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The "Village" Model: A Consumer-Driven Approach for Aging in Place

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Purpose of the Study: This study examines the characteristics of the "Village" model, an innovative consumer-driven approach that aims to promote aging in place through a combination of member supports, service referrals, and consumer engagement. ***Design and Methods:*** Thirty of 42 fully operational Villages completed 2 surveys. One survey examined Villages' member characteristics, membership types, and fee structures. An additional survey collected information about organizational mission, goals, methods of operation, funding sources, challenges, and older adults' roles. ***Results:*** Villages provide a variety of support services designed to help members age in place, meet service needs, and promote health and quality of life. Most Villages operate relatively autonomously, relying primarily on member fees and donations. Village members typically are highly involved in organizational development and oversight and provide services to other members in almost half of the Villages. Members predominantly are aged 65 years or older, White, non-Hispanic, homeowners, and have care needs that are slightly lower than those of the elderly U.S. population overall. ***Implications:*** Villages are a promising model for addressing service needs among middle-class seniors who seek to age in their own homes and communities. Financial sustainability is apt to be a challenge unless Villages secure more stable sources of funding. Organizational sustainability may be promoted through affiliations with social service agencies and other sources of technical and financial assistance. Future evaluation is needed regarding the impact of Villages on elders' ability to age in place as well as the long-term sustainability of the Village model.

Key Words: Access to and utilization of services, Autonomy and self-efficacy, Consumer-directed care, Home- and community-based care and services, Social capital

Nearly all older adults would like to stay in their own homes as they age (Feldman, Oberlink, Simantov, & Gursen, 2004). Currently, 55.4% of older

adults in the United States live with a spouse and 27.4% live alone; 9.8% live with other family members, 2.6% live with other relatives, and 4.9 live in an institutional or group setting, such as a nursing home or assisted living facility (U.S. Bureau of the Census, 2009). Nearly half will enter a nursing home at some time during their lives (Kemper & Murtaugh, 1991), and 20% are likely to die there (Johnson, 2005).

The preference of the majority of older adults to continue to live in familiar environments is captured in the term "aging in place," a contested concept that here refers to the ability to remain in one's residence of choice as one ages, avoiding unwanted relocation associated with age-related personal or environmental limitations (Rowles, 1993). Aging in place is consistent with recent public policy initiatives to promote home- and community-based services (HCBS) in order to reduce nursing home use (Benjamin, Matthias, & Franke, 2000; Carlson, Foster, Dale, & Brown, 2007; Grabowski, 2006). However, such initiatives are directed primarily toward low-income elderly population who are covered by Medicaid or other public programs. Those who do not qualify for Medicaid must rely on private sector services, which can be unaffordable, unavailable, inaccessible, or otherwise inadequate, resulting in unmet assistance needs (Shea et al., 2003; Williams, Lyons, & Rowland, 1997) or social isolation (Portacolone, 2011) for many community-dwelling elderly. This situation has prompted an increasing interest in affordable nongovernmental strategies to support aging in place for seniors who are not eligible for public programs.

One such nongovernmental approach is called the "Village" model. Villages are grassroots organizations that provide community-dwelling older adults with a combination of nonprofessional services, such as transportation, housekeeping, and companionship, as well as referrals to existing community services, sometimes at a reduced rate (NCB Capital Impact, 2009). Villages are similar to Naturally Occurring Retirement Community with Supportive Service Programs (NORC-SSP) and other HCBS in that they help older adults to obtain needed health and social services in order to increase their ability to age in place. However, unlike NORC-SSP and other HCBS models, Villages purportedly are initiated and governed by the consumers they serve rather than community service providers and funded by annual membership dues rather than fees for individual services or grants (Bookman, 2008; Gross, 2006; McWhinney-Morse, 2009; NCB Capital Impact, 2009).

