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A Tale of Two Community Initiatives for Promoting Aging in Place: Similarities and Differences in the National Implementation of NORC Programs and Villages

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Purpose: Villages and Naturally Occurring Retirement Community (NORC) Supportive Service Programs (NORC programs) are among the most prominent community-based models for promoting aging in place. To advance systematic understanding of their development, this study examined how these models have been implemented nationally and the models' similarities and differences. ***Design and Methods:*** A survey of program leaders representing 69 Villages and 62 NORC programs was conducted from January to June of 2012. Bivariate analyses compared measures of the initiatives' services/activities, beneficiaries, service delivery processes, and funding sources. ***Results:*** Village members were reportedly more likely than NORC program participants to be younger, to be less functionally impaired, to be more economically secure, and to reside in higher socioeconomic communities. Reflecting these differences in populations served, NORC programs reported offering more traditional health and social services, had more paid staff, and relied more on government funding than Villages. ***Implications:*** Findings indicate that Villages and NORC programs both aim to promote aging in place by offering a diverse range of supports and services to older adults within a locally defined geographic area. Nevertheless, key differences were found in the means through which they seek to achieve these aims, as well as the populations likely to benefit from their efforts. These differences raise questions regarding the models' inclusivity, sustainability, expansion, and effectiveness and have implications for community aging in place initiatives more broadly.

Key Words: Home and community-based care and services, Interpersonal relations, Social capital, Social services, Social work, Long-term services and supports

The potential benefits of aging in place have received growing attention in recent years (Greenfield, 2012; Wiles, Leibing, Guberman, Reeve, & Allen, 2012), prompting a number of innovative community initiatives, the most prominent of which are Naturally Occurring Retirement Community (NORC) Supportive Service Programs (NORC programs) and Villages. Although Village and NORC program models have

been described in the popular press (e.g., Gleckman, 2010) and by their leaders (Bedney, Goldberg, & Josephson, 2010; Vladeck, 2004; Willett, 2012), there has been very little empirical analysis of actual implementation approaches and practices. Previous studies of NORC programs and Villages typically have used relatively small samples, and findings might not adequately reflect recent developments in these models (Bookman, 2008; Ivery & Akstein-Kahan, 2010; MacLaren, Landsberg, & Schwartz, 2007; Scharlach, Graham, & Lehning, 2012). Furthermore, there has been no research focused on how Villages and NORC programs are similar and different from each other in practice. Although these two models share a number of conceptual similarities, differences between them have implications for the expansion of each model and for their effectiveness and sustainability over time.

As this area of aging services continues to rapidly evolve, it is essential for research to incorporate more recent and national data to understand the development of these innovative models. Guided by prior descriptions of these program models and their origins, as well as a multidimensional framework for analyzing social welfare policies and programs (Gilbert & Terrell, 2005), we present the first in-depth examination of the ways in which Villages and NORC programs have been implemented nationally. More specifically, this multidimensional framework highlights four important dimensions that we use to examine the implementation of NORC programs and Villages: "*what* benefits are offered, to *whom* they are offered, *how* they are *delivered*, and *how* they are *financed*" (p. 67, italics from original text).

Brief Overview of the Program Models

The NORC program model has been defined, in part, as a "community-level intervention in which older adults, building owners and managers, service providers, and other community partners create a network of services and volunteer opportunities to promote aging in place . . . " (Bedney et al., 2010, p. 304). Other core features of the model include developing supports that are responsive to local needs, spearheading community-wide age friendliness, and serving as a vehicle for other innovations to promoting older adults' well-being (Vladeck, 2004). The NORC program model is intended for geographic locations with dense concentrations of older persons that were not designed originally as senior housing (Vladeck, 2004). NORC programs are intended to receive funding through private-public partnerships, including support from government, foundations, housing providers, and individuals' contributions (Ormond, Black, Tilly, & Thomas, 2004). The NORC program model began in 1986 at a co-op in New York City, and since then advocates have secured both private philanthropic and local government funds to support the expansion of the model throughout New York and the United States (Altman, 2006; Bedney et al., 2010). To date, approximately 100 NORC programs have been developed nationally, with approximately half in New York.

