SUMMARY TECHNICAL REPORT

Building Late-Life Resilience to Prevent Elder Abuse

A Randomized Controlled Pilot Study of the EMPOWER Program

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We thank the Phoenix-based Area Agency on Aging, Region One, for frontline expertise in codeveloping and implementing the EMPOWER: Building Late-Life Resilience program, and specifically Mary Lynn Kasunic, president and CEO; Melissa Elliott, senior vice president of programs and services; and Heidi Donniaquo, director of behavioral health, for their incredible commitment to this research-and-practice partnership. We also thank the social work professionals who delivered EMPOWER to the study participants, particularly Brienna Bruce, Bayleigh Roth, and Irmine Bursey. Established in 1974, the Area Agency on Aging, Region One, is a 501(c)(3) nonprofit organization that has served as the hub of aging services in Maricopa County, Arizona, for 47 years. The Area Agency plans, coordinates, develops, funds, administers, and delivers more than 50 programs and services both directly and through subcontracted services from its vast network of providers. The Area Agency has consistently committed to investing time and resources in the prevention of elder abuse and late-life domestic violence. For over 25 years it has coordinated the Maricopa County Elder Abuse Prevention Alliance, made up of 150 community members who raise awareness and educate the public about elder abuse issues. Additionally, it has created nationally recognized, innovative programs such as the DOVES (Domestic Violence Does Not Respect Age) program, which focuses on victims of late-life domestic violence, and the APS Care Coordination program, which works with clients who have been referred to Adult Protective Services to connect them with resources and support.

We also appreciate the guidance of two Elder Justice Initiative consultants, Shelly L. Jackson and Sidney M. Stahl, and of the project's current and former federal monitors. The study further benefited from the guidance of an advisory board that included Sherry Hamby, Anthony Ehren Rosen, Pamela Teaster, and Page Ulrey, as well as Urban Institute experts Janine Zweig, William Adams, and Kamala Mallik-Kane.

Building Late-Life Resilience to Prevent Elder Abuse

Over the past two decades, as the proportion of older Americans has increased, so too have instances of elder abuse,[1] including physical, emotional, and sexual abuse; financial exploitation; and caregiver neglect (Ervin and Henderson 2020; NCEA 2021). The most recent national survey estimates show at least 1 in 10 community-residing older adults experience elder abuse each year (Acierno et al. 2010; Rosay and Mulford 2017), which translates to over 7 million Americans annually. Rates of abuse are magnified for older adults with the least financial and social resources, including those with low incomes, living in isolated rural communities, and facing structural barriers such as systemic racism (Jervis et al. 2016; Joseph and Gonzalez 2018).[2] Emerging research on the COVID-19 pandemic prompts even greater concern for elder abuse: the virus has disproportionately affected older adults, resulting in increased social isolation, physical health impairment, and exposure to COVID-related fraud (Makaroun, Bachrach, and Rosland 2020).

Recognizing the urgent need to develop and rigorously evaluate programs aimed at preventing elder abuse, the US Department of Justice's National Institute of Justice funded a demonstration from 2017 to 2021 during which researchers from the Urban Institute and practitioners at the Phoenix-based Area Agency on Aging, Region One ("the Area Agency") codeveloped an elder abuse prevention program in Maricopa County, Arizona, which Urban's team then evaluated through a randomized controlled pilot study. This multiphase demonstration included an initial planning phase (the activities of which are summarized in Hussemann and Yahner [2019]) and a subsequent pilot study, which is the focus of this report.

The EMPOWER Program

The EMPOWER: Building Late-Life Resilience program is a 12-week in-home intervention, with one-hour weekly visits designed to empower community-residing older adults with the resiliency and resources to lead safe and healthy lives throughout the aging process.[3] EMPOWER provides one-on-one assessments, client-centered prevention education, and needs-responsive life skills training embedded in a series of cognitive reframing conversations with an experienced facilitator. The program has eight modules, each of which culminates in an action plan focused on strengthening a client's internal assets and identifying sources of positive social support. Caseworkers facilitate motivational

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discussions centered on clients' self-identified goals and action planning, with the aim of optimizing clients' home safety, physical health, social connectedness, and emotional and financial well-being.

