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Planning for Aging Services: Implications of Recent Amendments to the Older Americans Act (With 2019 Postscript)

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Implications of Recent Amendments to the Older Americans Act[1]
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The 1978 Amendments to the Older Americans Act called for the establishment of social planning, greater emphasis on the needs of the frail elderly ("those in greatest social and economic need"), the establishment of community "focal points" and "comprehensive and coordinated service delivery systems" in rural and urban communities. The amendments were implemented in the 1980 guidelines to Area Agencies on Aging. In this unpublished paper portions of which were presented at several conferences, a Guttman Scaling Technique developed in rural New York state was used to examine the development of aging services in 13 counties in North Central West Virginia. A 2019 postscript to this paper notes the "medicalization" of aging services since the original paper.

Introduction

It is not often that the interests of practitioners and academics are truly merged in a single issue. Despite all the pious hopes of academically based policy scientists of various disciplines during the past decade and the sincere efforts of numerous policy makers at all levels, the vision of informed, enlightened policy decisions is still largely a hoped-for ideal rather than a working reality through the American political system.

This is all the more reason to sit up and take note when a genuine practical and theoretical convergence occurs on a single issue – as it does in the case of the subject of this paper. The question of service continua is one of the central dimensions of both theoretical work on the nature of the American community and applied research on the question of the design of comprehensive, coordinated service delivery systems. In the case of services for the aged a similar set of concerns has been written into policy through the 1972 and 1978 Amendments to the Older Americans Act and were implemented for the first time in 1980, when the guidelines for the 1978 Amendments were issued on March 31 (DHEW, 1980).

The 1978 Older Americans Act Amendments

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The 1978 Amendments to the Older Americans Act raise a number of critical issues for the delivery of services in rural areas. Some of the key provisions of those amendments need to be identified here:

First and most importantly for our purposes, Congress specifically and explicitly stipulated that greater attention must be paid to the needs of the rural aged and attempted to ensure such additional attention by mandating that future expenditures in rural areas in each state be at least 105 percent of the FY 1978 levels (DHEW, 1980, pp. 21132 and 21152). A major problem with this however, is that the law and the guidelines fail to make clear whether this means that there should be more attention to actually locating aging services in rural areas,(thereby presumably making those areas less rural) or that more services must be available to rural residents. This ambiguity in federal policy is of particularly critical importance with respect to the concept of *community focal points* as noted below.

In the state of West Virginia, this ambiguity over how to implement priorities in rural areas also entered debate over how funds were to be divided among the seven Area Agencies on Aging (AAAs) in the state, with the two predominantly urban and the five predominantly rural AAAs at odds over this question. A workable compromise formula for distribution of funds could not be arrived at during FY 1981 but by the following year a compromise agreement acceptable to all parties seems to have been worked out. The question of distribution of funds within a state is one which is clearly related to the feasibility of achieving *comprehensive and coordinated service delivery systems* in both urban and rural communities. This is a key objective of the 1978 Amendments.

A second key provision or theme of the 1978 OAA Amendments was increased emphasis on services to those in greatest need. Although the term *frail elderly* does not appear in the guidelines, this was a major contemporary interest in the Administration on Aging at the time of the amendments and thereafter. In addition, an emphasis on services to those with the *greatest social and economic need* has been part of the language of the Older Americans Act since it was first adopted in 1965. The 1980 guidelines mandate that at least one half of social service allotments to AAAs must be spend in three priority areas: outreach services designed to enhance service availability and utilization; in-home services; and community services designed to prevent or forestall premature institutionalization. A close policy analysis of these three concepts would probably reveal that they are primarily variations on a single theme, which is greater priority on the older, more frail and "problem prone" elderly and less on the younger, healthier "well elderly" leisure time users who once made up the bulk of the Administration on Aging constituency.