Villages are defined as "membership-driven, grassroots organizations run by volunteers and paid staff (to) coordinate access to affordable services . . . and offer vetted-discounted providers" (Village to Village Network [VtV Network]). The Village model emphasizes the provision of supportive services (e.g., transportation, home maintenance, companionship) and referrals to existing community services. Villages are expected to be initiated and governed by the consumers they serve rather than service providers and to rely on membership dues more than government funds, grants, or fees for individual services (McWhinney-Morse, 2009). The model was first developed in 2001 with the founding of Beacon Hill Village (BHV) by a group of seniors in Boston, MA, who wanted to remain as long as possible in the Beacon Hill neighborhood. Since the model's initial development, at least 80 Villages have been initiated, with more than 120 others in development.

Similarities and Differences Between NORC Program and Village Models

Based on prior theoretical descriptions, the Village and NORC program models appear to share a number of essential features, including an emphasis on promoting aging in place; serving a geographically defined service area; coordinating efforts of voluntary and formal support systems; enhancing social capital among older adults; promoting consumer engagement; and enhancing the availability, accessibility, and affordability of existing services (Greenfield, Scharlach, Lehning, & Davitt, 2012). These features reflect a number of emerging trends in aging services designed to enhance older adults' health and well-being, as well as improving service delivery systems—such as consumer direction (Carlson, Foster, Dale, & Brown, 2007), colocating services where people

live (Golant, 2008), service integration (Burns & Pauly, 2002), and facilitating older adults' civic engagement (Kaskie, Imhof, Cavanaugh, & Culp, 2008).

At the same time, given differences between their program philosophies and emphases, the historical contexts in which they have developed and the relatively decentralized manner in which the models have been implemented, there is apt to be substantial variation in the ways in which core features of these program models are actually implemented in local communities.

NORC programs and Villages might be expected to offer different types of services given their unique developmental histories. The NORC program model was designed to be connected to existing housing and service organizations and emphasizes collaborations among diverse stakeholders (Vladeck, 2004). In contrast, the Village model was developed outside of the existing health and social service systems by older adults themselves and has been described as doing "anything and everything that . . . members want and need" (VtV Network, n.d.).

The models' distinct origins also raise questions regarding potential differences in the types of communities and groups served. Whereas the prototypical model for NORC programs was a large apartment building with a dense concentration of moderate-to-low income older adults in Manhattan, NY (Altman, 2006), the initial model for Villages were developed in a relatively high socioeconomic neighborhood in Boston, MA (McWhinney-Morse, 2009). Likewise, the NORC program model was designed to be led by social workers and other social service providers trained to work with vulnerable populations (National Association of Social Workers [NASW], 2008; Vladeck, 2004). In contrast, the Village model is described as being founded, led, and funded primarily by older adults themselves (McDonough & Davitt, 2011), suggesting that Village participants might be in better health and have more financial resources.

Regarding how benefits are offered, differences between the program models suggest possible variations regarding the roles likely to be played by older adults, other community members, and formal service professionals. The NORC program model views older adults as partners in administering the initiative, along with lead agency professionals, collaborating service professionals, housing providers, and other community volunteers and stakeholders (Vladeck, 2004). In contrast, the Village model emphasizes members' direct leadership in every aspect of the initiative, including in the provision of services (McDonough & Davitt, 2011). Moreover, a defining feature of the Village model is referral to discounted providers (VtV Network, n.d.).

Finally, the models likely differ in how they are funded. The Village model emphasizes economic self-reliance rather than obtaining financial support from governmental and organizational sources (McWhinney-Morse, 2009). In contrast, the NORC program model explicitly includes various government funding sources (Bedney et al., 2010; MacLaren et al., 2007) and funds from other entities (Ormond et al., 2004).

Methods

Data and Sample

We used data from an organizational survey of NORC programs and Villages conducted from January to June of 2012. The survey aimed to provide a national snapshot of the implementation of NORC program and Village models and to examine variations within the models. Guided by previous descriptions—including research, media reports, and organizational websites—the survey instrument asked structured questions regarding each program or organization's history, community context, goals, governance structures, collaborations, services and activities, staff, volunteers, funding, and participant characteristics.

