SUPPLEMENTAL MATERIAL
Supplemental Methods

Study Design Additional Detail

Recruitment and enrollment timeline. See Table S1.

Randomization. For each racial/ethnic cohort, the study coordinator (D.A.) created randomization tables using permuted block randomization with randomized block sizes, stratified by gender. For each cohort, a designated research staff member, unblinded to facilitate intervention coordination and scheduling with the community sites, uploaded these tables to the Research Electronic Data Capture (REDCap) web application and used the REDCap randomization feature to assign participants to conditions. All research staff collecting data were blind to condition assignment.

Measurement Additional Detail

Daily steps. We chose to count pedometer step data as valid only on days when participants had at least 50 steps that day. The median expected daily steps for older individuals with disabilities from a previous publication was 1,214 steps per day, so very low number of steps could be valid data in this sample. Yet, even if someone was virtually bedbound on a given day, we would expect them to still walk more than 50 steps. We ran sensitivity analyses with the observed data by testing whether results differed if we used a different lower limit step threshold (e.g., 100 or 600 steps per day) for data to be considered valid and included in the calculated mean daily steps. The conclusions from change score analyses using a 50, 100, or 600 daily step threshold did not differ, nor did the ANCOVA or repeated-measures mixed-effects model sensitivity analyses.

We decided to compute mean daily steps only when at least three valid days of data were recorded within the 7 days prior to the interview because (as stated in the Results section) overall 62% of participants had valid data for 7 days at baseline, and 10% had less than 3 days. Limiting the analyses to the 62% of participants with 7 days of valid data would undermine generalizability and external validity by focusing on the most compliant participants. Although we imputed missing data, we still wanted to minimize the proportion of imputed data. By instead calculating the mean daily steps for participants with at least three valid days of data, we only needed to impute 10% of the step data at baseline.
Self-efficacy. An adapted chronic disease self-efficacy scale combined all items from the Self-Efficacy to Exercise Regularly subscale of the Self-Efficacy to Perform Self-Management Behaviors scale and three items from the Self-Efficacy to Manage Disease in General scale (which assessed confidence in one’s ability to do different tasks and activities to prevent stroke, reduce need to see a doctor, and do things other than take medication to manage stroke risk).² Cronbach’s alphas range 0.88 to 0.91 across time points.

ADL categorization. The raw ADL scores were generated based on participant reported difficulties with walking, bathing, dressing one’s upper body, dressing one’s lower body, transferring from bed to chair, going to the bathroom, eating, and grooming. Participants were asked if they had difficulty in the past month in each domain and were scored 0 = no difficulty, 1 = difficulty but no help, or 2 = needed help; final scores could range from 0 to 16. The multiple imputation model would not converge when treating ADL scores as continuous, so we recoded the continuous data into a categorical variable; 0 = no limitations, 1 = scored 1 to 2 (roughly equivalent to one limitation), 2 = scored 3 to 4 (roughly equivalent to two limitations), 3 = scored 5 to 6 (roughly equivalent to three limitations), 4 = scored 7 to 16 (roughly equivalent to more than three limitations).

Blood pressure. Blood pressure was measured with the Omron HEM-907XL. Left arm bicep circumference was measured for each participant to determine the appropriate cuff size. Once the cuff was placed, participants sat quietly for five minutes prior to the first measurement. Three measures were taken, with a five minute rest between. The three measures were summarized for analysis by taking the average of the closest measurements (i.e., the average of the two closest measurements, or all three measurements if they were equidistant).

Blood collection and assays. All blood-based assays were conducted using specimen collected from capillaries via finger prick. Prior to collection, research staff ensured participants were well-hydrated. Heating pads were placed around the hand for 5-10 minutes to promote blood flow. Participants’ fingers were pricked with a blue BD Contact-Activated Lancet and the first drop wiped away. The goal was to collect a minimum of 3 spots on a Whatman 903 Protein Saver card. The cards were air-dried overnight and then stored at -70°C in sealed Ziploc bags with desiccant packs until assay.

