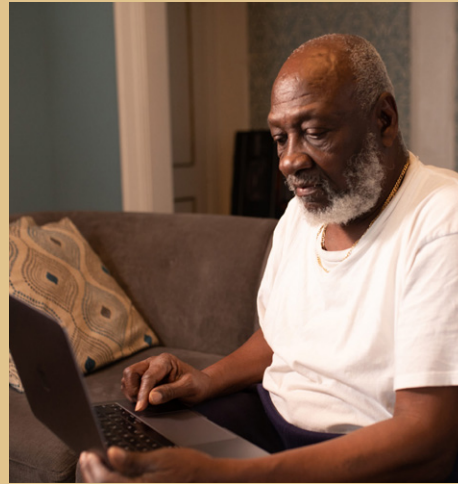




CARING FOR WASHINGTON'S OLDER ADULTS IN THE COVID-19 PANDEMIC: INTERVIEWS WITH ORGANIZATION LEADERS ABOUT THE STATE OF SOCIAL AND HEALTHCARE SERVICES



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Executive Summary

The COVID-19 pandemic presents significant and costly disruptions to social service and health care systems. Eight in ten deaths from the COVID-19 virus in the U.S. have occurred in people age 65 and older (CDC, 2020). In addition to the mortality risk, the pandemic presents grave health and economic risks by disrupting services to older adults that prevent institutionalization, emergency room visits, and other negative health outcomes. This report examines how the pandemic has affected the operation of social service and healthcare organizations that support Washington's 1.7 million older adults (60+), including 107,000 people with Alzheimer's disease and other dementias (State Plan on Aging, 2018).

Drawing on surveys and interviews with 45 senior leaders of social services and health care organizations serving older adults throughout Washington State, this report identifies current challenges confronting service delivery and client care, as well as those that will persist to shape future strategy and planning. Several key findings and themes emerge relevant to policy and practice:

Senior leaders describe rapid declines in the physical and mental health and functioning of their older adult patients and clients as a result of the pandemic. Healthcare providers report that chronic medical conditions are often not being well managed, resulting in significant physical deconditioning, increased frailty, and heightened health risks.

Providers believe that a high number of older adults are not seeking care for existing or new conditions, which will have important downstream effects on the health of older adults. Care organizations are particularly concerned about people living with dementia because they are less active and engaged during the pandemic, leading to increased severity and frequency of delusions as well as worsening behavioral symptoms. Moreover, many vulnerable older adult population sub-groups may be falling through the cracks of Washington's service systems, including those with low-incomes, those who are living alone or unhoused, Latinx immigrant and migrant older adults, people with limited English proficiency, and tribal elders.

Social isolation creates a "double pandemic" and is believed to exacerbate problems of dementia, depression, suicide risk, and disrupted care. Organization leaders described making inroads to address social isolation during the pandemic but also expect the problems created by isolation to persist for some time. Leaders want to see guidelines evolve from isolating in place to recommending ways to provide safe social interaction.

The pandemic is exacerbating service gaps and leading to caregiver strain in Washington. Demand for aging services during the COVID-19 virus remains steady and is expected to increase over time due to demographic trends and caregiver shortages. Family caregivers now have limited respite options and have to assume additional caregiving responsibilities because of service restrictions due to the pandemic.

A digital divide exists in many parts of Washington State, particularly for older adults of color with low incomes and those in rural communities, where unreliable and costly internet and cell phone services may negate well-intended telemedicine and videoconferencing efforts. Senior leaders report barriers to the use of digital tools and training among the oldest adults and those with sensory disabilities or dementia.

Social service and healthcare organizations serving older adults report urgent fiscal shortfalls and budget crises. Layoffs and furloughs have occurred in many organizations, with senior leaders emphasizing the need for additional public funds to prevent further layoffs and staffing shortages. In addition, organizations need assistance obtaining PPE and purchasing supplies or equipment to accommodate new service realities and to provide nutrition services.

Interviews identify several strategies for addressing the challenges of the pandemic and providing high-quality care to older Washingtonians:

- Organizations leveraged targeted funding, partnerships, and transportation networks to enable delivery and drive-through meals on a larger scale than previously possible.
- Some in-person services and programming have been moved to virtual platforms, expanding their reach and capacity. Virtual support groups and activity-based socialization groups have been particularly successful.
- Providing technology skills training to older adults through staff, peers, family members, and targeted tutorials has been effective for some.

- Many organizations provide digital devices, particularly prepaid cell phones.
- Organizations creatively adapted where trial and error showed that non-digital service delivery was needed, such as wellness and reassurance phone calls, care packages with pantry staples, outdoor distanced social events, and pod formation for limited social contact.
- Existing and new partnerships have been leveraged to reach older Washingtonians in their homes. Collaborations formed to meet the crisis, however, could be expanded to better serve immigrants and older adults of color.



It is critical for public agencies and private philanthropy to ensure service providers in the aging network are able to continue supporting the needs of older Washingtonians. These service organizations play an essential role in alleviating loneliness and isolation, meeting nutritional needs, improving health outcomes, and enabling access to health care, long-term services and supports, care transitions, and housing. Current and future reductions in revenues from public and private sources jeopardize the sustainability of these critical organizations, particularly those serving older adult populations on fixed incomes.

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Introduction

The COVID-19 pandemic presents significant and costly disruptions to the social services and healthcare systems nationally. Eight in every ten deaths from the COVID-19 virus in the U.S. have been in people 65 and older (CDC, 2020). On top of the mortality risk, the pandemic presents grave health and economic risks by disrupting services to older adults that prevent institutionalization, emergency room visits, and other negative health outcomes.

This report examines how the pandemic has affected the operation of social service and healthcare organizations that support Washington's 1.7 million older adults (60+), including 107,000 people with Alzheimer's disease and other dementias (State Plan on Aging, 2018). In July and August of 2020, a University of Washington study team composed of social work, neuropsychology, public health, and public policy researchers interviewed and surveyed senior leaders of 45 social service and healthcare organizations across the state, including senior centers, Areas Agencies on Aging, healthcare providers, adult day centers, home care agencies, and community social services and health organizations. Participants were asked about service demand and new challenges in supporting older adults as well as service and organizational adaptations and needs. Please see the Appendix for details on the study methods.

Many organizations reported having received funds from the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Our findings reflect initial experiences with the CARES Act as well as how organizations have adapted during the initial months of the pandemic. At the beginning of the study period, more than 1,500 Washingtonians had died from COVID-19, with an average estimated daily infection of 1,800 in July and 760 in August (IHME, 2020). Nearly all participants commented on the impact of loss of life among clients and staff. We acknowledge and hold the loss suffered by these organizations and their service communities and thank organizations for speaking with us during these challenging times.

Below, we review key findings and recommendations for practice and policy.

Characteristics of Study Participants

We identified 100 social service and healthcare organizations across the state that primarily or only serve older adults living in the community and invited a senior leader from each to participate in this study. Forty-five leaders from this initial group completed an interview, and 37 also completed a short survey about the clients/patients they serve and services they provide. Organizations participating in this study provide a wide range of services to older Washingtonians and caregivers. Figure 1 shows the percent of organizations that are providing some of the most common services. However, it is not an exhaustive list of services offered. Two-thirds of the participants represent social services organizations and one-third are in healthcare. We oversampled Central and Eastern Washington relative to the state population share. Half of our participants are in Western Washington, 30% are in Central Washington and 20% are in Eastern Washington. Some organizations also serve residents in adjacent regions.

