Transforming Aging Services: Area Agencies on Aging and the COVID-19 Response

Haley B. Gallo, BS* and Kathleen H. Wilber, PhD

Leonard Davis School of Gerontology, University of Southern California, Los Angeles, California, USA

*Address correspondence to: Haley B. Gallo, BS, 3715 McClintock Ave #208J, Los Angeles, CA 90089

USA. E-mail: hgallo@usc.edu

Abstract

For over four decades, Area Agencies on Aging (AAAs) have served as focal points to help older adults remain in their homes and communities. AAAs partner with other organizations to administer services authorized under the Older Americans Act (OAA). AAAs represent loosely coupled systems; they are responsive to guidelines established by the OAA while maintaining flexibility to leverage limited resources, establish partnerships, and create innovative programs to meet community needs. As stay-at-home orders and concern for safety have kept many older adults homebound during the COVID-19 pandemic, an important question is how the Aging Network, including the over 600 AAAs, has responded to these rapidly changing needs. Although time and more systematic assessments are required, available information suggests that the loosely coupled network of AAAs has been a key, adaptable resource. This article begins with a description of the Aging Network and its history before turning to how the community-specific, collaborative, and evolving nature of AAAs places them at a unique position to respond to the challenges that arise with COVID-19. It concludes with how AAAs can continue to adapt to meet the needs of older adults and the people who care for them.

Introduction

The COVID-19 pandemic has presented decision makers at all levels of government with a rapidly changing world, creating new challenges and concerns. Much of the response has fallen to state and local governments, which were largely unprepared for a crisis of this complexity and magnitude. People in many states were told to shelter-in-place, and seemingly overnight economies were devastated with large numbers of Americans of all ages facing food and housing insecurity, health care concerns, and social isolation.

Older adults are particularly at risk for negative outcomes from the pandemic, including death, as they are more likely to have preexisting health conditions that increase their risk (Verdery, Newmyer, Wagner, & Margolis 2020). Among adults aged 60 and older living in the community, more than one quarter live alone (Ausubel, 2020) and, in many states, orders to shelter-at-home have further increased the need for instrumental support and risk of social isolation (Berg-Weger & Morley, 2020). Stay-at-home orders and concern for safety have also shut down the network of services for people aged 60 and older, including congregate meals, in-home services, caregiver support, and social, recreational, and educational activities. Limiting social interactions to suppress the coronavirus increases social isolation, anxiety, depression (Santini et al., 2020), and potentially elder abuse and neglect (Han & Mosqueda, 2020).

Confronted with these problems, the Aging Network infrastructure (comprised of the Administration on Aging (AoA), State Units on Aging (SUAs), Area Agencies on Aging (AAAs), Title VI Native American aging programs, and service providers that contract with these agencies) has had to transform its programs and services. Although time and more systematic assessments are required, available information suggests that the Aging Network's local infrastructure of AAAs have been a key, adaptable resource to respond to rapidly changing needs.

Conceptual Framework

Shortly after AAAs were established, Hudson noted that "the notion that there are untapped resources lying around out there to be taken merely for the asking is untenable. That such an assumption could find its way into regulations and guidelines bespeaks of the importance of utilizing a conceptual model which can account for the dynamics of interorganizational activity" (Hudson, 1974, pp. 54). Almost five decades later, Kunkel (2019) observed that AAAs are able to respond to the adapting and diverse needs of older adults because of their unique combination of local flexibility with a shared mission across the Aging Network. The flexibility/shared mission dichotomy suggests a system that is expected to be highly rationalized and predictable, yet sufficiently adaptable to manage a range of uncertainties, including emergencies.

The concept of loose coupling captures the paradox of interdependent system components that are standardized, predictable, and efficient (coupled), while remaining adaptive, responsive, dynamic, and flexible (loose) (Orton & Weick, 1990). For example, the Aging Network is a standardized hierarchy through which categorical grant funding is distributed from the federal government through designated state and territorial agencies on aging and local AAAs, each with their own unique networks, providers, and stakeholders. The Older Americans Act (OAA) explicitly authorizes AAAs to engage in opportunities through non-OAA funding streams (e.g., Sec. 204, Sec. 212), offering AAAs a pathway to innovate.