Lipids were measured using the CardioChek PA analyzer. Following the dried bloodspot collection, research staff collected 40 ul of capillary blood in pipettes and applied it to the CardioChek Lipid test strip. The specimen was immediately analyzed and results entered in REDCap. Research staff did prick an additional finger if the first did not yield enough specimen. When measurements were out of range, the highest or lowest in range value in the corresponding direction was substituted to retain information.
Dried blood spots were analyzed for Hemoglobin A1c and C-reactive protein at the University of Washington Department of Laboratory Medicine. Dried blood spot (DBS) quality control (QC) samples and DBS assay calibrators created by the University of Washington Department of Laboratory Medicine (UW Lab Med; Seattle, WA) were sealed in Ziploc bags with desiccant packs and stored at -70°C. A BSD700 Semi-Automated Dried Sample Puncher (BSD Robotics, Brisbane, QLD, Australia) was used to punch a single 3.2mm (1/8in) diameter disc from each DBS sample into a deep-96 well microtiter plate well (Greiner Bio-One, Monroe, North Carolina). Separate microtiter plates were filled with DBS discs for each analyte of interest. The plates were either immediately assayed or were sealed (CapMat, Greiner Bio-One) and stored at 70°C. Microtiter plates were warmed to room temperature (RT) prior to assaying.

The hemoglobin A1c (HbA1c) assay used to measure the percentage of glycosylated hemoglobin (%HbA1c) in the DBS was performed on an automated ion-exchange high-performance liquid chromatography system (Variant II HPLC Hemoglobin A1c Testing System, Bio-Rad, Hercules, CA). HbA1c buffer (Wash/Diluent Reagent, Bio-Rad) was added to each microtiter plate well and the plate then sealed and vigorously shaken for 1 hour on a Delfia microplate shaker (PerkinElmer, Waltham, MA) to reliquefy the dried blood. The reliquefied blood was transferred to a sample vial containing Wash/Diluent Reagent, gently agitated for approximately 30 seconds and then analyzed. A buffer gradient of increasing ionic strength was applied by the HPLC to separate hemoglobins based on their ionic interactions with the cation exchange cartridge resin. Hemoglobins, identified by 415nm absorbance and the time of passage through a filter photometer flow cell, were displayed as chromatogram curves. Curve integration was used to quantify the HbA1c and total HbA areas and %HbA1c then calculated from the ratio of the HbA1c:total HbA areas adjusted by the calibration curve slope and intercept (Variant II Clinical Data Management Software, Bio-Rad).

DBS HbA1c QC samples were constructed by pipetting 75µl aliquots of blood with known %HbA1c values onto Whatman No. 903 filter paper (GE Healthcare, Pittsburgh, PA) and drying for 4 hours at RT (UW Lab Med). Assay acceptability was determined by comparing the %HbA1c concentrations of QC samples (Lyphochek Bilevel Diabetes Control, Bio-Rad) and DBS QC samples at the beginning, middle, and end of each assay run against established values. Acceptability of the analysis of each sample was determined by examining the chromatogram for proper form, absence of interfering peaks, acceptable total area, and %HbA1c value within the analytical measurement range (AMR).

The HbA1c assay AMR was 3.1% to 18.5% per established limits (Bio-Rad). The within-assay CV was 2.5% and between-assay CV was 2.9%. The %HbA1c values of DBS samples analyzed by the DBS assay correlated with the %HbA1c values of DBS-matched liquid blood samples (Pearson R = 0.98) and were linearly related (blood %HbA1c value = 2.245 + DBS direct %HbA1c value X 1.378). The linear regression equation was used to convert the directly measured %HbA1c value of each WTW DBS into a blood-equivalent (B-E) %HbA1c value.
The DBS high-sensitivity C-reactive protein (CRP) Assay used a sandwich ELISA (BC-1119, Biocheck, Foster City, CA). CRP Sample Diluent (Biocheck) was added to each microtiter well containing a DBS disc and the plate was then sealed and gently shaken for 1 hour on a Delfia microplate shaker (PerkinElmer) to reliquefy the dried blood and elute CRP. An aliquot of the eluate was transferred to an ELISA microtiter plate (Biocheck) pre-coated with an anti-CRP monoclonal antibody (mAb) that recognized and bound CRP (solid phase immobilization). CRP Enzyme Conjugate Reagent (Biocheck) containing anti-CRP Ab coupled to peroxidase (enzyme-linked antibody) was then added to each well to sandwich CRP between the solid phase and enzyme-linked antibodies. The plate was gently shaken at RT for 45 minutes and then washed 5 times with di/ddH2O. TMB Reagent containing H2O2 (Biocheck) was added, and the reaction of H2O2, cleaved by the peroxidase, with TMB was stopped after 20 minutes by addition of Stop Solution (Biocheck). The absorbance of each well at 450nm, measured by a plate reader (Synergy HT, BioTek), was directly proportional to the CRP concentration. A 5-parameter calibration curve, constructed by plotting the absorbance of the calibrators against the assigned CRP concentrations (Gen 5 Software, BioTek), was used to convert the absorbance of each sample into a DBS direct CRP concentration.