This Study's Purpose and Objectives

The purpose of this demonstration project was to collaboratively develop and rigorously test an elder abuse prevention program focused on the resilience of community-residing older adults. Resilience comprises the strengths and protective factors necessary to respond to and overcome adversity, including the adaptations needed to support safe and healthy aging (Hamby, Grych, and Banyard 2018).[4] In the theoretical framework underlying EMPOWER's development, elder abuse can occur in different ways, many of which are outside older adults' control. EMPOWER focuses on the paths that *are* theoretically controllable. Specifically, it aims to strengthen older adults' knowledge and awareness of community resources and social supports, attitudes toward and motivation to adapt to age-related changes, and life skills and behaviors that facilitate self-empowerment throughout the aging process.

We had the following five objectives for this pilot study:

- conduct a multimethod randomized controlled trial of the EMPOWER program's implementation, targeting at-risk adults in Maricopa County ages 60 and older referred for home and community-based services who had been authorized to receive those services and had been waitlisted owing to insufficient funding
- assess implementation fidelity and the process by which the program is delivered
- assess the short-term outcomes associated with elder mistreatment, as well as mistreatment itself, by comparing the adults randomly assigned to EMPOWER with those in a control group
- revise and finalize the EMPOWER intervention and evaluation toolkit so it could be scaled up and replicated for at-risk older adults nationwide if it demonstrated efficacy
- contribute to the foundation of knowledge regarding interventions intended to prevent elder abuse and neglect

Summary of Methods

During the demonstration's first two years (the planning phase, conducted from 2017 to 2019), Urban and the Area Agency codeveloped the EMPOWER program, compiling a 112-page facilitator manual

and a client journal and identifying supportive program materials (e.g., night-lights, pillboxes, calendars, gratitude journals, health care forms).[5] The Urban and Area Agency teams developed the content of the program after conducting multiple reviews of relevant literature and holding meetings with an advisory panel of violence prevention and elder abuse experts, including the Maricopa County Elder Abuse Prevention Alliance. An initial test of EMPOWER and the planned data collection were conducted at the end of the planning phase, and findings informed revisions to the program and research design. The next sections describe the pilot study's timeline and activities.

Pilot Study Timeline

After the planning phase, the EMPOWER pilot study launched in January 2019 with a series of preparation activities, including the revisions made in response to the initial test findings, approval of procedures for human subjects' protections, training in program delivery for the Area Agency's caseworkers, and training in data collection protocols (pretest, posttest, interviewer survey) for Urban's researchers. Pilot study recruitment and program delivery began in September 2019 and continued through March 2020, when the COVID-19 pandemic brought in-person study activities to a halt. Working with study participants recruited as of March 2020, the Area Agency continued delivering the program via telephone through July 2020 and Urban collecting data through August 2020. We restarted recruitment in December 2020 and continued until September 2021. During this second recruitment period, the Area Agency offered EMPOWER participants the option to participate in person, via telephone, or via video. Most (81 percent) chose to receive the program via telephone, 14 percent chose to receive it in person, and 5 percent opted for video. From December 2020 to September 2021, Urban researchers collected all data remotely via telephone with participants and via secure file transfers and videoconferencing with Area Agency program staff.

Recruitment, Participation, and Randomization

Older adults were recruited from the Area Agency's list of people waiting for home and community-based services to support safe and independent living in Maricopa County, Arizona. People on this waitlist had reached out directly for help or had had another person do so on their behalf to the Area Agency's 24-Hour Senior Help Line for some type of residential assistance (e.g., housekeeping, personal care). They had then received an in-person Arizona Standardized Client Assessment Plan to determine they were eligible for assistance (meaning they were lower income and had a confirmed need), which they then awaited pending the Area Agency's resources.

