Staying Power: Aging in Community and the Village Model

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Dissertation submitted to the faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirement for the degree of

Doctor of Philosophy
in
Planning, Governance, and Globalization

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January 30, 2017
Blacksburg, VA

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ABSTRACT

The population of adults over age 65 in the United States is expected to reach 89

million by 2050. This population growth will increase demand for aging services at the

local and federal levels. Older adults are remaining in their homes in increasing numbers

and are part of a paradigm shift that is transferring healthcare services from a centralized

institutional model to a decentralized home-based model. However, a majority of homes

older adults reside in lack basic accessibility features and are in predominantly suburban

locations that have limited transportation options. Villages, a multi-faceted aging support

program, were established to address limitations encountered by older adults as they age

in their homes and communities. These volunteer-based, membership organizations are

becoming a popular and rapidly adopted community-based intervention, but research on

Villages has been limited. The purpose of this qualitative case study was to examine how

two groups of older adults living in a suburban Naturally Occurring Retirement

Community (NORC) aged in community. One group belonged to a Village and the other

did not. The theory of residential normalcy provided the theoretical framework for

examining how the older adults adapted to their environments through service use and

support. Data analysis from interviews revealed four themes: access to information

among the Village members and nonmembers; the role of social networks; useful services

when aging in community; and the importance of trusted guidance as provided by the

Village director. Because Village members have access to additional and consistent

support sources, they may be better able maintain residential normalcy and therefore age

in community longer and more safely than non-members.

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GENERAL AUDIENCE ABSTRACT

Citizens in the United States have been increasingly establishing Villages, a multi-faceted aging support program, to address limitations encountered by older adults as they age in Naturally Occurring Retirement Communities (NORCs). These volunteer-based, membership organizations are becoming a popular and rapidly adopted community-based interventions, but research on Villages has been limited. The purpose of this qualitative case study was to examine how two groups of older adults living in suburban neighborhoods aged in community. One group belonged to a Village and the other did not. Data analysis from interviews revealed that older adults who belonged to the Village may be better able to adapt to aging in their homes and communities, due to the supportive services the Village offered such as access to aging-related information, transportation, and trusted guidance as provided by the Village director.

ACKNOWLEDGEMENTS

I would first like to thank my committee chair, Dr. James Bohland for his continued guidance, support, and positive energy through this process. Thank you for shepherding me through the lulls and being available to answer my questions despite the long distance.

I also want to thank my Blacksburg-based committee members: Dr. Rosemary Blieszner, Dr. Ted Koebel, and Dr. Karen Roberto. You gave me great advice and were so wonderfully welcoming to me during my visits to Blacksburg. Thank you for your contributions and mentorship. The Center for Gerontology was an invaluable resource to me and contributed to my appreciation of the Blacksburg campus and faculty. Special thanks go to my committee member Dr. Stephen Golant, who counseled me with good humor from Florida and took the time to problem solve with me at length during conferences.

I am grateful for the assistance of Mt. Vernon at Home staff, volunteers, and members. I appreciate the sharing of their fascinating stories, experiences, and the sense of community they provided me. They introduced me to so many warm and wonderful people whom I will remember for the rest of my life.

Thank you to all of my friends and family who encouraged me along the way and didn't keep asking me when I was ever going to finish. You kept me motivated and calm.

Most of all, I thank my wonderful husband Rick for his boundless love and support. His patience, humor, and sunny outlook made it possible for me to find time to write and finish what I started.

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CHAPTER I

Background and Purpose of Study

And I remember I was quite offended as a widow when people would say, "What are you going to do with that big house?" And I would smile and answer truthfully, "I'm thinking of expanding."
                                        Ellie, 86 year-old widow, non-member

Problem Statement

The aging of the Baby Boomers is causing a rapid increase in the number of older Americans. The U.S. Census projects that the over-sixty-five age population will grow from 35 million in 2000 to 72 million in 2030 to 89 million in 2050 (Vincent & Velkoff, 2010). The 85-years-and-older population will more than triple between 2010 and 2060, the fastest growth of any age group over this period (AARP, 2016). This increase in population will cause more demand for long-term care services, or what has more recently become known as long-term services and supports (LTSS). LTSS involve the delivery of medical, social, and personal care services on an on-going basis to people with chronic physical and mental conditions. These services can be delivered in various settings, including homes and assisted-living facilities. In 2010 it was estimated that nearly 10 million Americans required ongoing help with their functional impairments through LTSS. By 2020, this number is expected to increase to 15 million (Frank, 2012).

Most older Americans desire to remain in their homes and communities rather than move away after retirement. According to a 2010 AARP survey, nearly 90 percent of people over age 65 preferred to stay in their homes for as long as possible, and four out of five believed their current home is where they will always live (Mather, Pollard, & Jacobsen, 2011). Of persons aged 65-79 years, almost 50 percent have lived in the same

house for 20 or more years, and two-thirds of adults aged 80 and over have lived in the same house 20 or more years (Joint Center for Housing Studies of Harvard University, 2014).

A majority of the over age 65 population in the United States resides in suburbs, and will most likely continue to do so as they age (Kotkin, 2010). Most expected growth in the over age 65 population in the coming years will take place in the suburbs and the growth will be due to "aging in place" rather than in-migration (Frey, 2011). In 2008, 71 percent of 55- to 64-year-olds lived in suburbs and their numbers grew faster in suburbs than in cities during the 2000s. Of those adults living in suburban locations, most reside in single-family owner-occupied homes that lack basic accessibility features required by many older adults, such as no-step entries, single-floor living, wheelchair accommodation, or lever-style handles (Joint Center for Housing Studies of Harvard University, 2014). This is especially concerning as the lifetime probability of becoming disabled in at least two activities of daily living (ADL) or of being cognitively impaired is 68% for people age 65 and older (AARP, 2003).

Because the majority of suburban communities in the United States were built for young families during the post-World War II economic boom, homes during this period were not designed to meet the needs of older adult residents; needs that include mobility assistance, health care, social support, transportation, and self-sufficiency (Golant, 2015a; Pekmezaris et al., 2013). The widespread American reliance on the automobile for personal transportation impacts individuals' ability to access resources critical to daily life and healthy aging (e.g., medical appointments, social events, grocery shopping).

When persons who live in an area with limited transportation options can no longer drive, they can face dire consequences.

Middle-income, community-based older adults often find themselves in a "service gap" – they are in need of aging services but do not meet the low-income requirements of many programs (Davitt, Lehning, Scharlach, & Greenfield, 2015). They may be living in an affluent neighborhood, but have fixed incomes from sources such as pensions and social security. These older adults are "house rich but cash poor" and dependent, if the need should arise, on family, friends, or neighbors for help. They may be aging in place, but service options aimed at the most physically and financially vulnerable are unavailable to them. Additionally, health service information and delivery have become increasingly fragmented and confusing (Stange, 2009). Older adults must become their own advocates in the ever-changing landscape of health care and community service policies. Aging at home rather in an age-segregated or quasi-institutional environment may be the preference of most American adults, but it is a situation fraught with potential pitfalls.

In this study, I explored one community-based intervention that addressed older adults' desire to age in place or "age in community" in low-density urban environments by providing needed services. Villages, sometimes known as, "Elder Villages," "Virtual Villages," or "Senior Villages," are a rapidly proliferating form of assistance in Naturally Occurring Retirement Communities (NORCs), communities containing a comparatively large proportion of residents over age 60, that purport to help older adults remain in their homes and engaged in daily life. They are grassroots organizations relying on an informal network of community members to provide assistance and support to targeted areas that

have aging populations. Assistance is in the form of transportation, social events, vetted

discounts, and minor home repairs (Davitt et al., 2015). Villages are designed to help

older adults age in community more comfortably and effectively, but little is known

about the effectiveness of this intention. To date, research on Villages has focused on

operations, services, and potential sustainability (Greenfield, 2013; McDonough &

Davitt, 2011; A.E. Scharlach, Graham, & Lehning, 2012). The results are unclear on

whether these small-scale organizations are able to support all of the needs of older

adults. Two studies (Lehning, Davitt, Scharlach, & Greenfield, 2014; Lehning, Scharlach,

Price Wolf, Davitt, & Wiseman, 2015) have concluded that Villages will mostly likely

face organizational challenges and will need to adapt to the changing demographics of

their clientele. Therefore, it is important to study not only how older adults use Villages,

but also whether Villages are sufficiently flexible in design and operation to meet the

needs of future generations of older adults.

Study Overview

As an urban planning researcher, I became fascinated with the physical, social,

and policy implications associated with an aging population. I was surprised by how

underprepared communities were as they began to address the challenges created by these

new realities. I was familiar with programs targeted to low-income older adults but was

unaware of what types of support were available to older middle-income persons. Some

older adults whom I knew from my Alexandria, VA neighborhood were living in large

suburban homes even though they had lost the ability to drive. Others were living in

houses that were becoming increasingly run-down and unsafe. One of my neighbors, a

widowed woman in her mid-80s who could no longer drive, walked several miles to the

neighborhood shopping center frequently during the week, even in the snow and rain. The walk was undoubtedly arduous as there were no sidewalks on parts of her route, and she would walk along a narrow shoulder next to speeding traffic (I have walked this route myself and it is dangerous). She loved her house (in which she had lived in since 1963) and refused to move, even if running routine errands put her life in danger. I wondered if programs were available to help her live safely in her home and community.

This study is an exploration and expansion of that initial question I asked myself several years ago. It is an intensive study of older adults who reside in a middle-income, low-density suburban community in Fairfax County, VA. A majority of the older adults had lived in the neighborhoods for several decades (most often in the same house), had no immediate plans to move away, and were therefore "aging in community."

Some of the older adult residents (about 180) in the study area belonged to a Village (Mount Vernon at Home), a membership and volunteer organization that provided support through social events, transportation, minor home repairs, access to information about aging, and companionship. Other older adult residents in the study area chose not to join the Village, which raised a number of questions: What characteristics differentiated the members from the non-members? Did those who joined retain membership for extended periods? What challenges was the Village facing as its membership aged or left? These and other questions piqued my interest in better understanding how a Village contributed to the fabric of a community.

My research design became very clear. I needed to interview both groups to see why the individuals either chose or did not choose to join Mt. Vernon at Home. I believed their reasons for participating (or not) could inform understanding of how they were able

to age at home and what types of support, if any, they were using. To gain further insight into how members used the program, I interviewed Mt. Vernon at Home volunteers. The volunteers lived in the study area (i.e., the Mt. Vernon at Home service area) and provided various forms of assistance to the Village organization and its members. I analyzed the responses to form a picture of how older adults were aging in community in a suburban NORC, including what types of coping mechanisms they had developed, and what Mt. Vernon at Home meant to them.

Research Questions

The purpose of this research was to explore how older adults age in community with or without the use of a Village. Does, in this case, the Village make a difference in how older adults manage to age in community? I was interested in determining what resources these older adults used and if Village membership offered advantages—the most important one of which seemed to be able to adapt to challenges safely—and how residents were able to remain in their communities as long as they preferred.

In order to determine if (and how) Village membership enhanced the ability of older adults to age in place in an automobile-dependent suburb, I focused on four questions:

1. What are the primary reasons older adults join or do not join the Village?

2. What sources of support do non-members use in comparison to Village members?

3. Which features of the Village contribute to being able to age in community, according to the volunteers and members?

4. What are the challenges to the sustainability of the Village?

To address these questions I used a case study approach to identify patterns in the data that informed my conclusions (Creswell, 2013). The theory of residential normalcy

(Golant, 2011b, 2015b) was the theoretical framework that guided the conceptualization of the research, the data collection and the analysis. It posits that environmental congruence or incongruence is related to how older residents interpret their residential spaces (home and community) and thus will influence adaptive behaviors (e.g., joining a Village, moving away).

Significance of Study

The significance of this study is two-fold. It (1) addresses limitations in the empirical urban planning and gerontology literatures on aging in community and (2) informs aging in community policy at the local level. Overall, this study will help fill gaps in the literature on the effectiveness of NORCs in meeting the needs of older adults.

Limitations in the Existing Empirical Literature

Despite urban planner and social critic Lewis Mumford's prescient 1956 article, "For Older People, Not Segregation but Integration," only within the last ten years has the urban literature begun to focus on the integration aspects of aging in community. The catalyst for this interest was the significant demographic shift caused by the aging Baby Boomer population (Myers & Ryu, 2008). Within this literature much of the focus was on infrastructure, housing, and pedestrian safety (Dumbaugh & Zhang, 2013; Ewing, Hajrasouliha, Neckerman, Purciel-Hill, & Greene, 2016; Joh, Nguyen, & Boarnet, 2012; S. K. Smith, Rayer, S., & Smith, E.A., 2008; Warner, Homsy, & Morken, 2016) rather than on older adults' participation in their communities.

Scholars and policymakers now frequently discuss the suitability of age-friendly communities as an approach to accommodating the environmental needs of older adults. Age-friendly community policies are aimed at improving physical and social

environments to make cities more livable and amenable to social participation by older adults (World Health Organization, 2007). However, the topic is rarely covered in the policy and planning literature on housing. Instead, most of the literature concerning age-friendly communities (Emlet & Moceri, 2012; Lynott & Harrell, 2012; Scharf, 2013) is found in gerontology and social work. Although urban planning professor M.E. Hunt developed the term NORC in 1986, the topic of NORCs has received the most attention from social work and health researchers through numerous articles in the *Journal of Housing for the Elderly* (Bennett, 2010; Enguidanos, Pynoos, Denton, Alexman, & Diepenbrock, 2010; Greenfield, 2013; Kloseck, Crilly, & Gutman, 2010). The planning profession has paid little attention to the opportunities created by Villages, and consequently, community policy stakeholders have given scant attention to the community contexts in which older adults reside (A.E. Scharlach & Lehning, 2013). Additionally, environmental gerontology studies have tended to focus on vulnerable older adults in crisis rather than older adults who are experiencing more comfortable, harmonious, residential experiences (Golant, 2011b).

In response to these shortcomings, while this dissertation is grounded in environmental gerontology theoretical concepts, I have also addressed the policy or planning dimensions. The advantage of using environmental gerontological concepts is that this approach considers older adults' needs and responses at multiple scales (e.g., home, neighborhood, community). Environmental gerontology seeks to describe, explain, and optimize the relationship between aging persons and their physical-social environment (Wahl & Weisman, 2003). The concept also offers a means of bridging gerontology and urban planning in areas such as design and functionality of housing

(Lawton, 1980); older adults' motivations regarding relocation (Lofqvist et al., 2013; Perry, Andersen, & Kaplan, 2014), residential satisfaction (Oswald, Jopp, Rott, & Wahl, 2011; Oswald & Wahl, 2004), and professionals' roles in shaping age-friendly communities (Scharf, 2013; A.E. Scharlach & Lehning, 2013).

