
Engaging Older Adults in High Impact Volunteering that Enhances Health: Recruitment and Retention in the Experience Corps® Baltimore

Iveris L. Martinez, Kevin Frick, Thomas A. Glass, Michelle Carlson, Elizabeth Tanner, Michelle Ricks, and Linda P. Fried

ABSTRACT *Engagement in social and generative activities has benefits for the well-being of older adults; hence, methods for broadly engaging them in such activities are desired. Experience Corps Baltimore, a social model for health promotion for older adult volunteers in public schools, offers insight to such successful recruitment and retention. We report on data over a 4-year period in Baltimore City, Maryland, and describe a five-stage screening process implemented to recruit a diverse group of senior volunteers who would remain in the program for at least 1 year. The sample consisted of 443 older adults expressing an interest in and screened for volunteering. Comparisons were made with Chi-square and Fisher's t-test between those who entered the program and those who did not and those who were retained in the program. Gender, race, age group, and prior volunteering were significant in ultimate volunteer service in the schools. Overall, 38% of 443 persons recruited entered the schools; 94% of participants were over 60 years ($p = 0.05$) with a mean age of 69 years; 90% were women ($p = 0.03$), and 93% African-American ($p = 0.005$); 57% had not volunteered in the past year ($p = 0.004$). Ninety-two percent were retained in the first year; 80% returned a second year. Among the latter, 83% had <12 years of education ($p = 0.001$). Participants remained in the program for a second year of volunteering regardless of baseline MMSE score, self-reported health, and motivation for volunteering. In conclusion, it is possible to recruit and retain a diverse pool of older adults to participate in a high-intensity volunteer program, including non-traditional volunteers. Of special note is the success in recruiting African-American women and those with lower education, who may particularly benefit from health promotion.*

KEYWORDS *Health promotion, Recruitment, Volunteerism.*

Martinez is with the Center on Aging and Health, Department of Medicine, Johns Hopkins Medical Institutions, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205-2223, USA; Frick is with the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, 624 N. Broadway, Room 606, Baltimore, MD 21205, USA; Glass is with the Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe Street, Baltimore, MD 21205, USA; Carlson is with the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205, USA; Tanner is with the Johns Hopkins School of Nursing, Johns Hopkins Center on Aging and Health, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205, USA; Ricks is with the Johns Hopkins Center on Aging and Health, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205, USA; Fried is with the Center on Aging and Health, Division of Geriatric Medicine and Gerontology, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205, USA.

Correspondence: Iveris L. Martinez, PhD, Center on Aging and Health, Department of Medicine, Johns Hopkins Medical Institutions, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205-2223, USA. (E-mail: imartinez@jhmi.edu)

INTRODUCTION

The United States population is aging rapidly. Persons aged 65 and older represented 34 million persons (12% of the U.S. population) in 2000; the numbers are expected to almost double to 64 million persons (19%) by 2025.¹ Although the social costs of population aging are well-documented, the potential benefits of an aging population are less recognized. Older adults represent a significant, though often underutilized, resource in many communities.^{2,3} If roles were organized to involve older adults in useful or important tasks and if senior volunteering could take place on a large enough scale, it could substantially impact a range of unmet societal needs.^{2,4-6}

Volunteering appears to confer substantial benefits to the older adults themselves.⁷⁻¹⁵ The benefits range from the opportunity to be productive and to be socially engaged and generative,¹⁶ to known health benefits of regular, structured activities and remaining physically and cognitively active. These individual benefits, if organized on a larger scale, could have substantial public health benefits if senior volunteer roles were carefully designed to double as a social model for health promotion for an aging society.^{7,8}

In general, volunteers in service programs in the U.S. have typically been white, female, highly educated, and with high incomes¹⁷ or have been recruited through religious organizations.^{3,18} Moreover, volunteers in community-based research programs tend to be healthier, younger, better educated, female, use fewer human services than non-volunteers,¹⁸⁻²⁰ and have higher cognitive function than randomly selected samples.¹⁹ At the same time, we know that population subsets with lower rates of volunteering are subject to greater health disparities, have greater unmet health promotion needs, and may have fewer volunteering opportunities. Specifically, lower levels of socio-economic status (SES) are associated with poorer health and greater disability, reduced access to care and health seeking behaviors, lower access to activities that promote physical and cognitive activity²¹⁻²⁵ and greater health disparities at all ages.²⁴ Health promotion programs for older adults, such as exercise programs, have demonstrated greatest success in recruiting those with higher SES.²⁶ Therefore, older adults with lower income, and/or education, and fewer opportunities for productive activities might particularly benefit from generative social engagement through volunteering designed to have high impact on their communities.