We use a loose coupling framework to analyze the interdependent, yet autonomous nature of AAAs' response to the pandemic. We begin with a description of the Aging Network and its history before turning to how the community-specific, expanding, and collaborative nature of AAAs places them at a unique position to address challenges related to COVID-19. We describe how loose coupling has helped AAAs mobilize community resources, partner to expand their services, and quickly respond to the pandemic. We further discuss how progress related to technology and aging (Coughlin, 2020) has accelerated during the pandemic. Building on Applebaum and Kunkel's (2018)

phases, we argue that AAAs are now entering a fourth phase accelerated by the pandemic: technology integrating. We conclude with a discussion about how AAAs can continue to leverage their networks to carry out the mission of the OAA and meet the needs of their communities.

A Brief History of the Aging Network

After years of advocacy, the OAA was passed in 1965 in a bipartisan effort to provide services to older adults who were at risk of losing their independence. The AoA was created to administer the OAA titles and be the "federal focal point and advocacy agency for older Americans" (Olah & Harvey, 2019, pp. 46), an ambitious goal with limited resources. In 1973, an "Aging Network" of state and local area agencies on aging (AAAs) was created to promote local decision-making that best served each community. AAAs administer core services authorized under the OAA: supportive services (Title IIIB), nutrition services, including congregate (IIIC-1) and home-delivered meals (IIIC-2), health and wellness programs (IIID), caregiver services (IIIE), and vulnerable elder rights programs (VII). Since their inception, AAAs were charged with dual herculean tasks: 1) develop and support core programs and gap-filling services, and 2) draw in outside resources (Hudson, 1974). AAAs rely largely on federal OAA funding to achieve the former task, while the latter requires mobilizing and organizing resources at the local level. AAAs link older adults to a variety of services and programs as outlined in the OAA, and they increasingly rely on additional community partnerships to supplement funding and services that are not provided by federal mandates (Brewster et al., 2018).

AAAs act as focal points to promote inter-organizational cooperation among other local agencies and to reduce gaps in service (Myrtle & Wilber, 1994). The OAA titles mandate specific programs, funded through categorical grants, that AAAs implement and monitor in their communities (i.e., information and referrals, congregate and home-delivered meals, socialization programs). Thus, they are bureaucratically responsive to federal and state directives while reflecting the priorities and resources of their communities. As Alter noted, the Aging Network created by the

OAA is "not as tightly coordinated as it might be but certainly as comprehensive as intended" (1988, p. 94).

AAAs are expected to do a lot with limited resources, including an administrative cap for many programs. Over the last several decades, AAAs haven been expected to do more with ever fewer federal dollars (Ujvari, Fox-Grange, & Houser, 2019). Across a range of communities, AAAs have demonstrated that they can leverage limited resources, establish partnerships, and create innovative programs to meet the needs of the growing population of older adults (Brewster et al., 2018). Their continued ability to perform these tasks during the pandemic is essential, as they provide community-specific support to serve populations who are among the highest risk of physical and mental health threats.

The Evolving Role of AAAs

In the same reauthorization that resulted in the formation of AAAs, the OAA also began to set specific national objectives (Hudson, 1974). Although this reauthorization came with substantial funding increases, the OAA encouraged AAAs to leverage resources from public and private agencies to provide additional programs and services their communities needed. Developing a broader base of support from other state and local sources helped AAAs, as Hudson (1974) argues, to "free themselves" from the constraints mandated by state or federal officials (pp. 48).

AAAs have adapted over time to reflect the AoA's evolving priorities. Applebaum and Kunkel (2018) identified three major phases that reflect these shifts: age-mitigating in the 1960s and 1970s, vulnerability-mitigating in the 1980s and 1990s, and care integrating in the 2000s. Age-mitigating services (e.g., congregate and home-delivered meals, transportation, senior center activities, employment opportunities) were born out of the idea that aging was a universal problem, and older people were deserving of support. Although this "compassionate ageism" (Binstock, 1983) is a mindset that gerontologists now largely reject (see the Gerontological Society of America's lead role

in the Reframing Aging Initiative), these concerns in the early years of the Aging Network resulted in developing and prioritizing services and programs that remain popular today. Vulnerability mitigating, which recognized that older adults are not a homogenous group, was reflected in the Aging Network's shift to establish, promote, and support programs that target those with the highest needs (e.g., home- and community-based services Medicaid waivers, elder abuse prevention, Ombudsman programs) (Applebaum & Kunkel, 2018). Most recently, the Network has focused on integrating care with large health and social service providers to support peoples' preferences to remain in their homes and communities (e.g., support for family caregivers, Medicare Prescription Drug Benefits, combination of aging and disability services) (Applebaum & Kunkel, 2018).