A third major theme of the 1978 Amendments concerns what might be termed the planning mandate for the development of *comprehensive and coordinated service delivery systems* and the elimination of duplicate and overlapping services. It should be noted that comprehensiveness sufficient to require extensive coordination

and service duplication have seldom been problematic in rural areas where aging services are seldom developed at sufficient scale for such problems to emerge.

Nevertheless it is of interest that Section 305 of the Older Americans Act defines a comprehensive and coordinated service delivery system as "a system for providing all necessary services, including nutrition, in a manner designed among other things to facilitate accessibility to, and utilization of all social services and nutrition services provided within the geographic area served by such a system by any public or private agency or organization. (DHEW, 1980, pp).

According to the 1980 guidelines, the primary means for enhancing coordination and perhaps comprehensiveness is both rural and urban areas is to be the *Community Focal Point* defined by the regulations as "a place for collocation and coordination of service delivery (DHEW, 1980, pp.). The 1980 guidelines attempt to review the controversies sparked during the review and comment period by this concept and note, somewhat coyly, that "many commenters stated that a strict interpretation of this section would have an adverse effect on rural areas." (DHEW, 1980, pp.). However, no real attempt is made to present or summarize the actual arguments offered in support of this point.

The general consensus interpretation of the Community focal point concept, at least in West Virginia and federal Region III, has been an organizational one. The concept is generally agreed to refer to a multi-purpose service center which "co-locates" a mixture of different services in a single building or set of offices. We might term this the *focal point in community* approach . This approach ignores or suppresses a number of key questions for aging planning in rural and urban areas. The most important of these is which communities among the many candidates available should be the *host site* for such multi-purpose centers and in order to achieve maximum coordination (aka efficiency and comprehensiveness (aka availability and utilization).

A Guttman Scaling Approach

The implementation of the national system of Area Aging Agencies with a high level of autonomy in decision making about programs, varying degrees of independence from federal and state control and regional variations in the nature and character of the *interconnectedness* of communities makes answering of these questions both interesting and challenging.

One approach with considerable potential for addressing this problem was suggested by Philip Taietz and involves the use of Guttman scaling procedures (Taietz, 1975). Working within the traditions and concepts of rural community research, Taietz collected data on a sample of 144 communities in New York state. The communities studied were of three types: cities villages (under 10,000) and unincorporated places. In examining the human services provided for the aged in these New York state communities, Taietz reported finding a unidimensional, cumulative system of services as measured by the Guttman scaling procedure

(Taietz, 1975). Further, the data indicated a close relationship between the sale score for a community and community size. The apparent conclusion was that communities with comprehensive services were consistently larger communities.

By its nature, Guttman scaling measures the degree to which a list of items is unidimensional and cumulative – that is, the extent to which, if a given trait is present, lower level traits can be assumed to be present also. By general convention, Guttman scale score with a Coefficient of Reliability of .9 or above and a Coefficient of Scalability of .65 or higher are considered valid (Nye, et. al., 1975). Selltiz, et. al. note however that a common problem with Guttman scales is the discovery or two or more equally valid scales with different item=orders for different samples in the same universe (Selltiz, et. al., 1959). This point is critically important in this case, because Moore, Taietz and Young (19XX) make a theoretical link between the existence of a cumulative unidimensional service delivery system in a community and the dynamics of community development:

> "If an institution is specialized it will fit into a community that has an equal or higher level of structural differentiation than that of the institution itself. Specifically, an establishment like a bank can locate in a community only when other supporting institutions such as modern transportation and communication, real estate offices, legal services and policy already exist. (Moore, Taietz & Young, 1974)

Table 1 shows the continuum of aging-related services found by Taietz in the New York State study. To the extent that this same continuum is established for other parts of the country, evidence would exist for this hierarchical infrastructure dependency argument and a major planning strategy for Area Agency on Aging would be outlined.

In other words, this approach literally suggests a kind of building block approach to planned community development in general and aging planning in particular. In this approach, universally available primary services (that is, those with the lowest Guttman scores) would be built first, while tertiary services (with the highest Guttman scale scores) would be built only on top of primary and secondary ones (with middle-range scores).