Since the development of Beacon Hill Village in 2001, the Village model has received substantial media attention (Adler, 2009; Festa, 2007; Gleckman, 2010; Green, 2008; Gross, 2006, 2007). By early 2011, there were at least 60 operational Villages in the United States and at least 90 more in some stage of development (Village-to-Village Network, 2011). A Village-to-Village Network has been developed to support Village development, and there is at least one active electronic mailing list of Village organizations.

Despite the proliferation of the Village model, there have been no national examinations of its implementation, effectiveness, or population served. Questions have been raised as to whether the Village approach represents a widely replicable model and whether it has the potential for meeting the needs of culturally and economically diverse seniors (Gross, 2007). Moreover, given its similarities to other HCBS models, it is unclear whether Villages truly represent a new organizational field in the domain of aging services.

This study examines the distinctive characteristics of the Village model as it is actually implemented throughout the United States, including Villages' goals, organizational structures, and membership composition. In so doing, this research not only describes this innovative HCBS model and its implementation but also lays important groundwork for future studies of model sustainability and effectiveness.

Without this essential base of understanding, it is almost impossible to examine empirically the model's efficacy or effectiveness or to understand its potential impact on participants' health, well-being, or ability to age in place.

In considering organizational characteristics of the Village model that may have relevance for Village sustainability and effectiveness, we gave particular attention to four key factors identified by institutional theory (Greenwood & Hinings, 1993; Scott, 1987) and resource dependency theory (Pfeffer & Salancik, 1978): (a) mission; (b) organizational structure and methods of operation for achieving this mission; (c) resources; and, (d) interorganizational affiliations. Institutional theory suggests that Villages' missions are apt to be embodied in their formal mission statements and organizational goals, whereas their methods of operation for achieving those missions are apt to reflect the various approaches identified in the community practice literature, including data collection, interorganizational collaboration,

planning, peer support networks, service provision, community education, and advocacy (Weil & Gamble, 2005). Resource dependency theory suggests that access to human, economic, and interorganizational resources are important factors affecting organizational development and evolution (Pfeffer & Salancik, 1978). Primary Village resources include members and membership fees as well as their affiliations and collaborations with other community organizations. Examining these organizational characteristics and related operational challenges is essential for understanding the Village model, including its potential sustainability and effectiveness.

Methods

Sample

Fifty-one existing Villages in the United States were identified in consultation with Beacon Hill Village and the Village-to-Village Network in March 2010. Nine were found not to be fully operational (i.e., they had not yet enrolled members or were not yet providing services). Of the remaining 42 Villages, 30 completed both of the study's surveys, resulting in a final response rate of 71%.

Data Collection

Two brief surveys were emailed to Village directors between April 1, 2010 and November 30, 2010. The first survey collected basic demographic information about Village membership, including age, gender, race, ethnicity, living arrangements, home ownership, and need for assistance, as well as membership categories and associated annual member fees. The second survey, part of a larger study of aging-friendly initiatives (CASAS, 2010), used fixed-choice questions to gather data on organizational characteristics such as (a) the extent of elder involvement in various aspects of village development, oversight, and service delivery; (b) primary and secondary sources of funding; and (c) the extent to which specific methods were used for achieving goals. The survey also included open-ended questions asking respondents to describe the Village's organizational mission or vision, up to five specific goals or objectives and up to three challenges or barriers they have encountered. Village websites were also consulted when necessary to clarify information about organizational characteristics.

Analysis

Data analysis focused on describing the characteristics of the participating Village implementation sites, including organizational mission, goals, challenges, methods of operation, economic resources, interorganizational affiliations, member participation, and member characteristics. Quantitative data from the two surveys were merged, and descriptive analyses were conducted using SPSS. Member characteristics were calculated by summing the total number of members with each characteristic across all responding Villages as a percentage of the total number of members of those Villages. Content analysis of open-ended responses was conducted in two phases. The project team developed an initial list of relevant codes, which one researcher used to code all open-ended responses, and then the research team reviewed this coding. Through an iterative process, new codes were added as themes emerged, and codes were merged to achieve parsimony. The final code list was then used by one researcher to code the data a final time. Codes are reported as "themes" in the results when they appeared in at least 25% of the Villages' responses.