The study sample targeted NORC programs and Villages that were providing at least some services to older adults. The sampling frame for NORC programs was developed by obtaining program rosters from the United Hospital Fund's (UHF) Aging in Place Initiative (UHF, 2012a) and the Jewish Federations' National NORCs Aging in Place Initiative (Bedney et al., 2010). Villages were identified through a list on the website of the VtV Network (n.d.). Of the 84 operational NORC programs identified, 62 participated, yielding a response rate of 73.8%. There were 80 operational Villages, of which 69 participated, yielding a response rate of 86.3%. The study's overall response rate was 79.9%.

A representative from each initiative served as the respondent. For Villages, this was typically the executive director or president of the Board of Directors, and for NORC programs, this was typically the program coordinator or director.

Those who agreed to participate were e-mailed a questionnaire to return to the research team prior to an hour-long telephone interview to review their responses and answer any additional questions. Participants were offered a $60 incentive to participate. Because the study focused on organizations as opposed to individuals, it was deemed exempt by the Rutgers University Institutional Review Board.

Measures

We measured focal benefits first by calculating the percentage of initiatives that indicated each of the following as their most important goal: (a) strengthening older adults' social relationships and reducing social isolation, (b) promoting older adults' contributions to their community, (c) promoting older adults' access to services, and (d) helping the general community to become more aging friendly. We further asked respondents to report whether each of 25 specific types of services and activities was provided to participants in the last year by staff, by older adult members, by other community volunteers, and/or through referrals. Participants could indicate more than one provider category for each type of service. We first summed the total number of services provided and then calculated the percentage of Villages and NORC programs that had offered each type of service through any mode of delivery. Table 1 lists the individual types of services.

We assessed types of beneficiaries using measures of the service environment and participant characteristics. We measured the type of service environment by asking respondents to indicate whether the primary service area for their initiative was (a) a single apartment building or group of apartment buildings, (b) a neighborhood or section of a town or city, (c) a single town or city, (d) more than one entire town or city but not an entire county, or (e) an entire county or more. Respondents were also asked to describe the composition of the initiative's primary service area as either (a) low income, (b) low to middle income, (c) middle income, (d) middle to high or high income, or (e) other (which respondents specified as "mixed"). We measured intended age group of beneficiaries by asking whether the initiative aimed to serve adults of all age groups, adults aged 50 and older, 55 and older, 60 and older, 65 and older, or another age group. Respondents reported actual beneficiary ages by indicating the percentage of participants aged 49 or younger, 50-64, 65-74, 75-84, and 85 and older. We further asked respondents what percentage of participants were (a) impoverished (i.e., likely eligible for Medicaid or food stamps) and (b) economically vulnerable (i.e., likely not eligible for Medicaid or food stamps but without enough resources to manage in an emergency, such as a major home repair). Finally, we asked respondents to estimate the percentage of participants needing assistance on a regular basis with (a) household chores and (b) personal care (e.g., bathing, dressing).

Four measures assessed modes of service delivery: the percentage of all types of services provided by staff, the percentage of service types provided by older adult participants, the percentage of service types provided by other community volunteers, and the percentage of service types provided through referrals to discounted providers. We also assessed the number of paid and unpaid staff. The latter was defined as people who were not paid but who held a specific title within the organization other than general volunteer.

We measured sources of funding by asking respondents to estimate the percent of their total budget for the most recently completed fiscal year from each of the following sources: membership dues, government grants and contracts, private foundations and corporations, parent organization (if applicable), other nonprofit organizations, and fund-raising or charitable donations. Respondents were instructed not to include the dollar equivalence of in-kind contributions in budget estimates.

Data Analytic Strategy

We calculated descriptive statistics for the total sample, as well as for Villages and NORC programs separately. We examined differences between Villages and NORC programs using chi-square tests for categorical measures and independent samples *t* tests for continuous measures. Because missing data on any given measure was no more than 10% of the sample, we used listwise deletion to address missing data.

