Journal of Community Medicine & Public Health
Aranda MP, et al. J Community Med Public Health 8: 474
www.doi.org/10.29011/2577-2228.100474
www.gavinpublishers.com

OPEN ACCESS

GAVIN PUBLISHERS

Research Article

'It Took a Pandemic.' Initial Impacts of the Pandemic and Public Health Orders on Area Agencies on Aging in Los Angeles County

María P. Aranda[1,2*], Jiaming Liang[1,2,3], Iris Aguilar[1,4], Beatrice Martinez[1,2], Alyssa Brissett[2,5], Laura Trejo[6], Lorenza C. Sánchez[6], Mónica Pérez Jolles[2,7]

[1]USC Edward R. Roybal Institute on Aging. 669 W. 34th Street, Los Angeles, CA 90090-0411, USA

[2]USC Suzanne Dworak-Peck School of Social Work, University of Southern California. 669 W. 34th Street, Los Angeles, CA 90090-0411, USA

[3]School of Public Health, University of Texas Health Science Center at Houston, 7411 John Smith Dr, Suite 1100, San Antonio, TX 78229-6041, USA

[4]Florida International University. MARC 430, 11200 S.W. 8th Street, Miami, Florida 33199, USA

[5]New York University Division of Libraries. Elmer Holmes Bobst Library, 70 Washington Square South, New York, NY 10012, USA

[6]Los Angeles County Aging & Disabilities Department. 510 S. Vermont Ave., 11th Floor, Los Angeles, CA 90020, USA

[7]University of Colorado Anschutz Medical Campus. Fitzsimons Building, 13001 East 17th Place, Campus Box C290, Aurora, CO 80045, USA

[*]**Corresponding author:** María P. Aranda, USC Edward R. Roybal Institute on Aging, USC Suzanne Dworak-Peck School of Social Work, University of Southern California. 669 W. 34th Street, Los Angeles, CA 90090-0411, USA

Citation: Aranda MP, Liang J, Aguilar I, Martinez B, Brissett A, et al. (2024) 'It Took a Pandemic.' Initial Impacts of the Pandemic and Public Health Orders on Area Agencies on Aging in Los Angeles County. J Community Med Public Health 8: 474. DOI: https://doi.org/10.29011/2577-2228.100474

Received Date: 17 September, 2024; **Accepted Date:** 28 September, 2024; **Published Date:** 03 October, 2024

Abstract

Area Agencies on Aging (AAA) are the backbone of home and community services for older Americans and people with disabilities, yet limited research exists on COVID-19's impact from an organizational perspective. We conducted a qualitative study through key informant interviews via videoconferencing on COVID-19's impact from the viewpoint of directors in Los Angeles County. Based on a semi-structured interview guide, key informant interviews were conducted with 27 self-identified male and female directors from small, mid-size, and larger agencies. Interviews were transcribed and analysed with *Nvivo* using an iterative thematic analysis: 6 primary themes and 13 subthemes on COVID-19's impact: the initial impact and parallel toll, unprecedented times in uncharted territory, unique needs and disparities, organizational strategies, and the ecosystem of aging services. Staff exerted heroic-like measures to mitigate the emotional, psychological, economic, social, and organizational impacts. 'It took a pandemic,' to unveil a system of services that is underfunded, understaffed, and unprepared for community-wide disasters. Future research and disaster planning will need to address unique needs of participants, the workforce dedicated to their wellbeing, robust public policies, and optimal funding levels.

Keywords: COVID-19; Disparities; Emergency Preparedness/Disaster Response; Area Agencies on Aging; Qualitative Analysis

Introduction

Home and Community-Based Services (HCBS) are the backbone of population health, and social services for older adults and persons with disabilities in the US. Largely funded by the Administration on Community Living, local municipalities, and a patch quilt of federal, state, and local public-private partnerships, over 600 Area Agencies on Aging (AAA) provide HCBS for almost 11 million older Americans [1,2]. Established under the 1973 Older Americans Act, AAA services assist people to participate fully in their communities [3], while delaying or avoiding nursing home stays, extended hospitalizations, and emergency care [4]. A community safety net, AAA coordinate services such as home-delivered and congregate meals, senior center activities, case management, homemaker assistance, transportation, health and wellness programs, family caregiver support, elder abuse prevention, employment program, among others. Program evaluations show that AAA enhance health outcomes and lower costs through health and social services integration [3,5,6].

The COVID-19 pandemic disproportionately affected at-risk populations served by AAAs: older adults, people with physical, mental and cognitive disabilities, people with low incomes, racial/ethnic minorities, people living in rural areas, family caregivers and care attendants [7-15]. Although not considered "first responders," AAA assist with participants' safety and well-being during a disaster, developing an organizational disaster plan, and assisting emergency responders in their local areas [16,17].

At first-glance, the extant scientific and practice literature on the effects of disasters on AAA, and recovery during the initial stages of a global pandemic reveals a serious gap. When crises are noted, the literature typically covers climate-specific disasters such as extreme heat, hurricanes, wild fires [18-20]. This is problematic as it does not respond to how HCBS/aging services respond to public health concerns that may arise during pandemics: 1) Safety net programs serve the most at-risk populations who have a harder time preparing for and recovering from disasters [21]; 2) Rates of housing and food insecurity are high [22]; 3) The digital divide is exacerbated due to low access and navigation skills [23]; and 4) Participants often experience social isolation, elder victimization, and undetected medical conditions [24].

To address these situations, we conducted key informant interviews to elucidate the impact of disasters—and specifically COVID-19—from the viewpoint of AAA directors in Los Angeles County, California which collectively serve over 1.8 million adults--the largest region supported by AAA [25].