Results

Mission and Goals of Villages

Respondents were asked to describe their Village's mission or vision as well as up to five specific goals or objectives. Because of substantial overlap in the themes that emerged from the responses to these two questions, the researchers merged mission and goals data for analysis. This analysis resulted in 12 codes for mission and goals: aging in place (e.g., helping members live in their own homes or apartments as long as possible), serving seniors/older adults (e.g., focusing specifically on serving seniors or older adults), independence (e.g., promoting independence and/or autonomy among members), quality of life/well-being (e.g., promoting well-being or quality of life among members), assessment (e.g., conducting assessments of members), information (e.g., providing members with information or linking to information sources), services (e.g., providing services or linking members to existing services), safety (e.g., using home assessments or education to promote safer environments for members), confidence/empower (e.g., promoting confidence, peace of mind, or empowering members), engage

(e.g., the initiative is consumer driven or seeks to engage seniors in either the village or the community), low income (e.g., providing services to or recruiting more low-income members), and volunteer (e.g., using volunteers to provide services or organizational support). Eight of these codes emerged as predominant "themes," appearing in responses of at least 25% of the Villages.

Almost all the Villages (93.3%) reported that promoting aging in place was a primary mission or goal:

> [We are a] consumer-driven, membership organization that helps people 50 and over stay in their homes and the neighborhood that they love.

Providing or referring services to members (86.7%); improving members' health, well-being, or quality of life (66.7%); and empowering or increasing the confidence of members (46.7%) were also identified by many Villages as a primary mission or goal:

> [We] provide programs and services to seniors to help them feel confident about staying in their own homes.
> [Our mission] is to provide individualized services to help older adults remain in their own homes, safely, securely and with confidence and a high quality of life.

Promoting elder involvement was also a mission/goal of approximately half (46.7%) of Villages:

> [Our goal is] to provide opportunities for members to participate in the growth and development of the organization so it addresses the interests and needs of the membership.

Other common themes included providing information (30%), volunteer support (26.7%), and creating partnerships with other organizations (26.7%).

Challenges and Barriers Faced by Villages

Villages also were asked to describe up to three challenges or barriers they have encountered. After examination of the data, five codes were developed including organizational development (challenges developing the internal infrastructure, including recruiting volunteers, staff, or board members); funding (challenges obtaining funding for Villages citing the poor economic climate or difficulty obtaining grants); recruitment (challenges with outreach/recruitment of members, engaging seniors, and overcoming resistance to paying dues); community barriers (challenges with geography or community/political infrastructure); and diversity (challenges recruiting lower income or more racially or ethnically diverse members). Three of these codes emerged as primary "themes," appearing in responses of at least 50% of the Villages.

The most common challenge, cited by 83.3% of respondents, was difficulty recruiting new members. Some of the difficulty was attributed to the newness of the Village concept:

> Biggest challenge is to get people to understand what it is—messaging.

Other Villages attributed difficulty recruiting members to resistance to paying dues:

> Recruiting members is a challenge. Our dues are $XXX per year and that's a lot for this area. So we have a challenge educating seniors about the value of the Village.

Other Villages attributed difficulty recruiting members to older adults' resistance to admitting they needed help:

> People over X age don't feel like they need help. Many survived the Depression era, so they feel like they need to be in control. 'I'm not ready yet' is common.

Two thirds of Villages (66.7%) indicated that obtaining funding was a major challenge:

> The final challenge is to find ways of raising funds so that along with a modest membership fee, we can sustain our program.
> Search for funding beyond membership dollars - especially difficult in a down economy.

About one half of Villages (53.3%) said that growing the organization, including recruiting staff, volunteers, vendors and recruiting board members, was a challenge:

> [Our biggest challenges are] getting enough drivers for ride requests and getting enough home visitors for the homebound.
> . . . funding a position to handle incoming requests.