People eligible for the EMPOWER pilot study were those who had been waitlisted, were at least 60 years old, lived alone in Maricopa County, and spoke English.[6] Area Agency staff determined whether people met these criteria using the Arizona Standardized Client Assessment Plan data collected for waitlisted people. Participating in the study did not affect people's waitlist status. But the waitlist was dynamic: as soon as the Area Agency had resources to meet a waitlisted person's needs, those services were provided and that person was removed from the waitlist. For the EMPOWER pilot study recruitment, the Area Agency "pulled" Arizona Standardized Client Assessment Plan data on waitlisted people at several points in time and attempted to reach everyone by telephone. Out of 869 waitlisted people (an unknown percentage of whom were duplicates), the Area Agency was able to recruit 301 people who had expressed interest in the study.[7] The most frequent reasons people were not recruited included their being unreachable after at least three attempts on different days and at different times and their being deemed ineligible upon further assessment (for instance, it turned out they did not live alone).

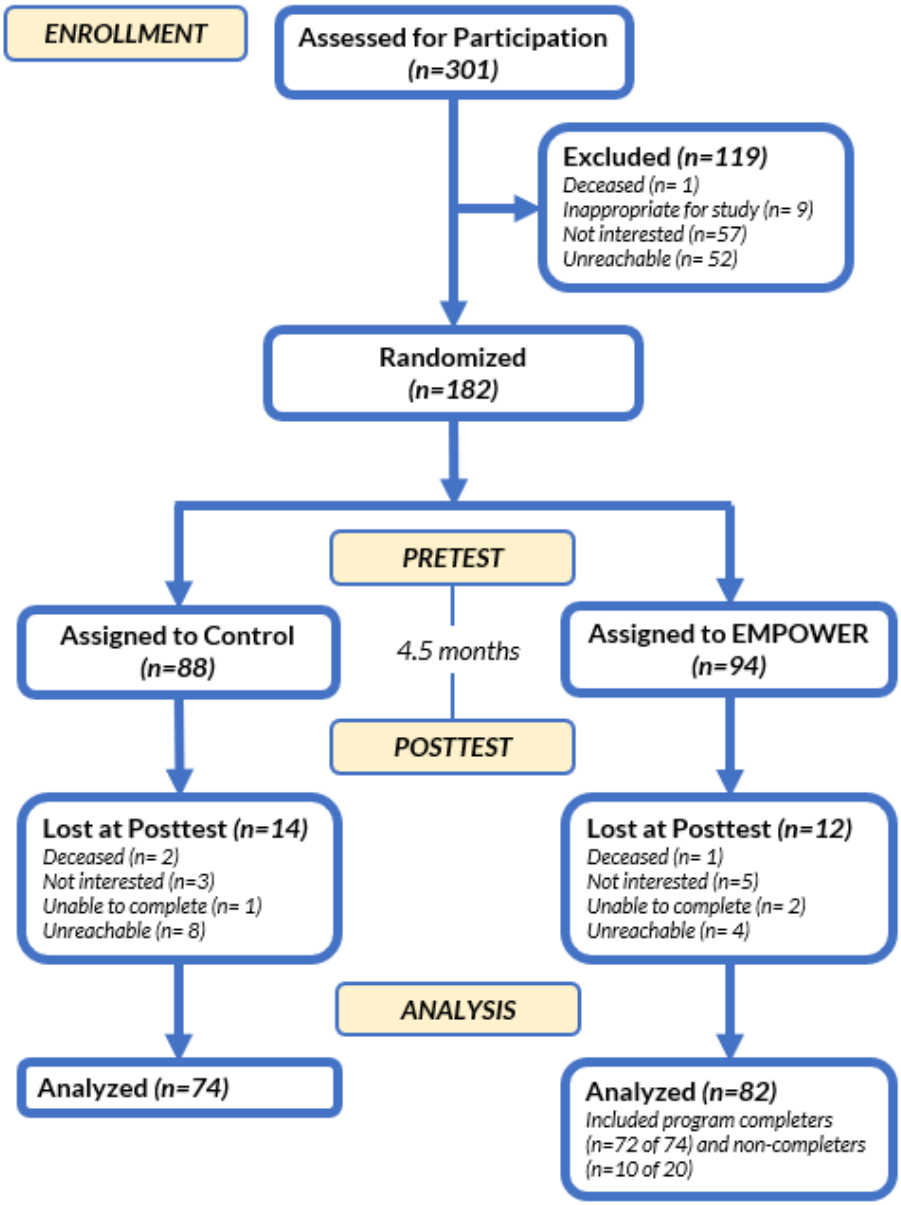
As shown in the figure 1 consort flow diagram, 61 percent of the people recruited for the study (182 people) provided study consent to Urban researchers and completed a 75-minute pretest survey. The two most common reasons people did not consent to participate were that they were disinterested after learning more about the study or were repeatedly unreachable or unavailable. We used a simple randomization process integrated into a Qualtrics-based pretest survey instrument.[8] Of the 182 participants, 94 (52 percent) were randomly assigned to receive the EMPOWER program and 88 (48 percent) were randomly assigned to the control group. Approximately four and a half months after the pretest survey, 156 participants (86 percent) completed a 65-minute posttest survey; this included 82 people (87 percent) from the EMPOWER group and 74 people (84 percent) from the control group.