While the implications of this approach for community practice are fascinating, our primary concern here is with the policy implications involved (Taves, 1975). For example, if Taietz, et .al, have indeed discovered a standard, uniform developmental pattern for building health and human services for the aged in American communities, it would appear to be possible to construct empirical indices of given communities which might summarize current levels of community

action and community function as well as to suggest specific next steps in community development practice. This, a community which scores 10 (high) on a valid, reliable Guttman scale but lacks a nursing home (item 5) would appear to have a case for placing higher priority on development of such a nursing home than on development of a sheltered workshop.

Federal and state agencies might also use such an approach to set priorities for granting funds. Lower scoring communities would presumably have a stronger case for greater need than high scoring communities.

In addition, the Guttman scaling approach suggests a plausible general explanation for failures and deficiencies in community services. If services do not succeed, it would seem based on this hypothesis that one reason might be an inadequate or insufficiently grounded community infrastructure. Although the Taietz, et. al. research has not spelled out the underlying functional dependencies, it is not difficult to visualize them, at least in broad outline.

Thirdly, this approach suggests a specific conceptual architecture for empirically defining and measuring the concept of comprehensive and coordinated service delivery systems and community focal points in the OAA guidelines. A comprehensive service delivery system in a community could be operationally defined, for example, as one which has an adequate Coefficient of Reliability, a coordinated system could be defined as one which has a satisfactory Coefficient of Scalability and community focal points would be those organizations (or communities with the highest scores.

All of these speculations are premature, however, until we establish the utility of the scale shown in Figure 1 for settings other than New York State. At least two possible confounding influences are suspected here: regional variations in community types and state and local public policy influences.

Both of these confounding factors are suspected in West Virginia and much of the rest of the Appalachian region. The New York state sample, for example, is easily classified into cities, villages and unincorporated places by population size alone, and most of the population clearly lives in organized cities and towns. Furthermore, it would appear that towns serve as primary service enters for rural residents who live near them, and cities serve as secondary service centers for all types of residents as well as primary centers for their own residents. Thus, the task of service location is essentially one of establishing the level of the primacy of services.

The pattern of community inter-relationships is somewhat more complex and difficult in West Virginia and the rest of the Appalachian region. First, the state and region are characterized by literally thousands of unincorporated places – communities with small populations lacking (among other things) certain key basic local governmental powers. This means, in particular, a much stronger role for the county as a critical unit for the implementation of public policy (Taietz, 1973). Also, the New York pattern of small towns and cities as nested hierarchies of service centers is by no means assured in Appalachia because of local ethnocentrisms, historical differences, communication and transportation barriers and a number of other factors.

Finally, because it is a different state with fewer people, a less well established social welfare delivery system, lower tax rates and a different set of legal, legislative and administrative infrastructures, it I reasonable to speculate about additional impacts on the pattern of community services. Thus, West Virginia and the rest of Central and Southern Appalachia represent important test cases of the existing findings regarding coordinated and comprehensive systems for the aged and the underlying hypothesis of infrastructure development.

Research Design

This study began with an examination of the pattern of services found in communities in three counties of north central West Virginia – Monongalia, Marion and Preston – and was eventually extended to the entire six-county area designated by the State of West Virginia as Planning and Development Region Six, which also includes Taylor, Harrison and Doddridge counties, and then to Planning and Development Region Seven as well.

Because of the question of community definition alluded to above, the initial effort was to identify all candidate communities in the initial three counties. Using detailed highway maps of the three counties showing the locations of all organized municipalities and all buildings and landmarks in rural areas, together with key-informant interviews, a total of 171 communities were identified. Of these, two (Morgantown and Fairmont) were county seats and major regional retail service centers in the 25,000 – 50,000 population range and a third (Kingwood) was a county seat town in the 2,500-5,000 population range. In addition, six other communities had 1970 populations exceeding 1,000 and there were 162 additional verifiable communities with populations under 1,000.