During the initial months, much of the response to COVID-19 fell to state and local governments unprepared for a crisis of this magnitude and complexity which was especially noxious for older adults and people with comorbid medical conditions [24]. On January 25, 2020, the first case was confirmed in Los Angeles County. By March 4, 2020, the state of California declared a state emergency, and by March 29, 2020, executive stay-at-home orders were issued. AAA closed all on-site and in-home services. The impacts of such large-scale closures of essential services for older adults and adults with disabilities are significant, yet minimal empirical work addresses the scope, breadth, and sequelae of the pandemic on participants and the people who serve them. As stated by the national network of AAA (n4a), "Almost overnight, AAA revamped their critical supportive programs to address the needs of older adults" (National Association of Area Agency on Aging, 2020). AAA saw a dramatic increase both in the numbers of new and existing participants (up 93% and 69%, respectively) [26].

Our study contributes to the literature by elucidating the initial impact of the pandemic and public health orders on AAA programs in Los Angeles County. By systematically documenting these impacts, our findings can optimize services, operations, and disaster-readiness across AAA.

Materials and Methods

We conducted key informant interviews of executive-level managers (herein, directors) who direct said programs. This approach allows for in-depth examination of the programmatic impact of the pandemic on aging services, and is necessary to guide future HCBS programming for populations at-risk. All study procedures were approved by the University of Southern California Institutional Review Board.

Qualitative Approach

We explored in-depth descriptions of AAA directors' experiences with the initial impact of the 2020 pandemic on service participants, agency personnel, and the directors themselves. In order to ensure comprehensive reporting of qualitative results, our procedures were guided by standard COREQ criteria [27]. We followed the qualitative methodology of Thematic Analysis (TA), specifically a subgroup of TA known as a "coding reliability approach" [28,29], whereby evidence for themes defined as topic summaries of the most frequently endorsed areas reside in the data via transcripts and field notes. Using a coding frame or codebook we drew from multiple coders from our research team working independently to apply the coding frame to raw data. Research bias was managed through multiple coders, establishing agreement between coders, and relying on ongoing coding consensus meetings with the author team to determine final themes and subthemes. This intense methodology allowed for in-depth understanding of the human, structural and contextual factors that impacted HCBS during the early months of the pandemic [30,31]. All qualitative procedures

were conducted by the authors (anonymized for peer review) who live in Southern California and have significant qualitative research and practice experience with the target population and organizational processes.

Sample

Our sample consisted of 27 AAA directors in Los Angeles County responsible for directing their agencies' responses to the pandemic. Subject recruitment included reviewing publicly-available agency lists and contacting directors via email and telephone. 29 participants were approached and 27 (93.1%) agreed to participate. Each completed a brief online demographic survey. Lasting between 45-60 minutes, interviews were conducted in English via videoconferencing between May and June 2020. Participant and agency-related characteristics are presented in Table 1.

Characteristics (self-reported)		Number	Percent
Directors			
Age	<= 44	6	22.22%
	45 - 54	7	25.93%
	55 - 64	7	25.93%
	>= 65	7	25.93%
Gender	Male	5	18.52%
	Female	22	81.48%
Current Positions	Director/President/CEO	10	37.04%
	Vice President/Assistant Director/Program Director	12	44.44%
	Program Manager/Services Supervisor	5	18.52%
Years in the current role	<=4	7	25.93%
	5 - 9	4	14.81%
	10 - 14	5	18.52%
	>= 15	11	40.74%
Agency			
Funder	Los Angeles City only	1	3.70%
	Los Angele County only	8	29.63%
	Others only	3	11.11%
	Multiple funders	15	55.56%
Rural Area Coverage	Yes	5	18.52%
	No	22	81.48%
No. of Paid Employees	<= 9	8	29.63%
	10 - 49	12	44.44%
	>= 50	7	25.93%
No. of Volunteers	<= 9	11	40.74%
	10 - 29	4	14.81%
	>= 30	12	44.44%
Unique Participants	<=1000	6	22.22%
	1001 - 5000	5	18.52%
	5001 - 10000	8	29.63%
	>= 10001	5	18.52%

Percentage of Racial/Ethnic Groups (%)	Black or African American		15.74%
	Asian or Asian American		16.85%
	Hispanic/Latina(o)		35.15%
	Non-Latino White		28.11%
	Other		4.15%

Table 1: Key informant interviews: Characteristics of Directors and Agencies (N=27).

Interview Guide and Procedures

Our interview guide was comprised of open-ended questions and probes that allowed fluid dialogue around the pandemic's impact including the stay-at-home orders (Supplementary Material File 1). Master-level interviewers were intensively trained on interview protocols including how to manage affective responses. Data saturation was reached by the 27th interview as themes and perceptions began to repeat themselves with no new information yielded [32,33].

Analysis

Interviews were audio-recorded, transcribed verbatim by a professional transcriber, and reviewed for accuracy. Using *NVivo* 12 data management software [34], coders conducted open line-by-line coding of transcripts in order to "open up" the data and assign codes [35]. We created a codebook of detailed themes/subthemes to capture individual experiences with the pandemic's impact on their organizations, consumers and collaborators [36,37]. The codebook contained text examples to illustrate each code's definition and inclusion criteria.

The coding team used a multi-phase iterative comparative coding process that started with preliminary open coding on the same group of transcripts (n=10, randomly selected) to refine the codebook: Each person coded separately and then met as a team with supervising coders to discuss the emergent themes, discrepancies, code refinement, and final consensus. In order to integrate the themes from the qualitative data with studies identified in the review, we identified matching and divergent themes in order to add new information to existing codes or to add codes. We refined the codebook iteratively by revising, collapsing, dropping and adding new codes until we reached a high Inter-Rater Reliability (IRR) of 0.61 across coders (proportion of agreed codes over the total number of codes) [38]. At this phase, individual coding was pursued. Axial coding was used to reorganize specific text segments according to conceptual domains during subsequent coding.

To increase rigor, we used inter-coder reliability as noted above, peer debriefing and reflexivity during data coding and analysis, as well as query reports and memos [39,40]. We used member checking by sharing study results with AAA directors to ensure accuracy of results, enhance transparency, and guide recommendations [41].

Results

Based on 27 AAA directors' key informant interviews, we identified 6 primary themes and 13 subthemes elucidating the pandemic's impact on their agencies and diverse consumers and collaborators (Table 2).