Sample Characteristics

The demographic characteristics of the study sample are presented in table 1. Of the 182 participants, 94 were randomly assigned to receive EMPOWER and 88 were assigned to the control group. Approximately 80 percent of the participants identified as female (80 percent of the control group, 82 percent of the treatment group), and over 70 percent identified as white (78 percent of the control group, 74 percent of the treatment group). Participants' ages ranged from 60 to 96, with an average age of 73 (74 for the control group, 72 for the treatment group). More than 90 percent reported annual incomes of $20,000 or less; this included 91 percent of the control group and 92 percent of the treatment group.

FIGURE 1

Consort Flow Diagram for the EMPOWER Pilot Study



Source: Urban Institute.

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Data Collection and Analysis

This study included mixed-methods collection of quantitative and qualitative data. Qualtrics-based surveys of treatment and control participants were the primary source of data. Owing to the demonstration's brief timeline, the decision was made to measure participant data at only two points: pretest and posttest approximately four months later (given that EMPOWER was designed as a three-month intervention). Surveys were administered in person until the COVID-19 pandemic lockdown in Arizona (March 11, 2020),[9] after which Urban interviewers administered surveys by telephone. All participants were offered stipends for their time. The surveys consisted predominantly of closed-ended (quantitative) questions, though the posttest included open-ended questions about the EMPOWER program (for the treatment group).

TABLE 1

Characteristics of the EMPOWER Pilot Study Sample

	Total (*N* = 182)		Control (*n* = 88)		Assigned to EMPOWER (*n* = 94)	
	N	%	n	%	n	%
Sex						
Male	35	19.2	18	20.5	17	18.1
Female	147	80.8	70	79.5	77	81.9
Race[a]						
Black/African American	29	16.1	15	17.0	14	15.2
White	137	76.1	69	78.4	68	73.9
Other race[b]	30	16.7	16	18.1	14	15.3
Ethnicity						
Hispanic/Latinx	10	5.5	5	5.7	5	5.4
Non-Hispanic/non-Latinx	171	94.5	83	94.3	88	94.6
Age						
Mean	72.9 years		73.5 years		72.3 years	
Employment						
Disabled/cannot work	68	37.6	32	36.4	36	38.7
Retired	112	61.9	56	63.6	56	60.2
Annual Income						
$20,000 or less	160	91.4	78	90.7	82	92.1
More than $20,000	15	8.7	8	9.4	7	7.8
Education						
College education or higher	118	64.8	55	62.5	63	67.0
High school graduate or GED	45	24.7	26	29.5	19	20.2
Some high school education or lower	15	8.2	4	4.5	11	11.7

Source: EMPOWER pilot study baseline survey data collected by Urban.

