or providing writing guides like a plastic check guide that keeps the pen writing in the correct area. Staff will also provide emotional support to clients by reassuring them that there is hope to remaining independent despite vision loss. Many clients express feelings of depression and

[5] Journal of the American Medical Association. 2013. *The Status of Baby Boomers' Health in the United States: The Healthiest Generation?*; Health Affairs. 2010. *Recent Trends in Disability and Related Chronic Conditions Among People Ages Fifty to Sixty-Four.*

anger over losing their vision and fear for the future. Staff provides comfort and reassurance that encourages acceptance of the vision loss and a willingness to learn new skills to remain independent. Staff may refer clients to other services either with another organization or individual that provides rehabilitation training under a contract with SSB.

SSU staff are not the only service provider interacting with the client. Many clients have social workers, public health nurses, and other kinds of personal care assistants. And staff will receive referrals for their service from these people. Because staff will spend a lot of their time travelling to a client visit, staff prefers to have a minimum of two visits scheduled before they will leave the office. In our interviews, some staff also expressed that they prefer not to conduct more than two visits in one day as they are time and energy intensive, each often lasting up to two hours. Staff will conduct a follow-up with clients to determine whether their needs have been met and some staff are able to accomplish this over the phone rather than travelling again to the client's home. Prior to payment, staff will conduct follow-up visits with the clients they referred to other organizations or individuals for training. After all visits, staff are required to record notes on client interactions in a computerized case management system.

The services that SSU staff provides are time intensive and focused on individualized attention, favoring the few to the many. On average, SSU serves approximately 3,000 clients per year. But even with a conservative prevalence estimate of 3.8%[6], or approximately 26,000[7] Minnesotans aged 65 and older, SSU is currently only serving about 12 percent of the eligible population.

This does not mean that individuals in need of service are being turned away by SSU, rather our findings indicate that there are a myriad of barriers or constraints preventing SSU from reaching all potential clients. Barriers can include lack of awareness among potential clients of available services or even resistance by potential clients to accessing services out of fear of the condition of vision loss. Lurking in the background is a financial reality where SSU relies on federal and state funds for the majority of its budget (85%; the other 15% comes from gifts and in-kind support) and today's financial story is one of fiscal constraints, including a trend toward belt tightening with stagnant funding at best, and decreasing at worst, from state and federal sources. No one has a mirror into what the future will hold, but SSU is framing its future around one of fiscal constraint, meaning that despite population growth trends, the assumption is there will be no financial growth trends from traditional sources. Some are calling this the "New Normal" and that we must seize the opportunity to creatively rethink and redesign how things are done.

With the input of SSB leadership and project stakeholders like the Redesign Team, the following problem statement was crafted to capture the anticipated gap in need versus agency capacity; as well as a desired outcome for future clients were this gap to be filled:

[6] 3.8% is the NIH prevalence rate for individuals aged 70-79. The range of prevalence rates grow from 1.2-23.7% for individuals aged 60 and over. The older you become, the higher the incidence rate of vision loss.
[7] 26,000 is calculated using 2010 population numbers for individuals aged 65 and older (683,121) multiplied by the 3.8% NIH prevalence rate.

Problem Statement Basis for Redesign Project:

The anticipated continued growth of elderly individuals in Minnesota with vision loss will exceed the current capacity of SSB's Senior Services Unit (SSU) to serve their needs.

Desired Outcome:

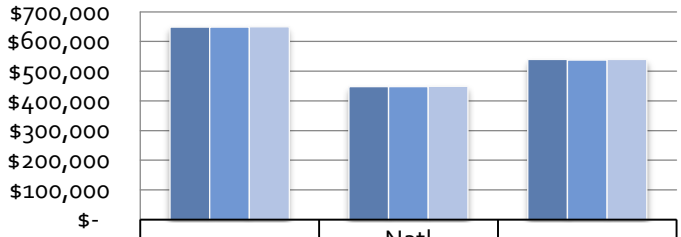
All elderly individuals with transition needs in response to loss of vision have quality services, devices, and support that are locally accessible and utilized.

