A Broader Framework for Minnesota's Solos

Phase 1: Population Snapshot and Literature Review

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Executive summary

Solos are individuals who, by choice or circumstance, function without the support systems traditionally provided by family. Status as a solo can be defined by demographics, relationships, behavioral traits, and other combinations of characteristics (Camp, 2023, p. 2).

This report is the first part of a phased approach to expand on previously completed work about solos. The overall goal of Phase 1 is to summarize current data on:

- Characteristics and circumstances of solos in Minnesota
- Solos' access to services across Minnesota
- Literature references related to ways in which solos interact with systems and systems may work to address the unique needs of solos

Phase 2 work will include a more in depth study of the ways that professionals and networks in Minnesota currently address the needs of solos, and where opportunities exist to revise existing policies and procedures, programs, and services available to solos. Key to this work is a focus on the systems with which solos interact, rather than the service sectors themselves.

For this study, **systems** are defined as groups of independent but interrelated elements that interact with one another to meet the needs of solos. **Solos** are considered adults born before 1982, screened according to living arrangements to include only adults living alone, without other family members or unrelated individuals present in the household.

PREVALENCE AND CHARACTERISTICS

In Minnesota, there are currently 515,315 solos. Of these solos, one quarter each are in Generation X and the Greatest generation, and half are Baby Boomers. As a group, large proportions of Minnesota's solos are high school graduates (93%); White (88%); divorced, separated or widowed (67%); and female (57%).

Solos are also slightly more concentrated in the 7-county metro area (54%), compared to greater Minnesota (46%). Outside of the 7-county metro area, higher proportions of households are headed by solos in the Arrowhead region, including Duluth.

Nearly one in three (29%) of all solos reported that they have at least one disability, including more than half (53%) who said they have two or more disabilities. Disabilities associated with walking, independent living, hearing, and cognitive concerns top the list.

Solos in Minnesota reported an overall median income of $40,682, although this amount varied by generation. More than one-third (35%) of solos overall are at or below poverty level (200% of poverty). Solos with income levels at or below the poverty thresholds are concentrated in the Arrowhead region, southwest suburbs of Minneapolis, and southern suburbs of St. Paul.

ACCESS TO SERVICES

Large swaths of Minnesota counties are designated as partial or total shortage areas for primary health and dental care. Compared to the metropolitan areas, rural areas of Minnesota in northern, central and southeastern regions, have fewer health care facilities available to residents. Outside of the 7-county metro area, solos are concentrated in two regions served by Area Agencies on Aging, which also correspond to health care shortage areas.

RESEARCH AND LITERATURE

Largely absent in current literature is an assessment of the ways in which systems may inadvertently create barriers for solos through policies and procedures, programs, or services that are designed exclusively for people who are not solos. While a body of literature exists, related to health systems, much of it focuses on health outcomes of very frail older adults and ethics considerations for health care delivery.

Even so, awareness of solos is increasing, along with services and supports that help solos address and navigate their needs. A small number of newer reports and articles mention collaborations and partnerships within the ecosystem of services and supports for older adults. The authors suggest that engaging across sectors, examining assumptions about what people need, and developing flexible responses will improve solos' access to the services and supports they need to remain independent.

Several recent state plans on aging include references to solos. State governing bodies related to aging may serve an important role as champions for coordinated efforts to develop inclusive supports and policies that address the needs of solos.

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Introduction

Solos are individuals who, by choice or circumstance, function without the support systems traditionally provided by family. Status as a solo can be defined by demographics, relationships, behavioral traits, and other combinations of characteristics (Camp, 2023, p. 2). While solo adults can be of any age, the literature (in research and practice) largely focuses on older adults.

While the existence of solos is not new, individuals, communities, and organizations are growing increasingly aware of their existence and their unique circumstances. Data are available that can tell us about the characteristics of solos. Current literature that addresses the topic of solos is particularly extensive, with plentiful information about the needs of individuals, including checklists and advice for solos to organize their lives, protect their assets, and define their futures. Several states have taken preliminary steps to acknowledge solos and address their needs.

Unfortunately, with a few exceptions of mentions of collaborations and partnerships, literature about the ways in which systems interact with solos is largely absent. While there is a significant amount of information about health care systems, much of it relates to health outcomes of solos who are deemed "incapacitated" or unable to speak for themselves due to infirmity or acute crises. (In many cases, "incapacity" seems to be synonymous with a status as "unrepresented.") The literature also focuses on stress on health care services and providers, and the ethics of treating older adults without representatives.

The overall goal of this study is to describe the current landscape of information about solos and expand on previous work completed by Linda Camp, as described in a 2023 article entitled, "Why We Need a Broader Framework for Solo Agers." More specifically, focusing on how "outdated, incorrect, and/or biased assumptions become embedded in policies, customs, and practices, creating often invisible barriers for individuals (p. 6)," and many systems are not designed to respond to the diverse needs of solos. Shifting from a perspective that exclusively centers individuals and their actions to a broader perspective that includes the multiple systems with which solos interact can inform procedure and policy change, and improve system functions and individual agency.

TERMS AND DEFINITIONS

Several terms and definitions frame this work.

SOLOS

In census data used to access information about demographics and other characteristics, solos are identified according to living arrangements—living alone, without other family members or unrelated individuals present in the household. It is important to note that this is not a precise count. It is not possible to discern via census data which solos may have strong connections with people they do not live with, and these figures do not include solos who are living in institutional settings. Nonetheless, using this standard designation allows reliable, historical comparisons over time.

In addition, "Solo ager," "solo," or "solo older adult" are the currently preferred terms used to describe adults who are aging without the reliable support of adult children or other family members. However, some literature retains the older terms used in early references, describing solo older adults with modifiers such as:

- Unbefriended
- Orphaned
- Incapacitated, without advocate
- Unrepresented
- Isolated
- Without surrogate
- Kinless

The terms were initially employed within medical systems. Once used more broadly, the terms were recognized as being limited, inaccurate, and rife with social stigma (Farrell, 2021).

THREE GENERATIONAL COHORTS: Generation X, Baby Boomers, and Greatest

Cohorts included in this report include generations with the following birth years:

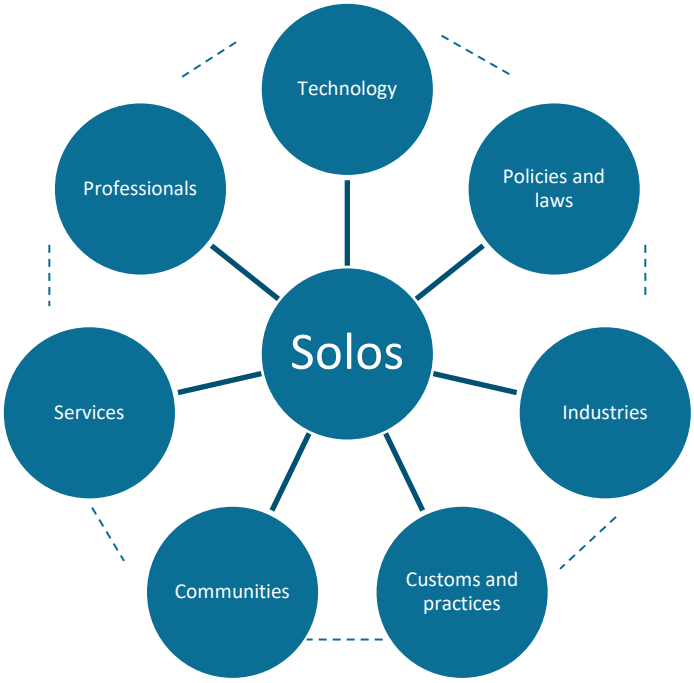
- Generation X: born between 1965-1982
- Baby Boomer: born between 1946-1964
- Greatest: born 1945 and earlier

While Baby Boomer and Greatest generation cohort members are over age 60, we have included solos in Generation X (ages 43-60), as they may be on course to become older solos.

SYSTEMS

For this study, *system* is defined as a group of independent but interrelated elements that interact with one another for a common purpose. Distinct components can affect each other, and may include people, laws and policies, customs and practices, technology, and equipment or tools, all in a broad array of industries and service areas. With this system perspective, solos function as the hub (Figure 1).

1. Solos as the hub of systems interactions



PROJECT PHASES

PHASE 1

This study uses a phased approach to the work. This report, completed for the first phase, is a summary of currently available information about solos, in census data, as well as in articles and reports. It builds on work completed by Wilder Research in 2019, which established a profile of solos in Minnesota and is intended to be used as a foundation for future work.

PHASE 2

The second phase will involve a deeper dive into an assessment of the systems with which solos interact. The following overarching questions will guide the work.

When a solo individual interacts with a service sector or network, and encounters existing policies and procedures, programs, or services designed for people who are not solos:

- How do professionals and networks respond to address the unique needs of solos?
- What and where are the opportunities to make changes?

Solos in Minnesota

Four guiding questions provide a framework for this work:

1. What is the current number of Minnesota solos and what is their distribution by county?
2. What are the key demographic characteristics of solos?
3. What are the unique circumstances of Minnesota solos, including income, health insurance, and access to long term care insurance?
4. What are the key resources/systems available to older adults by county, including hospitals and clinics, care management services, assisted living facilities, and transportation?

BACKGROUND AND CHARACTERISTICS

POPULATION SUMMARY

There are 515,315 solos in Minnesota, defined as adults born before 1982, who are living alone, without other family members or unrelated individuals present in the household. Solos make up 18% of all adults born before 1982. Of all solos in Minnesota, one quarter each are in the Generation X (25%) and Greatest (25%) generation groups, and one half (50%) are in the Baby Boomer generation (Figure 2).

2. Population summary

	Number of solos	Percentage of solos by generation in the total	Percentage of each generation that are solos
All solos	**515,315**	**100%**	18%
Generation X *(1965-1982)*	130,049	25%	10%
Baby Boomer *(1946-1964)*	258,460	50%	21%
Greatest *(1945 and earlier)*	126,806	25%	36%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

Since 2017, the total number of solos remained flat. Generation X and Baby Boomer solos increased 8% each, while Greatest generation decreased 19% (Figure 3).