	Primary Themes		Subthemes
Theme 1	***'It took a pandemic': The initial impacts of the pandemic and the parallel toll.***	1a	Fears and survival
		1b	Abrupt disconnection
		1c	In the same boat
Theme 2	***'Working like never before': Unprecedented times in uncharted territory***	2a	Abrupt halts and pivots
		2b	The sheer volume and nature of services
		2c	Shifts in problem-solving
Theme 3	***No cookie cutter approaches: Unique needs and disparities***	3a	Social isolation
		3b	Cognitive impairment and caregiving
		3c	The digital divide
		3d	Disparities among at-risk populations
Theme 4	***Lifelines: Organizational strategies to respond and mitigate impacts***	4a	Vertical and horizontal relational supports
		4c	Funding and operational modifications
Theme 5	***'It takes a village': The ecosystem of aging services***	5a	Expansive, interconnected systems

Table 2: Qualitative Themes and Subthemes.

Theme 1: It took a pandemic: The initial impacts of the pandemic and the parallel toll

Subtheme 1a: Fears and survival

Without exception, the initial months of the pandemic where wrought with heightened fears about testing positive for COVID-19. The emotional and psychological toll intensified by the ongoing uncertainty about the virus, multiple public health orders, and infection mitigation measures.

[It] took a pandemic to show how critically important older adults are to our society . . . at the same time this pandemic has caused so much emotional stress on workers, on their families and on our partners. But now the responsibility has gotten even greater.

There was a great deal of anxiety . . . some seniors were just panicking because they weren't sure if the [Stay-at-Home] order meant [that if] they left their house, they were getting arrested.

Fears intensified among staff who dealt with parallel fears and financial worries. Notwithstanding, all directors reported resilience in the face of challenges.

In the beginning it was just kind of that fear, [not knowing] how are we going to be impacted, 'Are we still going to receive our paychecks?' was probably the biggest fear . . . 'Are we being laid off, are our hours going to be cut, like how is that going to affect my paycheck really because that's my livelihood?'

I think we found some new rhythms [and] new strengths that we all didn't know we had, which is very cool, but it's still not easy . . . even a couple of months in, there are things that don't quite work as well from home as just being in an office and having access to everyone on your team and all your equipment and everything. But I would say by and large, I'm really proud and surprised at how quickly and how well we were able to adapt.

Subtheme 1b: Abrupt disconnection

The pandemic excised an abrupt impact on the degree of social connectedness between peer-to-peer, participant-to-staff, and between line staff and directors. Agencies caseloads declined due to the Stay-at-Home order, and many did not resume contact by the time of these interviews. The only contacts were the ever-increasing free-food giveaways and home delivered meals.

So, everything is web-based (now), so it's been a little bit of a challenge just because we usually had face-to-face meetings with individuals. And now it's been very difficult for us to connect, not because they don't have a connection to us, but because the need has been so great for nutrition services . . .

Given multiple public health orders, directors' attempts to maintain intact caseloads and social connections with participants stalled as they no longer allowed onsite services

So, when the first [public health] order came out there were like three orders in one day. So that meant that at first it was, okay, fifty people or less will have social distancing. Then it went to ten people by that afternoon, right, and so I believe either that evening or the next evening it was nobody can come to the center.

Subtheme 1c: In the same boat

A clear indication of the breadth and scope of the pandemic's impacts was that multiple consumers and collaborators—directors, staff, participants and families—experienced impacts concurrently. The parallel process became evident as both participants and staff were deemed "at-risk" for COVID-19, and distancing measures became less financially viable.

Well, I have Title V workers [senior employment program] who are all older adults, and they can't be here. So that's impacted their employment income. I had three [senior workers]. I know one clearly is being impacted by income . . . He took off a few weeks but came back because he needed the money, he said he was having a hard time getting to see a doctor . . . to get the [family medical leave] form filled out, because they were only taking COVID [patients].

I've learned over the past several months that going with the flow and not assuming anything is going to be the only way to keep my sanity. Like yesterday reading the news about three more months of stay at home, I was like, 'No, I'm not going to, I'm not going to feed into this, I'm not going to get into a panic.'

Theme 2: Working like never before: Unprecedented times in uncharted territory

Subtheme 2a: Abrupt halts and pivots

Directors described in fine detail the abrupt service disruptions, and ongoing pivots in their workload and supervision responsibilities aimed at managing crises. Directors and staff engaged in heroic-like measures to decipher a dynamic landscape of consumer needs, budget uncertainties, and rapidly changing supply and demand chain for goods and services.

I'm working more so than I've ever worked, just trying to stay ahead of the curve. And it's something new so it's one of those things that you're trying to be more proactive than reactive.

[We've] had facilities that have had to close overnight because someone has been infected and kitchens have had to close so there's been a disruption to not only workers, the workforce, but also participant services and we've had to rapidly shift and ramp up services to provide meals to people from one day to the next . . . My kitchen had to close Monday at 3 and by Tuesday the next day I had to find an emergency meal provider to provide meals to 700 people so I say that because we have never had to deal with a pandemic.

Subtheme 2b: The sheer volume and nature of services

The sheer volume of the need for services outstripped the operational capacity especially around food and nutrition services.

. . . but our nutrition program, the cost of that has skyrocketed. So, on a weekly basis we would serve, say on average anywhere between 500 to over 600 meals a week, we're now serving over 1,500 meals a week. So, with that, when the city shut down they also implemented a Safer-at-Home for employees, so now we're using a taxi company to deliver these meals so there's that added cost.

Subtheme 2c: Shifts in problem-solving

Notwithstanding emergency federal funding and remote service allowances, covering operating costs was a constant exercise in problem-solving. Contracts were terminated for many agencies because they stipulated on-site and in-home case management, which were now prohibited. Costs to cover workforce safety added to the fiscal instability.

The funding issue, a lot of the drivers were saying, well, they're not getting hazard pay, and they're right, they're the working poor . . . So my other request was to increase their wages and to give them something for hazard pay.

