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Final Research Report

Evaluability Assessment of the Weinberg Center for Elder Justice's Elder Abuse Shelter Services

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About This Report

As the number of older adults in the United States increases, there will be a corresponding increase in the need for services to prevent elder abuse and intervene in cases when it has already occurred. Because elder abuse cases often accompany a complex array of needs for support from multiple sectors—such as criminal justice, medical attention, social services, and housing—it is difficult to develop an intervention that can address cases of elder abuse. The Elder Abuse Shelter (EAS) model, pioneered by the Harry and Jeanette Weinberg Center for Elder Justice in New York City, has emerged as a promising intervention to support and protect victims of elder abuse. There are no rigorous evaluations of the EAS model. This model is based on nursing home placement, which might be counterintuitive because placement is associated with morbidity and mortality. Thus, a thorough evaluation of the Weinberg Center is critical. With this report, we aimed to document the work of one of the longest-standing, most well-established EASs, the Weinberg Center; assess its readiness for a rigorous outcome evaluation; and provide the Weinberg Center, other EASs, researchers, and policymakers with a blueprint for conducting a rigorous evaluation of this model.

Justice Policy Program

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Summary

Elder abuse is a growing problem with few evidence-based solutions. In the United States, estimates suggest that 10 percent of the "community-residing, cognitively-intact elderly respondents" (aged 60 or older) reported some form of abuse or neglect (Acierno et al., 2010). As the number of older adults increases, there will be a corresponding increase in the need for services to prevent elder abuse and intervene when it has already occurred.

Elder abuse cases often accompany a complex array of needs for support from multiple sectors, such as criminal justice, medicine, social services, and housing. Despite a National Research Council call for rigorous evaluations of elder abuse prevention and intervention programs, evidence of effective approaches remains scant (National Research Council, 2003). The lack of a sufficient evidence base on which to make decisions about policy and practice in addressing elder mistreatment represents an acute need for the field.

The Harry and Jeanette Weinberg Center for Elder Justice, located in New York City (NYC) inside the Hebrew Home at Riverdale, developed an elder abuse shelter (EAS) that combines multidisciplinary team efforts with emergency housing, both of which have been identified as promising practices in the prevention of elder abuse (Heck and Gillespie, 2013; Pillemer et al., 2016). Briefly, clients are referred to the program through a professional organization (e.g., hospital, police), are screened by Weinberg Center staff, and become Weinberg Center clients. Becoming a client entails moving into the Hebrew Home at Riverdale (long-term care community in the Bronx); connecting with a case worker; and obtaining on-site legal, medical, and social support services. Clients work with the Weinberg Center staff to determine when they no longer need Weinberg Center services. At this point, the Weinberg Center staff supports their transition back home or to another agreed-on location.

The Weinberg Center EAS model—which has been adopted in several cities across the country—employs theoretically robust programming and support, yet no evaluation of this model exists. Furthermore, placing residents in nursing homes might be counterintuitive because it is associated with morbidity and mortality, making a thorough evaluation of the Weinberg Center critical given its adoption by organizations across the country. With this study, we aimed to document the work of the Weinberg Center and assess its readiness for a rigorous outcome evaluation. We also sought to provide the Weinberg Center, Shelter Partners: Regional. National. Global. (SPRiNG) Alliance Members, and others in the research community with a blueprint for conducting a thorough evaluation of this model that will capture its positive and negative impacts on victims of elder abuse and other stakeholders.

Approach

We conducted a formative evaluation; an evaluability assessment of the Weinberg Center's EAS consisting of an examination of their organizational, programmatic, and evaluation readiness; and a comprehensive literature review of shelter model evaluations. We drew on a variety of data sources, such as interviews with Weinberg Center staff, partners, and other organizations that have EAS models across the country. We also reviewed quantitative data from the Weinberg Center and program documents that were available. Finally, we used the results of our systematic literature review of evaluations of other shelter models to inform the evaluation blueprint options we offer as potential approaches for a rigorous evaluation of this model.

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Key Findings

- The Weinberg Center's client numbers have fluctuated over time but are typically between 16 and 34 per year. This is a relatively small proportion of individuals who experience elder abuse in NYC and the surrounding area each year. The small number of clients is largely because of the Center's admissions and exclusion criteria, such as substance abuse and mental health conditions, and the requirement for a discharge plan on admission.
- Clients mostly identify as women, are ethnically and racially diverse, and are from the NYC area. Many clients also have cognitive impairment and limited financial resources.
- The coronavirus disease 2019 (COVID-19) pandemic corresponded with a decrease in the number of clients by decreasing potential clients' desire to stay in long-term care facilities and increasing turnover in referring agencies (therefore reducing knowledge about the Center's services among key partners).
- The Weinberg Center has a clear program logic model that connects inputs and outputs with measurable short- and long-term outcomes.
- The core staff consists of eight full-time individuals, including attorneys, social workers, and public health experts. Weinberg Center staff are well trained, work well together, and engage with external stakeholders successfully. Many senior staff have been with the organization for more than a decade and have substantial and valuable training in addressing the needs of victims of elder abuse.
- Organizationally and programmatically, the Center is ready to embark on an evaluation, with scores of 77 and 84 percent, respectively, in those areas of the evaluability assessment.
- However, a low score for evaluation readiness of 43 percent, driven largely by insufficient data-collection processes, indicates that the Center would need to strengthen its data collection capacity to complete a rigorous evaluation. To address this, the organization could invest in new software (e.g., to track legal services provided to clients) and develop a clearly defined training program for staff. Another relatively simple way to achieve stronger data access would be to work with partners to establish stronger data collection and sharing.
- Three evaluation designs could help the Weinberg Center rigorously evaluate its impact: (1) a quasi-experimental design using nonrandom self-selection into the program, (2) a propensity score matching design that pairs clients with Adult Protective Services data, and (3) a robust pre- and post-evaluation design. These three designs range in labor days required and would take three to six years to complete or similar. The time it takes to recruit an adequate number of study participants will shape the length and cost of the study.
- When conducting an evaluation of an EAS, researchers must consider equity, data safety, and consent. The experience of elder abuse and the tools needed to help someone heal will differ across individuals depending on their background and cultural expectations. Data related to abuse and recovery must be carefully monitored to ensure privacy is protected. Finally, consent might be difficult, though not impossible, to obtain from individuals experiencing cognitive decline. Researchers should consider consulting experts in all these areas when implementing their evaluation of an EAS.

Recommendations

Because the Weinberg Center is largely ready to embark on an evaluation, its leadership should review the proposed designs and consult with partners and potential evaluation teams as needed to decide how to proceed. Federal and state partners interested in protecting victims of elder abuse should consider funding one of these evaluation designs to determine whether EASs should be supported and encouraged to proliferate as the population ages.

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CHAPTER 1

Introduction

In the United States, estimates suggest that 10 percent of the "community-residing, cognitively-intact elderly respondents" (aged 60 or older) reported some form of abuse or neglect (Acierno et al., 2010), defined as "an intentional act or failure to act that causes or creates a risk of harm to an older adult" (Centers for Disease Control and Prevention, undated). Yet elder abuse and elder mistreatment (EM) might be grossly underestimated. The elderly population often cites being fearful of reporting abuse, and many prevalence studies limit their surveys to cognitively intact individuals (Ploeg et al., 2009). One study of elder abuse in New York found that self-identified cases of any form of abuse in the past year was nearly 24 times greater than the number of cases documented by service providers and government agencies (Lachs and Berman, 2011).

EM cases often accompany a complex array of needs for support from multiple sectors, including criminal justice, health care, and social services. Although existing interventions often cover these needs (Olomi et al., 2019; Wiglesworth et al., 2006; Yonashiro-Cho et al., 2019), housing remains a critical gap in the infrastructure for victims. Research from Olomi et al. (2019) suggests that stable emergency housing was a need among nearly 25 percent of victims of elder abuse interviewed. One review identified 115 programs that address issues around EM, but only seven addressed emergency housing needs (Rosen et al., 2019).

Against this backdrop, many worry that the high prevalence of EM will become a larger problem as the size of the older adult population increases. According to the U.S. Census Bureau, the number of Americans aged 65 and over will double between 2018 and 2060, from 52 million to 95 million (Mather et al., 2019). With this growth, there will be a corresponding growth in the need for services to prevent EM and for interventions in cases in which it has already occurred. However, despite a National Research Council call for rigorous evaluations of EM prevention and intervention programs 20 years ago (National Research Council, 2003), evidence of effective approaches remains scant. The lack of a sufficient evidence base on which to make decisions about policy and practice in addressing EM represents an acute need for the field.

It is in this challenging context—a growing population of older adults, a significant prevalence of EM, and limited knowledge of what works—that our RAND Corporation research team conducted an evaluability assessment of an Elder Abuse Shelter (EAS) that combines multidisciplinary collaboration with emergency housing: the Harry and Jeanette Weinberg Center for Elder Justice at the Hebrew Home at Riverdale (hereafter "Weinberg," "the Weinberg Center," or "Center") located in New York City (NYC). The Weinberg Center incorporates two approaches—stable and temporary housing and a collaborative multidisciplinary team—that have been identified as promising despite the limited evidence in this field (Heck and Gillespie, 2013; Pillemer et al., 2016). Moreover, an initial evaluation of the Weinberg Center's approach using cost data from existing literature and hypothetical vignettes suggested that the model could generate savings that exceed its operating costs (Smucker et al., 2021). However, it is important to stress that this initial investigation was based on hypothetical scenarios, and a rigorous evaluation of this approach and any potential cost savings is essential as its use expands.

Our team partnered with the Weinberg Center and other communities implementing the EAS model in association with the Weinberg Center's Shelter Partners: Regional. National. Global. (SPRiNG) Alliance. With this project, we aimed to document the work of the Weinberg Center; assess its readiness for a rigor-

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ous outcome evaluation; and provide the Weinberg Center, SPRiNG Alliance members, and others in the research community a blueprint for conducting a rigorous evaluation of this model.

The Weinberg Center

The Weinberg Center is an elder abuse prevention and intervention program located within the Hebrew Home at Riverdale. The Weinberg Center's comprehensive EAS was launched in 2004 and provides temporary shelter and extensive services for victims of elder abuse aged 60 and over. The Weinberg Center's multidisciplinary team of attorneys, social workers, and public health professionals offer case management, intensive therapeutic support, and a full range of legal services through trauma-informed strategy aimed at remedying abuse; promoting healing; and, whenever possible, placing the older adult safely in the community.[1] The Hebrew Home at Riverdale is a nonprofit, faith-based long-term care community in the Bronx. Clients receive a full complement of medical attention and rehabilitation services to meet their needs, including skilled nursing, dementia care, or services for any other age-related condition. The mission of the Weinberg Center is to champion dignity and justice for older adults with the goal of ensuring a client's long-term safety and wellbeing.

The program was developed in response to a gap in services for people aged 60 and older who experience abuse. Clients are typically individuals who have complex needs that a traditional domestic violence shelter cannot accommodate, such as cognitive impairment or physical limitations related to aging. Because the Weinberg Center is housed within an existing long-term care community, clients have immediate access to medical care, social work, therapy, and other services provided to residents. There are also opportunities for social engagement and interaction with other residents.

The Weinberg Center also provides expert guidance and technical assistance to other communities developing EAS programs through its SPRiNG Alliance program. Formed in 2012, the Alliance is a collection of 23 organizations and individuals that support the development and growth of the EAS models across the country. Members of the SPRiNG Alliance advocate for shelter, offer support to their peers, and gather once a year to discuss their progress and share best practices. The Weinberg Center staff also encourage SPRiNG Alliance members to collect data to track progress over time and identify gaps in services.

In addition, staff at the Weinberg Center provide trainings to organizations with aligned professions and institutions, such as law enforcement, legal professionals, hospital staff, Adult Protective Services (APS), social service agencies, and financial services. The team also designs and distributes educational marketing material to inform community partners about EM and abuse, as well as about services at the Weinberg Center. Finally, staff at the Weinberg Center serve on multidisciplinary teams to discuss cases, share resources, and develop plans for people who experience elder abuse.

The Weinberg Center is leading the effort to expand the use of the EAS model in diverse communities across the United States. However, the Weinberg Center EAS implementation and impact have not been formally assessed.

[1] *Trauma-informed services* are defined as services that recognize the traumatic experiences and their sequalae in clients. Key steps to providing trauma-informed services are "meeting client needs in a safe, collaborative, and compassionate manner; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff" (Center for Substance Abuse Treatment, 2014).

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Research Objectives

Working closely with the staff at the Weinberg Center, our key goals for this study were to:

1. document the EAS model implementation process and desired outcomes using a logic model
2. perform an evaluability assessment of the Weinberg Center's EAS
3. provide an evaluation design that can be used to assess the effectiveness of a variety of EAS models.

Conducting site-level formative evaluations and evaluability assessments before starting work on a full-scale impact evaluation has several advantages, including identification of appropriate internal program logic that stakeholders have agreed on, outcomes that can be measured, and feasible designs that can be implemented at reasonable cost and duration. Trevisan and Huang (2002) identified additional benefits to evaluability assessments, including that they allow researchers to identify whether any observed failure was the result of the program or the evaluation itself; gaining stronger buy-in from stakeholders and potential evaluation users through participation in the evaluability assessment process; and, with evaluability assessments' emphasis on program logic, strengthening understanding of a program's long-term outcomes.

This Report

This report documents the results of our study organized across the three research objectives outlined above. The remaining chapters are structured as follows:

- **Chapter 2. Data Collection and Analysis** describes the methodology for this study, including sources of data and the analysis plan.
- **Chapter 3. Formative Evaluation** provides an overview of the Weinberg Center's EAS, including client engagement and needs, services provided, and benefits and expected outcomes. This chapter also provides a logic model to visually summarize the program and expected impact.
- **Chapter 4. Evaluability Assessment** presents the results of our evaluability assessment of the Weinberg Center. The chapter focuses on organizational culture, capacity, staff, and partners; program readiness (which focuses on program design, implementation processes, procedures, collaborators, and staff capacity); and evaluation readiness (which focuses on quasi-experimental design elements, enrollment of clients, and data collection).
- **Chapter 5. Program Evaluation Design Options** outlines three options for a rigorous evaluation design for evaluating the Weinberg Center. The chapter includes potential data collection protocols and instruments for evaluation, evaluation plans, and cost estimates for the evaluations. It also includes discussion of how evaluation plans could be applied to other EASs.
- **Chapter 6. Conclusion** summarizes the findings and outlines evaluation next steps.
- **Appendixes A–D** summarize the data collection tools used and the detailed outcomes of our literature review that are summarized in the main text.

Changes in Approach from Original Design

Our original design included developing fidelity measures for an EAS model. However, over the course of our data collection and analysis, we found that the EAS model is still developing across sites. While the Weinberg Center's EAS is clearly defined, this model does not carry exactly to other EASs across the country.

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This is because each EAS responds to a different context with differences in funding models, geography, and partnership models with local assisted living facilities and law enforcement. Therefore, any fidelity measures should be designed around each EAS individually at this time and broad measures would not be appropriate.

Artifacts

As part of this study, we created several artifacts. First, we created a streamlined logic model that focused specifically on client experience and outcomes. This model presents items from the Weinberg Center's own logic model (Smucker et al., 2021) and new items identified by the RAND team. The second artifact is a case flow diagram that captures the core components of a client's experience at the Weinberg Center EAS. We also created a list of measures that could be leveraged in a future outcome evaluation of an EAS. Finally, we developed two tables that reflect the core components of a rigorous outcome evaluation for an EAS model. The first lists the inputs needed, research questions, and pros and cons of the design. The second outlines key steps in the research timeline. To facilitate wide dissemination of the information in this report, we also created a short research brief that we planned to hand out at the SPRiNG Alliance conference in March 2023 (Smucker et al., 2023). We will also present the results of our report at the same conference and make recommendations about how the EAS leaders can strengthen their data collection and evaluation capacity going forward.

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CHAPTER 2

Data Collection and Analysis

In this chapter, we review the key components of our study and the methods used to document the EAS model implementation process, perform an evaluability assessment of the Weinberg Center's EAS, and provide an evaluation design that can be used to assess the effectiveness of a variety of EAS models. All components of the project were approved by RAND's Institutional Review Board, which includes the approval of all data collection methods and verbal consent for qualitative data collection.

Formative Evaluation

A formative evaluation aims to capture the mechanisms that make up a program and contribute to its impact on clients (Owen, 2007). Identifying these mechanisms is critical to designing an evaluation because it allows the researchers to discern whether a change in participant outcomes is because of the program's planned impact or more likely because of another factor.