Results

What Benefits Are Offered

Table 1 presents the benefits and services offered by Villages and NORC programs. First, most Villages and NORC programs similarly identified

Table 1. Focal Benefits and Services Provided by Villages and Naturally Occurring Retirement Community (NORC) Programs

	Total	Villages	NORC programs	χ^2 or t statistic test[a]
Primary goal				
Enhance access to services	67.94	71.01	65.57	
Reduce social isolation	27.48	24.64	29.51	
Promote older adults' civic engagement	2.29	2.90	1.64	1.17
Enhance overall age friendliness	2.29	1.45	3.28	
Mean number of types of services[b]	17.49 (4.61)	15.64 (4.60)	19.59 (3.64)	6.01***
Access services[c]				
Central telephone number	96.95	98.55	95.16	1.27
24/7 helpline	29.77	28.99	30.65	0.04
Assistance with activities[c]				
Transportation	93.89	98.55	88.71	5.52*
Technology support	82.44	90.14	72.58	7.91**
House cleaning	81.68	81.16	82.26	.03
Home maintenance or repair	79.39	97.10	59.68	27.95***
Grocery shopping	78.63	81.16	75.81	0.56
Home-delivered meals	73.28	59.42	88.71	14.31***
Congregate meals	50.77	33.33	70.49	17.89***
Healthcare and health promotion[c]				
Group exercise	82.44	72.46	93.55	10.03***
Health care advocacy	72.52	57.97	88.71	15.48***
Health education and promotion	72.52	53.62	93.55	26.12***
Preventive health services	67.18	39.13	98.39	52.00***
Other medical services	63.36	47.83	80.65	15.15***
Social services[c]				
Professional coordination of services	87.02	76.81	98.39	13.46***
Financial services	64.89	57.97	72.58	3.08†
Benefits counseling	69.47	44.93	96.77	41.39***
Legal services	67.94	55.07	82.26	11.08***
Mental health counseling	61.83	36.23	90.32	40.49***
Employment placement	24.43	4.35	46.77	31.84***
Socialization and civic engagement activities[c]				
Recreational activities	95.42	92.75	98.39	2.37
Volunteer opportunities	88.55	85.51	91.94	1.33
Friendly visitors	83.97	86.96	80.65	0.97
Reassurance calls	82.44	82.67	82.26	0.00

Notes: Data are from a sample of 62 NORC programs and 69 Villages.
[a]Test of statistically significant differences between Villages and NORC programs.
[b]Range = 0–25.
[c]Mean percentage that offered the service either directly (i.e., through volunteers and/or staff) and/or through referrals).
†$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$ (two tailed).

promoting older adults' access to services as their most important goal (71.01% of Villages and 65.57% of NORC programs). The second most commonly identified goal among Villages and NORC programs alike was strengthening older adults' social relationships and reducing social isolation (24.64% of Villages and 29.51% of NORC programs).

Regarding types of services provided, Villages reported facilitating 15.64 types of services on average and NORC programs reported facilitating a mean of 19.59 types. We found no differences between NORC programs and Villages in their provision of access services or socialization and civic engagement activities. However, Villages were more likely to provide assistance with some types of activities—specifically transportation, technology assistance, and home maintenance or repair—whereas NORC programs were more likely to provide assistance with home-delivered meals and congregate meals. Moreover, NORC programs were more likely to offer all types of health care and health promotion activities, as well as social services.

To Whom Benefits are Offered

As shown in Table 2, there were significant differences between the models by types of service environment. NORC programs were most likely located in apartment buildings (45.16%), although a sizeable percentage (40.32%) was in neighborhoods or sections of towns or cities. Villages were most likely located in larger catchment areas, with the largest proportion (39.13%) in more than one town or city. Also, according to respondent self-report, NORC programs were more likely than Villages to be in communities whose predominant socioeconomic status (SES) was low (25.81%), low to middle (35.48%), or middle (32.26%), whereas Villages reported greater likelihood of operating in communities whose predominant SES was middle (20.59%) or middle to high or high (57.38%).