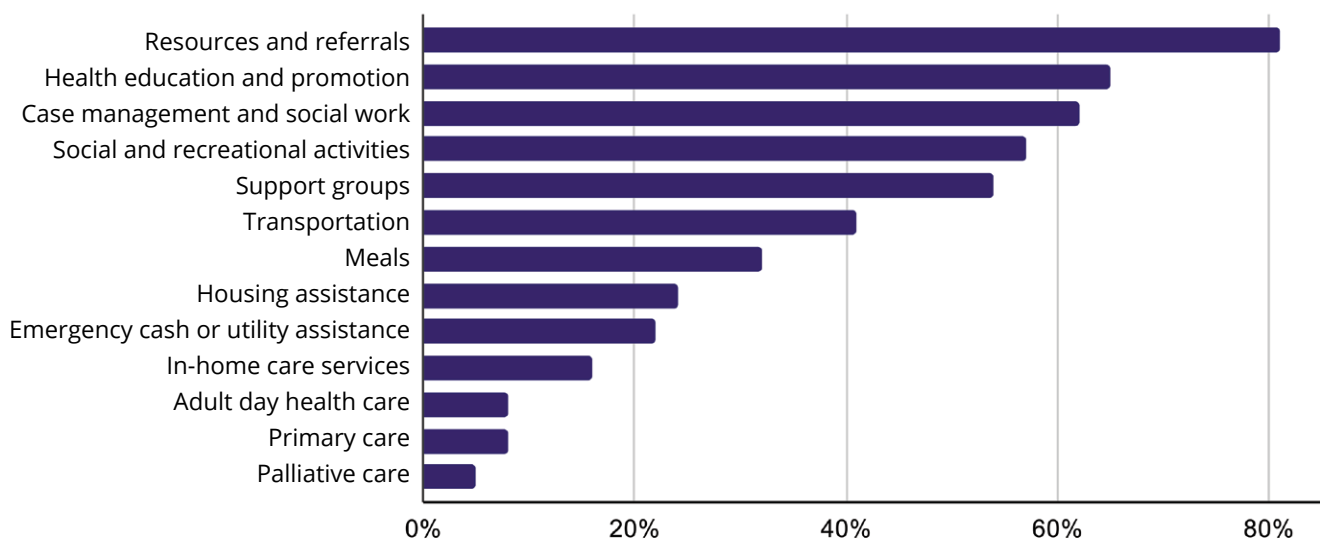


Figure 1: Percent of Participating Organizations Providing Each Service (N=37)

Participating organizations serve some of the most vulnerable Washingtonians. Of the organizations we interviewed who provided client demographic data, a significant share reported that half or more of their clients live at or below the poverty line (54%), are people of color (29%), or have limited English language proficiency (20%). Twenty-seven percent reported that some of their clients are unhoused.

Study Findings

The challenges facing clients during the pandemic were top of mind for senior leaders. We begin by identifying those challenges they described as most salient as well specific populations they are worried about. We then report on barriers faced by organizations to meeting client needs, followed by promising service adaptations and specific organizational needs that present opportunities for a policy response.

The Pandemic's Negative Effect on the Health of Older Adults

Clinical providers highlighted the negative impacts of the pandemic on management of common chronic conditions, such as hypertension, diabetes, and exacerbation of symptoms. Others described problems related to delaying care for both new and chronic conditions. And providers who work with people living with dementia had observed functional decline accompanied by worsening caregiver mental health.

Social isolation is a core concern. In the initial months of the pandemic, many assisted living facilities were put in “lockdown,” and residents were unable to leave their apartments. As a result, it was common for social service and healthcare providers to express concern regarding social isolation. Senior centers and other social services play an essential role in alleviating loneliness and isolation as well as helping people connect with their communities. For example, a senior center with a large African American membership sees its clients who have been pushed out of the gentrified area travel back to stay connected to the center because it has been a trusted, safe place for decades. However, during the COVID-19 pandemic, opportunities for socialization and community engagement offered through senior center programming have been greatly limited. A service provider explained, “Our drive to stop senior isolation, to empower people, to enhance their lives has just been put on hold. And that’s, I think, the worst thing about it because the scare and the fear, that’s real, with COVID and the way it affects seniors. But the side effects, I think are just 10 times worse had they not got it. The decline in mental health and physical health, I think has been the worst part of it.”

Before the pandemic, a few organizations had provided valued congregate meals and other social gatherings for older adults who share a cultural background and language other than English. A service provider who works with Asian older adults said, “...especially the communities that we serve, the opportunities for them to socialize with people who speak their language, who share the meals and the dishes that they’re familiar with, that’s on hold right now. And I imagine it’s just a challenge.” Another participant whose organization works with East African older adults echoed this concern: “...outreach to the community is really difficult given the language barrier, and also, culturally, they were really coming there for a safe space to chat with their friends in the same language with the same kind of background, and so, trying to adapt programs to them – it’s really difficult since we can’t do large group things, so that’s been another really big challenge – figuring out how to do outreach to certain communities and try to continue to keep them engaged.” They continued, “I’d really like to reengage that group, so that’s not something we’re doing right now, but I’m worried that if it continues like this, we won’t be able to restart that program. It’ll just be dead in the water.” Leaders worry about how they are going to be able sustain these unique programs that are on hold.

Declines in functioning. Providers noted the impacts of social isolation and social distance restrictions on physical and mental health. Increased physical deconditioning, frailty, and falls were reported. One facility manager noted, “Falls have increased in our elderly in the last hundred days because they’re weak, they haven’t moved, their nutrition is probably not the best, no social interaction. I mean, there’s been a rapid decline in our elderly people in facilities.” Providers also explained that older adults with existing mental health and substance use problems may be more impacted by social isolation and that they are observing increased risk of suicide.

Isolation and living alone have intensified more rapid declines in physical and mental functioning in older adults. This is particularly evident in assisted living facilities where residents are required to limit time outside their apartments because of close quarters and a high threat of viral spread. A provider in an assisted living facility said, “So, what you see with that is an acceleration of decline. People are walking less. People are using their minds less. People are eating less because food is left

outside of their door and there's a knock and they can't hear it and they don't go to the door. It's definitely increasing mortality I would imagine across the board with whatever your diagnosis is..."

Delaying care for ongoing or new conditions. Healthcare providers have seen drastic reductions in return visits for chronic conditions. People are avoiding routine medical appointments that require in-person visits and delaying care for new-onset problems. One healthcare provider noted, "This is the piece that I'm nervous about and I think everybody in healthcare is and should be if they're not already – and that is the amount of people out there that are not getting problems solved early and/or other problems not being identified at all, and what the downstream effect of that is going to be, with whether it be an undiagnosed cancer, an undiagnosed heart disease, or an increasing heart disease that is not gonna result in cardiac arrest."

Healthcare providers believe that the initial decline in visits is related to shut-down clinics, reduced clinic times, and staffing shortages, but they have yet to see a return to patient volumes in outpatient settings, even after clinics modified their schedules and safety protocols. Instead, they've observed an increased use in emergency services. As noted by EMS staff at one organization, a 20% drop in call volume was followed by an up-tick in calls for medical problems that would have been easily managed with preventative healthcare: "In recent weeks, we have had a significant increase in calls...It is not unheard of, but it is rare for us to get dispatched on a standard medical event and then walk in and find a patient in cardiac arrest. It happens. It doesn't typically happen a lot. We have been seeing it a couple of times a week for the last couple of weeks. That, to me, is significant. When crews are getting dispatched on a diabetic problem and they walk in the door and the person's in cardiac arrest."

