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Testimony

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Minority Participation in Administration on Aging Programs

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Before the Subcommittee on Aging Senate Committee on Labor and Human Resources

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Mr. Chairman and Members of the Committee:

It is a pleasure to be here today to share the results of our work on minority participation in programs and services administered by the Administration on Aging (AoA). As you requested, we examined the extent to which minority participation can be adequately measured at this time. In our testimony today, we will present information on (1) the methodology AoA uses to collect data on minority participation and (2) data collection methods employed in two other client tracking systems.

BACKGROUND

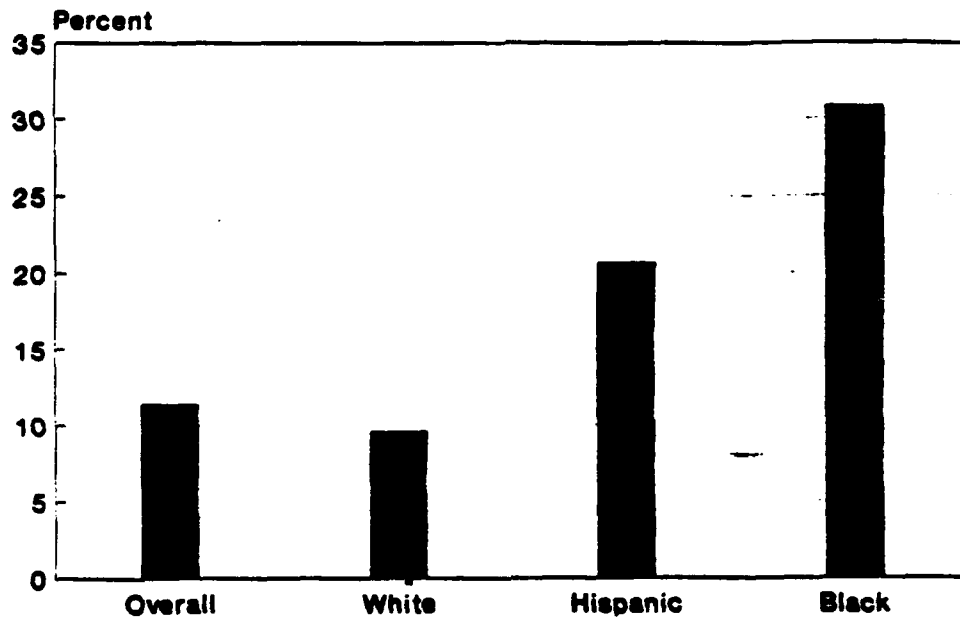
Before turning to the results of our work, I think it is important to discuss its context. As a result of numerous advances in U.S. medicine and public health, the life span of the average American has been prolonged by effectively bringing under control those acute diseases that previously caused widespread death and disability among children and young adults in this country. Since the turn of the century, life expectancy in the United States has increased for both sexes. This improved longevity, coupled with a decrease in the national birth rate, has led to an explosion in the number and proportion of people in this country who are elderly. In 1989, 29.6 million Americans, about 12 percent of the total U.S. population, were 65 years of age or older. By 2030, an estimated 66 million people will be 65 or over, and they will represent 21.8 percent of the total population. The elderly minority population is also growing. In 1989, 2.5 million

blacks and 1 million Hispanics were elderly. By 2020, the elderly black population is projected to more than double to 5.5 million. By the same date, the number of Hispanic elderly is projected to more than quadruple to over 4 million.

Moreover, many of the elderly are poor or nearly poor. Eleven percent of the elderly population (3.4 million persons) had incomes below the poverty level in 1989, compared to about 10.2 percent of the American population between the ages of 18 and 64. Another 8 percent of elderly persons (2.2 million people) were classified as "near-poor,"--that is, they had incomes that fell between the poverty level and 25 percent above this level. In all, nearly one-fifth of our older population (5.6 million elderly individuals) were poor or near poor in 1989.

Furthermore, while the overall poverty rate among people 65 and over was 11.4 percent, this rate was much higher for the minority elderly. As shown in figure 1, one of every three elderly blacks (766,000 individuals) and one of every five elderly Hispanics (211,000 individuals) were poor in 1989--compared to one of every ten elderly whites (2.5 million individuals). Findings from several studies also indicate that, in addition to a higher poverty rate, (1) elderly minorities have greater needs in areas such as health services and supportive social services; and (2) despite these needs, many minority elderly persons do not receive adequate services because of access problems, cultural barriers, and their lack of awareness concerning the availability of these services.