In Chapter 3 of this report, we summarize the findings of our formative evaluation of the Weinberg Center EAS. The chapter sections discuss the overall program approach, program goals, staffing, clients, services and engagement, training, evaluating effectiveness, the effects of coronavirus disease 2019 (COVID-19) on the program, and successes and challenges of the Weinberg Center over the course of its history. The formative evaluation is based on (1) interviews with key staff and collaborators to gain a better understanding of the program, its implementation, and its evaluation readiness, (2) documents provided by staff about training and outreach, and (3) a logic model documenting the inputs and outputs of the program. The formative evaluation sets the stage for Chapters 4 and 5, which dive into the evaluation readiness of the program and possible evaluation designs that could rigorously evaluate the impact of the program.

Evaluability Assessment

For the evaluability assessment, we used a tool developed by RAND researchers called the Program Implementation and Evaluation Readiness (PIER) report that we adapted to reflect the features of the Weinberg Center EAS.[1] The overarching criteria used to evaluate the program are organizational culture, program capacity, leadership and key staff, program staff, program design and implementation, staffing and training, possible evaluation design, and data collection capacity.

[1] The PIER report is composed of key constructs that have been identified by scholars of implementation science as important to successful program implementation and evaluation (Damschroder et al., 2009; Barwick, 2011; Barwick, Dubrowski, and Damschroder, 2020; Kaufman-Levy et al., 2003). Note that the PIER Report is not intended to serve as a validated scale, but is a useful way of assessing the extent to which a program meets a broad set of characteristics that are linked to strong implementation and program evaluation. RAND is currently engaged in the early stages of testing a standardized version of the scale for broader dissemination and use.

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Three RAND team members scored the Weinberg Center's EAS using interview data to determine the prevalence of evidence for each criterion. Any disagreements between the three researchers were discussed until consensus was found. Scores were assigned as follows: 0 = no evidence of metric, 1 = minimal evidence of metric, 2 = some evidence of metric, 3 = (nearly) complete agreement with metric. Individual scores were then summed across all metrics to create a final score, with higher scores indicating greater readiness for evaluation. The results are presented in Chapter 4. Appendix D provides a complete list of factors included in the PIER report and the scores the Weinberg Center EAS received.

Options for Evaluation Designs

As the introductory chapter outlined, there is a dearth of rigorous evaluations of elder justice interventions. To address this, we developed a tailored suite of evaluation designs that could be used for an evaluation of the Weinberg Center's EAS or other EASs. To develop these evaluation design options, we started with a comprehensive review of executed evaluations of shelters (elder focused and non-elder focused). We used an extraction form to collate possible evaluation designs, data, and measures and identified practices that could fit an evaluation of the Weinberg Center's EAS. We also collected information from evaluation experts at RAND (including members of our team) about cost, ethics, and feasibility to determine our top three recommended evaluation designs. Those three recommendations are described in Chapter 5.

Data Collection and Analysis

To complete the formative evaluation and evaluability assessment, we collected and analyzed data from three main sources: staff interviews,[2] systematic literature review, and data collected by the Weinberg Center from SPRiNG Alliance members.

Staff Interview Data

To develop a deep understanding of the Weinberg Center and SPRiNG Alliance member organizations, we conducted interviews with key staff and consultants of the Weinberg Center and SPRiNG Alliance member organizations. First, we conducted in-person interviews in March 2020 with seven program leadership and staff members at the Weinberg Center.[3] This effort consisted of ten interviews with staff across a variety of professions including lawyers, social workers, accountants, and data analysts. Staff were selected to represent Weinberg senior leadership and at least one member of each professional discipline (i.e., type of service provided at the Weinberg Center). When more than one person occupied a role, the more senior person was interviewed. However, in many cases, all individuals from the respective roles were interviewed.

We also conducted four virtual follow-up interviews: three with Weinberg Center staff and one with an external consultant working with the Weinberg Center to develop an evaluation plan for APS-involved clients in August 2022. This second round of interviews improved our knowledge of the impact of COVID-19 on the Center and captured lessons learned from a new evaluation effort the Weinberg Center had undertaken since 2020. We paired these interviews with conversations with staff at six organizations that refer clients to the Weinberg Center or work with similar populations in the community. These interviews provided

[2] Clients, families, nursing home staff, and other stakeholders were not interviewed in this initial report.

[3] Part of this interview process took place in tandem with another project that our team conducted with the Weinberg Center to minimize the burden on staff (see Smucker et al., 2021, for details)

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us with information about possible comparison groups to the Weinberg Center clients and a better understanding of the strength of the relationships between the Weinberg Center and its partners.

Finally, to improve our understanding of how the Weinberg Center compares with similar organizations, we also conducted video interviews with staff from six of the SPRiNG Alliance member organizations between May and August 2022.[4] The Alliance members we spoke with reflected a variety of locations and shelter models: Three were based on the East Coast, one in the Midwest, and two in the Southwest. Three were embedded within an assisted living facility, and three were based in the community. All interviews were conducted via Microsoft Teams by a two-person RAND team. The interviews were semistructured and lasted 30 to 60 minutes each.

Interviews followed two detailed but flexible interview guides—one for Weinberg Center staff and one for other interviewees—to capture core information about client engagement and needs, services provided, benefits and expected outcomes, and data collection practices for each program. Both interview guides can be found in Appendix A.

To synthesize the large quantity of qualitative information generated by the interviews and program documents, we first used a method that has been used successfully in several qualitative studies (Hussey, Ridgely, and Rosenthal, 2011; Ridgely, Giard, and Shern, 1999; Wu et al., 2007). We manually coded the qualitative data by key dimensions using a codebook using the interview protocol and emergent themes. Thorough notes were taken during each interview; to aid identification of themes, the notes were taken with the interview protocol on hand, allowing interviewers to record what was said and note other relevant issues. Interviews were also recorded to allow the notetaker to review and fill in any pertinent missing information. The transcripts and codebook were uploaded to a qualitative data analysis tool, Dedoose.

One senior qualitative researcher on our team coded the interviews with input from the other team members. The coder and team members met to review and reconcile coded interviews. Interview data were analyzed to detect meaningful differences, compare stakeholders' roles, and identify salient themes. This coding scheme formed the basis of an analytic matrix composed of excerpts that exemplify a code that allowed us to organize the qualitative data into manageable units. This matrix was used as an organizing tool to facilitate documentation of the basic features of the program as implemented and to provide contextual information for the evaluability assessment.

Literature Review

We conducted a review of the literature to inform our suggested evaluation designs. Our search broadly aimed to capture existing evaluations of shelter models with the intention of drawing on these examples for approaches to identifying strong comparison groups, statistical methods, and options for longitudinal data collection among a shelter-based population.

We worked with RAND Knowledge Services librarians to pilot and finalize search strings to search the following literature databases: Academic Search Complete, Business Source Complete, Criminal Justice Abstracts, HeinOnline Law Journal Library, EconLit, Google Scholar, Index to Legal Periodicals, National Criminal Justice Reference Services (EBSCO), PAIS (ProQuest), Policy File Index, PsycINFO, PubMed, Scopus, Social Science Abstracts, Sociological Abstracts, and Web of Science. (Appendix B provides a full list of search terms.)

[4] This data collection was in addition to demographic data the Weinberg Center provided from the SPRiNG Alliance Members.

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We complemented the search strings with a set of inclusion and exclusion criteria to help determine whether a source identified through the searches should be retained for review. Our inclusion and exclusion criteria were as follows:

- The source was published between 2010 and 2022.
- The source was published in English.
- The source included no limitations on geographical scope or temporal scope of intervention.
- The source's substantive scope of intervention focused on either a shelter model (including EAS) or addressing EM or abuse.
- Dissertations were included but could be deprioritized.
- Nonempirical sources were included but used only for background and context.[5]

RAND Knowledge Services librarians retrieved, deduplicated, and consolidated the search results in Endnote (a reference manager). Members of our team screened titles and abstracts against the inclusion and exclusion criteria. Ten percent of the sources were independently double screened by two researchers on our team to establish intercoder consistency with reasons for exclusion logged by each reviewer. Any disagreements between reviewers were collaboratively resolved, and any clarifications to the inclusion and exclusion criteria were distributed to all reviewers. This process yielded 102 articles, which were retrieved and reviewed in full by members of our team (Table 2.1). A total of 35 articles were ultimately included in our study.

To record information from each of the 35 documents, our team developed a data extraction template with the objective of ensuring a unified approach to reviewing included articles. The template took the form of an Excel spreadsheet, with each row corresponding to individual sources (or individual interventions or studies, if the source covered multiple interventions or studies) and each column corresponding to various categories of information to extract. Researchers also reviewed bibliographies of included articles for any potentially relevant material but did not find any additional relevant items. The findings from this review are primarily found in Chapter 5, which draws on the evaluation frameworks, data, and measures from existing evaluation to develop potential evaluation designs for EASs.

TABLE 2.1
Sources Returned by Search and Screening Process

Screening Step	Number
Unique sources screened	1,565
Sources removed after title screen	1,122
Sources removed after abstract screen	306
Sources removed after full-text review	102
Total sources included in study	**35**

[5] We excluded qualitative studies from this part of the analysis in an effort to focus on quantitative focused designs and measures that could produce findings that could be generalizable to other populations. However, our research designs in Chapter 5 do suggest collecting and analyzing qualitative data in tandem with quantitative data to develop a more complete picture of the impact of the intervention.

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CHAPTER 3

EAS Description and Logic Model

Our interviews with key staff from the Weinberg Center provided an opportunity to learn about the approaches that the organization takes to support older adults experiencing abuse. This chapter presents information from our data collection methods, including documentation review and interviews, that has been organized into nine domains: description of the Weinberg Center's EAS, staffing of the EAS, services and engagement provided to clients, characteristics of clients, training for EAS staff, evaluating effectiveness, COVID-19, and successes and challenges. Interviews with key staff were not for attribution, so no names are provided. Where appropriate, however, we include information on the interviewee's position, department, or status.

Program Description

The Weinberg Center is an elder abuse shelter and intervention program of the Hebrew Home at Riverdale, a large continuum of care community located in the Bronx. The clients who come into the shelter are placed throughout the Hebrew Home's campus based on their medical needs and have access to all medical, cognitive, rehabilitation, and therapeutic services available to Hebrew Home residents. The Weinberg Center's multidisciplinary team works with each client to create and execute a comprehensive, trauma-informed strategy aimed at remedying abuse; promoting healing; and, whenever possible, returning the client safely to the community. The goal of the Weinberg Center is to reduce personal and societal health costs of elder abuse by providing a safe respite for older adults. To achieve this goal, the Weinberg Center leadership designed its programs to support safe recovery in shelter, increase knowledge among victims and advocates about resources for victims of abuse, increase the number of intervention efforts and shelters for older adults, and promote empowered aging and elder justice.

Figure 3.1 presents a visual depiction of the program goals in the form of a logic model. It details the following components with corresponding measures: (1) inputs, (2) program activities, (3) anticipated outputs, (4) anticipated client outcomes, and (5) anticipated impact on clients in the longer term. The anticipated outputs and short- and long-term impacts on clients are hypotheses that have not been evaluated. Any outcomes evaluation of the Weinberg Center model should test these hypotheses and capture any unintended or negative consequences emerging from the model. Note that this logic model focuses only on Weinberg Center clients and does not include other work like community outreach and legal training that Weinberg Center staff also engage in. For a more complete logic model of the Weinberg Center that covers all components of their work, see Smucker et al. (2021).

Inputs to the program are key staff, site capacity (in this case, for the Hebrew Home at Riverdale Nursing Home), funding, leadership support from the Hebrew Home at Riverdale, support from community partners, and time needed to provide services and community outreach. The program is made up of key staff, including four Staff Attorneys, three social workers, and one Public Health Specialist. The core staff also work with the Hebrew Home foundations and grants team, research department, and medical staff who are based in the

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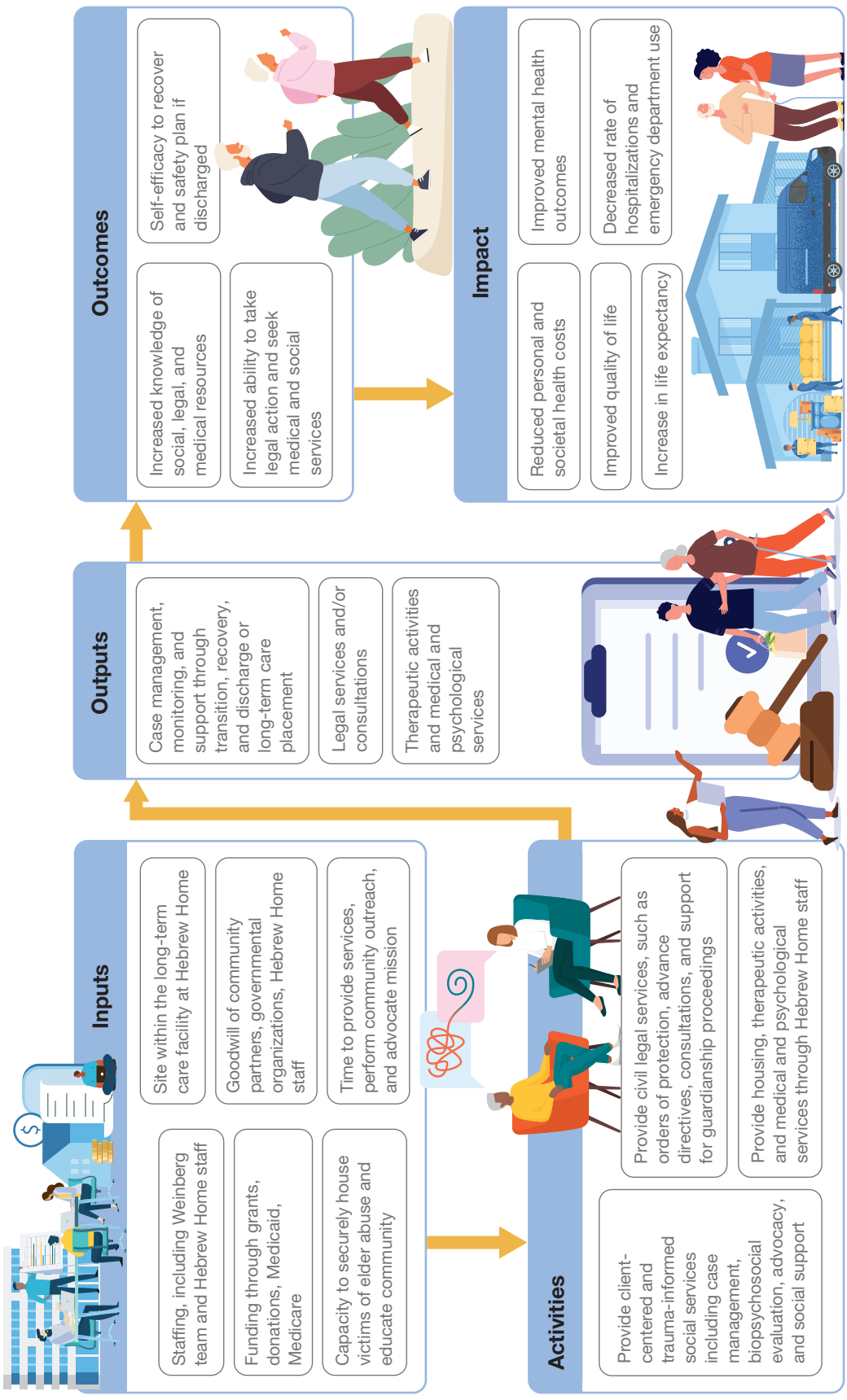
FIGURE 3.1
Weinberg Center's EAS Logic Model



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Hebrew Home and receive funding from grants, donations, and Medicare and Medicaid. The program also relies on the active involvement and guidance of the chief executive officer of the Hebrew Home, as well as community partners and governmental organizations that refer clients to the Weinberg Center.

These inputs are used to implement a variety of activities. The program offers both client-centered and trauma-informed social services, including case management, biopsychosocial evaluation, advocacy, and social support, as well as a variety of legal services provided by the Weinberg Center's legal team. These inputs are designed to translate into several key outcomes. First, the Center aims to improve the self-efficacy and health of clients through improved medical care and the development of a safety plan to reduce the risk of future victimization. Legal services also aim to increase the likelihood that victims benefit from legal action, and perpetrators are deterred from enacting further abuse in the future. Finally, the Weinberg Center educates clients about resources available to them both to address any future abuse and generally to support healthy and happy living. Together, these outcomes should link to long-term impacts like reduced personal and societal costs of health care, improved quality of life, increase in life expectancy, improved mental health, and decreased rates of hospitalizations and emergency department use.