Increased demand for emergency services for preventable conditions among people with memory loss was also highlighted by healthcare providers. One provider said, "I've seen a great deal of the conditioning, progression of their dementia. A lot of emergency visits. They've been falling, and I think it's social isolation that they also experience. They're losing weight. They're not being able to monitor how the intake of the residents are doing. I've seen dehydration, visits to the emergency room. It's very common now." Providers have seen more rapid declines in cognitive health as well: "We're definitely seeing more-more loss of cognitive skills as the—as this pandemic is going on longer, so we have early stage memory loss programs for people with memory loss and many of those people are declining quite a bit."

Healthcare providers also noticed hesitation to seek medical care for new-onset symptoms, either due to concern of infection at the clinic or hospital, transportation barriers, or a perception that "It's not that important." As one said, "The other thing that we are seeing is that a lot of folks who would access services are putting them off...The doctor suggested I go see a specialist for whatever, I'll do it when COVID's over. Which is scary because you never know what else is underlying all that...They're waiting, which is not good."

Another healthcare provider offered a possible solution: "If we could bring preventative medicine to the home, even just to take labs so that a person doesn't have to get up at 6:00 and not drink any or eat anything and then go stand in line at 7:00 a.m. to go get their cholesterol checked. If we could do those things and really minimize the possibility of people getting or spreading COVID-19, I think that would be phenomenal."

Exacerbation of chronic conditions. Healthcare providers stated that people with chronic health conditions faced the most extreme social isolation, in part because they are more at-risk for contracting COVID-19 and/or experiencing more severe symptoms. One discussed how in-person services might be interrupted for clients with chronic conditions: "People who have high needs, which means whether they are immediately released from a hospital, or maybe they are bed-bound, those clients are the clients that we worry the most because sometimes we have to find several caregivers to take care of that type of client. And because of the pandemic, a lot of caregivers are afraid to go into the client's house to provide care for them. So, we are seeing a shortage of caregivers who are willing to have that kind of personal contact with a client."

Healthcare providers for people living with dementia have noticed worsening behavioral symptoms during the pandemic: "They're more withdrawn, less motor active, less engaged despite encouragement because they're kept in their rooms a lot. They're getting more so." Severity and frequency of delusions have also increased. In some cases, these behavioral symptoms led to more hospitalizations than usual, as one provider explained, "Last week, I feel like every call I talked to was the same story. And it was somebody that had been living – clients living in retirement communities where their families haven't had access to them. They have dementia, and it's a cumulative effect. So, they've had a flare-up in symptoms, leading to hospitalization."

Typically healthcare providers include both non-pharmacological and pharmacological interventions to manage such symptoms, but with social and physical constraints due to COVID-19, there are fewer options for treatment. One provider shared, "Usually with those [behavioral symptoms], we try all these non-pharmacological approaches to address them because that's really the

– kind of the fastest and safest way. But a lot of those are not an option right now, and so we're turning more to medications which I kind of hate to deal with. We're kind of stuck with that right now, so I'm finding myself prescribing more antidepressants and antipsychotics." Generally, this reflects a departure from best practices, but what seems like an unavoidable adaptation to the current situation.

Regional differences in isolation disadvantage rural Washingtonians. Isolation may be more pronounced in rural regions of the state. Rural geographies and population density means clients in rural areas are traveling greater distances to receive services. As one provider stated, "Senior programs are really needed for all of our communities. The small, rural areas get left behind." In rural regions, some respondents reported struggling with consistent internet connection. For both in-person and virtual services, poverty was also noted as a barrier for access.

Paratransit services provide necessary connectivity to the community for older adults, but they are suspended during COVID. Even before COVID, not all regions had robust paratransit, and participants in rural communities spoke about distinctive challenges facing older adults who need paratransit for essential medical visits, such as dialysis. Volunteer transportation services were largely halted or had dramatically reduced capacity to serve clients. For example, both paratransit and volunteer transportation resources were redirected to delivering food. Without volunteer transportation, non-medical travel (e.g., essential errands, social trips) is limited for older adults. While fares for public transportation were briefly lifted, they have been reinstated in most regions across the state. Because of older adults' economic vulnerability, providers worried that this shift was premature. Trips outside the home can be taxing, and providers wondered how care for clients on both ends of their trips when indoor environments are closed could be ensured.

Older adults living alone and those living with dementia in facilities where visitors have been restricted are most at risk for social isolation, as discussed in the next section. Promising practices that organizations have developed to mitigate isolation are provided below in Table 1.

Vulnerable Groups At Risk of Falling Through the Cracks

In addition to people living alone, organizations are most worried about these groups: those who are living with dementia, caregivers of older adults, those with low-incomes, those who are unhoused, people with limited English proficiency, Latinx immigrant and migrant older adults, and tribal elders.

Older adults living alone. With public health recommendations that identify older adults as a high-risk group for contracting COVID-19, many providers expressed concern that those living alone have had extremely limited social contact since March. One service provider described the challenging nature of the problem: "I have a woman who called me last night in tears. She's living alone...she's afraid to leave her apartment. She doesn't know anybody. Her husband's dead. She needs groceries. She needs cat food, dog food, medication, a thermometer. Stuff you can't get without leaving your apartment, she has no way to get to the store because she's in a walker. She doesn't have a car. She doesn't feel safe in Access or on a bus. So, there are people that have needs that are unique to the situation."

Digital technology is not a viable solution if older people living alone don't have help setting it up, making them less likely to access virtual services. For them, phones can be a lifeline. A participant who reaches clients by phone explained that "Sometimes I'm the first person they've talked to in a few days, and there's 15 minutes where we're just practicing talking. Just 'Okay, I'm getting my coffee.' If you haven't talked to anybody in three or four days, it's a flood of thoughts are coming. So, just trying to help people organize their thoughts, a lot of normalizing that this is a really challenging time."

People living with dementia. As noted above, many providers have seen declines in psychosocial and physical wellness due to social isolation and loss of sensory stimulation among older people living with dementia. An increased frequency of health and mental health events can prompt a move to hospitalization or higher levels of care.

"He has one lung, and he cannot leave his apartment. If he gets COVID, he's dead. He has been told by his doctor, 'You cannot leave your apartment until there's a vaccine.' So, he's basically isolated, and he calls us two or three times a week to say, 'Thank you for the meal, and all you guys are saving me. My wife died. I don't know what I'd do. I'm so lonely. It's nice to hear your voice.' So, there's a lot of isolation and depression going on. And even for the ones that lost their spouses prior to COVID, if anything, this is making it more difficult for them because there's nobody now."



Social service providers who make meal deliveries and telephonic wellness checks to people living in the community described a new role in safeguarding their clients and a duty to report if a client is not home. For homecare and other caregiving services, attempts to minimize COVID exposure risk means reducing the number of caregivers entering the home, reducing continuity of care.

Of particular concern were those living with dementia in assisted living, skilled nursing, and memory care. Because of the relationship between social contact and problematic behaviors, isolation is a significant problem. In one assisted living facility, a healthcare provider explained, “The families are not allowed to go in, and I would get calls from the family members that they would see their family members less engaged, less verbal output, more agitation or more behavioral changes, more falling, and weight loss.” Without in-person access to their care teams, those who rely on others for advocacy may experience lapses in their care.