Prior studies on the Village model have been national in scope. None included interviews with older adults who use the Village services or with the volunteers who are the backbone of the Village model. The older adults interviewed in this study resided in their homes rather than in assisted living or other facilities. They were eager to share their views on aging in the community that they had helped establish and grow. It is important that the views of older adults be included not only in the community planning process (World Health Organization, 2007), but also in academic research related to urban planning and community development (Phillipson, 2015).

While academics, community planners, and public officials provide guidance and develop programs in support of age-friendly communities (Winick & Jaffe, 2015), few planners are fully aware of grassroots and community-based organizations such as Villages. Villages are fundamental components in age-friendly communities (A. E. Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014). It is, therefore, important that planners educate themselves on how citizens use resources such as Villages and the challenges these organizations face in the current climate of scarce funding resources.

Informing Aging in Community Policy at the Local Level

The second objective of this study was to provide research that will add to a growing understanding of how older adults age in place and make use of community supports through Villages. Currently, researchers are unaware of how older adults

perceive Village programs or what attracts (or does not attract) older adults to these organizations. Clearly, older adults are going to age in place in increasing numbers, and the Village model offers potential solutions to address issues residents face such as mobility loss, isolation, and timely access to valuable information regarding healthcare (Greenfield, Scharlach, Lehning, & Davitt, 2012).

The mission of Villages is consistent with public policy initiatives that encourage reduced nursing home use and increased home-based care (Fox-Grage & Walls, 2013; Kaye, LaPlante, & Harrington, 2009). However, Medicaid and other public programs are primarily targeted towards low-income older adults. Those who do not qualify for these programs must rely on market-rate services, which can be unaffordable, unavailable, or difficult to access. This paucity has generated a recent interest in innovative public-sector strategies, such as Villages, to support aging in place for middle-class older adults who are not eligible for certain public programs (A.E. Scharlach et al., 2012).

Villages aim to be crucial links in their communities. Although designed with socialization as a primary component, Villages intend to fill gaps left by current aging policies and programs (Greenfield, Scharlach, Lehning, & Davitt, 2012). They can serve as centralized sources of information for older adults and their children in the fractured landscape of aging services. As the number of older adults in the United States increases, Village services may be an effective way to mitigate the challenges associated with aging at home by allowing older adults to have an expanded social network, a caretaking safety net, and the resources to make informed decisions about how and where they will live.

Developing age-friendly communities has become a public policy focus, but there is a need for research to capture the experiences of those who are the targets of these

policies (Phillipson, 2015). Urban planners will increasingly need to educate themselves

on the needs of older adults and combine awareness of these needs with their knowledge

of physical design, service delivery, policy development, and community participation.

      In the next chapter, I presented some of the factors that older adults consider or

encounter when deciding to stay in their long-term homes and communities and explain

the theoretical framework that guided this study. Chapter three provides a context for

Mount Vernon at Home, with a description of its place within Fairfax County, one of the

largest districts in the Washington, DC metropolitan area and chapter four is a description

of the methods I used. In chapters five and six, I presented the study's findings and

conclusions, respectively.

CHAPTER II

Literature Review

Aging at home may not be an easy adjustment for many older adults. However, a majority of adults are aging in communities where they have lived for decades rather than moving away to age-segregated retirement communities (Bookman, 2008; Frey, 2007; Lawler, 2001). This chapter begins with a discussion of the difference between the terms aging in place and aging in community. It is followed by an overview of possible factors that influence aging in community and the theoretical framework, residential normalcy, which was used to develop the remainder of the study.

Aging in Place Versus Aging in Community

Aging in place has had different meanings over the past several decades and the literature definition is ambiguous. Before the 1980s, "aging in place" was a demographic indicator referring to older occupants staying in their rented or owned dwellings (Golant, 2015a, p. 65). The term then grew to include a range of housing environments and meanings as the study of the residential situations of older adults broadened (Cutchin, 2003). Aging in place is a fluid concept that goes beyond a person's home to include other "place" definitions such as nursing homes, assisted living facilities, or a new residence moved to after retirement (Golant, 2011a). Time is often a dimension in aging in place, for example, how long a person has lived in one location or when aging in place ends and begins (Lee, 2008, p. 20).

Changing demographics, combined with the legal requirement of all states to support community-based settings for all individuals regardless of age or disability (Olmstead v. LC, 1999) prompted policymakers and researchers to explore ways to

improve the living environments of older adults (Prosper, 2004). No longer did older

adults have to view age-segregated housing as an inevitable end. Instead they could

choose to stay in their homes and communities while receiving services. From this

movement evolved the most commonly used connotation of aging in place: to age in

one's current and usually long-term home for as long as is safely possible (Cisneros,

Dyer-Chamberlain, & Hickie, 2012; Joint Center for Housing Studies of Harvard

University, 2014; Lee, 2008; Morley, 2012).

Although aging in place strategies included the use of supportive services

(Lehning, Scharlach, & Price-Wolf, 2012), the term's emphasis on housing as the "place"

led aging advocates to develop a more expansive term, aging in community. The process

of aging in community assumed collaboration among various stakeholders to provide

each other with support and social capital while working to improve accessibility and

engagement (Thomas & Blanchard, 2009). Blanchard (2013) argued that because more

older adults choose to age in place, researchers must see beyond simply improving the

home environment and service delivery. Although these are important, researchers and

practitioners should also consider aspects of social architecture, interdependence, and

collaboration. Blanchard gave the example of an older adult who was aging at home with

the help of a part-time caregiver or Meals-on-Wheels, but experiencing depression,

isolation, and "social death" (p.10). Aging in community strategies include social

components to ensure that older adults have the option to engage in supportive activities

outside of their homes. It can take place in the context of supportive purposefully-built

housing environments such as the Elder Spirit community in Abingdon, Virginia

(Elderspirit Community, n.d.) or other forms of cohousing. Thomas and Blanchard stated

aging in place components are reactive, services are unidirectional, and work mainly to avoid institutionalization while aging in community tends to be proactive, communal, and seeks to foster independence (Rath, 2012).

For the purposes of this study, I used the term "aging in community" rather than "aging in place" to acknowledge the need to include the broader integrated view of housing, services, and social support. Additionally, I was not solely focused on the services or supports participants used inside their homes, but how they viewed aging within the context of the community. Their decisions to stay in their homes were not only influenced by the home itself, but also by their social networks and attachments to the wider geographic areas (neighborhood, community, metropolitan area).

A gap in the literature exists on the meaning of aging in community to older adults. Only two studies have explored how older people understand aging in place within the wider context of their communities (Rosel, 2003; Wiles, Leibing, Guberman, Reeve, & Allen, 2011). The Global Age-Friendly City project (World Health Organization, 2007) used a participatory approach, but there continues to be a dearth of information on older adults' perspectives on their long-term communities. To this end, environmental gerontologists Scheidt and Windley (as cited in Wiles et al., 2011) called for "more research *with* older people rather than *on* them." This urging, along with the increasingly important context of community, became an important factor in my decision to conduct a qualitative study with older adults.

Influences on the Decision to Age in Community

The decision to stay at home during old age can be complex and is not always a choice. Some older adults move immediately after they retire, some are determined to

stay in their homes where they have lived for decades until they leave "feet first," while others move due to a crisis—family, health, or financial, for example. Aging at home is born out of attachment to the familiar, including not just homes, but communities, belongings, and social ties (Giulliani, 2003; Hidalgo & Hernandez, 2001). Moving disrupts the familiar and can be physically difficult for the oldest of old. Factors predicting a move or staying in place include financial considerations and the availability of assistance, from informal or paid caregivers.

Older Adult Migration Patterns

Younger adults may be perplexed by an older persons' decision to stay in his or her home despite challenges. This may be due to a resounding cultural stereotype of older Americans: they leave their homes, where for decades they raised families, to relocate to more hospitable climates so they may enjoy their retirement and live out their final years in leisure. This perception was introduced to the popular imagination in Calvin Trillin's 1964 essay on Arizona's retirement community Sun City, "Wake up and Live!" for *The New Yorker* and reinforced in long prevailing television situation comedies such as *Seinfeld* and *The Golden Girls*. However, research does not support this as the predominant lifestyle choice for most American retirees (Frey, 2007, 2011). From the 1960s until the early 1990s, there was a small but established trend of older adults migrating from the Northeast and Midwest to warmer climates in the Southern United States (particularly from New York to Florida). This slowed as traditional retirement destinations became more expensive and the availability of local retirement communities increased (Lin, 1999).

The locations of retirement destinations are changing, as seen in the growth of retirement destinations such as North Carolina (Sharma, 2012) and around college campuses (Kressley & Huebschmann, 2002; Tsao, 2003), but the number of older adults who move is relatively low. From 2013 to 2014, only three percent of those 65 or older moved. Most movers (81%) remained in the same state and 60% stayed in the same county. Only 19% of the movers moved from out-of-state or abroad (Administration on Aging, 2014).

Data indicate that older adults tend to stay put until they must move, usually for health reasons and health-related moves usually occur at a later age. A relatively small percentage (3.4%) of the 65 or older population in 2014 lived in institutional settings such as nursing homes. The percentage was higher with age, ranging from 1.1% for persons 65-74 years to 3% for persons 75-84 years and 10% for persons 85 or older (Administration on Aging, 2014).

While deciding whether or not to relocate, older adults will examine a variety of factors and resources that include health, wealth, social supports, the housing market, costs of living, ties to the current community, and how successful the relocation may be (Perry et al., 2014; Wiseman, 1980). Another important factor according to Wiseman is the type of move itself—a permanent migration to a new community, seasonal migrations between homes in different climates, or relocation to a new type of residence within the same general area. Factors related to moving that are confronted in late life usually begin with a triggering event that motivates older adults to reevaluate their residential satisfaction. Triggers may be anticipated events, such as a change in preferred lifestyle or

unanticipated critical life events that force an abrupt change. Triggering events differ and may be described as either "push" or "pull" factors.

"Push" factors that influence older adults' moving include declining health, loss of a driving license, home accessibility, and burdensome home maintenance (Walters, 2002; Weeks, Keefe, & Macdonald, 2012). The death of a spouse is also influences residential mobility later in life, especially when that spouse was a caregiver to a partner (Bloem, Van Tilbur, & Thomese, 2008; Sergeant & Ekerdt, 2008). Conversely, "pull" factors may attract retirees as in-migrants to new locations. These "pull" factors also may encourage older adults to age at home (Walters, 2002). For example, older adults may be already living in areas that have low crime rates, low unemployment, manageable climates, quality medical care, and other attributes (e.g., libraries, cultural events, universities) that are regularly listed in "best places to retire" publications. In that case, moving would offer no tangible benefits.

Building on Wiseman's model, Litwak and Longino (1987) theorized that older adults move in three stages: the first occurs upon retirement ("amenity seeking"), a second by moderate functional decline ("assistance seeking"), and a final transition by major disabilities. The first move may bring older adults closer to family as an amenity (e.g., grandchildren) but the second move usually brings them closer to sources of support. The third move necessitates institutional support because routine care needs of the older adult exceed the abilities or availability of caretakers. Litwak and Longino's seminal work was helpful in the understanding why older adults move. However, it lacked identification of nuances within each of these stages. More recent research examined specific motivations behind older adults' decisions to relocate (or stay),

including the location of and the quality of relationships with kin (Bradley, Longino, Stoller, & Haas, 2008; Ha, Carr, Utz, & Nesse, 2006; Lofqvist et al., 2013) and the influence of the availability of aging resources (Tang & Lee, 2011; Tang & Pickard, 2008). It was Tang's research on the availability of aging resources within Litwak and Longino's relocation framework, that led me to consider the important role a community-based support such as a Village could play in how older adults experience aging in community.

Demographic and Policy Shifts

Social Security, Medicare, Medicaid, and Great Society initiatives lifted many older adults out of poverty and provided improved access to health care (Harrington Meyer & Frazier, 2012). In turn, successive cohorts of older adults can live longer, more independently, and have greater freedom of choice about where they will spend the last years of their lives. A child born in the United States in 1900 could expect to live for about 48 years, approximately 30 years less than the average life expectancy of 78.8 years (81.2 years for females and 76.4 for males) for those born in 2012 (Xu, 2014).

The older adults (often widows) at the turn of the twentieth century who could not stay at home for physical, familial, or financial reasons were relegated to almshouses (Fleming, Evans, & Chutka, 2003). With the advent of Social Security in the 1930s, combined with the abysmal conditions of existing care, state-funded and private nursing homes became the providers of long-term care for older adults. The establishment of Medicare and Medicaid in 1965 accelerated the growth of nursing homes (Institute of Medicine (US) Committee on Nursing Home Regulation, 1986). By 1970s many of these institutions were providing substandard care and were termed "human junkyards" that

were perceived as warehousing older adults (Foundation Aiding the Elderly, n.d.).

Although the United States government had succeeded in dismantling the almshouses,

conditions of many nursing homes had become sub-standard. Contemporary American

nursing homes, although somewhat improved over the past decades, have been described

as, "the shotgun marriage between the poor house and the hospital." (Rossato-Bennett,

2014) The negative stereotype of a nursing home had become so pervasive that a

surveyed group of Americans feared going into a nursing home more than death (Clarity,

2007). Not only was the nursing home viewed as the housing of last resort, but also older

adults had to deplete their financial resources in order to receive state relief from the

associated costs of living in such a facility (Ng, Harrington, & Kitchener, 2010).

During the late 1970s, state governments and professional adult care providers

began to respond to consumer preferences and developed alternatives to nursing homes.

The Assisted Living movement sought to bring four basic principles (hybrid, hospitality,

housing, and health care) to residential care for older adults and to avoid the mistakes of

the earlier nursing home dominated era (Brown Wilson, 2007). Older adults were now

able to live in comparatively more commodious assisted living environments while being

provided meals and assistance with ADLs. However, the costs of assisted living

residences could still be prohibitive. The national US median cost for a one-bedroom unit

in an assisted living facility was $43,536 per year in 2016 (Genworth, 2016).

Other demographic changes, such as smaller family size, changing family roles,

and geographic dispersion of adult children, create a potential shortage in available

caretakers for those who wish to age at home (International Longevity Center, 2006). As

a consequence family members, particularly women, become responsible for the majority

of the informal caretaking of older adults in the United States (National Alliance for Caregiving & AARP, 2015). However, the supply of family-based caretakers is unlikely to keep pace with future demand (Redfoot, Feinberg, & Houser, 2013) because the rapid growth of the over 65 population and their preference to stay outside of formal caregiving institutions strains an already undersupplied network of homecare providers. Author and long-term care reform advocate Ai-Jen Poo (2015) believes 3 million people in the home care workforce cannot meet current needs, and will certainly not meet the demand for care that will accompany the increased population of aging adults. She predicts the United States will need least 1.8 million additional home care workers in the next decade.