The Weinberg Center draws on two primary sources of funding. First, the Weinberg Center pays for housing and medical care for clients through insurance (e.g., Medicaid or Medicare).[1] Clients who enter shelter benefit from the Hebrew Home's medical, therapeutic, and rehabilitative services during their temporary shelter placement. Second, the program draws on grants and donations to cover services outside those provided by the Hebrew Home. Additional funding comes from NYC support for domestic violence services, State Victims of Crime grants, and grants from foundations. These additional funds go toward funding staff salaries, programmatic costs, and administrative costs. The remainder of these funds are used to provide for clients' basic needs, including transportation to court hearings, a companion for outpatient medical appointments, a cell phone or tablet, clothing, credit checks, electronic pets, staffing for a personal aide, toiletries, a monthly allowance for clients with no income, a track phone once discharged from shelter, clients' unpaid bills, and other essential items. A detailed examination of the Weinberg Center's funding sources, budget, and actual costs to implement the model was outside the scope of this evaluability assessment but should be included in any future evaluations to assess replicability and sustainability.

Staffing, Services, and Engagement with Clients and Community

As mentioned above, the Weinberg Center historically maintained seven core staff members. However, to increase the number of victims identified, the Center also recently added an eighth staff member: a specialist who screens new residents at the Hebrew Home for elder abuse.[2] Additionally, a new grant has allowed the Weinberg Center to hire another social worker on a contract basis to follow up with clients when they return to the community. The key roles of each staff member are summarized as follows (client-focused activities are discussed more fully in the description of the case flow):

- Staff Attorneys
  - provide legal consultation and advocacy in the criminal and family court systems, prepare witnesses, strategize the legal components of discharge, draft and review legal documents, and advocate on behalf of clients to local law enforcement and district attorney's offices

[1] Staff confirmed that they do not recall an instance in which a client used private insurance to support their stay at the Hebrew Home.

[2] Note that the Hebrew Home is the larger skilled nursing facility that the Weinberg Center's EAS is housed in.

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  - support clients who need orders of protection, advanced directives, consultations, and assistance in obtaining or changing guardianship arrangements
  - provide training and technical assistance to partners
  - advocate for changes in policies and laws.
- Elder Justice Specialists (Licensed Master Social Worker [LMSW]) (based in the Hebrew Home)
  - provide case management, individual counseling, court accompaniment, safety planning, shelter and housing application assistance, client capacity assessments, biopsychosocial assessments, client advocacy, group counseling work, Medicaid conversion, client discharge planning, and victim compensation applications
  - guide clients through relationship restoration if desired and appropriate
  - conduct trainings and create educational materials for other professionals and providers in the community.
- Public Health Specialists
  - develop and distribute outreach materials
  - collect program data
  - write grant reports
  - contribute to case discussions
  - maintain relationships with community partners
  - provide a public health perspective to Weinberg Center activities.
- Elder Abuse Screening Specialists (Licensed Clinical Social Worker-Mandatory Legislation [LCSW-R[3]])
  - screen existing and new Hebrew Home clients for EM and connect to services at the Weinberg Center as needed
  - train other Hebrew Home staff to screen for EM
  - connect Hebrew Home clients to community-based services as needed.
- Transitional Care Social Workers (Licensed Clinical Social Worker [LCSW]) (based in the community)
  - follow-up with clients at 30, 60, and 90 days after moving into the community and report back to Weinberg Center staff
  - provide clients with supportive counseling, advocacy, and referrals to appropriate community-based resources.

These staff come together to offer a slate of services to every client, including basic case management, emotional and mental health support, medical care, and legal support. The legal team and Public Health Specialist also do significant public engagement work. The team produces and conducts trainings for other legal professionals, develops website text, and writes articles about their work for the legal, social work, and research communities. One senior staff member explained:

> We create trainings for professionals—not typically for the general public—[we] also try to create very specific targeted info for specific professionals. For example, we are working with the New York State court system to create a guide for court personnel throughout the state—anyone working with older adults through a court system throughout the state—what do they need to know when a person comes into the courtroom; that will be combined with trainings alongside the rollout of that guide.

[3] An R denotes an LCSW who fulfills the requirements of the insurance law for supervised experience providing psychotherapy and is recognized in New York as a reimbursable psychotherapist. An LCSW-R requires insurance carriers to provide reimbursement for psychotherapy services whenever a health insurance contract includes reimbursement of qualified psychologists and psychiatrists (Clinical Social Work Association, undated).

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These staff also work closely with members of the SPRiNG Alliance to develop their capacities and work. This entails coaching leaders at new shelters through the process of grant writing, community connections, and client services. The Weinberg Center team also hosts monthly calls and a yearly symposium of all SPRiNG alliance members to discuss the state of their work and allow staff at all centers to discuss best practices and areas where they are struggling.

Case Flow

The typical path of a client flows like this: The Weinberg Center receives a referral from a professional in the community, typically a partner organization familiar with the Weinberg Center's work, like hospitals, APS, the court system, and the police.[4] A detailed breakdown of referral sources was not collected at the time of the evaluability assessment but should be included in any future evaluation. The Weinberg Center Elder Justice Specialists and Staff Attorneys communicate with the referral source and any other relevant parties (e.g., non-abusive family members, official guardians, etc.) to assess the status of the case and determine whether the elder adult is appropriate for shelter placement. There are several requirements that a potential client must meet before entering the EAS. First, the EAS is not equipped to support individuals with untreated mental health or substance misuse issues. Thus, individuals with untreated mental health or substance misuse issues are not accepted to the Weinberg Center. Second, the Weinberg Center requires that clients have a clear discharge plan that is feasible (e.g., the person or their guardian can make decisions about their next steps after their stay at the EAS). It is not known whether or how these eligibility requirements shape the number of referrals or the sources of referral to the Weinberg Center.

Weinberg Center staff also confirm that the older adult understands the Weinberg Center's program and policies, including a two-week no-contact policy. This policy restricts clients from contacting friends and family during the two weeks following shelter admission. The idea behind this approach is to give the client time to determine his or her own needs and wishes, without the influence of a possible abuser. The team also considers which Hebrew Home residential neighborhood is the best for the client based on their medical and social needs, as well as any safety measures needed to ensure the client's safety while in shelter. The Weinberg Center staff also considers the special care needs of the client and communicates with the Hebrew Home clinical team to make sure that the Hebrew Home can meet such needs. Additionally, the Weinberg Center communicates with the other providers at the Hebrew Home, such as the nursing team, to ensure that they have the information they need to provide person-centered care while also respecting the client's wishes about privacy.

After a client arrives at the Hebrew Home, staff address that client's basic needs (such as clothes, books, and music), help the client get settled in their new accommodations, and speak with the client about possible goals. Next, staff provide case management services and help the client sort out issues directly related to their victimization. This process could involve calling banks, having locks changed, connecting with APS and police, obtaining personal items from an unsafe home, and conducting credit checks, among other activities. Weinberg Center staff will also help clients contact other non-abusive family members to update the family on the client's situation. All staff members' goals are centered on the clients' goals, whether that be returning to the community or continuing in new accommodations or long-term care.

The legal team plays a central role in providing services to clients at the Weinberg Center. First, the team creates a tailored plan for each client. The work begins before the client arrives, learning about their case and possible legal remedies to their situation. When the client arrives, the legal team conducts an intake process

[4] The Weinberg Center will not accept self-referrals or referrals from family members or friends.

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to discuss the client's legal needs. Much of the work is geared toward paving the way for the client to move home, back into the community, while remaining separate from their abuser. This might involve going to housing court to remove a person who refuses to leave the client's home or obtaining a restraining order to prevent the abuser from interacting with the client. The team may also attend guardianship hearings if the client needs a new guardian or would like to remove a guardian who is abusing their power. They can also support cases in civil court, annulments or divorces, advanced directives, and the creation or restructuring of wills.

The Weinberg Center's elder abuse specialists provide trauma-informed care and case management to clients. Their work largely involves offering individual counseling and supportive services to clients, as well as psychotherapy. These counseling sessions center on helping clients deal with the trauma and posttraumatic stress associated with experiencing abuse from a loved one. One social worker noted that approximately " . . . 90 percent of abuse I see is from family members [and] 80 percent is from children." This situation requires a unique skill set from social workers because being abused by a child is very different than intimate partner abuse. Clients typically see themselves as parents of a difficult child who needs help, as opposed to struggling to manage or escape a troubled relationship. This often leads to a greater desire to reconnect with the abuser as soon as possible.

The elder abuse specialists work with clients to restore their relationships in a healthy way if that is the client's wish. The Weinberg Center's EAS includes a program, Restorative Steps, designed by Weinberg Center staff, that is available and appropriate in a limited number of cases in which the client is interested in restoring a relationship with a person who caused harm. The Restorative Steps program is client-initiated and followed by an assessment from the elder abuse specialist on the safety concerns presented by restoring the relationship in question. If the client expresses a desire to restore a relationship with the person who caused them harm and it is deemed safe to do so, all involved parties will establish a process and terms for supervised visits. Then, the social worker will supervise visits with the client and the person who caused harm, and subsequently reassess whether unsupervised visits can happen after that.

The Weinberg Center also offers a screening program and community transition monitoring. The Elder Abuse Screening Specialist screens every new client entering the Hebrew Home to ensure that residents receive support for EM if they need it. A Transitional Care Social Worker engages with the Center on a per diem basis to support the transition of clients back into the community. One staff member described this role as "checking in with clients regularly over those first weeks, dealing with any unaddressed needs, crises that might emerge, which sometimes happen. But just making sure that everything that's been put in place actually comes to fruition and stabilizes." This social worker reports back to the Weinberg Center.

Figure 3.2 provides a visual overview of the case flow at the Weinberg Center, including key participants and tasks accomplished in each phase.

Clients

Weinberg Center clients are typically over 60 years old, although staff reported that some exceptions are made if younger clients have similar physical and mental health needs as older clients. Clients mostly come from the five boroughs of NYC, but some also come from Westchester County and Putnam County, New York. Weinberg Center data from 2020 to 2021 indicate that clients are 76 years old, on average, and mostly female (82 percent) which is in keeping with demographic data on those who experience elder abuse (Pillemer et al., 2016). Table 3.1 outlines the demographics of 2020–2021 clients. About one-half of all individuals referred became clients in 2020 and 2021, but, again, it is not clear whether and how the strict inclusion criteria might have shaped who was referred to the Weinberg Center or who accepted treatment. It might be, for example, that referring agencies are gaining a better understanding of which elder abuse cases are eligible for

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FIGURE 3.2

Case Flow at Weinberg Center

Referral

Community-based professional, potential client, Weinberg Center Elder Justice Specialists (LMSW), and Staff Attorneys

- Assess case status and shelter appropriateness (e.g., client's medical, safety, and social needs)
- Consider feasibility of discharge and potential plan
- Confirm client's understanding of Weinberg Center program and policies

Placement and service coordination

Client, Weinberg Center Elder Justice Specialists (LMSW), Staff Attorneys

- Provide basic needs such as clothing and books
- Work with client to determine goals
- Provide case management services (e.g., have locks changed, call banks, connect with police or APS)
- Determine what legal remedies are needed (e.g., restraining orders, guardianship hearings)
- Provide trauma-informed support
- Work with client to restore relationships, if desired

Transition monitoring

Client, Transitional Care Social Worker (LCSW)

- Check in with clients after discharge (30, 60, and 90 days); report back to Weinberg Center
- Provide supportive counseling, advocacy, and referrals to community-based resources

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TABLE 3.1
Weinberg Center Referred and Admitted Client Demographics (2020–2021)

	2020	2021	Total	%
Referrals	51	50	101	–
Admissions	17	34	51	50.50% of referrals
Admitted clients				
Average age	77	76	76.5	–
Female	15	27	42	82.35
Male	2	7	9	17.65
White	5	10	15	29.41
Black	8	14	22	43.14
Asian American and Pacific Islanders	0	0	0	0.00
Hispanic	3	9	12	23.53
Other	0	1	1	1.96
Unknown	1	0	1	1.96

SOURCE: Features data from the Weinberg Center.

the program and which are not. The Weinberg Center does not maintain a database of reasons why referrals do not translate into new clients but aims to collect this data in the future.

Most clients have needs that cannot be addressed by traditional domestic violence shelters. More than one-half of clients have some form of cognitive impairment, and nearly all have some limited mobility and depression (Smucker et al., 2021). Clients also typically have low incomes, sometimes because of financial abuse. One Weinberg Center staff member stated, "we serve mostly Medicaid patients, maybe only a single private-pay client in last three years." This staff member noted that this demographic profile speaks to "how elder abuse can really ruin you financially unless you are extremely wealthy." To this end, the Weinberg Center also provides financial assistance and, if needed, such items as clothing and spending money.

One unique aspect of the Weinberg Center's program is the requirement that clients have a two-week no-contact period at the beginning of their stay. During this time, clients cannot accept visitors and must stay in the Hebrew Home unless they are leaving to access medical care or other approved activities. However, clients are able to maintain contact with professionals during this period, such as health care providers or case managers. Again, the idea behind this approach is to give the client time to determine his or her own needs and wishes, without the influence of a possible abuser. Because perpetrators of elder abuse are typically a close family member, this component of the program can be difficult for potential clients. One senior staff member described it this way:

> Part of the reason that we have the [two-week no-contact rule] is because elder abuse is so complex and sometimes the person who presents as caring family member is the person who is abusing . . . usually it's an adult child who is the perpetrator. The parent-child dynamic is hard and different from other relationships which makes things difficult.

However, this requirement can be a barrier for clients. Staff and referring partners noted that the two-week period of isolation can lead to potential clients declining services. In rare instances, the Weinberg

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Center team is open to modifying the policy dependent on their professional assessment of the client's best interests, such as when there is a clearly established safe family member and there are significant medical or health-related concerns. Weinberg Center staff note that this policy is one of the most common reasons referred individuals do not become clients of the center.

Training

The Weinberg Center does not use a formal training program for all staff. Instead, staff leadership creates a tailored training program to meet the needs of new hires who support the EAS. One staff member explained:

> There's no systematic training plan. . . . It's not like there's so much on-boarding . . . and I think a lot of it really depends on not just the person's position, but also what experience they've already brought to the table they already have and . . . what gaps need to be filled.

In general, new staff will receive documents that bring them up to speed on the work of the Weinberg Center, training in elder abuse in general, and a robust mentorship program that involves shadowing another senior member of staff. One established staff member explained that training

> consists of like a lot of shadowing, a lot of being included in everything, a lot of asking questions and then a lot of trying to find relevant, more formal training opportunities that help to fit with whatever that person's particular needs are.

The legal team and social workers also attend Continuing Legal Education and Continuing Education Unit presentations and workshops to ensure that their skills are refined in line with developments in the field. The Weinberg Center is also the only exclusively elder-justice focused and accredited Continuing Legal Education provider in New York and regularly provides trainings to attorneys and legal professionals about EM.

Evaluating Effectiveness

When possible, the team at the Weinberg Center uses research and integrates promising practices in the field to strengthen their offerings for clients, though staff are aware of the limited research on effectiveness in EAS research. However, the Weinberg Center team does not regularly engage in formal evaluation projects using its own data and staff. The Weinberg Center team's commitment to evaluation has led them to engage with outside groups to develop a better understanding of the benefits of Weinberg Center services to clients and society more broadly (for example, see Smucker et al., 2021). Weinberg Center staff indicated an eagerness to conduct rigorous research on their own model, as well as a desire for guidance and support from experts. Chapter 5 includes our team's ideas on this topic.

Coronavirus Disease 2019 Impacts

When the COVID-19 pandemic swept NYC, Weinberg Center staff were designated as essential workers. This designation underscored the acute need for the services they provided. Despite staffs' continuing efforts, the COVID-19 pandemic severely affected the reach of the Weinberg Center by reducing the number of clients they were able to serve. Like other victims of violence within the home, fewer victims felt safe or were able to come forward to obtain help during the pandemic's stay-at-home orders (Smucker, Revitsky-Locker,

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and Najera, 2020). One senior staff member suggested that the association of COVID-19 with nursing homes at the start of the pandemic also deterred clients from considering the Weinberg Center as a safe resource. Pandemic-related strain on skilled nursing staff and social workers, including APS staff, led to increased turnover and put additional stress on an already strained workforce. One staff member noted, "one thing we've heard recently is that there's a lot of turnover at APS . . . so if that's the case, those new workers might not always be aware of services. Same with health care staff that often refer." Reductions in staff in these positions likely led to fewer referrals from professional agencies on which the Weinberg Center relies.

The Weinberg Center has also seen member organizations of the SPRiNG Alliance close during the pandemic. Client and staffing shortages affected newer shelters more severely than organizations that were more firmly established, as they had fewer funding reserves to draw on to keep their shelters afloat. One staff member decried the closure of a SPRiNG Alliance member in Cleveland that served a historically marginalized community:

> The Cleveland partner served historically [Black and Indigenous People of Color] community—they've had to shut down. Whoever they had in their skilled nursing is going to disperse. COVID really brought them down.

In sum, the COVID-19 pandemic reduced the Weinberg Center's and other organizations' capability to run EASs. While the staff at all locations is rebuilding, the impact of the COVID-19 pandemic will not be easily remedied.