Caregivers of older adults. With service sites and community spaces either shut down or virtual, informal caregivers have limited respite from caregiving responsibilities. The closure of respite services such as adult day programs is a problem for caregivers of people living with dementia. Caregivers are facing isolation of care dyads from the rest of their communities and difficult decisions about allowing paid caregivers into the home and deciding between at-home and residential care when in-person contact is restricted. Providers also expressed concerns about the impact of stress on both the caregiver and those they care for: “That leaves

them [caregivers] open to stress related illnesses and even death to put a finer point on it. Not to mention, it’s also not good for the person with dementia because the care partner with the stress can – and again, I’m not trying to paint everybody with the same broad brush, but can get short with the person, can leave situations open – or leave it open to more potential abuse or neglect. If you do have someone with Alzheimer’s or dementia who is feeling abused or neglected, are they able to call with that? Same thing with, for that matter, residents or care agencies.”

Older adults with low incomes. As the pandemic continues, many providers anticipate that those who currently rely on community nutrition services and are protected by emergency rent and mortgage moratoriums will face increased food and housing insecurity. In the words of one healthcare provider, “I think poverty among elderly people is like a national emergency, and we don’t ever talk about it. Mainly the population in my region is from agricultural farm workers...So many people don’t have the ability to prepare food for themselves and then Meals on Wheels can only really give you certain kinds of food. If you have a low sodium diet, you can get that, but if you need pureed foods – The people just don’t generally, so many older adults just live on social security if they’re disabled, and they have no money. You can order a CT, which costs \$6000 for your patient, but you cannot provide basic things like meals to them. I think that it is such a small amount of money to spend in the big picture to give food to elderly people, but you can’t just give them like beans and rice and have them cook it because they’re not functionally capable of doing things like that. So, just the issue of poverty underlies all the stuff that gives me moral distress in my home visits.” The health and well-being of older adults getting by on very low incomes are further threatened by service and care disruptions caused by the pandemic.

Racism and economic hardship intersect to create even greater vulnerabilities. Service providers were aware of how classism and racism interacted to create heightened disadvantages for members of their lowest-income service populations. A service provider described the struggle of their low-income clients of color, “They’re just trying to skimp and save and trying to survive in their own home whilst still maintaining some kind of dignity being at home by themselves.” The economic downturn creates further challenges, as indicated by the following respondent whose organization serves a large Latino population, “We have a lot of families that are living together because that’s the only thing they can afford. And with the economy the way it is...the way everything was shut down made it that much harder for those people that are struggling to make a living.”

Unhoused older adults. For clients without a consistent phone number or mailing address, the ability to drop in to a physical service site is imperative. Providers who serve homeless older adults express concern about the suspension of in-person services, especially when community spaces like public libraries are closed. One provider described their organization's attempt to address spatial concerns when people pick up boxed lunches: "We have a very limited amount of seating for people who want to stay inside. A lot of our clients are homeless, and so there's really no good place for them to sit down and eat a meal in any kind of peace. In a room that would fit 126 people before times, we have about 25 or 26 chairs that are all heavily spaced out."

Other service providers have lost contact with unhoused clients and those without phones to return calls during the pandemic. One explained, "I have some clients that're homeless, and they'll call me every once in a while, but they have no phone to call back...my male clients that I don't really see on a regular basis, but come for a specific service. That just aren't really reaching out anymore, aren't calling. And I haven't been able to get ahold of folks, lots of folks."

Older adults with limited English-language proficiency. Senior leaders had greater concern for older adults with limited English-language proficiency because of barriers to accessing and understanding public health information as well as navigating healthcare systems.

Participants noted that language coverage is underdeveloped for services funded by the Older Americans Act. A senior leader said, "We've done a lot of it that's been intentional with our Russian and Ukrainian communities because we've got a large number of Russian and Ukrainian elders in [city], but we haven't done a ton with other language groups or ethnic groups." Community organizations that do provide targeted language services for older adults report much success and might be looked to for models of outreach and engagement. As described previously in the section on social isolation, many have been closed due to COVID-19 and are struggling to replicate their socializing and meal services.

Latinx immigrant and migrant older adults. Migrant and undocumented immigrants, such as those whose families are dependent on the agricultural or meatpacking industries, are less protected from the virus and are at greater risk due to unequal access to health and healthcare. They are also underserved by the aging network when they feel threatened and afraid to seek services or inquire about eligibility in the current political context.

A service provider described those older adults who aren't getting their needs met: "For us, I would say a lot of them are probably undocumented seniors in our area here because a lot of them are afraid to reach out and ask for help. We don't have our – the people that we provide meals to, especially the Hispanic community, we don't have too many people that are in the program. We probably have about – it's probably about six or seven percent. But a lot of the, I know, those are the ones that would probably fall through the crack because they're afraid of getting any type of services." Another explained the relationship between the political environment of fear among immigrants and their struggle to serve their entire community: "But with the people who are at risk of the safety net, basically uninsured minorities. We have a...pretty good Latino community who were primarily engaged in – The agriculture over here is huge...And there's mistrust. There's a lack of communication...our country is polarized politically, physically, and otherwise...We've noticed that the people who are Latino that contact us have...I was going to say lack of trust, but it's more hesitant. Like, 'Can I qualify?' And they might not want to say that they're undocumented, and they might be documented. Whether they are or aren't, but it seems to me to be more than just a language barrier. Certainly part of it is language, but it takes a little bit of time initially to get that element of trust where you can tell that they feel comfortable and they feel relaxed if that makes any sense, because they're calling this program and they don't know."

Uncertainty about eligibility for services was a core concern for those living in multigenerational households, as this provider explained about their Hispanic community: "They maybe might not be needing the services or they might think they don't qualify

"The husband was actually at [a skilled nursing facility] when this was all starting, and he got infected and then taken to a hospital...the wife did not know what was going on. No one was telling her what to do until our case manager called in to check in and see how she was doing and said, 'Oh, I'm so glad you called me. I haven't heard anything from anybody. I don't know what's happening to my husband'... We're providing services, not just to the clients that we're funded to serve, but to the system that the client belongs to... Language was a big piece of that. And I don't know if those institutions didn't think to communicate with the wife because they didn't have the language capacity or at that time those systems were just slammed. They were, their focus was just making sure that their patient was okay and being served."

because they live with somebody and then they're able to provide meals, even though they have family there, that they live with family, that doesn't mean that they're there during the day or have enough money to provide meals for them. So, I think that's the main reason is just that a lot of them just live in that situation. Or a lot of them are just – they just might not think that they qualify for services.”

Unprotected labor conditions that are conducive to virus spread put Latinx older adults at particular risk. This service provider described how these conditions impact multiple members of their community: “Early on, long-term care – February, March, April – and then as the H-2A Visa workers were coming to town. And our locals that stay here around that do work in the agricultural industry – many of them are seniors. And they're out working – Tyson Foods actually had a death in a worker, and I believe he was 66 years old...You look at your workforce, they're not dispensable. You need to provide for them because you have vulnerable adults because of age and many other reasons. And you have to protect that workforce because that's now where we're dealing with the majority of our outbreaks. Has to do with the agricultural industry.”