Experience Corps Baltimore (ECB) is a senior volunteer program designed to both support the academic success of children in kindergarten through third grade and to promote the health of older volunteers by enhancing physical, social, and cognitive behavioral risk factors.^{4,7,8} The program serves to mobilize the experience, wisdom and energy of older adults from the community to enhance academic outcomes in public elementary schools.^{5-8,27} Overall, Experience Corps is designed for volunteers from diverse socio-economic and ethnic background to participate in high impact roles that could be feasible, meaningful and mutually beneficial.^{4,6-8,27}

ECB draws on many known best practices in senior volunteer programs, as well as research evidence for enhancing health promotion in older adults, with core elements including high intensity service, 15 h per week through at least one full academic school year; meaningful and high-impact roles in schools meeting unmet, high priority needs; a critical mass volunteer serving in teams in a school; training and ongoing programmatic support volunteer; and diversity of volunteers.^{4,8,27} In

creating meaningful and productive roles for seniors in underserved elementary schools, the program also demonstrates the positive attributes of an aging society by providing an intergenerational exchange that can improve the lives of children, teachers and participating seniors and enhance the social capital of the wider community.^{7,27} Secondary goals of ECB include the development and refinement of methods to recruit and retain a broad range of older volunteers to a public health program. ECB hypothesized that older adults who might not otherwise have access to or be attracted to participate in physical activity or other prevention programs might be drawn to programs that offered the opportunity to “give back” and have high impact on the next generation.

In this paper, we describe the methods and the effectiveness of volunteer recruitment over the initial 4 years of the intervention, between 1999 and 2003, by 1) describing the recruitment process and rationale; 2) describing and comparing the characteristics of those originally screened by the program and who volunteered with those who, ultimately, did not participate; 3) providing retention rates; and 4) evaluating characteristics of those retained for 1 versus 2 or more years of service in schools.

METHODS

Design

Experience Corps Baltimore program started as a pilot randomized, controlled trial in 1999 based on the design initially developed by Linda Fried and Marc Freedman.⁴ National Experience Corps demonstration programs from 1996–1999 showed a 33% dropout after training and enrollment. We therefore sought to develop methods to minimize dropout prior to school placement, given the investment of resources required to train, place, and support volunteers, so as to provide an effective and stable volunteer force for the schools. A five-stage screening process was designed by the Baltimore program to maximize retention after placement in schools.⁸ This process was developed to ensure that volunteers were fully informed about the commitment necessary and the program elements and demonstrated interest and ability to follow through on commitments prior to training.

The program goal was to achieve a critical mass of 15–30 volunteers in each of six participating schools, placing 1–2 volunteers in each K-3 classroom, as well as in library support roles, after-school literacy activities, enhancing attendance, violence prevention, and a variety of additional roles requested by principals and volunteers.^{5,8,27} Critical mass was defined by the principals to meet the goal of a sufficient number to meaningfully improve outcomes for entire grades of children in grades K-3 and improve the school climate.²⁷ Critical mass was theorized to also support collective efficacy and retention of the volunteers.^{8,27} Participants were required to volunteer for at least 15 h per week (morning and/or afternoons) for a minimum of 450 h during the school year. This time commitment was based on 1) feedback from school principals as to the time investment required for volunteers to integrate into the schools and be entrusted with high impact roles and 2) the frequency and dose likely to maximize health promotion benefits.⁸