Successes and Challenges

Interviewed staff highlighted numerous ways they believe that the Weinberg Center supports clients. Primarily, staff stressed that the Weinberg Center is often the only viable option for an older adult with needs that cannot be accommodated by a typical domestic violence shelter, such as cognitive impairment, chronic medical conditions, and mobility restrictions. However, it is important to note that the Weinberg Center model has restrictions of its own in that it does not accept individuals with substance use or mental health concerns, for example. Staff underscored the value of the Weinberg Center's holistic and multidisciplinary approach to care, giving each client access to an array of services. Staff training in trauma-informed care is critical to helping address the needs of individuals in abusive environments. Integration of the Weinberg Center into the Hebrew Home also ensures that clients receive high-quality care that is tracked using established measures that can be evaluated over time.

Staff emphasized the strong integration of the Weinberg Center with NYC's overall response to EM. Weinberg Center staff participate in multidisciplinary teams (MDTs) established by the city to deal with complex cases of abuse. The Center makes efforts to engage with key stakeholders, including hospital staff, community-based elder care providers, the Department of Aging NYC, the Mayor's office, domestic violence advocacy programs, and state legal authorities. The breadth and depth of the Weinberg Center's connections increases the probability that a person who needs the Center's services will be connected to them.

However, as noted above, the organization is not able to support individuals with serious untreated mental health problems (like schizophrenia) or substance misuse issues. The Weinberg Center also does not accept clients who cannot consent to treatment and do not have someone who can consent on their behalf. This is because without any consent, the client will not be able to receive services from the staff at the Weinberg Center. One staff member noted that it was difficult to refuse individuals for such conditions: "it's hard to turn those people away; I understand that we can't take on people that we can't support—but it's hard to turn them away." Experts in the elder abuse field noted that the exclusion criteria used by the Weinberg Center

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might paradoxically make the shelter unavailable to victims who need it most, since several of these criteria are risk factors for elder abuse.[5]

Finally, while being based in a supportive living facility provides significant resources to the Weinberg Center, it can be a prohibiting factor for some clients because it comes with some restrictions to clients' independence. Staff underscored that some people are unwilling to become residents of a nursing home, even if they could benefit from the Weinberg Center's services. One staff member summarized:

> Others who don't do well [at the Weinberg Center] are those who struggle with being in a nursing home—people who are very independent, who want to be able to come and go as they please. There is a lot of structure because at the end of the day it is a nursing home—for insurance purposes, they can't have people out all night, sleeping somewhere else every night of the week.

[5] This point was made by interviewees from referring organizations, as well as an expert who reviewed the manuscript of this report.

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CHAPTER 4

Evaluability Assessment of the Weinberg Center

Building on the formative evaluation and logic model presented in Chapter 3, we conducted an evaluability assessment of the Weinberg Center's EAS. The goal of this exercise was to determine whether the Center's EAS is ready to be rigorously evaluated. We used a RAND-developed tool called the PIER report, which is composed of key constructs that are critical to successful program implementation and evaluation (Barwick, 2011; Kaufman-Levy et al., 2003). The overarching criteria used to evaluate the Weinberg Center's EAS consisted of organizational readiness, which focuses on organizational culture, capacity, staff, and partners; program readiness, which focuses on program design, implementation processes, procedures, case flow, and training; and evaluation readiness, which focuses on quasi-experimental design elements, enrollment of clients, and data collection.

Table 4.1 outlines the domains and subdomains used in the PIER tool and some sample criteria used to assess the program's demonstration of the domains described. Scores range from 0 to 3, with 0 meaning no evidence of the criteria and 3 indicating strong evidence of the criteria. Three researchers from our team independently scored the Weinberg Center's EAS and discussed all items for which any member disagreed with another until all three researchers reached consensus. The full PIER reporting tool and the scores that the Weinberg Center's EAS received can be found in Appendix D.

Figure 4.1 outlines the results of our analysis. While there is no official cutoff established for the RAND PIER report, scores in each domain help identify areas where additional support might be needed to improve readiness. The program received high marks in organizational and program readiness, but support is needed to bolster capacity around evaluation readiness. The following section provides an overview of the key factors that led to the overall score for each category.

TABLE 4.1
PIER Tool Scoring Domains, Subdomains, and Selected Criteria

Domain	Subdomain	Example Criteria
Organizational readiness	• Organizational culture • Capacity • Leadership, key staff • Program staff • Collaborative partners	• Key staff hold positive attitudes toward the intervention and evaluation • Adequate dedicated human resources and time are allocated for the intervention • Staff are knowledgeable and clear about their roles and responsibilities in the program
Program readiness	• Program design • Implementation: processes and procedures • Implementation: staffing and training • Implementation: client retention techniques	• Program outputs are clear and can be used to measure activities • Logic model includes measurable outcomes targeted by each program component • Program staff receive ongoing training and supervision in the program
Evaluation readiness	• Quasi-experimental design • Program enrollment of clients • Data collection	• Staff can identify comparison group that is not exposed to the key elements of the program • Staff and evaluation team can estimate annual study enrollment for the treatment (specify the target number)

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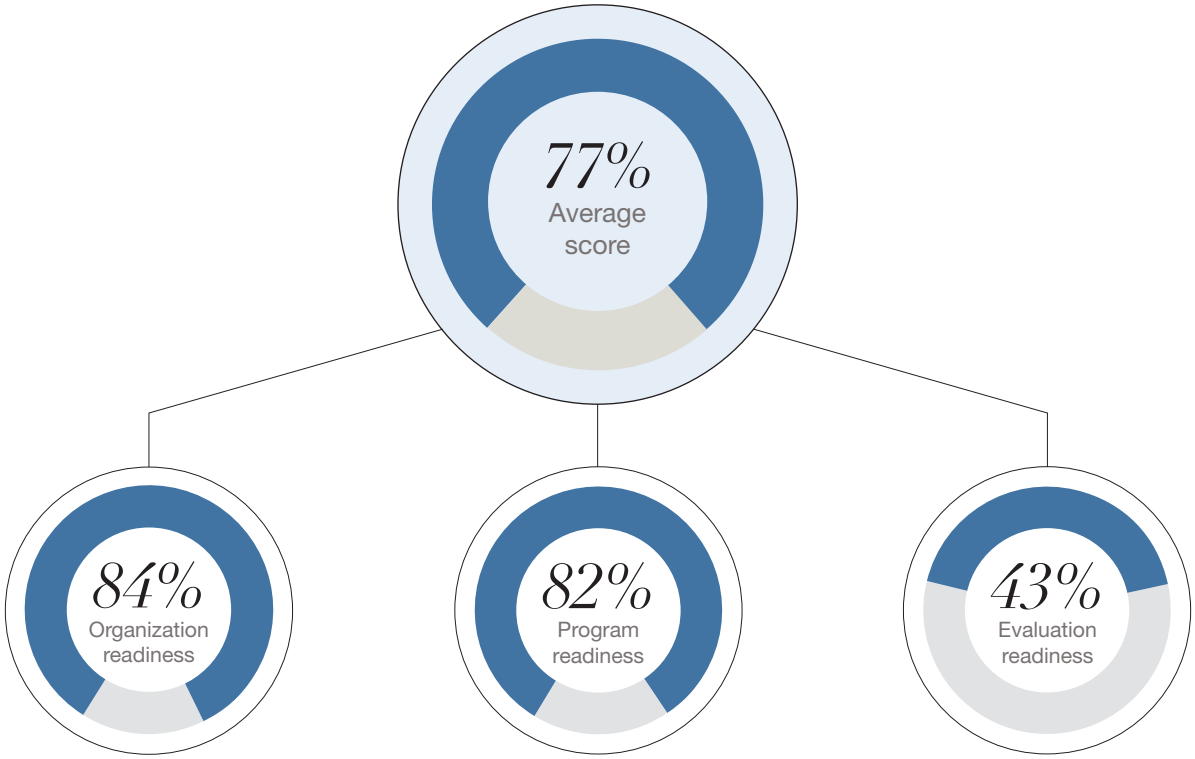
FIGURE 4.1
Results of PIER Tool Evaluability Assessment



Key Findings of the Evaluability Assessment

Organizational Readiness

Overall, the Weinberg Center scored 84 percent on organizational readiness for an evaluation. The leadership team at the Weinberg Center expressed deep commitment to addressing elder abuse and supporting victims. In interviews, leadership and staff underscored their commitment to furthering the development of the EAS model, reflecting on and improving their own practice, and sharing their best practices with others across the country. Their team also demonstrated significant experience in this area because of their extensive tenure at the Weinberg Center. The three core staff members have been employed at the Weinberg Center for 18, 15, and ten years.

Staff at the Weinberg Center also displayed commitment to the intervention and showed a staff culture of collaboration and support. The team members step in to support all parts of the organization when needed and respect each other's unique professional perspective (i.e., legal versus public health). As one senior staff member said, "Yes, we work very collaboratively and very closely together. We have weekly case update meetings where you know we're all [present]." Another newer staff member noted:

> I've been here two months and I am still learning a lot, but I am always included in conversations about what everyone is doing. It is not at all segmented. Very cohesive and collaborative. We pride [ourselves] in being multidisciplinary and it is very genuine.

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This internal emphasis on collaboration provided evidence of a healthy program culture and team, increasing the likelihood of a successful program.

Staff also said that they believed that the intervention would lead to improved outcomes for clients. In turn, staff were excited by the prospect of using rigorous evaluation methods to demonstrate the value of the program. One senior staff member summarized:

> It is important for people to understand what works and doesn't work. We want to show the world what we are doing and how it's impactful. Elder justice isn't a super researched field. We are really excited about developing evidence of the outcomes. We see the value of seeing someone else evaluate the value of what we are doing.

While the team seeks to draw on new evidence to inform its practice, staff acknowledged that there is a lack of rigorous evaluations of the EAS model. Because of this, and limited internal data collection, Weinberg Center team members have yet to fully incorporate evidence from their own work into their program.

As noted in the previous section, the Weinberg Center staff have developed close relationships over the past decade with a variety of stakeholders in NYC who refer clients to their services. Our conversations with several key Weinberg Center partners—including APS, local hospital staff who screen for elder abuse, the NYC District Attorney's Office, NYC Family Justice Centers, the NYC Department for the Aging (DFTA), community aging groups (e.g., Family Services of Westchester), and the Enhanced Manhattan Multidisciplinary Team (of which the Weinberg Center staff are members)—confirmed that the Weinberg Center has a strong and ongoing relationship with these organizations.

One interviewee who organizes a citywide team to address high-risk elder abuse cases highlighted the central role of the Center when cases require emergency housing, saying "Weinberg Center comes in, they are a core member, they chime in on the case, when appropriate they talk about whether a referral makes sense."

A member of law enforcement described their work with the Weinberg Center:

> [I talk] with them often. I call them shelter but it's a beautiful facility on the river, it's independent living, assisted living, nursing home; if you're a victim, they have high medical care [needs]. We have victims who can't go back home either because the abuser lives there or because they are not physically able to go home and need care. . . . I call them to say we may have an eligible person to see if they could do the screening.

In sum, key collaborative partners understand the services of the Weinberg Center and include it in their menu of options for their own clients. However, these collaborative partners have yet to conduct a rigorous evaluation together. Consequently, they have little practice with developing data sharing agreements that might support an outcome evaluation. To develop a strong evaluation that includes collaborative partners, the Weinberg Center and the evaluation team would need to develop a robust plan for evaluation partnership between relevant stakeholders.

Program Readiness

Overall, the Weinberg Center scored 82 percent in program readiness criteria. The EAS has a well-defined target population and a clear program design, captured in Figure 3.1 (Chapter 3). While the program has evolved in some ways, it retains the same core elements it started with over a decade ago: emergency housing, mental and physical health care, legal support, and social work for victims of elder abuse. The target population for the Weinberg Center is relatively broad, though well defined. While the Center does not accept clients with significant mental health needs (e.g., schizophrenia) or substance use disorders, it is generally open to accepting clients who need emergency housing services because of elder abuse. Finally, all clients must come to the Weinberg Center through a professional referral (e.g., APS, hospital staff, police).

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Once a new client is referred to the Weinberg Center, the staffs' goals for the client reflect a mix of standard outcomes (e.g., improved or stabilized health) and the client's own goals (e.g., returning to the community). To achieve its goals, the Weinberg Center has activities that include client-centered and trauma-informed case management, biopsychosocial evaluation, advocacy, and social support. This first set of services is typically provided by the social work staff. Their initial evaluation and interaction lead to relevant legal services, including support obtaining orders of protection, advanced directives, and guardianship proceedings, as needed.

However, there are some areas where the Weinberg Center could strengthen its programming. For example, the Weinberg Center could develop a concrete framework for continual training for specific staff positions (e.g., specific training for Public Health Specialists, screening specialists, attorneys). As the organization grows and develops its internal evaluation capacity, the team will also need to develop a clear schedule for introductory and ongoing training. The team is well trained by senior mentors and on-the-job experience, and legal professionals engage in Continuing Legal Education to ensure that their skills are refined in line with developments in the field. Developing continuing education courses for other members of staff could improve the likelihood that clients receive consistent care regardless of the staff makeup. Such growth might also result in increased capacity and an opportunity to revisit or loosen its admission criteria to accept more clients.

Evaluation Readiness

The Weinberg Center did not score as highly on the evaluation readiness criteria, with 43 percent. While the organization has key elements for an evaluation in place (e.g., clear logic model, case flow, outcomes, and clients), it is not yet equipped with data collection processes and personnel to perform an outcome evaluation. The Hebrew Home captures medical data for clients that the Weinberg Center has access to,[1] but the team does not have a robust tracking system for its own services (e.g., legal supports, financial support). The staff acknowledged this limitation and is working to develop methods to improve it, including plans to purchase legal software that can track services more precisely.

In addition, the team does not, in a systematic manner, follow up with clients who have left the Weinberg Center, nor does it collect relevant outcome data that could support a longer-term outcome evaluation. While the team has temporarily hired a contractor to support clients who move back into the community, this person engages in minimal data collection on clients and the position is, thus far, nonpermanent.

As it stands, the limited number of clients served by the Weinberg Center could undermine a statistical analysis of outcomes across clients. Staff acknowledged that they have struggled to recruit clients in the wake of the COVID-19 pandemic, and they appreciate that there are reasons beyond COVID-19 that might decrease the likelihood that victims opt to use their services. The staff is making efforts to improve recruitment while brainstorming ways to differentiate the organization from a homeless shelter, such as avoiding terms like "shelter" in favor of terms like "respite." The staff is also regularly reaching out to referring agencies to ensure that new staff know about their offerings, as some of their partners have faced significant turnover in recent years.

[1] The Minimum Data Set (MDS) captured by the Hebrew Home is a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status. It is commonly used in long-term care facilities and outpatient and home-based social service programs for older adults.

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Finally, the Weinberg Center has yet to identify a relevant group that could serve as a comparison group for their clients in an outcome study. One senior staff member summarized some of the difficulties in identifying such a group:

> It is really hard because basically we need to get people who say no, not going to leave home, or going to go back home, and we need to be able to follow that person and see what happens to them. What is the effect and impact financially, health wise, emotionally, mobility wise, when you don't seek comprehensive intervention. To me, that is the most relevant comparison, are people who are in the same situation. At least 20 percent of people say no. How would you get their consent? A lot of our people are cognitively impaired. Their ability to consent is complicated, and their ability to make good decisions is complicated.

Despite these difficulties, support from a professional research partner could address the limitations highlighted by the PIER reporting tool. To address data collection deficiencies, that research partner could work with the Weinberg Center staff to develop a data collection process that would support an evaluation and continue to serve the Weinberg Center after the close of the evaluation. An evaluation team could also include members tasked with following up with both clients and a secondary group of individuals who could serve as a comparison group in the study. Recruitment is a difficult issue, but research partners could also support recruitment efforts by supporting Weinberg Center staff outreach to referring organizations.

Thus, while challenges remain, a strong partnership between the Weinberg Center and a professional research partner could support evaluation of the EAS at the Weinberg Center. The final chapter of this report outlines three evaluation designs that could be implemented by the Weinberg Center staff despite the limitations documented with the support of professional research partners.

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CHAPTER 5

Evaluation Designs

In this chapter, we outline three evaluation designs that could assess the impact of the Weinberg Center's EAS and other EASs on clients. First, we describe the results of our review of evaluations of shelters, which we used to inform our proposed evaluation designs. Then, we outline key measures—identified through this review and consultation with the Weinberg Center logic model—that we recommend, including in an evaluation of an EAS. Next, we describe three different study options that could answer key questions about the impact of the Weinberg Center's EAS and other EASs. We also provide a summary table of each design to highlight the key features, trade-offs, limitations, and cost of each. We conclude the chapter by highlighting some key considerations for those contemplating an evaluation of an EAS using our proposed designs, including how to incorporate family members and how to expand the evaluation to other types of shelter models.