3. Solos percentage population change, 2017-2025

	Number of solos in 2017	Number of solos in 2025	Percentage change
All solos	**516,752**	**515,315**	– <1%
Generation X *(1965-1982)*	120,464	130,049	+ 8%
Baby Boomer *(1946-1964)*	239,646	258,460	+ 8%
Greatest *(1945 and earlier)*	156,642	126,806	– 19%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

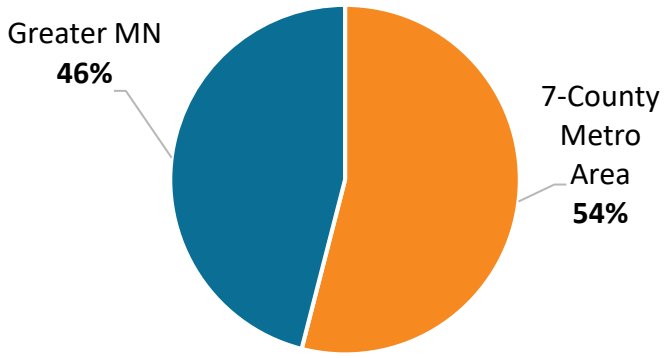
DEMOGRAPHICS

As a group, large proportions of Minnesota's solos are:

- High school graduates (93%)
- White (88%)
- Divorced, separated, or widowed (67%)
- Female (57%)

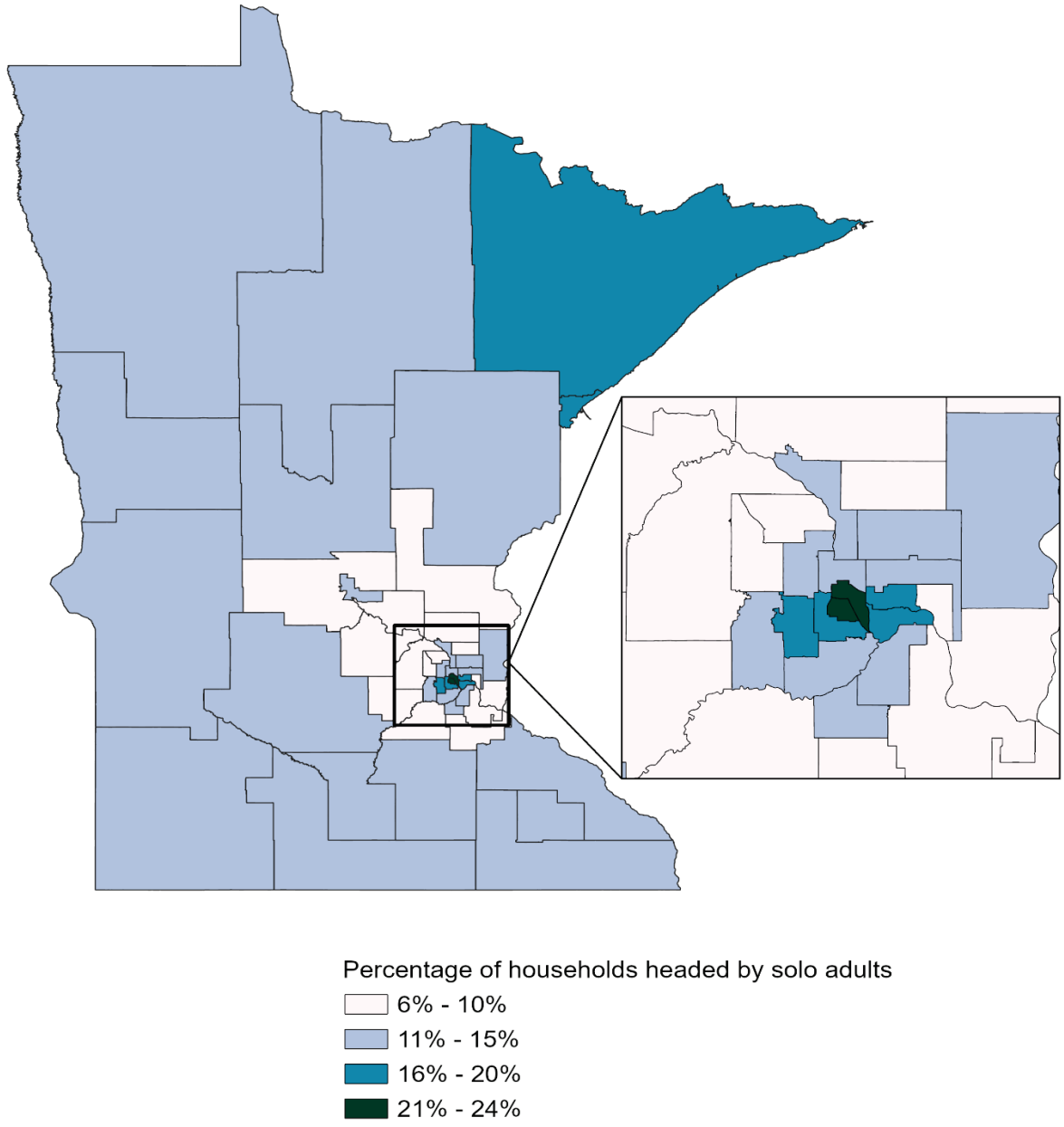
Solos are also slightly more concentrated in the 7-county metro area (54%), compared to greater Minnesota (46%; Figure 4).

4. Percentage of solos by location



Outside of the 7-county metro area, higher proportions of households headed by solos are concentrated in the Arrowhead region (Cook, Lake, St. Louis counties), including Duluth (Figure 5).

5. Map of percentage of households headed by solos, Minnesota



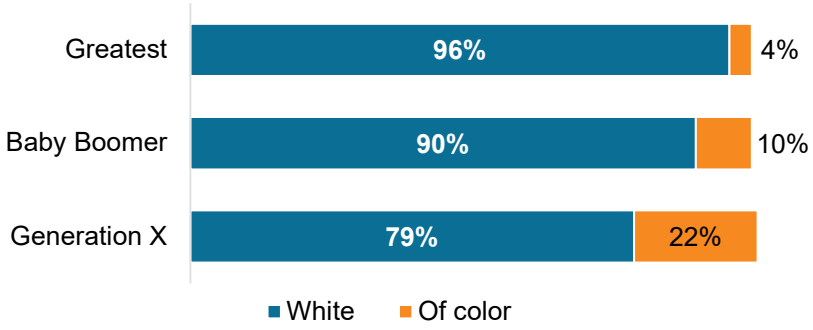
Source: IPUMS USA, University of Minnesota, www.ipums.org. Calculations by Minnesota Compass, Wilder Research.

By generation

Key characteristics of solos—race, gender, marital status, geography—vary by generation in the following ways:

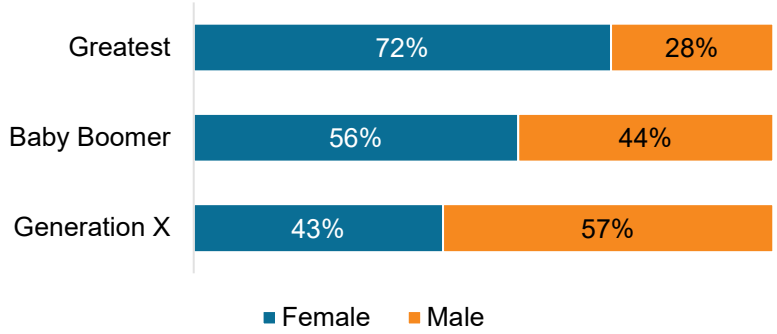
- A greater proportion of solos in the **Greatest generation** are White (96%), compared to 90% of **Baby Boomers** and 79% of **Generation X** (Figure 6)

6. Differences in race by generation



- A smaller proportion of solos in **Generation X** are female (43%), compared to 56% of **Baby Boomers** and 72% of the **Greatest** generation (Figure 7)

7. Differences in gender by generation



- The greatest proportion of solos in **Generation X** are never married or single (55%), while the greatest proportion of **Baby Boomers** are divorced (46%) and the greatest proportion of **Greatest** generation are widowed (69%) (Table A4)

Of households headed by solo individuals:

- 20-30% of those who are in **Generation X** are located in three 7-county metro area locations, including portions of Minneapolis and St. Paul (Map B1)
- 40-50% of those who are **Baby Boomers** are located in portions of Minneapolis; 30-40% are located in three other 7-county metro area locations (Map B2)

- 40-50% of those in the **Greatest** generation are located in:
  - North and Northeast Central locations, including Duluth and St. Cloud
  - 7-county metro area locations (Carver, Dakota, Hennepin, Ramsey counties), including portions of Minneapolis and St. Paul (Map B3)

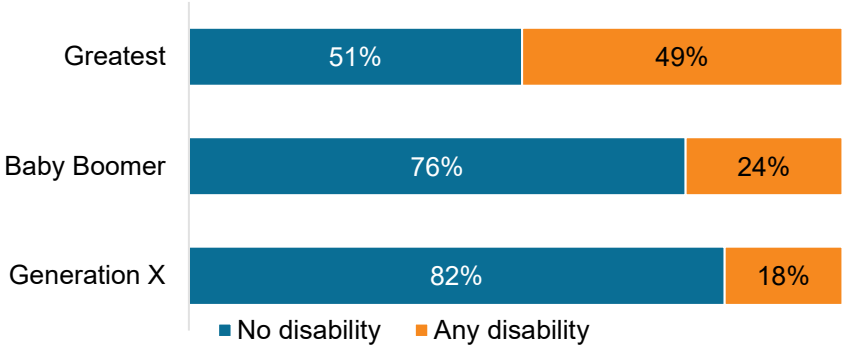
HEALTH CHARACTERISTICS

Disability status

Overall, nearly one in three (29%) solos of all ages in Minnesota reported that they have at least one disability. Of those, more than half (53%) said they have two or more disabilities. They most commonly reported an ambulatory limitation[1] (59%), followed by independent living[2] (38%) and hearing[3] (33%) limitations. One in three (30%) also reported a cognitive limitation[4] (Table A2).

As would be expected with age-related disabilities, a greater proportion of older solos (49%) reported any disability, vs. 24% of Baby Boomer and 18% of Generation X generations (Figure 8). Solos in the Greatest and Baby Boomer generations most often reported an ambulatory limitation (63% each), while Generation X solos most commonly reported a cognitive limitation (56%) (Table A5).

8. Disability status, by generation



Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

1 Respondents were asked if they had "serious difficulty walking or climbing stairs."
2 Respondents were asked if due to a physical, mental, or emotional condition, they had difficulty "doing errands alone such as visiting a doctor's office or shopping."
3 Respondents were asked if they were "deaf or… [had] serious difficulty hearing."
4 Respondents were asked if due to a physical, mental, or emotional condition, they had "serious difficulty concentrating, remembering, or making decisions."

Health insurance

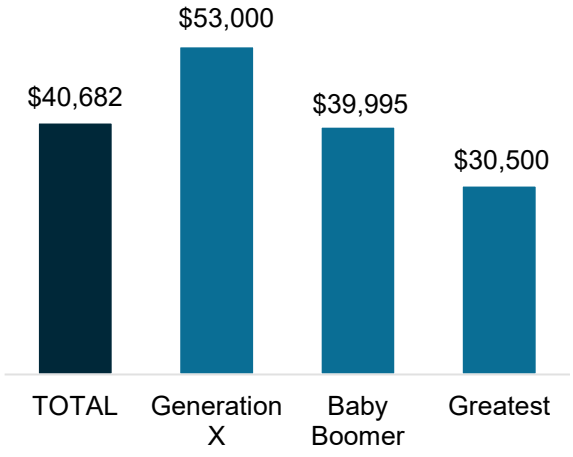
Nearly all solos (96%) have some form of health insurance coverage (Table A2), including all solos in the Greatest generation (100%), 97% of Baby Boomers, and 91% of Generation X solos (Table A5). All solos (100%) in the Greatest generation said they have Medicare coverage.

ECONOMIC CHARACTERISTICS

Less than half (43%) of all Minnesota's solos are currently in the labor force (Table A3). A greater proportion of solos in Generation X (82%) are employed, compared to just 42% of Baby Boomer and 5% of Greatest generation solos, which reflects the reality of retirement for many adults born between 1946 and 1964 (Baby Boomers) and before 1946 (Greatest generation). In fact, most of the Greatest generation solos (94%) reported receiving income from Social Security, while most of the Generation X solos (83%) reported receiving income from wages or salaries (Table A6).

Solos in Minnesota reported an overall median income of $40,682. This amount varied by generation, with Generation X solos reporting the highest median income of the three groups, at $53,000. Baby Boomers reported a median income of around $40,000 and Greatest generation solos reported a median income of around $30,000 (Figure 9).