Table 2 also presents findings regarding beneficiary characteristics. The intended age of beneficiaries for most NORC programs (91.94%) was 60 and older. The intended age of beneficiaries among Villages was more mixed and generally younger, with 50 and older as the modal response (33.78%). In terms of the actual reported ages of beneficiaries, Villages were more likely to serve adults aged 65-74, whereas NORC programs were more likely to serve adults aged 85 and older. Consistent differences were found in terms of the economic and health status, with NORC programs reporting a greater percentage of participants as impoverished, economically insecure, needing help

Table 2. Service Environments and Participant Characteristics of Villages and Naturally Occurring Retirement Community (NORC) Programs

	Total	Villages	NORC programs	χ^2 or t statistic test[a]
Mean percentage indicating each type of catchment area				
Apartment building(s)	21.37	0.00	45.16	
Neighborhood	33.35	28.99	40.32	
Single town or city	12.98	18.84	6.45	56.76***
More than one entire town	22.90	39.13	4.84	
Entire county or more	8.40	13.04	3.23	
Mean percentage indicating each socioeconomic setting of catchment area				
Low	13.08	1.47	25.81	
Low to middle	25.38	16.77	35.48	49.24***
Middle	26.15	20.59	32.26	
Middle to high or high	29.23	51.47	4.39	
Other (mixed)	6.15	10.29	1.61	
Mean percentage indicating each intended age group				
People of all ages	5.34	10.14	0.00	
50 and older	18.32	33.78	0.00	
55 and older	16.03	27.54	3.23	
60 and older	51.15	14.49	91.94	82.09***
65 and older	6.12	7.25	4.84	
Other age group	3.05	5.80	0.00	
Mean percentage of participants' ages				
Younger than 50	1.26 (8.90)	0.50 (16.65)	0.49 (1.42)	–0.03
50-64	8.39 (9.20)	9.13 (10.81)	7.55 (6.90)	–0.98
65-74	30.08 (18.38)	32.30 (18.56)	25.93 (15.49)	–2.09*
75-84	39.71 (16.11)	39.63 (17.72)	39.80 (14.17)	0.06
85 and older	23.39 (18.49)	18.44 (15.53)	27.48 (18.03)	3.06**
Mean percentage of participants' financial status				
Impoverished	24.24 (31.17)	12.43 (26.86)	37.52 (30.64)	4.77***
Economically insecure	22.17 (25.53)	12.17 (18.95)	27.44 (3.57)	4.67***
Mean percentage of participants' functional health				
Need assistance with chores	32.03 (27.22)	23.52 (28.92)	41.75 (21.55)	3.87***
Need assistance with personal care	19.26 (23.26)	13.84 (26.44)	25.26 (17.49)	2.76**

Notes: Standard deviations are reported in parentheses. Data are from a sample of 62 NORC programs and 69 Villages.
[a]Test of statistically significant differences between Villages and NORC programs.
*$p < .05$. **$p < .01$. ***$p < .001$ (two tailed).

with household chores, and needing help with personal care than Villages.

How Benefits are Delivered

As shown in Table 3, NORC programs were more likely to use staff to provide services than Villages: 58.16% of services provided by NORC programs had been offered by organizational staff in the past year, in contrast to 29.31% of service types among Villages. In contrast, 45.69% of service types provided by Villages had been offered by older member volunteers in the past year compared with 14.07% among NORC programs. Villages also were more likely to report using community volunteers. Approximately 27.55% of service types provided by Villages had been offered by community volunteers in the past year, in contrast to 18.22% among NORC programs. NORC programs also reported a greater number of paid staff, whereas Villages reported a greater number of unpaid staff. We found no differences in the average percentage of service types referred to discounted providers.

How Benefits are Funded

Table 4 presents findings regarding sources of funding among Villages and NORC programs. Membership dues comprised a much larger average percentage of the budgets of Villages (47.80%) than of NORC programs (1.52%). In contrast, government grants and contracts comprised a bigger percentage of NORC programs' budgets (64.72%) than Villages' (2.38%).

NORC programs also received a greater percentage of funds from a parent organization, whereas Villages received a greater percentage of funds from fund-raising and charitable donations.