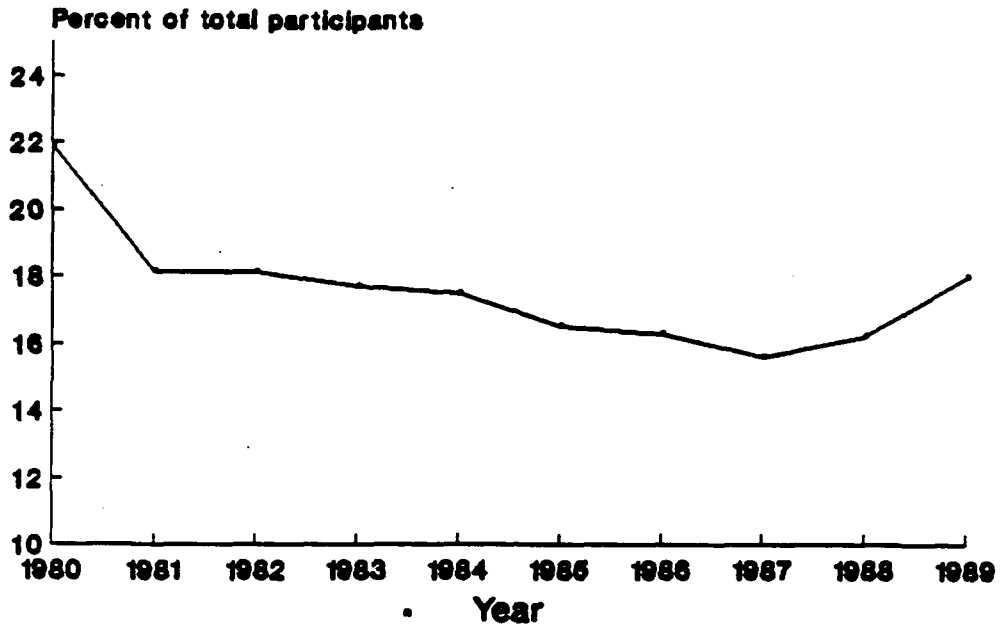
Figure 1: Percent of Elderly at or below Poverty Level, by Race/Ethnicity



Source: 1989 census for persons 65+

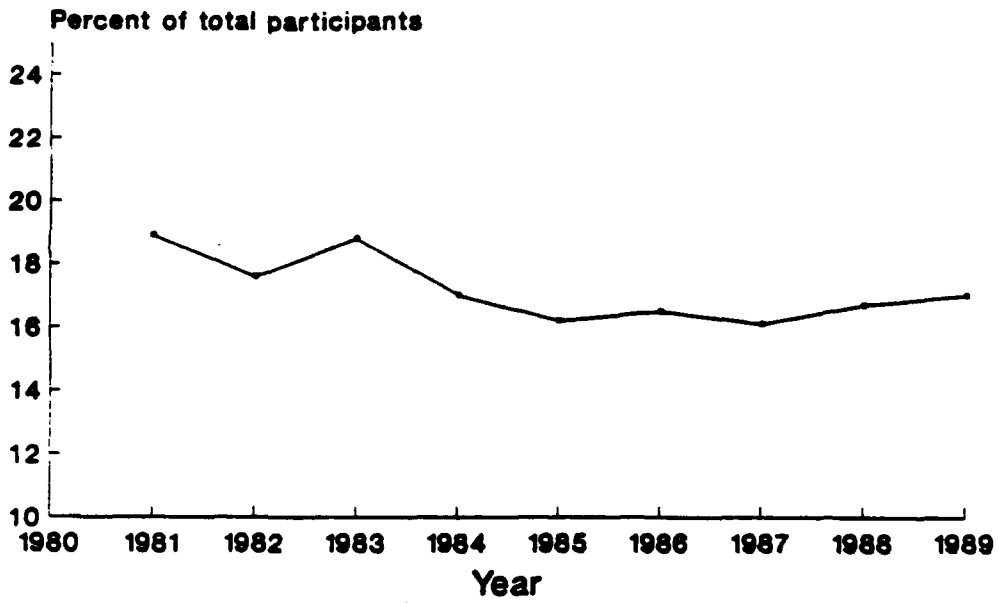
While the elderly minority population continues to grow, the participation rate among minorities in programs authorized under the Older Americans Act was believed to have declined in the 1980s, as shown in figures 2, 3, and 4. Concerned about this decline, the House Appropriations Committee requested in 1986 that AoA provide a report on the participation rates of special populations in programs funded under title III of the act. In its report, however, AoA concluded that the decline in the minority participation rate was "spurious" for two reasons. First, changes in states' reporting methods and in AoA requirements made it impossible to compare data collected before 1981 with that collected in subsequent years; therefore, trends either up or down could not be validly established. Second, the level of accuracy in some states' reporting could have increased in recent years, thereby eliminating artificially high earlier counts of minority participation.