Organizational Approach

The survey asked respondents to rate the extent to which their Village used various methods to achieve organizational goals. As shown in Table 1, the primary method used most often was service provision (46.4%), followed by peer support

Table 1. Organizational Approach ($N = 30$)

Methods of achieving goals	Not used, *n* (%)	Used, but not primary, *n* (%)	Primary method, *n* (%)
Data collection process (e.g., conducting surveys, focus groups, and other research methods, resulting in a comprehensive description of the needs of seniors in a particular geographic area)	2 (6.7)	24 (80)	4 (13.3)
Interorganizational collaboration (e.g., helping various community organizations and/or government agencies to work together in new ways)	2 (6.7)	24 (80)	4 (13.3)
Planning (e.g., producing a plan that identifies community needs and recommendations for meeting those needs)	3 (10)	24 (80)	3 (10)
Peer support networks[a] (e.g., organizing individual community members to assist one another)	5 (17.2)	17 (58.6)	7 (24.1)
Service provision[b] (e.g., providing various kinds of home- and community-based support services to disabled seniors)	4 (14.2)	11 (39.3)	13 (46.4)
Community education (e.g., public awareness campaigns regarding the needs of seniors)	8 (26.7)	16 (53.3)	6 (20)
Advocacy (e.g., organizing community members to take assertive action to influence policymakers)	14 (46.7)	13 (43.3)	3 (10)

Notes: [a]$n = 29$, one missing.
[b]$n = 28$, two missing.

networks (24.1%), community education (20%), data collection (13.3%), interorganizational collaboration (13.3%), planning (10%), and advocacy (10%).

Organizational Resources

Funding Sources.—As shown in Table 2, all but two Villages (93.3%) reported receiving at least some funding from member fees; 80% reported receiving gifts; 56.5% reported receiving grants; and 20% reported some funding from either federal, state, or local government. The most common primary funding sources were member fees (40%) and gifts (37%), with grants a primary funding source for 13% of Villages and government sources a primary funding source for only 10%.

Membership Fees.—As shown in Table 3, 27 Villages (90%) offered the option of both an individual and a household membership, whereas two Villages offered only household memberships and one offered only individual memberships. Of all Village memberships, 51% were for individuals and 49% were for households. Annual dues for individual memberships ranged from $35 to $900, with a median of $425, whereas household memberships cost between $75 and $1,200 a year, with a median of $625.

Slightly more than half (53%) of Villages offered a discounted membership, at a reduced annual fee ranging from zero to $150, with a median of $100. About one in six members (16.2%) in those Villages received the discount, representing 9.2% of all Village members in this study. The annual income cutoff for an individual discounted membership varied from a low of $16,000 up to $54,000, with a median of $40,000. Six Villages did not have a specific income cutoff but rather evaluated the need for a discounted membership on a case-by-case basis.

Table 2. Village Funding Sources ($N = 30$)

	No funding, *n* (%)	Some funding, *n* (%)	Primary funding source, *n* (%)
Member fees	2 (6.7)	16 (53.3)	12 (40)
Gifts	6 (20)	13 (43)	11 (37)
Grants	13 (43.5)	13 (43.5)	4 (13)
Government	24 (80)	3 (10)	3 (10)

Consumer Involvement.—Villages were asked to report the extent of elder involvement in various aspects of Village operations. As shown in Table 4, the majority of Villages reported that older adults were highly involved in receiving services (90%), providing input regarding organizational development (86.7%), participating in the process of developing the initiative (83.3%), or providing oversight or guidance (76.7%). Almost half (46.7%) of the Villages reported that older adults were highly involved in providing services or support to other members.

Table 3. Membership Types and Costs ($N = 30$)

Annual memberships	Villages offering type of membership, *n* (%)	Lowest cost	Median cost	Highest cost
Individual	28 (93.3)	35	425	900
Household	29 (96.6)	75	625	1200
Discounted	16 (53.3)	0	100	150
Discounted income cutoff				
$16,000–$30,000	4 (13.3)			
$30,000–$40,000	3 (10)			
$40,000–$54,000	3 (10)			
Other (e.g., case-by-case basis)	6 (20)			

Organizational Affiliations.—Analysis of survey responses with additional website review revealed that almost three quarters (73%) of the Villages in the study were freestanding, whereas about one quarter (27%) were affiliated with, or a subsidiary of, another agency. Of the eight Villages that were affiliated with other agencies, four were membership options for preestablished social services agencies, two were membership options developed by a residential care facility or continuing care retirement community, one was sponsored by a community foundation, and one was sponsored by a county office on aging.