In addition to responding to federal and state mandates, the loosely coupled nature of AAAs enables them to be innovative and responsive to community involvement (Alter, 1988). AAAs were designed as population agencies, primarily serving people aged 60 and older; they also coordinate with local functional agencies to leverage their limited resources, addressing everything from food insecurity, recreation, homelessness prevention, and more. As the population of older adults grows and federal OAA funding remains stagnant (Ujvari, Fox-Grange, & Houser, 2019), AAAs are increasingly extending their services beyond those of the OAA categorical funding by leveraging their expertise and partnering with other entities. These partnerships include other government departments, Adult Protective Services (APS), mental health centers (Lebowitz, Light, & Bailey, 1987), nursing home transition programs (Bardo, Applebaum, Kunkel, & Carpio, 2014), managed care organizations, and hospitals (Kunkel, Reece, & Straker, 2014; National Association of Area Agencies on Aging (n4a), 2020a, 2020b). In 2013, AAAs reported having informal partnerships with an average of 10.9 types of organizations—including long-term care facilities, advocacy organizations, and emergency preparedness agencies—and formal partnerships with an average of 5.5 types of organizations— including state health insurance assistance programs, Medicaid, and

transportation agencies (Brewster et al., 2018). These existing partnerships are positioning AAAs to be at the forefront of a response to the pandemic.

In addition to creating innovative partnerships, many AAAs leverage other funding sources to supplement those provided by the OAA. Examples include dedicated sales taxes (i.e., the Dignity Fund in San Francisco, CA), creating non-profit arms, providing services for other county departments (i.e., Riverside, CA's case management services), donations (i.e., Clearfield, PA's Sponsor a Senior program), and bringing in local general funds and other grants.

AAAs Needed a Rapid Response to the COVID-19 Pandemic

AAAs' loose coupling places them in a unique position to respond to emergencies, including the pandemic. The President declared the COVID-19 pandemic as a national emergency on March 13, 2020, authorizing states to use OAA Title III funds for disaster relief as they saw fit, without the need to submit a transfer request to the Administration for Community Living (ACL, 2020a). In addition to freeing OAA funds for disaster relief (e.g., providing take-out meals and pharmacy delivery), OAA programs received nearly $1 billion in supplemental funds through the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Over $900 million was awarded to states, territories, and tribes for further allocation to local service providers (ACL, 2020b). AAAs' role as conduits for federal funding allowed them to receive additional funds quickly, while their role as community leaders and innovators afforded them flexibility in how they used the aid.

Of the 46% of National Association for Area Agencies on Aging (n4a) members that responded to a survey, 93% said they were serving more clients since the pandemic began, and 69% saw an increased need for AAA services among clients they were already serving (n4a, 2020a). Almost overnight, AAAs were confronted with the need to transition clients who participated in congregate meals programs to receive home-delivered meals, expand or adapt new activities to

reduce social isolation, and forge new partnerships with community organizations to ensure their clients' physical, mental, and emotional health needs were being met.

AAAs' established partnerships with community organizations helped them to mobilize quickly to meet growing demands, even before supplemental federal funds became available. Partnerships with health care entities are becoming increasingly common among AAAs (Brewster et al., 2020), and almost a quarter reported that health care organizations have expressed interest in forming partnerships as a result of the pandemic (n4a, 2020a). Before the pandemic, these partnerships were associated with lower Medicare spending and reduced nursing home use (Brewster et al., 2020). While these trends will likely continue in a post-COVID world, their current impacts are important as hospitals become overburdened and nursing homes are a hot spot for COVID-19 outbreaks.

AAAs also formed new partnerships to respond to increased demand as a result of the pandemic, including with the Boy Scouts of America (Sunbury, PA), nursing students looking for community practice hours (Spokane, WA), the National Guard (Norwich, NY), and nonessential county employees who could not perform their regular duties (n4a, 2020c). Other partnerships are also helping stimulate the economy. For instance, California and Florida AAAs are participating in programs that provide delivered meals from restaurants to older adults in the community (n4a, 2020c).