DBS CRP assay calibrators were constructed from pooled human plasma with a negligible CRP concentration (UW Lab Med) spiked with CRP concentrate (Cell Sciences, Canton, MA) and serially diluted with negligible CRP plasma to the desired final concentrations. DBS QC samples were constructed from a separate pool of human plasma, either undiluted (high CRP concentration QC sample) or diluted with negligible CRP plasma (medium CRP concentration QC sample and low CRP concentration QC sample). Each calibrator and QC sample solution was mixed with a constant volume of washed human erythrocytes (UW Lab Med), pipetted in 75µl aliquots onto Whatman No. 903 filter paper (GE Healthcare) and dried for 4 hours at RT. Acceptability of an assay was determined by comparing the CRP concentrations of the QC samples with the established values.

The CRP assay LLOD was 0.035mg/L, within-assay imprecision (CV) was 8.1% and between-assay imprecision was 11.0%. The CRP concentrations of DBS samples analyzed by the DBS assay correlated (Pearson R = 0.99) with the CRP concentrations of paired plasma samples determined by analysis on an automated chemistry analyzer (UniCel DxC 800 Synchro Clinical System, Beckman Coulter, Miami, FL) and were linearly related (DBS direct CRP concentration = 0.370 + plasma CRP concentration X 1.077). The linear regression equation was used to convert the directly measured CRP concentration of each WTW DBS into a plasma-equivalent (P-E) CRP concentration.

Healthcare utilization. Participants also reported number of visits to the emergency room (ER) and number of times they had an overnight stay in the hospital in the past 3 months, but these outcomes were not included in the manuscript because of challenges with multiple imputation model convergence (see “Relevant Deviations from the Previously Published Protocol” below). Outcomes such as total nights in the hospital in the past 3 months had limited distribution ranges. For example, at baseline 217 participants (94% of
the observed sample) spent 0 nights in the hospital in the past 3 months; the remaining 6% ranged from 1 to 14 nights in the hospital.

Multiple Imputation Model Specification

Trace plots indicated that BMI imputations did not converge as well as other outcomes, even though only one person was missing BMI at baseline (T0). Thus, missing data was imputed from least to most missing, with the BMI variable imputed last to avoid negatively impacting the remaining data imputation. Education (whether or not completed high school), gender, ethnicity, cohort order, intervention condition, age, and the complete baseline data for health related quality of life (QOL), depressive symptomology, stroke risk factor knowledge, and number of physician visits were included in the model as complete auxiliary variables. The amount of missing data for each variable at each time point is presented in Table S2.

Relevant Deviations from the Previously Published Protocol

Due to time constraints during the interviews and participant difficulties remembering to bring medication lists, medication usage was discontinued as a measured outcome and was not analyzed.

Although the initial clinicaltrials.gov preregistration indicated LDL was the key cholesterol outcome of interest, the researchers shifted to non-HDL cholesterol prior to data analysis because it was difficult to ask participants to fast prior to measurement. Non-fasting LDL is not clinically meaningful, so researchers determined that a more appropriate measure would be non-HDL cholesterol (total cholesterol value − HDL cholesterol value).

The multiple imputation with chained equations model would not converge when trying to impute number of emergency room visits or number of times participants had an overnight stay in the hospital in the past 3 months. Thus, these variables are not analyzed in the multiple imputation models but are still included in the complete case analyses in this data supplement.

Intervention Additional Curriculum Information

Overview (consistent across all racial/ethnic groups)

- Main teaching points
  1. Being physically active is an expected part of life that decreases our risk for stroke. We should continue being physically active throughout life, regardless of age, physical ability or medical conditions.
  2. Some stroke risk factors can’t be changed but there are several that can at any age.
3. Age alone doesn’t cause stroke. Stroke risk should be attributed as much as possible to factors that are within a person’s control.

- **Key procedures**
  - **Promises**: At the end of every other session, time was set aside for each participant to make a promise for the week (a specific thing that will be done before the next meeting to improve his or her stroke risk factors—e.g. walk for 15 minutes every other day) which the group leader wrote down on a flip chart. The promises needed to be realistic and attainable. Group leaders made a promise as well. At the beginning of every other session (starting with session 3), participants were encouraged by the facilitator to share how they did in carrying out their promises. Participants were encouraged to describe any challenges they faced (and did or did not overcome).
  - **Reflection**: At sessions 5, 6, 7, and 8, participants were asked to reflect on whether their beliefs about increasing physical activity as an expected part of aging have changed at all since the previous session. Previous research has shown that changes in attitude are more likely to be sustained if people reflect in a meaningful way on their changes in beliefs.