3. There is no "perfect model" of service delivery.

Federal OIB grants are distributed to all fifty states. Prior to fiscal year 2000, when the federal appropriation was less than $13 million, OIB grants were awarded on a competitive basis. Since the appropriation for fiscal year 2000 exceeded $13 million for the first time, award criteria changed to reflect a formula based on a state's population of individuals who are 55 years of age or older (see Figure 3 for national OIB funding figures). States must match every $9 of federal funds with $1 in nonfederal cash or in-kind resources (i.e. 10% state match) in the year for which the federal funds are appropriated. Minnesota has a history of matching more than the required ten percent. There is no one type of state agency that receives OIB funds, but they all serve the purpose of helping older individuals maintain independence. Figure 2 presents the different ways in which OIB funds are administered at the state level by showing the different types and frequency of agencies among the fifty states. The majority of states administer OIB funds through a department of health, human, or social services. Of note are the eight states that have a stand-alone department for the blind and visually impaired (ID, IA, NE, NM, OR, SC, VA, and WA).

Figure 2. Agency Type receiving OIB funds	# of States
Departments of Blind/Visually Impaired	8
Departments of Voc/Rehab or Disability	9
Departments of Health/Human/Social Services	18
Departments of Labor/Economy/Workforce	11
Departments of Education	4

Figure 3. State Allocations of Federal OIB Funds



	Natl Mean	Natl Median	Minnesota
Current Awards FY 2013	$649,402	$448,754	$540,100
Total Awarded FY 2012	$649,197	$448,435	$538,279
Total Awarded FY 2011	$650,072	$449,972	$539,676

The decentralized nature of the program administration of OIB funding has meant that each state has developed its own methods for delivering services to the elderly blind and visually impaired. Our findings indicate a range in service delivery models from states that provide all services through a state agency and state employees (e.g. AZ, IA, MO, NM, OR, TX) to states that pass through funding by purchasing all services with non-state entities (e.g. CA, FL, OH, PA). There are states, like Minnesota, that operate within this range combining both state employee service delivery and contracts with private entities. Additionally, some states will pass money to private entities through grants to a particular part of the state in order to provide services in areas where the state has no providers. The way in which a state structures its service delivery model depends on many factors, including, but not limited to, the historical trends in service delivery, the presence of private and nonprofit service providers, and the perspective a state may take on where services for older blind fit within other state-provided services for the elderly. The call-out box below is an example that the federal OIB program has highlighted as an example of an innovative approach to serving the needs of seniors.

Alabama's Deaf and Blind Services (DBS) is implementing a statewide collaborative network involving Area Agencies on Aging, Alabama Institute for the Deaf and Blind (AIDB) regional offices, senior centers and centers for independent living as part of the Older Alabamians System of Information and Services (OASIS) "center-based" service provision model. The collaboration involves shared office space, shared rehabilitation teachers and orientation and mobility specialists; underserved populations outreach strategies; and close collaboration among Vocational Rehabilitation and Independent Living specialists through a "joint service" staffing model.

Our findings also revealed that there are mixed opinions on the methods of delivering services. Specifically, our interviews revealed a lively debate over the efficacy and merits of providing services in a group format versus in a one-to-one format. On the one hand, arguments are made that in groups you can achieve greater efficiencies by serving many more individuals in a single visit. And groups encourage peer interactions, creating connections among individuals with shared experiences that are often sustained as local "support groups" after the training is completed. On the other hand, the argument is made that there is a decrease in the quality of services in a group format, particularly because it may be too difficult to address individual needs and concerns when each person's situation is unique. Groups also tend to occur outside of the individual's home; therefore, the argument is also made that staff will not be able to assist someone with needs particular to their living situation.

4. There are currently few sources of income beyond federal and state funding, which is projected to either remain at the same level or decrease into the future.

SSU provides its services free of charge to all clients, including any assistive technologies, aids, and devices. SSB solicits voluntary donations from its clients through its SSU direct service staff; however, this is not conducted in a systematic way nor is all direct service staff currently willing to ask clients for donations. Our findings show that there are some clients (and sometimes their caregivers) who are surprised that services and devices are free when they were prepared to pay, but there are also others who expect these services and devices to be provided free of charge because it is the state who is delivering them. But the fact remains that SSU currently serves clients with the ability and the willingness to pay.