What the COVID-19 Response Portends for the Future of the Aging Network

Decision makers are aware of, if not always responsive to, the aging of the U.S. population. There is also growing awareness of the increasing diversity of older Americans in terms of race/ethnicity, urban/rural residences, and socioeconomic status (Mather, Jacobsen, & Pollard, 2015). These demographic trends suggest that services for older adults will need to expand their capacity to address a variety of languages, cultures, incomes, and health needs. As researchers seek

to learn more about the risks, needs, and contributions of older individuals experiencing the pandemic's health, social, and economic shocks, it is also important to examine the adaptability, resilience, and lessons learned from the Aging Network's approach. As the country continues to adapt to and eventually recovers from the pandemic, AAAs will play a pivotal role as innovators, advocates, and coordinators in their communities. The loosely coupled Aging Network offers AAAs flexibility to continue to mobilize resources, expand their advocacy role, and establish and test promising practices in their responses to the pandemic.

AAAs and their community partners have had an important role to play as the country tries to manage pandemic-related health concerns, social isolation, and economic hardships. As demonstrated in n4a's (2020a) survey, AAAs have adopted innovative practices to ensure that clients receive physical, mental, and emotional support safely—whether through online activities or telephone check-ins. In the near-term, available information suggests that AAAs are: 1) leveraging a range of services in their communities on behalf of older adults and 2) building on their networks, adding new partnerships, and applying flexible funding to address rapidly changing needs. In the longer term, lessons learned, relationships built, and innovations tested during the crisis have the potential to expand and transform the Aging Network's role in service delivery and emergency management.

AAAs Can Mobilize Communities and Expand Their Advocacy Role

Messaging about the COVID-19 pandemic, which requires top-down consistency (coupling), has been fragmented and at times conflicting (i.e., modes of transmission, mask use, physical distancing). The Aging Network is in a position to engage leaders at the state and local level to provide appropriate information that promotes older adults' safety. Similarly, marshalling resources from federal (i.e., n4a and ACL), state (i.e., ADvancing States members), and local leadership (AAAs and their providers) is essential to identify and address the needs of older adults. AAAs were established as the "linkage services" and the "mobilizer of area resources" (Hudson, 1974, pp. 48),

and they have decades of experience mobilizing and leveraging limited resources to serve older adults in a community-specific way.

Given the increased ageism that has emerged during the pandemic (Morrow-Howell & Gonzales, 2020), AAAs are well positioned to combat negative stereotypes by building on previous community education efforts. For instance, San Francisco's AAA launched a Reframing Aging campaign to combat ageism, and the AAA in Kansas City has led efforts to demonstrate older adults' positive contributions to the economy (Boyer-Shesol et al., 2015). Such efforts also help AAAs increase their visibility within the community. Residents may be unaware of the role that AAAs play, because they associate the services and opportunities they value with the public-facing community-based organizations that contract with AAAs. While some AAAs have strong partnerships and rely on their elected officials as "champions," others are largely invisible to County Boards of Supervisors and other departments within their local governments. New partnerships and expanded roles for AAAs in response to the pandemic may improve their visibility among a range of stakeholders (e.g., older adults, elected officials, other departments, service providers). These expanding roles can support AAAs' standing as communities' aging experts and enhance their ability to advocate for clients.

Flexibility to Innovate

AAAs have initiated a variety of innovations (e.g., exercise, nutrition, and disease management services), contributing to a repertoire of evidence-based health and wellness programs. Evidence-based program development builds on local, on-the-ground experiences (loose), which are then subject to rigorous, standardized testing protocols (coupled). Those that meet ACL's evidence-based program criteria (e.g., positive, measurable results; published in peer-reviewed journals) can be diffused throughout the network. (ACL, 2015).

Building on the role of AAAs in the diffusion of evidence-based OAA programs, the response to COVID-19 offers an opportunity to examine the roles and outcomes of AAAs, including identifying problems, testing promising innovations, experimenting with modifications to existing programs, and tracking lessons learned in response to the pandemic. The 2020 reauthorization of the OAA proposed a Research, Demonstration, and Evaluation Center to assess the programs authorized under the OAA and to lay the groundwork for the development of new evidence-based programs and interventions (Supporting Older Americans Act of 2020). The Center was not awarded funding in this reauthorization, yet its work remains critically important.