Results of the Literature Review

We reviewed the existing evaluation literature on shelter models to develop our evaluation designs. Our review focused on 35 sources, consisting of journal articles, government reports, nongovernmental organization reports, and one dissertation (Table 5.1). Some sources we reviewed were themselves reviews: A total of 13 were systematic reviews or meta-analyses. We classified an additional six sources as nonsystematic reviews: sources that reviewed literature on a topic of interest but did not use the formal methods of a systematic review or meta-analysis. Two sources focused exclusively on the methods of an evaluation, while another developed the logic model of a prevention program.

Of the 35 sources, 13 described first-hand evaluations of violence prevention or intervention programs (of the 13, 12 sources presented data; the other published the methods of longitudinal studies). We focused on these articles to identify strong approaches to a potential evaluation of the Weinberg Center and other EAS models.

TABLE 5.1
Results of the Literature Review

Study Type	Count
Meta-analysis	1
Quasi-experiment	9
Randomized Controlled Trial (RCT)	2
Nonsystematic review	6
Systematic review	12
Method description	2
Program description	3
Total	**35**

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The sources we reviewed evaluated interventions that are similar in some ways to the Weinberg Center programming. Three sources evaluated community-based services for people experiencing elder abuse. Four sources focused on the Forensic Center in Los Angeles, California, which provides legal services for people experiencing elder abuse. The final sources evaluated services provided within a shelter setting for people experiencing domestic or intimate partner violence. None of the sources we reviewed evaluated shelter models for people experiencing elder abuse.

The sources used a variety of evaluation designs. Two drew on data from RCTs and ten from quasi-experimental designs, including propensity score matching, pre- and post-evaluations, and post-only descriptive analyses. The studies examined a variety of populations from the United States, the Netherlands, South Africa, and Israel. Outcome measures also varied across studies. Some studies focused on the mental and physical safety and well-being of victims and evaluated constructs like depression, anxiety, and risk for re-abuse. Others evaluated the legal or financial outcomes for cases involving abuse. Finally, studies took different approaches to follow-up time. Some studies measured outcome data at intervention completion, and one study we reviewed used longitudinal approach to track participants over time.

Measures

A key component of any evaluation is identifying reliable outcome measures to answer research questions. In this section, we present a select set of measures that could determine whether participation in the Weinberg Center's programming affects the trajectory of the client across a variety of outcomes (Table 5.2). We compiled these outcomes and related measures through our review of existing evaluations, an examination of the Weinberg Center logic model, and consultations with experts. Note that these measures are designed to capture whether Weinberg Center clients experience positive or negative outcomes following the intervention. While research has demonstrated that components of the Weinberg Center model are promising practices for supporting victims of elder abuse (Heck and Gillespie, 2013; Pillemer et al., 2016), there is also literature that finds high rates of abuse among residents of nursing homes (Lachs et al., 2016). Thus, it is important to determine whether EAS clients face risk of abuse in a different setting by virtue of the EAS being colocated within a nursing home. We highlight 18 outcome measures that allow for robust data collection across a variety of outcomes to capture positive and negative impacts while minimizing burden on participants.

We grouped the outcomes and measures into four key areas: mental and physical health and well-being, legal and justice outcomes, abuse risk, and client-centered goals. While we drew heavily on the outcomes used in existing studies, we focused on measures that put the least burden on participants (i.e., take the least time or come from secondary sources that do not require client action to obtain) with the highest reliability and validity. For example, the legal and justice outcomes would ideally come from the district attorney data or Weinberg Center records to reduce burden on participants.

Researchers evaluating an EAS must also assess whether the client has been abused since the time of the intervention. We recommend using the Weinberg Center Risk and Abuse Prevention Screen (WC-RAPS)—a validated instrument that is also available in Spanish—to determine whether a person is at risk or has been abused since the last assessment (Ramirez et al., 2019). The wording should be adjusted to clarify that the questions refer to the time between the previous assessment and day of the next assessment. If time permits, we also recommend using abuse risk scales developed by Mariam et al. (2014), which evaluated an elder abuse intervention, though one different from the Weinberg Center's EAS. These measures capture key risk factors for EM, including isolation and dependency, economic stress, social and community functioning, and ability to live independently. Such measures could be self-reported or assessed by an interviewer or caregiver given the participant's consent.

We also included measures for public services, such as emergency room visits, hospitalizations, and the cost of hospitalizations. These measures could be obtained through surveys with clients or caregivers or, ide-

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TABLE 5.2

Suggested Outcome Measures for Weinberg Center Evaluation

Outcome	Measure	Data Collection Method
Mental and physical health		
Impact on depression	Patient Health Questionnaire (PHQ)-9 (Löwe et al., 2004)	Client survey or caregiver/ interviewer assessment or MDS (while at WC)
Impact on anxiety	Generalized Anxiety Disorder (GAD)-7 (Spitzer et al., 2006)	Client survey or caregiver/ interviewer assessment or MDS (while at WC)
Impact on general self-efficacy	Schwarzer and Jerusalem Generalized Self-Efficacy Scale (Schwarzer and Jerusalem, 1995)	Client survey or caregiver/ interviewer assessment
Impact on cognition	Clinical Dementia Rating (CRD) (Hughes et al., 1982[a])	Client survey or caregiver/ interviewer assessment
Impact on variety of health and cognition concerns	Physical and Mental Health Functioning Checklist (Mariam et al., 2015)	Client survey or caregiver/ interviewer assessment
Legal/justice		
Legal action to obtain justice	Case submitted to DA's office	Secondary data (DA or WC records)
Legal action to obtain justice	Charges filed	Secondary data (DA or WC records)
Legal intervention to reduce risk	Protective order obtained	Secondary data (DA or WC records)
Legal intervention to reduce risk	Guardianship addressed (if necessary)	Secondary data (DA or WC records)
Abuse/safety		
Re-abuse	WC-RAPS augmented to cover the time between the last assessment and current assessment	Client survey or caregiver/ interviewer assessment
Change in risk of elder abuse (isolation)	Isolation and dependency (Mariam et al., 2015)	Client survey or caregiver/ interviewer assessment
Change in risk of elder abuse (financial and housing)	Economic and housing functioning (Mariam et al., 2015)	Client survey or caregiver/ interviewer assessment
Change in risk of elder abuse (social life)	Social and community functioning (Mariam et al., 2015)	Client survey or caregiver/ interviewer assessment
Change in risk of elder abuse (independence)	Independent living functioning (Mariam et al., 2015)	Client survey or caregiver/ interviewer assessment
Public services		
Demand for health care	Hospitalizations	Survey with client or caregiver/ secondary data (Medicare or Medicaid)
Change in pressure on public services	Cost of health care	Survey with client or caregiver/ secondary data (Medicare or Medicaid)
Change in pressure on public services	Emergency room visit	Survey with client or caregiver/ secondary data (Medicare or Medicaid)

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Table 5.2—Continued

Outcome	Measure	Data Collection Method
Client-centered outcomes		
Meeting/failing to meet client goals	Identify client's top three goals of going through the program and ask about progress at each subsequent data collection point	Survey using clients' unique goals
Satisfaction with WC intervention	Survey client regarding satisfaction with WC intervention	Survey/open ended

NOTES: WC = Weinberg Center. DA = district attorney.

[a] This measure requires contacting the original authors before using.

ally, through a secondary data source like Medicare. These measures could contribute to a cost analysis to determine the value of the Weinberg Center intervention over time (testing the initial estimates developed in Smucker et al., 2021). Finally, we incorporated client-centered measures. The first measure is of a client's personal goals on entering the Weinberg Center. Follow-up questions will focus on whether the person moved closer to or met those goals. We also provided a satisfaction measure of Weinberg Center services to capture client feelings about the intervention.

Covering each of these sections in a survey instrument will ensure that the study results speak to a variety of outcomes relevant to different stakeholders (e.g., policymakers, health care providers, law enforcement, advocates, and victims).[1]

Evaluation Designs

The goal of the following evaluation designs is to identify the unique impact of an EAS on participants, ruling out the possibility that other factors could have caused a change in an outcome. The clearest way to come to this conclusion is to randomize individuals into either a treatment or control condition, where the former is program participation, and the latter is care as usual. While this type of study could be used to evaluate the Weinberg Center's EAS under ideal conditions, it is less clear whether the randomization could be conducted ethically.

Our literature review surfaced two RCT designs evaluating programs like the Weinberg Center, though neither study evaluated the shelter model itself. The first, conducted by Lako et al. (2013) in the Netherlands, compared shelter care as usual with a critical time intervention for people experiencing either homelessness or intimate partner violence. Participants in both the treatment and control conditions received shelter services (Lako et al., 2013; Lako et al., 2018). In the second RCT we reviewed, participants were randomized to either receive mental health services or a mental health referral, both of which were in addition to community-based services (Sirey et al., 2015). The randomization was likely deemed ethical because of the strong "care as usual" condition.

[1] Importantly, this table represents only a small set of possible measures for an evaluation of an EAS model that focuses on clients and the use of public services after leaving the shelter to make the study manageable in size and scope. However, a variety of additional measures could be used to evaluate the impact of certain features of the Weinberg Center on client experience or on public services. For example, discussions with stakeholders suggested that wait times for transfers from the hospital to the Weinberg Center could be longer than other locations, putting pressure on hospital capacity. Given this, evaluators may wish to include measures of the impact of possibly modifiable elements of the Weinberg Center program to improve access to the EAS for victims and to improve EAS outcomes for both victims and for society in general.

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However, no such standard of care exists for people experiencing elder abuse who need housing in New York. Other options like domestic abuse shelters or homeless shelters simply do not have the capacity to care for adults who are also dealing with medical conditions associated with older age. Given the paucity of alternative housing and legal support for victims of elder abuse, it would be unethical to deny Weinberg Center—or other shelter—services to people in need. Conversely, there is evidence that residency in a nursing home can increase the risk of abuse by other residents or staff (Lachs et al., 2016). Thus, requiring that some participants become residents at the Hebrew Home would also be ethically unjustifiable. Consequently, our menu of possible evaluation design options does not contain a true RCT. We instead focused on quasi-experimental designs that could demonstrate impact with limited possibility of bias from external factors.

In addition, the evaluation designs that follow focus specifically on the impact of the Weinberg Center intervention on clients. As described in the previous chapters, the Weinberg Center's goals include educating key stakeholders about their work and supporting SPRiNG Alliance members. Certainly, a study of the impact of Weinberg Center's outreach to community partners and capacity-building work with new EASs would improve understanding of the importance of this type of work. Another important study would examine the impact of including an EAS in a long-term care facility on nursing staff who might find it stressful to support individuals experiencing elder abuse. However, our narrower goal here is to establish the impact of the intervention on clients and then move to these other important areas.

Option 1: Randomization Using Opt-In Nature of Treatment

The first potential evaluation design uses a natural separation of qualified potential clients of the Weinberg Center to identify impact. From our interviews and review of client data, we determined that approximately 20 to 50 percent of referrals do not become clients for a variety of reasons (e.g., refusal to comply with the two-week no-contact rule, resistance to becoming a resident of a nursing home, desire to return home despite abuse, lack of long-term plan for care [a requirement to become a Weinberg Center client]). A rigorous study could compare the outcomes of Weinberg Center clients with outcomes for those who were referred but do not become clients.[2]

Such a study design could answer, at minimum, three key questions. In comparison with similar victims of elder abuse who receive care as usual in the community, this design could assess whether Weinberg Center EAS clients have divergent

1. physical and mental health outcomes
2. likelihoods of seeking and obtaining legal justice
3. rates of elder abuse.

The answers to these questions are highly relevant to policymakers, advocates, and private funders who are looking for innovative ways to support the increasing number of victims of elder abuse.

However, this method of creating a comparison group for Weinberg Center clients introduces bias. It could be that people who choose not to become a client of the Weinberg Center differ from Weinberg clients on some important characteristics. For instance, they might have cases that are less serious, have greater resources to support their recovery without the Weinberg Center, or be physically and mentally healthier

[2] If focusing on referred individuals as study participants is not possible, another option for a control group could be individuals who are judged to be at moderate to high risk of elder abuse in a hospital setting but are sent to a facility other than Weinberg's EAS or back into the community. Recent work by our colleagues at Weill Cornell New York Presbyterian Hospital, who launched the Vulnerable Elder Protection Team (VEPT), could provide such a control group. However, we believe that tracking clients referred to the Weinberg Center represents the best way to reduce differences between the comparison and control groups.

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than those who become Weinberg Center clients. One way to minimize this bias would be to collect baseline data across all participants that capture information relevant to factors that could introduce bias (e.g., case complexity, risk, mental and physical health). With this information, the Center and the evaluation team would be able to consider whether such factors affect the results of the evaluation.[3]

To ensure a sample size large enough to identify intervention impacts, the evaluation team and the Weinberg Center should codify a clear evaluation partnership with key referring agencies. These agencies should be selected based on their capacity to allocate resources to the evaluation project, their ability to collect baseline data, and their access to potential clients (organizations with greater access to potential clients should be prioritized). Based on our interviews with referring agencies, we recommend building evaluation partnerships with referring hospitals (e.g., New York Presbyterian), state government departments (e.g., the DFTA NYC), APS, family justice center organizations (e.g., Family Justice Center NYC, Safe Horizon), and community-based elder care organizations (e.g., Family Services of Westchester).

In addition to being the most common referring agencies, these organizations already collect data on clients that could be adapted to fit the needs of the evaluation. This partnership should outline a clear and mutually agreed on plan for discussing the study with the potential client, obtaining consent,[4] collecting baseline information, and arranging for follow-up. The group should also arrange to meet regularly during the study period, especially during the data collection phase. Maximizing the evaluation partnerships could also maximize the study population and increase the likelihood of identifying impact.

Continuous follow-up with clients will be critical for the success of this study design. Consequently, we recommend offering participants compensation to maximize recruitment and retention. For the treatment group, this compensation should be offered while the person is a client and after they are discharged. Similarly, those who choose not to become clients should receive compensation on agreeing to be part of the study until data collection ends. Based on existing literature and conversations with experts, we recommend $20 for the first survey and adding $10 for every additional follow-up (McFarlane, 2007). This would maximize the likelihood of a strong longitudinal follow-up. Follow-up would ideally take place via online survey, but, given the high percentage of clients with cognitive issues, some clients might require in-person follow-up.

This study design could also incorporate a qualitative component. Qualitative interviews with clients and those that do not become clients could provide important context for the quantitative outcomes identified through statistical analysis. Moreover, in-depth interviews with EAS clients who do not benefit from the program (if others do) could be used to determine whether additional services are needed for different groups of clients, potentially including the equitability of service provision.

We estimate that this study would require (1) three doctoral researchers, four midlevel researchers, and a junior staff member; (2) between 450 and 530 labor days; (3) report production (one report, one journal article); (4) support for Weinberg Center staff collecting follow-up data (support for data collection by two staff members trained in trauma-informed work with victims of elder abuse); and (5) participant compensation (assuming a total of $140 per participant over the course of the study and 200 participants). Other possible costs could include travel if the research partner is not local and a professional survey staff if desired.

In addition to the variation in costs listed above depending on the research organization, the biggest determining factor in project cost will be the time required to recruit an acceptable sample of participants in both groups. To determine the sample sizes likely required, we performed a simple power analysis for dichotomous outcomes (e.g., the proportion of study population experiencing an event such as receipt of service or recurrence of adverse event). The results are presented in Table 5.3 and show the sample sizes required

[3] Note that this evaluation plan could also include propensity score matching (discussed in the next evaluation design) to enhance the approach and minimize the risk of bias in the sample skewing the results of the evaluation.

[4] We discuss the difficulties associated with this later in the chapter.

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TABLE 5.3
Sample Sizes Required in Each Study Arm to Detect Various Impact Sizes at Various Baseline Levels of Proportions

Baseline Risks (%)	Impact Size (Difference Between Intervention and Control in Percentage Points)				
	5%	10%	15%	20%	25%
5	474	160	88	59	43
10	726	219	113	72	51
25	1,291	349	165	98	66
50	1,605	408	183	103	66

in each study arm corresponding to various levels of baseline probability and various effect sizes (expressed here as the difference in percentage points between the proportion in the intervention and control groups). We selected four different baseline risks, ranging from 5 percent to 50 percent. We did not have any theory-driven indication as to what impact size to expect; therefore, we selected four different possible impact sizes ranging from 5 percentage points to 25 percentage points. The analysis assumes two-sided tests with a significance level of 0.05, power set at 0.80, and an equal number of participants in each arm.

The results show that having approximately 100 participants in each arm of the evaluation study would enable the detection of a 20-percentage-point change irrespective of the baseline level. It would also be sufficient for detecting a 15-percentage-point change in situations with an extreme baseline. It is important to recognize, however, that the numbers in the table represent the samples needed for the analysis. Given the likely drop-off of some participants during the study, the number of participants it will be necessary to recruit will be somewhat higher.