The Older Americans Act was the first federal program to fund health and social services so that older adults could follow their preferences to age at home and avoid immediate, permanent institutional care. It supports a range of home and community-based services (HCBS) such as Meals-on-Wheels, in-home services, transportation, legal services, elder abuse prevention, and caregiver support. These programs are focused on offering aid to persons with the greatest economic need and years of limited funding have resulted in waiting lists (National Committee to Preserve Social Security & Medicare, 2016). In an attempt to curb costs and acknowledge consumer preferences to stay at home, Medicare and Medicaid programs allow for in-home care, but each has numerous restrictions. Older adults who wish to receive home care under Medicare must be homebound and need skilled care, but Medicare may not pay enough for other supportive services (e.g., 24-hour-a-day-care, meal delivery, house cleaning, personal care) to allow them to stay in their homes. Use of these programs still requires levels of coordination and awareness of available of supplemental resources. However, research, based on state-

level analyses, has shown that HCBS have proven to be cost-effective alternatives to nursing home care (Fox-Grage & Walls, 2013). As older adults age in community in increasing numbers, consumer-directed aging services programs that promote independence such as Program of All-Inclusive Care for the Elderly (PACE) and adult day service centers will continue to be in high demand although consistent funding at the federal and state levels is often uncertain (Gross, Temkin-Greener, Kunitz, & Mukamel, 2004; Robison, Shugrue, Porter, Fortinsky, & Curry, 2012).

To qualify for the Medicaid HCBS waiver program, a person must meet the state's level-of-care or functional eligibility requirements and have income and assets below certain guidelines. Older adults who have incomes or assets above the mandated limits and are considered middle-income will not qualify for HCBS and similar programs. Nor, unlike the independently wealthy, will they be able to afford expensive private-sector long-term care options. Knickman, Hunt, Snell, Alecxih, and Kennell (2003) referred to this group as "Tweeners" and predicted that they would need to sacrifice their assets in order to obtain long-term care. Tweeners typically comprise Village memberships (Greenfield, Scharlach, Graham, Davitt, & Lehning, 2012) and will need to become increasingly inventive and educated on how they can receive health care assistance.

Villages may ameliorate confusion regarding health care assistance by providing members information (e.g., vetted referrals for care providers, workshops, answering questions related to benefits) (Greenfield, Scharlach, Lehning, et al., 2012). The potential of the Village to provide this type of information led me to develop my third research question regarding which features of the Village foster aging in community. Access to

trusted, accurate information, is crucial to older adults who want to stay in their homes and community (Golant, 2015a, p. 176). Did members receive appropriate information from the Village and, if so, did they consider it helpful in their goal to stay?

Home is Where the Heart (and Equity) Is: Security, Family, and Legacy

To older adults, homes are a powerful economic and emotional symbol signifying security, family, and legacy (Sabia, 2008). The home is often the single largest asset of older adults—a group that has a stable history of home ownership. During the Great Recession (2007-2009), home ownership rates among older adults remained largely unchanged, with most maintaining ownership at the same address for 20 years or more (Joint Center for Housing Studies of Harvard University, 2014). Older adults prefer to hold on to housing equity they have built up over many years to ensure against costs of future health problems or to pay for long-term care and will sell their homes only as a last resort (Jones, 1997). Recently, reverse equity loans have become an important, but controversial tool that allows older adults to stay in their homes (Fisher, Johnson, Marchand, Smeeding, & Torrey, 2007; National Council on Aging, 2009) by allowing them to have an additional income stream and finance the installation of safety features. Additionally, many older adults associate their homes with their legacies to their children which lead them to hold onto their homes for as long as possible (Sabia, 2008).

Aging at home may also be born out of cost and convenience. Although maintenance and property tax costs can become burdensome, remaining in a home that is owned, mortgage-free, in a location with which one is familiar can seem a natural choice (Rowles, 1993). Other older adult homeowners may be unable to sell their homes due to a soft real estate market (McIlwain, 2012), unable to receive a desired price due to deferred

maintenance or comparative condition of their homes (Davidoff, 2004), or do not have a family network or the financial resources to move away. A home's economic and emotional importance, combined with the costs of assisted living, underscore why an older adult would prefer not to relocate and instead seek out community-based assistance such as a Village.

Material Items: From Boon to Bane

Older people experience attachment to their homes and neighborhoods from everyday routines and social affinity (i.e., interactions with neighbors and friends) (Rowles, 1993). Powerful feelings can also drive attachments to items within the home. Items of daily life, as well as long held mementos, form a person's biography. Downsizing during a move can mean the loss of identity through the loss of possessions (Golant, 2015a, p. 49). Acquiring and holding on to possessions can be borne out of wanting to pass on heirlooms, pleasure, or simply because owning a large house allows the accumulation of lots of "stuff " (Ekerdt & Sergeant, 2006). The sheer volume of items they own can overwhelm older adults who are contemplating downsizing. The possessions become a "drag on well-being" and a matter of concern to adult children who might be faced with the time-consuming task of disposing of the items after the parent's death (Luborsky, Lysack, & Van Nuil, 2011; G. V. Smith & Ekerdt, 2011). Mount Vernon at Home provided organizational and downsizing assistance, which could help members who were perhaps overwhelmed by too many personal items. As it arose in the interviews, I explored the topic of decluttering within my third research question, which features of the Village contribute to aging in community.

Social Networks, Support, and Aging

"Social relationships" is a term that refers to social networks, social integration, and social support (Greenfield, Scharlach, Lehning, et al., 2012). Social networks refer to the structure of social relationships, such as the number, types, and homogeneity of contacts. Social integration is the quantity and frequency of social relationships. Social support is a function of social networks, including informational support, emotional support, and tangible assistance.

Social support, although generally positive, may have a downside. Older adults, particularly in the United States, can have a strong need for self-reliance and autonomy and therefore may not seek assistance from others as it could be seen as embarrassing or a sign of failure (Krause, 1997b). Consequently, those who receive support may have lower-self esteem and feel too dependent on their network. Those who give assistance may also feel burdened by repeated requests or not be able to offer help due to financial or logistical constraints. Krause (1997a) hypothesized those who are encouraged to take care of their needs and make use of anticipated support—the feeling that there are people available to them if the need arises—may have better aging experiences. Older adults who were asked about their network and knew of people that would support them were better able to weather the effects of stress (Krause, 1997a). Therefore, a person's knowledge of having supportive relationships may improve feelings of self-worth and independence.

The awareness of the need for social support beyond a person's current network can inspire local citizens and governments to improve services (Bookman, 2008). Family, church members, neighbors, and friends may be able to provide informal support, but if

an older adult develops increasing personal care needs, formal support from the community may be needed. Older adults with knowledge of existing local aging-related community-based services (e.g., senior centers, visiting nurses, adult day care, transportation) reported that they not only plan to age in place but for a longer period than those who did not (Tang & Lee, 2011). A lack of knowledge about supportive aging services may be a barrier to aging in place and cause individuals to move from their homes sooner. Additionally, the availability of family members may not guarantee an older person will receive appropriate care. Formal support from community-based services may be more important than informal support in addressing age-related health problems and allowing older adults to age at home (Tang & Pickard, 2008).

Social ties are related to individuals' general comfort in their surroundings, and there is substantial research on the positive effects of social relations and optimal aging (Bassuk & Glass, 1999; Depp & Jeste, 2006; Krause, 2002). Activities such as volunteering and church attendance are not only associated with positive health effects in older adults (Cohen & Koenig, 2003; Population Reference Bureau, 2011; Yoon & Lee, 2006), they also become important anchors in a social network. The longer people have lived in a neighborhood, the better the chances are that they have developed meaningful social networks (e.g., neighbors, church members, family, doctors) that they may not want to distance themselves from by moving away. It can take years, perhaps time older adults feel they do not have, to form new versions of these relationships (Golant, 2015a, p. 49).

The importance of support, its consistency, and the awareness of it (i.e., anticipated support) to aging in community were integral to forming my first three

research questions regarding why older adults join (or do not join) Villages and how the two groups of older adults operationalized their community and family resources. I was interested in not only if older adults joined the Village for support, but what kind (social, transportation, information). Additionally, I wanted to examine how non-members used their support networks in comparison to members who seemed to have an expanded network from participation in the Village. How was the support the Village provided different from the support non-members used?

Community-Based Support: Villages

Community-based aging in place programs have evolved to serve older adults in response to unmet needs and service gaps (A.E. Scharlach, Graham, & Berridge, 2015). Older adults who wanted to stay in their age-integrated neighborhoods, but the aging-related services they needed did not exist or they did not qualify, developed the Village – a grassroots, community membership, fee-based organization offering aging in community assistance through social (e.g., dinners out, lectures) and instrumental support (e.g., minor home repairs, referrals, transportation). The term "Villages" is somewhat of a misnomer. They are not purposefully-built residential developments, but virtual constructs bounded by a defined geographic area, such as a group of existing buildings, neighborhoods, or a district of several miles (Ansello, 2014).

The first Village, founded in Boston in 2001, was driven by a philosophy of human interdependence, a shared sense of community (McDonough & Davitt, 2011), and an "it takes a village" approach to help people in need to succeed. The founders, a group of neighbors aging in place, surmised current aging programs were not only preventing

them from staying at home as they aged but were encouraging segregation and isolation (Brooks, 2013).

Villages are one of the fastest growing of all the age-friendly community initiatives (Grantmakers in Aging, 2013). However, Villages have not been widely studied (Greenfield, Scharlach, Lehning, et al., 2012) and relatively little empirical research exists that examines the older adults' perspectives on Villages. Consequently, researchers note the need for studies that examine the conditions under which Villages are effective at helping older adults age in community (Greenfield, Scharlach, Lehning, et al., 2012; Ormand, Black, Tilly, & Thomas, 2004; Oswald & Wahl, 2004; Phillipson, 2015).

The Village model is promoted as an innovative private sector, consumer-led effort to enable older adults not only to age at home despite physical decline but to also age in community while preserving or enhancing their social networks. They are typically located in NORCs—neighborhoods that have higher than average concentrations of adults over the age of 60. The goals of the Village model are to enable persons to age at home independently, encourage participation in their communities, offer social relationship building activities, and enhance participants' access to resources (A.E. Scharlach et al., 2012). They are encouraged to be active within the organization by serving on committees and the board of directors. Villages offer a variety of services (Figure 1) such minor home maintenance; home health care referrals; and transportation (Poor, Baldwin, & Willett, 2012; A.E. Scharlach et al., 2012).

However, Villages have been criticized for serving primarily middle-to-upper income populations, offering membership fees that are too cost prohibitive for low-

income older adults, and because initially they were not designed as a medical model or a replacement for long-term care, they usually do not support those who are cognitively or severely physically impaired (Lang, 2012, p. 35). Villages are beginning to widen the scope of their services to include staff social workers and nurses (Maggioncalda, 2014). The Village model does not attempt to replace long-term care services. It is intended to raise awareness about resources and provide relief to older adults and their families involved in their caretaking (McDonough & Davitt, 2011).

Members are integral partners in the Village model. Young-old members serve as volunteers and anticipate that they will become greater consumers of the Village's services as they advance in age. Various social movements (e.g., disability rights) have pushed for enhanced control by consumers, and publically funded participant-directed services have become available. However, many of these programs are managed in a top-down manner and are developed by professionals, rather than the consumers (Davitt et al., 2015). The consumer-led nature, along with the intergenerational volunteer aspect, contributes to the uniqueness of the Village model.
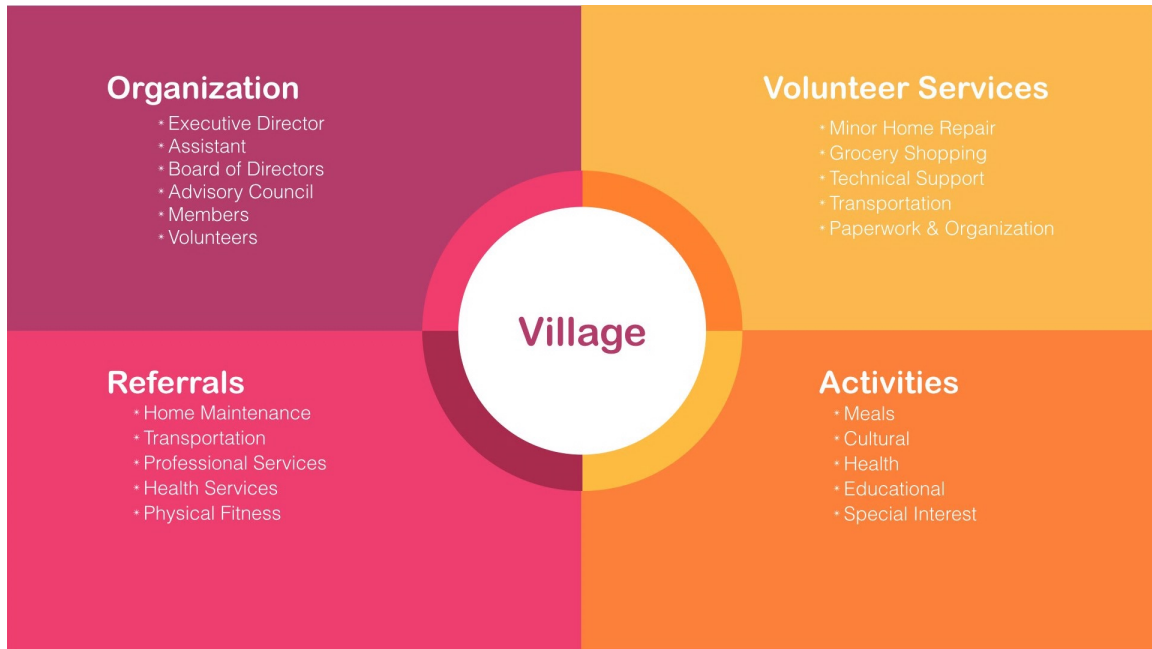
Figure 1. Typical Village organization and services. Source: Author's survey of Village literature and websites.

The Village model differs from traditional aging in place models, such as Naturally Occurring Retirement Communities with Supportive Services Programs (NORC-SSPs) as it (a) relies on community-based volunteers for service provision rather than outside agencies; (b) typically does not receive government funding but relies on membership dues and donations; (c) develops without the input of healthcare and social service care providers; and (d) is typically located in generationally-mixed neighborhoods. Villages are located in affluent neighborhoods with a mix of housing types, while NORC-SSPs are typically located in apartment buildings inhabited by moderate to low-income residents who are more likely to have a disability (Greenfield, Scharlach, Lehning, Davitt, & Graham, 2013).