*Class Schedule and Objectives for Each Session.* Full curriculum information and materials in each language are available upon request.

- **Session 1: Why Walking is Worth It**
  1. Introduce yourself and the participants to each other.
  2. Introduce stroke.
  3. Introduce the idea that being physically active and controlling stroke risk factors should be an expected part of normal aging and should continue at any age.
  4. Focus on physical inactivity as a risk factor and identify causes of being less physically active.
  5. Differentiate between causes of physical inactivity that are modifiable and causes that are not (like age).
  6. Teach that aging itself does not cause stroke or decreased physical activity.
  7. Make individual promises to improve stroke risk factors through increasing walking and physical activity.

- **Session 2: What’s Worth Looking Out For**
  1. Introduce stroke warning signs.
  2. Reinforce the idea that preventing stroke and being physically active should be an expected part of normal aging and should continue at any age.
  3. Reinforce physical activity as a modifiable risk factor for stroke and the difference between modifiable and non-modifiable contributors to being less physically active.
4. Identify common changes with aging and teach that modifications can make activity once again possible.
5. Introduce diary and reminder to keep up with promises.

• **Session 3: Worth the Talk: Me and My Doc**
  1. Review promises and problem-solve on barriers to completion.
  2. Reinforce the idea that knowing stroke symptoms and being physically active are modifiable risk factors for stroke and should be an expected part of normal aging.
  3. Identify common challenges with communicating with your doctor.
  4. Problem solve solutions or ways to manage these challenges.
  5. Make new promises.

• **Session 4: Taking Control, One Step at a Time**
  1. Introduce blood pressure control.
  2. Reinforce the idea that preventing stroke and being physically active should be an expected part of normal aging and should continue at any age.
  3. Reinforce the idea that difficulty walking and controlling stroke risk should not be attributed to old age.
  4. Teach about importance of incremental goal setting.
  5. Problem solve on how to avoid feeling overwhelmed when trying to manage stroke risk.
  6. Reminder to keep up with promises.

• **Session 5: It’s Never Too Late To Make Walking (Fun and) Worth It**
  1. Review promises and problem-solve on barriers to completion.
  2. Reflect in a meaningful way on whether expectations and beliefs about aging have changed.
  3. Teach that being unable to learn a new habit is not caused by aging.
  4. Problem-solve on how to establish an exercise or walking plan as a new habit.
  5. Make new promises.

• **Session 6: (Culturally-relevant Class)**
  • **African American: Walking is Good for the Body (and Relieving Stress)**
    1. Review stroke warning signs.
    2. Reflect in a meaningful way on whether expectations around aging and habit formation have changed.
    3. Teach about chronic emotional stress and stroke risk.
    4. Problem-solve on how walking can be used to reduce emotional stress and stroke risk.
    5. Teach that we have control over how we choose to cope with stress, and that walking is an excellent choice.
6. Reminder to keep up with promises.

- **Chinese American: The “3 Highs:” High Blood Pressure, High Cholesterol, High Fat**
  1. Review stroke warning signs and habit formation.
  2. Reflect in a meaningful way on whether expectations and beliefs about aging have changed.
  3. Teach about the “3 highs” and heredity as risk factors for stroke.
  4. Problem-solve on how to combat modifiable stroke risk factors.
  5. Reminder to keep up with aims.

- **Korean American: Relieve Stress, Walk!**
  1. Review stroke warning signs.
  2. Reflect in a meaningful way on whether expectations around aging and habit formation have changed.
  3. Teach about chronic emotional stress and stroke risk.
  4. Problem-solve on how walking can be used to reduce emotional stress and stroke risk.
  5. Teach that we have control over how we choose to cope with stress, and that walking is an excellent choice.
  6. Reminder to keep up with promises.

- **Latino: Walking is Good for Health and Relieving Stress**
  1. Review stroke warning signs.
  2. Reflect in a meaningful way on whether expectations around aging and habit formation have changed.
  3. Teach about chronic emotional stress and stroke risk.
  4. Problem-solve on how walking can be used to reduce emotional stress and stroke risk.
  5. Teach that we have control over how we choose to cope with stress, and that walking is an excellent choice.
  6. Reminder to keep up with commitments.