Sample

Experience Corps Baltimore (ECB) recruited older adults from communities throughout Baltimore City. Several eligibility criteria were established to meet

school requirements and maximize effectiveness and safety of the older adults and of the children they would serve. These criteria included a) age 60 years or older in Years 1 and 2; decreased to age 55 or older by requirements of Americorps funding beginning in Year 3; b) commitment of 15 h per week through the full school year, September through June; c) demonstrated ability to read (added as of Year 3); d) clearance on the school system's required criminal background check, e) ability to travel to the schools, and f) cognition sufficient for functioning effectively in the schools. The goal in community recruitment was maximal inclusiveness, effectiveness and safety. All subjects provided written informed consent in compliance with the clinical research guidelines of the study institution, and the study was approved by the Johns Hopkins School of Medicine IRB.

Recruiting for ECB was conducted through a partnership between scientists at The Johns Hopkins University and the Greater Homewood Community Corporation, an umbrella community organization serving 40 neighborhood organizations in Baltimore City. The messages used for recruitment focused on opportunities for older adults to use their life experience to make a difference for children in public elementary schools. We set out to describe the goals and benefits of the program to a large and diverse group of older adults and to recruit and screen them for eligibility. Recruiters, including a field director and investigators, utilized a wide range of strategies, from "pounding the pavement," handing out brochures on city streets and at health fairs, to presentations at churches, community organizations, retiree organizations, senior housing sites, and senior centers. We also recruited through collaboration with AARP, utilizing their mailing list for the catchment area, and various media outlets.

Measures

Data are presented from the initial screening, and baseline evaluations collected through a five-stage process from 1999 through 2003. First, a screening form was completed (Stage 1) by recruiters, in person or by phone. Those expressing interest through the screening process and meeting initial age criteria and 15 h minimum availability were then invited to an informational intake meeting (Stage 2), where investigators presented information about the program, the commitment asked of volunteers, and the need to evaluate the impact of the program both on the schools and on the well-being of the older adults.

After intake, baseline evaluations (Stage 3) were completed by study staff on those individuals who provided written consent to participate in the research. Baseline and follow-up data were collected using standardized instruments designed to assess self-reported and performance-based physical and cognitive health status, and social characteristics.

The minimum cognitive requirements for participation were set to maximize volunteer potential for success in a dynamic school setting. They were operationalized using indices of global cognitive and executive function, or the ability to flexibly plan, organize and carry out actions. The minimum requirement for cognitive function that we established was a score of ≥ 24 on the Mini-Mental State Examination (MMSE),²⁸ using standard scoring procedures for volunteers with more than 12 years of education. MMSE is the most broadly used screening tool for cognitive impairment with clear education cut-offs. To maximize the inclusion of older adults who have less education, if volunteers had 12 or fewer years of education, then the score for spelling WORLD backwards was added to the MMSE score. If the score was still below 24, then completion of the Trail Making Test

(TMT), Parts A and B,²⁹ within 240 and 360 s, respectively, was considered. Those who failed to complete the TMT within the allowed time and scored ≤ 19 on the MMSE were not eligible for the program. Trails is a measure of executive function determined to be a critical skill for functioning in the school environment.

Criminal background checks (Stage 4) were then conducted by the school system on those meeting cognitive as well as other eligibility criteria. Participants received training (Stage 5) for 6 days over 2-weeks, focusing on literacy skills, behavioral management, and school environment. This prepared volunteers to perform effective and meaningful roles and facilitated integration of the volunteers into the schools.^{6,27} With completion of all of these steps, volunteers were then eligible for placement in a school. Participants could opt out at any stage.

Analysis

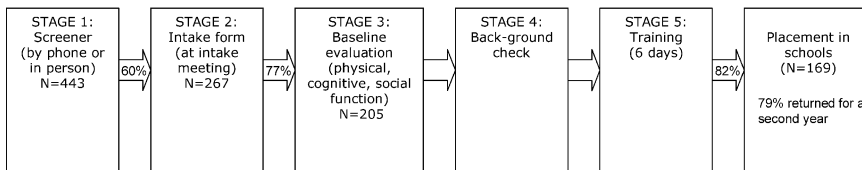
In this analysis, we report on MMSE, self-reported health status, limiting physical conditions, total chronic disease, difficulty walking several blocks and difficulty climbing several flights of stairs. Differences in the characteristics of those who were initially screened and ultimately participated in the program versus those who did not were evaluated using Chi-square and Fisher’s *t*-test. The retention rate was calculated based on actual placement in the school and then on those who returned to the schools for a second year of volunteering. The characteristics of those who volunteered initially and of those who remained in the program for a second year compared with those who left after 1 year of service are described.