Although the Aging Network has a strong track record of evidence-based program development, it has faced cumulative budget cuts over the last several decades. This is due, in part, to lacking recognition of the value of supportive services (Applebaum & Kunkel, 2018). Conducting studies that test "value" is challenging, and may seem out of reach especially for AAAs that operate solely on federal funding with only a handful of staff. Nevertheless, many AAAs have opportunities to partner with local colleges and universities to study outcomes. Similarly, those interested in research (e.g., gerontology, public health, social work, public policy) at all stages in their careers may be enlisted to study and evaluate programs related to efforts to address the pandemic. This includes undergraduate interns under the supervision of a mentor, graduate students working on a thesis, faculty with grant writing experience, and practitioners with evaluation skills. As AAAs have demonstrated, gerontology in a time of pandemic requires innovative thinking and the formation of new partnerships.

Is the Aging Network Entering a New Stage?

The development and application of technology to improve the lives of older adults has evolved in waves based on the priorities of governments, businesses, and researchers (Coughlin, 2020). Technology has played an increasingly important role for the Aging Network, offering a range of tools to the AoA, SUAs, AAAs, and tens of thousands of service providers and volunteers.

Technological tools have been used to centralize core functions, communicate within the Network and with partner agencies, and disseminate information. At the federal level, tools such as the Elder Care locator help connect older adults and their families to services, while the increasing emphasis on assistive technologies help support independence (Supporting Older Americans Act of 2020). States are updating their information technology to adopt uniform and comprehensive assessments (e.g., Michigan, New York, Pennsylvania, Washington). At the local level, AAAs are piloting the development of data sharing agreements and client tracking software (e.g., San Francisco Human Services Agency).

Urgent challenges from the pandemic, including shelter-in-place requirements, closing congregate meals sites and senior centers, and restricting home visits, have accelerated the Aging Network's transition to technology adoption. SUAs and AAAs are working to help clients connect to the internet to access family and friends, faith communities, services, and health care (California Executive Order No. 73-20, 2020; n4a, 2020a). Building on Applebaum and Kunkel's (2018) work, we argue that AAAs have been steadily entering a fourth phase: technology integrating.

The loosely coupled nature of the Aging Network has the potential to solidify this stage using both a top-down and bottom-up approach. Future OAA reauthorizations might consider greater discretion and/or additional funding streams to support technology integration. For example, AAAs could be permitted to use Title IIIB funds to help clients pay for broadband or other technology that supports the goals of the OAA (e.g., reducing isolation, participating in telehealth). In addition to federal support, AAAs can pilot programs and leverage community partnerships to expand technology integration efforts. For example, some AAAs are distributing animatronic pets to help combat loneliness; about half want to offer telehealth support for their clients; some are providing technology and Wi-Fi to help clients keep their medical appointments (n4a, 2020a). While internet use and smartphone adoption are growing among older adults (Anderson & Perrin, 2017), many remain on the other side of the digital divide. This includes people aged 85 and older, racial/ethnic

minorities, and older adults with low educational attainment (Yoon et al., 2020). If the transition to technology integration continues, this will require policymakers and researchers to focus on equity and inclusion, training, and safeguards to ensure that no groups are left behind (Coughlin, 2020). Future research is needed to address a variety of questions related to processes and outcomes of technology use among older adult clients and the Aging Network itself.

<h2 style="text-align:center">Conclusion and Implications</h2>

Until safe and effective vaccines are widely available, AAAs will have to continue to adapt their service delivery systems to a "new normal." Responses to the n4a (2020a) survey indicated that many AAAs responded quickly and creatively, leveraging limited resources to serve their clients during the pandemic. As loosely coupled organizations, AAAs have localized innovations and responses to change (Myrtle & Wilber, 1994). Successful innovations have spread throughout the Aging Network, while failures are buffered from impacting other AAAs (Orton & Weick, 1990). AAAs have demonstrated outcomes of loosely coupled organizations characterized by Orton and Weick (1990), including *adaptability* to changes precipitated by the pandemic. Anecdotal evidence suggests that AAAs have been *effective* in their responses, though future research is needed to further explore this. When the dust settles from the crisis, AAAs may face several different outcomes. If it becomes evident that the AAAs were essential to optimizing resources and flexibly leading community efforts, policy makers may conclude that they were able to do more with fewer resources. Demonstration that they can be innovative with limited funding may prove to be a double-edged sword, as the U.S. enters another economic recession and many social services will be placed on the chopping block.