Notes: For each characteristic, valid data were available for 96 percent or more of the 182 participants. The treatment and control groups were statistically equivalent at assignment.

[a] Race categories were not mutually exclusive (i.e., multiple categories could be selected).

[b] Includes American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and/or some other race.

In addition to the pretest and posttest surveys, Urban researchers completed a short "interviewer survey" after each to indicate concerns about the quality of the survey's administration (e.g., interruptions, confusions). Urban also collected limited Arizona Standardized Client Assessment Plan data on participants and is working with Maricopa County Adult Protective Services to collect data from it. Process evaluation data we collected included an Excel-based implementation-fidelity checklist that EMPOWER caseworkers completed after each weekly encounter and qualitative notes from biweekly conference calls between Urban and the Area Agency regarding the successes and challenges of implementation. Agency staff also shared some notes in Microsoft Word documents with Urban regarding the program's administration.

Urban's analytic strategy involved the use of SPSS Statistics software and Excel for quantitative data analyses and of Word for thematic coding of qualitative data. In addition to descriptive statistics, we ran comparison tests for equivalency between the treatment and control groups at pretest and compared program and survey completers and noncompleters. For the outcome analyses, we conducted a series of bivariate tests followed by multivariate logistic and linear regression models that controlled for participants' demographic characteristics, the pretest survey measure of each tested outcome, and a period of time to/since the COVID-19 shutdown in Arizona. The key independent variable in each outcome analysis was random assignment to EMPOWER or not. Subsequent publications will explore each analysis in greater depth; these will include an assessment of the impact of COVID-19 and comparisons of program completers with control participants (i.e., as treated analyses).

Limitations

As with any real-world study, limitations affected this randomized controlled pilot study of the EMPOWER program. Foremost were the effects of the COVID-19 pandemic, which halted recruitment from April to December 2020 and ultimately led to a sample less than half the size originally targeted. Before the pandemic, we aimed for a sample of 500 older adults, which would have enabled detection of small to medium programmatic effects. After recruitment was paused, the new sample target dropped to 250 older adults. Upon resuming study activities, however, Area Agency and Urban staff found that older adults were harder to reach for potential participation in 2021. This likely owed to older adults' reengagement with previously postponed medical appointments and increased wariness of phone calls because of the prevalence of COVID-related frauds. In addition to reducing the study's statistical power, the pandemic affected the lives of older adults in disproportionately severe ways. Although Urban included a control for time to/since COVID-19 in multivariate outcome analyses, the pandemic

likely introduced unobservable errors beyond this correction. One scholarly paper Urban is writing will examine the impact of COVID-19 more explicitly. Other limitations relate to the generalizability of our findings: as a pilot study, this demonstration was limited to one location (Maricopa County, Arizona), the sample was predominantly female and white (reflective of the waitlisted population), and the posttest period was only four and a half months. Studies with more resources should aim to expand the geographic and demographic diversity of the sample as well as the time frame for observing potential outcomes.

Summary of Findings

In this section, we summarize our findings as they pertain to the two fundamental research questions that have guided this pilot study:

- How well was the EMPOWER program implemented in terms of providers' fidelity to the intervention model and older adults' receptiveness to program content?
- Did participants assigned to EMPOWER show short-term gains in late-life resilience outcomes hypothesized as protective against elder abuse?

Findings are explored in greater depth and detail in scholarly articles Urban's researchers are currently completing. In these articles, we focus on the program's theory-informed development and implementation; evaluate the full set of randomized controlled pilot study outcomes, including impacts for the "as treated" subgroup and variations in effects for different subgroups of participants; estimate the prevalence of different types of elder abuse within the study sample; and explore the impacts of COVID-19 on the lives of participants.

