Members of racial and ethnic minority groups in the United States continue to face disproportionate chronic illness burden and disparities related to healthcare access (U.S. Department of Health and Human Services [HHS], 2013). These disparities must be addressed because older adults with multiple chronic conditions are at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and high healthcare costs (Parekh et al., 2011).

To help mitigate the growing impact of chronic diseases, since 2003, the Administration on Aging (AOA), a program division within the Administration for Community Living (ACL), has supported Stanford University’s Chronic Disease Self-Management Program (CDSMP) and other evidence-based prevention programs (HHS, 2010). Repeated studies have demonstrated that CDSMP participants experience many positive benefits, including significant improvements in self-reported health and in specific symptoms such as pain, fatigue, and depression; increased frequency of exercise; and greater self-efficacy (Brady et al., 2013). Some studies also have shown decreases in outpatient visits, emergency room visits, and hospital days (Lorig et al., 2001; Ory et al., 2013a). These positive health outcomes have been replicated among participants from diverse age groups, racial and ethnic backgrounds, geographic settings, and health status (Lorig, Ritter, and Jacquez, 2005; Swerissen et al., 2006; Tomioka et al., 2012; Smith et al., 2013).

This article describes recent AOA initiatives to increase access for diverse populations to evidence-based programs, and synthesizes key lessons learned from initiative evaluations in the context of the “RE-AIM” (Reach, program Effectiveness, Adoption, Implementation, and Maintenance) framework (Glasgow, Vogt, and Boles, 1999; Glasgow et al., 2004; Belza, Toobert, and Glasgow, 2008).

**Relevant AOA and ACL Initiatives**

The AOA administers the Older Americans Act (OAA), which authorizes state-based formula grants to fund health and human services, including prevention and health promotion activities. Priority is given to serving older adults (ages 60 and older) who live in medically underserved areas, or who are in greatest
economic need. Since 2012, congressional appropriations require this funding be used only for evidence-based programs. Recently, ACL refined its definition of evidence-based programs. Effective October 1, 2016, funding will be restricted to programs that meet the criteria listed in Table 1 (above). AOA also provides formula grants to tribal organizations that support health promotion programs and home- and community-based supportive services (HCBS) for Native American, Alaskan Native, and Native Hawaiian elders.

Since 2006, AOA also has provided three major competitive grant programs to support dissemination of evidence-based programs (Table 2, below). The Evidence-Based Disease and Disability Prevention Program (EBDDP) grants supported CDSMP and evidence-based physical activity, falls prevention, nutrition, and behavioral health programs. Both the American Recovery and Reinvestment Act (ARRA) and the prevention and Public Health Fund (PPHF) grant programs have supported the generic CDSMP and also self-management programs developed for specific chronic conditions (arthritis, diabetes, HIV/AIDS, and chronic pain), Spanish-speaking populations, and in an online format.

The three grant programs were aimed at increasing the number of older adults who participate in evidence-based programs, and building delivery infrastructures and systems to sustain program delivery. Reaching underserved populations was an explicit expectation. The ARRA and PPHF funding announcements included the requirement that grantees demonstrate capacity and ability to achieve health equity among disparately affected populations, as follows:

Applicants must identify and select a specific targeted population(s) including at least one low-income, minority, rural, limited

Table 1. AOA Evidence-Based Criteria

- Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability, or injury among older adults;
- Proven effective with older adult population, using Experimental or Quasi-Experimental Design;
- Research results published in a peer-review journal;
- Fully translated in one or more community site(s); and,
- Includes developed dissemination products that are available to the public.

Source: Administration on Aging, 2014

Table 2. Major AOA Discretionary Grant Programs Supporting Evidence-Based Health Programs

<table>
<thead>
<tr>
<th>Grant Program</th>
<th>Years of Funding</th>
<th>Number of Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-Based Disease and Disability Prevention Program (EBDDP)</td>
<td>2006–2012</td>
<td>27 states*</td>
</tr>
<tr>
<td>PPHF—2012—Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs, financed by the Affordable Care Act Prevention and Public Health Fund (PPHF)</td>
<td>2012–2015</td>
<td>22 states</td>
</tr>
</tbody>
</table>

*Includes three states funded by The Atlantic Philanthropies

Source: Kulinski et al., in press.
English speaking or other underserved older and/or disabled population with chronic conditions and provide a rationale for this selection. Grantees are expected to coordinate with tribal entities in their jurisdiction, if applicable, and during the project period to negotiate and implement at least one written partnership agreement with a tribal entity or other agency... (AOA, 2012).