Member Characteristics

Number of Members.—Villages reported a median of 105 members, but the number varied widely from a low of 8 to a high of 476 members.

Age Range.—As shown in Table 5, individuals aged 65 years and older constituted slightly more than 90% of the membership in the 28 Villages that reported members' ages. Nearly 10% of Village members were between the ages of 50 and 64 years, and less than 1% was aged 49 years or younger.

Target Population.—Although Villages tended to serve older adults, many were open to middle-aged adults as well. One half of Villages indicated that individuals aged 50 years and older were their target population, 7% targeted persons aged 60 years and older, approximately 30% targeted persons aged 65 years and older, 10% targeted persons 75 years and older, and one Village had no age restrictions.

Gender.—Among the 29 Villages reporting the gender of their members, females outnumbered males from 65% to 35%, a slightly higher female sex ratio than found in the U.S. population aged 65 years and older (i.e., 59% female and 41% male; He, Sengupta, Velkoff, & DeBarros, 2005).

Race/Ethnicity.—Of the 27 Villages that reported race and ethnicity, 95% of Village members were White, 2% were Black or African-American, less than 1% was Asian, less than 1% was Latino or Hispanic, and 1.3% were of another race or ethnicity. Village membership comprised more individuals who are White compared with the U.S. population aged 65 years and older, which is 83% White, 8% African-American, 3% Asian, and 6% Hispanic (He et al., 2005). Three Villages in this study reported memberships that were at least 15% non-White, with one 60% non-White or Hispanic.

Living Arrangements.—Of the 29 Villages that reported members' living arrangements, nearly all either lived alone (48.4%) or with a spouse or

Table 4. Older Adult Involvement in Villages ($N = 30$)

Role of older adults in initiative	Not involved, *n* (%)	Moderately involved, *n* (%)	Highly involved, *n* (%)
Providing input	0	4 (13.3)	26 (86.7)
Developing the initiative	2 (6.7)	3 (10)	25 (83.3)
Providing oversight or guidance	1 (3.3)	6 (20)	23 (76.7)
Providing services or support	4 (13)	12 (46.7)	14 (46.7)
Recipients of services or support	0	3 (10)	25 (90)

Table 5. Characteristics of Village Members

Age (years, n = 28)	%
49 and younger	0.3
50–64	9.6
65–74	34.9
75–84	35.9
84 and older	19.3
Gender (n = 28)	
Male	35.5
Female	64.5
Ethnicity (n = 27)	
White	95.2
Black	2.0
Latino/Hispanic	0.6
Asian	0.9
Other	1.3
Living arrangements (n = 29)	
Live alone	48.4
Live with spouse or partner	48.7
Live with other relative or nonrelative	3.0
Type of membership (n = 30)	
Individual	50.5
Household	49.3
Discounted	9.2
Home ownership (n = 25)	
Own	87
Rent	13
Need for assistance (n = 23)	
Need assistance with personal care	9.3
Need assistance with household chores	17.1

partner (48.7%), with only approximately 3% living with another relative or nonrelative. Village members were more likely to live alone compared with the overall U.S. elderly population of which 31% live alone, 54% live with a spouse, and 15% with other individuals (He et al., 2005).

Home Ownership.—Of the 25 Villages that reported the home ownership of their members, an overwhelming majority of members (87%) owned their own homes or condos and only 13% rented an apartment or house. Home ownership rates of Village members are slightly higher than that of older adults in the United States of which approximately 80% own their own homes (Callis & Cavenaugh, 2010).