9. Median annual income for solos, by generation

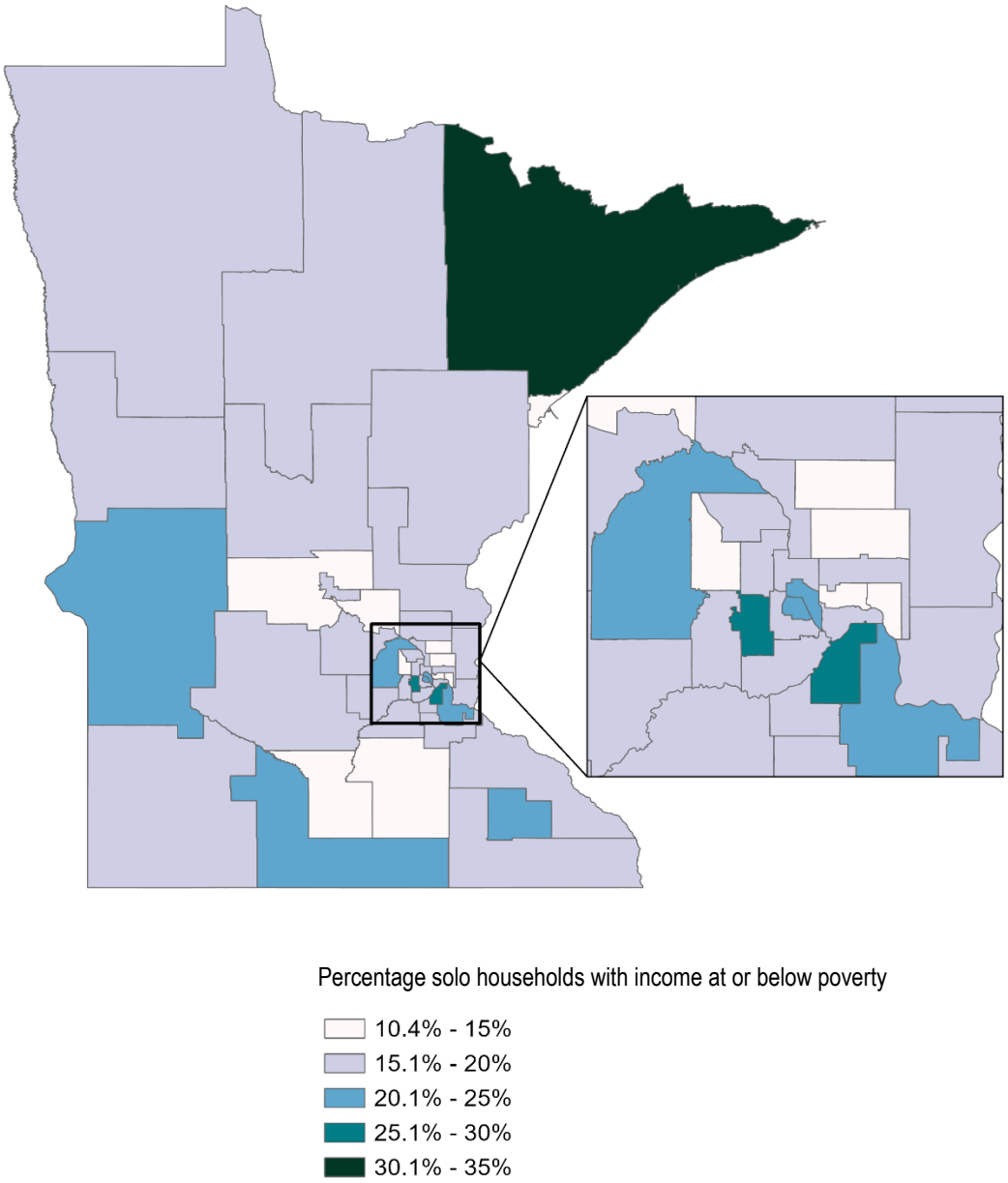


Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

For 2023, the threshold for poverty status, set by the federal government, was $15,852 for an adult *under age 65* living alone and $14,614 for an adult *age 65 and older* living alone.

Solos with income levels at or below the poverty thresholds are concentrated in the Arrowhead region of Minnesota (Cook, Lake, St. Louis counties), southwest suburbs of Minneapolis, and southern suburbs of St. Paul (Figure 10).

10. Percentage of solo households with income at or below poverty



Source: IPUMS USA, University of Minnesota, www.ipums.org. Calculations by Minnesota Compass, Wilder Research.

A designation of “low income” is used for individuals with incomes at or below 200 percent of these thresholds. Poverty status varies for the three generations of solos, and increases with age. While 63% of solos overall are considered above poverty level, 44% of Greatest generation, 36% of Baby Boomers, and 23% of Generation X solos are considered low income (Figure 11).

11. Low income status of solos, by generation

Low income status (at 200% of poverty)	ALL Solos	Generation X	Baby Boomer	Greatest
Above 200% of poverty	63%	74%	62%	54%
At or below 200% of poverty	35%	23%	36%	44%
Poverty status not determined	2%	2%	2%	2%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

Key resources available in Minnesota

Successfully meeting the needs of diverse older adults requires coordination between multiple agencies and sectors. While many services and supports exist, information about services or initiatives is not consistently centralized, and implementation is oftentimes completed at a local or personal level.

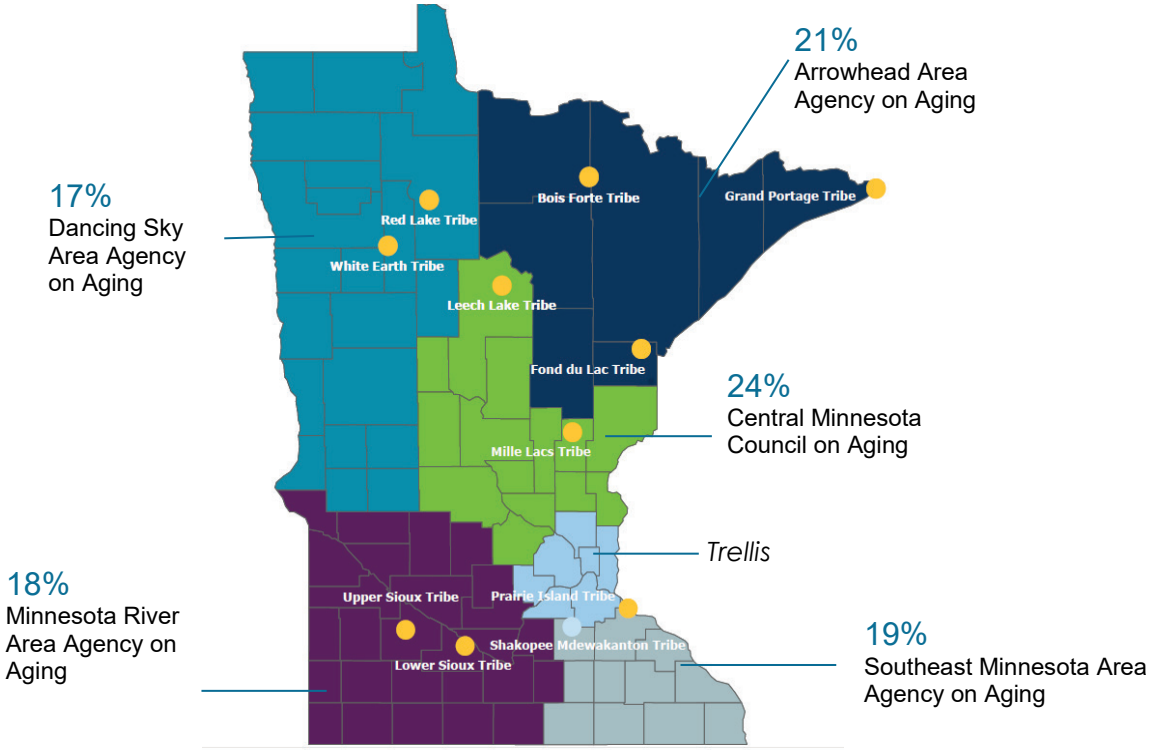
AREA AGENCIES ON AGING

Area Agencies on Aging (AAA) are regional organizations that serve as fiscal agents for Older Americans Act funding, provide information and access assistance, and connect residents to services and supports, such as nutrition, transportation, and other home and community-based services. AAAs also work closely with regional agencies and organizations to develop community capacity and programs that support older adults and caregivers. In Minnesota, there are seven AAAs, including Trellis in the 7-county metropolitan area and the Minnesota Indian Agency on Aging.

Note: Information on the AAAs is included here as a reference. Staff within the AAAs may be valuable connections and champions for future work on policy change related to solos.

Just under one half of solos (46%) live in greater Minnesota, in the regions served by five Area Agencies on Aging. The proportion of solos within the service areas of Central Minnesota Council on Aging (CMCOA; 24%) and the Arrowhead Area Agency on Aging (AAAA; 21%) are larger overall than in the other AAAs (17-19%; Figure 12).

12. Percentage of solos living in greater Minnesota, by Area Agencies on Aging service regions



Source: Minnesota Board on Aging

Of the solos who live in greater Minnesota, larger proportions of Generation X solos live in the CMCOA and Southeast MN Area Agency on Aging (SEMAAA) regions, while Baby Boomers are concentrated in the AAAA and CMCOA regions. Greater proportions of solos in the Greatest generation live in the AAA, CMCOA, and MN River Area Agency on Aging service regions (Figure 13).