Additionally, SSU provides services that are not currently reimbursable under public or private insurance plans. This is due, in large part, to the historically distinct separation of blind and vision loss services from the traditional medical model of treating illness and disease. At the core of this separation is an acknowledgement that blindness and vision loss is not something to be 'cured' but rather something that is a characteristic of a healthy individual. Adjustment to blindness or vision loss is not currently considered a reimbursable activity if the services are administered by a low vision specialist. Interestingly, occupational therapists (OT) can be reimbursed for low vision therapy, but there is a cap on the amount of money per year per client that can be reimbursed by an OT who is providing their services under medical supervision. Likewise, clients are not traditionally qualified to receive care from other insurance reimbursement eligible professionals such as Personal Care Attendants (PCA) unless they qualify under another health condition.

SSU is currently not authorized to be reimbursed for services under the Elderly Waiver Program (EW), and has had mixed success in the past working with this program due to varied information on eligibility and general concerns over the limited availability of program funding. EW funds home and community-based services for individuals 65 and older who are eligible for Medical Assistance and who would like to remain in their homes but are in need of the level of care found in nursing homes.

It should be noted that there is a new program under development in Minnesota called the Community First Choice option that is a part of the implementation of the Affordable Care Act. Minnesota will be

implementing Community First Services and Support (CFSS) that will replace the Personal Care Attendant program and the Consumer Support Grant program. According to interviewees, CFSS will offer similar services that are already covered by EW.

5. The future of technological and medical advances will affect this population and its services.

It seems as though there is a steady stream of new technologies rolling out every day; therefore, it would be fair to imagine that by 2030 there will be technology advances that may significantly impact the vision loss field and the lives of the blind and visually impaired. In fact, the current technology of the smart phone and tablet has already opened up greater possibilities in mobility, communication, and access to information. For example, the iPhone, which first came out in 2007, has built-in accessibility allowing the blind and visually impaired to navigate the device with ease despite its touch screen that has no physical differentiation. This is possible because the user can press anywhere on the screen and the device speaks to tell them where their finger is. There are also endless applications that have been developed by the blind and visually impaired, including speech texting, GPS navigation, and even an app that can tell you the color of your clothing.

Likewise, it would also be realistic to imagine that by 2030, there will be medical advances to impact the vision loss field and lives of the blind and visually impaired. While the general philosophy behind vision loss rehabilitation asserts that blindness is a natural part of the human experience will likely remain the same, it is also likely that the understanding of and treatment for medical conditions leading to the majority of vision loss among the elderly will also have evolved. For example, in Summer 2012 there was a popular news story about how blind mice had their vision restored with a device that allowed diseased retinas to send signals to the brain. The implications of the study's results are the expectation that future devices will be developed for humans that will return sight to those who have lost some, or all to retinal degenerative diseases, such as macular degeneration.

Solution Options

There is significant financial constraint on the agency to meet a projected increase in client needs and demands given their finite resources and limited capacity. However, our findings show there is great opportunity for SSB to creatively rethink how they can contribute to achieving the desired outcome for older blind and visually impaired. The following presents four broad solution categories that have emerged from our research and analysis. Each of these categories is not mutually exclusive, rather it is our expectation that multiple solution options from within each of these categories might be chosen for implementation. Some may require a longer time horizon, but may still need immediate action to initiate the process; while others may be more short-term in nature:

The four solution categories offer opportunities for SSU to increase capacity with:

1) More funding sources to pay for additional service providers and devices.

2) More opportunities to serve more individuals with the same number of providers.

3) More providers.

4) A network of trained providers.