Problem-solving at the managerial levels involved assessing contract regulations and deliverables, program closures, staff redeployments, agency-wide hiring freeze, etc. during shifting priorities and pandemic unknowns.

So, we have to shift, so we shifted staff to other programs, and then we had to shift the coordinator over to do care management for the people that were in our Alzheimer's daycare. So, we had to move around the budget and try and figure out what we're doing with those staff because obviously care management . . . is going to telephonic. . . We had six 30-hour home care workers . . . so we had to suspend that program right off the bat.

So, you know, pretty much everybody's got a hiring freeze right now because of the pandemic. I can't just hire another care manager and move the dollars around . . . I would have to hire more care managers to do that. So, I'm not able to do that right now.

Directors reported dealing with the disrupted food supply chain on a daily basis as they attempted to make good on what service delivery capacity they had remaining. Oftentimes managing the supply chain disruptions entailed being at the mercy of out-of-state vendors.

There was one day where our milk company who delivers our milk was short on drivers so they didn't deliver meals. And we called the dairy company and they're just like, 'Well, we're sorry, there's nothing we can do . . . if you want to come pick it up.' It's like, 'There's no way I can come [laughter] pick up all of that milk.'

[So] transitioning from all hot to an all frozen is quite a process. Like the first couple of weeks I had to order frozen meals from Mississippi, from Sacramento, because my caterer is not used to doing frozen meals. I had to order some emergency ration meals [laughter] that came from Ohio . . . Well, all of a sudden across the country everybody had this huge demand for frozen meals.

The routinization of daily life was disrupted for all directors and their respective staff and participants.

[The] routine events in the year were disrupted. [We're] a pretty efficient operation and we plan things out months in advance so we can promote them in our [newsletter]and people are used to knowing exactly what we're doing . . . . got things planned all the way through the rest of the year. So, people are used to that, and all of a sudden, we have to say, 'Well, we're putting a hold on that.'

Theme 3: No cookie cutter approaches: Unique needs and disparities

Directors frequently discussed the unique needs of older adults and challenges with offering services the same way they did before the pandemic as discussed in prior themes. Social isolation emerged given the abrupt disconnections and fears of public exposures. Directors relied on tried-and-true approaches (e.g., telephonic check-ins) to mitigate the abrupt decline in social connectedness.

Subtheme 3a: Social isolation

The wellness piece has been impacted. First of all, they're not here so we can't say to them, 'Did you eat? You know lunch is being served.' Then we have people who come and just drop in the center, so that's not available. We are right down the street from a rehab for substance abuse for older adults, [they] haven't been able to come here to socially engage.

We saw them congregating [outside the front door] and having . . . time together. And it was disheartening because you could see how they missed each other . . . it was very difficult to see them and knowing that they couldn't come in, and some of them were asking for me.

We've expanded our telephone reassurance programming to check in on people. Before we were doing 300 calls a week but [all] our members, 3,600 of them, they're now on telephone reassurance calls to try to avoid anybody from being completely isolated.

Subtheme 3b: Cognitive impairment and caregiving

Participants living with cognitive impairment and family caregivers experienced an additional toll. Staff reported increased confusion, wandering behaviors, and requests for personal identification bracelets. Policy recommendations such as mask-wearing were

deemed inadequate, as they did not consider implementation challenges among participants with cognitive impairment.

But what happens if you have dementia, and you do not understand why someone put something [mask] on your face and you want to keep ripping it off. So, does that make the facility out of compliance? . . . What are they going to do? Sedate you? Restrain you? I had to reach out to my colleagues at [Public Health] and say, 'Does this make sense to you?'

I have no research or evidence to prove this but it seems like it's affecting some of their memories, like they get confused a little easier because they're not engaging . . . normally like they would.

Family caregivers' responsibilities and requests for support services increased substantially especially with termination of paid help.

[Paid in-home] caregivers have left [their] older adults because they're scared. And some older adults don't want their caregivers there. So, [we see] this whole shift of service delivery where your gatekeeper is that caregiver who has now left--who [no longer] cooks and cleans.

But with the pandemic the primary caregiver is taking the bulk of the responsibilities, so we are seeing a high level of stress and caregivers needing a lot more supportive counseling.

The caregivers mainly are the ones that have been calling. [They ask for] resources like the food bank, the meals program, transportation, [and respite care]. So, we just refer them to Alzheimer's [services].

Subtheme 3c: Digital divide

All directors expressed frustration with the digital divide experienced across participants, agency staff and the public. Due to the Stay-at-Home order, many older adults who wanted to continue receiving services encountered technology barriers such as lack of personal computing devices (smartphones, computers), high-speed internet, lack of knowledge navigating technology (videoconferencing, internet websites), and scamming fears.

[Dealing] with a community that's 70 years old, 80 years old, that they don't have that [digital capability]. I know that a lot of agencies, they're trying to do these Zoom classes and all that. We did a survey and we asked . . . how many seniors had [smart] phones or computers . . . 90% [said] they don't.

[We're not able to physically help them fill out [forms] . . . and we have to do things via virtually or even the phone . . . not a lot of seniors know how to use virtual . . . they don't know how to use Zoom, they can't scan the paper to us, they can't really fax . . . so, their phone session gets extended because they're trying to read the document to our case manager.

Agency staff where typically not required to use remote technologies to the degree that was required during the pandemic; nor were participant records accessible remotely within federal compliance standards.

I think the biggest difference is that we had to change to virtual, and technology practice has been difficult for us because technology is expensive, and . . . all the HIPPA compliance . . . setting up technology at home, making sure [staff] have access and everything is in compliance with federal and state laws.

Reports of victimization due to fraud schemes increased whereby "phone scammers" were obtaining private information to defraud participants who were at home.

Because all of these scammers know now that seniors are home . . . [participants] are more apt to pick up the phone now. [We] are constantly warning older adults about these scams. I get phone calls saying, 'Oh, someone called me and said . . . they can help me get my stimulus check quicker, and so we'll fill out the application for you free of charge.' Well, they've giving away their social security number and their address.