Implementation Evaluation Findings

This section summarizes findings for our first research question, which concerns the implementation of the EMPOWER pilot. We focus on assessing the program's appropriateness and implementation fidelity and clients' satisfaction (Dusenbery 2020; Proctor et al. 2011). Notably, the Area Agency's leaders have already committed to sustaining EMPOWER delivery after the study period ends (December 31, 2021).

Despite some staff turnover, EMPOWER was primarily implemented by three Agency staff, each of whom has professional experience delivering social services to older adults. These staff received 30 hours of training on the EMPOWER program that included supervisory instruction by the Area

Agency's director of behavioral health, intensive self-directed study of the 112-page program manual and supporting materials, and practice-focused conversations (e.g., role-playing) with Area Agency colleagues. When the third facilitator joined the Area Agency, she shadowed the two more experienced ones before engaging with her own EMPOWER clients.

Seventy-nine percent of those assigned to EMPOWER completed the program (74 participants), and facilitators conducted an average of 10 in-home or telephone sessions over an 11-week period. Although designed to last up to 12 weeks, EMPOWER emphasized client-centeredness in delivering its eight program modules, meaning clients could be engaged for the amount of time that suited their circumstances. For example, the home safety module took only one session for some clients but took two or more weeks for some with hoarding behaviors. Clients who did not complete the program (21 percent, or 20 participants) did not complete for various reasons, including personal reasons, disinterest, unwillingness to connect by phone during the pandemic, and cognitive or behavioral health challenges (in addition, one participant passed away). Program completers did not differ significantly from noncompleters on any of the demographic characteristics shown in table 1.

Posttest survey results showed the vast majority of program completers (*N* = 72 surveyed of the 74 completers) *strongly agreed* the EMPOWER facilitator treated them with respect (96 percent), fostered a safe and trusting environment (96 percent), made them feel comfortable sharing thoughts and questions (88 percent), and understood their problems and concerns (85 percent); nearly all others simply *agreed* with these statements. Even program noncompleters (*N* = 10 surveyed) spoke similarly highly of their interactions with EMPOWER facilitators. Regarding program content, most completers agreed EMPOWER made them more aware of personal strengths (58 percent *strongly agreed*, 35 percent *agreed*), improved their ability to solve problems in their life (49 percent, 35 percent) and accomplish goals (46 percent, 39 percent), and made them aware of social relationships they should be cautious about (56 percent, 24 percent). About three-quarters believed the program's 12-week period of weekly visits was an appropriate period, though one-quarter wanted the program to last longer. Open-ended responses from the surveyed program completers were positive, as demonstrated in one 76-year-old participant's response:

> I think this program should be in every state, especially with what's going on right now in the world. People are feeling very insecure and frightened, and for me I looked forward every Monday to having that call. She covered so much. I felt like it was really complete. I would just like for more people to have it. And I just felt good that somebody cared enough to do this with me because I live alone—it's just me and my cat—and I didn't feel like I could go out anywhere.

Throughout delivery, EMPOWER facilitators felt similarly positively about the program—so much so that the Area Agency's leadership sought funding to continue the program after the study period.

Staff perceived that clients' greatest benefits came from discussions of home safety, physical health, and financial well-being, discussions in which staff provided concrete examples and resources for strengthening older adults' preparedness for age-related changes (e.g., financial scams, health care directives, and preventing falls). But the modules on social connectedness and emotional well-being were also vital to some participants; for instance, one participant was connected with a senior group across the street from their home, another returned to college classes, and another renewed her relationship with her daughter. Program facilitators also felt EMPOWER clients appreciated the focus on gratitude and the help identifying community resources, particularly those with few or no family members and friends.