Another service provider concurred about how hard hit people are who work in meat packing and agricultural industries in Washington: “The spread of COVID among those people has been terrible...There's been terrible problems with meat processing. Again, three, four, five guys get in the car. They're from different families. They go, somebody gets COVID. It spreads through the family.” Senior leaders are particularly worried about unprotected older adult workers who are living in households with multiple generations of unprotected workers. They observe that this combination of fear of seeking services with high-risk work and exposure is a very dangerous one for their communities.

Tribal elders. A limitation of this study was the absence of tribal organizations in the participant sample; however, some participants spoke of tribal member vulnerabilities. Tribal communities have been hit hard by COVID, both medically and economically. Providers working with tribes noted disparities in COVID illness and death among elders, and how this has had a profound negative impact on tribal government. With Indian Country borders closing, contact between off-reservation providers and older adults living on tribal land has been limited to telephone communication. Participants noted that providers within tribal communities are under-supported and underfunded to support current needs.

Service Provision: A State of Flux

Changes in service provision. Study participants were asked how many unique clients they served in May of 2019 compared with May of 2020, and to describe how the pandemic had affected service demand and provision. Of the 21 providers who shared information on numbers of unique clients served, only three organizations reported no change between May 2019 and May 2020. Twenty-nine percent reported a decrease and thirty-three percent reported an increase in clients served over the two periods, although these totals mask variability over a tumultuous 12-month period.

Nutritional needs are the biggest driver of the demand increase. Although congregate meals stopped, the need for meals increased. One program director noted, “[our home food delivery program] requires people to be homebound...which basically everybody became overnight.” Another recounted how “the phone just rang off the hook as far as people needing food delivered.” Referrals for meals skyrocketed in March and April, and then leveled off to higher than normal levels. Organizations without sufficient funds for items like refrigeration and delivery vans face challenges providing food assistance in the current environment. Some organizations have been able to creatively respond to nutrition needs by mobilizing local community resources and relationships. As this director observed, they emphasized solutions tailored to local needs and partnerships: “I think what's really successful is that it has to get down to the local level. It can't be somebody sitting in Olympia knowing what's best for everybody. It can't be somebody sitting at an entity's headquarters.” Another senior executive commented, “It's not a one-size fit thing. You really have to look at what works best in this kinda community vs. that more metro place. And that's why area agencies do function in that pretty quickly because of their relationships with their vendors and those who deliver services.”

Providers reported other challenges providing in-person services during the pandemic. For example, senior centers have had to stop recreational and social engagement activities, even though demand remains high. Many members of these centers want to participate in activities and report feeling agitated and restless without social outlets. Others also emphasized the need for funding to address the fuller scope of services, beyond basic nutritional needs, provided by these organizations pre-pandemic. A senior center program manager explained, “We are providing some food security, but that’s not really the extent of what they might need, so we haven’t been able to provide the same amount of social services and referrals as we were when we were more open.”

Demand and provision of in-home care services decreased at the onset of the pandemic but was trending upward by late summer. A clinical director of a home care agency reported a 30% decrease in service provision because clients living in facilities weren’t allowed to receive outside services. Clients receiving help with instrumental activities of daily living (IADL) opted to halt those services out of fear of contracting the virus. Some family members who were laid off lost funds to pay for in-home care but gained the time to provide it directly. The phenomenon of families moving older adults out of assisted living and nursing homes has created demand for in-home services and family caregiver training. With adult day centers closed, managing care themselves when skilled home care is needed is a challenge.

Guidance is needed to navigate risk assessment. Providers noted diversity in how their clients assessed their risk for COVID. While some were cautious and abiding by public health guidance for high-risk groups, others were ambivalent about risk and acutely aware of the tradeoffs between isolation and well-being, particularly regarding being with loved ones in the last years of life. A respondent illustrated this tension: “[They] are vocalizing sadness and anxiety and whether or not this is how – do I really wanna spend possibly the last couple years of my life not seeing the people I care about? And that’s something I noticed with some of them saying, ‘Why is society making this decision for me? And can I, as a person, decide that I might get COVID and I might die of COVID, but I’d rather see my family and friends?’” In order to address isolation during the pandemic in a way that also allows for self-determination, respondents felt that older adults need the following: increased access to public health information, help assessing risk, flexibility to allow for distanced and outdoor in-person community services, and less stringent visitation policies for family, friends, and service providers entering facilities.

Uncertain Fiscal Context

Falling revenues. As has occurred in a wide range of social service and health care settings, organizations serving older Washingtonians have experienced a more complex and uncertain fiscal landscape since the start of the pandemic. Agencies charging fees for services faced immediate drops in revenue. Falling revenues were often due to drops in demand for services. An emergency medical services provider described the fiscal realities common across our study participants: “When we see a 20% reduction in [ambulance] transports, you see a 20% reduction in billing.” Similarly, an owner of a care management company described, “Our revenues have been down anywhere from 50% to 60% since really the start of this. So, we’ve been hit pretty significantly, and we imagine that we will be hit significantly for the foreseeable future.”

Rising costs. Organizations faced increased costs as they adapted to resume services safely. Healthcare and in-home care providers, in particular, saw their personal protective equipment (PPE) budget escalate. One provider compared their current hand sanitizer use to past years, saying, “We maybe used 20 gallons a year prior to COVID-19. And now, I’ll go through 20 gallons in a day. It’s crazy. And then N-95s and face shields...It is a significant financial impact.” Meal providers faced increased costs as they shifted from providing fresh congregate meals to to-go, frozen, and delivery options to an expanding service population. PPE, plastic trays for take-home meals, and insulation to keep delivered meals hot pose new costs.

Finding ways to fill budget gaps. Despite the difficult budget environment, a relatively small number of organization leaders reported that temporary policy and funding changes kept them afloat and able to adapt. Some funding agencies used their discretion to temporarily waive contractors’ performance requirements and at times provided additional funding to help meet new demands. In addition, federal policy provided resources early in the pandemic. Many healthcare providers lauded Medicare’s new reimbursement for telemedicine. Most meal-providing organizations saw an influx of federal funding from two

“Places like ours, nonprofits that are there for the people, have been forgotten about. And so, there’s nothing for us...I mean, they’re giving a lot of money to Meals on Wheels and food places, and I get that, because that’s a real need. But what about mental and physical health? That hasn’t even been broached?”



pieces of emergency legislation passed in March: the Families First Coronavirus Response Act (FFCRA) and the CARES Act. One executive director reported, “Those two [pieces of legislation] brought about \$2 million to our organization and COVID relief for Older Americans Act program, so that was a lifesaver in and of itself because our meal production in all of our areas just doubled within a couple weeks.”

It was common for community-based organizations, particularly those with food banks, to be bolstered by an influx of cash and material donations. One executive director reported, “Now, all of a sudden, all this money’s been pumped into the system. They are inundated with food. They have milk. They have vegetables coming from [city], from all these different funding sources. And it’s the first time ever that we’ve been able to send a big check down to the grocery store and say, ‘Hey, all pantries, you have \$400.00 to spend on whatever you need.’ And they were like, ‘Really?’ We’ve never done that before. We’ve been able to do it a couple times now.”