Discussion

Guided by a multidimensional framework for analyzing social welfare policies and programs (Gilbert & Terrell, 2005), this study examined the implementation of NORC and Villages program models and their similarities and differences. Findings indicated that NORC programs and

Table 3. Predominant Modes of Service Delivery Among Villages and Naturally Occurring Retirement Community (NORC) Programs

	Total	Villages	NORC programs	*t* statistic test[a]
Mean percentage of types of services provided through				
Organizational staff	42.58 (23.76)	28.80 (20.14)	58.16 (17.00)	8.92***
Older adult volunteers	30.85 (27.08)	45.69 (27.58)	14.07 (13.24)	−8.16***
Other community volunteers	23.17 (21.93)	27.55 (24.61)	18.22 (17.35)	−2.47*
Referral to discounted providers	25.96 (21.59)	27.80 (20.66)	23.88 (22.59)	−1.03
Average number of[b]				
Paid staff	2.79 (1.70)	1.73 (1.34)	3.97 (1.21)	9.81***
Unpaid staff	0.53 (1.18)	0.89 (1.48)	0.15 (0.48)	−3.64***

Notes: Standard deviations are reported in parentheses. Data are from a sample of 62 NORC programs and 69 Villages.
[a]Test of statistically significant differences between Villages and NORC programs.
[b]Respondents were asked to list up to five staff persons total.
**$p < .01$. ***$p < .001$ (two tailed).

Table 4. Mean Percentage of Budget From Various Sources Among Villages and Naturally Occurring Retirement Community (NORC) Programs

	Total	Villages	NORC programs	*t* statistic test[a]
Membership dues	25.40 (31.84)	47.80 (30.01)	1.52 (5.35)	−11.86***
Government grants and contracts	32.56 (38.39)	2.38 (9.62)	64.72 (30.56)	15.64***
Private foundations and corporations	11.98 (20.52)	11.48 (18.02)	12.51 (23.03)	0.31
Parent organization	7.43 (17.14)	4.27 (15.68)	10.85 (18.11)	2.19*
Other nonprofit organization	4.36 (13.27)	5.15 (15.68)	3.51 (10.16)	−0.69
Fund-raising and charitable donations	14.35 (19.54)	25.45 (21.34)	2.49 (5.84)	−8.11***

Notes: Standard deviations are reported in parentheses. Data are from a sample of 62 NORC programs and 69 Villages.
[a]Test of statistically significant differences between Villages and NORC programs.
*$p < .05$. ***$p < .001$ (two tailed).

Villages both strive to promote older adults' aging in place by facilitating access to a diverse range of services and strengthening social supports. At the same time, results demonstrated consistent differences in the methods used by NORC programs and Villages for achieving these goals, as well as the populations likely to benefit from their efforts.

Villages

The Village model was developed initially by and for residents of Boston's relatively affluent Beacon Hill neighborhood who had the social and economic resources to create and sustain a new freestanding membership organization (McWhinney-Morse, 2009). Because the model depends on consumer involvement, it is not surprising that BHV and subsequent Villages tend to include persons who are younger, who are less functionally impaired, who are more economically secure, and who reside in communities whose predominant SES is middle class or higher. Higher levels of discretionary time and resources likely enable participants to take a more active role in overseeing operations, providing peer support services, and financing the organization. Perhaps because Village membership tends to require greater personal involvement and attract members with higher functional capacities, services more consistently focus on socialization and service access rather than on more intensive health and social services. As a consequence, Villages, on average, do not currently seem to require high levels of resource inputs from formal sources, such as paid staff and government subsidies.

Findings suggest that implementation of the Village concept varies somewhat from the original model. Although the model was originally developed to serve a neighborhood, less than one third of the Villages in this national sample reported targeting such a small area, with the majority serving an entire town, multiple cities and towns, or an entire county. This raises questions regarding the ability of Villages to facilitate members' involvement and foster social connections across a large geographic region. In addition, although Villages target persons aged 50 and older, nearly all members are aged 65 or older. Furthermore, fewer than half of service types are provided by member volunteers, in contrast to the peer support model of members helping members. Although nearly all Villages offer a central telephone number, less than one third are available all the time, in contrast to the idea of providing assistance whenever needed. Therefore, it appears that there is substantial variation in the implementation of the Village model and that many Villages differ from the original BHV. It is unclear how these variations affect the ability of Villages to meet their goals, such as helping members age in place.