In 2016, 190 Villages existed and more than 150 were under development the United States. They were concentrated in California, New York, Connecticut, the Washington, DC metropolitan area, and Massachusetts (Figure 2), with fewer in the

Plains and Midwest. Villages tended to form in or near major cities on the coasts of the

United States, and slightly more than a third were located in suburbs ("Village to village
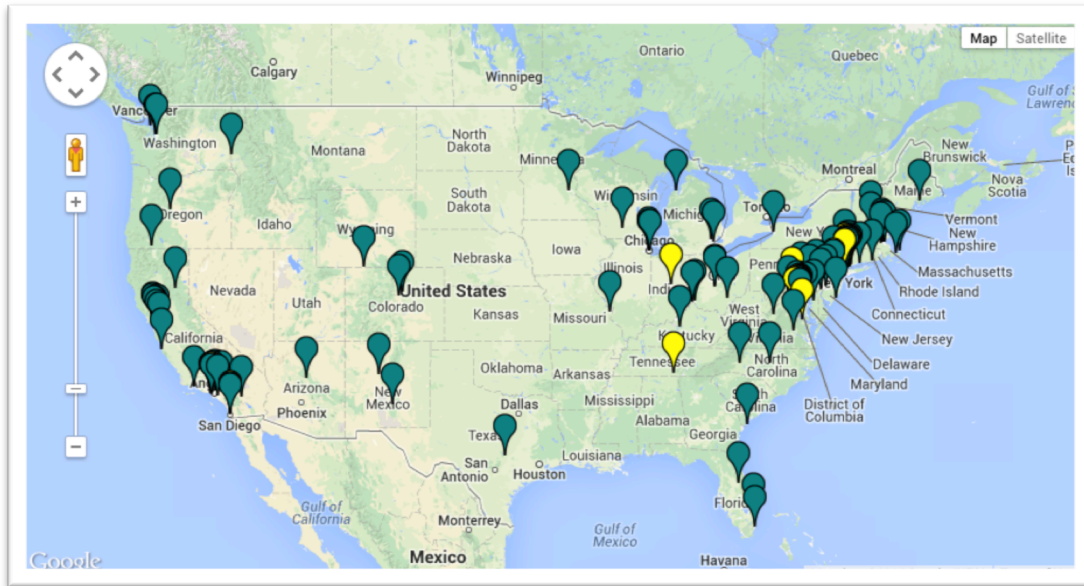
network," 2015).

Figure 2: Distribution of operational Villages in the United States in 2015. Source:
Village to Village Network, 2015.

   A majority of the Villages are stand-alone non-profits and are dependent on

membership dues for funding (Greenfield, Scharlach, Graham, et al., 2012). Some exist

as part of a larger organization that assists the Village with overhead costs and

fundraising (Greenfield et al., 2013). Villages in this model are typically part of

established social agencies. According to the Village to Village Network's website, some

communities use the "hub and spoke" or centralized approach as it allows Villages in

different areas within a state or county to share resources and provide an economy of

scale. Others are based on a time bank or reciprocity model wherein members share skills

and resources for time rather than money ("Village to village network," 2015).

The majority of the literature, albeit limited, on Villages has been based on the work of Andrew Scharlach at the School of Social Welfare at the University of California, Berkeley in conjunction with social work and health researchers from University of Michigan, University of Maryland, and Rutgers University. Their research indicates that Villages are a promising model for addressing service needs among older adults who wish to age in their homes but questions the sustainability of the organizations due to their unproven track record and limited resources (Greenfield, Scharlach, Lehning, et al., 2012). In 2013, Scharlach and his research team conducted a survey of Village leaders and identified funding, membership recruitment, and leadership development as challenges to the ability of Villages to survive (Lehning et al., 2014; Lehning et al., 2015). Villages may provide needed services, but what happens if these self-funding organizations cannot be maintained? This question led me to develop my fourth research question regarding the sustainability of the Village according to the study participants.

Several of the Village-related articles within the social work literature provide frameworks for studying the organization and goals of Villages using qualitative and quantitative survey methods (Greenfield, 2012; Lehning et al., 2012; A.E. Scharlach et al., 2012). Greenfield (2012) proposed examining Villages and other aging in place programs within ecological frameworks (Lawton's general ecological model of aging and Bronfenbrenner's biological systems theory) to create an integrated body of research that could be applied to policy and practice realms. She emphasized the importance of recognizing the interplay between not only an older adult's physical and social environment and also other influences such as policies, resources, and timing relative to other events in that person's life. Scharlach and his colleagues' have undertaken an

important goal of not only studying Villages as a movement but also placing Villages within the larger context of national and local aging programs.

Despite the importance of comparing Villages with other programs, there is a current paucity of literature regarding in-depth studies of older adults who are the consumers of the Village services. One study (Guengerich, 2009) examined several Villages in Washington, DC and reported on best practices within the Village organization, but it does not include extensive member or volunteer interviews. This study will contribute to the Village literature not only by examining how members participate in the Village model, but also by obtaining feedback from two groups heretofore not included in other Village studies, a comparison group (non-members) and volunteers.

Theoretical Framework

Aging in community is a process in which an older individual, using skills developed over a lifespan, continually adapts to changing health and environmental concerns (Granbom et al., 2014). Adaptation is not always successful (e.g., necessitating a move) and the decision to age in an incongruent environment may be based on emotion rather than reason. Although the American Housing Survey reported adults aged 65 and over have high residential satisfaction (U.S. Census Bureau, 2013a), there are many personal, physical, financial, and environmental characteristics that influence satisfaction levels (Ahn & Lee, 2015; Oswald et al., 2007). Theory from the field of environmental gerontology guided this exploration of how older adults living in a low-density suburban community have used a variety of resources to meet their goals of staying in their homes

and community. Specifically, I used the theory of residential normalcy, which links subjective assessments of one's residential settings to an array of coping mechanisms.

In order achieve a state of residential normalcy, older adults must change their thoughts and actions not only to stay in a long-time home but also to adapt to new environments such as downsizing to a new home or moving to an assisted living facility. Community-based interventions, such as Villages, may reduce environmental incongruence for some members and lead to a sense of residential normalcy concerning their existing situations.

Environmental Incongruence

How older adults adapt to their environment and socio-spatial surroundings has been the focus of environmental gerontology since its evolution in the late 1950s (Wahl & Weisman, 2003). Environmental gerontologist M. Powell Lawton developed the Press-Competence model, proposing that the lower a person's competence (e.g., cognitive and physical health) and the stronger the environmental press (e.g. stress, depression, incongruence), the more the person's well-being will be impacted. This model was later renamed person-environment fit in order to emphasize personal needs and recognize that a person does have the ability to shape his or her environment (Phillips, Ajrouch, & Hillcoat-Nallétamby, 2010). However, press is not necessarily negative nor should it be associated with "stress." Rather press is a situation that elicits adaptive actions, which may create greater or lesser environmental congruence for the resident.

Residential Normalcy

The theory of residential normalcy evolved from Lawton's work and attempts to explain how older adults, through feelings of competency and control, can occupy

residential environments that fit their needs and goals (Golant, 2011b). Individuals who have lived in a house and community for several years may feel satisfaction with their surroundings, have pleasurable memories, perceive themselves as having control over their environment, and are eased by a sense of familiarity. This combination of residential comfort and mastery is a state of "residential normalcy" (Golant, 2011b, 2012) as opposed to "residential (environmental) incongruence." According to Golant, older adults who are beginning to age in place may be in the "sweet spot" of environmental fit: they are in well-known, comfortable surroundings with few barriers or inconveniences. Therefore they would be less inclined to move away and perceive aging at home as an ideal situation. However, residential normalcy will most likely not last.

When older adults encounter environmental incongruence because of the death of a caretaking spouse, a physical disability, or a decrease in mobility due to the inability to drive, for example, they cope through a variety *accommodative* (e.g., mind strategies such as denial, withdraw, comparing themselves to others who are "worse off") or *assimilative* (e.g., action strategies that include moving away or seeking outside assistance) strategies. Moving away, according from a residential normalcy perspective, is the most strenuous coping strategy and employed when other adaptive efforts have failed. Figure 3 illustrates the various combinations of residential comfort and mastery and the relationships between each concept. Older adults who are out of both their comfort and mastery zones are most likely to move away from their homes.
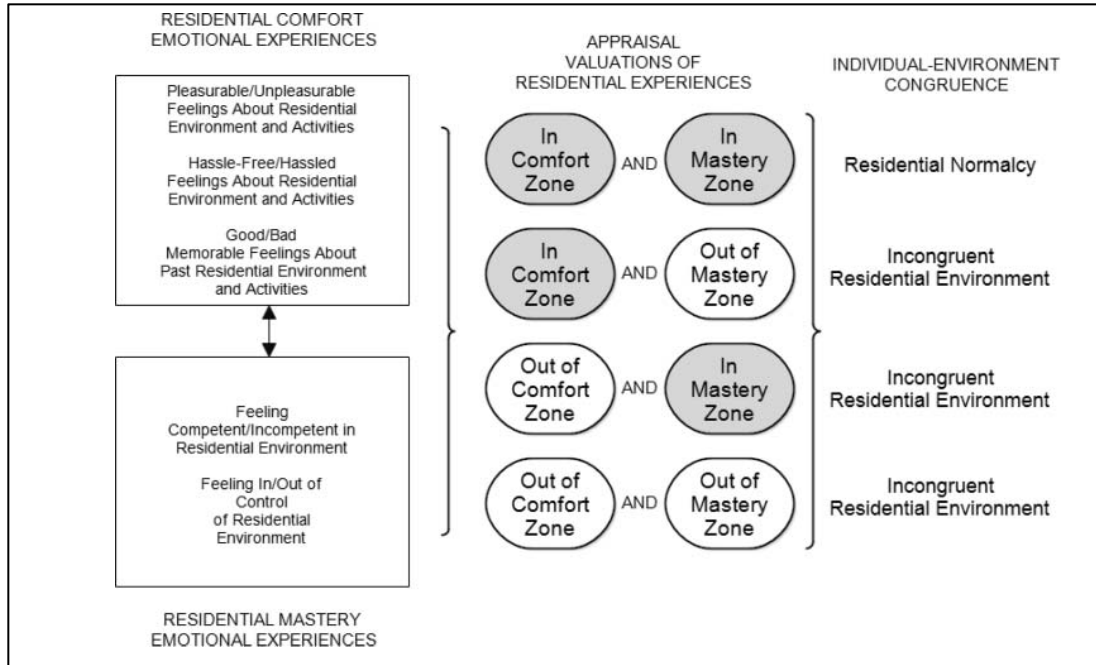
Figure 3. Alternative residential scenarios in residential normalcy and incongruence. Adapted from "Out of Their Residential Comfort and Mastery Zones: Towards a More Relevant Environmental Gerontology," by Stephen M. Golant, 2012. Journal of Housing for the Elderly, 226:1-3, pp. 26-43. Copyright 2012 by Taylor and Francis Group.

Residential normalcy theory can be applied to any environment an older person may be living in—a private home, apartment, assisted living, or nursing home. It is not so much the type of environment, but how the person interacts with and assesses his or her surroundings. For example, an older adult could downsize from an unmanageably large single-family home to an apartment, but the new environment depresses him or her; it is just not "the same." This person would be out of his or her residential comfort zone and therefore would not be experiencing residential normalcy. It is important to consider that the residential normalcy appraisal process is subjective yet interactional (Golant, 2015b). Older persons can view the same situation differently—one older adult may view living in a large home alone as ideal, while another may see it as dangerous and isolating. Similarly, aging and health professionals may not agree with an older person's positive

assessment of his or her environment and come to different conclusions regarding that person's ability to age at home safely.

Older adults experiencing environmental incongruence who insist on staying in their homes will most likely need to accept assistance and modifications to their ways of life (Golant, 2015a, p. 38). Although older adults may try to regain residential mastery or comfort, they may not succeed. Complex solutions may need to be applied immediately but they may not be within an older adult's financial or physical means, or the older adult may lack information (Golant, 2015b). The older adult may then withdraw, become depressed, and experience increased levels of incongruence (Lawton, 1989). Older adults' appraisals of their living situations can apply to different environments, involve a variety of assimilative and accommodative coping strategies, and can take place in several stages.

Villages as Mediators of Residential Incongruence

Older adults may encounter incongruence through many ways such as isolation, illness, a lack of information, losing the ability to drive, or being unable to navigate stairs or showers. Villages, through their supportive services and social opportunities, may help older adults maintain or recapture residential normalcy thereby allowing them to age at home more comfortably and effectively, but this idea has not been extensively studied (McDonough & Davitt, 2011; A.E. Scharlach et al., 2012). It is unknown why older adults choose to join Villages, but environmental incongruence may be a catalyst. Choosing to join a Village is in itself an assimilative act (Geboy, Moore, & Smith, 2012). Some older adults who join Villages may not be experiencing environmental incongruence, but are anticipating needing some form assistance in the not too distant

future. Others may join due to a crisis hoping that the Village will help them adapt (i.e.,
regain a sense of residential normalcy) and therefore prevent them from having to move.
According to Lazarus and Folkman (as cited in Golant (2015b), p.72), "older people will
have more enriched coping repertoires when they are aware of coping strategies that they
believe are more efficacious (leading to successful outcomes) and viable (doable and
implementable)." Older adults may join Villages, as they perceive these organizations
offer "efficacious and viable" ways of being able to age in community. The decision to
use certain aging resources and coping mechanisms can depend on a person's resilience,
life history, and socio-economic situation (Golant, 2015b).

Residential normalcy has intellectual roots in the literature on socio-ecological
systems (SES) theory, which provides insights into how to conceptualize the role of
Villages in residential adaptation. SES expands ecology systems theory to recognize the
role of humans in ecological adaptation. The central premise of SES is the mutual
interaction of environmental and human dynamics when the existing system of
interdependency is stressed by new conditions in the physical or socio-economic
environments. When individuals, communities, economies, or ecological assemblages,
experience stress, they respond in different ways. Holling (1973, 2009) and others
(Gunderson & Holling, 2002) have argued that stressed systems seldom return to the pre-
existing state but instead create a new equilibrium. The structures and relationships in the
new equilibrium will not be the same as previously experienced, however, the system
retains its fundamental norms, rules and functions despite changing internal demands and
external forces (Carpenter & Brock, 2008). In essence the system adapts. Folke et al
(2012) argued that in some circumstance when the stress is great, mere adaptation is not

feasible. Walker, Abel, Anderies, and Ryan (2004) argued, "Transformability means defining and creating new stability landscapes by introducing new components and ways of making a living, thereby changing the state variables, and often the scale, that define the system." In the context of aging, a transformative change would occur when an individual strives for physical safety and security.

The SES literature also induces the idea of agency through the concept of adaptive management (Berkes, Folke, & Colding, 2000; Berkes & Ross, 2013). Adaptation or transformation is not simply a function of system dynamics as would be the case in ecological theory, but organizations or individuals become actors who may guide or direct the behavior of the system to meet their own specified goals. In this context, Villages can be viewed as agents (stakeholders) that contribute to an adaptive process that enables older adults to maintain their existing life norms through modest changes in their living environment. Villages may, in fact, forestall the need for transformative adjustments, as would be required after moving in to assisted living, by allowing individuals to maintain existing relationships and living environments.