**Figure 2: Minority Participation
In Title III-B Programs**



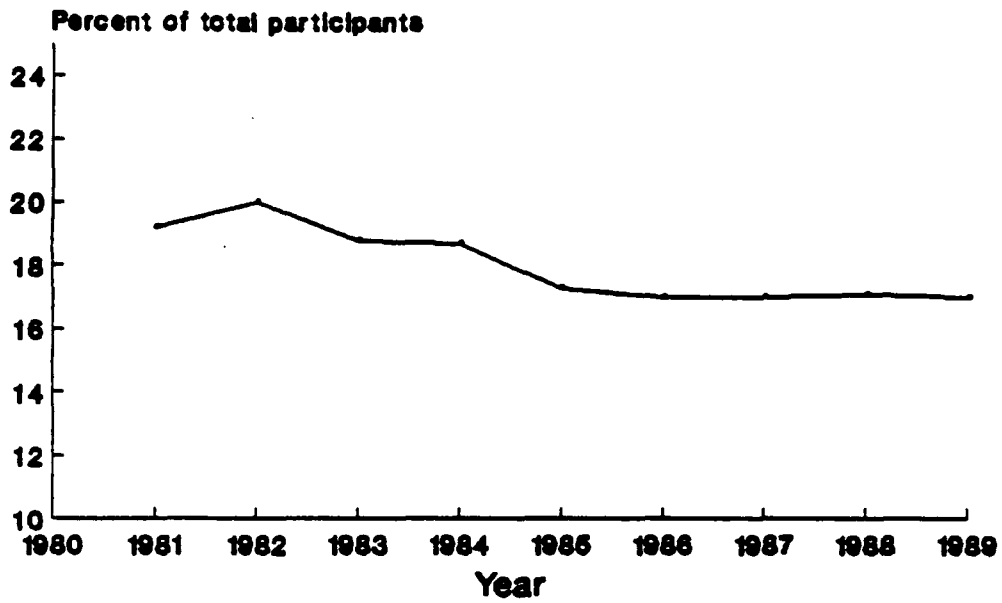
Source: AoA

**Figure 3: Minority Participation
In Title III-C1 Programs**



Source: AoA
Data are not available for 1980

**Figure 4: Minority Participation
In Title III-C2 Programs**



Source: AOA
Data are not available for 1980

In 1990, a study conducted by the Public Policy Institute of the American Association of Retired Persons concluded that a number of factors make it difficult to evaluate minority participation in title III programs. The study found

"large fluctuations in minority participation from year to year within many states, resulting in data volatility at the national level. One of the major problems identified was the difficulty of most states in reporting an unduplicated count of participants--the sole measure upon which minority participation is evaluated."¹

As this quotation suggests, the decline in minority participation may be artifactual rather than real. Nevertheless, some experts in the field, while acknowledging existing data problems, believe that a decline in participation is credible and have identified several potential explanations for it.² These explanations include (1) the increased utilization of means-tested programs as a way of serving minorities, (2) the increase of requests for voluntary contributions from participants, (3) funding formula problems, and (4) the effects of targeting programs and services to the frailest and oldest members of the elderly

¹Bonnie Sether Hasler, "Reporting of Minority Participation under Title III of the Older American Act," Public Policy Institute of the American Association of Retired Persons, March 1990.

²These experts include Percil Stanford of the National Resource Center on Minority Aging Populations at San Diego State University and William Bechill of the University of Maryland at Baltimore School of Social Work.

population.³

Concerned with the lack of essential program data, the Congress amended the Older Americans Act in 1987 to require increased data collection by AoA. In response to this new mandate, AoA revamped its data collection instrument, and in October 1989, states began to collect data using the new instrument.

CAN MINORITY PARTICIPATION BE MEASURED ADEQUATELY AT THIS TIME?