1. More Funding

1.a. Solicit Voluntary Contributions

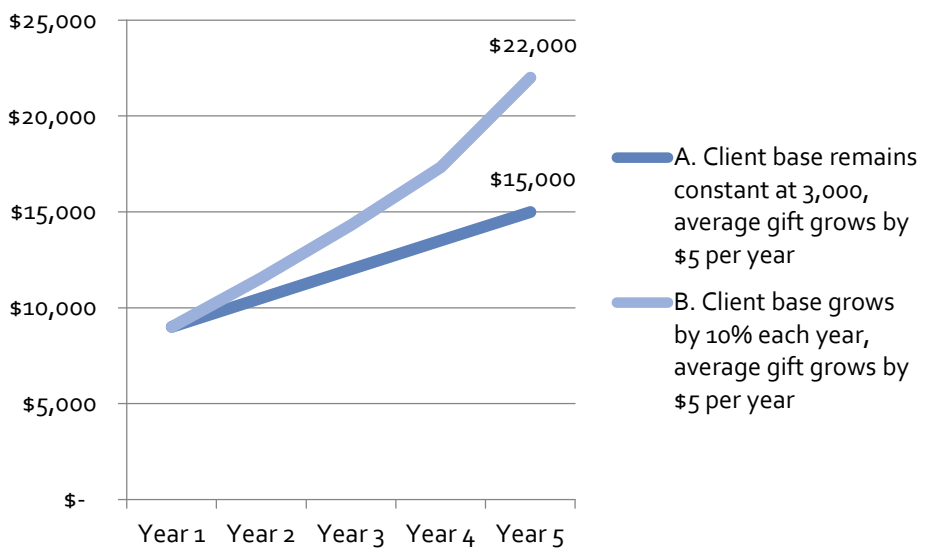
Description: SSU direct service staff representatives will provide a *Voluntary Donation Cost Sheet* at the end of the initial meeting with the client. Cost sheets will present a suggested cost for each of the services and devices provided and give information on how to make a one-time, or ongoing, contribution. The staff representative will *"check"* the services and devices provided and describe the importance of voluntary contributions as a means to augment state and federal funding in order for SSU to sustain services to its growing number of senior clients.

Potential Gains:

- Increased revenues from voluntary contributions can supplement the SSU operating budget with unrestricted funds that provide the flexibility for discretionary investment, including efforts to serve a greater number of clients.
- The act of making a voluntary contribution may give the client, and perhaps their family or caregivers, a sense of investment in SSU and the critical services and devices that are contributing to their ability to remain living independently in their home.

- Quantitative Analysis: Figure 4 shows two potential scenarios of contributions over a 5-year period (these scenarios are for illustration purposes only and they do not assume a guaranteed occurrence). In both scenarios, a contribution rate of 10%, or one in ten clients, is assumed.

Figure 4. 10% Contribution Scenarios over 5-yr Period



Each scenario starts with an average gift of thirty dollars. In scenario A, the base of clients is held constant at 3,000 across all years with the average gift amount increasing by five dollars each year, reaching an average of fifty dollars in year 5. By year 5, total contributions have reached a yearly total of $15,000 and a total accumulated amount across five years of $60,000. Assuming approximately ten percent in overhead costs for managing the contributions, this leaves a net total of $54,000. Based on the itinerant rehabilitation teaching services hourly contract rate of $75/hour and an estimated first visit of three hours, or $225/client; an **additional 240 new clients could be served** over the five year period. Scenario B increases the client base by ten percent in each year and continues from scenario A in increasing the average gift amount by five dollars each year, for an average of fifty dollars in year 5. In this scenario, by year 5 total contributions have reached a yearly total of $22,000 and a total accumulated amount across five years of $74,175. With overhead removed, there is $66,757.50 remaining for an **additional 297 new clients served**. Another way to look at the potential impact of contributions would be **for every $1,000 raised, four new clients are served**.

Potential Drawbacks:

- Clients and their family or caregivers may feel pressured into making contributions when they may not have the ability to donate.
- The practice of soliciting contributions may prevent some potential clients from seeking SSU services and support.
- Some SSU direct service staff will need training and support in adopting solicitation practices into their work habits. Adopting these practices may cause some staff to feel uncomfortable.
- There will be an administrative cost to processing and tracking contributions into the SSB budget system.

1.b. Implement a Fee-for-Service Model

Description: SSU charges clients for services delivered. The fees could be based on a tiered model of service where everyone receives a basic level of service for free (see Table 1 for a description of the tiered service levels). Basic services could include the social and emotional support of reassuring informing clients and their caregivers that they can remain independent. Basic services could also provide clients with information and access to the Communications Center and other media services for the blind and visually impaired. Fees would begin at the Intermediate level of service which might include assistive technology and group trainings for clients and caregivers. An advanced level of service would include in-home training and other advanced training in mobility. Fees could be implemented on a sliding scale based on client-identified ability to pay (thereby alleviating the hassle of independently determining income levels). Donations could be used to supplement or cover the costs for those who cannot pay.