Our findings also prompt potential concerns regarding the inclusiveness and long-term sustainability of the Village model as currently implemented. Given the model's heavy reliance on consumer social and economic resources, Villages may be challenged to provide more intensive health and social services as their members' age and experience increasing levels of functional impairment, although the involvement of community volunteers might help to compensate for declines in member participation. Heavy reliance on member financial and nonfinancial resources also might expose Villages to potential economic vulnerability as members' resources decline with age, requiring increased dependence on external sources of economic support. Villages' emphasis on volunteers also might limit access to professional knowledge and expertise in critical areas, such as organizational development, service provision, and financial management. Finally, social and economic demands on members, in the context of an organizational culture that values autonomy and consumerism, might make it difficult for Villages to engage individuals with limited discretionary time and money. Given these challenges, sustainability and expansion of the Village model might require additional community volunteer involvement and collaborations with other governmental and nongovernmental entities. It remains a question whether Villages can retain their unique consumer-engaged program model if they pursue such inputs from other entities.

NORC Programs

In contrast to Villages, the NORC program model was initially developed in an apartment complex in New York City in response to age-related challenges that threatened older adults' ability to age in place (Altman, 2006). Consistent with the original focus of the model, NORC programs in this study were more likely to include individuals who were older, more functionally impaired, less economically secure, and living in communities predominantly middle class or lower. Fitting with this focus on more vulnerable older adults, NORC programs more consistently than Villages reported providing traditional health and social services,

involving a greater number of paid staff, utilizing staff more frequently as providers of services, and relying more on government funding.

Specifically, findings indicated that approximately one quarter of NORC program participants needed help with personal care and two fifths were likely eligible for Medicaid or nutrition assistance programs. These results indicate that NORC programs serve older adults at more immediate risk for not being able to age in place. It is important to interpret these results in light of the fact that the NORC program model was not designed to serve exclusively vulnerable older adults. In fact, an innovative feature of the model—relative to other aging services, programs, and policies—is serving older adults based on residence and age as opposed to economic or functional requirements (Vladeck, 2004). Nevertheless, it appears that other key features of the program model—such as NORC programs' being connected to existing service delivery systems, being led by a parent organization with paid professionals, garnering support from government grants and contracts, and explicitly emphasizing the provision of health and social services (Bedney et al., 2010; Ormond et al., 2004)—makes NORC programs especially well suited to accommodate the needs of more vulnerable older adults. Previous studies have found that many of the services more consistently provided by NORC programs are especially likely to benefit older adults with greatest needs, such as professional coordination of services (Peikes, Chen, Schore, & Brown, 2009), health education and promotion (Lorig & Holman, 2003), and mental health services (Akincigil et al., 2012). Group activities, which both NORC program and Villages consistently offered, are also likely to benefit more vulnerable older adults, such as those who are socially isolated (Findlay, 2003).

Despite promising features of NORC programs for benefiting community-residing older adults with various levels of needs, these very features also suggest challenges to further implement and sustain the program model. First, NORC programs' predominant source of funding was from government grants and contracts. On average, two thirds of NORC programs' budgets reportedly came from this source (whereas the largest budget source for Villages—membership fees—was an average of about half of their budgets). Findings from previous research suggest that initiatives with diversified funding, including government, private donations, and nonprofit organizations, are more financially secure than organizations dependent on a single source (Crittenden, 2000). Especially in an era of limited government support for community-based aging services and as a federal demonstration program for NORC programs ended in 2010 (Greenfield, in press), it likely will be a continued challenge to garner major supports from government sources. Furthermore, NORC programs' greater inclusion of older adults with acute needs suggests difficulties in garnering significant additional financial support from older adults themselves. NORC programs are challenged to find diverse sources of support—such as in-kind contributions from partnering service organizations and greater efficiencies in-service delivery processes—as well as to engage in social entrepreneurship whereby governments, nonprofits, and businesses employ enterprising strategies to address major social problems (Light, 2006).