13. Percentages of solos living in greater MN, by Area Agency on Aging service areas and by generation

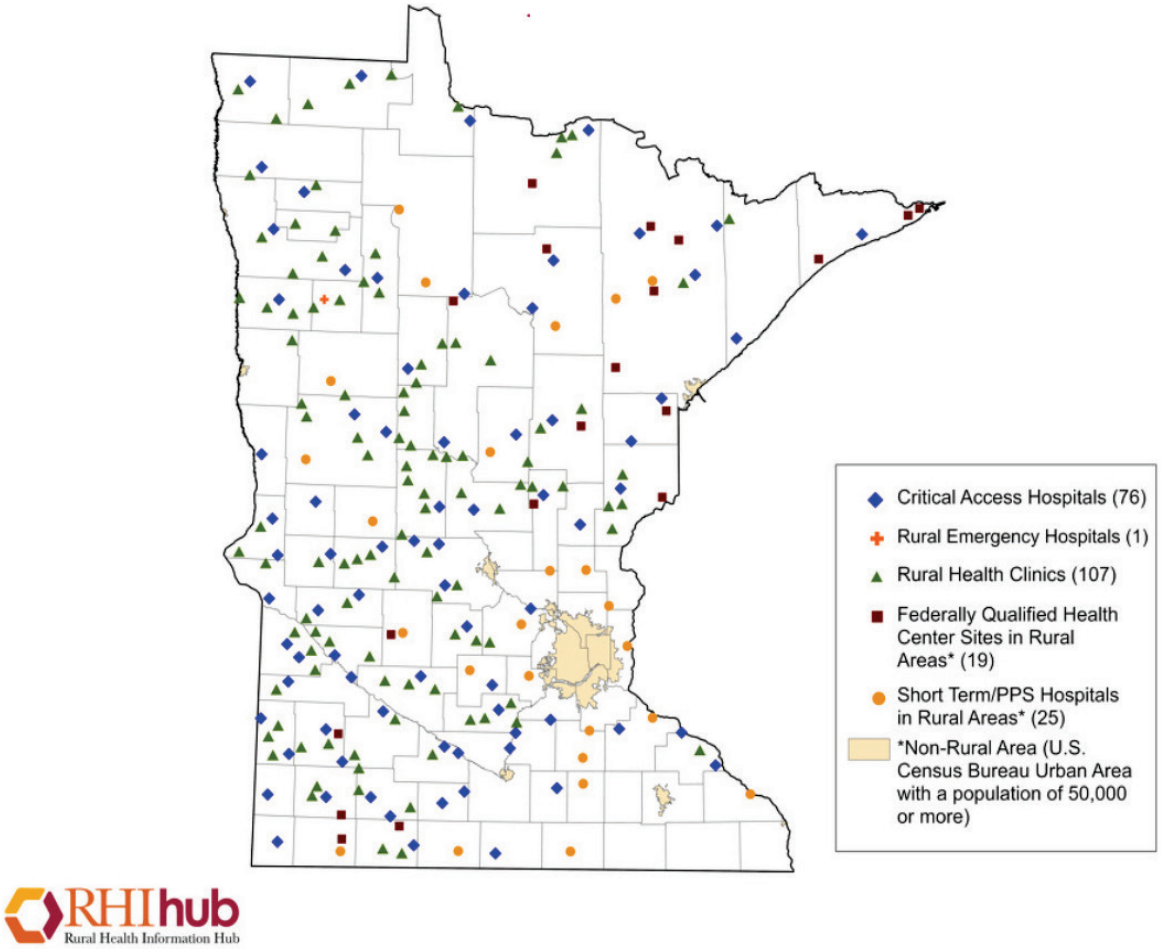
	Generation X	Baby Boomer	Greatest
Greater Minnesota	**N=54,662**	**N=120,572**	**N=63,447**
Arrowhead Area Agency on Aging	19%	23%	21%
Central Minnesota Council on Aging	25%	24%	23%
Dancing Sky Area Agency on Aging	15%	17%	18%
Minnesota River Area Agency on Aging	17%	17%	20%
Southeast MN Area Agency on Aging	23%	19%	18%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

ACCESS TO HEALTH CARE

Access to health care in facilities and staff vary across Minnesota. Northern, central, and southeastern regions of Minnesota, outside of the metropolitan and urban areas, have fewer health care facilities available (Figure 14).

14. Selected rural health care facilities in Minnesota

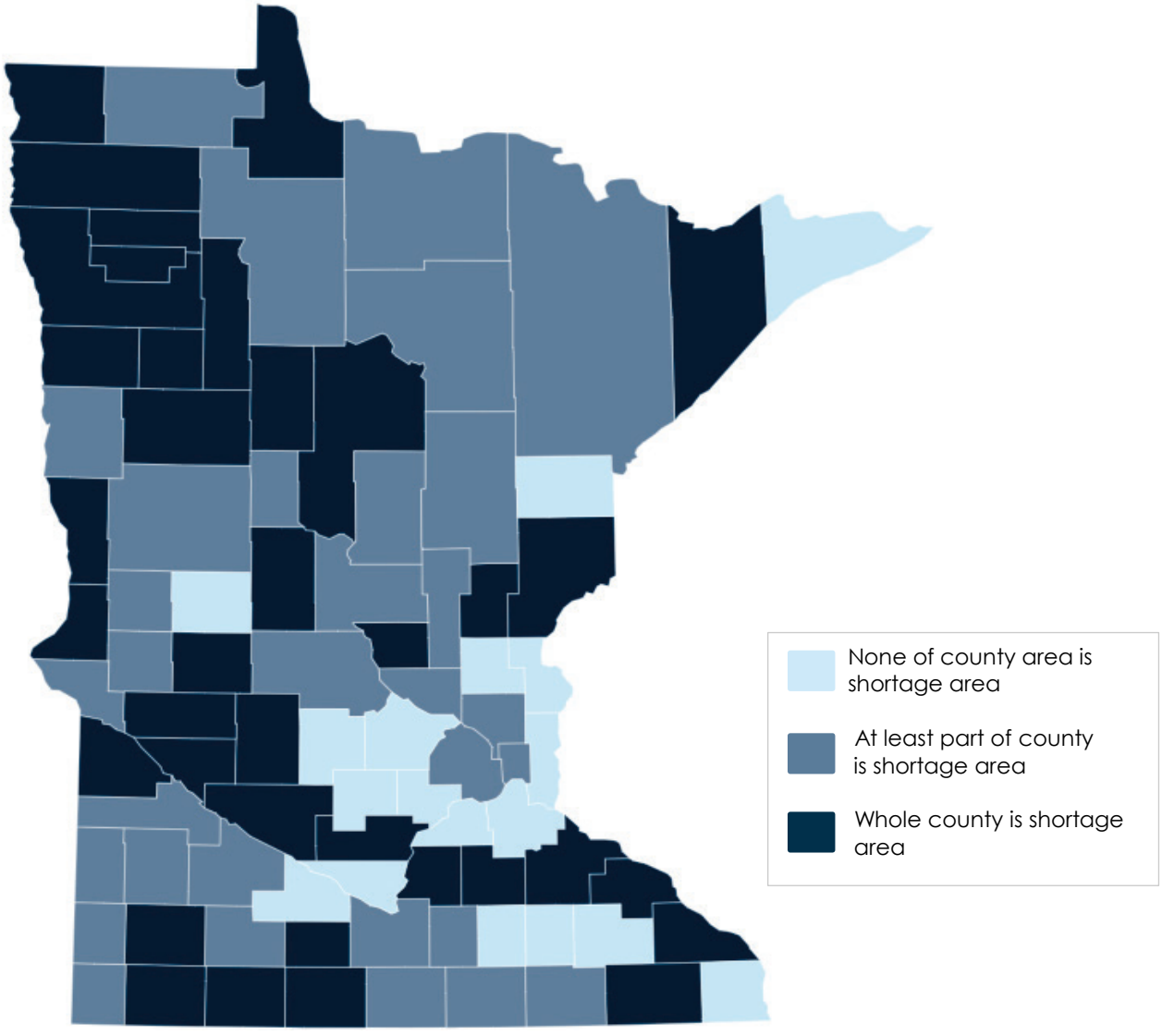


Source: data.HRSA.gov. U.S. Department of Health and Human Services, April 2025

From Selected Rural Healthcare Facilities in Minnesota, by Rural Health Information Hub, 2025 (https://www.ruralhealthinfo.org/states/images/minnesota-rural-health-facilities.jpg?v=793). Copyright 2025 by Rural Health Information Hub.

Multiple counties in Minnesota are also designated as Health Professional Shortage Areas (HPSA), meaning access to health care such as dental and primary care can be limited because of a lack of providers. Large swaths of Minnesota counties are partial or total shortage areas for primary care, while most Minnesota counties are total shortage areas for dental care. Figures 15 and 16 are maps of Minnesota, color-coded by the extent of the shortages.

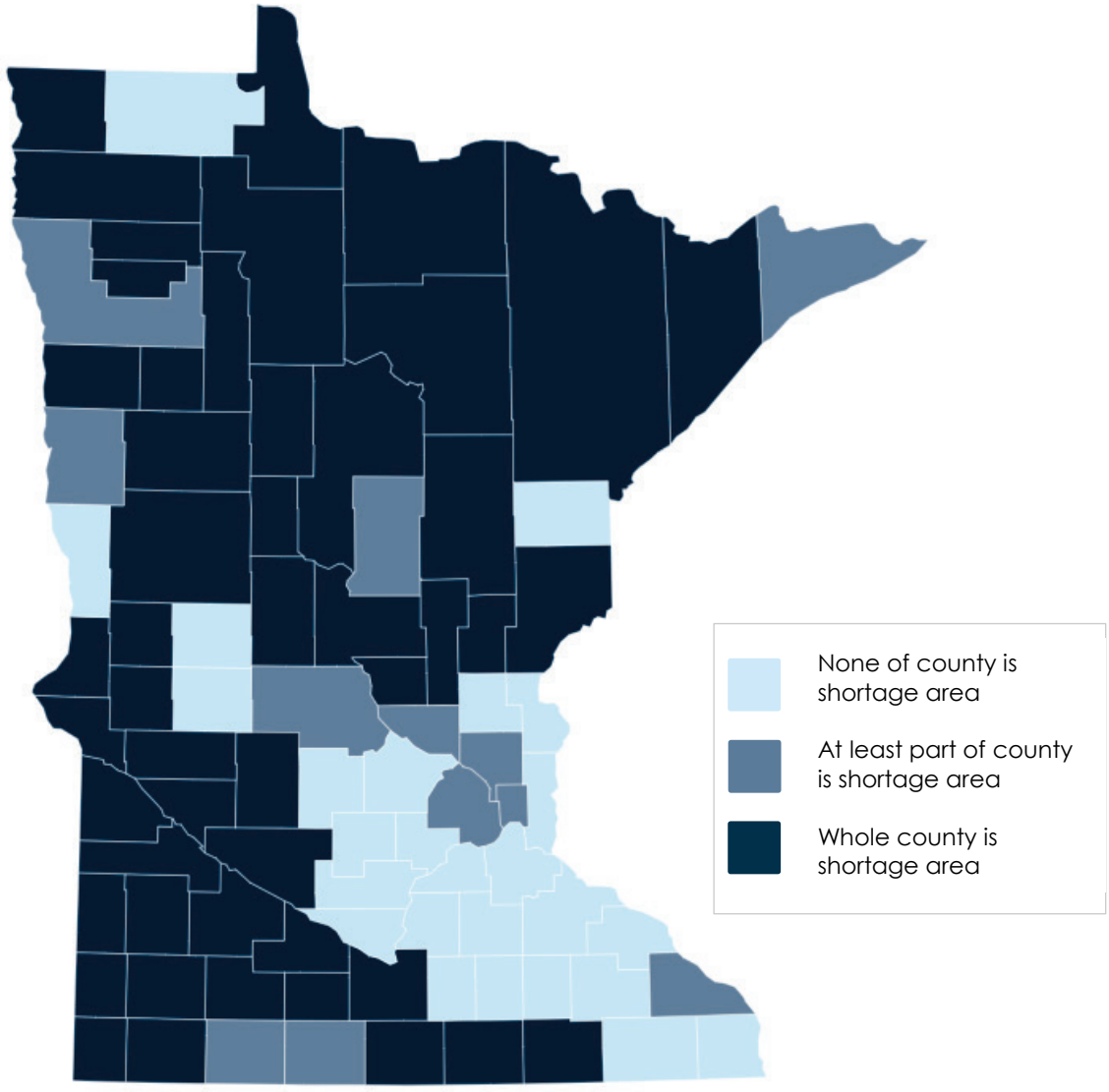
15. Health Professional Shortage Areas: Primary care for Minnesota



Source: data.HRSA.gov

From *Health Professional Shortage Areas: Primary Care, by County, April 2025 - Minnesota*, by Rural Health Information Hub, 2025 (https://www.ruralhealthinfo.org/charts/5?state=MN).

16. Health Professional Shortage Areas: Dental care for Minnesota



Source: data.HRSA.gov

From Health Professional Shortage Areas: Dental Care, by County, April 2025 - Minnesota, by Rural Health Information Hub, 2025 (https://www.ruralhealthinfo.org/charts/9?state=MN). Copyright 2025 by Rural Health Information Hub.