Table 1. A Potential Model for Tiered Levels of Service

Tier Level	Description	Fee
Basic	• Emotional support • Encouragement of ability to remain independent with vision loss • Connect with Communication Center and other media services	No
Intermediate	• Assistive technology • Group trainings (for clients and their caregivers)	Yes
Advanced	• In-home training • Other advanced mobility training	Yes

Potential Gains:

- Revenues from service fees will help support the increased client demand, contributing to more SSU staff and to contracted services.
- Quantitative analysis: To quantify the potential impact of charging service fees, several assumptions must be made for purposes of illustration (again, these assumptions are for illustration only and do not imply guaranteed occurrence): First, let us assume there is a flat service fee of $100 for a deposit on a device or for a group training session and a $100/hour fee for in-home and advanced training. Let us also assume only half of all clients can pay for services and only half of them can pay the full price:

(1/2)3,000 Clients = 1,500 Clients can pay
(1/2)1,500 Clients = 750 Clients can pay full price, the rest pay half-price

In addition, let us assume that ninety-percent of clients receive at least intermediate level service and that fifty percent receive advanced services at an average of 5 hours total.

(.90)1,500 Clients = 1,350 Clients at Intermediate
($100 full price device)750 + ($50 half-price device)750 + ($100 full price training)750 + ($50 half-price training)750 = $225,000

(.50)1,500 Clients = 750 Clients at Advanced
($500 full price)375 + ($250 half-price)375 = $281,250

Total Revenue = $506,250

Potential Drawbacks:

- ▼ There will be an administrative cost to processing and tracking fees into the SSB budget system.
- ▼ The prospect of having to pay may prevent some potential clients from seeking services and support.

1.c. Seek additional Federal and/or State funding.

Description: Launch a stepped-up campaign with political partners and allies to seek additional Federal and State funding to meet the increased demand in services.

Potential Gains:

- ▲ Increased awareness of the need
- ▲ Potential new opportunities for collaboration with partner agencies and political advocates
- ▲ Additional funding to apply towards the increased number of clients

Potential Drawbacks:

- ▼ Staff time to educate potential allies and gain their support
- ▼ Potential conflict with other agencies who are also seeking funding and political support for their programs.

2. More Clients Served With Existing Providers:

2.a. Relocate SSU Direct Service Staff Office Locations

Description: SSB relocates SSU Direct Service Staff offices to a location where seniors are already congregating in the community; e.g. senior centers, medical/optometric offices.

Potential Gains:

- ▲ Relocation may offer greater ease of parking and ground-floor access for senior clients; as well as familiarity and comfort with a location they are accustomed to visiting.
- ▲ Improved satisfaction of clients who feel that services are easy to access.
- ▲ Greater opportunity for office visits by clients and multiple clients at one time.
- ▲ A potential for cost savings by acquiring rented space at a cost lower than current rates.

Potential Drawbacks:

- ▼ Separation from DEED office setting where there is greater opportunity for sharing resources such as office supplies, and joint use of automation systems.
- ▼ Some existing long-term office space contracts might prevent near-term relocation.

2.b. Increase the Practice of Scheduling Initial Meetings with Groups of Multiple Clients at One Location

Description: SSU Direct Service Staff representatives consolidate multiple requests to meet by scheduling an initial meeting in a group setting to present information to both the client and a caregiver (family member or friend). The group meeting will focus on how caregivers and clients can develop independent living skills at home, and learn about aids/devices available to support these needs. Note: this solution set may be a more viable option in higher density urban areas where there is greater demand for client visits.

Potential Gains:

- ▲ Clients and supporting caregivers gain an opportunity for greater interaction and relationships with other senior clients and caregivers who are experiencing similar circumstances relative to vision loss.
- ▲ Group meetings may remove the need for, or reduce the number of in-home visits required for clients; thus saving costs for travel and time which can be used to service a greater number of clients.
- ▲ Quantitative Analysis: For example, if staff schedules 2 group meetings in a month for 12 clients in lieu of 2 travel days for 4 home visits, then there is the potential to serve 96 additional clients per staff per year. Multiply this by 16 direct service staff and you have **1536 additional clients served in one year.**

Potential Drawbacks:

- ▼ Clients without supporting caregivers may have difficulty obtaining transportation to the group meeting location.
- ▼ The Direct Service Staff is unable to assess the client's unique home circumstances needed to complete a comprehensive diagnosis for services and/or devices.