Need for Assistance.—Of the 23 Villages reporting care needs of their members, slightly more than 9% of members were considered to require assistance with personal care and about 17% required assistance with household chores, although 4 Villages reported that more than 25% of their members needed personal care. Village members' care needs appear to be slightly less than those of the elderly U.S. population overall of which an estimated 11.5%–15% have a personal care limitation (Center for Personal Assistance Services, 2009; Redfoot & Houser, 2010) and approximately 20% need assistance with household care and other instrumental activities of daily life (Redfoot & Houser, 2010).

Discussion

Like other HCBS models, Villages aim to help older adults age in place, meet service needs, and promote health and quality of life. But this research confirms that Village organizations differ operationally from other HCBS models in several important ways. First, Villages have a multitiered service consolidation approach that combines service provision with peer support and consumer engagement. Village staff and volunteers provide a variety of nonprofessional support services, such as companionship, homemaking, and transportation, while also referring members to preferred providers for services, which are vetted by the Village and often discounted for members. This multitiered approach seems to combine the characteristics of an information and referral service, a care management approach, an aggregated consumer review list (such as Angie's List), and a collective bargaining association. Although none of these approaches is original in and of itself, the combination of approaches appears to be quite innovative.

Second, members serve as Villages' primary source of fiscal and human resources. The membership-based structure of Villages reflects a cooperative ownership approach that may help to foster a greater sense of community, mutual responsibility, social integration, and community social capital (Ohmer, 2008) while potentially reducing the cost and improving the quality of goods and services through joint purchasing power and increased leverage with suppliers (PolicyLink, 2009). Consumer engagement also serves as an important human resource, with members typically involved in organizational development, ongoing governance, and often service provision. Consumer involvement in community organizations and related volunteer activities has the potential to enhance organizational capacity and improve organizational responsiveness to community needs (Chaskin, 2001; Kubisch et al., 2002) while potentially benefitting those involved through reduced health disparities, better self-rated health, greater perceived self-efficacy, and enhanced psychological

and emotional well-being (Hinterlong, 2006; Hinterlong, Morrow-Howell, & Rozario, 2007; Litwin & Shiovitz-Ezra, 2011; Ohmer, 2008; Tang, Choi, & Morrow-Howell, 2010).

Villages' operational model, emphasizing autonomy and self-reliance, appears to be both a potential strength and a limitation. Almost three fourths of Villages are freestanding entities, with only about one fourth reporting affiliations with existing health or social service providers. Autonomous control provides Villages with flexibility to meet their members' unique needs while potentially attracting seniors who find traditional social service agencies stigmatizing or unresponsive to individual needs and preferences. At the same time, in the absence of strong interorganizational affiliations or connections to the formal aging network, sustainability is an ongoing concern of most Villages.

Potential Challenges

Proliferation.—Although most public HCBS target low-income seniors, the Village model apparently appeals to middle-income seniors who generally do not qualify for means-tested public services. Our study findings suggest that the majority of Village members are White, non-Hispanic, and own their own homes. Though we do not have income data, most Village members apparently have sufficient discretionary incomes to pay up to $900 a year for membership alone, not including the additional cost of services.

Member recruitment is a substantial challenge for many Villages, and it remains to be seen whether or not Villages can recruit and respond to the needs of a more economically diverse senior population. Given that the Village model is predicated on being self-funded, with membership dues and gifts currently serving as Villages' primary funding sources, a well-resourced membership base may be essential for organizational sustainability. Moreover, because Villages depend so heavily on member involvement, elders with reduced physical, cognitive, psychological, or financial capacity may find participation difficult, reflecting limitations associated with some emerging models of consumer engagement (Martinson & Minkler, 2006).

The underrepresentation of African-American, Hispanic, and Asian-Pacific individuals also raises questions about the generalizability of the Village model, especially given increasing racial and ethnic diversity among elders in the United States. It is possible that Villages' individualized consumer-oriented service model may not be culturally consistent for some population groups and that a more family-centered approach developed collaboratively with existing faith-based entities, and cultural organizations may be more appropriate. Villages that have been successful in recruiting and serving a more economically and ethnically diverse mix should be examined more closely to ascertain effective strategies for meeting the needs of diverse populations of older persons.