- **Session 7: (Second culturally-relevant class, topic varied based on CAB recommendations)**

- **African American: Walking Is Good for the Soul**
  1. Review promises and problem-solve on barriers to completion.
  2. Reflect in a meaningful way on whether expectations and beliefs about aging have changed.
  3. Teach that pairing walking with a favorite routine activity and walking with others can help make exercise a new habit.
4. Problem-solve on ways to incorporate walking into your regular routine and also on ways to involve family and friends.

5. Make new promises.

• Chinese American: Family Matters
  1. Review aims and problem-solve on barriers to completion.
  2. Reflect in a meaningful way on whether expectations and beliefs about aging have changed.
  3. Teach that taking care of yourself does not mean you are selfish.
  4. Problem-solve on dealing with family-related challenges to exercise or self-care habits
  5. Make new promises.

• Korean American: Family Matters
• Latino: Family Matters
• Note: Even though the session title and objectives were the same for the Latino, Korean, and Chinese American sessions, the individual scenarios were tailored to the cultural group and varied based on CAB recommendations.

• Session 8: My Time to Shine
  1. Review progress with promises and problem-solve on barriers to completion.
  2. Reflect in a meaningful way on whether expectations and beliefs about aging have changed.
  3. Reinforce the idea that being physically active should be an expected part of normal aging and should continue at any age.
  4. Reinforce the idea that difficulty walking should not be attributed to old age.
  5. Identify good things about getting older.
  6. Problem solve on how to maintain an exercise or walking plan.
  7. Make new promises.
**Table S1. Dates and Sites Enrolled.**

| Racial/Ethnic Group | Cohort 1                              | Cohort 2                              |
|---------------------|---------------------------------------|---------------------------------------|
| African American    | Oct. to Nov. 2014, Site 1             | March to April 2015, Site 1           |
| Latino American     | Feb. 2015, Site 2                     | July to Aug. 2015, Site 3             |
| Korean American     | Sept. to Oct. 2015, Site 2            | Feb. to March 2016, Site 2            |
| Chinese American    | March to April 2016, Site 4           | April to May 2016, Site 4             |

Due to lead staff turnover at the organization recruiting Latino participants, the second Latino cohort was conducted at another project site. Although Site 2 hosted both Latino and Korean American cohorts, the interventions were specific and separate for each racial/ethnic group.
Table S2. Sensitivity Analysis 1: ANCOVA Results from Multiple Imputation.

| Outcome                          |               | T1         | p value |               | T2         | p value |
|----------------------------------|---------------|------------|---------|---------------|------------|---------|
|                                  | Intervention b | [95% CI]   |         | Intervention b | [95% CI]   |         |
| Primary: Steps/day               | 805 [159 to 1450] | .015 |         | 712 [-169 to 1593] | .112 |         |
| Secondary, self-report           |               |            |         |               |            |         |
| Stroke preparedness              | 0.20 [0.13 to 0.27] | <.001 |         | 0.18 [0.11 to 0.25] | <.001 |         |
| Inactivity as stroke risk factor*| 0.5 [-0.1 to 1.0] | .102 |         | 0.1 [-0.5 to 0.8] | .69 |         |
| Self-efficacy                    | 0.4 [0.01 to 0.7] | .046 |         | 0.6 [0.2 to 1.0] | .005 |         |
| Exercise outcome expectations    | -0.1 [-0.2 to -0.002] | .046 |         | -0.1 [-0.2 to 0.01] | .088 |         |
| Secondary, clinical              |               |            |         |               |            |         |
| Systolic BP (mmHg)               | -0.6 [-4.6 to 3.4] | .77 |         | 0.2 [-4.0 to 4.4] | .93 |         |
| Diastolic BP (mmHg)              | 0.9 [-1.4 to 3.3] | .44 |         | 1.0 [-1.5 to 3.5] | .45 |         |
| BMI (kg/m²)                      | -0.1 [-0.3 to 0.1] | .49 |         | -0.1 [-0.4 to 0.1] | .34 |         |
| Non HDL cholesterol (mg/dl)      | N/A           |          |         | 8.6 [-3.1 to 20.2] | .147 |         |
| % HbA1c                          | N/A           |          |         | -0.1 [-0.3 to 0.1] | .39 |         |
| Log CRP (plasma equivalent)      | N/A           |          |         | -0.1 [-0.2 to 0.1] | .41 |         |
| Exploratory                      |               |            |         |               |            |         |
| Physical health related QOL      | 0.4 [-1.7 to 2.5] | .74 |         | -0.5 [-2.6 to 1.6] | .66 |         |
| Mental health related QOL        | -0.6 [-2.8 to 1.6] | .58 |         | -0.8 [-3.2 to 1.5] | .49 |         |
| Depressive symptomology          | 0.4 [-0.7 to 1.5] | .51 |         | -0.01 [-1.1 to 1.0] | .99 |         |
| ADL category**                   | 0.2 [-0.4 to 0.9] | .49 |         | 0.1 [-0.5 to 0.8] | .70 |         |
| Physician visits***              | N/A           |          |         | -0.1 [-0.3 to 0.1] | .42 |         |
| Nights in hospital***            | N/A           |          |         | 1.1 [-0.4 to 2.7] | .155 |         |