Subtheme 3d: Disparities among at-risk populations

All directors detailed pandemic-exacerbated vulnerabilities associated with age, financial instability, service navigation gaps, and unmet medical and psychiatric care as well as language and immigration issues.

Financial vulnerability and service navigation gaps: Directors increased resource navigation services for financially-vulnerable participants who depended on community and government programs that address disparities: supplemental nutrition, health insurance, medical care, transportation, and income benefits.

[The state food program] CalFresh, has been a little bit harder because prior to COVID we did a lot of outreach, so now [staff member] can't really [go to] resource fairs.

[We] deal a lot with Medi-Cal, Medicare, health coverage (plans), I mean, even medical services . . . a lot of times we tell them to call or complete this paperwork, and it's very difficult for them to communicate because they have to navigate all these governmental agencies.

I wish we could go and pick up medication . . . a lot of older adults aren't getting . . . the therapy that they need, if they were on dialysis are they going to the dialysis center the way they did before, if they had regular cardiologist appointments are they getting that . . . None of those [needs] stopped because of COVID-19.

One director's agency serves nursing home residents as part of their ombudsman mission and thus faced additional barriers.

We work with older adults, predominately who are the nursing home population. We have been very concerned about their well-being because nursing homes are closed to visitors . . . bad things can happen, and we had no way of being inside and seeing and making sure that people were safe.

Mental health: Disparities concerning access to routine care for pre-existing mental health conditions were exacerbated. Agencies increased referrals to Adult Protective Services to address unmet psychiatric needs including among unhoused participants.

[Most]of our participants are older adults and receive (Department of Mental Health) services . . . you can imagine the magnitude of individuals getting psychiatric care that now has stopped, and so we have tried to address that through Adult Protective Services. We've also seen this change in mental health issues in the homeless older adult population. They have been heavily impacted because [both] their mental health services and [congregate] meals stopped.

Language and immigration: Most directors noted the additional toll on limited-English speaking participants' access to essential services and information including service limitations for undocumented individuals.

[Someone called], 'I have a neighbor, she's 87, she only speaks Korean. I noticed she had no food in her fridge. So, language barrier has always been a challenge. This is even more so now because they can't just walk up and we can't try to have a conversation in person, it has to be over the phone. For those who have hearing impairments, that's an even bigger challenge for them because their telephone is the only way for them to communicate.

Remember that our agency, we deal mainly with the Latino population so a lot of times . . . they have the [language] barrier, it's very difficult for them, even [when] the services or resources are bilingual, the interpretation is [still] very hard for them.

And then on the other side of it, a lot of our Latino population, they're you know, they're undocumented so they don't have access to regular medical help. I don't know if the testing sites, ask any of those sort of questions . . . they're going to stay sick before they go to a doctor.

Theme 4: Lifelines: Organizational strategies to combat impacts

Directors described several organizational lifelines or strategies to mitigate early pandemic impacts.

Subtheme 4a: Vertical and horizontal relational supports

Strategies involved providing support to staff many of whom had to report to the service sites to provide services. Examples of vertical relational supports (within an agency) occurred when directors showed concern and reached out to their staff with regular check-ins, or when staff pitched in to fill different roles.

My organization has been wonderful. They sent out little presents to staff which came in the mail with personally written notes from our CEO. And there's a regular check-in with each of the managers about how staff are doing and does anyone need more help. And, if they are ill they can take sick leave, and if the illness goes beyond your allowable sick time, we're going to extend sick time.

Everybody is willing to take on a role that's a little different than it was before. So, my office manager, who is really very skilled on the computer . . . she's now representing my center as far as the (interagency) task force . . . so everybody has to wear different hats. My security guard . . . because he's Russian-speaking [he's] helping deal with all the Russian callers, and he's also helping pack food. Everybody is pitching in, we are really a team that works together.

Also evident were horizontal relational supports (external to the agency) such that directors reached out sometimes multiple times per day to peer directors across their local service areas, statewide regions, and county departments. These supports allowed the network of AAA agencies to form tight alliances, share strategies and lessons learned, provide latest information on resources, and foment affirmational and emotional support.

And so [across] each senior center we have one designated person who is in charge of making sure that their role is specific to food needs, and once a week, and sometimes even twice a week, we meet via Zoom [to share this information].

Several directors discussed the need to develop interagency strategies that expand the capacity of horizontal relational supports.

We [need to] have a community workgroup that deals with this population . . . either we take it on as a lead agency, or one of the nonprofits, to talk about how we're doing outreach. Like when we do the homeless count, we can employ some of those strategies with the senior population.

Subtheme 4b: Funding and operational modifications

Directors reported that government funders and several non-public funders responded to their immediate requests for increased fiscal flexibility to allow agencies to incur non-typical costs (commercial freezers), reimburse remote services (phone, videoconferencing), guarantee funding for normal working hours, etc. More liberal work site arrangements were approved by board of directors, where available. These waivers and funding enhancements provided flexibility needed to respond to the unprecedented needs identified in prior themes.

For the first couple of weeks it was full-time staff that was working from home, and then they were able to kind of phase in some of

our part-time staff [to work] some remote assignments. And so, we have most of our staff working on some aspect of the program from home [and] we got flip-phones to three of our staff so they're monitoring our virtual front desk from home.

Theme 5: 'It takes a village.' The ecosystem of the aging services network

The last theme to emerge from the key informant interviews provided evidence that the aging services network existed within an expansive, interconnected ecosystem (subtheme 5a) of organizations, agencies, departments, and diverse consumers and collaborators across local, state, and national entities—many with no aging-specific expertise or explicit mandate to serve older adults. The previously-discussed themes included references to several entities that comprise this ecosystem.

Figure 1 depicts the ecosystem during COVID-19. To illustrate, if participants had nutrition needs, agencies contracted with vendors with commercial kitchens across states to provide frozen meals. Taxi companies were paid to deliver meals, and grocery and big box stores partnered with government agencies to provide set-aside shopping hours for people who needed assistance. Funders, donors and board of directors identified emergency funding sources to augment existing services. If a need arose for legal representation due to unemployment, evictions, changes in benefits, or maltreatment, agency staff worked with diverse entities such as government benefit offices, low cost legal counsel, countywide information and referrals (211 call-in), adult protective services, and emergency response teams.