In addition to granting money directly to states, since 2003, AOA has been funding the National Council on Aging’s (NCOA) Center for Healthy Aging as a technical resource center, providing leadership and support to the field to promote evidence-based programming. Since 2010, NCOA has maintained an online data collection system used by state grantees and program sites to report workshop and participant data. NCOA continues to host Web seminars on engaging racial and ethnic minority populations, disseminates customized marketing materials for specific populations and other resources developed by grantees on its website, and provides a listserv to allow discussion of issues such as offering CDSMP within tribal communities.

In 2012, the ACL established the National Aging Resource Consortium on Racial and Ethnic Minority Seniors. It is made up of four national minority aging organizations: the National Caucus and Center on the Black Aged, Inc.; the Asociacion Nacional Pro Personas Mayores; the National Asian Pacific Center on Aging, Inc.; and, the National Indian Council on Aging, Inc. The Consortium is a resource center, providing expertise in designing, developing, and disseminating culturally competent information and materials for racial and ethnic minority older adults (see Table 3 on page 110).

**The Essential Evidence-Based Program Evaluations**

This article synthesizes key lessons learned about reaching and serving diverse populations, drawn from four AOA/ACL grant program evaluations: the EBDDP post-grant report (Frank and Lau, 2013); the ARRA post-grant report (NCOA, 2013; Ory et al., 2013a); an ARRA CDSMP process evaluation conducted by IMPAQ International and Altarum Institute through an ACL contract (Woodcock et al., 2013; Korda et al., 2013; Erdem and Korda, 2014); and, an unpublished 2014 PPHF mid-term program analysis. This article also incorporates relevant findings from the National Study of CDSMP, partially funded by AOA (Ory et al., 2013b, 2013c).

**Evaluation study objectives, data sources, and methods**

The four AOA/ACL evaluations were designed to document grantee successes, challenges, accomplishments, lessons learned, and products produced. Research questions included populations served; how grantees implemented, disseminated, and sustained their programs; and, how programs differed in completion rates, distribution channels, and delivery systems. The evaluations included descriptive analyses for the programs and populations served based on data available in the NCOA database and AOA grantee program files (i.e., original grant applications, grantee progress and final reports, state profiles, and the results of an annual grantee “Integrated Services Delivery System Assessment” online survey). The CDSMP process evaluation also included regression analyses examining the influence of participant and workshop characteristics on workshop completion. These data were complemented by additional qualitative data gathered from site visits, interviews with AOA stakeholders and state-level key informants, and input from a Technical Advisory Group of academics, state- and local-level practitioners,
and leaders of relevant advocacy groups.

The objective of the National Study of CDSMP was to determine the effectiveness of CDSMP among a national sample of participants organized around healthcare reform’s “Triple Aim” goals of better health, better healthcare, and lower costs (Berwick, Nolan, and Whittington, 2008). The National Study of CDSMP used a longitudinal design and obtained participant and workshop data from twenty-two organizations holding CDSMP licenses in seventeen states across the nation (Ory et al., 2013c). Data were collected at the start of each workshop and again at six and twelve months.

**Discussion and synthesis of key lessons learned**

Key lessons learned from the four AOA/ACL evaluations and the National Study of CDSMP are