Preparing for tough fiscal futures. At the time of our study, the state had not started its biennial budgeting process for 2021-2023, with state agencies only beginning to prepare budget submissions with significant reductions as instructed by the Governor’s office. Even amidst the presence of fill-in revenues during the early phases of the pandemic, concerns remained about long-term budget and revenue streams. Organizations with “good” fiscal news often had a powerful caveat: they expected fiscal challenges to mount in the coming months, especially as the state was just

beginning to grapple with a grim fiscal future. For example, while organizations reliant on program grants often reported fiscal stability in the current moment, many were cautiously awaiting the next grant cycle. As one community program manager said, “I think that’s what helped us that the grants that were given to us to do the projects, they gave it this year already so we are good right now. But they give it every year, so we don’t know if they’re gonna cut that funding for next year. So, we don’t know what’s gonna happen next year with this pandemic. We don’t so we have to prepare ourselves for the worst because we don’t know what’s gonna happen.” Similarly, organizations that rely on renting out event space and event-based fundraisers for additional revenue were confronting the reality that those revenue sources may not come back as soon as may have been expected in the initial months of the pandemic.

With the prospect of future funding cuts, organizations have started to weigh changes to service provision in a more constrained fiscal environment. One participant explained, “We are looking at ways to reduce [spending], and our budget, 93% is in client services. So, there’s no way that we can do a 15% reduction. We can’t just administratively tighten the belt. It has to come out of client services. So we’re looking at an eligibility cut that could potentially remove almost 10,000 people off of services because it has to be acuity-based, according to federal law, if we make reductions. So, the least acute folks have the smallest benefits. And so, it takes more of those folks coming off of services to get the reductions that we need. So, it’s really painful work to be trying to figure out how to remove people from services.”

Organizations are continuing to seek additional ways to adapt to current and future fiscal challenges. Some are contemplating using “rainy day funds.” One senior leader said, “I wanna go on record as saying, ‘It’s raining’... our federal funding that’s come for COVID, those things are all gonna start drying up. They just are.” Others are trying more creative media strategies or appeals. “I just did a social media video for a social media campaign, and that, where they’re asking me questions, like you’re asking, and I’m just being honest with them. And so, there are tears in that one, because I just can’t help myself. And we’re going to attack it on three different levels and try to raise that money and see what we can raise, because at this point, we’re just— You have to think, the box is gone. I always say that, everybody, the box is gone. It’s in recycling, and I’m now just thinking way out in left field, whatever we got to do to survive.”

Staffing and Volunteer Shortages: Doing a Lot with a Little Is Unsustainable

A number of organizations are struggling with staffing shortages as a result of revenue cuts that have led to layoffs, furloughs, and other payroll reductions. Cuts and shortages are due to declines in service demand and closures, as well as fear among staff about continuing to work, particularly those who are older and have health conditions or family members with health conditions. Such fears have especially impacted home care services.

Staff lay-offs and shortages. More than a quarter of the organizations reported having laid off staff, with most letting go of more than five staff members. Ten have issued furloughs, although five of those have been able to bring furloughed workers back. Five organizations have moved staff to part-time or further cut their hours, and three have seen hiring freezes and are not filling vacancies. Salary cuts were also reported, as explained by a healthcare provider: “My salary got cut. My manager’s salary got cut. The clinician administrator’s salary got cut. We lost a nurse and we haven’t replaced her. We lost an MA [medical assistant]. We haven’t replaced her.”

Adult day centers have been hit hard with staffing cuts. A home care agency program director reports that 60 home aides put themselves on leave. They said, “Of course, we still had the clients that needed the services, and so trying to recruit and stuff has been more of a challenge during COVID. That’s for sure. I think a lot of them look at it as they hear so many stories about nursing homes and things and to try to recruit for homecare they kind of put us in that category unfortunately.”

Challenge of engaging volunteers. At the same time as they are experiencing staffing shortages, organizations reported dramatic fluctuations in volunteer activities, which they predict will continue to change as people go back to work and as outbreaks trigger restrictions. Some have lost interns and Americorp volunteers. Many noted that older volunteers are restricted from certain tasks or unwilling to volunteer.

“It’s like a no-win situation with COVID. You have the client with high-risk problems, and you have a volunteer with high-risk problems.”

Staff are stretched thin. As a consequence of staffing reductions and increased demand for certain services, remaining staff are “doing it all,” either by increasing their responsibilities or being reassigned duties. Managers are prepping food and directing traffic in drive-through food lines. Multiple senior center directors are the only staff working. A director of a senior center who laid off all the center’s staff after spending their Paycheck Protection Program (PPP) loan explained how she is left “running it from top to bottom” and applying for every grant possible: “I’ll be working on the newsletter this week. That’s usually a position that does that on their own. And then, I have a tour coordinator that does all of our trips and daily trips and I do that because we have pushed all of our fundraising trips. [I] manage bookkeeping. I’m doing all of that and the janitor position, obviously. And then, my Executive Director position on top of all of that. So, yeah, it adds up.” Other participants described how furloughs restricted hours at a time when more time was needed to adequately address the crisis.

Remaining staff are experiencing burnout. Working in a support-provision role can be particularly difficult during a pandemic that also personally impacts staff. An increase in burnout has required extra support from upper management who are stretched thin and forced to adapt in ways that do not feel sustainable to them or their staff. There is evidence that staff dedication to their service population and willingness to put in extra hours doing tasks beyond their job descriptions is taking its toll and is not sustainable.

Participants in health care settings report that furloughs have strained systems, undermining remaining clinicians’ capacity to serve patients adequately. Adult day programs all faced lay-offs due to changes in funding and the services they are able to provide. For people living with dementia and their care partners, these programs are essential by providing socialization, engagement and caregiver respite. Many adult day health programs had their contracts suspended by the Department of Veterans Affairs (VA) and closed at the beginning of the pandemic. Unsure whether and how the VA will step in to fill this service gap, one program director described continuing to reach out via phone to former clients to maintain connection: “I ask them if their meds are okay, if they’ve seen the doctor, if they’ve seen their optometrist, anything. And most often than not, they say, ‘No, because we can’t get to there,’ or, ‘No. The social worker hasn’t called,’ or, ‘They haven’t called me back,’ things like that. Yeah. It’s kinda tough.”

Promising New Practices and Successful Adaptations

Over the past several months, providers have generated creative ways of staying engaged with their clients, summarized in Table 1. These strategies were often effective due to community partnerships, which have also aided planning for the future and preparing for next steps.

Table 1: Promising Adaptations and New Practices
Transitioning Congregate Meals to Delivery and To-Go
Using senior center transportation services for meals instead of appointments
Drive-through meal pickup
Care packages with pantry staples, over the counter medications, puzzles/brain teasers
Collaboration with local grocers and farmers
Mobile pantry food truck
Moving Online
Telephonic and Zoom-based telemedicine lowers burden of appointment for care dyad
Medicare billing for telemedicine (medical/nursing, mental health/care management, physical therapy)
Webinars broadcast live and asynchronously
Support groups for caregivers
Activity-based socialization groups on Zoom (e.g., bridge, mindfulness)
Distributing cell phones with prepaid minutes/data
Outreach to Clients
Mailed and e-mailed newsletters with interactive material and messages and updates from staff
Wellness checks and reassurance phone calls
Phone and email outreach to past participants
Senior center television show
Engagement through social media and organization webpages
Purchasing television ad spots for public health announcements and resource alerts
Engaging family and peers to encourage technology use (e.g., featured in a newsletter an 86-old client that was having a positive experience using technology to stay connected).
Creative In-Person Adaptations
Drive-through social events (e.g., parties, health fairs, movie screenings)
Forming pods for limited social contact
Outdoor distanced congregate meals/picnics
Walking tours/programmed walking routes for solo and small group use
Porchside live music performances
Sidewalk/driveway chalk art for isolated clients
Changes to physical environment (e.g., plexiglass at front desk, moving programming to bigger rooms with more aeration)
Outdoor exchanges (e.g., garden visits, craft/puzzle/book table)
Thank you note display/bulletin board for staff and volunteers
Homemade videos featuring directions to community resources (e.g., bike route)
Community Partnerships
Local restaurants making meals for delivery and takeout
Partnerships and networking to support grant writing and application
Repurposing relationships with transportation agencies to provide meal delivery
Using online platforms (e.g., Nextdoor, neighborhood Facebook groups) to increase small donations

Congregate meal site adaption. Overall, congregate meal sites reported success adapting to meal delivery and socially-distanced meal pickup. Even those with limited resources reported that drive-through and walk-up meal and pantry delivery reached more older adults than before the pandemic. Their level of success depended on volunteer and staff capacity, area geographies, transportation resources, and partnerships and networks.