Literature scan

This literature scan includes articles that aligned with project questions and mentioned a systems perspective or collaborative approach to understanding and meeting the unique needs of solos. In some cases, article contents may appear more loosely connected to systems, but are included for consideration and context. Some of the insights may help to develop a foundation for the next phase of work, including interviews with stakeholders. In general, while the body of research and reports is growing, there is still limited information in current literature about solos and efforts by states to address their needs.

Four guiding questions provide a framework for the literature scan:

1. What does research say about how well-equipped Minnesota and other states are to address the needs of solo older adults?
2. To what degree are agencies, jurisdictions, and states identifying solos as a group to target? If they are identifying solos, what are they doing to address the needs of solos?
3. Are best practices or models emerging in addressing the needs of solos?
4. What can we learn from work on other initiatives or efforts on related topics that can guide the work on solos?

This summary of literature about solos is grouped according to five main sections:

- Terminology and background
- Systems and policy
- Medical systems involvement
- Other partnerships
- State plans on aging and multi-sector blueprints

TERMINOLOGY AND BACKGROUND

Adults Without Advocates and the Unrepresented: A Narrative Review of Terminology and Settings

Brenner, R., Cole, L., Towsley, G. L., & Farrell, T. W. (2023). Adults without advocates and the unrepresented: A narrative review of terminology and settings. *Gerontology and Geriatric Medicine, 9*. https://doi.org/10.1177/23337214221142936

The authors completed a review of literature to catalog widely used terminology for adults without advocates, as well the range of settings in which individuals may require support. Relevant to this study are the authors' references to the multiple systems that interact with adults without proxies or advocates. They explained that using consistent terminology "can allow community services and health care systems to identify patients who could become unrepresented" (p.5). They also found that such efforts must "span the continuum of health care settings and professions, and link with legal services, social services, and other community-based supports" (p. 5) in order to successfully meet the needs of the individuals who may need "medical, social, financial, and legal supports" (p. 7). The authors also urged additional cross-sector collaborations (p. 7).

Unrepresented Older Adults: A Critical Review and Future Agenda in the Context of the Quintuple Aim

Brenner, R., Dixon, J., & Farrell, T. W. (2024). Unrepresented older adults: A critical review and future agenda in the context of the quintuple aim. *Current Geriatrics Reports*, *13*(1), 10–17. https://doi.org/10.1007/s13670-024-00406-x

In this 2024 article, the authors state that their review of recent literature indicates that "unrepresented" is the preferred term for referencing older adults without advanced care directives or surrogates.

2023 Solo Agers: Attitudes and Experiences

Childs, S. (2023). *2023 Solo agers: Attitudes and experiences*. AARP Research. https://doi.org/10.26419/res.00602.001

This report outlines recent research completed by AARP on solo agers. While many of the findings are not new to the body of work on this subject by Linda Camp and Wilder Research, the focus on vulnerabilities and advanced care directives may illuminate prospects for further investigating the ways in which health care and legal systems

respond to the needs of solos. It could also support efforts to make the case for new legislative language and actions.

Of note are the following findings:

- "Solo agers are more concerned than other adults 50-plus about potential negative occurrences as they age, especially dying alone and being moved somewhere against their will. They are also more concerned than in 2020 about scams, medical wishes, their possessions, and strangers making their decisions" (p.15).
- "Most solo agers have a primary care doctor (88%), and that doctor tends to know they live alone (87%). Fewer than half (45%) have shared a copy of their living will or advance treatment directive with their doctor, lower among those in their 50s (32%)" (p. 37).
- "Less than half (41%) have a living will or advance treatment directive, down from 2020 (50%)" (p.6).

SYSTEMS AND POLICY

Caring for Unbefriended Older Adults and Adult Orphans: A Clinician Survey

Farrell, T. W., Catlin, C., Chodos, A., Naik, A., Widera, E., & Moye, J. (2021). Caring for unbefriended older adults and adult orphans: A clinician survey. *Clinical Gerontologist*, *44*(4), 494–503. https://doi.org/10.1080/07317115.2019.1640332

Innovations in interprofessional education and practice, as well as transdisciplinary approaches such as collaboratives involving stakeholders including the health professions, legal system, and community advocates, are needed to promote uniformity in legal standards for unbefriended adults and to improve communication across disciplinary silos (p. 9).

The authors report on a study implemented as a follow-up to the AGS position statement, to hear directly from clinicians. Key findings relevant to this study include the following:

- Clinicians reported a high degree of awareness of solos and high rates of clinical encounters with solos (p. 6).
- Clinicians reported that risk management officers were more often available for consultation in inpatient settings (p. 6).
- The authors suggested that "identification of [solos] should become a health care policy priority" (p.8), including standard alerts in electronic health care records.

- "Models of care in which social workers are embedded in outpatient clinics may be particularly valuable in caring for unbefriended older adults" (p.8).

State Multi-Sector Plans for Aging Can Promote a More Coordinated "Ecosystem" for Older Adults

Graham, C. (2025). State multi-sector plans for aging can promote a more coordinated "ecosystem" for older adults. *Generations Journal, 49*(1). https://generations.asaging.org/mpas-promote-coordinated-ecosystem-elders

The author highlights the importance of ecosystems, or cross-sector collaborations, to develop cost effective and secure systems of services and supports for older adults, and promote policy changes. Ecosystems are particularly critical now, in light of the changes in federal funding for vital programs (para.1).

The author also suggests that state multi-sector plans on aging are uniquely positioned to facilitate the development of ecosystems, given their existing roles in coordinating efforts of various state government entities, for profit and nonprofit agencies, and other stakeholders. According to the author, "Multisector Plans for Aging hold the promise of building and sustaining high-level policy structures for coordinating comprehensive systems that prioritize the needs of older adults" (para. 14). Given their locus of control, state-backed initiatives may also have the greatest opportunities to influence the transformation of systems (para. 13).

Barriers in Health and Social Care Access and Systems Navigation Among Older Adults Without Advocates: A Scoping Literature Review and Framework Synthesis

Kervin, L. M., Riadi, I., Chamberlain, S. A., Teo, K., Churchill, R., Beleno, R., Hung, L., & Cosco, T. D. (2023). Barriers in health and social care access and systems navigation among older adults without advocates: A scoping literature review and framework synthesis. *Journal of Population Ageing*. https://doi.org/10.1007/s12062-023-09430-9

In this scoping review, the authors discussed dimensions within systems that can improve or hinder solos' access to health care, and services and supports. These key dimensions include approachability, acceptability, availability and accommodation, affordability, and appropriateness (p.18). Of these, appropriateness is most relevant to this project.

The authors point out that even when services are available, solos may be less likely to access those services if they are not aligned with their needs and circumstances. They reference systems designed with an assumption of the presence of informal caregivers, and suggest that "preventative models promoting individualized care planning, early risk-identification, and targeted intervention better allow adults to age well within their

communities, regardless of informal care availability" (p. 25). In short, promoting cross-sector collaborations, flexible service delivery models, and a tailored approach to meeting the individual needs and preferences of solos can improve their access points within the systems that provide care, and support their independence and agency.

Creating a Harmonious Age-Friendly Ecosystem that Delivers

Phillips, K., Wolfe, M., & Shue, J. (2025) Creating a harmonious age-friendly ecosystem that delivers. *Generations Journal, 49*(1) https://generations.asaging.org/creating-age-friendly-ecosystem-delivers

Changes in policy and systems that lead to effective support and care for older adult health and well-being require collaboration and coordination across all sectors (para. 3).

A promising new framework—The Age-Friendly Ecosystem (AFE)—is boosting an approach that includes multiple sectors, with the goal of a cohesive system of care and supports for older adults.

Elements from the following five themes from an AFE convening may be related to the nascent collaboration with colleagues at Consortium for Aging Policy Research and Analysis (CAPRA) and could potentially be applied to this project.

1. **Build relationships and trust**

   Key action - Take measures to understand multi-sector organizations' "unique goals, challenges, priorities…and areas of expertise" (para.10-11)

2. **Foster leadership engagement**

   Key action – Engage leaders across multiple sectors to facilitate coordination and collaboration, and share ownership (para.13-14)

3. **Explore opportunities for collaboration and addressing challenges and barriers**

   Key action – Evaluate opportunities to take action, including with partnerships through work on Multi-Sector Plans on Aging (para.15-16)

4. **Identify or develop innovative tools and resources**

   Key action – Create a clearinghouse of information and best practices, so that organizations can more efficiently apply solutions (para.12)

5. **Consider advocacy opportunities**

   Key action – Establish areas of alignment to more effectively advocate for policy and systems change (para.17)

Patient Advocates – A New Player in the Solo Safety Net

Young, M. (2021, November 9). *Patient advocates – A new player in the solo safety net*. The Davis Financial Group. https://www.davisfinancialgroup.com/soloist/patient-advocates-a-new-player-in-the-solo-safety-net

The author describes patient advocates, a new group of professionals who are poised to support solos in navigating health care, acknowledging that "systems [aren't] always listening. That includes not just medical professionals and institutions, but also insurers, billing departments, and benefit programs such as SSI and Medicare" (para. 3).

The author also references the work of Ailene Gerhardt and her Solo Agers Advocacy Initiative, which focuses on creating more awareness and inclusion of solos within professional service sectors. While associated with paid professional services rather than the broader system perspective of this study, the author offers the following related summary of Gerhardt's approach related to a systems' perspective:

> **Too often providers are dimly aware of Solos, but have no idea how that population differs from the couples and families they typically serve. They might not realize that the language and client tools they use—or even their websites—may be irrelevant to Solos or appear to be exclusionary or even offensive.**
>
> **Working with Solos individually or in small groups isn't enough, she says. Not everyone can afford this out-of-pocket expense, nor is it widely available. The entire landscape of professionals, institutions, community services, and public policies—in fact, all of the systems that have anything to do with aging—will need to wake up to a demographic reality: The percentage of older adults who are Solo has grown and will continue to grow. Every node in the elder-support network—from senior housing to financial and state planning and other legal services—needs to be asking itself this question:**
>
> ***How well do we understand what Solos need and want? And how well are we addressing it?*** **(para. 12 & 13)**

MEDICAL SYSTEMS INVOLVEMENT

Wishard Volunteer Advocates Program: An Intervention for At-Risk, Incapacitated, Unbefriended Adults

Bandy, R., Sachs, G. A., Montz, K., Inger, L., Bandy, R. W., & Torke, A. M. (2014). Wishard Volunteer Advocates Program: An intervention for at-risk, incapacitated, unbefriended adults. *Journal of the American Geriatrics Society*, *62*(11), 2171–2179. https://doi.org/10.1111/jgs.13096

In Indiana, 2004 legislation established the legal framework for the Volunteer Advocates for Seniors or Incapacitated Adults (VASIA) program. The authors conducted a study in 2014 to document an initiative implemented within a health care system to respond to the needs of vulnerable adults in need of advocacy. Trained volunteers acted as surrogates for solos who became patients at a hospital. Results indicated that acute and emergency care rates declined, while reimbursement rates increased. The model was deemed "an efficient and quality mechanism for providing unbefriended individuals with surrogates" (p. 2171).