3. More Providers with Existing Budget:

3.a. Contract more of SSU Services through a competitive RFP process.

Description: SSB receives the call for assistance and refers the individual to an SSU contracted service provider for training and/or aids/devices.

Potential Gains:

- ▲ Greater opportunity for SSB to establish and enforce quality control measures and obtain feedback from clients.
- ▲ There is a potential to gain cost efficiencies by replacing salaries from some SSU providers to go to contracted services that may result in SSU serving more clients.

- ▲ Quantitative Analysis: Contract rates obtained during the study period show a range in hourly rates of skilled contract trainers at $40-$75/hour. Currently, SSU spends $1.3 million in staff salaries and benefits and serves an average of 3,000 clients annually. Just converting salary and benefits into clients served yields an average of $433/client. Calculating this average staff cost per client would yield a range of 5.7 contracted hours ($75/hr) to 10.8 contracted hours ($40/hr) per client. Another way to look at this would be to assume 4 hours per visit at $75/hr for a contractor would equal $300/client. If you compare this rate to the SSU staff rate of $433/client, the difference yields approximately **1,330 more clients to be served** by contractors each year.

Potential Drawbacks:

- ▼ SSU staffing would be reduced; however, this could occur through natural attrition from retirements and other voluntary job departures.

3.b. Seek New Partnerships in Service Delivery Including Expanding network of providers by utilizing government-provided or medical insurance reimbursable providers.

Description: There is great potential for SSU to grow its network of providers by recruiting and training other professionals who already interact with the elderly population to provide at least a basic level of service to clients. There is also opportunity to engage with service providers such as Occupational Therapists (OT), Veterans Affairs, agencies authorized for reimbursement through Elderly Waivers, and the brand new Community First Choice program who are providers already interacting with potential and existing SSU clients. OTs are an interesting example of a rehabilitation trained group of providers who are currently authorized by Medicare to provide low-vision therapy for individuals who are transitioning to greater impairment of vision. Though Minnesota's network of OTs who are trained in low-vision care is small, this option includes the need to work with the Minnesota Occupational Therapy Association to train and certify additional OT providers who can be called on to provide services currently provided by contracted vendors. A similar opportunity exists in working with DHS Aging and Adult Services on the potential of using the Elderly Waiver.

Potential Gains:

- ▲ Less money spent on vendor-contracted training, making more money available for training and more clients who can develop independent living skills from qualified professionals.
- ▲ Quantitative Analysis: Using OT professionals as an example, Medicare recipients are authorized to receive up to $1,900 in therapy services per year. Therefore, theoretically, any client on Medicare that receives services from an OT would have their first $1,900 of services covered by insurance; and, therefore, this would be $1,900 less in expenses per Medicare client incurred by SSU through contract payments. For example, contracting with OTs could replace some regular vendor contracts. At the current rate of $75/hr, if each SSU direct service staff member establishes even just one 10-hour contract each month would equal:

  10 hrs x $75/hr = $750

  $750 x 16 staff x 12 months = **$144,000 in annual cost savings**

Potential Drawbacks:

- ▼ This option would require establishing new relationships and building capacity to understand the various requirements of billing to third-party payers, all of which will take time and resources.
- ▼ There could be an unwillingness or lack of interest on the part of some professionals to become trained and certified in low-vision care.

4. Sustain or Improve Service Delivery

4.a. Transition SSU from a direct service agency, to one that trains, certifies, and provides quality assurance of service/device delivery

Description: Over time, SSU could evolve their mission and purpose from one of a direct service provider to one who cultivates, trains, and monitors a fleet of service providers. SSU is already excellent at providing the emotional support that most clients are in immediate need of when reaching out for help. SSU also has the knowledge and capacity of understanding what it requires to work with an individual experiencing significant change in their vision. SSU should harness this knowledge and serve as a catalyst to educate and train other professionals about the importance of meeting these clients' needs at a time when this population is growing exponentially. Additionally, Minnesota's consumer groups, such as National Federation of the Blind, American Council on the Blind, and United Blind of MN offer models for the effective use of peer mentors, support groups, and basic care services that can augment the efforts of SSU and its network partners

Potential Gains:

- ▲ There is potential to significantly increase the number of high quality, trained service providers who are meeting the needs of the older blind and visually impaired. This includes incorporating the value and availability of volunteers in performing basic levels of service by participating as peer mentors and offer local support groups.
- ▲ By nurturing a network of trained service provides, there is the potential to unite a system of providers around the philosophy that the older blind and visually impaired can remain fully functional as independent adults.