<table>
<thead>
<tr>
<th>Table 3. Sample Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name/ URL</strong></td>
</tr>
<tr>
<td>ACL National Aging Resource Consortium on Racial and Ethnic Minority Seniors</td>
</tr>
<tr>
<td>National Caucus and Center on the Black Aged, Inc. (NCBA)</td>
</tr>
<tr>
<td>Asociacion Nacional Pro Personas Mayores (ANPPM)</td>
</tr>
<tr>
<td>National Asian Pacific Center on Aging, Inc. (NAPCA)</td>
</tr>
<tr>
<td>National Indian Council on Aging, Inc.</td>
</tr>
<tr>
<td>National Council on Aging (NCOA)</td>
</tr>
</tbody>
</table>
organized below using the RE-AIM framework (Glasgow, Vogt, and Boles, 1999; Glasgow et al., 2004; Belza, Toobert, and Glasgow, 2008). This framework was developed to foster consistent reporting of research results about reach (extent to which a program attracts and retains its intended audience); effectiveness (participant outcomes and program value); adoption (participation rate among potential settings); implementation (extent to which the program is delivered with fidelity, as intended by the program developers); and, maintenance (extent to which participant benefits and programming are sustained).

Reach
The grantees and their partners have successfully reached many diverse populations. As of July 2014, the cumulative data in the NCOA database showed that of the nearly 200,000 participants reporting demographic data since 2010, 69.2 percent were white, 22.3 percent were African American, 17 percent were Hispanic, 3.8 percent were Asian, 1.9 percent were American Indian/Alaska Natives, 0.9 percent were Hawaiian/Pacific Islanders, and 1.9 percent were multiracial or other. As highlighted in Table 4 (below), each of the evaluation reports documented successful reach within various racial and ethnic groups, often in greater rates than in the older U.S. population. The most common racial minority group reached was African American, ranging from 13 percent to 22.8 percent, compared to a prevalence rate of 8.5 percent of the U.S. population ages 65 and older (West et al., 2014). The percentage of Hispanic participants ranged from 11 percent to 22.3 percent, compared to 6.9 percent of older Americans.

Participation of African Americans and Hispanics was even greater for the Diabetes Self-Management Program (DSMP) than for the generic CDSMP (27.8 percent versus 17.3 percent, and 18.2 percent versus 13.1 percent, respectively). This finding could reflect more focused DSMP outreach efforts to recruit African Americans and Hispanics, groups disproportionately affected by diabetes. However, the higher prevalence was maintained whether or not the participants had diabetes (Erdem and Korda, 2014).

The grantees also have been successful in reaching many linguistic minorities. In addition to offering Tomando Control de su Salud (the

Table 4. Percentage of Participants by Race and Ethnicity Reported in Evaluation Studies Compared to U.S. Census Data on Americans Ages 65 and Older

<table>
<thead>
<tr>
<th></th>
<th>Evidence-Based Disease and Disability Program</th>
<th>ARRA CDSMP</th>
<th>IMPAQ/Altarum CDSMP</th>
<th>Prevention and Public Health CDSME</th>
<th>National Study of CDSMP</th>
<th>2010 U.S. Census Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>17</td>
<td>14</td>
<td>13.2</td>
<td>22.3</td>
<td>6.9</td>
</tr>
<tr>
<td>American Indian</td>
<td>2</td>
<td>1.7</td>
<td>2</td>
<td>2.2</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>3.9</td>
<td>4</td>
<td>3.8</td>
<td>2.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Black or African American</td>
<td>13</td>
<td>22.6</td>
<td>19</td>
<td>22.8</td>
<td>16</td>
<td>8.5</td>
</tr>
<tr>
<td>Hawaiian or Pacific Islander</td>
<td>0</td>
<td>0.9</td>
<td>1</td>
<td>1</td>
<td>2.9</td>
<td>0.1</td>
</tr>
<tr>
<td>Other/ Multiracial</td>
<td>2</td>
<td>2.1</td>
<td>5</td>
<td>1.7</td>
<td>2.9</td>
<td>1.7</td>
</tr>
<tr>
<td>White</td>
<td>68</td>
<td>68</td>
<td>61</td>
<td>68.5</td>
<td>55.2</td>
<td>84.8</td>
</tr>
</tbody>
</table>

Spanish CDSMP) and Programa de Manejo Personal de la Diabetes (the Spanish Diabetes Self-Management Program), grantees reported delivering CDSMP workshops to populations speaking Arabic, Cantonese, Chinese, Farsi, Haitian Creole, Hindi, Korean, Mandarin, Navajo, Portuguese, Russian, Somali, Tagalog, Tongan, and Vietnamese.