RESULTS

Screening

A total of 443 older adults were recruited and screened between 1999 and 2003. Out of 443 persons screened, 267 (60%) completed an intake form; 205 (77%) completed evaluations after intake, and 169 (82%) of those evaluated entered the schools (see Fig. 1). Overall, 38.1% of those initially screened completed the full 5-stage process and entered the schools; fewer than 5% dropped out between

All 4 years: 38.1% completed the 5-stage process and entered the schools.



Year 1: 49.8% completed the 5-stage process and entered the schools.

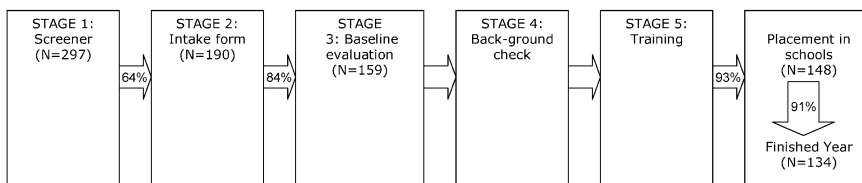


FIGURE 1. Five-stage recruitment process.

evaluation and assignment to the schools. In the first year, 297 potential volunteers were initially screened (Stage 1); 190 (64%) completed the intake, and 159 (84%) completed baseline evaluations (Stage 2 and 3). In Year 1, the year of heaviest recruitment, 3.8% (3/159) of those evaluated did not pass the cognitive screening; another eight dropped out post baseline evaluation because of a conflict or loss of interest. Thereafter, 93% (or 143) of those completing evaluations were randomized to either an “intervention” (entering the schools) or a comparison control group (wait-listed 1 year). Both groups completed follow-up evaluations at the end of the school year. In the second year, controls from the first year were offered the opportunity to be placed in the schools, and additional volunteers were recruited. For recruitment analysis, first year controls were treated as Year 1 recruits.

Characteristics of Population Screened

Among those screened between 1999 and 2003 (Table 1), 85% were women, and 87% were African-American. Only 26% were married. The average age of those screened as potential participants was 68.7 years, with a range of 42.2 to 93.9; 90% were 60 years and older. The self-rated health of those screened ranged from fair to excellent, with 27.6 and 16.8% rating their health as very good and excellent, respectively; 16.1% reported health as fair. Only 5.5% reported a limiting physical condition. Ninety-six percent of persons initially screened were available for 15 h or more per week, and 88.7% had no time commitment or other conflict that would interfere with their volunteering. Thirty-four percent had volunteered in some other capacity in the past year.

Participation in Schools

Participation in the program was defined as those “ever assigned to a school” after completing the five stage process. Significant differences existed between those who were ultimately assigned to service in the schools and those who did not serve (referred to as participants and non-participants, respectively, in Table 1), including gender and racial composition: A greater proportion of the participants were black (92.9%) and female (89.9%), versus non-participants (82.6 and 82.4%, respectively). Age group was also approaching significance ($p = 0.05$). Participant ages ranged from 51 to 86 years of age, while non-participants ranged from 42 to 94 years of age, with the majority of volunteers serving in schools between 60 and 75 years of age. Approximately 94% of participants were over 60 and 41% over 70 years of age. Persons under 60 years of age were less likely to volunteer after initial enquiry about the program. No significant differences existed in mean age, marital status, self-reported health status, or limiting physical conditions between participants and non-participants.

Availability for a minimum 15 h per week and the absence of conflicting responsibilities were also significant factors in whether those screened entered the schools. Persons who had volunteered in the past were significantly more likely to participate. The latter finding is consistent with the literature. However, over half of persons who served had not volunteered in the prior year. While we did not systematically collect data on attendance for research purposes during the first 6 years of the program, our experience is that program participation was high. In 1999–2000, average participation was 24 h per week.⁸ Data collected for the 2001 and 2002 school year indicate that participants volunteered on average 413 and 406 h, respectively, in those years, with some volunteering more than 600 h during the school year.