In order to understand the nature and scope of the problem of measuring minority participation in Older Americans Act programs, we reviewed the literature and interviewed experts and officials from AoA, state units on aging, and area agencies on aging in order to determine the types of data they are currently collecting, including the methodology used to collect and analyze data on minority participation. We also discussed this problem with officials of national organizations such as the National Association of State Units on Aging, the National Association of Area Agencies on Aging, and the National Caucus and Center on the Black Aged.

Our analysis has identified problems with the methods used by AoA to collect program data, including problems with the current data collection instrument, that have a direct impact on the

³Voluntary contributions may contribute to a decline in low-income minority participation because they may appear mandatory to low-income participants who do not have the financial capability to make them.

ability of AoA to measure minority participation in its programs. As a result of these problems, which I will discuss in a moment, it is our conclusion that minority participation cannot be measured adequately at this time. Therefore, it is still impossible to determine accurately whether minority participation in programs and services authorized under the Older Americans Act is increasing, decreasing, or remaining constant.

AoA's Data Collection Instrument

We have identified three problems with AoA's data collection instrument. While these problems are not limited to the measurement of minority participation, they do impede AoA's ability to measure that participation.

First, the current data collection instrument is not designed to collect data on program participation, but rather, participation data according to generic service categories. The problem here is that several different programs may provide services that fall under the same service category. For example, participation data in an adult day care program would be added to participation data from a home health program under the generic service category "personal care." As a result, it is difficult to establish the participation rate in an individual program because the data cannot be disaggregated.

Second, although AoA provides service definitions to states, our analysis, confirmed by discussions with state units and area

agencies on aging, indicates that these definitions lack specificity and place the burden on each state to decide on the appropriate category for each service rendered. For example, there is no standard category for "day care." It could be placed under several categories, including "personal care," "treatment," or "supervision." Therefore, not only are program data aggregated into service categories, the services themselves are not clearly and comparably defined across states.

Third, service categories used in the current data collection instrument are not comprehensive. For example, the Older Americans Act requires AoA to collect information on "supportive services for families of elderly victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction." However, there is no service category in the current reporting form to report this information. As a result, this information may either be reported in a different service category by each state or not be reported at all.

More importantly, the Older Americans Act mandates that in the provision of services, preference should be given to older individuals with the greatest economic or social needs, with particular attention to low-income minority individuals. However, the current reporting form only asks for total minority participation in each program part (for example, title III-B). There is thus no way to determine minority participation in priority services.

In sum, the data collection instrument instituted by AoA does not permit the generation of accurate counts of all participants, including minority participants, in mandated programs and services,

AoA's General Methodology

We have the following concerns about the methodology currently being used by AoA as reflected in the agency's general procedures for data collection: (1) the lack of a unique identification number for participants in programs and services mandated under the Older Americans Act; (2) the absence of guidance for the determination of low-income and minority status; and (3) the lack of standardized data collection procedures

Double-Counting

The first and most serious problem with AoA's data collection methodology involves the absence of a unique identification number for participants; it is this absence which results in AoA's inability to generate an accurate unduplicated count of participation, including minority participation. In order to determine accurately the extent to which AoA programs are serving the low-income and minority elderly populations (or even the elderly population in general), it is necessary to identify participants by unique identification numbers that permit the tracking of participants in programs and services provided under the Older Americans Act. However, current AoA procedures do not require states to use a unique identification number; this can

result in individuals being counted more than once. (These are called duplicated counts.)

Without a unique identification number, there are at least three ways in which duplicated counts can occur. First, two different providers may give identical services to the same person during a reporting period. For instance, one provider may do some chores for Jane Doe one day, and a second provider may do similar chores for her the next day. Each provider simply notes that a service was given to somebody--anybody. When the AAA receives service records from the providers, it cannot know that two different providers gave virtually identical services to Jane Doe--so Jane Doe gets counted twice. However, the intent of AoA's reporting requirements is to count Jane Doe only once.

Second, two providers may give different services to the same person, again resulting in a duplicated count. For instance, one provider may shop for Jane Doe, and another provider may give her home-repair services. Because the two providers do not coordinate their data, the AAA cannot distinguish that the same Jane Doe received two different title III-B services. Therefore, she is counted twice.

Third, a single provider may offer a multitude of services to the same person, but may not coordinate its data between the services. For example, a program may offer such services as assessment/screening, diagnosis, counseling, and advocacy to a single participant, Jane Doe. When the provider consolidates its

program data for all service categories, Jane Doe would be counted several times, resulting in a duplicated count.