Once enrolled, racial and ethnic minority participants were likely to continue in the CDSMP workshops and have high “completer” rates (i.e., attending four or more of the six workshop sessions). Table 5 (below) presents data from the ARRA CDSMP process evaluation about completer rates by race or ethnicity. A separate analysis showed that the odds of completing the workshops were 47 percent higher for participants in the Spanish CDSMP workshops and 106 percent higher for the Spanish DSMP, as compared to the English-language workshops (Erdem and Korda, 2014).

Reaching these diverse populations was challenging. Across the various evaluation studies, two main methods emerged for successfully reaching diverse populations: partnering with agencies and personnel representative of the population, and using specific, targeted marketing strategies.

<table>
<thead>
<tr>
<th>Ethnicity/Race</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity: Hispanic or Latino origin</td>
<td>77.7%</td>
</tr>
<tr>
<td>Ethnicity: Not Hispanic or Latino origin</td>
<td>76.9%</td>
</tr>
<tr>
<td>Race: American Indian/Alaskan Native</td>
<td>73.1%</td>
</tr>
<tr>
<td>Race: Asian or Asian American</td>
<td>77.6%</td>
</tr>
<tr>
<td>Race: Black or African American</td>
<td>78.6%</td>
</tr>
<tr>
<td>Race: Hawaiian Native or Pacific Islander</td>
<td>90.5%</td>
</tr>
<tr>
<td>Race: Other/Multiracial</td>
<td>77.8%</td>
</tr>
<tr>
<td>Race: White or Caucasian</td>
<td>76.1%</td>
</tr>
<tr>
<td>Total</td>
<td>76.4%</td>
</tr>
</tbody>
</table>

"Dom Warriors" program with great success among elders from seven tribes. Many states effectively recruited low-income racial and ethnic minorities through Federally Qualified Health Centers, tribal clinics, and other community health and wellness centers.

Some states also found it useful to partner with agencies whose mission it was to address health inequities. New Jersey’s State Office of Minority and Multicultural Health provided grants to community agencies to deliver evidence-based programs to reach African American, Asian Indian, Chinese, Korean, Haitian, Hispanic, and Vietnamese groups. The Nebraska Office of Health Disparities helped target tribes and provided ambassadors to recruit participants. Oklahoma worked with its Health Equity Resource Opportunity Network and leveraged health literacy resources to conduct outreach to African Americans, Hispanics, and Native Americans through community health centers, interfaith groups, and area agencies on aging.

Specific, targeted marketing strategies included the use of Geographic Information System (GIS) mapping in Michigan to identify high-risk groups and geographic areas in need of additional workshop site development and leader training. Word-of-mouth marketing appears to be a highly effective marketing tool using promotors, tribal elders, pastors, and other local champions. Missouri and South Carolina used former class participants in an Ambassador Outreach program (Centers for Disease Control and Prevention, 2013). California and Washington translated culturally relevant marketing materials into a variety of languages. Massachusetts collaborated with the Multicultural Coalition on Aging (www.hebrewseniorlife.org/research-multicultural-coalition-on-aging) on a conference that provided orientation workshops in Spanish, Portuguese, Chinese, Vietnamese, Haitian Creole, and Cape Verdean Creole.

Utah specifically targeted the Tongan population, the fastest growing and largest Pacific Islander community in the state. To help maintain its successful recruitment and high completer rates (more than 90 percent) among Tongan participants, Utah has used a champion program coordinator, pastors, and respected community members as peer leaders. Workshops are marketed through Tongan outlets, including a newsletter, weekly radio show, website, Facebook, churches, and clubs.

Findings showed significant health-related improvements among diverse participants at six- and twelve-month follow-up assessments.

Practices that appeared to help retention in other groups included over-enrolling in workshops and holding “session zero” orientation classes prior to the first class. These information sessions provide a program overview and explain expectations for workshop participation. Additionally, administrative paperwork often is collected at this time (Jiang et al., in press). Other strategies involve using a buddy system to follow up with participants who miss a session; holding workshops at housing sites to eliminate transportation issues; scheduling workshops at times and places when and where the group already congregates; and, encouraging workshop members to bring healthy snacks to share.