TABLE 1. Characteristics of volunteer population screened and recruited for Experience Corps Baltimore, 1999–2003

Variables		Screened % (<i>n</i> = 443)	Participants % (<i>n</i> = 169)	Non-participants % (<i>n</i> = 274)	<i>p</i> value
Age in years	Mean (SD)	68.7 (7.05)	68.7(6.39)	68.7(7.44)	0.92
	Range	42.2–93.9	50.9–85.9	42.2–93.9	
Age in years	<60	10.5	6.2	13.1	0.054
	60–65	24.1	27.6	22.0	
	66–70	25.1	25.5	24.9	
	71–75	21.8	26.2	19.2	
	>75	18.5	14.5	20.8	
Gender	Male	14.7	10.1	17.6	0.03
	Female	85.3	89.9	82.4	
Race	Black	86.6	92.9	82.6	0.0053
	White	10.9	5.3	14.4	
	Other	2.5	1.8	3.0	
Education	0–11th grade	33.9	32.5	36.0	0.30
	12th grade	40.8	44.4	35.0	
	> 12th grade	25.4	23.1	29.0	
Marital status	Married	25.8	26.2	25.6	0.95
	Widowed	40.9	39.9	41.5	
	Other	33.3	33.9	33.0	
Volunteered in past year	Yes	33.9	43.1	27.9	0.0036
	No	66.1	56.9	72.1	
Available 15 h	Yes	98.1	100.0	97.0	0.02
	No	1.9	0.0	3.0	
How learned of the program	AARP	13.3	13.2	13.33	0.34
	Church	7.8	6.0	8.9	
	CARE	9.6	9.0	10.0	
	Friend/relative	33.6	37.1	31.5	
	Media	9.6	12.6	7.8	
	Public Housing	11.2	8.4	13.0	
Conflict	Other	14.9	13.8	15.6	0.03
	No	91.8	95.8	89.3	
	Yes, workable	6.8	4.2	8.4	
	Yes, not workable	1.4	0.00	2.3	
Self-rated health status	Excellent	16.8	16.3	17.1	0.93
	Very Good	27.6	27.7	27.5	
	Good	39.5	38.6	40.2	
	Fair	16.1	17.5	15.2	
	Poor	0.0	0.0	0.0	
Limiting physical conditions	Yes	5.5	3.6	6.7	0.16
	No	94.5	96.5	93.3	

Recruitment Approaches

Notably, how people learned about the program was not a significant factor in participation (see Table 1). A key strategy in Year 1, when the program was relatively unknown in the community, was to recruit potential volunteers through senior housing, senior centers, churches, community organizations, and on the sidewalks throughout the city. After the first year, referrals by friends and current volunteers were the most frequent source of attracting program participants.

A letter of information about the program was endorsed and sent out by AARP to all members in the program catchment area. Response rates to the AARP letter varied from year to year, in large part based on time of year. Response to AARP mailings was best in Year 4 when it was mailed out in early spring, as compared to prior summer mailings, suggesting that potential recruits make their volunteer commitments by July. Baltimore City's Commission on Aging and Retirement Education (CARE) contributed to recruitment by promoting and presenting the program through their venues, such as senior centers, CARE health fair and Action in Maturity Newsletter.

Retention

There were two aspects of program retention that were measured. First, we measured retention during the school year. During the first year of the program, 91% of those placed in the schools finished the year. Retention rates during the school year were similarly high in each year. Secondly, retention over the 4-year period was defined as returning to the schools for a second year of volunteering. Over the 4 years, 79% of all participants returned to the schools for a second year after completing 1 year in the program. When comparing those who remained in the program for more than 1 year with those who participated for only 1 year (Table 2), education was highly significant in retention ($p = 0.001$). Those with 12 years of education or less were highly likely (83%) to be retained in the program. Those who were not retained were more likely to have more than 12 years of education (47%).