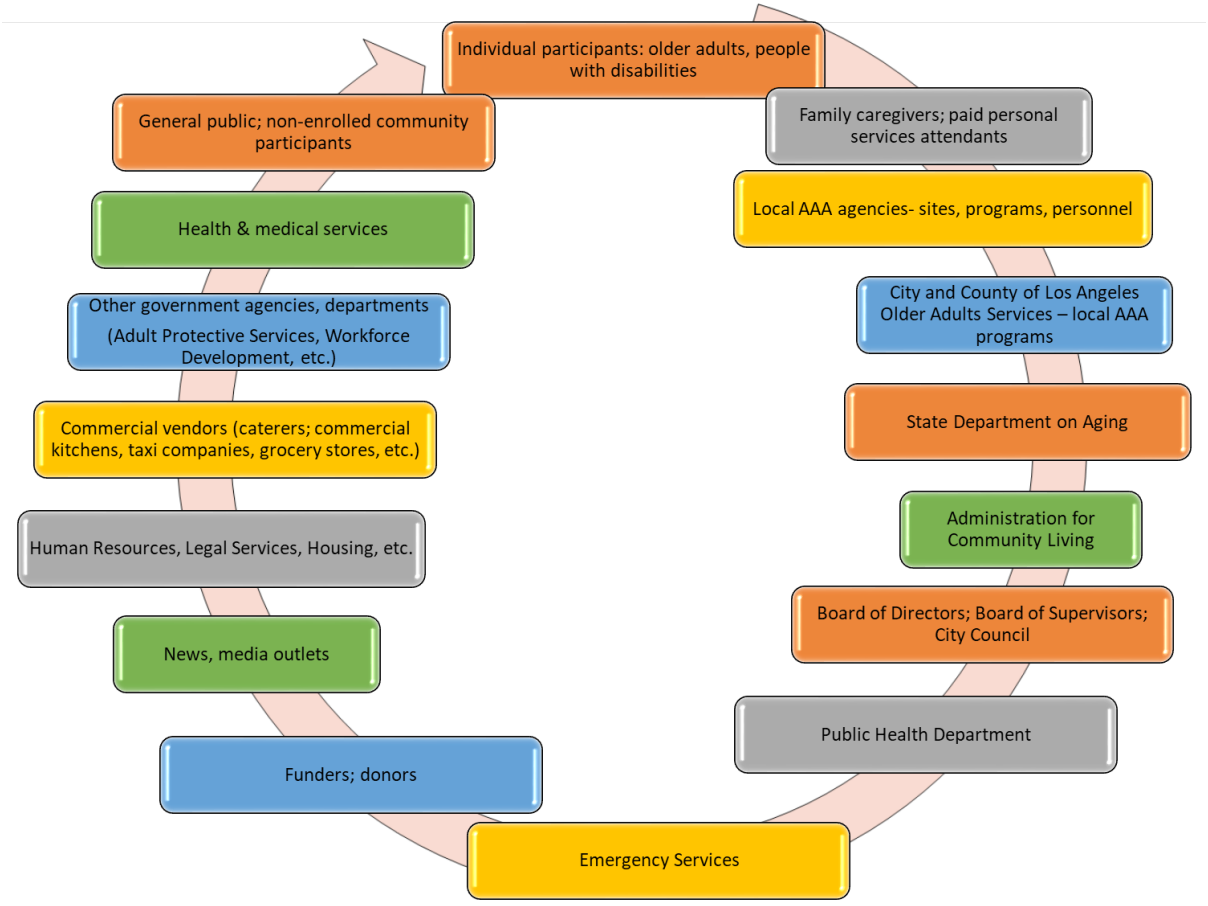

Figure 1: Ecosystem of Area Agencies on Aging network in Los Angeles County during COVID-19.

Discussion

Based on key informant interviews, our study provides insights into the in-depth experience of agency AAA directors with the COVID-19 pandemic during its initial phase, its diverse impacts, organizational strategies, and recommendations.

Our findings point to directors and staff exerting heroic-like measures to mitigate the emotional, psychological, economic, social, and organizational impacts of COVID-19 unlike any previous disasters in Los Angeles County. 'It took a pandemic,' to unveil a system of services that is underfunded, understaffed, and unprepared for community-wide disasters let alone a pandemic which transformed every aspect of daily life. Having no precedent, agencies were left to decipher an ever-changing landscape of participant needs, budget uncertainties, staff and workplace disruptions, parallel risks and burdens, and rapid expansion of inter-agency/inter-vendor collaborations. Directors described multiple pandemic impacts and disruptions elucidated by our qualitative primary themes and subthemes among at-risk populations facing unique needs and disparities.

AAA are lifelines, which '*went from being socially engaged (centers) to a minimal food line*.' What was once a hub of services and socialization activities, became a disaster relief organization doling out food, crisis calls, PPE, emergency information, and elder maltreatment referrals. Moreover, parallel activities related to management of human resource issues (unemployment, leaves) and workplace safety and redesign (public health guidelines in the workplace) increased exponentially.

Although true, if it were not for the AAA, many older adults, persons with disabilities, and their families would not have received the needed services during the pandemic when staff acted on their behalf in a surrogate-caregiver role attending to their health and wellbeing. All directors related the narrative that '*we are touching lives, and we are saving lives,' and '[we are seeing] how critically important older adults are to our society . . . and who the AAA are, when no one saw that before until now*.' Several accounts emerged regarding the positive side of dealing with the pandemic that elucidated resilience, strengths, and caring for others even when the routinization of daily life was upended on such a mammoth scale.