As the nation recovers from this crisis, it will be important to examine lessons learned from the COVID-19 response. AAAs—which are adaptive by design—were given increased flexibility in service delivery and allocated additional funds through the CARES Act. Future research should examine how this brief surge of flexible funding was spent and whether it resulted in any

transformational, sustainable changes to service delivery models. Future research should also identify and catalog promising practices in AAAs' responses (e.g., reducing isolation, increasing home safety, reducing food insecurity, leveraging partnerships), with the goal of contributing evidence-based and evidence-supported programs to the repertoire of AAA services. Another important area is to further explore the role of technology integration for both Aging Network providers and clients in light of pandemic-related challenges.

Ultimately, Gerontology in a time of pandemic will require an effort to ensure that policy makers recognize that COVID-19 has presented many challenges for older adults, including elevated risk, ageist responses, and rapidly shifting needs and resources. It is important to identify and systematically describe what older adults and those on the front line experienced, and the community-specific solutions that were developed to address changing needs. The lessons learned from these responses can be used to guide aging policy decisions at every level of government.

References

Administration for Community Living (2015). *Aging and Disability Evidence-Based Programs and*

Practices (ADEPP) Guide to Reviewing Evidence-Based Programs.

https://acl.gov/sites/default/files/programs/2017-03/ADEPP-Guide-15.pdf

Administration for Community Living (2020a). *Older Americans Act Disaster Relief*.

https://acl.gov/sites/default/files/COVID19/OAADisasterRelief_2020-03-16.pdf

Administration for Community Living (2020b). *ACL Announces Nearly $1 Billion in CARES Act Grants*

to Support Older Adults and People with Disabilities in the Community During the COVID-19

Emergency. https://acl.gov/news-and-events/announcements/acl-announces-nearly-1-

billion-cares-act-grants-support-older-adults

Alter, C. F. (1988). The changing structure of elderly service delivery systems. *The Gerontologist*,

28(1), 91-98, https://doi.org/10.1093/geront/28.1.91

Anderson, M., and Perrin, A. (2017). Tech adoption climbs among older adults. Pew Research Center.

http://www.pewinternet.org/2017/05/17/technology-use-among-seniors/

Applebaum, R., & Kunkel, S. (2018). The life and times of the aging network. *Public Policy & Aging*

Report, 28(1), 39–43, https://doi.org/10.1093/ppar/pry007

Ausubel, J. (2020, March 10). *Older people are more likely to live alone in the U.S. than elsewhere in*

the world. Pew Research Center. https://www.pewresearch.org/fact-

tank/2020/03/10/older-people-are-more-likely-to-live-alone-in-the-u-s-than-elsewhere-in-

the-world/

Bardo, A. R., Applebaum, R. A., Kunkel, S. R., & Carpio, E. A. (2014). Everyone's talking about it, but
does it work? Nursing home diversion and transition. *Journal of Applied Gerontology*, *33*(2), 207–
226. https://doi.org/10.1177/0733464813505702

Berg-Weger, M., Morley, J.E. (2020). Loneliness and Social Isolation in Older Adults during the

COVID-19 Pandemic: Implications for Gerontological Social Work. *Journal of Nutritional

Health and Aging*, 24, 456–458. https://doi.org/10.1007/s12603-020-1366-8

Binstock, R. H. (1983). The aged as scapegoat. *The Gerontologist, 23(2)*, 136-143.

https://doi.org/10.1093/geront/23.2.136

Boyer-Shesol, C., Lenk, F., Nagel, M., Pinkerton, J., & Trillo, M. (2015). *Economic Impact of an Aging

Population in the Kansas City Region.* https://www.marc.org/Community/KC-Communities-

for-All-Ages/PDFs/Economic-Impact-of-an-Aging-Population-DRAFT.aspx

Brewster, A. L., Kunkel, S., Straker, J., & Curry, L. A. (2018). Cross-sectoral partnerships by Area

Agencies on Aging: Associations with health care use and spending. *Health Affairs,* 37(1), 15-

21. https://doi.org/10.1377/hlthaff.2017.1346

Brewster, A. L., Wilson, T. L., Frehn, J., Berish, D., & Kunkel, S. R. (2020). Linking health and social

services through Area Agencies on Aging is associated with lower health care use and

spending. *Health Affairs*, 39(4), 587-94. https://doi.org/10.1377/hlthaff.2019.01515

California Executive Order No. 73-20. (2020). https://www.gov.ca.gov/wp-

content/uploads/2020/08/8.14.20-EO-N-73-20.pdf

Coughlin, J. F. (2020). The fourth wave of technology and aging: Policy innovation to ensure equity
and inclusion. *Public Policy & Aging Report*, 30(4), 138–141. https://doi.org/10.1093/ppar/praa032