Other socio-demographic characteristics, such as age, gender, race, marital status and income, were not associated with retention for a second year. However, volunteers in the program were largely African-American widowed and unmarried women, and it appears that men were more likely to leave after 1 year. The program was just as likely to retain persons across all income levels. However, fifty-three percent of those retained reported incomes under \$10,000. The poverty threshold for a family of 1 for 2004 is \$9,310. Having volunteered in another program in the prior year did not significantly affect retention. Those retained were almost equally likely to have volunteered, or not, in the past.

Self-reported physical health measures and cognitive health status (as measured by the MMSE) did not make a difference in retention. Average number of chronic diseases for those retained was 2.5 (compared to 2.3 among those not retained). Twenty-four percent of retained volunteers scored less than 24 on the MMSE (compared to 17% of those who were not). Self-reported mobility difficulty was not significantly associated with retention. Among those retained, 39% reported difficulty walking several blocks, and 61% reported difficulty climbing stairs (compared to 30 and 56%, respectively, among those not retained). While self-reported health status declined slightly at follow-up, this does not appear associated with retention in the program.

TABLE 2. Characteristics of experience corps volunteers remaining in schools more than one year in comparison to those remaining only 1 year, 1999–2003

Variables		Retained in school >1 year % (<i>n</i> = 133)	Not retained in school >1 year % (<i>n</i> = 36)	<i>p</i> value
Age in years	Mean (SD)	68.7 (6.32)	68.5 (6.74)	0.83
	Range	52.0–85.8	50.9–84.2	
Age in years	<60	6.00	7.1	0.97
	60–65	26.5	32.1	
	66–70	26.5	21.4	
	71–75	26.5	25.0	
	>75	14.5	14.3	
Gender	Male	8.3	16.7	0.14
	Female	91.7	83.3	
Race	Black	93.2	91.7	0.47
	White	4.5	8.3	
	Other	2.3	0.00	
Education	0–11th grade	35.7	20.6	0.0009
	12th grade	47.6	32.4	
	>12th grade	16.7	47.1	
Marital status	Married	23.5	36.1	0.31
	Widowed	41.7	33.3	
	Other	34.9	30.6	
Income(\$)	<10,000	53.3	38.9	0.46
	10,000–24,999	33.3	38.9	
	25,000>	13.3	22.2	
Volunteered in past year	Yes	45.5	33.3	0.25
	No	54.6	66.7	
How learned of the program	AARP	12.2	16.7	0.48
	Church	5.3	8.3	
	COA	10.7	2.8	
	Friend or relative	37.4	36.1	
	Housing	8.4	8.3	
	Media	10.7	19.4	
	Other	15.3	8.3	
Self-rated health status	Excellent	13.0	28.6	0.13
	Very good	29.0	22.9	
	Good	41.22	28.6	
	Fair	16.8	20.0	
	Poor	0.00	0.0	
Limiting physical conditions	Yes	4.5	0.0	0.34
	No	95.5	100.0	
MMSE \geq 24	Yes	75.8	82.9	0.37
	No	24.2	17.1	
Total chronic diseases	Mean (SD)	2.5(1.38)	2.3(1.57)	0.47
	Range	0–6	0–7	
Difficulty walking several blocks	Yes	39.1	30.3	0.35
	No	60.9	69.7	
Difficulty climbing several flights stairs	Yes	61.4	56.3	0.59
	No	38.6	43.8	

TABLE 2. *Continued*

Variables		Retained in school >1 year % (<i>n</i> = 133)	Not retained in school >1 year % (<i>n</i> = 36)	<i>p</i> value
Self-rated health status at first year of follow-up	Excellent	3.3	0.0	0.20
	Very good	32.5	44.5	
	Good	54.2	33.3	
	Fair	10.0	22.2	
	Poor	0.0	0.0	

Analyses of data on self-reported satisfaction with volunteering in the first year of the program (the only time this data has been collected) show that overall 98% of subjects in the schools reported that they were either satisfied or very satisfied.⁸ While there were more persons who reported that they were “neither satisfied nor dissatisfied” with the program among those who did not return (10 v. 0% of returnees), there was no significant association between program satisfaction and retention. No participants reported dissatisfaction with the program (data not shown).