Potential Drawbacks:

- ▼ This option would radically shift the purpose and operations of SSU from its current role. Any kind of significant change like this requires time, energy, and patience; which can be difficult when also trying to serve a growing population with direct service needs.
- ▼ SSU direct service staff would no longer provide services directly to clients, changing the very nature of the work that many have been doing for decades. Therefore, there is the potential that staff will need care and attention, as well as their own training and skill building to adapt to their changing role.

Conclusion

All of the conversations we have had over the course of this study reveal a resounding consensus over the merit and need for the desired outcome as articulated by the key stakeholders of this study:

Desired Outcome:

All elderly individuals with transition needs in response to loss of vision have quality services, devices, and support that are locally accessible and utilized.

Our findings demonstrate that SSB cannot achieve this desired outcome alone and that services for the older blind and visually impaired cannot operate in a vacuum. There is a large network of service providers (e.g. public health, OT, social work, CILs, and many other volunteer organizations) who share in this desired outcome and may already interact with SSU clients and there is a tremendous opportunity to harness and engage with this network.

The desired outcome for SSU clients is not just for the future, but is desired for today's clients. There is a referral process; an intake process; and the service delivery process – all of these deserve attention and the redesign options may impact some, or all of these. SSB has the opportunity to move closer to this desired outcome by implementing redesign solutions that range from system-wide change down to specific processes and practices within SSB. Every option will have near-, mid-, and long-term strategies and tactics.

In closing, we would like to share a passage from a recent report by the Bush Foundation titled, *Beyond the Bottom Line: Big Ideas. Better Outcomes. Bending the Cost-Curve*:

> "Fundamentally changing the way a service is delivered is incredibly difficult – whether healthcare, human services, public safety or something else. It takes bold vision to imagine new ways of conducting business, strong leadership to move a collaborative process forward, and the commitment of staff and stakeholders to see that vision through." (p.15)

Appendices

Appendix A: Interviewee Affiliations

Appendix B: (Re)design Team Member Affiliations

Appendix C: April 2013 Redesign Team Newsletter

Appendix D: August 2013 Redesign Team Newsletter

Appendix E: Map & Descriptions of Services for Older Minnesotans

Appendix A: Interviewee Affiliations

Affiliation/Organization	# Persons Interviewed
MN State Services for the Blind Staff	3
MN State Services for the Blind Client	6
MN State Government Agencies	4
US Federal Government Agencies	2
Agencies and Organizations within Vision Loss Field	9
Agencies and Organizations within Aging Field	2
Other Nonprofit, Public and Private Organizations	2
Total	**28**

Appendix B: (Re)Design Team Member Affiliations

Affiliation/Organization	# Team Members
MN State Services for the Blind Staff	4
MN State Services for the Blind – Senior Services Unit Staff	4
MN State Services for the Blind Client	2
National Federation of the Blind of Minnesota	1
United Blind of Minnesota	1
American Council of the Blind of Minnesota	1
Lighthouse Center for Vision Loss	2
Blindness: Learning In New Dimensions (Blind Inc.)	1
Vision Loss Resources	2
MN Statewide Independent Living Council (SILC)	1
Aging Services of Minnesota	1
Minnesota Visiting Nurse Agency	1
Humphrey School of Public Affairs	2
University of Minnesota Institute on Community Integration	1
Design Professional	2
Social/Political Advocacy Professional	1
Total	**27**

Appendix C: April 2013 Redesign Team Newsletter

(separate attachment)

Appendix D: August 2013 Redesign Team Newsletter

(separate attachment)

Appendix E: Map & Descriptions of Services for Older Minnesotans

(separate attachment)