Moving services online. For the most part, webinars and support and socialization groups were able to continue virtually, mostly via Zoom. Some even grew in size with the ability to stream live online and post content asynchronously. While providers faced challenges with fitness groups, other activity-based socialization groups (e.g., bridge, Pictionary, bingo, mindfulness) were well-attended and perceived as successful. Device distribution was challenging without sizable funding to support it or when clients lacked consistent internet connectivity or informal tech support at home. Prepaid cell phones appeared to be the exception and were reportedly largely successful in helping older adults connect with providers and loved ones. For healthcare providers, Telemedicine's success is contingent upon the ability to bill Medicare for both telephonic and web-based services. Many participants observed decreased burden for older patients and their care partners in the shift to virtual care but also a loss of important social contact. Telemedicine was often referred to as "better than nothing."

Outreach to clients. Most organizations were already modernizing their modes of outreach prior to the COVID-19 pandemic, with emergent digital newsletters and social media pages. Having multiple approaches to outreach already underway was beneficial in meeting a variety of client access needs. Organizations made changes to content in their outreach to help older adults stay occupied and feel connected. Phone-based wellness checks were used by many as an approach to maintain social connectedness and assess client need.

Technology Support is Needed - and It's Not a Panacea.

Barriers to engaging clients virtually shed light on the digital divide impacting older adults. A major barrier was access: many older adults did not own the types of devices (e.g., smartphones, tablets, laptops) required to participate in virtual services, or did not have access to broadband internet at home. Senior leaders described a lack of affordability for older adults with low incomes, a preference not to own or use digital technology, and living in rural areas where high-speed broadband internet is limited.

They described how technology access beyond flip phones was not possible for many clients living on low levels of income, which tended to be people of color. Some older Washingtonians with low incomes had government-sponsored cell phones or prepaid cell phones, but these were limited in features (basic flip phone) and plan (limited data, texting, and minutes).

Even when older adults had access to these technologies, they did not always have the necessary digital literacy skills to use them. One service provider said, "...people of color and the Latinx community have less access, so we tried to do a tech drive and get some donations for used tablets and laptops, so we've gotten some of those. So, we're actually in the process of distributing those out to folks who need them who would engage in our programs, but the challenge with that, then, is not everyone has internet, so, trying to get them set up with internet as well, but also, training them in how to use the technologies. That has been really difficult, especially since we can't go inside or sit at the table and do this, and then, we're kind of stretched thin, too, so that's been pretty challenging." Organizations also encountered a reluctance by older adults, particularly the oldest adults, to want newer technologies and to learn how to use them.



Another major barrier was engaging older adults with particular disabilities. For example, meaningful interactions were difficult in a virtual environment with clients who were hard of hearing, low vision, bedbound, or living with memory loss or cognitive impairment. For healthcare providers, it was difficult to conduct telemedicine visits with patients with severe cognitive impairment; they need additional support and how-to tutorials. For outpatient care, instead of interacting directly with patients, providers often spoke to a family caregiver, which impacted quality of assessment and is a barrier to billing for the virtual visit. In palliative care and hospice settings, healthcare providers commented on the loss of human touch during difficult conversations about end-of-life decisions, "...the conversation content, that's a big, tough conversation, but that's what I do. That's okay. But not being physically with him when that happened didn't feel right. It didn't feel like I was giving him my full presence, my full attention for something like that."

Several practices to address these barriers were adopted. Organizations assisted older adults who lacked access to devices or broadband internet in applying for government-sponsored cell phones; others purchased and distributed devices free of charge and with pre-loaded data, texting, and minutes. Older adults with low digital literacy skills received individual skills training by staff, peers, and family members. Organizations also created synchronous and asynchronous tutorials (for example, a pre-recorded video on how to download and use different features of Zoom). During telemedicine visits, staff and providers spent the beginning of visits helping older adults troubleshoot technical problems, although at the expense of clinical time allotted for the visit.

Finally, because many older adults perceived a loss of personal connection in a virtual environment, some organizations adopted non-technological options, such as outdoor gatherings or window visits to enable individuals to socialize in-person while adhering to physical distancing guidelines. They relied heavily on phone calls and print materials (e.g., newsletters) delivered via the postal service. Among the practices identified as promising and successful, many were low-tech solutions aimed at reaching the most isolated older adults, such as those living alone and uncomfortable or unable to access virtual programming.

Opportunities for Policy Response

Funding. Funding uncertainty is impeding organizations' innovation and ability to respond with creative tools. A respondent illustrated the urgency: "You know when you're about to get into a car accident, and you see the car's coming at you, but there's nothing you can do? But you have to brace for that impact. So, we are in a situation like that. And then I don't know what to do. We don't know what to do in terms of that because it just needs money. We just need money. And bottom line is the funding, financial situation."

Material items. Organizations need material items to mitigate the negative health impacts on medically vulnerable clients and their family caregivers. The use of PPE has risen dramatically, particularly among frontline staff, such as delivery drivers, home health aides, and nurses. Many aging services are supplying older adults with suitable masks. Although respondents noted that the spike in PPE shortage happened early on in the pandemic and has partially subsided, many also described how they are tracking, monitoring and rationing PPE now in anticipation of future supply issues. Since PPE prices reportedly increased during the pandemic, organizations expressed a need for continued funding to enable procurement. As another example of material needs, organizations that quickly prioritized nutrition services at a time of heightened food insecurity struggle to refrigerate and deliver the newly funded meals. Vans and appliances for expanded kitchen output are needed.

Accessible, quality public health information. Organizations need high-quality public health information in formats that do not require clients' use of the internet. Early in the pandemic, this need centered on separating public health fact from misinformation, and has evolved into the importance of guidelines on how to provide safe social interaction. One participant explained that "telling older adults to stay home until the end of phase four is not an adequate supportive response to our many, many, many, many, many older adults in our state. So I would say let's be more creative about thinking here how we can make sure we create safe spaces in places – not just the grocery store but

"As we've seen, COVID-19 has affected people of color a lot more, and given everything that's happening, there's so much going on right now. That's something as well just to take into consideration, that these are at-risk already populations, and then, within the population, there's people that are even more at risk. I would hope that this is a learning moment for us as a society, and particularly as Washington State, of not being so reactive. I feel like nobody was really prepared, but we should have been."

throughout our state – or times for older adults to be able to be out and about and to feel safe.” With the same sense of urgency, another spoke of their service population who “need socialization...are not getting any of it, and they are feeling sad, depressed, they don’t know what to do.” In addition to information in accessible formats, they are looking for guidance beyond isolating older adult populations who are put at risk by isolation itself.