Practice, Policy, and Research Recommendations

Recommendations for future work across practice, policy and research are presented in Table 3. These emerged from the key informant interviews and discussions of the findings with representative directors. The recommendations address gaps in policies and decision-making at the organizational or institutional level. Although discussion of each recommendation is beyond the scope of this paper, we highlight a subset that garnered significant support across the directors and extant literature [24,42-45]:

1. Adoption of a whole community model is needed to foment partnerships across consumers and collaborators, including AAA, non-AAA agencies, emergency responders, government, citizens, etc.;
2. Establishment of a local standing disaster mitigation task force to address regional-level disaster planning and fiscal protections, sustainability of core services and best practices;
3. Designation of a disaster-preparedness coordinator within each AAA to train and coordinate personnel, and set aging-specific policies and practices in place; and
4. Implementation of management and direct staff disaster training programs that incorporate assessment of risk, unique needs, and tailored recovery efforts across multiple consumers and collaborators.

Recommendations	Action Items (examples)
1. Funding of a Standing Local Disaster Mitigation Group	Local, regional level
	Peer-centered approach to local problem-solving
	Examine emergency response systems including epidemics/ pandemics
	Fiscal protections
2. AAA Full-Time Disaster Preparedness Coordinator	Training and planning
	Inter-department/inter-agency coordination
	Aging-specific content expertise/consultation
3. Integration of Aging Content Expertise on Emergency Management Planning Bodies	Train the network
	Develop protocols
	Collaborate with Office of Emergency Management
4. Build Infrastructure and Protocols to Sustain Emergency Communications across Agencies and Households	Cohesive communication
	Reverse 911 calls
	Not one-off but sustainable and cohesive
	Consumer registry (immediate assistance) Volunteer bank
5. Principles of Do No Harm and Flexibility	Partnerships with representatives of target population (integrating voices of people with lived experience) Changing or relaxing policies at multiple levels of government to avoid more harm (waivers, reimbursement for virtual/ remote service delivery, relax policies pertaining to vendors)
	Transportation funding (home to provider; on-demand)
	Home-based testing, vaccinations
6. Special Populations	Risk assessment/profiles to identify levels of risk and response
	Persons with physical frailty, sensory conditions, cognitive, intellectual disabilities
	Under-resourced communities
	People experiencing homelessness
	Persons with psychiatric conditions
	Family caregivers Older employees/volunteers
7. Future Research	Follow-up qualitative studies (multiple stakeholders, include later pandemic phases)
	Quantitative studies examining sociobehavioral impacts of the pandemic on individuals, families, communities
	Program evaluation for best practices Leadership attributes and profiles
	Fiscal models to enhance disaster-related services
	Data warehouse (leverage administrative, clinical data, etc.)

Table 3: Recommendations and Examples of Action Items.

While not exhaustive, the recommendations illustrate the untapped potential to develop disaster prevention, mitigation and recovery efforts for older Americans facing disasters in general, and epidemics/pandemics in particular.

Limitations

We note study limitations: We queried only agency directors; future work should include interviews with multiple consumers and collaborators [46]. Our work focused on Los Angeles County which may not reflect less populated and less resourced regions. Lastly, we limited our focus to the earlier phases of the pandemic; our findings may be less indicative of long-term disaster responses.

Conclusion

The study findings shed light on the pandemic's impact on Area Agencies on Aging (AAA) in Los Angeles County, California, and their diverse consumers and collaborators. These identified themes encapsulate a range of experiences and challenges, from fears and survival to abrupt halts and pivots in service delivery, social isolation, cognitive impairment, caregiving, the digital divide, and disparities among at-risk populations. In conclusion, the study highlighted that AAA are hubs of daily activities in support of older adults' social, health, psychological and instrumental needs held together by a dedicated cadre of family caregiver, service providers, volunteers, and funders. Disaster planning, response, and recovery strategies need to be aligned with unique needs and preferences of AAA participants, the direct and managerial workforce dedicated to their wellbeing, and optimal funding at sustainable levels from diverse sources.

Funding Support

Funding for this work to María P. Aranda was provided by the National Institute on Aging (NIA) of the National Institutes of Health (NIH) under award numbers P30AG066530, and P30AG043073. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Acknowledgements

We would like to express gratitude to our key informants for their dedication to older adults and people with disabilities during the COVID-19 pandemic.

Conflict of Interest: We have no conflict of interest to disclose.

References

1. Kunkel SR (2019) Building on the past, securing the future: Area Agencies on Aging and Older Americans Act reauthorization. Public Policy & Aging Report 29: 52-55.
2. Kunkel SR, Reece HR, Straker JK (2014) The evolution, innovation, and future of area agencies on aging. Generations 38: 30-39.
3. ACL (2018) FY 2018 Older Americans Act Report to Congress. Administration for Community Living.
4. ACL & The Lewin Group (2020) Aging and Disability Resource Center/No Wrong Door Functions: A Leading Indicator in the 2020 Long-Term Services and Supports State Scorecard.
5. ACL (2020b) Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities (Vol. 2021). Administration for Community Living.
6. ACL (2020a) Community Integrated Health Networks: An Organizing Model Connecting Health Care & Social Services.
7. Birkmeyer JD, Barnato A, Birkmeyer N, Bessler R, Skinner J (2020) The Impact Of The COVID-19 Pandemic On Hospital Admissions In The United States: Study examines trends in US hospital admissions during the COVID-19 pandemic. Health Aff 39: 2010-2017.
8. CDC (2020) COVID-19 racial and ethnic health disparities.
9. Laing CM, Moules NJ (2017) Social return on investment: A new approach to understanding and advocating for value in healthcare. J Nurs Adm 47: 623-628.
10. Gil RM, Marcelin JR, Zuniga-Blanco B, Marquez C, Mathew T, et al. (2020) COVID-19 Pandemic: Disparate Health Impact on the Hispanic/Latinx Population in the United States. J Infect Dis 222: 1592-1595.
11. Reitsma MB, Claypool AL, Vargo J, Shete PB, McCorvie R, et al. (2021) Racial/Ethnic Disparities In COVID-19 Exposure Risk, Testing, and Cases at the Subcounty Level in California. Health Aff 40: 870-878.
12. Tai DBG, Shah A, Doubeni CA, Sia IG, Wieland ML (2020) The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States. Clin Infect Dis 72: 703-706.
13. Verdery AM, Newmyer L, Wagner B, Margolis R (2021) National Profiles of Coronavirus Disease 2019 Mortality Risks by Age Structure and Preexisting Health Conditions. Gerontologist 61: 71-77.
14. Hooper MW, Nápoles AM, Pérez-Stable EJ (2020) COVID-19 and Racial/Ethnic Disparities. JAMA 323: 2466-2467.
15. Yancy CW (2020) COVID-19 and African Americans. JAMA 323: 1891-1892.
16. Ablah E, Tinius AM, Horn L, Williams C, Gebbie KM (2008) Community health centers and emergency preparedness: An assessment of competencies and training needs. J Community Health 33: 241-247.
17. California Department of Aging (2021) Disasters Preparedness.
18. Cherry SM, Allred K (2012) Models of disaster response: Lessons learned from Filipino immigrant mobilizations for Hurricane Katrina evacuees. Criminal Justice Studies 25: 391-408.
19. Ingham V, Redshaw S (2017) Vulnerable voices on fire preparedness: Policy implications for emergency and community services collaboration. Australian Journal of Social Issues 52: 313-330.
20. Okwuofu-Thomas B, Beggs PJ, MacKenzie RJ (2017) INTERNATIONAL PERSPECTIVES: A Comparison of Heat Wave Response Plans from an Aged Care Facility Perspective. J Environ Health 79: 28-37.