Based on the discussion above, we recommend no less than 100 people in each group (200 total) to identify meaningful differences in outcomes. While a power calculation is difficult to do because of the paucity of research on the impact of interventions on victims of elder abuse, our assessment is that 200 individuals is a reasonable and achievable goal for this study population. As mentioned earlier in this report, the number of clients of the Weinberg Center has decreased since the onset of the COVID-19 pandemic. Thus, the time it would take to obtain an acceptable sample of clients could be up to six years, assuming up to 30 percent of people decide not to participate. However, if referrals increase in the next few years, this time spent recruiting could be shortened. Using our knowledge of the program and the likely increase in demand for services in the future, we believe the study would take from three to six years depending on how long different elements take.

Option 2: Propensity Score Matching

Another quasi-experimental approach to an evaluation of the Weinberg Center EAS model would use propensity score matching. As mentioned above, propensity score matching connects data from a sample of individuals who receive an intervention (treatment) with a secondary dataset of similar individuals who did not (control). This strategy controls for differences that might exist across individuals in each sample by matching individuals across a set of characteristics. One of the most rigorous evaluations of an elder abuse intervention in our review used this method (Wilber, Navarro, and Gassoumis, 2014).

If this method is chosen, the evaluation team would need to review the important criticisms of this method (King and Nielsen, 2019), but, overall, it is a strong option for demonstrating causality when true randomization is not possible. RAND researchers developed an approach to reducing the likelihood that differences

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between the groups could be attributed to underlying differences in cases, demographics, or other variables and thus approximated true randomization to the extent possible. The Toolkit for Weighting and Analysis of Nonequivalent Groups (TWANG) contains a set of functions to support causal modeling of observational data through the estimation and evaluation of propensity score weights (Livingston et al., 2013). Using this approach would improve the likelihood that the study results identify the true impact of the intervention on participants. Using TWANG would allow researchers to more easily develop the correct weights for the treatment (Weinberg Center clients) and control (individuals in secondary data source) groups in the analysis.

At minimum, this approach could answer whether, in comparison with victims of elder abuse who receive care from the organizations providing secondary data (APS, hospital, etc.), those who become Weinberg Center clients differ in terms of

1. the types of services offered
2. short-term health outcomes
3. legal interventions used
4. legal outcomes
5. re-abuse or risk of abuse.

On the basis of our interviews with community partners, the database we recommend using is held by APS.[5] While we have not seen the data ourselves, our conversation with APS revealed that they keep records of the physical and mental health statuses of all clients. Clients are reassessed every month to determine whether they continue to be at risk of elder abuse. The information available in this dataset would likely be enough to isolate a subgroup of victims who meet the Weinberg Center's key criteria and are similar to Weinberg Center clients in age, gender, and type of abuse. APS did not provide the exact measures used to capture health outcomes; therefore we cannot comment on data quality, timeliness, or completeness. We recommend obtaining additional information to make sure these data align with the needs of the evaluation, once those are determined.

APS also has experience partnering with organizations to conduct research. In our conversation with them, APS reported that they have participated in published studies using their data and have the infrastructure for data requests from researchers. Moreover, the Weinberg Center has partnered with APS on a qualitative analysis of the cost savings that the Weinberg Center provides APS by caring for clients. This established relationship would likely lead to a strong working relationship in an evaluation.

These data are, however, limited in three ways. First, as of this writing, APS data do not include whether a person received care from the Weinberg Center. A matched dataset would only include individuals who did not receive care from Weinberg. Researchers will need to determine whether or how to isolate cases that did not involve the Weinberg Center while ensuring people still meet Weinberg Center criteria. This could be done by providing APS with a list of names from the Weinberg Center records and having APS flag these individuals and exclude them from the matched dataset. Researchers would need to take care to protect personally identifiable information because linking files would make information identifiable.

The second issue with these data is the length of follow-up. A strong research design would include at least one year of follow-up. However, APS follows clients only if they are at risk, according to their assessment. This means the length of follow-up will vary across individuals, and this length will correlate strongly with the complexity and severity of the case. One solution to this problem would be to develop an assessment of typical risk among Weinberg Center clients and match that with APS clients in the dataset. However, this

[5] Another option may be to use data from a team like the VEPT based in the Weill Cornell New York Presbyterian Hospital. This group also has a robust data collection program, though likely a smaller population than APS.

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solution would not address the need for additional follow-up among individuals identified for the comparison group. If possible, APS could contact the individuals in the control group and ask to assess them again for the study in exchange for appropriate compensation. These extra assessments would likely involve retrospective data collection (e.g., recalling feelings and experiences from an earlier time), and researchers performing the data collection would need to be trained in methods to optimize the veracity of these data.

Finally, these data likely do not include all the outcome measures recommended in this report. As discussed further in the measures section, we recommend covering a variety of physical health, mental health, legal, and abuse outcomes for a rigorous evaluation of the Weinberg Center. APS assessments likely include some of the measures we propose but not all of them. It is possible that researchers could determine legal outcomes through access to public records, but it would be difficult to go back and collect baseline data from study participants. Ultimately, the contents of the APS dataset (or alternative dataset) would largely determine the outcome measures used in the study. This final limitation makes this option less appealing than the first because randomization of participants would allow researchers to include whatever outcome measures were appropriate.

Using our interviews, community-based elder support groups like Family Services of Westchester could also supply secondary data necessary for a propensity score matching-based evaluation design. These organizations collect detailed data on clients and screen for elder abuse. However, these data do not extend to full mental and physical health evaluations. Thus, while such datasets do not provide information about all relevant outcomes, they could be used to answer narrower research questions about services provided, legal strategies and outcomes, and short-term health impacts. Researchers could also use Medicare and Medicaid data linked to client information to look at data outside APS outcomes.

At some point in the future, this type of evaluation could draw on data from SPRiNG Alliance partners. Because SPRiNG Alliance partners use very different arrangements (i.e., while some are centralized like the Weinberg Center's EAS, others use multiple long-term care facilities to house clients), comparing outcomes across the Weinberg Center's EAS and another SPRiNG Alliance member's EAS could indicate which model is best suited to which type of elder abuse. However, the development of data collection capacity by the other SPRiNG Alliance members is not yet sufficient to consider using their data for a study. Furthermore, we also do not recommend using existing hospital data. These data rarely have long-term follow-up of clients unless they reappear in the medical system. Accessing medical records can also be costly. Our conversations with hospital staff underscored the difficulty associated with using these materials.

Like the first option, this study design could also include a qualitative component. Qualitative interviews with clients could provide important context for the quantitative outcomes identified through statistical analysis. Moreover, in-depth interviews with EAS clients who do not benefit from the program (if others do) could be used to determine whether additional services are needed for different groups of clients, potentially including the equitability of service provision.

We estimate that this study would require (1) three PhD researchers, including one statistician, four mid-level researchers, and a junior staff member; (2) between 360 and 435 labor days over three to five years; (3) the cost to purchase APS (or similar) data; (4) support for Weinberg Center staff collecting follow-up data (support for data collection by two staff members trained in trauma-informed work with victims of elder abuse); (5) participant compensation (assuming a total of $140 per participant over the course of the study and 100 participants);[6] and (6) report production (one report, one journal article). Other possible costs could include travel if the research partner is not local and a professional survey staff if desired.

[6] We used the power analysis outlined for Option 1 for Option 2, but, depending on the secondary dataset used, this power analysis may need to be adjusted to reflect the comparison group created by the propensity score matching process.

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The cost estimate is slightly higher than the previous evaluation design because preparing a secondary dataset used for propensity score matching will take significant researcher expertise and time. Moreover, APS or another organization might require funds to transfer the data for evaluation. The range in cost reflects unknowns, like the time it will take to recruit a sufficient sample and any unforeseen costs associated with obtaining data preparation. APS or another organization will also require funding to process and provide the data. We believe three to six years should be enough time to complete the project depending on how long different elements take.

Option 3: Pre- and Post-Evaluation Design

Our third recommended design is a pre- and post-evaluation design. Instead of a separate comparison group, this approach uses a baseline measurement of clients as the comparison. The study would assess all clients of the Weinberg Center over a set period. To evaluate the impact of the services provided, researchers would examine baseline measures taken before the client received Weinberg Center services and compare those datapoints with client outcomes at set intervals after treatment. We recommend collecting data from each client every three months after leaving the care of the Weinberg Center EAS for a total of four datapoints (one before treatment and three following exit from treatment). This design could also include interviews and focus groups and an analysis of larger datasets like Medicare, Medicaid, or the Health and Retirement study to triangulate the client data with rich qualitative and external quantitative data. This study could answer several key questions, such as the following:

1. Do the mental and physical health outcomes of Weinberg Center clients improve after they receive services? If so, how long does this improvement persist?
2. How do Weinberg Center client outcomes compare with those of other similarly aged adults?
3. What percentage of Weinberg Center clients experience re-abuse in the two years after treatment?
4. What percentage of Weinberg Center clients meet their own goals (as defined by the client) during or after treatment?
5. How do clients feel about their time in the Weinberg Center?

However, unlike the first two designs, this study would not be able to confirm whether Weinberg Center services improved outcomes relative to care as usual. If researchers identified improvements in client outcomes after the Weinberg Center's services, they could not be certain that Weinberg Center services caused the improvement, or those same improvements would have occurred over time without intervention from the Weinberg Center. This is because a pre- and post-evaluation design does not use a comparison group of individuals who do not receive services, and it does not otherwise control for confounding variables (factors that could affect outcomes that are not accounted for). Qualitative data and a comparison to another dataset like the Health and Retirement study could help move the results closer to uncovering any unique impacts of the Weinberg Center EAS Model. The study could also benefit from secondary data sources, like Medicare and Medicaid, that could be linked to participants and provide information on hospitalizations, emergency room visits, and health care costs. Linking these datasets would reduce burden on participants who would otherwise need to recall and report these instances to researchers.

We estimate that this study would require (1) three PhD researchers, four midlevel researchers, and a junior staff member; (2) between 320 and 350 labor days over four to six years; (3) the cost of support for Weinberg Center staff collecting follow-up data and survey design (two staff members trained in trauma informed work with victims of elder abuse); (4) funds for any linked data purchases (e.g., Medicaid, Medicare); (5) participant compensation (assuming a total of $140 per participant over the course of the study and 200 participants); and (6) report production (one report, one journal article). Other possible costs could include travel if the research partner is not local and a professional survey staff if desired.

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Because this model would not require extensive effort to recruit or statistically develop a comparison group, the cost is slightly lower than the other two options. The project would require less labor and travel to complete. However, this design would require a longer follow-up with clients to improve the rigor of the study (i.e., likelihood of identifying impacts of the intervention) or exploration of secondary datasets to create a benchmark with which to compare the results. The determining factors for the cost are the time it takes to recruit an acceptable sample and the compensation provided to study participants. We believe four to five years should be enough time to complete the project.

Summary of Evaluation Designs

Table 5.4 outlines the time frame, cost, description, participants, and pros and cons of each evaluation design. Importantly, designs are laid out as is to demonstrate sample options with associated costs, but components of each could be discussed, depending on the goals (e.g., there could be a qualitative component with both Options 1 and 2).

Timelines

All the evaluation designs follow the same general timeline. We estimate that phase one will take between two and four months and will include developing consent forms, designing internal data processes for data collection and secure storage, obtaining approval from the relevant independent review board to ensure participant safety, and developing processes for delivering compensation for participants. Phase two will likely be the longest phase of the project because it will involve collecting data and achieving a suitable sample size. We estimate this will take between two and four years. This phase will involve identifying the treatment and control group, implementing the treatment, collecting data from participants, and obtaining data for comparators if that is included in the research design. Phase three will last one year and will cover analysis of the data to determine impacts of the program, and phase four will last six months and will encompass writing, publishing, and publicizing the report. Figure 5.1 visually displays these phases.

Important Considerations for Evaluators

Working with Victims of Elder Abuse

It is important to emphasize that conducting research with individuals experiencing cognitive decline can be difficult. Because victims of elder abuse are often also experiencing cognitive issues, researchers working on an evaluation of the Weinberg Center's EAS model will need to think carefully about data collection with this population. It will be difficult, for example, to identify improvements in clients' cognition if their overall cognitive capacity is declining. Moreover, our conversations with staff at the Weinberg Center revealed that clients can become more depressed when they start to contend with the reality of their situation (e.g., a family member has been abusing them). Understanding the nuances of victim experience will be important to incorporate into the results of any evaluation. This possibility points to a larger concern, which is that of the need for ethical oversight to ensure that vulnerable individuals are not being placed at increased risk for harm (e.g., abuse by other nursing home residents). Any evaluation should align with existing oversight and protections afforded to those admitted to the program.

We recommend working closely with trained staff at the Weinberg Center or from other academic institutions to ensure that data collection and analysis respects these sensitivities and realities. Another resource is the Person-Centered, Trauma-Informed (PCTI) evaluation planning tool (Bruski and Erkes, 2022). The PCTI evaluation tool walks evaluators through a series of principles to ensure that program evaluations respect traumatic experiences that older adults have experienced and to reduce the risk of retraumatizing older adults and their family members who are involved in the study. Moreover, developing adequate consent

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TABLE 5.4
Summary of Evaluation Design Options

Study Option	Description	Participants	Pros and Cons
Option 1: Randomization using opt-in nature of treatment	This study would compare the outcomes of a group of people who experienced elder abuse but one group used the services of the Weinberg Center's EAS while the other did not.	**Treatment Group:** 100+ Weinberg Center clients **Control Group:** 100+ victims of EM referred to Weinberg Center's EAS who refuse treatment	Pros: • Can collect data for any measure across groups and thus more directly assess impact of the full slate of Weinberg Center services Cons: • Some bias associated with selection into groups (nonrandom) • Small sample size may limit detection of impact
Option 2: Propensity score matching	This study would compare outcomes experienced by clients of the Weinberg Center's EAS with outcomes of similar individuals who were not referred to the Weinberg Center but whose experiences were captured by APS or VEPT in the past because of their experience of elder abuse.	**Treatment Group:** 100+ Weinberg Center clients **Control Group:** Similar individuals identified in secondary data source who did not receive Weinberg Center services Total sample for control group will vary based on secondary data source but best comparable example used more than 33,000 entries	Pros: • Larger comparison group • Reduced bias in self-selection Cons: • Limited control over outcomes measured as researchers will need to use outcomes available in secondary dataset • Lack of control over data (baseline will be treatment provided by organization collecting secondary data [e.g., APS, hospital]) • Depending on data selected, could be difficult to identify patients who meet Weinberg Center referral requirements with secondary data
Option 3: Pre- and post- evaluation	This study would track Weinberg Center clients over time to determine whether client outcomes improve.	**One group:** 200+ Weinberg Center clients (sample not split into treatment and control)	Pros: • Likely easier to recruit and maintain follow-up with participants • Could include rich primary qualitative and secondary data for comparison to primary quantitative data collection Cons: • Without clear control group, difficult to determine how clients would have fared without intervention and determine true value of care

NOTE: "The Weinberg Center's EAS" could be replaced with other EASs.

materials to ensure participants understand their rights as research subjects will be critical. It is important that researchers undertaking this evaluation are well-versed in working with vulnerable populations, including those with cognitive impairments.

Equity

As with all evaluations, it is critical to think about equity when designing and implementing an evaluation. Acknowledging the fact that this program is not available to all victims of elder abuse, an evaluation of an elder abuse intervention must address and incorporate the fact that those who are admitted, and any other study participants, might have different experiences of and beliefs about abuse. Variation in expectations around the treatment of elders in different communities could also affect victims' experiences and needs when in an EAS. This variation could also include language differences where a high-quality translation

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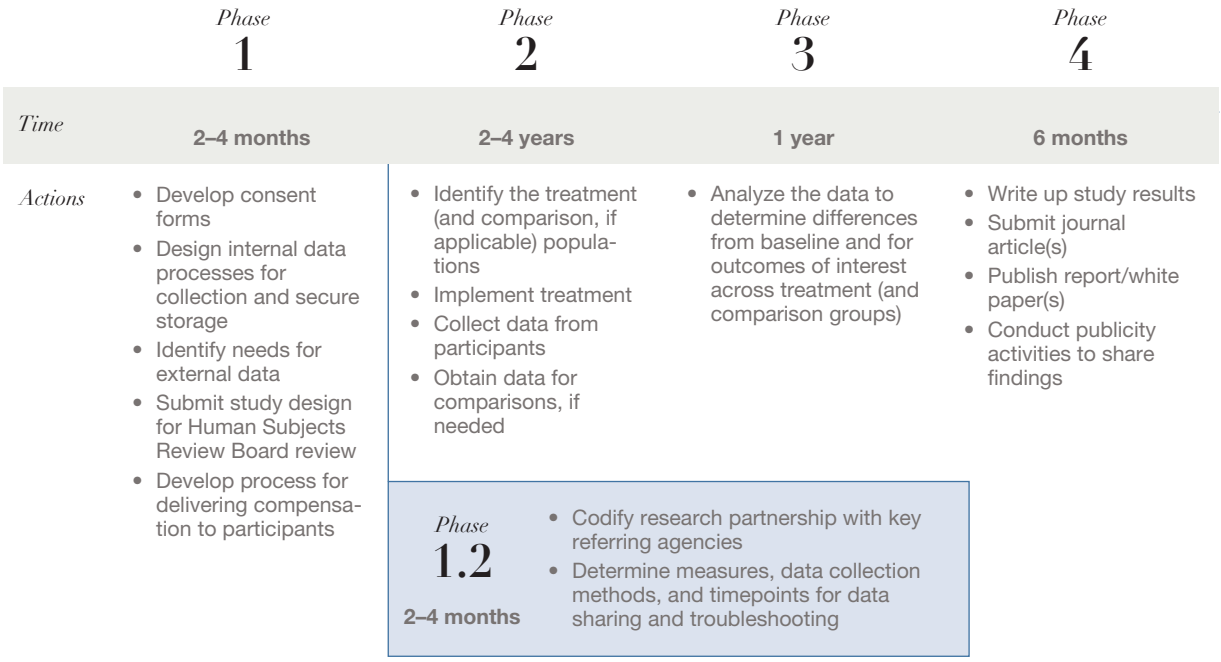
FIGURE 5.1
Timeline for Evaluation Designs



could mean the difference between correct and incorrect interpretations of evaluation data. Understanding these differences will allow evaluators to capture relevant baseline data and ensure that comparisons across groups incorporate variation across cultures.