Effectiveness

Some grantees were able to leverage other resources to provide state-specific information about program effectiveness. Hawaii partnered with the University of Hawaii to evaluate the impact of CDSMP on its multicultural participants (Tomioka et al., 2012). At six months, all groups showed significant improvements in social and role activity limitations and physician communications. In comparison with white participants, Asians and Native Hawaiians had increased self-reported health and exercise time. Asians also reported reduced physical limi-
tions, health distress, fatigue, shortness of breath, pain, and physician visits, as well as increased aerobic exercise, ability to cope with symptoms, and self-efficacy.

Findings from the National Study of CDSMP showed significant health-related improvements among diverse participants at six- and twelve-month follow-up assessments (Ahn et al., 2013; Ory et al., 2013b, 2013c). At six- and twelve-month follow-up, participants showed improvements in better health outcomes such as reduced pain, fatigue, and depression. There was also a decrease in unhealthy mental and physical health days and in sleep problems. At twelve months, participants reported significant improvements in better health outcomes, such as improved communication with physicians, medication compliance, and confidence completing medical forms. At six months, participants reported significant improvements in better value outcomes, including reduced emergency room visits and hospitalization. Further reductions in emergency room visits were seen at twelve months. Findings show that CDSMP participation resulted in potential net savings of $364 per participant.

Adoption
Across studies, CDSMP and other evidence-based programs were successfully adopted by, and implemented in, many organizational settings including senior centers, area agencies on aging, healthcare organizations, residential facilities, community centers, and faith-based organizations. Grantees frequently partnered with tribal, faith-based, and other community agencies already serving the racial minority groups of interest. These agencies appeared to be more effective in reaching and retaining participants. Faith-based organizations had the highest CDSMP completion rates of any type of implementation site (79.7 percent compared to 72.7 percent in healthcare organizations).

Lessons learned about fostering the adoption of evidence-based programs by agencies serving ethnic and racial minority populations include the following:

• Obtain the support of upper-level management to commit personnel and key resources, and expect that tribal approval and other agency review procedures can be time-consuming;
• Use easily accessible tools to assess organizational readiness (such as those available on the NCOA website at www.ncoa.org/improve-health/innovation-readiness.html);
• Invest time to clarify all expectations, roles, and responsibilities, and document in a written memorandum of understanding or letter of agreement;
• Engage local champions (e.g., representatives

Table 6. Common CDSMP Accommodations

<table>
<thead>
<tr>
<th>Accommodation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling smaller workshop sizes to better accommodate challenges of reaching rural populations and to accommodate Somali cultural norms;</td>
<td></td>
</tr>
<tr>
<td>Changing program names to increase interest; for example, in Hawaii, the program is called “Better Choices Better Health—Ke Ola Pono”;</td>
<td></td>
</tr>
<tr>
<td>Using opening or closing prayers in some faith-based agencies;</td>
<td></td>
</tr>
<tr>
<td>Holding voluntary six-month participant reunion meetings to provide opportunities for participants to reconnect, socialize, and compare progress since workshop completion;</td>
<td></td>
</tr>
<tr>
<td>Using a tracking stick to designate speakers or discussants in Navajo groups;</td>
<td></td>
</tr>
<tr>
<td>Postponing workshops when there is a death in a tribe;</td>
<td></td>
</tr>
<tr>
<td>Allowing some participants to maintain the same partner instead of changing partners at each workshop session; and,</td>
<td></td>
</tr>
<tr>
<td>Providing male- and female-specific workshops to honor Tongan cultural sensitivity.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Woodcock et al., 2013.
of the target group) to serve as program coordinators; and,

- Offer additional, complementary evidence-based programs to agencies to help embed ongoing programming and increase opportunities for cross-marketing.