21. Brewster AL, Wilson TL, Kunkel SR, Markwood S, Shah TB (2020) To support older adults amidst the COVID-19 pandemic, look to Area Agencies on Aging. Health Affairs Blog.

22. National Association of Area Agency on Aging (2020) AAA National Survey Report: Meeting the Needs of Today's Older Adults (pp. 1-33). National Association of Area Agency on Aging.

23. OATS (2020) AGING Connected: Exposing the Hidden Connectivity Crisis for Older Adults (Vol. 2021). AARP.

24. Gallo HB, Wilber KH (2020) Transforming Aging Services: Area Agencies on Aging and the COVID-19 Response. Gerontologist 61: 152-158.

25. The Purposeful Aging Los Angeles Initiatives (2018) Age-Friendly Action Plan for the Los Angeles Region 2018-2021. City of Los Angeles, County of Los Angeles Departments of Aging.

26. National Association of Area Agencies on Aging (2020) #AAAsAtWork for Older Adults: A Snapshot of Area Agency on Aging Responses to COVID-19.

27. Tong A, Sainsbury P, Craig J (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Health Care 19: 349-357.

28. Braun V, Clarke V (2021) Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. Counselling and Psychotherapy Research 21: 37-47.

29. Clarke V, Braun V (2018) Using thematic analysis in counselling and psychotherapy research: A critical reflection. Counselling and Psychotherapy Research 18: 107-110.

30. Crowe M, Inder M, Porter R (2015) Conducting qualitative research in mental health: Thematic and content analyses. Aust N Z J Psychiatry 49: 616-623.

31. Yin RK (2014) Case study research: Design and methods (Volume 5). Sage Publications, Inc.

32. Guest G, Bunce A, Johnson L (2006) How many interviews are enough? An experiment with data saturation and variability. Field Methods, 18: 59-82.

33. Hagaman AK, Wutich A (2017) How many interviews are enough to identify metathemes in multisited and cross-cultural research? Another perspective on Guest, Bunce, and Johnson's (2006) landmark study. Field Methods 29: 23-41.

34. Wong LP (2008) Data analysis in qualitative research: a brief guide to using *nvivo*. Malays Fam Physician 3: 14-20.

35. Chenail RJ (2012) Conducting Qualitative Data Analysis: Reading Line-by-Line, but Analyzing by Meaningful Qualitative Units. The Qualitative Report 17: 266-269.

36. Reeves S, Albert M, Kuper A, Hodges BD (2008) Why use theories in qualitative research? BMJ 337: a949.

37. Ryan GW, Bernard RH (2003) Techniques to Identify Themes: Field Methods 15: 85-109.

38. McAlister AM, Lee DM, Ehlert KM, Kajfez RL, Faber CJ, et al. (2017) Qualitative coding: An approach to assess inter-rater reliability. 2017 ASEE Annual Conference & Exposition.

39. Corbin J, Strauss A (2014) Basics of qualitative research: Techniques and procedures for developing grounded theory. Sage publications.

40. Krefting L (1991) Rigor in qualitative research: The assessment of trustworthiness. Am J Occup Therapy 45: 214–222.

41. Creswell JW, Miller DL (2000) Determining validity in qualitative inquiry. Theory Into Practice 39: 124-130.

42. Karliner L, Ponce A, Nguyen T, Kaplan C (2021) The Impact of COVID-19: Multiethnic Older Adults and the Community-Based Organizations Serving Them, Policy Implications. The Center for Aging in Diverse Communities and the Multiethnic Health Equity Research Center, University of California San Francisco.

43. Kyler-Yano JZ, Tunalilar O, Hasworth S, Kohon J, Winfree J, et al. (2022) "What Keeps Me Awake at Night": Assisted Living Administrator Responses to COVID-19. Gerontologist 62: 190-199.

44. Pendergrast C (2021) "There Was No 'That's Not My Job'": New York Area Agencies on Aging Approaches to Supporting Older Adults During the COVID-19 Pandemic. J Appl Gerontol 40: 1425-1436.

45. Wilson TL, Scala-Foley M, Kunkel SR, Brewster AL (2020) Fast-track Innovation: Area Agencies on Aging Respond to the COVID-19 Pandemic. J Aging Soc Policy 32: 432-438.

46. Markkanen P, Brouillette N, Quinn M, Galligan C, Sama S, et al. (2021) "It changed everything": The safe Home care qualitative study of the COVID-19 pandemic's impact on home care aides, clients, and managers. BMC Health Serv Res 21: 1-14.