The service census of this three county area found that one county seat community (Morgantown) contained all the listed services, and

two others (Fairmont and Clarksburg) contained all but one. Twenty two other communities were home to only a senior center or club while the remaining 146 communities contained no relevant services. Thus, the communities in this three county area fell into three very clearly defined categories: *Well-developed (or mature) service centers* with virtually all of the services in question (scale scores between 13 and 11); *Minimal service centers* with only a senior center or club (and scale scores of 1); and *undeveloped* communities with no relevant services (scores of 0).

While there appears to be a very strong relationship between size and development for the largest communities, the relationship between the presence or absence of senior centers is not, strictly speaking, a function of size. Our hypothesis is that another variable -proximity or closeness to a large service center – explains this relationship, and data on the distance of various communities from the mature service centers have been collected to test this relationship.

Based on examination of these three counties several conclusions were immediately apparent. First, although a limited hierarchical clustering of aging services was found, the distribution was extremely bi-modal and no real continuum – as measured by Guttman scale scores – of community types was apparent for the three counties. Thus, it was obvious that in a macro-social sense the standards and guidelines calling for co-location of services are already in effect in North Central West Virginia whether or not such co-location is the product of AoA policy. The likely impact of that policy is, in fact, doubtful since many of the services predate the 1980 guidelines and are completely independent of Aging Network control. Closer examination of organizational co-location patterns in the communities with the highest scores also suggests some tendency to co-location with five of the service categories offered by a single hospital, and another cluster of three services "co-located" in a single office building merely because the building's owner offered the spaces to the agencies at favorable, below-market prices.

However, Congressional interest in using Senior Centers as community focal points has yet to be realized and none of the other 12 service categories is presently co-located there. It is clear that these three counties do not in themselves form a comprehensive, coordinated service delivery system as detailed in the legislative guidelines because of the bimodal distribution of scores.

In the next phase, three additional counties in the southern tier of counties in Region Six were added to the investigation. Again, the county seats (Clarksburg, Grafton, and West Union) are the major service centers in each county, although one is a city in the 25,000-

50,000 range, another is in the 5,000-10,000 range and the third is a community of only slightly over 1,000.

In the case of these three counties, seventeen additional communities with satellite senior centers or clubs were identified (scale scores = 1), and no additional communities with services were identified. When the Guttman scale procedure was applied to the entire six county region using the item-order established by Taietz it was determined that a valid, reliable scale cannot be assumed for Region Six as a whole. Although a coefficient of reproducibility of .9292 was found, the coefficient of scalability of .0707 was well below the acceptable level of .65 (See Table 2).

Conclusions

Although the Guttman scaling procedure failed to provide evidence of a comprehensive, coordinated system in Region Six, a number of additional interesting conclusions appear warranted:

First, there is clearly some tendency toward of continuum of community service levels in the region, and two factors – population size and status as a county seat – together appear to account for the observed variation. Thus, the largest communities have the highest scores (and all three are also county seats). However, county seat status is also independently important. Although there are numerous smaller communities in Region Six with populations of 5,000 or less, only the two county seats (Kingwood and West Union) have more than a single service (scores greater than 1).

Secondly, the pattern of services found in Region Six does not support the building block infrastructure hypothesis. In fact, the pattern of service availability in this area instead tends to be consistent with the alternative hypothesis offered by Marvin Taves (1975) in a critical commentary on the Taietz theory. He wrote:

> There is little reason to conclude that rurality alone or principally explains the observed variance in presence of social services in a community. . . An alternative hypothesis is that presence of such facilities is associated even more directly with the availability of the financial base or a combination of such a base and appreciation for the benefits produced by the facilities or services That is, facilities tend to be present in a service area whenever there are sufficient aggregates of persons believing in or capable of paying for them (from local, state or federal, public or private resources).