Sustainability.—One of the major challenges faced by Villages is long-term sustainability. Already, few Villages have closed or abandoned development efforts, and most of the Villages in this study reported challenges related to funding or organizational functioning. Villages rely heavily on unstable funding sources, including membership fees, gifts, and grants, creating continuous pressure to seek or retain members and develop additional sources of external funding.

Consumer-driven organizations such as Villages may lack a fully developed theory of practice for institutionalizing their organizational models as well as adequate technical capacity for carrying out critical operational functions such as organizational development, business planning, senior programming, serving persons with disabilities, and HCBS service delivery and financing systems. Grassroots support organizations (Martinez, 2008) represent a potential mechanism for assisting underresourced community initiatives such as Villages to enhance their human and fiscal capacity, whereas greater interorganizational collaborations may help to enhance organizational stability (Banaszak-Holl, Zinn, & Mor, 1996) as suggested by resource dependency theory.

Inclusion in existing federal and state HCBS public policy provisions ultimately may be necessary if Villages are to achieve organizational stability and serve a more diverse population of seniors. Participation in state Medicaid waivers, for example, would enable Villages to serve low-income older adults who otherwise may be at risk for nursing home placement. Villages also might explicitly be included in Older Americans Act demonstration programs, such as Community Innovations for Aging in Place, and state and local funding could be used to subsidize membership fees for low-income individuals. Federal and state HCBS policies might also prioritize consumer-initiated approaches such as this, building upon the apparent success of

consumer-driven care models, such as Cash and Counseling.

Conclusions

The Village model represents an innovative and potentially promising approach for supporting aging in place among older adults, especially for middle-income seniors who often fall outside the purview of shrinking public programs. The study reported here is an important first step in developing an evidence base regarding the implementation of the Village concept, including the operational characteristics of existing Villages, resources obtained, challenges faced, and populations served. In so doing, this study provides useful insight into the strengths and limitations of this emerging model and its potential significance to local and national efforts to support aging in place.

Our research reveals some distinctive characteristics apparently shared by most existing Villages, including a service consolidation model of operation, reliance on membership dues and other internal resources, substantial consumer involvement, and relative organizational autonomy. However, there also is evidence of substantial variation in the implementation approaches that Villages have adopted. The earliest Village is less than 10 years old, and it may be premature to identify a single "Village model" that reflects the realities of all such efforts. To date, a relatively limited range of older adults have been served, and it remains to be seen whether the Village model can attract and respond to the needs of a more economically and ethnically diverse senior population.

Limitations.—Twelve of the 42 Villages thought to be operational at the time of this study did not participate in all aspects of the research, and their characteristics may differ from those of the 30 included here. Also, member data were provided by Village staff members and may not adequately capture the perspectives of Village members, their actual involvement in organizational functioning, or the perceived benefits and challenges associated with that involvement. It also should be noted that qualitative analyses of themes identified in this study did not include an examination of interrater reliability.

Need for Future Research.—More detailed examinations are needed regarding the operational characteristics of Villages, the services they provide, and the challenges they face in order to provide the necessary foundation for examining the significance and potential impact of this emerging model of HCBS. Next steps also include a more rigorous examination of the 13 mission and vision themes and the five challenge themes identified here. Data also need to be obtained directly from a representative sample of Village members in order to more accurately reflect their characteristics, perceptions, and experiences. Perhaps most importantly, future research needs to examine the efficacy of the Village model itself, preferably through longitudinal studies that track Village members from the time of their initial enrollment, using adequate comparison groups of relatively similar individuals if random assignment is not feasible. Policy makers, funders, Villages, and consumers all stand to benefit from better evidence regarding the sustainability and effectiveness of the Village model, including the ability of Villages to meet members' service needs, enhance their health and well-being, and enable them to age in place.

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