**Implementation and fidelity**

To ensure program quality, grantees and their partners are expected to adhere to program fidelity standards such as those outlined in Stanford’s Program Fidelity Manual for its self-management programs (Stanford Patient Education Research Center, 2012). The evaluation studies showed that while grantees understood the need for monitoring and maintaining fidelity, they encountered many challenges and several sought permission from Stanford and other program developers to make accommodations to be more culturally sensitive to the needs of their targeted populations. For instance, agencies serving Somalian populations found it difficult to meet Stanford’s class-size requirements for a minimum of ten participants per workshop. Smaller classes were offered to accommodate cultural norms. Table 6 (see page 114) lists other reported accommodations.

**Maintenance**

Maintenance involves sustaining individual participant benefits as well as programming. The National Study of CDSMP demonstrated that participant benefits were maintained at six and twelve months. Findings suggest the ability of CDSMP to sustain program benefits related to better health, better healthcare, and better value for up to a year after workshop initiation. Given the diverse composition of study participants, findings indicate that CDSMP can benefit different participant sub-groups and these health-related changes can be maintained over time.

Much has been learned about maintaining programming over time. Most (twenty-five out of forty-seven) of the ARRA-funded states and territories did not receive PPHF grants, but have continued offering programs. The ARRA CDSMP process evaluation found that to try to sustain their program efforts, including those involving diverse populations, states focused on working with coalitions and securing partnerships with health systems, health insurance groups, and other larger partners with their own funding sources. States identified multiple challenges to recruiting such partners, including a lack of state-specific research on program impact, limited understanding of existing evaluation results, and limited availability of information about program cost-effectiveness and value needed to persuade potential partners and funders.

Another challenge was retaining leaders with special cultural and linguistic skills—individuals who often come from the community and have low incomes. Many were unable to participate without receiving stipends. The tribal, faith-based, and other local community agencies often cannot sustain the program on their own. To address these issues, some grantees have established state or regional networks or collaboratives that encourage resource-sharing and economies of scale for purchasing supplies, training activities, and recruiting and retaining trainers and leaders.

In general, past and current grantees reported that to sustain the programs they also needed to develop and implement business plans to secure diversified sources of funding, and use outcomes data to secure external financial support, engage multiple program champions, and have a strong management and technical assistance structure in place to support leader and participant recruitment, training, and program logistical activities.

**Conclusion**

The AOA has played a critical role in closing the disparity gap for diverse older populations with chronic illnesses through its support of resource centers and formula and discretionary grants that fund evidence-based programs. Within the RE-AIM framework, key lessons were learned...
from past and current grant initiatives. Grantees and their partners have been able to reach and retain substantial proportions of racial and ethnic minority group participants, exceeding national population percentages. Partnering with agencies and personnel already involved with the targeted populations remains critically important. Program participants from diverse backgrounds have shown significant improvements in better health, better healthcare, and better value outcomes, which were maintained at twelve months.

One challenge was retaining leaders with special cultural and linguistic skills—individuals who come from the community and often have low incomes.

Programs were successfully adopted by and offered through a variety of organizational settings. Grantees made acceptable cultural accommodations that attracted and retained diverse participants. Further, the majority of states were able to continue at least some level of programming to diverse populations after their AOA discretionary funding ended. The fact is that after the end of federal funding, many states continue to offer programs reflects successful partnering (e.g., with other state agencies or medical care organizations) to diversify funding streams and create a multi-pronged approach to funding.

Despite the successes in serving diverse groups, many challenges remain. The evaluations summarized here highlight the need for additional research to address practical programmatic and policy concerns. More information is needed to identify why more African Americans and Hispanics participate in the DSMP versus the CDSMP, even when they do not have diabetes, and what aspects of the Spanish CDSMP and the Spanish DSMP contribute to the higher completion rates in these programs compared to the English versions. There also is a need for more diverse sources of financial support beyond federal grants, which require being able to document which sub-groups benefit the most from these programs and their cost-effectiveness.

The future portends a growing diversity among the rapidly growing older population. Great strides have been made, as exemplified by AOA evidence-based initiatives over the past decade. Looking ahead, we can make a difference in reducing disparities, but it will require making integrated efforts across public and private sectors and involving key stakeholders from the aging, public health, minority health, clinical, and academic fields. Varied partner types yield benefits such as increased reach to diverse populations, access to new funding streams, and assistance with evaluation and outcome measurement—all critical factors leading to programmatic successes.

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References


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