All models control for baseline levels of the outcome. Unless otherwise specified, all models use multiple regression and present the unstandardized regression coefficient. Bonferroni adjustments for multiple comparisons mean the primary steps/day significance threshold is p < .025 and the significance threshold for the remaining secondary and exploratory outcomes is p < .0018. *Logistic regression model. **Ordinal logistic regression model. ***Negative binomial regression model.
Table S3. Sensitivity Analysis 2: Repeated-Measures Mixed-Effects Results from Multiple Imputation.

| Outcome                        | Intervention x T1 | Intervention x T2 | Overall Estimated Slope [95% CI] | Intervention | Control | p     |
|--------------------------------|-------------------|-------------------|----------------------------------|---------------|---------|-------|
|                                | b (SE)            | p                 | b (SE)                           | p             |         |       |
| Primary: Steps/day             |                   |                   |                                  |               |         |       |
| Intervention x T1              | 717 (313)         | .022              | 817 (404)                        | .043          | 26 [-174 to 225] | .80 | -249 [-431 to -67] | .007 |
| Intervention x T2              |                   |                   |                                  |               |         |       |
| Secondary, self-report         |                   |                   |                                  |               |         |       |
| Stroke preparedness            | 0.22 (0.03)       | <.001             | 0.20 (0.04)                      | <.001         | 0.03 [0.02 to 0.05] | <.001 | -0.01 [-0.02 to 0.01] | .39 |
| Inactivity as stroke risk factor | 0.5 (0.5)         | .31               | 0.1 (0.5)                        | .88           |         |       |
| Self-efficacy                  | 0.4 (0.2)         | .067              | 0.6 (0.2)                        | .008          |         |       |
| Exercise outcome expectations  | -0.1 (0.1)        | .043              | -0.1 (0.1)                       | .116          |         |       |
| Secondary, clinical            |                   |                   |                                  |               |         |       |
| Systolic BP (mmHg)             | 1.5 (2.3)         | .51               | 2.1 (2.4)                        | .37           |         |       |
| Diastolic BP (mmHg)            | 1.4 (1.3)         | .29               | 1.4 (1.4)                        | .30           |         |       |
| BMI (kg/m²)                    | -0.1 (0.1)        | .49               | -0.1 (0.1)                       | .36           |         |       |
| Exploratory                    |                   |                   |                                  |               |         |       |
| Physical health related QOL    | 1.1 (1.2)         | .37               | 0.3 (1.1)                        | .82           |         |       |
| Mental health related QOL      | -0.2 (1.2)        | .86               | -0.4 (1.3)                       | .73           |         |       |
| Depressive symptomology        | 0.02 (0.6)        | .98               | -0.4 (0.6)                       | .52           |         |       |

We did not test ADL category as an outcome because there is no ordinal logistic option within mi estimate. Other outcomes not included in the table were not measured at each time point. Bonferroni adjustments for multiple comparisons mean the primary steps/day significance threshold is p < .025 and the significance threshold for the remaining secondary and exploratory outcomes is p < .0025. Overall estimated slopes (i.e., change over time) are based on analyses treating time in months as continuous (T0=0, T1=1, T2=3); they are only presented if the overall Intervention x Time interaction was significant at p < .05 for steps/day and p < .005 for the remaining outcomes (Bonferroni adjusted significance threshold).
Supplemental References:

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3. Baruch L, Chiong VJ, Agarwal S, Gupta B. Discordance of non-HDL and directly measured LDL cholesterol: Which lipid measure is preferred when calculated LDL is inaccurate? *Cholesterol.* 2013;2013:1-6