NORC programs' inclusion of more vulnerable older adults suggests another challenge: utilizing older adults as initiative leaders and partners. Although the NORC program model, similar to that of Villages, emphasizes older adults' involvement beyond the traditional role as service recipient (Vladeck, 2004), results of the present and prior studies (Anetzberger, 2010) suggest that this is among the more challenging aspects of the NORC program model to implement. Although we found that nearly half of all types of services provided by Villages were provided by older adults themselves, only 14% of service types provided by NORC programs were provided by older adults. Although NORC programs were more likely to provide health and social services than Villages, which likely require more formally trained professionals, there is evidence that with adequate support, some of these services could be provided by older adult volunteers, such as health care advocacy (Pope, 2012) and health promotion (Dossa & Capitman, 2011). Barriers to facilitating older adults' volunteerism and other forms of civic engagement within NORC programs potentially include their reliance on paid staff who are likely more oriented to older adults' vulnerabilities relative to strengths and the programs' greater inclusion of more vulnerable older adults (who are least likely to be perceived as potential contributors; Anderson & Dabelko-Schoeny, 2010).

Study Limitations and Directions for Future Research

This study has a number of limitations that are important for future research to address. First, this

study was guided by a framework for comparing NORC programs and Villages that highlighted particular dimensions that do not reflect all relevant aspects of the models. For example, this study did not examine Villages' and NORC programs' organizational history (e.g., how the initiatives started) and how they potentially advance broader community change efforts.

Second, all measures were gathered through organizational representatives' self-reports. Additional studies are necessary to employ other data collection strategies to triangulate the validity of the measures. For example, administrative records regarding budgets—including in-kind contributions, the designation of matching funds, and the types of outside organizations providing support (e.g., publically funded social service agencies)—would provide better understanding of the initiatives' financial information and interorganizational collaborations. Furthermore, this study only examined whether particular types of services were offered at all; additional studies using utilization records would help indicate how frequently particular types of services are made to older adults. Also, studies that incorporate U.S. census data and geospatial coding would provide more information to compare types of communities served by Villages and NORC programs, especially in relation to SES. Data from this study are limited in that they provide respondent estimates of service area demographics. Because many programs do not collect or maintain records on participant incomes, the study was not able to compare the service area SES to that of actual program participants. This is an important area for future studies to understand whether diverse segments of the service area population are accessing these initiatives.

Also, this study focused on Villages and NORC programs in the aggregate. There is likely meaningful variation from one NORC program to another NORC program, as well as from one Village to another Village. For example, NORC programs in New York likely differ in some ways from NORC programs nationally, given different organizations overseeing their development (Bedney et al., 2010; UHF, 2012a), as well as distinct public policies defining the programs and eligibility criteria (House of Representatives (H.R.) Report No. 111–220, 2010.; UHF, 2012b). This was not a focus of this study due to space limitations. It is also important for future research to consider hybrid models whereby organizations incorporate predominant characteristics of both models (e.g., relying heavily on membership fees, such as Villages, but offering extensive health and social services, such as NORC programs). Furthermore, this study examined the implementation of Villages and NORC programs at a single point in time. Therefore, we are unable to determine whether the differences observed reflect persistent differences between the models or whether they reflect each model's stage of organizational development. The NORC program model was developed more than a decade before the Village model, and longitudinal research is needed to consider whether our findings will persist over time. For example, as Villages members advance into later life, they might need to turn to more external sources of funding—such as government grants—to offer more costly professional services for an older membership. Additionally, despite the study's overall excellent response rate, there remains the possibility that organizations that participated differ in systematic ways from those that did not, which might bias the representativeness of this study's findings.

Despite these limitations, this study advances understanding of how NORC programs and Villages have been implemented nationally. The study also indicates ways in which NORC programs and Villages differ from each other, such as by their organizational characteristics, types of communities they serve, service delivery strategies, and budget compositions. It is essential for future research to build from this basic understanding to examine the extent to which these features influence key programmatic outcomes, including their effectiveness and long-term sustainability. Advancing such research has implications not only for NORC programs and Villages, but also for other community-based efforts to promote aging in place.

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