In other words, it is suggested that discovery or definition of a "catchment area" or planning region large enough to encompass sufficient need to make efficient and effective service delivery possible and wealthy enough to subsidize services are the underling institutional factors involved.

In a next step the same procedures were applied to again services in Region Seven, a seven-county area in central West Virginia adjacent to Region Six, and of comparable size in total population, with a somewhat larger and more inaccessible land area, fewer urban concentrations and among the lowest income counties in the state. In Region Seven the differential effects of size and county-seat status on aging services become clearer. All seven county seats in this region – all of which are in the under 10,000 population range and yet are the largest communities in their respective counties. A total of 128 communities were identified in the seven counties, the majority of which scored 0 on the scale and had no available services. Thirdly, regardless of size, all county seats were also the most important service centers, although of varying importance in all thirteen counties of the two regions.

It was also apparent that Region Seven, like Region Six, is not a free-standing comprehensive and coordinated service delivery system by itself (See Table 2). The coefficient of reproducibility of .7692 is well below the accepted level of .9 and several computer runs using SAS repeatedly produced a rather bizarre coefficient of scalability of 3.73!

Implications

It should be apparent from this that communities in New York state and north central West Virginia are obviously not part of the same uniform pattern of community development suggested by Moore, Taietz and Young, and the general applicability of "institutional infrastructure" arguments they raise are therefore open to serious question.

However, when each region and both regions combined are released from the rank ordering found by the earlier study and run separately for their own best fit, a valid scale is formed for each region and for both regions together. However, each of these statistically valid scales has a different rank ordering of items from the others and from the earlier study (See Table 2). Further, the genuine regional and likely developmental character of this service delivery system is highlighted by the fact that excluding the bottom rung – the communities scoring only 1 for senior centers or clubs – generates an unsatisfactory scale (see column 5 on Table 2).

What does this prove? One possibility, certainly, is that the objections to the Guttman scaling procedure raised by Selltiz, et. al, and to this specific application raised by Taves are born out. A Guttman scale test only for reliability and validity is, in insufficient as a criterion for establishing the existence of a comprehensive, coordinated service delivery system as prescribed by the 1980 federal guidelines. In order to be adequate, such a procedure should also spell out 1) a fixed rank ordering of items in the scale (rather than a distinct ordering in each sample); and 2) a developmental argument of the type implied but not discussed by Taietz, Moore and Young; one which clearly states why and how high scoring services are functionally dependent on lower scoring services. If such a scale could be established, the theoretical and practical applicability of such an approach would be very great indeed.

Table 1

Community Facilities Scale

(1974 New York State Configuration)

Scale Score	*Item*	*Pct. Of Communities w/ Scale Score*	*Cumulative Percentage*
0	None	24.2	24.2
1	Senior Citizens Club and/or Center	16.0	40.2
2	Hospital w/ Operating Certificate	0.7	40.9
3	Accredited Hospital	8.3	49.2
4	Nursing Home(s)	9.0	58.2
5	Psychiatric Clinic	7.6	65.8
6	Home Health Agency	2.8	68.6
7	Dept. of Social Services	6.3	74.9
8	Homemaker Service	5.6	80.5
9	Department of Health	4.9	85.4
10	Family Service Agency	2.1	87.5
11	Sheltered Workshop	2.1	89.6
12	Free-standing Clinic	1.4	91.0
13	Accredited Hospital w/ Medical Specialty	9.0	100%

Coefficient of Scalability = .66
Coefficient of Reproducibility = .93

Table 2
Five Possible Developmental Sequences for Aging Services
North Central West Virginia