Making Medical Decisions for Incapacitated Patients Without Proxies: Part II

Blackstone, E., Daly, B. J., & Griggins, C. (2020). Making medical decisions for incapacitated patients without proxies: Part II. *HEC Forum*, *32*(1), 47–62. https://doi.org/10.1007/s10730-019-09388-2

The authors discussed the challenges faced by health care institutions when a patient is without a person to speak on their behalf. They noted that "individual institutions have likely developed their own procedures for patients without proxies, but their protocols are not widely disseminated and their outcomes are understudied" (p. 48). Using case studies, the authors explored the engagement of an ethics committee of volunteers serving as surrogates for patients without proxies within one hospital.

Elder Orphans Hiding in Plain Sight: A Growing Vulnerable Population

Carney, M. T., Fujiwara, J., Emmert Jr., B. E., Liberman, T. A., & Paris, B. (2016). Elder orphans hiding in plain sight: A growing vulnerable population. *Current Gerontology and Geriatrics Research*, *2016*(1). https://doi.org/10.1155/2016/4723250

While the term the authors use—elder orphan—is no longer considered current, their suggestion that medical providers routinely screen for solo status is increasingly relevant.

The authors make the case for the importance for health care providers and government agencies to understand the unique needs of older adults who may be isolated and with no close family member or other advocate to help them navigate medical care. They also recommend, in addition to standard screening questions about health and well-being and social connectedness, that medical providers create a detailed treatment plan that is based on the unique needs and personal goals of each individual. Their point is that this level of detailed planning can support solos in advocating for themselves while also helping medical providers offer appropriate care without delays.

Unrepresented Adults Face Adverse Healthcare Consequences: The Role of Guardians, Public Guardianship Reform, and Alternative Policy Solutions

Catlin, C., Connors, H. L., Teaster, P. B., Wood, E., Sager, Z. S., & Moye, J. (2022). Unrepresented adults face adverse healthcare consequences: The role of guardians, public guardianship reform, and alternative policy solutions. *Journal of Aging & Social Policy*, *34*(3), 418–437. https://doi.org/10.1080/08959420.2020.1851433

The authors' focus is on the important role of guardians to speak on behalf of "unrepresented adults" in health care settings, citing additional research about the long-term impacts on individuals' health outcomes and strains on the medical system of longer hospital stays and delays in receiving appropriate care for solo adults with no representatives.

Relevant to the current work on solos in Minnesota, however, the authors also call for multidisciplinary teams to develop solutions to effectively and quickly address the needs of diverse solos, noting that guardianship is not the best solution for everyone.

American Geriatrics Society Position Statement: Making Medical Treatment Decisions for Unrepresented Older Adults

Dixon, J. D., Josyula, A. V., Javier, N. M., Zweig, Y., Singh, M., Kim, L., Thothala, N., & Farrell, T. W. (2024). American Geriatrics Society position statement: Making medical treatment decisions for unrepresented older adults. *Journal of the American Geriatrics Society*, *73*(5). https://doi.org/10.1111/jgs.19288

The American Geriatrics Society published the following five policy recommendations and five pieces of advice for clinical practice, intended to guide health care systems, practitioners, and policymakers. Relevance to this study includes additional insight into context and potential opportunities for further investigation.

Policy recommendations include the following:

- “The term 'unrepresented' should replace the term 'unbefriended' when referring to a person who (1) lacks decisional capacity to provide informed consent to a particular medical treatment; (2) has not executed an advance directive that addresses the medical treatment at hand and lacks capacity to do so; and (3) lacks representation from a surrogate decision maker (i.e., family, friend, or legally authorized surrogate).
- National stakeholders should work together to identify best practices and to create more uniform legal standards regarding unrepresented older adults that could be considered for adoption by all states.
- States should expand their laws to explicitly allow nontraditional surrogates to serve as representatives for older adults, and clinicians and health care institutions should advocate for the inclusion of nontraditional surrogates whenever appropriate.
- Clinicians, healthcare organizations, communities, and other stakeholders should work proactively to prevent older adults without potential surrogates from becoming unrepresented.
- Clinicians, healthcare organizations, communities, and other stakeholders should develop innovative, efficient, and accessible approaches to promote adequate protections and procedural fairness in decision making for unrepresented older adults” (p.1356).

Clinical practice advice includes the following:

- “Medical decision making for unrepresented older adults should include adequate safeguards against *ad hoc* approaches, seek consensus where possible, and ensure procedural fairness.
- Clinicians should assess medical decision-making capacity in a systematic fashion.
- Clinicians and healthcare institutions should develop, standardize, and systematize methods to make decisions for unrepresented older adults in urgent, life-threatening situations.
- Clinicians and healthcare institutions should ensure that patients with long-term incapacity have longitudinal access to a decision-making surrogate who is familiar with the patient's medical condition and specific circumstances.
- When applying the best interest standard to unrepresented older adults, institutional committees should synthesize all available evidence, and should take steps to guard against perpetuating forms of potential bias in decision making for this highly vulnerable population” (p.1356).

OTHER PARTNERSHIPS

Solo Agers Can Find Independence in Planning and Advocacy

Einhart, E. J., Flynn, J. M., & Flowers, R. K. (2023, June 21). Solo agers can find independence in planning and advocacy. *Generations Journal*, 47(2). https://generations.asaging.org/solo-agers-find-independence-planning

The authors explain the critical role of attorneys in establishing protections and provisions for solos. Legal documents, in particular, completed with the assistance of attorneys, can create a framework that will support self-agency and choices.

Medical-Legal Partnerships and Prevention: Caring for Unrepresented Patients Through Early Identification and Intervention

Lively, C. L. P. (2024). Medical-legal partnerships and prevention: Caring for unrepresented patients through early identification and intervention. *HEC Forum*, *36*(4), 527–539. https://doi.org/10.1007/s10730-023-09518-x

The author makes a case for multi-disciplinary (multi-system) preventative measures that may reduce the number of *unrepresented adults* or solos, and address legal and ethical considerations. As such, the author suggests that partnerships with health care and legal professionals offer solutions that can address multiple perspectives, including person-centered supports for solos and risk-management for health systems.

Solo Aging: Long-term Care Concerns

Migliaccio, J. N. (2024). Solo aging: Long-term care concerns. *Journal of Financial Service Professionals*, *78*(2), 24–28.

The author makes the case for the role of financial professionals as key players in a network of supports for solos, in addition to health care and legal perspectives. Financial stability, based on planning, can contribute to self-agency and well-being.

STATE PLANS ON AGING AND MULTI-SECTOR BLUEPRINTS

Note: State-level information, in alphabetical order, is shared here when plan language references solos or another term associated with this topic.

California

California Department of Aging. (2021, January). *Master plan for aging*. https://www.aging.ca.gov/download.ashx?lE0rcNUV0zYXf9JtT7jkAg%3d%3d

The California Master Plan for Aging specifically mentions the numbers of solos older adults:

> **1.8 million Californians age 60 and older live alone**
>
> **The number of people aging alone is increasing (p. 6).**

Minnesota

The Minnesota Board on Aging. (2023). *Minnesota State Plan on Aging FFY 2024-2027*. https://mn.gov/board-on-aging/assets/FFY2024-2027%20State%20Plan%20on%20Aging_Amendment_1_tcm1141-632575.pdf

Written in 2023, the Minnesota State Plan on Aging includes multiple references to solo older adults, including work completed by The Citizens League and Linda Camp.

The executive summary addresses the MN Board on Aging's commitment to advancing equity and addressing disparities in populations with the greatest social and economic needs, and includes individuals who "identify as solo (defined as individuals who, by choice or circumstance, function without the support system traditionally provided by family)" (p.3).

Another key reference is located in the main goal to promote and support healthy aging for all Minnesotans:

> **Objective 4.2 Strategize and develop effective supports for solos**
> **a. Explore expanding and creating roles to support solos, such as expansion of Caregiver Consultant and Community Health Worker services, and creation of Personal Health Decisions Assistants, including utilizing AmeriCorps Senior (especially RSVP)**
> **b. Promote supported decision-making models that prioritize individual choice and autonomy related to issues such as financial decisions, advanced care planning, and family relationships, among others**
> **c. Expand language (in policies, on forms, etc.) to be inclusive of solos (p. 30)**

Minnesota

Age Friendly Minnesota. (n.d.). *Minnesota's Multisector Blueprint for Aging.* https://irp.cdn-website.com/2c41a412/files/uploaded/Minnesota_Multisector_Blueprint_Report_V1-1_03312025.pdf

The Minnesota plan includes two references to solo adults:

> Domain 2: Emergency, preparedness, individual rights and safety
> *Strategy A, Objective 2.* "4a. Prepare for the growing number of people in the community who may need greater assistance in emergencies; this should include identifying 'solos'" (p. 6).
>
> Domain 3: Optimized health and longevity
> *Strategy D, Objective 1.* "2. Strengthen caregiver relationships and social connections to reduce isolation and family strain. Caregivers are often burdened with decisions and lack of support from family and/or friends. a) Ensure supports are inclusive of solos, LGBTQ+ individuals, and other underrepresented communities" (p.13).

Pennsylvania

Pennsylvania Department of Aging. (n.d.). *Aging Our Way, PA: A plan for lifelong independence.* https://www.pa.gov/agencies/aging/aging-our-way-pa.html

The Multisector Plan for Aging (MPA) for Pennsylvania acknowledges changing demographics and describes MPAs in the following way:

> **MPAs allow states to plan for the rapidly growing population of older adults, as well as the various compounding demographic shifts like increasing racial and ethnic diversity, increasing rates of solo aging, and greater longevity among the oldest of the older adult cohort (p. 6).**

Utah

Utah Commission on Aging. (2024). *Utah for the Ages: A master plan for aging in Utah.* https://ucoa.utah.edu/_resources/documents/UtahfortheAges2024-DRAFTv231222.pdf

The Master Plan for Aging from Utah includes a section entitled *Plan for Life – Personal Empowerment.* Priorities outlined in this section focus on advanced care planning, including participation policies around the use of the documents. One priority references solos:

- "Decrease incidents of orphaned and unbefriended adults in health care decisions" (p. 27)

Vermont

Vermont Department of Health. (2024). *Age Strong VT: Our roadmap for an age-friendly state. Vermont's Multisector Plan on Aging: 2024-2034.* https://www.healthvermont.gov/sites/default/files/document/hpdp-bh-age-strong-roadmap2024-2034.pdf

In making the case for the importance of a multi-sector plan on aging, the report notes:

> **For example, the percentage of adults living alone increases with age as does the percentage of those experiencing cognitive decline (p.4).**

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Appendix

A. DATA TABLES

A1. Demographic characteristics of solos in Minnesota (N=515,315)

	Percentage
Region	
Twin Cities 7-County Metro area	54%
Greater Minnesota	46%
Arrowhead Area Agency on Aging (NE)	*21%*
Central Minnesota Council on Aging (Central)	*24%*
Dancing Sky Area Agency on Aging (NW)	*17%*
Minnesota River Area Agency on Aging (SW)	*18%*
Southeast MN Area Agency on Aging (SE)	*19%*
Race and ethnicity	
Of color	12%
White (not Hispanic or Latino)	88%
Hispanic (of any race)	*2%*
Gender	
Male	43%
Female	57%
Marital status	
Divorced	37%
Never married/single	29%
Widowed	28%
Married, no spouse present	4%
Separated	2%
Educational attainment	
Less than high school diploma	7%
High school diploma	29%
Some college, no degree	24%
Associate degree	10%
Bachelor degree or higher	31%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A1. Demographic characteristics of solos in Minnesota (N=515,315) (continued)