Outcome Evaluation Findings

This section summarizes findings for our second research question, which concerns EMPOWER's late-life resilience outcomes. We compared older adults randomly assigned to the program with those assigned to the control group, using data for the 156 participants surveyed at both pretest and posttest. This "intention-to-treat" comparison is considered best practice for analyzing randomized controlled study results, though Urban's team is also exploring "as treated" results and interaction models and is conducting subgroup analyses in the scholarly article examining EMPOWER's effects.

Table 2 shows a series of multivariate regression models predicting 10-point Likert scale outcomes (1 = *strongly disagree* to 10 = *strongly agree*). Urban developed these outcomes specifically to measure the following concepts: **home safety** captured the extent to which participants knew how to make their homes safer or more secure, whom to contact in case of an emergency, and how to prevent falls in their homes; **physical health** captured whether participants knew whom to contact if they had a physical health issue and understood what medications they were taking and why; **financial well-being** captured whether participants did things to manage their money responsibly, knew whom to contact for help with financial decisions, and understood how to recognize and protect against financial scams and frauds; and **social support** captured whether participants were aware of organizations they could contact if they wanted to connect with someone and whether they knew whom to contact if they needed emotional support or help strengthening their well-being. Each model shows that participants assigned to the EMPOWER program scored significantly higher than those assigned to the control group for each of these outcomes, even while we controlled for pretest measures of the same outcomes, participants' demographic characteristics, indicators that participants were in poor physical health or had a lifetime history of violent victimization, and time to/since the COVID-19 pandemic.

TABLE 2

Regression Models Predicting Late-Life Resilience Outcomes

	Model 1: Home Safety	Model 2: Physical Health	Model 3: Financial Well-Being	Model 4: Social Support
	Coefficient (standard error)	Coefficient (standard error)	Coefficient (standard error)	Coefficient (standard error)
Predictor				
EMPOWER program	.358* (.206)	.425** (.205)	.599** (.255)	1.128*** (.360)
Outcome at pretest	.410**** (.068)	.359**** (.063)	.417**** (.065)	.448**** (.073)
Age	.020 (.014)	-.006 (.014)	.032* (.017)	.003 (.024)
Female	-.075 (.261)	.143 (.266)	-.215 (.321)	.175 (.461)
White race, non-Latinx	-.306 (.228)	-.213 (.229)	-.166 (.288)	-.278 (.403)
College education	.110 (.210)	-.122 (.212)	.067 (.265)	.092 (.374)
Poor physical health	.221 (.266)	.068 (.265)	-.320 (.332)	-.469 (.473)
Violent victimization	.140 (.224)	-.051 (.225)	-.138 (.283)	.073 (.397)
Days to/from COVID	.001 (.000)	.002**** (.000)	.000 (.001)	.000 (.001)
(Constant)	3.790**** (1.115)	6.278**** (1.114)	2.736** (1.327)	3.616* (1.868)
R-square	**27.6%**	**27.3%**	**35.3%**	**27.0%**
N	**152**	**152**	**148**	**149**

Source: EMPOWER pilot study pretest and posttest survey data collected by Urban.

Notes: For each model, valid data were available for 95 percent or more of the 156 participants who completed posttest surveys. Statistical significance is defined as * $p < .10$, ** $p < .05$, *** $p < .01$, **** $p < .001$. Unstandardized coefficients are reported. "EMPOWER program" refers to participants' random assignment at pretest. All predictor variables in the model were measured at pretest, including the same outcome at pretest; age; sex; race; college education; self-rated poor physical health; self-reported violent victimization in lifetime (as indicated by answering "yes" to any of five questions about physical or sexual assault). Equivalency tests of treatment and control participants at pretest showed no significant differences on any control in the model.