Places and adults can be resilient within the context of residential normalcy (Golant, 2015b). Resilient places (those with adaptive capacities) offer a variety of resources that enable older adults to easily and quickly rectify incongruence. The characteristics of resilient places operate across scales (e.g. place, activities, people, governance) but unequal levels of place resiliency will account for more variation in the coping repertoires of older adults. Communities that offer older adults a variety services and opportunities have adapted to the realities of their aging populations. Therefore

multi-level efforts to promote the health of communities, such as Villages, may also promote the resilience of older adults (Aldwin & Igarashi, 2012).

In chapter six, I organize my empirical observations around the two theoretical concepts of residential comfort and mastery (Figure 9, p.118). Village members were compared to non-village members in their potential abilities to retain or renegotiate residential normalcy. Obtaining residential normalcy or near residential normalcy will most likely allow older adults to remain in their homes. As Golant pointed out, residential normalcy is not dependent on older adults merely confronting undesirable circumstances, but on how effectively and skillfully they deal with these situations (2015a, p. 101).

Conclusion

Aging in community involves complex factors that go beyond the physical environment. An older adult living in in an incongruent environment should not simply be expected to move, as his or her home holds financial and emotional meaning. However, staying at home can be an isolating and precarious existence. Economic uncertainty, poor health, limited access to health care information, and lack of services are obstacles to resilient aging.

The reasoning older adults use as they assess their living situations can be an important factor in how they will age in community. The theory of residential normalcy, in conjunction with my literature review on why older adults may want to age in community, was key in developing my research questions. Were the study participants experiencing residential incongruence and if so, what kind and how did they cope with it? What forms of assistance, according to the Village volunteers and members, were helpful in maintaining the ability age in community? The academic literature described Villages

as offering assistive programs that may allow older adults to age in community. However

the literature does not include research on how older adults operationalize Village

services and how these services allow them to meet their goals of aging in community.

Residential normalcy refers to living in an environment where an older adult feels

competent and control despite limitations. Examining the role of Villages in this context

shed light on how older adults aged in community and what factors may contribute to the

older adults' resiliency.

CHAPTER III

Context: Growing Older in Fairfax County

"In short, the…suburb was a collective effort to live a private life."
--Lewis Mumford, The Culture of Cities (1938)

In 2010, 39 percent of suburban residents near the nation's largest metropolitan areas were either Baby Boomers or from the older Silent Generation (Frey, 2011). Not only aging in place, but also the departure of younger, more typically mobile residents and the in-migration of retirees dictate this "graying of the suburbs." As percentages of older residents rise, neighborhoods become NORCs. As NORCs were not intentionally planned, they lack the built-in supportive services of formalized housing for adult populations. Therefore, NORC-residing older adults and their families must find and coordinate programs that enable healthy aging at home. The Village movement was a response to the paucity and fragmentation of aging services in NORCs. This chapter is a description of the geographical context of the study area and provides an overview of Villages in the Washington, DC region, including Mt. Vernon at Home.

Fairfax County: Then and Now

The Mount Vernon at Home Village is similar to a majority other Villages located throughout the United States as it is located in a prosperous, white, middle-to-upper income community (Lehning et al., 2014). Mount Vernon at Home supported neighborhoods in a section of Fairfax County, Virginia—a county that grew rapidly after World War II. In 1940, Fairfax County was a rural enclave outside of Washington, DC with 40,000 residents. By 1970, the population grew by ten times to 454,000 (Fairfax County, 2015). Fairfax County had become an ideal bedroom community for the ever-

increasing numbers of government workers. Northern Virginia's business-friendly

"growth machine" (Molotch, 1976), fueled by abundant parcels of developable land, the

Interstate Highway System, and easy access to federal government offices, spurred the

development of thousands of single-family subdivisions across the 407 square-mile

county.

Located south and west of Washington, DC, Fairfax County had just over one

million residents in 2015 and regularly ranks among the top five wealthiest (according to

median household income) counties in the United States (U.S. Census Bureau, 2013b).

Sixty percent of residents had a bachelor's degree or higher (Fairfax County, 2015),

while the state average for residents with a bachelor's degree Virginia in 2013 was 30

percent. In 2015, 11 percent or the population was over 65 years of age population and

six percent of all residents lived in poverty (Fairfax County, 2015).

The prosperity and high-quality of life experienced by many of the county's

residents led many older adults to age in place there despite the transience of the

Washington, DC metropolitan area population. This is demonstrated by the in- and out-

migration of older adults as a small percentage of total migration within the county.

According to US Census data, migrants who were 70 years of age and older constituted

only 2.3 percent of all domestic migration to and from Fairfax County[1] from 2006-2010.

Of those older migrants, 55 percent (1,867 out-migrants) moved from Fairfax County

while 45 percent (1,509 in-migrants) moved to the area (Maliszweski & Cahill, 2012).

The reasons Fairfax County grew are perhaps the same as why its older residents

have chosen to stay—access to the amenities of Washington, DC and large houses on

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[1] Including independent cities of Fairfax and Falls Church.

private lots. Large single-family homes, prevalent during the county's boom period and often requiring reliance on the automobile, have become primary obstacles to aging in place (Cisneros et al., 2012). Despite the urging of the urban sociologist Lewis Mumford (1956) regarding the benefits of integrating older adults into intergenerational settings, older adults' community needs were not given consideration during the suburban growth machine era (Fleming et al., 2003; Gilbert, 1999; Schwarz, 2012). Suburbs were built for young professionals with children; aging-related needs were not part of the development process. Perhaps it was the conventional belief at that time that older adults would most likely be faced with the traditional choices of that era—moving away from their homes into age-segregated housing (e.g., nursing homes) or living with younger relatives who could care for their needs.

Fairfax County is the largest locality in Virginia and houses 119,000 (or 11 %) of the Commonwealth's adults aged 65 years or over (U.S. Census Bureau, 2014).[2] The county's population of those 65 years and older and the median age of residents rose steadily from 1970 to 2014 (Table 1). Fairfax County planners project that the percent of residents over age 65 and older will grow to 15.2% of the population by 2030 (Fairfax County, 2014).

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[2] Highland County on the border of Virginia and West Virginia has the highest state percentage of adults 65 and over (33.2%).

Table 1
Percent of residents aged 65 and over and median age of Fairfax County residents, 1970-2014

Decade	1970	1980	1990	2000	2010	2014
Percent age 65 and over	3.0	4.5	6.5	7.9	9.8	11.0
Median age (years)	25.2	30.1	33.1	35.9	37.3	37.4

Note: Adapted from Fairfax Demographic Reports, 2014 and the American Community Survey, 2014 (5-year estimates).

Areas of Fairfax County contain several NORCs. Census tracts with higher populations of adults over 65 years of age are clustered around the edge of the county (Figure 4), particularly in the northeastern and southeastern areas along the Potomac River and close to Washington, DC where a significant amount of post-World War II housing development took place. As shown in Figure 4, tracts with populations in dark orange have over-65-year-old residents exceeding 20% of the total population. The Mt. Vernon at Home service area, well within a NORC, is located in the lower right-hand corner.
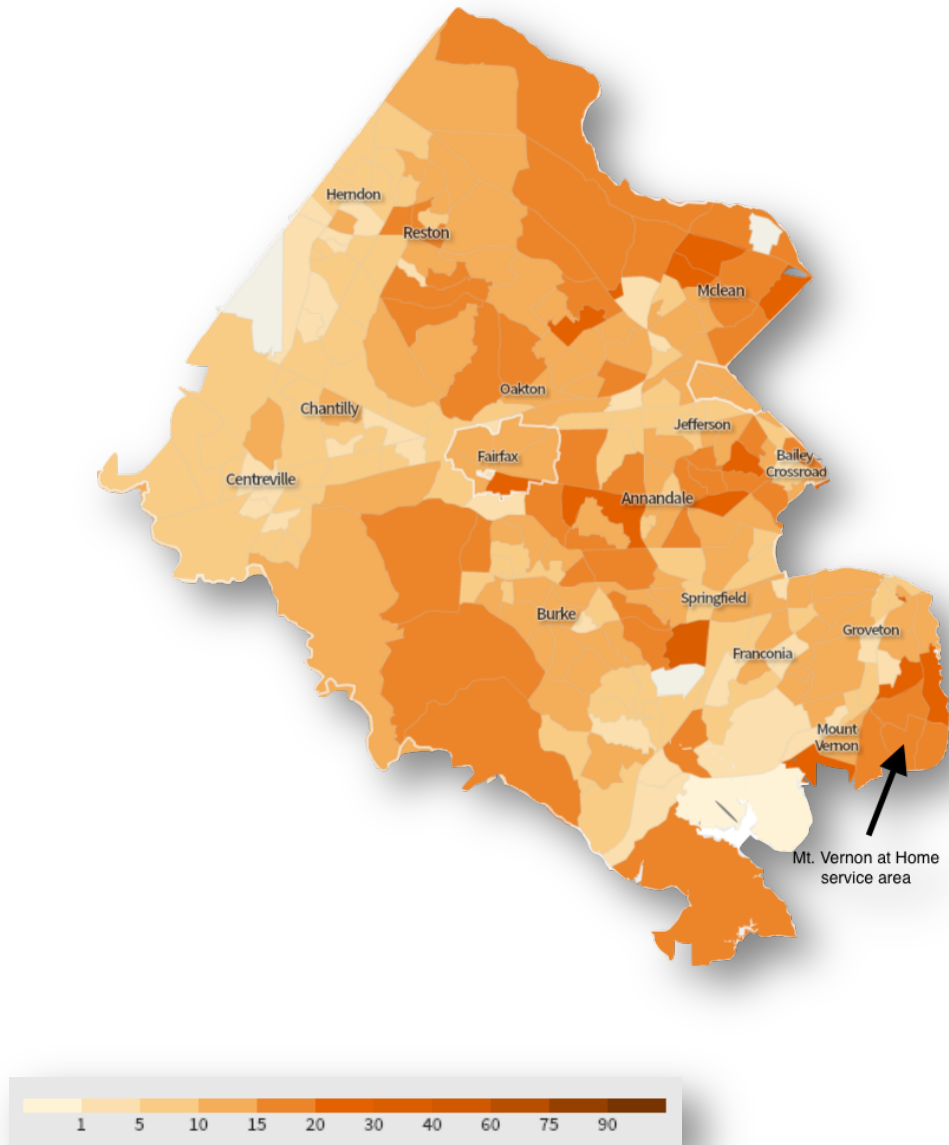
Figure 4: Percentage of population over age 65 in Fairfax County, VA by census tract
Source: ACS 2014 (5-Year Estimates), Social Explorer; U.S. Census Bureau, 2014.

Twenty-eight percent of adults over 65 years of age in Fairfax County report having

a disability, 31% aged 75 and above live alone, and 48% of residents aged 80 and older

have one or more of the following limitations: serious difficulty with walking and/or

climbing stairs, difficulty dressing and/or bathing, or a cognitive disability (Fairfax

County, 2015). The county has been preparing for the increase of an aging population by

supporting the development of affordable housing, creating awareness of Villages, and funding primarily low-income community-based aging services through non-profits, faith-based organizations (Fairfax County, 2014).

As of 2015, Fairfax County did not provide any direct financial support to Villages. It did provide grant funding to Northern Virginia Rides, a database overseen by The Jewish Council for Aging that Villages and other community-based aging organizations used to schedule and coordinate transportation requests among recipients and volunteers. Some non-profits and faith-based organizations, such as Shepard's Centers, provided rides to nearby community-dwelling older adults without income restrictions.

As a response to the county's changing demographics, the Fairfax Area Agency on Aging and the county board of supervisors enacted the Fairfax 50+ Action Plan (Fairfax County, 2014). The document contained action items specifically targeted to older adults that include identifying trends and incorporating them into long-range planning; providing improved services for older adults and family caregivers; promoting safe and healthy communities; supporting assistive home technology; and offering improved transportation options. Various stakeholders (e.g., George Mason University research centers, citizens, area aging agencies, county service departments) oversaw the implementation of the action items and the Fairfax County Commission on Aging is charged with tracking the plan's outcomes. Out of the 31 initiatives, two included the topic of Villages, and these action items were centered on promoting awareness of the Village model. Twenty action items were specifically targeted to residents currently aging in community. A recent progress report on the status of the initiatives stated that

five of these 20 action items have been implemented: conducting a transportation awareness fair, providing two volunteer programs for older adults, publishing an accessibility guide for home modifications, and establishing a database for coordinating transportation requests among community-based organizations (Fairfax County, 2016) These projects are seemingly small steps towards an increasingly important objective of creating age-friendly communities.

As the county's residents became older and more diverse, supportive services have become increasingly in demand and these programs compete against large budget categories for funding. Tax revenues must now support not only schools and infrastructure, but also social programs for older adults, immigrants, persons with disabilities, and low-income families. The Great Recession of 2007-2009 had a dramatic impact on Fairfax County. Since 2008, the county eliminated 700 jobs, the number of people living in poverty increased by 55 percent, and $300 million was cut from the general budget (Olivo, 2016). The demand for services has increased, but resources to support these programs dwindled. Fairfax County's efforts to address the needs of its aging population through collaborative and leveraged initiatives such as the 50+ Action Plan are necessary but are constrained by limited resources, stakeholders' willingness to participate regularly, and the amount of time it takes to implement such measures. Villages are a direct response to the time and financial limitations of local governments; their founders did not necessarily distrust government but believe that it did not offer many of the timely solutions they needed (Lang, 2012, p. 21). Villages build on the residents' feelings of self-reliance to create real-time solutions to issues that traditional agencies and organizations do not provide.