	Percentage
Generations (N=515,315)	
Generation X (1965-1982) (N=130,049)	25%
Baby Boomer (1946-1964) (N=258,460)	50%
Silent/Greatest (1945 & earlier) (N=126,806)	25%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A2. Health characteristics of solos in Minnesota (N=515,315)

	Percentage
Disabilities status - general	
Without a disability	71%
With any disability	29%
One disability	*47%*
Two or more disabilities	*53%*
Types of disabilities[a] (N=147,773)	
Ambulatory	59%
Independent living	38%
Hearing	33%
Cognitive	30%
Self-care	19%
Vision	15%
Health care coverage[a]	
Any health care coverage	96%
Private health care coverage	68%
Public health care coverage	65%
Types of public health care coverage[a] (N=334,812)	
Medicare	87%
Medicaid	25%
Veteran's Administration (VA)	8%
Indian Health Service	1%

[a] Percentages do not total 100; respondents could choose multiple responses

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A3. Economic characteristics of solos in Minnesota (N=515,315)

	Percentage
Total personal median income (2023 dollars): $40,682	
Employment status	
Not in the labor force	55%
Employed	43%
Unemployed	2%
Full- or part-time employment status (N=222,476)	
Full-time, year-round employment	70%
Part-time and/or part-year employment	30%
Types of income received	
Social Security income	52%
Wage and salary income	45%
Retirement income	35%
Interest, dividend, and rental income	24%
Other personal income	9%
Supplemental Security income	6%
Business and farm income	6%
Welfare (public assistance) income	4%
Poverty status	
Above 200% of poverty	63%
At or below 200% of poverty	35%
Poverty status is not determined	2%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A4. Demographic characteristics of solos in Minnesota by generation (N=515,315)

	Generation X (1965–1982) N=130,049	Baby Boomer (1946-1964) N=258,460	Greatest (1945 and earlier) N=126,806
Region			
Twin Cities 7-County area	58%	53%	50%
Greater Minnesota	42%	47%	50%
Arrowhead Area Agency on Aging (NE)	*19%*	*23%*	*21%*
Central Minnesota Council on Aging (Central)	*25%*	*24%*	*23%*
Dancing Sky Area Agency on Aging (NW)	*15%*	*17%*	*18%*
Minnesota River Area Agency on Aging (SW)	*17%*	*17%*	*20%*
Southeast MN Area Agency on Aging (SE)	*23%*	*19%*	*18%*
Race and ethnicity			
Of color	22%	10%	4%
White (not Hispanic or Latino)	79%	90%	96%
Hispanic (of any race)	*5%*	*2%*	*1%*
Gender			
Male	58%	44%	28%
Female	43%	56%	72%
Marital status			
Never married/single	55%	27%	8%
Divorced	34%	46%	20%
Widowed	2%	21%	69%
Married, no spouse present	5%	3%	3%
Separated	3%	2%	<1%
Educational attainment			
Less than high school diploma	5%	6%	10%
High school diploma	21%	28%	40%
Some college, no degree	24%	25%	21%
Associate degree	13%	10%	5%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A5. Health characteristics of solos in Minnesota by generation (N=515,315)

	Generation X (1965–1982) N=130,049	Baby Boomer (1946-1964) N=258,460	Greatest (1945 and earlier) N=126,806
Disabilities status - general			
Without a disability	82%	76%	51%
With any disability	18%	24%	49%
One disability	*49%*	*50%*	*44%*
Two or more disabilities	*51%*	*50%*	*56%*
Types of disabilities[a]	**N=23,351**	**N=62,228**	**N=62,194**
Ambulatory	42%	63%	63%
Cognitive	56%	31%	19%
Independent living	39%	30%	47%
Hearing	17%	29%	44%
Self-care	21%	16%	22%
Vision	14%	16%	15%
Health care coverage[a]			
Any health care coverage	91%	97%	100%
Private health care coverage	71%	63%	72%
Public health care coverage	23%	69%	100%
Types of public health care coverage			
Medicare	7%	60%	100%
Medicaid	18%	18%	11%
Veteran's Administration (VA)	3%	6%	8%
Indian Health Service	1%	1%	<1%

[a] Percentages do not total 100; respondents could choose multiple responses

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A6. Economic characteristics of solos in Minnesota by generation (N=515,315)

	Generation X (1965–1982) N=130,049	Baby Boomer (1946-1964) N=258,460	Greatest (1945 and earlier) N=126,806
Total personal median income (2023 dollars)	**$53,000**	**$39, 995**	**$30,500**
Employment status			
Employed	82%	42%	5%
Not in the labor force	14%	56%	95%
Unemployed	4%	2%	<1%
Full- or part-time employment status	**(N=106,907)**	**(N=108,960)**	**(N=6,609)**
Full-time, year-round employment	80%	64%	24%
Part-time and/or part-year employment	20%	36%	76%
Types of income received			
Wage and salary income	83%	45%	6%
Social Security income	5%	55%	94%
Retirement income	6%	38%	59%
Interest, dividend, and rental income	12%	23%	38%
Other personal income	7%	9%	10%
Business and farm income	9%	6%	2%
Supplemental Security income	5%	7%	5%
Welfare (public assistance) income	5%	4%	2%
Poverty status (at 200% of poverty)			
Above 200% of poverty	74%	62%	54%
At or below 200% of poverty	23%	36%	44%
Poverty status not determined	2%	2%	2%

Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

A7. Regional hospital capacity, Minnesota (2023)

Note: See also Map B4

SCHSAC Region	Number of hospitals	Available beds	Available beds per 1,000 population
Central	18	997	1.4
Metro	22	5,792	1.8
Northeast	17	1,120	3.4
Northwest	12	301	1.8
South central	14	463	1.6
Southeast	10	1,662	4.0
Southwest	23	535	2.4
West central	9	323	1.9
TOTAL	**125**	**11,193**	**2.1**

Sources: 2022 American Community Survey 5-year Estimates and MDH Health Economics Program analysis of hospital annual reports, Nov. 2024.

From Minnesota Department of Health, Health Economics Program, Chartbook Section 8A. (https://www.health.state.mn.us/data/economics/chartbook/docs/section8a.pdf)

A8. Group quarters for all adults born in 1982 or earlier, Minnesota

	TOTAL N=2,829,063	Generation X (1965–1982) N=1,257,525	Baby Boomer (1946-1964) N=1,222,903	Greatest (1945 and earlier) N=348,635
Living in group quarters[a]	2%	1%	2%	8%

[a] Defined by ACS as institutional and noninstitutional facilities such as nursing homes, hospitals, prisons, group homes, shelters, missions

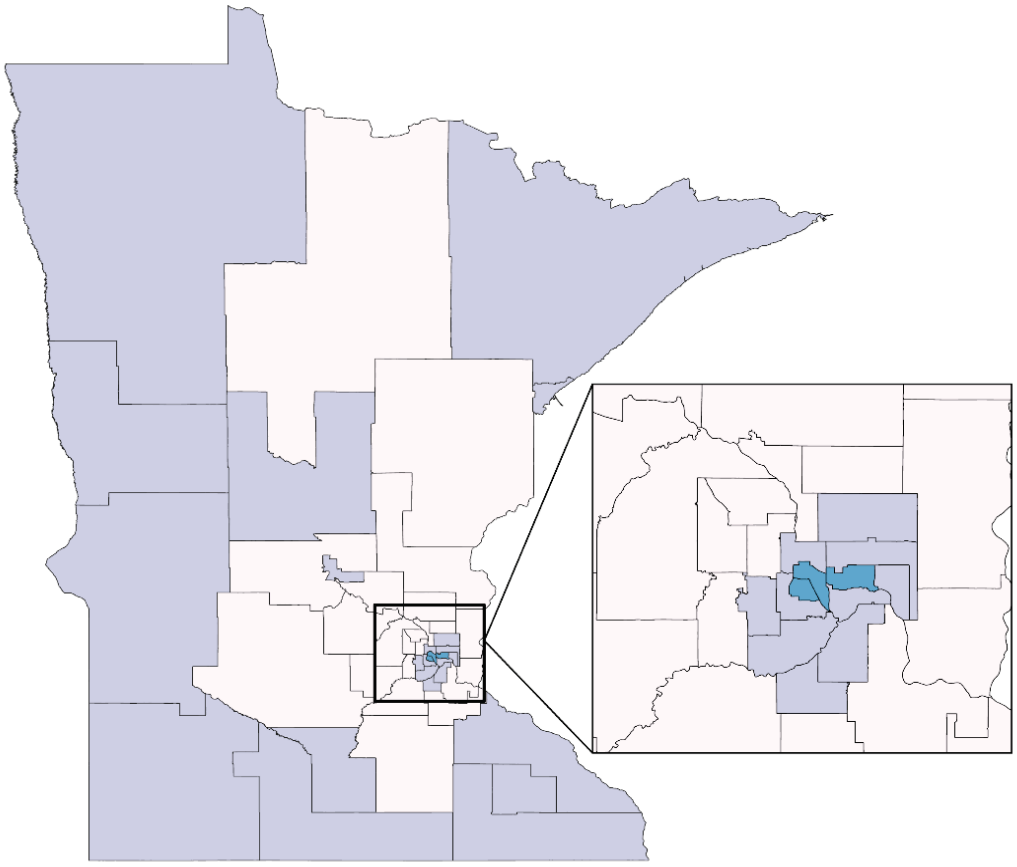
Source: Integrated Public Use Microdata Series from the U.S. Census Bureau's American Community Survey, 2019-2023

B. MAPS

All maps are included here to provide visual summaries about the geographic location of solos in the state, as well as overall status of health care access in Minnesota.

Note: Public Use Microdata Areas (PUMAs) geographic designations are used as alternatives to counties for grouping data, based on population density, and are the standard geographic reporting unit for the United States decennial censuses (Maps B1-B3).