Working closely with experts who have experience in the communities and cultures of victims of abuse will increase the likelihood that interactions with victims and measures of victim well-being will align with the needs and experiences of evaluation participants. For example, people with different cultural backgrounds or beliefs might have different ideal pathways to healing and trust. By understanding these nuances, evaluators will be better positioned to capture these differences at baseline, make more-appropriate comparisons, and report outcomes across relevant subgroups.

The evaluation should also capture variation in impact of the EAS across clients. Even if, on average, the EAS improves outcomes for clients, researchers should take care to use subgroup analysis where appropriate to determine whether the intervention is working equally well for all. If it is not, this should be explored and reported to the staff who should also act on the information to promote the equitable delivery of services.

Finally, any evaluation of an EAS should pay close attention to the exclusion criteria used to select from referred clients. While understandable given limited resources, resident safety, and clinical expertise, EAS shelters might not be able to accept clients who would benefit from their services because of factors beyond the victim's control. Moreover, these factors might also be correlated with elder abuse. Such exclusion criteria could significantly limit the possible reach of an EAS to the broader pool of older adults experiencing elder abuse and affect the generalizability of an impact evaluation to all victims of elder abuse. Consequently, carefully documenting the exclusion criteria of the EAS should be a key part of the evaluation.

Data Security

All the research designs outlined above involve collecting data from members of a vulnerable group. Any research design must also include a clear plan for maintaining data security and ensuring participant privacy and confidentiality. Researchers must work closely with the human subjects research board at their

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institution to create a robust data storage plan. Moreover, because this study includes subjects that are highly vulnerable (according to National Institutes of Health guidance) there might be value in implementing an independent data safety monitoring board to ensure the careful handling of data. This board would periodically review and evaluate the accumulated study data for participant safety and study progress, conduct, and efficacy. The board could also make recommendations concerning the continuation, modification, or termination of the evaluation (National Institute of Dental and Craniofacial Research, 2018).

Client and Family Input

EM can affect the whole family. Often, one family member is the perpetrator while others are well-intentioned and unsure how to become involved to ameliorate the situation. Families need support as they work with their loved one to maintain their safety and security. Moreover, family members are more likely to reach out to programs like the Weinberg Center or multidisciplinary task forces if they trust and feel heard by the organizations. Incorporating family voices into an evaluation of an intervention will be essential, but existing literature does not take a firm stance on the methods for doing so. In the studies we reviewed that evaluated shelter models, one included family voices in the evaluation process. However, the authors did not systematically interview family members and did not provide a protocol for an approach to evaluation (Alon and Berg-Warman, 2014).

We recommend providing an optional survey instrument that could go to a close family member if the situation of the client means it is safe to do so (i.e., there is a family member who is not complicit in abuse of the client who wishes to participate). This optional survey questionnaire should be short in length and designed to capture (1) how family members perceive the impact of the Weinberg Center on their loved one, (2) ways the Weinberg Center could improve services, and (3) how the Weinberg Center could better integrate non-abusive family members. Evaluators could also capture these data in longer, semistructured interviews if more information from family members is desired. This information should be integrated into the results of the study and inform recommendations by the authors.

If appropriate for the study design (e.g., Option 1), the study would also include family members of study participants who do not become clients. The survey of these family members should include questions about how the Weinberg Center could better market their services and explain possible benefits to prospective clients, as well as how to better cater to actual clients. This information would be extremely useful to the Weinberg Center as it struggles to recruit new clients after the COVID-19 pandemic.

All our research designs include client responses. We encourage all research on EM to include a qualitative interview portion where possible. However, as we outline above, this is particularly important when conducting nonexperimental evaluation designs, as the information can be used to triangulate and give greater context to quantitative findings. Finally, any interview with a vulnerable person, like a victim of elder abuse, should be undertaken by someone with sufficient training in trauma-informed interview techniques. We recommend working with an organization, like the Weinberg Center, that specializes in training and trauma-informed responses to ensure interviews are conducting in a thoughtful way.

Cost Benefit Analysis

As previously mentioned, RAND published a hypothetical cost-benefit analysis of the Weinberg Center's EAS (Smucker et al., 2021). The report found that, using cost estimates of elder abuse from the existing literature, the Weinberg Center's EAS could potentially produce cost savings that exceeded its operating costs. This study used cost data provided by the Weinberg Center and illustrative vignettes to demonstrate the value of components of the Weinberg Center EAS on one client and then a representative number of clients over a five-year time frame. It will be important for the evaluation to include a cost-benefit analysis to test whether these illustrative figures bear out in a rigorous evaluation with a comparison group that uses other community services. Such analysis could test whether the Weinberg Center's services do reduce the cost of

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EM within its narrowly defined population, or if the costs required for the Weinberg Center model could result in a better return on investment for other elder abuse interventions that might potentially serve a greater number of victims of elder abuse.

Evaluating Other EASs

There are three structures that elder shelters typically take. The first is the original Weinberg Center EAS, which, because of its colocation within a larger assisted living facility, can run a program for a cost far lower than possible outside such a facility. The second uses a central clearinghouse that connects with clients and then, through partnerships across the city or state, identifies assisted living facilities with available beds and matches victims with these facilities. The third includes models that fit community needs with resources—such as foster homes, apartments, and motels (among other residences)—to support victims of elder abuse. For example, one SPRiNG Alliance member rents their own apartment to provide shelter for adults and connects them to services from the apartment.

While EASs are being implemented across the country, the evaluability assessment and research designs ought to be centered on the model presented at the Weinberg Center. Ideally, an evaluability assessment would be conducted across other SPRiNG Alliance partners before a comprehensive evaluation was initiated. There are limited systematic data collection efforts around outcomes. Moreover, the data we collected on SPRiNG Alliance recruitment and admission suggest that these organizations would struggle to recruit enough clients to create a robust study sample and comparison group (if using an Option 1 evaluation model). Figure 5.2 visually represents the percentage of referred individuals who became clients of a SPRiNG Alliance–affiliated organization. On average, only 14.5 percent of referred individuals were admitted into shelter among SPRiNG Alliance members in 2020 and 2021, with an average of five admissions per year (for a detailed table, see Appendix C).

Given the variety of approaches to providing housing and services to victims of elder abuse, as well as low admission rates, these newer sites are not yet ready to complete a full evaluation. However, we believe the sites could be ready in the next three years, provided they receive sufficient guidance from the Weinberg Center or evaluation specialists to support robust data collection and an increase in the percentage of referred individuals who ultimately become clients.

FIGURE 5.2

Percentage of Referred Individuals Who Became Clients at a SPRiNG Alliance Partner

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CHAPTER 6

Concluding Thoughts

Elder abuse is a growing problem and, although interventions exist, few have been evaluated rigorously. Our study of the Weinberg Center's EAS—which included a formative evaluation, an evaluability assessment, and a review of shelter model evaluations—underscored the complexity of elder abuse cases and the need to support multidisciplinary approaches to tackling it. Older adults experiencing abuse often feel trapped in their situation because of a relative lack of viable housing alternatives in comparison with more readily available emergency shelters that have become a staple of support for domestic violence survivors. EASs, like the one implemented by the Weinberg Center, are critical for supporting people experiencing elder abuse, because of the program's ability to provide multidisciplinary support while also bridging the housing gap. In a world of limited state and local resources, a rigorous evaluation of the Weinberg Center EAS model would bring the field closer to helping policymakers, researchers, and clinicians understand where to invest to support a growing number of elder abuse survivors. This is particularly important given evidence that some nursing homes might put residents at risk of negative outcomes.

After years of providing services to clients, the Weinberg Center is ready for a full evaluation of its services with support from a strong external research partner that can help the staff improve evaluation readiness. Using our review of the literature, the Weinberg Center logic model, and consultation with key stakeholders, we believe that any evaluation of the EAS model should investigate its impact on (1) impact on client health outcomes (mental and physical), (2) legal outcomes, (3) risk factors for abuse, (4) health care utilization and cost, and (5) achievement or lack of achievement of clients' self-defined goals. While there remain some concerns about data collection capacity and comparison groups, our evaluation designs account for these existing limitations. Moreover, a partnership with an established research organization could help the Weinberg Center set up systems that could serve their evaluation goals over the longer term after the initial evaluation is complete.

By assessing the impact of the EAS model on these outcomes, such an evaluation could inform resource allocation for elder abuse by federal, state, and local officials. It could also support decisionmaking by hospitals, APS, and law enforcement, all of which are often on the front lines of the elder abuse crisis and must determine where victims should go when they cannot go home. Perhaps most importantly, it could inform organizations like the Weinberg Center about which of its practices are working and which should be adjusted to better support clients' needs.

We have outlined three types of evaluations that could shed light on these outcomes and the value of the Weinberg Center for clients and broader society. A rigorous evaluation would also create the first—to our knowledge—longitudinal dataset specifically of older adults experiencing abuse. Investment in maintaining contact with these individuals could also be beneficial for further research on the experience, needs, and recovery of older adults who are victims of elder abuse. Such an evaluation could also be replicated in other locations where EAS models are developing, testing whether the impact of the Weinberg Center is similar when applied in a different context and when EAS models are slightly different.

Because the Weinberg Center is largely ready to embark on an evaluation, its leadership should review the three evaluation designs we proposed and consult with partners and potential evaluation teams as needed

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to decide how to proceed. Federal and state partners interested in protecting victims of elder abuse should consider funding one of these evaluation models to determine where this intervention model should be supported and expanded as the population ages.

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APPENDIX A

Interview Guides

Weinberg Center Staff Interview Guide

Hello, and thank you for taking time to speak with us today. My name is [name] and I'm a researcher at the RAND Corporation. The RAND Corporation is a nonprofit, nonpartisan institution that helps improve policy and decisionmaking through research and analysis. I'll be leading our conversation today, and we're joined by [name], who is also taking notes while we talk so we can capture all of the important details we discuss today.

The purpose of the study is to document the [organization's] model and services and discuss whether and what types of data you may have available for researchers on clients. We are talking with you today to learn more about the services your organization provides, the characteristics and needs of clients served, and the type of information collected on your clients.

Your participation in this discussion is completely voluntary, and we can stop at any point or skip any question. Whether you decide to participate or not will have no consequences on your employment with [organization]. RAND will use the information you provide for research purposes only and your responses will be kept confidential and secure. In our reports or research products, your name won't be linked or attributed to any of the information you provide us today.

As I mentioned, [name] is taking notes. We also would like to record our conversation today so that we don't miss anything you say. The recordings help us supplement our notes after our discussion. All notes and recordings will be destroyed at the end of the study. No one outside the research team will have access to the recordings. We expect the interview to last no more than one hour.

If you have any questions about this interview or about your participation in this study, please feel free to contact the principal investigators, Dr. Meagan Cahill at (703) 413-1100, extension 5597 or Dr. Esther Friedman at (703) 413-1100, extension 7230.

If you have any questions about the research, please feel free to contact RAND's Human Subjects Protection Committee toll-free at (866) 697-5620 or by emailing hspcinfo@rand.org. The reference number of this research study is number 2020-0150.

Do you consent to participate in this interview?

If yes: Continue.

If no: Ask interviewee if they have specific questions or concerns about participating. Address as appropriate. If interviewer or interviewee needs more time to obtain information or make a decision, offer to follow up on a specific date. If interviewee declines participation (either with or without questions/concerns), acknowledge their decision and thank them for their time.

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Is it okay if we record our conversation?
If yes: Start recording.
If no: Request permission to proceed without recording but taking notes.

Introduction

To start, I'd like to know a little more about your role in the organization.

1. Can you state your name and give me a brief, 30-second overview of your role and responsibilities at [organization] and how long you have been in this role?
2. Can you walk me through what a typical day at [organization] looks like for you?

Client Engagement and Needs

Thank you. We would like to start by understanding more about [organization]'s clients and their needs.

1. What is the typical process of engagement for a new client? Can you walk us through the timeline from initial phone call until discharge?
2. How do clients typically find out about and start engaging with [organization]?
    a. Are some people who reach out turned away? How does the organization decide who to include?
3. What are the demographic characteristics of clients?
    a. How old are they, usually?
    b. Are clients typically on Medicaid? Low-income population?
    c. What geographic areas do they come from?
    d. What are their racial or ethnic groups?
    e. What kinds of disabilities do they have, if any?
4. Can you tell me a bit about the typical needs of your clients, whether or not [organization] is able to address them?
    a. Housing needs
    b. Health care needs
    c. Legal needs
    d. Needs for therapy
    e. Needs for other social services
    f. Other?
5. In your opinion, if clients had not been admitted to/come to the attention of [organization], where would they have gone?
    a. What alternatives are available?
    b. Where do people with similar needs go for help?

Organization Services

Thank you. We have talked about who the clients are and their needs, we would also like to learn about services provided by [organization] to address these needs.

1. What are the services [organization] provides to clients?
    a. Are there any services provided only to a subset of clients with specific needs (e.g., dementia, specific disabilities)?
2. Are there any services a client may need that [organization] does not provide (circle back to needs listed as part of questions above)?

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   a. Does your organization help connect them to these services?
3. How do clients pay for services?
   a. Insurance
   b. Medicare/Medicaid
   c. Out of pocket
4. [If residential services provided] How long do clients typically stay at [organization]?
   a. Where do they go next?
   b. How common is discharge to home versus institutional settings?
5. [If residential services provided] How are discharge decisions made?
   a. Care team only?
   b. In collaboration with clients?
   c. In collaboration with client families?
6. To what extent and how does the care team interact with families or other caregivers?
7. In your opinion, what are the strengths of this organization?
   a. What works well?
8. Are there things that don't work as well?
9. Are there any new services you wish would be rolled out or any that are already being planned for the future?

Benefits and Expected Outcomes

Thank you. We would like to learn about the benefits to clients of receiving services at [organization].

1. Can you tell us a bit about the kinds of benefits clients may get from services provided through [organization], for instance:
   a. Sense of safety and security
   b. Mental health
   c. Physical health (probe for examples)
   d. Ability to make care decisions
   e. Ability to age in the setting they desire
2. Are there other benefits to clients?
3. Are there some clients who do not benefit as much?
   a. Why?
   b. Who are they?
4. Do clients ever come back to [organization] after discharge?
   a. Why does this happen?
   b. How is that handled?

Data for Our Analyses

Thank you. Finally, I'd like to know more about the kind of data you collect on clients.

1. What types of information do you collect on clients while they are residing at/being served by [organization]?
   a. At intake?
   b. At discharge?
   c. How regularly is information updated?
   d. Are data mostly collected by hand or through electronic records?
2. Do you ever learn about how a client is doing after discharge/release from your care?

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a. How?
b. Is this information saved?

Conclusion and Wrap-Up

Thank you; that concludes our questions.

1. Is there anything else that you think is important for us to know about [organization]'s clients and services?

Thank you again for taking the time to participate in this study. If you have questions, feel free to contact us by phone or email at any time in the next few months. We are very appreciative of your perspective and input.

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Weinberg Assessment Interview Guide or Other EAS or Collaborators

Hello, and thank you for taking time to speak with us today. My name is [name] and I'm a researcher at the RAND Corporation. The RAND Corporation is a nonprofit, nonpartisan institution that helps improve policy and decisionmaking through research and analysis. I'll be leading our conversation today, and we're joined by [name], who is also taking notes while we talk so we can capture all of the important details we discuss today.