Definition of Minority and Income Status

The second problem with AoA's data collection system is that it provides no clear guidelines as to how the minority and income status of the participants should be determined, and by whom. Service providers sometimes arbitrarily determine the minority status of a participant simply by guessing, based on a person's name, appearance, or accent. Similarly, since the Older Americans Act does not require participants to disclose their incomes, it is often difficult for the provider to determine whether a particular client is poor or near-poor. Thus, data on both minority and income status often are unreliable, making it difficult to estimate the extent to which low-income minorities are being served.

Unstandardized Data Collection

The third problem is the lack of standardized, national data collection procedures. Indeed, each state has developed its own procedures for data collection, and these vary from one state to another. What this means is that comparing data collected in one state with data from another is difficult, if not impossible, and simply aggregating the data, as AoA does, cannot produce accurate national estimates of, for example, the number of low-income minorities being served by programs provided under the Older Americans Act.

In sum, the general methodology for data collection used by AoA, like its data collection instrument, does not permit the generation of accurate counts of all participants in Older Americans Act programs and services. Thus, minority participation cannot be adequately measured at this time.

DATA COLLECTION METHODS USED IN OTHER SYSTEMS

Although the barriers to generating accurate counts of minority participants under AoA's current reporting system are many, some states have instituted computerized client-tracking systems that apparently enable them to get an accurate count of minority participants. In addition, these systems permit the states to track clients across programs and to determine the intensity of service as measured by units of service provided to individual participants. Based on the recommendations of experts, we identified and examined two such systems: a centralized state-wide system in the state of Connecticut, and a decentralized system in the state of Georgia. It is important to note here that the computerized systems we discuss are in no way representative of the full universe of available systems, nor are we endorsing them as the best systems; rather, they were recommended to us as examples of the types of systems that some states have developed to keep an accurate count of program participation. Although we examined the capabilities of these systems during our site visits, we did not independently verify the accuracy of the computer-generated counts of participation.

Background of the Connecticut System

The data collection system in Connecticut, established in the mid-1970's, was funded by AoA grants and cost roughly \$600,000 to develop and implement, including money for improving the system in 1980. The annual operating cost is about \$130,000, which includes paying for the services of a part-time computer programmer.

Connecticut's system is centralized, employing a mainframe computer located in Hartford. Data on participants are collected on forms by providers, who send the forms to the area agencies on aging, which forward them to the state unit on aging. The state unit then sends the forms to the state's incarceration facility for women, where the information is keypunched. This arrangement allows the state to operate a sophisticated computer system without having to employ a multitude of computer experts and clerks. In addition, the centralized system enables state officials to analyze participant data without putting additional burden on the area agencies and providers. For instance, if someone needs to know how many low-income minorities were served in a given region of the state, the answer can be produced immediately from analysis of the data in the state's computer banks.

Connecticut also uses this computer system to maintain records concerning participation in other state-funded programs. This capability allows state officials to examine the extent to which individuals or groups of individuals, such as low-income

minorities, are participating in a whole range of social service programs. These records could be particularly useful in determining whether decreased minority participation, if any, in AoA-funded programs is the result of increased participation in other, means-tested programs, as some have suggested.

Background of the Georgia System

The data collection system in Georgia, in contrast to Connecticut's, is a relatively new system. It was implemented in 1989 for the Community Care Services Program and was adapted for use with the Older Americans Act programs in the summer of 1990. It was completely financed at a cost of about \$200,000 by the Community Care Services Program, and is maintained with money from that program.

The system in Georgia is decentralized, with microcomputers located in the state unit on aging in Atlanta and in each of the 18 area agencies on aging throughout the state. All the computers are connected through a network, allowing the area agencies and the state unit to communicate with one another electronically.

Providers collect data on participants using intake forms and pass the forms to the area agencies on aging. There the data are entered into the system using software designed by the state unit on aging that produces computer screens similar in appearance to the forms. This means that only limited computer skills are needed for area agency staff to enter data. Thus, each area agency on

aging is able to build and maintain its own data base concerning the participants in its planning and service area. The state receives periodic summary reports from each area agency on aging, allowing it to generate the necessary data for reporting to AoA. However, the state does not maintain the data for individual clients throughout the state.

One advantage possessed by the decentralized system is that it allows the area agencies on aging to monitor local program participation without needing to request that the state unit on aging conduct the analysis. Conversely, the decentralized approach has a disadvantage in that the state data base cannot identify whether a participant is receiving services from two providers in two different area agencies, because each area agency on aging maintains its own separate data base. However, officials believe this is a minor problem.