Han, S. D., & Mosqueda, L. Elder abuse in the COVID-19 era. *Journal of the American Geriatrics

Society, 68(7)*, 1386-87. https://doi.org/10.1111/jgs.16496

Hudson, R. B. (1974). Rational planning and organizational imperatives: Prospects for area planning

in aging. *Annals of the American Academy of Political and Social Science, 415(1)*, 41-54.

https://doi.org/10.1177/000271627441500104

Kunkel, S. R. (2019). Building on the past, securing the future: Area Agencies on Aging and Older

Americans Act reauthorization. *Public Policy & Aging Report*, 29(2), 52-55.

https://doi.org/10.1093/ppar/prz009

Kunkel, S. R., Reece, H. R., & Straker, J. K. (2014). The evolution, innovation, and future of Area

Agencies on Aging. *Generations,* 38(2), 30-39.

Lebowitz, B. D., Light, E., & Bailey, F. (1987). Mental health center services for the elderly: The

impact of coordination with Area Agencies on Aging. *The Gerontologist,* 27(6), 699-702.

https://doi.org/10.1093/geront/27.6.699

Mather, M., Jacobsen, L. A., & Pollard, K. M. (2015, December). "Aging in the United States,"

Population Bulletin, 70(2). https://www.prb.org/wp-content/uploads/2016/01/aging-us-

population-bulletin-1.pdf

Morrow-Howell, N., & Gonzales, E. (2020). Recovering from Coronavirus Disease 2019 (COVID-19):
Resisting ageism and recommitting to a productive aging perspective. *Public Policy & Aging Report*,
30(4), 133–137. https://doi.org/10.1093/ppar/praa021

Myrtle, R. C., & Wilber, K. H. (1994). Designing service delivery systems: Lessons from the

development of community-based systems of care for the elderly. *American Society for*

Public Administration, 54(3), 245-52. https://doi.org/10.2307/976727

National Association for Area Agencies on Aging (2020a). *#AAAsAtWork for Older Adults: A Snapshot*

of Area Agency on Aging Responses to COVID-19.

https://www.n4a.org/Files/n4a_MemberSurveyReport2020_Web_07July2020.pdf

National Association for Area Agencies on Aging (2020b). *AAA National Survey Report: Meeting the Needs of Today's Older Adults.* https://www.n4a.org//Files/AAA-Survey-Report-508.pdf

National Association for Area Agencies on Aging (2020c). *Examples from the Field.* https://www.n4a.org/covid19fieldexamples

Olah, J. L., & Harvey, D. K. (2019). The Older Americans Act: An example of bipartisan public policy. *Public Policy & Aging Report, 29(2)*, 45-47. https://doi.org/10.1093/ppar/prz004

Orton, J. D., & Weick, K. E. (1990). Loosely coupled systems: A reconceptualization. *The Academy of Management Review,* 15(2), 203-223. https://doi.org/10.5465/amr.1990.4308154

Supporting Older Americans Act (2020). 42 U.S.C.

Santini, Z. I., Jose, P. E., Cornwell, E. Y., Koyanagi, A., Nielsen, L., Hinrichsen, C., Meilstrup, C., Madsen, K., & Koushede, V. (2020). Social disconnectedness, perceived isolation, and symptoms of depression and anxiety among older Americans (NSHAP): A longitudinal mediation analysis. *The Lancet Public Health*, 5(1), E62-70. https://doi.org/10.1016/S2468-2667(19)30230-0

Ujvari, K., Fox-Grange, W., & Houser, A. (2019). *Older Americans Act.* AARP Public Policy Institute. https://www.aarp.org/content/dam/aarp/ppi/2019/02/older-americans-act.pdf

Verdery, A. M., Newmyer, L., Wagner, B., & Margolis, R. (2020). National profiles of Coronavirus Disease – 2019 mortality risks by age structure and preexisting health conditions. *The Gerontologist*. Advance online publication. https://doi.org/10.1093/geront/gnaa152

Yoon, H., Jang, Y., Kim, S., Speasmaker, A., & Nam, I. (2020). Trends in internet use among older adults in the United States, 2011-2016. *Journal of Applied Gerontology.* Advance online publication. https://doi.org/10.1177/0733464820908427