Addressing racial and ethnic inequities through enhanced collaboration. The pandemic has exacerbated existing problems within long-term care services and policies that had been put on the back burner. This includes development of and support for services in the languages used by immigrant older adults in a given region. The pandemic has also amplified the digital divide that disproportionately cuts off clients of color with low incomes. Organizations need the government to learn from this and acknowledge that their lack of preparation disproportionately harms older adults of color - particularly Black, Latinx, and Native elders.

This crisis has made evident missed opportunities to apply and coordinate resources to meet the needs of a diverse older adult population. Many participants lauded the localized, community-knowledgeable partnerships supported by community-based organizations and how the aging network facilitated such collaboration. This has resulted in successful advocacy for necessary items that were not immediately made available, such as PPE for home care aides to use. Others also spoke to the impromptu partnerships launched to meet the crisis, as noted by a director, “If there was anything good that came out of this pandemic is that it forced all of these providers to come out of their silos and say, ‘We’re in crisis. What does the community need and how can we work together?’ And I think that happened very well, at least in the food bank and addressing food insecurity in the community piece. Because shortly after Governor Inslee put us in that first shelter in place order, we had the 12 Metro Access buses coming through and picking up food. That was great. I was thinking why couldn’t we do this without COVID? Why does it need to have a crisis...And I hope that when we come out of this, we would have an opportunity to debrief to look at what we did during the crisis. Can we continue to do that post this situation we’re in, because there was and there is still a lot of good happening because of those partnerships that have developed over the course of the last four months when we’ve been in this situation.” These partnerships are helping to spotlight and address the most urgent needs of immigrants and older adults of color - some of which are not unique to the pandemic - and could be maintained or reimaged for the long term.

“The services are being used and there is a need, and that need is only getting bigger. And this pandemic pretty much proved it, that once things do happen, people look for services and people look for help. And to have something like this happen in the future and not have these programs set already, or have them be there for people, yeah, it’d be even worse. The catastrophe would be worse, the food insecurity would be worse. The isolation, the loneliness, it’s just – it’d be tenfold, basically, if we didn’t have these programs already – if we basically got rid of these programs and something else happened in the future. It’d be just horrible.”

Mitigating uncertainty. Organizations serving older adults have made quick changes and applied Band-Aids, but client needs are long-lasting and persistent, as is the virus. A small number of better resourced organizations are starting to think ahead to the future of aging services, but most do not have the luxury of thinking about the future while still in crisis mode. They are scrambling to confront a pandemic that is even more deadly and more isolating for their older adult clients than for other populations. Organizations have made impressive adaptations at a rapid pace, but with a backdrop of uncertainty and the possibility that waivers and relief in the form of targeted funds could be taken away. Uncertainty makes it harder to adapt to a once-in-a-century crisis. Future policy changes need to take these factors into account.

Conclusion

Washington State’s aging network is nationally known for its innovation and quality, making it a top-performing state in providing Long-Term Services and Supports (LTSS) (AARP, 2020). The state has been successful in rebalancing Medicaid LTSS spending from nursing homes to Home and Community-Based Services (AARP, 2020) and has pioneered the country’s first social insurance program to help workers cover long-term care costs without spending down to Medicaid (Koller & Fulmer, 2019). These accomplishments reflect concerted efforts by the aging network to build up services for the state’s older adults and their



families. Those established services and partnerships have enabled the network to spring into action to tackle the problems the pandemic poses for its service populations.

Yet organizational senior leaders know that some of the state's most vulnerable older residents are falling through cracks that existed before the pandemic. Social isolation among older adults was already a growing public health problem now made urgent by the pandemic. Although they have been agile and resourceful in their emergency response, the state's aging social and healthcare services sectors are struggling to reach vulnerable and isolated older adults. To equitably serve older Washingtonians, addressing the digital divide must be paired with sufficient services to reach those without digital access as well. The intensifying need for aging services, particularly those that reach older adults living at the margins, mean that going back to normal quickly is not necessarily the best thing for these communities or organizations, even if it were possible. The state's aging network leverages strong partnerships, expertise, and community knowledge to provide trusted essential services to older Washingtonians and their

caregivers. Of key concern for policy makers is how to support this essential network that will only see growing demand in the coming years.

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Appendix: Methods

The University of Washington Human Subjects Division (HSD) reviewed the study and determined that it qualified for exempt status.

Participant Recruitment

The research team purposively selected 100 senior leaders of social services and healthcare organizations throughout Washington State to invite for study participation. We identified these senior leaders from our own professional networks, web searches of service providers for older adults in Washington State, and referrals from other senior leaders. We were intentional about inviting senior leaders representing all regions of the State – Western, Central, and Eastern Washington. We emailed senior leaders to explain the purpose of the study and invite study participation. One week later, senior leaders received a follow-up email and/or phone call if they had not responded to the initial email. If a senior leader was interested in study participation, a study staff member scheduled a date and time to conduct the interview. In total, we conducted interviews with 45 of the 100 senior leaders invited for study participation.

Data Collection

We conducted all interviews via Zoom July 14th through August 27th of 2020. Two members of the research team (CF and IJ) conducted the interviews. Prior to interviews, senior leaders completed a short online survey with questions about what services the organization provides, the size and sociodemographic characteristics of their service population, and the organization's sources of funding. The interviewers reviewed organizations' survey responses to gain contextual knowledge prior to interviews.

During interviews, we used a semi-structured interview guide that contained five sets of questions related to our study's objective. The first set of questions asked senior leaders how they had adapted services during the COVID-19 pandemic, what challenges older adult clients had been experiencing as a result of the pandemic, and what client groups senior leaders were most worried about. The second set of questions asked how senior leaders were using technology to reach clients during the pandemic, what challenges they experienced in engaging older adult clients via technology, and how they were responding to those challenges. The third set of questions asked about possible changes senior leaders had seen in their funding since the pandemic began and how their organization had been affected by emergency legislation (e.g., CARES Act). The fourth set of questions asked what services were limited or stopped because of the pandemic and about the organization's most pressing needs (e.g., funding, staffing, etc.). The final set of questions asked what adaptations senior leaders desired to make, what were successful adaptations, and how the organization was approaching planning and budgeting for the upcoming year.

All interviews were audio recorded and transcribed verbatim by a professional transcription company. After completing interviews, interviewers created memos summarizing the discussion and their observations about the interview. The length of interviews ranged from 30 to 79 minutes with an average duration of 45 minutes to an hour.

Data Analysis

We used Dedoose version 8.3.35 to manage the coding process. The two interviewers developed an initial codebook containing deductive codes that were based on the interview guide and their post-interview memos. The codebook was structured using the flexible coding approach described by Deterding and Waters (2018). Each member of the research team independently coded two interview transcripts using the deductive codes in the initial codebook. We reviewed the coding over multiple group meetings. During these meetings, we refined the initial codes and added inductive codes based on content from the interview transcripts that went beyond the original deductive codes. After finalizing the codebook, two members of the research team (CF and IJ) independently applied analytic codes to the remaining interview transcripts. The themes presented in the findings section of this report were generated inductively.

Reference

Deterding, N. M., & Waters, M. C. (2018). Flexible coding of in-depth interviews: A twenty-first-century approach. *Sociological Methods & Research*, DOI:10.1177/0049124118799377.