Like the computer system in Connecticut, the one in Georgia is used to measure participation in programs other than those authorized by the Older Americans Act. This allows the state to examine the extent to which individuals, especially minority individuals, are participating in various non-AoA social service programs.

Measuring Minority Participation Using Computerized Data Systems

The computerized data systems in Connecticut and Georgia address two of the problems we identified above that relate to the

measurement of minority participation. First, these systems allow the states to generate unduplicated counts of all participants, including minorities. Second, they facilitate the state's ability to determine minority and low-income status.

How These Systems Ensure Unduplicated Counts

The systems in Connecticut and Georgia have two important features in common that should generate unduplicated counts of participants, including minorities. First, both assign a unique identification number to each participant. Second, both use computers to facilitate the generation of unduplicated counts of participants.

Both Connecticut and Georgia assign unique identifiers to their participants in Older Americans Act programs. Georgia simply uses the participant's social security number. In Connecticut, a unique identifier is assigned during intake--that is, when an elderly individual signs up to receive services from a provider.

The ways in which unique identifiers can eliminate duplicate counts of participants can best be illustrated by example. As I have pointed out, when two providers perform the same service for one person, the result may be a duplicated count. For instance, as in the example given earlier, a provider may do some chores for Jane Doe one day, and another provider may do similar chores for Jane Doe the next day. In many states, when the area agency on aging receives service records from the providers, it cannot

distinguish whether two providers gave nearly identical services to Jane Doe, so Jane Doe is counted twice, as if she were two persons. However, with a unique identifier, each provider informs the area agency that the same Jane Doe received service, so she is counted only once.

In sum, we believe that unique identifiers are necessary in order to generate unduplicated counts of participants and that their use in conjunction with computers greatly reduces the burden on providers, area agencies, and state units on aging, who otherwise would have the task of counting participation data manually. Both Connecticut and Georgia possess computer systems that allow these states to generate automatically unduplicated counts of clients, which are broken down by demographic characteristics and by services rendered. In addition, both systems provide, on a periodic basis, performance records to the providers concerning the extent of their success in targeting low-income minorities.

How These Systems Determine Low-Income and Minority Status

Both systems utilize standard intake procedures, allowing providers to gather demographic information at intake rather than at the time service is rendered. As a result, much of the "guessing" is eliminated in regard to identifying minorities--especially low-income minority clients. In Connecticut and Georgia, each provider conducts a standard intake procedure for a client before the client receives most services. During intake,

the provider gathers demographic information, such as race and ethnicity. The provider also collects information regarding the client's income, though this is done strictly on a voluntary basis.⁴ By gathering demographic information at the time of intake, the provider avoids having to guess race and income every time service is provided. Contrast this situation with that in states where providers must guess at the demographic information for every person who is served--every time that person is served. The central intake process thus greatly reduces the amount of error that is inherent in counting the demographic makeup of participants.

In sum, data collection systems such as the ones in Connecticut and Georgia can greatly increase the accuracy of minority participation data in two ways. First, states that use such systems can be quite confident that they are generating unduplicated counts of all participants, including minorities. This alone greatly increases the accuracy of their data, and contributes to the accuracy of data at the national level. Second, much of the "guessing" is eliminated from the process of identifying minority--especially low-income minority--clients.

Finally, it is important to emphasize that such data collection systems do not resolve the other problems associated with the national data on minority participation. Specifically,

⁴If a client refuses to provide information on his or her income level, then the provider simply does not have this information. However, we do not know the extent to which clients refuse to provide this information.

the problems associated with the data collection instrument--that is, ambiguous service definitions and missing service categories--and the problem posed by the lack of a standardized data collection methodology across states would continue to exist despite the implementation of systems like those in Connecticut and Georgia. These are issues that must be addressed by AoA in its efforts to gather uniform and accurate minority participation data.

RECOMMENDATIONS

Based on the results of our ongoing work, we recommend that the Commissioner on Aging take steps to (1) modify the current data collection instrument and methodology to ensure accurate participation data related to programs and services authorized under the Older Americans Act, and (2) develop specific standards for the data input to computer systems currently being used or contemplated by the states so that the information generated can be compared across states.

Mr. Chairman, we intend to issue our report on this important topic in a few months. At that time we will advise you of the agency's position on our recommendations and, if necessary, propose legislation to assure that needed actions are taken.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you may have.