Motivations

Participants were asked at intake about perceived benefits and motivations for volunteering. These motivations were classified as generative (helping children, “giving back,” leaving a legacy) and non-generative. Non-generative responses included social activity (having something to do, a reason to get out of the house, place to go, regular structured activities, interaction with others) and social support (to make new friends or participate with existing friends and find persons with a common purpose/interests). Sixty-seven percent of respondents indicated generative motives for volunteering, 21% both generative and non-generative, with only 12% volunteering for non-generative motives. Motivation for volunteering did not appear significantly related to attrition in this analysis (data not shown).

DISCUSSION

Findings previously reported from the randomized pilot of the Experience Corps program in Baltimore indicate the success in improving physical, social and cognitive activity risk factors through generative social engagement.^{7,8} The results presented here further indicate it is possible to recruit and retain older adults to this high-intensity volunteer and health promotion program, including a population of older adults at high risk for health disparities. These findings have important implications for addressing health disparities through a social model of health promotion among older adults. Thus, not only is it possible to recruit populations from a broad spectrum of social and economic backgrounds—with varied experience as volunteers, including those not usually targeted as volunteers (i.e. African-American, low SES)—for this health promotion program as well as research, but it is also possible to retain this population through generative social activities. These data demonstrate the potential for addressing health disparities by extending health promotion through voluntarism to all older adults, including those in lower SES groups with greater health promotion needs. When all criteria were

taken into account, we were able to accommodate people with education at levels as low as third grade; and over half of those retained reported incomes below the threshold poverty levels (under \$10,000).

The multi-level screening process was put in place to maximize retention in the program. The high retention rates provide evidence of the potential for capturing the skills of retired older adults through this process as a valuable resource to meet needs in schools through a high-impact program. Once completing the five-stage process and placed for service in the schools, the Baltimore program was successful in retaining 79% of volunteers for a second year of volunteering. A low dropout rate once placed in the school (8% in year 1) ensured minimal interruption to the school environment, as well as maximizing older adults' contributions and mutual benefits through continuity of roles and exposure to health promotion for the volunteers. Community-based recruitment in partnership with various agencies assured a diversity of participants, although ultimately where they were recruited did not appear to make a difference in participation and retention. Moreover, the data show that it is possible to recruit and retain volunteers with no prior history of volunteering.

Seniors in the schools were primarily supervised by a paid school-based volunteer coordinator who was in constant communication with EC investigators overseeing the project. The supervisor's role was to facilitate effective volunteer role performance and to insure adherence to the Experience Corps protocol. In cases where a senior was not performing at a sufficiently high level, the on-site coordinator addressed the concerns raised in consultation with school staff and the EC intervention committee. While we did not systematically collect information from school staff on the roles, participation, value, and skill level of volunteers, we did hold a comprehensive debriefing interview with each principal at the end of each program year. Without exception, we heard high praise for the program from the principals as reflected by the continued expansion of the program within and across the school system. We have recently begun collecting this information for current volunteers as part of a qualitative study on the contributions of older adult volunteers to reducing the costs associated with teacher retention in urban schools. We currently estimate that the screening questionnaire takes on average 7 min to administer. This information, along with estimated cost and time associated with the entire screening process, will be used to model the cost-benefits of the program.

These findings are limited by the necessarily non-random nature of a volunteer sample. We were also constrained by limited health and demographic data available for those initially screened, but who did not ultimately enter the schools. Self-reported health is available at time of screening; other health data, such as number of chronic diseases, mobility difficulties, and income were only available for those who entered the program and completed a full evaluation. Nonetheless, these findings are a first step in exploring facilitators, as well as barriers, for health promotion through social engagement for older adults across the socio-economic spectrum and have potential for generalization. They are an important initial step in understanding who can benefit from these programs and how to expand health promotion through broad targeting, screening, and training for generative roles. As the U.S. and world population ages, further research is necessary to understand motivations, socio-economic barriers, and facilitators for generative and social activity in post-retirement years.

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