Villages in the Washington, DC Metropolitan Area

Washington, DC and its suburbs have the highest number of Villages of any metropolitan area in the United States (Bahrampur, 2014, February). The number of operating Villages in the Washington, DC metropolitan area has tripled in the last five years. As of spring 2016, there are 35 operating (blue) Villages in the Washington, DC metropolitan area and another 12 in development (red) (Figure 5). A local association supports the Villages, WAVE (Washington Area Villages Exchange), and some of the Villages are part of a national association, the Village to Village Network. Each organization provides information, shares resources, and manages forums to assist the Village staff in capacity building. According to the WAVE website, most of the Villages are located in NORCs comprised of single-family homes ("horizontal NORCs"), while others are centered on high-rise towers ("vertical NORCs"). Each Village has its own approach to service delivery, and they do not follow a strict formula. For example, the Reston Village in Virginia uses a community time banking model and emphasizes neighbor-to-neighbor connections while the Capitol Hill Village in Washington, DC promotes in-home care and medical advocacy services (Maggioncalda, 2014) .
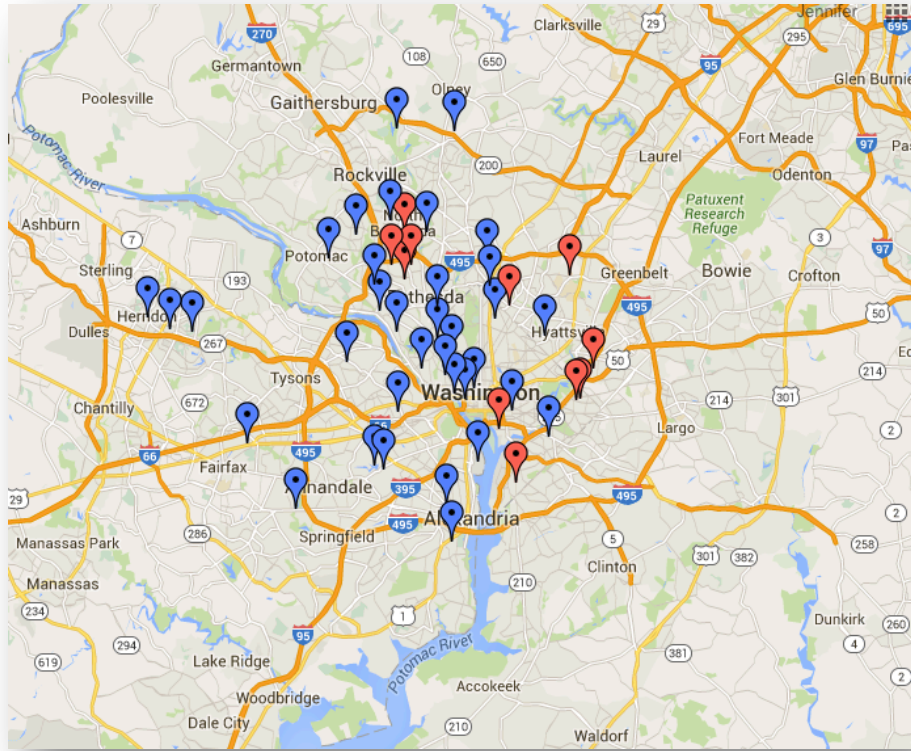
Figure 5. Locations of operating Village in the Washington, DC Metropolitan Area.
Source: Washington Area Village Exchange, 2016.

Conclusion

Fairfax County, once a sleepy suburb for young families who wanted to be close
to Washington, D.C., is now home to a rapidly aging and more diverse citizenry. Older
adults are determined to stay in the county. The existence of numerous Villages in
Washington, DC area indicates that the types of services they offer are in demand.
Although local governments are creating programs to enable aging in community, the
programs may take too long to implement for current populations of older adults or not
provide needed levels of service. In the next chapter, I described the methods used to
carry out research on aging in community in a part of Fairfax County.

CHAPTER IV

Method

This research was based on a case study analysis of older adults living within a Village service area in Fairfax County, VA. Using the lens of residential normalcy, I looked for patterns among the participants in relation to how they were aging in community. Specifically, I was interested in how older adults reported their current living situations and how they dealt with recent adversities in their living environments (e.g., home, community, social networks).

Case studies should be bounded (within a place and time) and have several sources of data (e.g., documents, interviews, observations) (Creswell, 2013). I chose to study one Village and its service area, the boundaries of which were used to identify the geographic area where sample interviewees were selected. The study took place over several years. I began volunteering with Mt. Vernon at Home in April 2012. I conducted formal interviews from August to September 2015. My volunteer duties were a form of participant observation that included transporting members to the grocery store, social events, and medical appointments; helping sort paperwork; providing minor assistance in members' homes (e.g., filling bird feeders, watering plants, companionship); working in the Village office answering phones and stuffing envelopes; and assisting at fund raising events. I completed 32 separate volunteer requests and wrote research memos for each. Resource documents included Mt. Vernon at Home annual reports, member rosters, the organization's website, and media accounts.

My volunteering with the organization led to the development of a rapport with the staff, members, and other volunteers. I was able to observe the processes within the

Village and establish trusting relationships that would further my research. I informed members I was conducting research on the Village, and was interested in their opinions, but they would not be identified or directly quoted in my findings. These conversations were informal in nature. I asked them how long they had belonged to Mt. Vernon at Home and what types of Village services they used. My volunteer work also helped inform my research questions and recruitment of potential participants (Mack, Woodsong, MacQueen, Guest, & Namey, 2005, p. 13).

Units of Analysis

The observational units in the study were the older adults residing within the Village's service area and the Village volunteers. The Village's service area bounded the study area and the participants. Within the study area were older adults aging in community (divided into four groups: Village members/volunteers, non-members, members only, and volunteers only). Individuals in each group discussed ways in how aging in community had affected their lives and how they viewed the role of Mt. Vernon at Home in those experiences.

Sampling Method

Miles and Huberman (1994) suggested that a case study sampling strategy should be relevant to the conceptual framework and research questions. For this case study, I conducted purposive sampling to generate detailed information that was theoretically appropriate (e.g., each member or non-member was aging at home and asked about their recent experiences, feelings, and plans to move away). I conducted sampling in two stages. The first stage was the selection of the Mt. Vernon at Home service area as the study site. The second stage involved identifying and selecting interview participants.

Sampling: Stage One

I chose not to take a multi-case study approach even though other Villages existed in Washington, DC, Maryland, and Virginia. I wanted to study a Village located in a large suburban county containing low-density residential environments, aging housing stock, an established history, and within a relatively small geographically specific service area. None of the other Villages in the three area jurisdictions met these criteria. The other Villages in Fairfax County were in the formation stages and had not established formal processes. Other features of the study area included:

- a variety of housing types composed of single-family homes, some garden-style and high-rise multifamily units, and an assisted living facility;

- limited public transportation options that made access to services difficult; and

- being contained precisely within Census Designated Places (CDPs), allowing me to access census data that was applicable only to the study area.

Community members founded Mount Vernon at Home (named after its proximity to George Washington's Mount Vernon estate) in 2007 (launching its programs in 2009). The Village had 177 members served by 80 volunteers who resided in the community/study area. Members' ages ranged from the mid 60s to the late 90s (median age was 81 years), most have lived in their homes for several decades, and worked in Washington, DC for most of their careers. A majority of the members lived in single-family home subdivisions and some used forms of assistance that included transportation, referrals, accessing aging-related information, organizational assistance, or minor home repairs. Mount Vernon at Home provided social activities, vetted consumer service referrals, and volunteer opportunities (Figure 6). The services listed in Figure 6 provide

assist with instrumental activities of daily living (IADLs) but not ADLs, as Mt. Vernon at Home did not provide direct in-home care services. The organization charged yearly membership dues of $700 for single members and $950 per couple.

Volunteers lived in the community/study area and ranged in age from teenager to early 80s. About one-third of volunteers were also members. A director and a full-time assistant oversaw day-to-day operations from donated office space in the local public library. The board of directors consisted of 17 Mt. Vernon at Home members and was complimented by an advisory council of 11 local business leaders, physicians, and attorneys.

Services, Activities, and Referrals Provided by Mt. Vernon at Home

Services:
- transportation to local medical appointments, hair appointments, grocery store, pharmacy, library
- shopping and errands
- simple household repairs and "handyman" jobs
- household chores (change light bulbs, hang pictures)
- computer and home technology (TV, DVD, telephone) support
- help with medical visits or hospital stays with trained volunteer advocates
- support during emergencies (hospitalization, family, bereavement)
- assistance with paperwork (medical forms, bill paying)
- companionship visits
- "Rise and Shine" telephone check in
- de-cluttering (organizing and sorting)

Activities:
- lectures on current events and wellness issues
- fall prevention exercise classes
- group visits to museums and theaters
- restaurant outings and potluck dinners
- bridge games, cocktail parties, movie nights

Referrals may include:
- specialized contractors to install safety features in homes
- home improvements/repairs
- home health care providers
- electricians, plumbers, locksmiths, roofers, etc.

Figure 6: Services provided by Mt. Vernon at Home. Source: Mt. Vernon at Home, 2014.

As of the summer of 2015, Mt. Vernon at Home membership comprised 137 households. Females as head of household comprised most of the membership and a majority of these women lived alone in detached, single-family houses. Less than a quarter of the membership lived in multifamily housing (e.g., townhomes, apartments, or condominiums) and a small percentage of members resided in Paul Spring, the local assisted living facility (Table 2).

Table 2

Household composition of Mt. Vernon at Home Members by Sex and Housing Type

	Head of Household (%)	Single-Family (%)	Multifamily (%)	Assisted Living (%)
Male	12 (8.8)	7 (6.3)	2 (10.0)	3 (50.0)
Female	86 (63.2)	68 (61.3)	15 (75.0)	3 (50.0)
Couple	39 (28.7)	36 (32.4)	3 (15.0)	0
All	137	111 (81.0)	20 (14.6)	6 (4.4)

Note: Adapted from Mt. Vernon at Home Annual Report, 2014.

In 2014, Mt. Vernon at Home filled 1,355 volunteer requests and provided 93 referrals to vetted contractors. Sixty-eight percent of all requests were for transportation. Remaining requests were for companion/errands (11%), home maintenance (6%), business referrals (6%), home technology (6%) and other (3%).[3] The operating budget for 2014 was $204,746, with a majority of revenues coming from membership dues.

While some members were volunteers, there was not a requirement for members to volunteer. Each volunteer must undergo a background check for criminal and driving offenses. Volunteer drivers are covered by Mt. Vernon at Home's liability insurance that supplements the volunteer's personal automobile policy.

Located in an unincorporated section of southeastern Fairfax County, VA, the Village service area (study area) was 12-miles south of Washington, DC. It is bounded by the Potomac River, George Washington's Estate (Mount Vernon) and U.S. Route 1 (Figure 7).

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[3] Source: Mt. Vernon at Home 2014 Annual Report
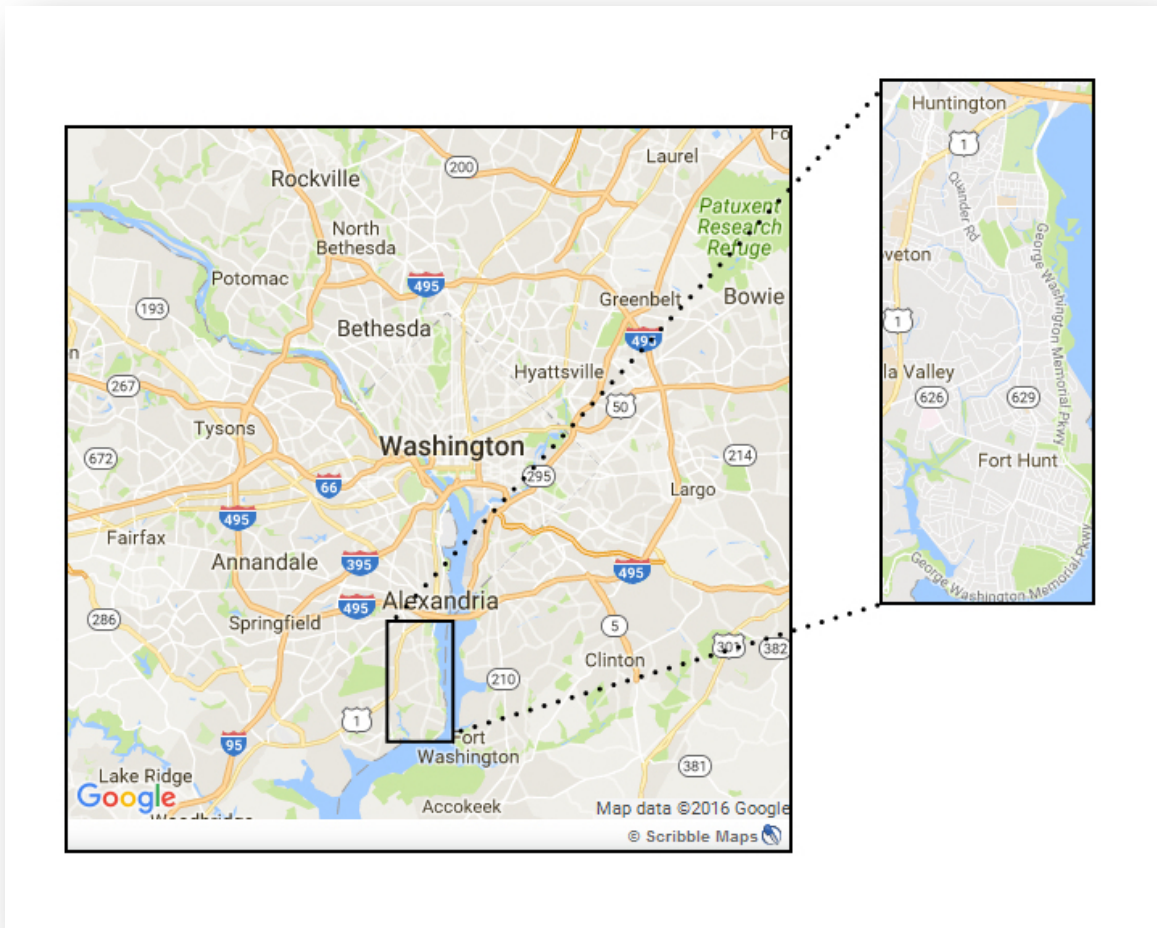
Figure 7. Mt. Vernon at Home service area's location in the Washington, DC metropolitan area.

The 14-square mile service area was contained within three CDPs in Fairfax

County (Belle View, Mount Vernon, and Ft. Hunt). According to data from the 2014

American Community Survey, this area had a relatively homogenous population:

residents are predominately white non-Hispanic (84%), have a median household income

of $134,000 per year, and live in owner-occupied homes (83%). The majority of the

housing stock was built during the 1950s and 1960s and the median home value for

owner-occupied units was $560,449. The total population of the study area was 36,000

with a density of 2,800 people per square mile.

In 2014, 16 percent of the population in the three CDPs was 65 years of age or

older, compared with 10% regionally and 13% in Virginia (U.S. Census Bureau, 2014).

Poverty levels for those over 65 were relatively low (4.3%) compared to 7 percent each

within the state of Virginia and the Washington, DC metropolitan region. A quarter

(26.4%) of the households reported receiving Social Security income, and a third (29.7%)

received retirement income. The study area's suburban location and demographics were

similar to other surveyed Villages' locations and membership demographics in the United

States (Lehning et al., 2014).

The inability to drive combined with a lack of other transportation choices can be

a detriment to aging in community (Black, Dobbs, & Young, 2015; Burr & Mutchler,

2007; DeGood, 2011). The study area had few public transportation options and was

composed mostly of detached single-family housing neighborhoods with limited access

to main roads. A county bus line ran from the south end of the study site to a Metro

station north of the study area boundary and the route was along a main thoroughfare in

the middle of the study area. The bus stops were located along the shoulder of a busy

road and difficult to access on foot from most of the neighborhoods. The bus and a

neighborhood retail center were most easily accessed from the multifamily condominium

units at the north end of the study area.

During my volunteer work, I observed that several Mt. Vernon at Home members

had relocated from their single-family homes in the study area to these properties in order

to be within walking distance to services. The availability of different types of housing

units within the community gave older adults the option of "moving out" but not "moving away." Some Village members who needed a higher level of care relocated to Paul Spring (at a discount provided by Village membership). Both groups were able to downsize yet remain in the community, maintain their social networks, and retain membership in Mt. Vernon at Home.