We are funded through the National Institute of Justice to develop an evaluation plan of the Weinberg Center for Elder Justice and the shelter model overall. Our goal is to understand the path that victims take after experiencing elder mistreatment or abuse, whether into the shelter, a hospital, or other type of facility. As an organization that [tailor according to organization], we are talking with you today to learn more about the services provided by [organization], the characteristics and needs of clients served, and the type of information collected on clients.

Your participation in this discussion is completely voluntary, and we can stop at any point or skip any question. Whether you decide to participate or not will have no consequences on your employment with [organization]. RAND will use the information you provide for research purposes only and your responses will be kept confidential and secure. In our reports or research products, your name won't be linked or attributed to any of the information you provide us today.

As I mentioned, [name] is taking notes. We also would like to record our conversation today so that we don't miss anything you say. The recordings help us supplement our notes after our discussion. All notes and recordings will be destroyed at the end of the study. No one outside the research team will have access to the recordings. We expect the interview to last no more than one hour.

If you have any questions about this interview or about your participation in this study, please feel free to contact the principal investigators, Dr. Meagan Cahill at (703) 413-1100, extension 5597 or Dr. Esther Friedman at (703) 413-1100, extension 7230.

If you have any questions about the research, please feel free to contact RAND's Human Subjects Protection Committee toll-free at (866) 697-5620 or by emailing hspcinfo@rand.org. The reference number of this research study is number 2021-N0032.

Do you consent to participate in this interview?

If yes: Continue.

If no: Ask interviewee if they have specific questions or concerns about participating. Address as appropriate. If interviewer or interviewee needs more time to obtain information or make a decision, offer to follow up on a specific date. If interviewee declines participation (either with or without questions/concerns), acknowledge their decision and thank them for their time.

Is it okay if we record our conversation?

If yes: Start recording.

If no: Request permission to proceed without recording but taking notes.

Introduction

To start, I'd like to know a little more about your role in your organization.

1. Can you state your name and give me a brief, 30-second overview of your role and responsibilities at [organization] and how long you have been in this role?
2. Can you walk me through what a typical day at [organization] looks like for you?

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Client Engagement and Needs

Thank you. We would like to start by understanding more about [organization] and client needs.

1. What is the typical process of engagement for a new client? Can you walk us through the timeline from initial contact (entry) until discharge (exit)?
2. How do clients typically start engaging with [organization]?
    a. Do clients reach out directly or are they referred?
    b. Are some people who reach out turned away? If so, how do you decide who to include?
3. What are the demographic characteristics of clients?
    a. How old are they, usually?
    b. Are clients typically on Medicaid? Low-income population?
    c. What geographic areas do they come from?
    d. What are their genders and racial or ethnic groups?
    e. What kinds of disabilities do they have, if any?
    f. Do you serve a population that differs significantly in any way from other people experiencing elder mistreatment (EM)? If so, how?
4. Can you tell me a bit about the typical needs of your clients, whether or not you are able to address them?
    a. Housing needs
    b. Health care needs
    c. Legal needs
    d. Needs for therapy
    e. Needs for other social services
    f. Other?
5. In your opinion, if clients had not been connected with [organization] for services, where would they have gone?
    a. What alternatives are available?
    b. Where do people with similar needs go for help?

Services Provided

Thank you. We have talked about who the clients are and their needs, we would also like to learn about services provided by [organization] to address these needs.

1. What are the services [organization] provides to clients?
    a. Are there any services provided only to a subset of clients with specific needs (e.g., dementia, specific disabilities)?
    b. How do you determine which client needs which services?
        i. Probe: intake form, intake assessment (and whether there is documentation)
2. Are there any services a client may need that [organization] does not provide (circle back to needs listed as part of Q's above)?
    a. Do you help refer or connect them to these services?
3. How do clients pay for services?
    a. Insurance
    b. Medicare/Medicaid
    c. Out of pocket
4. For inpatient facilities only: How long do clients typically stay?
    a. Where do they go next?

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   b. How common is discharge to home versus institutional settings?
5. For inpatient facilities only: How are discharge decisions made?
   a. Care team only?
   b. In collaboration with clients?
   c. In collaboration with client families?
6. For outpatient service providers: How long do clients typically continue to use services?
7. To what extent and how does your team interact with families or other caregivers?

Benefits and Expected Outcomes

Thank you. We would like to learn about the benefits to clients of receiving services at [organization].

1. Can you tell us a bit about the kinds of benefits clients may get from the services you provide, for instance:
   a. Sense of safety and security
   b. Mental health
   c. Physical health (probe for examples)
   d. Ability to make care decisions
   e. Ability to age in the setting they desire
2. Are there other benefits to clients?
3. Have you formally evaluated how your program impacts these outcomes?
4. Are there some clients who do not benefit as much?
   a. Why?
   b. Who are they?
5. Do clients ever come back after discharge/ceasing service use?
   a. Why does this happen?
   b. How is that handled?

Data for Our Analyses

Thank you. Finally, I'd like to know more about the kind of data you collect on clients.

1. What types of information do you or other organizations (e.g., health care providers, social service organizations) collect on your clients (e.g., conditions, needs, services, and outcomes)?
   a. At intake/entry?
   b. At discharge/exit?
   c. How regularly is information updated?
   d. Are data collected by hand or through electronic records?
2. What types of information do you keep on program activity use and costs?
   a. How regularly is information updated?
   b. Are data made publicly available (probe: if not, do they ever make them available to researchers, others upon request)?
3. Do you ever learn about how a client is doing after discharge/cessation of services?
   a. How?
   b. Is this information saved?
   c. If not, would it be feasible to collect this type of information? What would it take?
4. Have you done a formal assessment of the services you provide (e.g., related to cost, outcomes, etc.)
5. What types of information would you like to collect on clients?
   a. What would it take to gather this type of data?

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b. Do you know of other organizations that collect these types of data or do an assessment of their services?

Conclusion and Wrap-Up

Thank you; that concludes our questions.

1. Is there anything else that you think is important for us to know about [organization]'s clients and services?
2. Is there anyone else or other organizations you think we should talk with?

Thank you again for taking the time to participate in this study. If you have questions, feel free to contact us by phone or email at any time in the next few months. We are very appreciative of your perspective and input.

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APPENDIX B

Search Strategy for Literature Review

Search string—academic databases:

Search Terms A (2010 to June 2021, terms in title or abstract, English language)

(elder* OR old* OR senior OR aging OR age*)
NOTE: slight modification for PubMed because truncation requires minimum of 4 characters:
(elder OR old OR older OR senior OR aging OR ageing OR aged)*
WITHIN 5 WORDS
(abus* OR mistreat* OR victim* OR neglect* OR violen*)
WITHIN 10 WORDS
(interven* OR program* OR support* OR service* OR project* OR help* OR model* OR address* OR respon*)
WITHIN 10 WORDS
(evidence OR data OR information OR proof OR knowledge OR evaluat* OR effective* OR assess* OR review* OR estimat* OR result* OR impact* OR outcome)

Search Terms B (2010 to June 2021, terms in title or abstract, English language)

(shelter OR hous* OR home)
WITHIN 5 WORDS
(abus* OR mistreat* OR victim* OR neglect* OR violen*)
WITHIN 10 WORDS
(interven* OR program* OR support* OR service* OR project* OR help* OR model* OR address* OR respon*)
WITHIN 10 WORDS
(evidence OR data OR information OR proof OR knowledge OR evaluat* OR effective* OR assess* OR review OR estimat* OR result OR impact OR outcome)

Databases searched:

Academic Search Complete, Business Source Complete, Criminal Justice Abstracts, HeinOnline Law Journal Library, EconLit, Google Scholar, Index to Legal Periodicals, National Criminal Justice Reference Services (EBSCO), PAIS, Policy File Index, PsycINFO, PubMed, Scopus, Social Science Abstracts, Sociological Abstracts, Web of Science

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Search string—Google Scholar searches (2010 to June 2021, terms in title)

GS Search 1

"elder abuse" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 2

"elder mistreatment" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 3

"abuse of older people" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 4

"mistreatment of older people" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 5

"abuse of older adults" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 6

"mistreatment of older adults" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 7

"shelter model" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 8

"shelter home" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 9

"shelter house" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

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GS Search 10

"abuse shelter" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

GS Search 11

"violence shelter" AND (evidence OR data OR information OR proof OR knowledge OR evaluate or evaluation OR effective OR assess OR assessment OR review OR estimate OR estimating OR result OR impact OR outcome)

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APPENDIX C

Admissions to SPRiNG Alliance Partners

TABLE C.1
SPRiNG Alliance Client Referral and Admission Data (2020–2021)

Center Name		2020	2021
A&O: Support Services for Older Adults	Referrals	Not available	81
	Admissions	Not available	7
Shalom Sanctuary Center for Elder Abuse	Referrals	Not available	19
	Admissions	Not available	4
Saint Elizabeth Haven for Elder Justice	Referrals	46	50
	Admissions	5	2
Magen Center	Referrals	Not available	8
	Admissions	Not available	2
Monroe County Elder Abuse Shelter	Referrals	Not available	7
	Admissions	Not available	6
Utah Department of Homeland Security	Referrals	10	Not available
	Admissions	4	Not available
CHANA	Referrals	113	Not available
	Admissions	6	Not available
Petaluma People Services Center	Referrals	4	Not available
	Admissions	2	Not available
ElderSafe	Referrals	24	Not available
	Admissions	4	Not available
Jewish Senior Services	Referrals	10	Not available
	Admissions	0	Not available
Lifespan Rochester	Referrals	37	Not available
	Admissions	19	Not available

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Table C.1—Continued

Center Name		2020	2021
Eliza Bryant	Referrals	32	Not available
	Admissions	14	Not available
All Reporting	**Referrals**	**276**	**186**
	Admissions	**49**	**21**
	% of Referred to Admission	**18%**	**11%**

SOURCE: Features information from the Weinberg Center records of SPRiNG Alliance member data. Not all organizations reported in 2021 and 2022, therefore the 2020–2021 data are the most recent and complete.

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APPENDIX D

PIER Scoring Tool for Weinberg Center EAS

The scoring key for Table D.1 is as follows:

- 0 = No evidence of metric
- 1 = Minimal evidence of metric
- 2 = Significant evidence of metric
- 3 = Complete agreement with metric
- U = Unknown, no information available.

TABLE D.1
PIER Scoring Tool

Domain	Subdomain	Criteria	Score
Organizational readiness	Org culture	All key staff hold positive attitudes toward the intervention and evaluation	3
Organizational readiness	Org culture	Majority of staff have experience working with community partners that serve the target population	3
Organizational readiness	Org culture	Majority of staff have experience working with elder violence issues	3
Organizational readiness	Capacity	Adequate dedicated human resources and time are allocated for the intervention (leadership; program implementation staff; supervision resources [for counseling staff])	3
Organizational readiness	Capacity	Availability of appropriate technology and database(s) for program implementation (e.g., information and case management systems)	2
Organizational readiness	Capacity	Stable staff history (i.e., rate of staff turnover)	3
Organizational readiness	Capacity	Communication between the Weinberg Center EAS and partner agencies about program requirements and appropriate clients	3
Organizational readiness	Capacity	Relationships are established between Weinberg Center EAS and their referral agencies that ensure a sufficient number of referrals into intervention	2
Organizational readiness	Leadership, key staff	Recognizes the relationship between Weinberg Center EAS and possible improved outcomes	3
Organizational readiness	Leadership, key staff	Committed to evidence-informed practice	1
Organizational readiness	Leadership, key staff	Committed to data-driven decisionmaking	1

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Table D.1—Continued

Domain	Subdomain	Criteria	Score
Organizational readiness	Leadership, key staff	Experienced with implementing interventions and supporting evaluation	2
Organizational readiness	Leadership, key staff	Willing to share data on the program	3
Organizational readiness	Program staff	Sufficiently knowledgeable about all components of the program and evaluation	3
Organizational readiness	Program staff	Recognizes value of the intervention (i.e., perceives the need for intervention services)	3
Organizational readiness	Program staff	Recognizes value of participating in an outcome evaluation	3
Organizational readiness	Program staff	Recognizes the relationship between Weinberg Center services and possible improved outcomes	3
Organizational readiness	Program staff	Knowledgeable and clear about their roles and responsibilities in the program	3
Organizational readiness	Program staff	Experienced with or willing to learn about implementing program	3
Organizational readiness	Collaborative partners	All staff and additional partners have a clear understanding of how they will work together	2
Organizational readiness	Collaborative partners	Site has secured buy-in from local relevant stakeholders	1
Program readiness	Program design	Target population clearly defined and justified	3
Program readiness	Program design	Includes goals and objectives that are clearly stated and measurable (e.g., SMART goals and objectives)	2
Program readiness	Program design	Defines the activities specifically being implemented under the Weinberg Center EAS	3
Program readiness	Program design	Identifies outputs that are clearly stated and can be used to measure activities (units of service delivered—e.g., # of referrals, # of clients)	3
Program readiness	Program design	Defines measurable outcomes targeted by each program component (who and what is going to change, by how much, and by when)	1
Program readiness	Program design	Shows how the program components and processes clearly and logically link to the expected outcomes of the program components	2
Program readiness	Implementation: processes and procedures	Program components are sufficiently different from other Hebrew Home programs	3
Program readiness	Implementation: processes and procedures	Site has defined processes and procedures for identifying potential program participants/receiving referrals from external referral sources	3
Program readiness	Implementation: processes and procedures	Site has defined processes and procedures for recruiting/engaging individuals	3

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Table D.1—Continued

Domain	Subdomain	Criteria	Score
Program readiness	Implementation: processes and procedures	Site has defined processes and procedures for start and end points [e.g., how clients will be exited from the program]	3
Program readiness	Implementation: processes and procedures	Site has a process in place to document and track program implementation including recruitment, eligibility, intake, starting and ending dates of the program, dosage by program component, participation status (e.g., active, inactive), retention activities, and referrals.	2
Program readiness	Implementation: processes and procedures	Program "on board" with efforts to collect data for the evaluation	3
Program readiness	Implementation: program case flow	Program has developed detailed case flow from identification to the end for each intervention component	3
Program readiness	Implementation: staffing and training	Training plan contains at least essential training components	1
Program readiness	Implementation: staffing and training	Program has identified staff to provide initial and ongoing training and supervision	2
Program readiness	Implementation: staffing and training	Leadership has identified staff to participate in the initial and ongoing training	1
Program readiness	Implementation: staffing and training	Ensure program staff receive ongoing training and supervision in the program	1
Program readiness	Implementation: staffing and training	All staff and partners participate in trauma-informed training	3
Program readiness	Implementation: client recruitment techniques	Program creates thoughtful messaging about the services provided for recruiting participants	3
Program readiness	Implementation: client retention techniques	Establish program identity (i.e., Weinberg Center client's identity—who they are—is clearly defined and communicated to prospective participants)	3
Program readiness	Implementation: client retention techniques	Maintain regular contact with program participants	3
Program readiness	Fidelity: content and processes	Site has a clear and detailed description of the required intervention content covered by each intervention component and processes to deliver that content in an empowerment focused manner (e.g., treatment manual, fidelity monitoring checklist)	3
Evaluation readiness	Quasi-experimental design	Potential to identify comparison group that is not exposed to the key elements of the program (e.g., another group of individuals exposed to services but not those specifically part of the Weinberg Center EAS and related services)	2
Evaluation readiness	Quasi-experimental design	Potential to identify comparison group that is identified in the same way as the intervention group	1
Evaluation readiness	Quasi-experimental design	Potential to identify comparison group that has similar characteristics to those of the intervention group	2

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Table D.1—Continued

Domain	Subdomain	Criteria	Score
Evaluation readiness	Quasi-experimental design	Potential to identify comparison group that is feasible (no "spill-over" of services, selected before services begin)	1
Evaluation readiness	Quasi-experimental design	Description of potential comparison group (within org comparison, similar community, etc.)	0
Evaluation readiness	Program enrollment (of clients)	Site has projected annual study enrollment for the treatment (specify the target number) (including known retention/ dropout rates for individuals who are the same or similar to the target populations)	0
Evaluation readiness	Data collection	A data collection person is identified who can oversee data collection for all participants (intervention and comparison groups)	3
		Total score	116
		How many U responses	0
		Organizational readiness	53
		Program readiness	54
		Evaluation readiness	9

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Abbreviations

APS	Adult Protective Services
COVID-19	coronavirus disease 2019
DFTA	Department for the Aging NYC
EAS	elder abuse shelter
EM	elder mistreatment
LCSW	Licensed Clinical Social Worker
LCSW-R	Licensed Clinical Social Worker-Mandatory Legislation
LMSW	Licensed Master Social Worker
MDS	minimum data set
MDT	multidisciplinary team
NYC	New York City
PIER	Program Implementation and Evaluation Readiness
RCT	randomized controlled trial
SPRiNG	Shelter Partners: Regional. National. Global.
VEPT	Vulnerable Elder Protection Team
WC	Weinberg Center
WC-RAPS	Weinberg Center Risk and Abuse Prevention Screening

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