B1. Percentage of solo households headed by a member of Generation X, Minnesota

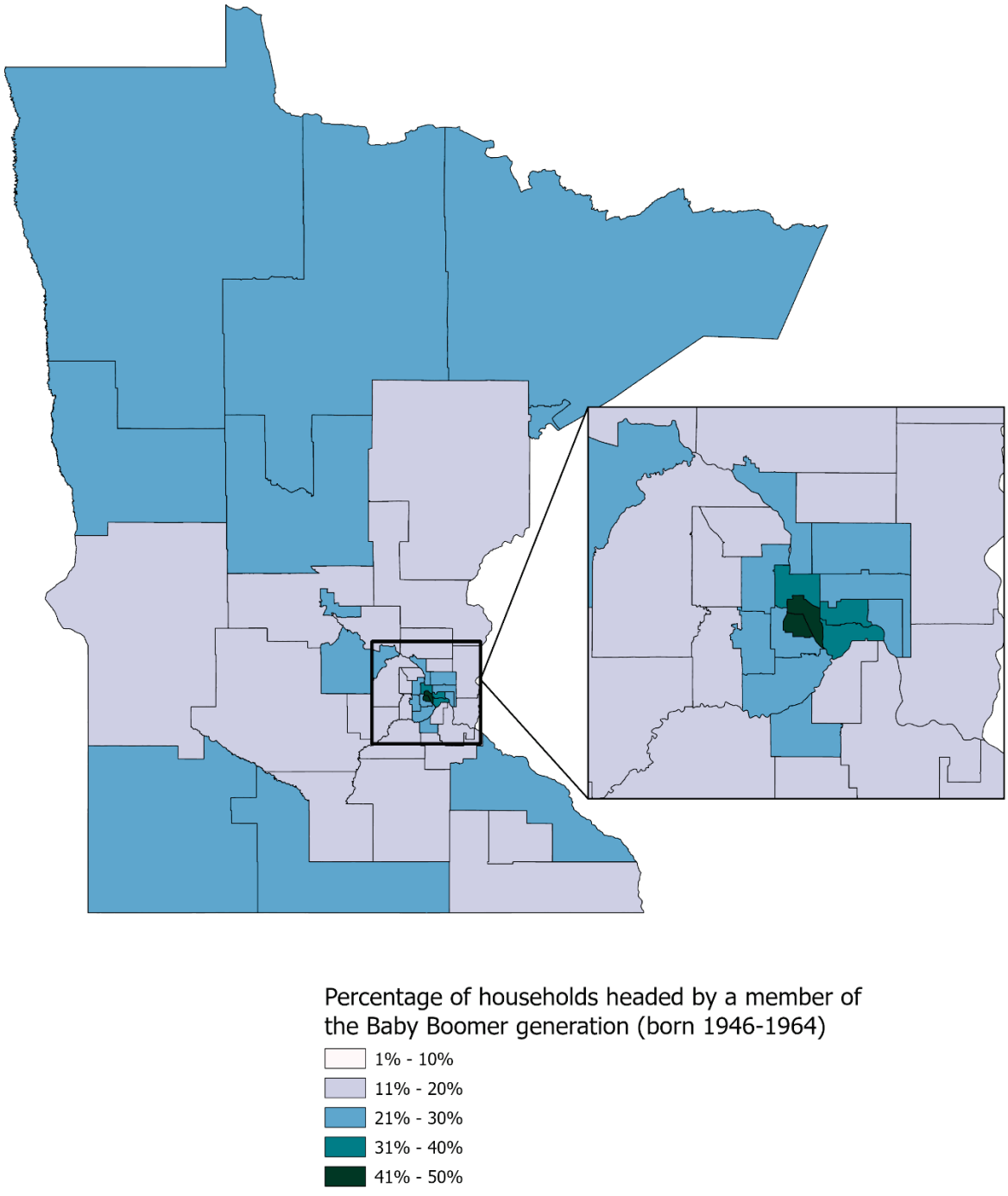


Percentage of solo households headed by a member of the Gen X generation (born 1964-1982)

- 1% - 10%
- 11% - 20%
- 21% - 30%
- 31% - 40%
- 41% - 50%

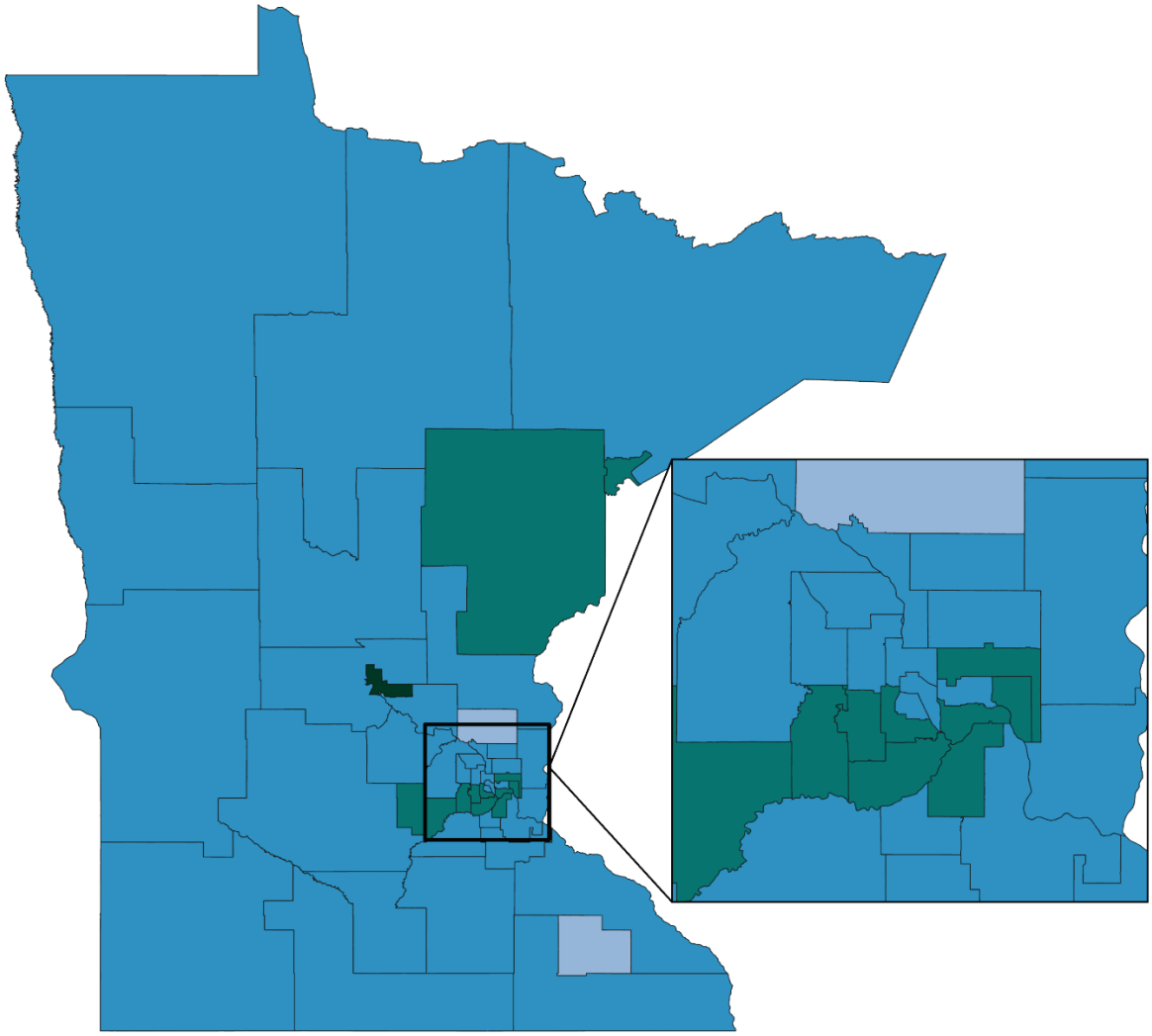
SOURCE: IPUMS USA, University of Minnesota, www.ipums.org. Calculations by Minnesota Compass. Wilder Research

B2. Percentage of solo households headed by a member of the Baby Boomer generation, Minnesota



Source: IPUMS USA, University of Minnesota, www.ipums.org. Calculations by Minnesota Compass, Wilder Research.

B3. Percentage of solo households headed by a member of the Greatest generation, Minnesota



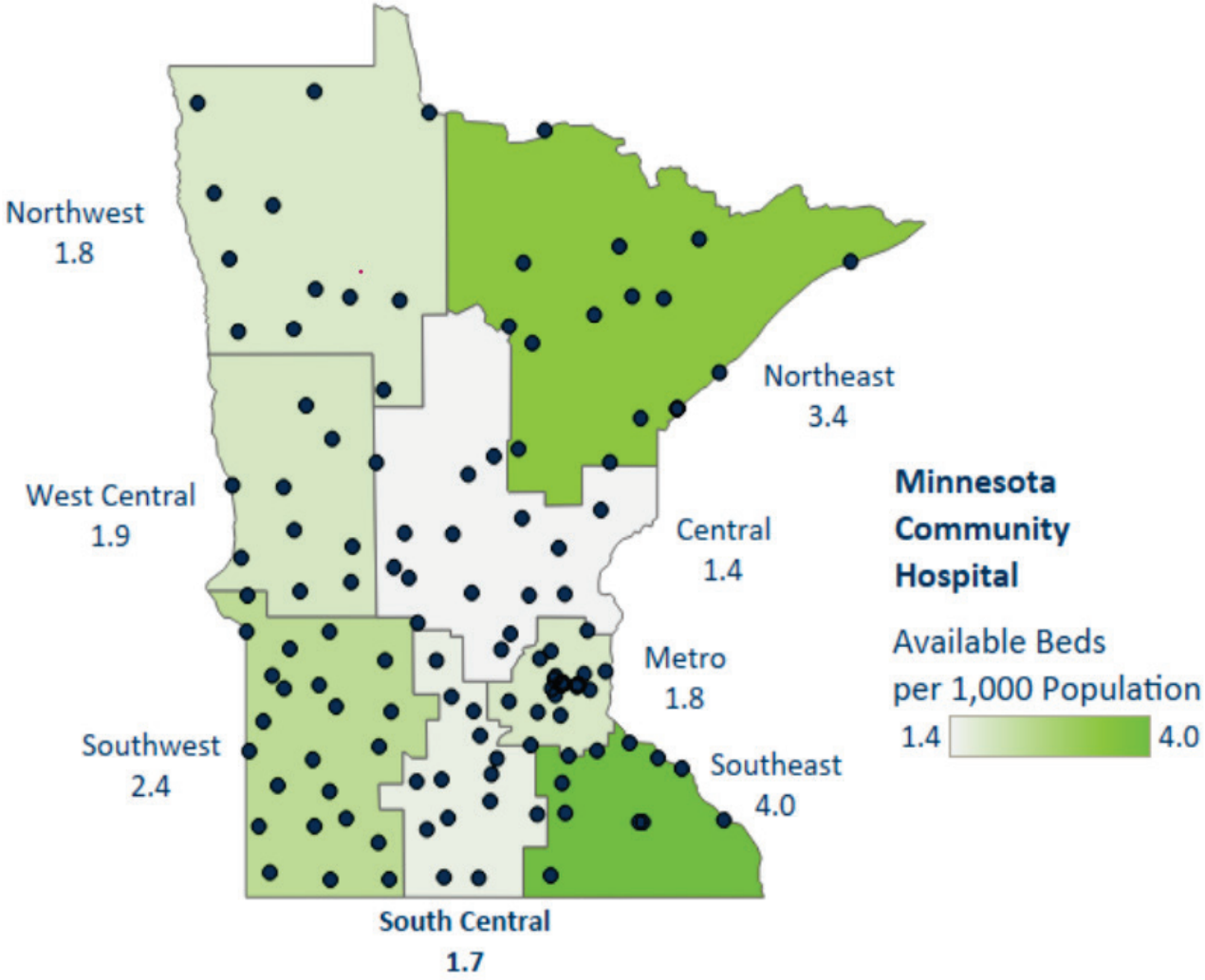
Percentage of household headed by a member of the Silent/Greatest generation (born before 1946)

- 1% - 10%
- 11% - 20%
- 21% - 30%
- 31% - 40%
- 41% - 50%
- 51% - 60%

Source: IPUMS USA, University of Minnesota, www.ipums.org. Calculations by Minnesota Compass, Wilder Research.

B4. Hospital beds per 10,000 population, Minnesota State Community Health Services Advisory Committee (SCHSAC) regions (2023)

Note: See also Table A7



Sources: 2022 American Community Survey 5-year Estimates and MDH Health Economics Program analysis of hospital annual reports, Nov. 2024.

From Minnesota Department of Health, Health Economics Program, Chartbook Section 8A. (https://www.health.state.mn.us/data/economics/chartbook/docs/section8a.pdf)

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