Service	Taietz Order	"Best Fit" Region Six	"Best Fit" Route Seven	Regions 6 & 7 Combined	Combined Regions w/o Clubs
Senior Citizen Club	1*	12	12	12	12
Senior Citizen Center	1*	7	5	5	6
Certified Hospital	2	8	9	10	8
Accredited Hospital	3	2	8	6	4
Nursing Home	4	3	11	11	9
Psychiatric Clinic	5	10	6	9	10
Home Health Agency	6	14**	14**	14**	14**
Dept. of Human Services	7	10	10	7	11
Dept. of Health	8	11	1	3	7
Homemaker Service	9	4	7	8	3
Family Service	10	5	2	1	1
Sheltered Workshop	11	6	3	2	2
Primary Care Clinic	12	9	4	4	5
Specialty Hospital	13	13	13	13	13
Coefficient of Reproduc.	.9292	.9985			
Coefficient of Scalability	.0707	.9798			
Coefficient of Reproduc.	.7692		.9897	.9870	.8623
Coefficient of Scalability	3.7368		.7895	.8333	.6421

* Clubs and centers were combined in the original NY study. They are separated in the WV data.

** Home health agencies separate from County Departments of Health (N = 0)

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Postscript (2019)

There have been many changes since this study was originally presented in 1979 and 1980, in the communities in question and for me. In 1980, I was an early middle aged Associate Professor recently arrived in West Virginia; in 2019, I am a senior citizen myself; one of the "old-old" in the latter half of my 70s and retired from teaching and public service for more than seven years. For the last year, my primary activity has been editing my papers and manuscripts like this one for posting on the WVU Libraries' Research Repository (https://researchrepository.wvu.edu).

One of biggest and most far-reaching change in aging services in West Virginia since the original presentation of this paper has been the "medicalization" of aging. When this study was first conducted, social gerontology was ascendant over geriatrics and the entire medical establishment in West Virginia had only a passing acquaintance with the problems of aging patients. The official assumptions of the Aging Network were that a genuine network of "comprehensive and coordinated *social* services" for the aged could be grounded in the local senior citizens centers, the county level Aging Agencies and the regional multi-county Area Agencies on Aging. Housing for the elderly was still officially discussed and thought of in connection with other social and medical services (See https://researchrepository.wvu.edu/faculty_publications/752).

Many elements of that "Aging Network" still exist and people are providing excellent, sometimes even heroic, services through the network. However, the distinctions between the well elderly and the infirm; and between the "young-old" and the "old-old" and the arrival of nationally coordinated services like Silver Sneakers have opened opportunities that were not even imagined in 1980.

Two other important changes have been the proliferation of new services in the service network and the further regionalization of services. Morgantown has become the "first among equals" among the thirteen county seats that figured importantly in the original study. This is due in part to the tremendous growth of the WVU Health Sciences complex (hospitals, five health related professional schools, and numerous clinics) which is now the largest employer in the state with more than 10,000 employees and provides tertiary medical care for the entire state and rural portions of western Maryland, southwestern Pennsylvania, and eastern Ohio. There are now "satellite" health care facilities in nearly all of the other dozen county seats. At the same time, a pair of two-county United Way fundraising and distribution programs have been established.

In addition, a broad range of meal and nutrition programs (Meals on Wheels and others), day care and respite programs and other services not envisioned in the 1980 Guttman Scale used in this study.

Another change with personal implications for my career and world view has been the collapse (and in some cases, complete disappearance) of the network of free standing social planning agencies and entities, like those concentrated in the

Region Six and Region Seven Planning and Development Agencies. It isn't that there isn't any health and human services planning taking place today; far from it. However, today, planning in West Virginia and most of rural America is no longer a community or regional function, but simply an organizational one.

Conceptually, the rather simple hierarchies described by the Guttman scaling approach has been replaced by much more elaborate service typologies like the UWASIS II and NTEE (Sumarawalla, 1976; Independent Sector, 1987). Yet, the underlying developmental idea that some services (e.g. optical shops) are functionally dependent on other services (ophthalmologists) remains an interesting and provocative suggestion. The likelihood of a whole series of such partial, fragmentary hierarchies remains strong. Even so, the "all in one hierarchy" notion behind the Guttman scaling approach now seems as dated as the "comprehensive and coordinated" aging network it sought to explain.