These types of late-life resilience impacts—summarizing changes in participants' knowledge and attitudes—may be the most realistic to expect given the study's short window of observation. Other outcomes we have examined to date—changes in behaviors, connections, and experiences—have shown no statistically significant treatment effects, though differences have typically favored the treatment group. Future analyses in Urban's planned scholarly papers will include various combinations of outcome items, compare those who completed EMPOWER with control participants, and examine effects for subgroups of participants defined by sex, race, age (younger versus older), poor health status, and exposure to victimization. Collectively, these analyses may help us better understand the program's outcomes.

Although we did not hypothesize that EMPOWER would impact elder abuse during the study period, we looked at those results and did not find statistically significant programmatic effects. Notably, however, participants had experienced abuse at extremely high rates: 65 percent said they had experienced a violent physical or sexual assault in their lifetime, and 75 percent said they had experienced at least one form of elder abuse (since the age of 60), including physical, psychological, sexual, or financial abuse or caregiver neglect. This means the older adults in this low-income

community-residing sample entered this study with a high level of prior victimization experience, making the fact that EMPOWER was able to strengthen their resilience knowledge, awareness, and attitudes regardless particularly noteworthy.

Summary of Implications

The EMPOWER demonstration was ambitious in its attempt to develop one of the first programs focused on empowering older adults to prevent elder abuse. Although merely a pilot study of a new program, Urban's team applied the strongest evaluation method possible, a randomized controlled trial, putting the program to a rigorous test. We also tested its impact on a population that had experienced trauma, including various types of elder abuse, at rates we did not expect. Despite these realities (i.e., pilot study of new program, randomized controlled design, high rates of past trauma) and the impact of COVID-19, there were several statistically significant treatment effects on the late-life resilience outcomes that EMPOWER aims to achieve for older adults.

The implication of these findings is that with a longer follow-up window and more diverse sample of older adults, EMPOWER may show more and stronger programmatic effects. For example, during our brief observation period, participants may not have faced opportunities to change behaviors, apply programmatic knowledge, and experience the benefits of increased community interaction and support. Also, given this sample's high prior exposure to abuse, EMPOWER was tested more as a tertiary prevention program than the primary prevention program it was designed as; future studies should explore its function for populations with varying histories of victimization.

Given elder abuse is one of the fastest-growing crimes nationwide, it is critical that the US Department of Justice, other federal partners, and aging-services providers continue focusing on elder abuse prevention. Importantly, the Area Agency on Aging continues to offer EMPOWER to qualifying older adults in Maricopa County, Arizona, because of the positive experiences of program facilitators and participating clients.[10] Overall, this pilot study showed some indication that EMPOWER should be replicated in diverse communities for larger samples of older adults. Materials to support such efforts will be available soon on Urban's website, the data used in this pilot study will be archived for replication analyses, and additional publications authored by Urban and the Area Agency are forthcoming.

Notes

[1] Elder abuse is any intentional or negligent act by a person that causes harm or serious risk of harm to an older adult, typically someone 60 years old or older.

[2] Rita Beamish, "Older Americans Act Limps Along at 50, Stressing Local and State Agencies," March 4, 2015, The Pew Charitable Trusts, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/3/04/older-americans-act-limps-along-at-50-stressing-local-and-state-agencies.

[3] The EMPOWER intervention manual is forthcoming and will be available on Urban's website at www.urban.org.

[4] An important, related concept is that of self-efficacy, which affects people's beliefs that they can cope with stressors successfully and proactively plan accordingly (Schwarzer and Warner 2013).

[5] The study's planning phase activities are summarized in Hussemann and Yahner (2019).

[6] We had intended to also recruit Spanish-speaking participants once the study was underway, but this was not possible given delays caused by the pandemic and challenges identifying Spanish-speaking staff.

[7] Brochures about the EMPOWER study were also mailed to all eligible people.

[8] Qualtrics is an online survey software program that securely encrypts information during storage and transmission.

[9] In-person survey administration was done by a third-party organization with which Urban contracted through March 2020.

[10] The Area Agency started by reconnecting with control group participants who had indicated interest in receiving EMPOWER. This was done after data collection was complete and using funds external to this pilot study.

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