Sampling: Stage Two

In 2012, I received the support of the director to conduct this research. In 2015, I worked with the director to obtain names of member interview participants. The director suggested some members and I chose a balanced sample of participants based on varying lengths of membership, a lack of cognitive or severe hearing impairments (ability to hold a conversation), age, sex, housing type, and marital status. The director also provided names of volunteers who were not members and had worked with the Village for more than one year. In order to avoid bias in the selection process, I stated to the director that I wanted to talk to a range of individuals, not just Village "boosters." I also used snowball sampling (Atkinson & Flint, 2001), a method of asking for referrals from participants.

Recruitment of Study Participants

The director of Mt. Vernon at Home called or emailed the participants I selected. She explained who I was, the nature of my research, and asked if they would be interested in participating in an interview. This approach let the members and volunteers know that the director was aware of and approved my research. In order to avoid bias, she was explicit with the members and volunteers that participation was optional. The director contacted seven Village members, four Village member/volunteers, and three volunteers. All agreed to have an initial email or telephone conversation with me wherein

I explained my research in more detail. I followed up with all of the identified

participants with an email or a phone call (Appendix A) to determine their interest and

schedule or confirm the interview time. Two members and one volunteer did not respond

to my inquiries and were therefore not interviewed.

At the end of each interview with a Village member, I asked if he or she could

suggest any other members or non-members whom I could interview. Most did not offer

any names, but one member, Florence[4], suggested another member and contacted her to

see if she was interested. She was interested in participating and I completed an interview

with her. Florence also suggested a non-member, Mary Ann. Mary Ann agreed to be

interviewed, and she suggested I talk to three other non-members. Of those three, two

agreed to be interviewed. The director of Mt. Vernon at Home suggested two non-

member interview participants and one agreed to be interviewed. Table 3 summarizes the

number of referrals I received from the director or other community members and

completed interviews according to type of respondent.

Table 3
Number of referrals and complete interviews by type of respondent

Type of Respondent	Referrals	Completed Interviews
Member/Volunteer	5	5
Non-Member	6	4
Volunteer only	3	2
Member only	8	6
Total	22	17

Informed consent. The participation of all interviewees was voluntary, and each

participant provided informed consent before completing an interview. This study was

approved, as required, by the Institutional Review Board (IRB) for research involving

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[4] All participants were assigned a pseudonym.

human subjects at Virginia Polytechnic Institute and State University. Each participant received a copy of the signed informed consent form. The approved Informed Consent form for Participants of Investigative Projects is included in Appendix B. A copy of the IRB approval letter regarding this study is included in Appendix D.

Data Collection Instrument and Process

For this study, I developed a semi-structured interview instrument informed by methods outlined by Weiss (1994) and Creswell (2013). I developed three open-ended interview protocols for members, volunteers, and non-members (Appendix C). I designed the member and non-member protocols using my research questions and residential normalcy theory. In order to address my research questions, I asked participants why they did or did not join the Village, and what sources of support they used, if any. I asked members which Village services they used the most (or least) and other types of services they wanted to see offered by the Village. To determine levels of residential comfort, participants were asked about their current housing situation, their neighborhoods, community, and living in the Washington, DC area. Additional questions about plans to move out of their homes, their relationships with their adult children, and supportive services they used informed me of participants' feelings of residential mastery. The protocols for the Village member and non-member groups were identical except the members were asked why they joined Mt. Vernon at Home and what they found useful or not useful about the organization. Non-members were asked how much they knew about Mt. Vernon at Home, if they had considered joining, and why or why not. Additionally, I gathered demographic data such as age, marital status, occupation, education level, income level, and years lived in the community. Volunteers (including

member/volunteers) were asked about their experiences with Mt. Vernon Home, what may be lacking in the organization regarding services, and how they had observed differences in aging in community strategies between members and non-members they knew. Member/volunteers were asked questions from the volunteer protocol, which also allowed them to report their experience as members.

Dr. Rosemary Blieszner, a member of my dissertation committee, reviewed my interview questions. I then pilot tested the non-member protocol with two community residents not associated with the Village. I conferred with the Village director on my research aims and general nature of my questions, although she did not review any of the protocols nor did she know the identities of the interviewees.

I interviewed three volunteers (two non-member and one member) in a private room at the local library. One member interview took place on the grounds of the Mt. Vernon Unitarian Church and all other interviews were conducted at the participants' homes. Conducting interviews in person at their residences rather than over the telephone allowed me to observe body language, how they lived in their environments, and the conditions of their surroundings (Josselson, 2013)—information that indicated, to some degree, their levels of residential comfort and mastery. As the only interviewer, I kept the tone conversational, allowing participants to briefly digress from the questions and then I gently redirected focus back.

I digitally recorded the interviews and took handwritten notes. After each interview or participant observer (volunteering) experience, I wrote memos describing the surroundings and my impressions of each event. Each interview lasted between 60 and 90 minutes. All of the interview participants received hand-written thank you notes.

Trustworthiness of Data

Primary strategies used to ensure that qualitative methods are valid and reliable (Anfara, Brown, & Mangione, 2002; Creswell, 2013; Shenton, 2004) included member checks, triangulation of sources, transparency, purposive sampling, practicing reflexivity, and establishing rapport with the group being studied. Throughout this dissertation, these strategies were used to address validity and reliability.

I conducted stakeholder checks (Suter, 2012) that allowed participants to comment at the end of the interview on some of my observations and my verbal summary of the conversation. Stakeholder checks ensure that what was interpreted held the participant's intended meaning. I encouraged participants to contact me if they had questions or concerns.

To verify my data from the interviews, I discussed my findings with the Mt. Vernon at Home director wherein she compared them with her observations and experiences. I regularly met with two doctoral students from the Planning, Globalization, and Governance program to critique each other's research. They reviewed my method and, within the context of my codes, I described my findings. They helped focus some of my conclusions, and we discussed how my codes fit within the theoretical framework. My advisor reviewed my coding approach within the context of my research questions and theoretical framework.

In December 2015, I presented my initial findings to the Mt. Vernon at Home board of directors, members, and staff. It was an opportunity for those involved in the organization to provide feedback on my research. All of the responses were positive; no one offered critiques or observed that my findings did not seem representative of the

Village. Additionally, the validity of the data gathered depended on numerous readings of the interview transcripts, interview notes, and memos reflecting my thoughts, observations of the participants, and my role in the research process.

Analysis and Coding

I coded each interview using qualitative management software (Atlas.ti). Using a thematic analysis approach (Braun & Clarke, 2006), I coded the text on a line-by-line basis using terms that were related to concepts of residential normalcy: health, personal background, living situations, support, socialization, and challenges. I developed 130 individual codes. The codes were then grouped into seven larger categories: Activities; Backgrounds; Challenges; Family; Observations about Mt. Vernon at Home; Organizations and Services; and Residential Options (the categories and codes are listed in Appendix E). Within these categories, I reviewed the codes and compared them with my post-interview research memos looking for patterns driven by my research questions: joining or not joining the Village, services offered by the Village, challenges to sustainability, and differences between the Village members' and non-members' supports. I discovered four main themes across the data:

- access to information;
- the role of social networks;
- types of services used; and
- trusted guidance.

Within these themes were descriptions of members' and non-members' coping repertoires with regard to aging in community and the observations of the Village volunteers. These themes are expounded upon in chapter five.

Study Limitations

Because Villages are founded and led by local older adults, they mirror their communities. Villages share common goals and purposes but as Judy Willet, director of the national association Village to Village Network, said, "You've seen one Village, you've seen *one* Village" (Grantmakers in Aging, 2013). As this study examined a single community and Village, the results may not be generalizable. However, Mount Vernon at Home's demographic profile was similar to other Villages in the United States as surveyed in the literature (C. L. Graham, Scharlach, & Price Wolf, 2014; Lehning et al., 2014): a majority of its members are white, middle-class, and between the ages of 70 and 89 years of age. Therefore, findings from this research may reflect characteristics of other Villages.

The study design was cross-sectional. Therefore I was not able to gain a full picture of the participants' capacity to age in community over time. The interviews gave me a glimpse of how older adults' are aging in community, but I was not able to definitively answer whether Village membership contributed to residential normalcy over time.

Due to time constraints and difficulty in finding participants, I was not able to interview those who joined the Village but eventually moved away. Future research may permit making this comparison, as it would be useful to examine what factors, in the context of residential normalcy, led older adults to move away from their homes.

CHAPTER V

Findings

This research explored why certain older adults living in suburban environments chose to join or not join a Village, a form of community-based support. Additionally, I sought to identify not only what forms of assistance older adults used as they aged at home, but also which of the Village services were conducive to enabling them to age in community.

This chapter presents the interview data in the context of my research questions and uses the theory of residential normalcy to frame how the participants in the study area viewed aging in community. First, I provide the characteristics of the study participants. The remainder of the chapter is organized around my four research questions. Within each of these sections, I discuss themes relating to access to information, the role of social networks, the services the Village offered, and the importance of trusted guidance.

Characteristics of Study Participants

Twelve of the 17 interviewees had lived in the study area between 40 and 55 years. None were originally from the metropolitan Washington, DC region. Most had moved to Northern Virginia from other parts of the United States to start their careers or, in the case of one participant, to be near her adult daughter. All reported involvement in community building activities such as homeowners' associations, founding schools, and being active in local politics. A majority of participants had successful careers in highly competitive fields in Washington, DC and raised their families in the same houses where they were still living. Memories of accomplishments, friends, and special occasions came flooding back during our conversations. Not all memories were positive, however; one

participant became emotional when recounting her son's suicide, others sadly

remembered how hard it was to care for their aging parents many years ago, and how

they hated to think about moving away. Although these interviews took place at one point

in time, the participants' viewpoints were influenced by their past. Their impressions

were not just of the moment, but were manifestations of life-long experiences (Golant,

2003). Residential choices were influenced by past experiences as well as by present and

future goals and needs (Granbom et al., 2014).

Demographics

The mean age of all study participants was 81 years, with ages ranging from 62 to

95 years. Table 4 summarizes the age ranges of participants by status. Volunteer-only

participants were the youngest group and member-only participants were older than

member/volunteers. This suggested that older members might be less inclined to

volunteer.

Table 4
Age range and number of participants by status

Status	Age Range	Number of Participants
Member/Volunteer	72-88	5
Non-Member	82-86	4
Volunteer Only	62-71	2
Member Only	81-95	6

All participants had lived in the community between 15 and 55 years. Village

members had lived in the community between 18 and 55 years with an average length of

44 years. Non-member residency ranged between 15 and 45 years with an average length

of 36 years. Members had belonged to Mt. Vernon at Home between 1 and 8 years, with

an average length of membership of 5 years.

The interviewed group consisted of 4 men (all members) and 13 women (a combination of members, volunteers, and non-members) who were retired educators, engineers, managers, librarians, and homemakers. All participants were White, of European descent, and homeowners. Four of the member participants were married couples. I interviewed each couple together but analyzed their responses as individuals. This approach could introduce bias, as the presence of a spouse may influence an individual's responses or the researcher may favor one respondent's account (Forbat & Henderson, 2003; Newman & Cantillon, 2005). To prevent any unfairness in my interpretation, I was sensitive to imbalances in responses and did not observe one spouse dominating the conversation in either interview (Ummel & Achille, 2016). The two couples spoke equally and enthusiastically without discord. Occasionally one spouse interjected to clarify dates of certain events, or a spouse asked another to confirm if they remembered a detail correctly.

None of the member or non-member interviewees had adult children living at home. All, except one participant, had living adult children. A majority of the participants lived alone in single-family homes, while three lived in multifamily housing. Additional characteristics of all members and non-members are included in Table 5. Marital status and housing situation were included as they are factors in residential normalcy. The presence of a spouse may influence feelings of comfort and mastery. For example, a spouse may provide companionship and assistance around the house or conversely, a spouse may be considered a source of stress. The death of a spouse also affects how an individual manages his or her environment. These experiences are not determinative but mitigated by features and feelings of their residential contexts (Golant, 2011b).

Volunteer-only participants were not asked questions beyond age, the number of years

with the Village, and length of time within the community.

Table 5
Characteristics of Village-member and non-member participants

Characteristic	Village Members (*n*=11)	Village Non-Members (*n*=4)	Total Participants (n=15)
Marital Status			
Married	6	1	7
Widowed	3	2	5
Divorced	2	1	3
Housing			
Single Family Detached, Alone[a]	6	2	8
Single Family Detached, Living with Spouse	3	1	4
Multifamily, Alone	0	1	1
Multifamily, Living with Spouse	2	0	2
Education			
Less than High School	0	1	1
High School	1	0	1
College	5	1	6
Graduate or Professional School	5	2	7
Household Income per Year[b]			
$35,000 to $49,999	1	0	1
$50,000 to $74,999	2	0	2
$75,000 to $99,999	4	3	7
$100,000 or more	4	0	4

[a] One member was married but living alone due to her husband residing in an advanced care facility. [b] A non-member declined to answer.

Research Question 1:

What are the primary reasons older adults join or do not join the Village?

Mt. Vernon at Home Members' Perspectives

Members' reasons for joining were due to either (a) being part of a community

social network that also anticipated future aging needs or (b) they were in need of the

Village's services, prompted by a crisis or their adult children. Seven members did not

have an immediate need for many of Mt. Vernon at Home's programs when they joined

but they believed that the organization would help them in the future. Four members

joined out of necessity.

Members who viewed the Village in terms of anticipated support said they would

enjoy attending informational lectures, participating in social events, and have access to

aging-related information until they needed more intensive assistive services such as

transportation or advanced care referrals. Others joined due to needing services that

otherwise would not have been as easily accessed within the community.

Four of the member respondents (Claudia, Florence, Todd, and Toni) were among

the first members of Mt. Vernon at Home. These "early adopters," through their

leadership abilities and social networks, had been critical in garnering community support

for the organization. They stated that they liked the ideas behind Villages—neighbors

helping neighbors and a way for them to stay in their homes and the communities they

helped shape.

The early Village members had long histories of community engagement,

volunteerism, leadership roles, and successful careers in Washington, DC. They knew

they wanted to stay in their homes and anticipated they would eventually need the help of

a neighborhood Village to do so. Founding members spread the word about Mt. Vernon

at Home among neighbors, church members, and friends. Within a year, there was a

cadre of highly motivated, somewhat like-minded, young-old (65 to 78 years of age)

volunteers who moved forward to establish Mt. Vernon at Home. Most of the members at

that point did not need assistance but knew people who did. Claudia, an 81-year old

widow, stated, "Many people were feeling more and more isolated either because their spouse had died or was dying. Or they couldn't drive so we had to keep thinking of events that would be of interest." Florence, a 73-year old divorcée, did not need assistance when she joined but did it as "insurance" in case she needed services such as transportation or information. The founding members had been involved with the Village for almost eight years. Some were using Mt. Vernon's assistive services, such as referrals, but all of them were driving, and only one member occasionally used the transportation service.

Once Mt. Vernon at Home was fully established in 2009, it was clear to the founders that the organization would need to recruit new members as current members died or moved away. The Village leaders reached out beyond their social networks and began actively publicizing the benefits of membership (e.g., talks, media outreach, flyers, information booths). Three of the members (Wes, Merrill, and Boyd) joined Mt. Vernon at Home because they also, like the founders, agreed with the mission and believed they would eventually age into needing more of Mt. Vernon at Home's services. They joined either after reading about Mt. Vernon at Home in the media or after hearing about it through their social networks. They attended some social events but did not use the transportation services. They had belonged to the Village for about five years. Wes, a 72-year-old married member and volunteer said:

> I read about it in the AARP magazine. They happened to mention Mt. Vernon at Home in an article on Villages. And they gave the address and I said, "Gee that sounds interesting. Let me stop over…My wife and I joined as a [household]. If we [eventually] need transportation, I could certainly feel that we could ask for it.

Three of the newer members (Zora, a 95-year-old widow, and Phillip and Georgia, a married couple aged 88 and 83 respectively) were strongly encouraged to join by their adult children. A tug of war had been happening; they wanted to stay as independent in their homes for as long as possible but their adult children were beginning to worry about their parents' safety or were unable to regularly provide the assistance their parents needed. Zora's daughter lived in Pennsylvania. Zora reported that membership in the Village would give her, "someone to call on and help me around the house" when her daughter could not be there. Mt. Vernon at Home seemed an ideal compromise. The older adults would not need to move to assisted living but would instead be assisted by community-dwelling volunteers, a skilled director, and vetted contractors. Further, they would have access to social opportunities. The Mt. Vernon at Home staff and volunteers would provide some caregiving relief, and the older adults would not feel they were a burden to their children. Georgia, who had recently downsized from a single-family home to a condominium, commented:

> Although my son-in-law kept saying, "You should get out of [your house]." So we didn't, for a long time. [laughter] My daughter said, "[My husband] is so glad you're getting out of there." Well, he could see what [we were struggling with]. I think he didn't want to have to deal with that someday.

A recent member, Birgit, a 73-year-old woman joined Mt. Vernon at Home due to a crisis. Her husband was experiencing neglect in an Alzheimer's residential care facility in the community. Birgit described an incident where her husband had wandered away from the grounds:

I'm driving by Liberty Taxes there, and at the time there was a guy that had a big

Uncle Sam hat on and he was doing a moon dance or something and I was

looking over and thinking, "Gee, that's pretty funny." And then all of a sudden, I

look, and who do I see walking down [US] Route 1? The worst traffic in the

whole nation here. My husband! So, I pulled into the shopping area and I just

opened up the door and I said, "John, get in the car." And so, he got in the car and

then I drove [to the facility], and these two nurses or whatever they were, they

were ready to go out [to look for him].

She had additional bad experiences with the facility, and as a last resort, contacted

Mt. Vernon at Home after seeing information posted at the local library. Previously, she

did not think she needed to join because she was driving, had her circle of friends, and

her husband was not living at home. She discussed her situation with the Mt. Vernon at

Home director who recommended another nearby facility and helped with his placement.

Birgit described herself as budget conscious but said the $700 yearly membership fee was

"worth it" for helping her husband could receive better care. The Village suddenly

became useful during a crisis to someone who thought they did not need it.

Non-Members' Perspectives

I interviewed four residents of the Village service area who chose not to belong to Mt. Vernon at Home. The women ranged in age from 83 to 86. Two were widowed, one was married, and the other divorced. Three of the women continued to live in single-family homes where they had each lived for over 40 years. The woman who was divorced lived in a condominium she had purchased 15 years ago when she moved to the area to be closer to her adult daughter.

All of the non-members were aware of Mt. Vernon at Home but had varying levels of knowledge about what it offered. Two perceived Mt. Vernon at Home as an organization that only provided transportation, and they were unaware of the availability of social events, discounts, or referrals. Mary Ann, an 83-year-old widow, said she might be interested in joining, but did not know what Mt. Vernon at Home did, "besides driving people around and I don't need that." Stella, an 83-year-old married woman, echoed Mary Ann, "If I can drive, I don't need to belong to Mt. Vernon at Home."

This perception of the Village was due to lack of information about the services Mt. Vernon at Home provided, but also reinforced pride in not asking for any help. Self-determination and a sense of control are one of the most important drivers in aging in place (Bedney, Goldberg, & Josephson, 2010; Sherman & Dacher, 2005). The Village was not designed as a social service agency that provided assistance to only disadvantaged populations. Those who did not know what types of services Mt. Vernon at Home offered might mistake it as a direct-assistance group rather than as a neighborhood collaborative. All of the interviewees expressed pride that they had dedicated their lives helping others either through their careers or volunteer work, but

they did not want to be recipients of assistance. Stella explained they might join someday, "This is kind of ugly to say, but I think we'll be forced to at some point. That's reality." Not joining the Village in this context was an accommodative coping strategy. Stella's belief that not joining Mt. Vernon at Home meant that they were relatively stable in their residential normalcy; they might have some issues aging at home but "at least" they did not have to join Mt. Vernon at Home. Joining the Village suggested an admission of an inability to cope with the existing situation. Not asking for help from "strangers" buttressed the nonmembers' belief that they were experiencing residential mastery.

Another reason nonmembers gave for not joining Mt. Vernon at Home, after I described the services the organization offered and the dues structure, was that its services were redundant to their current support options. All of the participants stated that they had a circle of close friends (so they did not need the Village's social aspect), had trusted contractors, could drive, belonged to helpful churches, and were very active ("busy") in their personal lives. Fawn, an 82-year-old divorced woman, stated that she and her friends thought it was too expensive to pay to belong to such an organization if they did not "need" it. They had their friends, churches, and adult children to help them if they ever encountered difficulty at home.

The non-members interviewed did not view the Village as potentially enriching their abilities to stay at home (feelings of residential comfort or mastery). Due to a lack of information and misconceptions, non-members perceived joining the Village useful only in a crisis. It was not means of anticipated support that could expand their social networks or provide access to information before the need for intensive services arose. However, not all of the non-members were aging effortlessly in their homes. The support they and

the members used is discussed in the following section in the context of the second

research question.

Research Question 2:

What sources of support do non-members use in comparison to Village members?

Both members and non-members could be described as resilient adults (Golant,

2015b). All were socially engaged, had extroverted personalities, and were achievement

oriented as revealed by their life stories. Golant stated these characteristics tend to lead

older adults to seek out various and creative forms of assistance that will help them age in

community. I was interested in finding out what kinds of supports, especially during

periods of environmental incongruence, Village members and non-members used as they

chose to age in community. Were the forms of assistance the non-members used different

than what the Village members used? Was the Village redundant in terms of services, as

the non-members had indicated? Seemingly, Village members had access to consistent

and expanded sources of support; non-members would most likely have to rely on other

means of assistance if such a need arose. Participants in each group had chosen ways in

which they adapted depending on their social networks, services they needed, and

lifestyles. Some of the coping mechanisms and supports were similar, such as not driving

at night, checking in regularly with adult children, attending church, or moving their

bedrooms to the first floor. Other sources were significantly different.

None of the participants stated they were using other aging-related non-profit,

private, or government sources of support (e.g., Meals-on-Wheels, transportation

programs, case managers). However, non-members indicated that they had a safety net

similar to what Mt. Vernon at Home offered. I observed two dissimilarities when I

compared non-members to the members: (1) most non-members did not believe their social networks would change in the near future and (2) non-members did not have the immediate access to assistance (physical or informational) available to Mt. Vernon at Home members. Non-members relied on their churches, family, and friends to meet the needs they encountered. However, these sources of support were not consistent or, in some instances, did not provide the level of help they needed. Members also participated in their churches and kept in touch with family and friends, but they had the additional source of consistent and expert-level support through the Village.

Although the members and non-members lived within the same 14-square mile boundary, were in the same age range, and had similar socioeconomic backgrounds, they had somewhat different social networks and expectations of those networks. The members joined because they acknowledged that their ability to age at home would somehow be compromised in the future or they were already experiencing residential mastery issues. The early supporters of Mt. Vernon at Home knew each other through their social networks, and this was indicative of the homophily principle: that the likelihood of two people having social ties increases as their number of shared social characteristics increases (Popielarz & McPherson 1995 cited in Davitt et al. 2015). They attended the same churches; shopped at the same grocery stores; had the same political leanings; their children knew each other; and they tended to "run in the same circles." They had discussed the advantages of joining the Village when encountering each other in daily life. The members knew from their social connections that help in the form of the Village was there, understood the value of membership, and were willing to join as either a form of "insurance" or immediate assistance.

Those who did not belong to Mt. Vernon at Home seemed to have a different social network from the members. Non-members were aware of the Village but were not exactly sure what advantages it offered. Joining Mount Vernon at Home, in their opinion, was not going to provide them with desirable social outlets or assistance. Although the non-members had friendships, adult children, and deep ties to their community, they did not seem to have many overlapping social or professional connections with Village members. For example, three of the non-members I spoke with had connections, usually through their spouses, to the US military. Mt. Vernon at Home members had careers in civilian government service, education, and medicine.[5]

Non-members emphasized the importance of their family, friends, and churches in their lives and stated that when or if they needed assistance, they could rely on those relationships. Ellie maintained her ability to drive her car and was fiercely independent. She had given up downhill skiing at the age of 77 but had found new interests in ballroom dancing and taking international cruises with her 88-year-old romantic partner. He lived in his own house, but she described them as "looking out for each other." Ellie was determined to stay in her large single-family home for as long as she possibly could. She stated that if she encountered any mobility or health issues, she could rely on her friends and, most importantly, her adult son who lived in the area. Another son negotiated a way of checking in with her:

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[5] Although not part of the interview protocol, interviewees did hint at their political affiliations and there did not seem to be a wide variance. The non-members did not appear to be significantly more politically conservative or liberal than the members. The voter precincts in the Village's service area tend to vote majority Democrat. In 2012, Obama won 7 of the 10 service area precincts and lost the other 3 by only 3-5% percentage points.

And then my son in Oregon, the very quiet one, says, "Mom, would you just send

me an email every day, so that I know everything's okay?" He said my emails

have become famous. He and his wife love to read them.

Ellie stated that she had a busy social life, could drive, and had people looking out

for her, therefore, she did not see the point in joining Mt. Vernon at Home. Her adult

children were concerned about her living alone, but she had adopted the email strategy to

maintain residential mastery. As the emails were so well received, this also reinforced her

feelings of autonomy (an accommodative strategy).

Mary Ann, a non-member, had hip replacement surgery in the year prior to the

interview and described how she called on friends to drive her to appointments and check

in on her. She preferred to rely on her friends rather than her children (one of whom lived

in the area). Mary Ann stated that she believed that she could continue to rely on friends

in the future; her many friendships (with people of varying ages, but mostly women her

age) were a source of pride and residential comfort for her. However, research has

revealed that social networks change as a person ages (Carstensen, 1995; Cornwell,

Laumann, & Schumm, 2008; Krause, 1997b). Although her friends may die, become

sick, or move away, Mary Ann did not think she would need an expanded network to

provide support as she continued to age at home.

Non-member Fawn also relied on her friends but came to the realization this

approach was not sustainable:

As my daughter pointed out to me, "Mom, they're not gonna do everything for you.

You cannot expect them to be at your beck and call and drive you here and drive

you there." Right now, my friends have all gotten... I'm the baby of these people.

One had open-heart surgery, and this one has this, but they don't belong to anything [e.g., Village] and refuse to, and they say, "That's what we're for. I'll call you, you'll do it for me." I can't do that to other people.

Fawn wanted to depend on her friends as they wanted to depend on her, but Fawn's daughter urged her to rethink this strategy, as the friends would not be able to rely on each other for assistance when they were out of their residential mastery zones. Fawn did not want to ask too much of her friends nor have them become dependent on her. Fawn's daughter was urging her to join Mt. Vernon at Home, and she was cautiously considering it.

The members were more open than the non-members about their limitations and what strategies they employed or would employ if they could no longer age at home easily. Village members also used a combination of support within their network; their adult children, churches, and friends would help them occasionally, but they did rely on the Village when they needed assistance either with referrals or aging-related information. Unlike the non-members who relied solely on their friends and family, the members had additional sources of support and an expanded social network. None of the members I interviewed or volunteered for stated that they regretted joining the Village. They were pleased with the services the Village offered and the levels of assistance they received.

Village as a Source of Information

One of the main benefits of Mt. Vernon at Home was not only the availability of guaranteed immediate assistance but also the flow of information from the Village staff that guides members to resources related to the aging process. Members, especially those

who joined during a period of residential mastery, had time to think about what they would do if they could no longer easily live in their homes (or reached advanced stages of residential incongruence). If they lost the ability to drive, they would not have to live in isolation, be dependent on their adult children, or immediately move out of their homes. Mt. Vernon at Home would provide transportation to necessary destinations as well as information about aging resources, giving the member time to make an informed decision as to what were his or her next steps.

Mary Ann, a non-member, was beginning to think about moving to assisted living but was not sure when or where and seemed somewhat overwhelmed by her options. She was also confused by her long-term care insurance coverage. She stated, "And so you've got to sit down and figure out, 'Is it worth it or do I just forget it and pay for it when I need it?' It's a very, very cloudy area and somebody needs to make it really well known [and help us figure it out]." If she were a member of Mt. Vernon at Home the director would have been able to assist Mary Ann with both of these issues. Mary Ann had discussed assisted living options and her long-term care questions with her friends but had not received useful information. Her lack of access to information had her feeling frustrated and impacted her sense of residential mastery. Mary Ann's situation had not yet reached a crisis level as it had with Birgit, whose husband needed a better level of care. Six members cited the Village's ability to provide aging-related information (e.g., access to health care lectures, advice about advanced care, answering questions about Medicare coverage) as important.

Church versus Village: Different Types of Support

Members and non-members described their churches as sources of support for not only themselves but for other individuals aging in the community. Several Mt. Vernon at Home founders lived in the same neighborhood and belonged to the local Unitarian Church. Village members who belonged to the Unitarian Church described it as having many similar features as Mt. Vernon at Home. For example, a caring committee provided transportation, condolences, or in-home assistance for members who were temporarily incapacitated. Individual church members provided assistance on an informal basis to older parishioners such as changing light bulbs, helping with paperwork or offering rides to and from the church. The Unitarian Church also held social events and offered volunteering opportunities. Participants described other local churches as having similar arrangements and services.

Unlike Mt. Vernon at Home, churches provided assistance to older members free of charge. Three non-members cited their church participation as part of the reason they did not join Mt. Vernon at Home. They could receive assistance through their churches and paying a fee to belong to the Village seemed unnecessary. Members stated that fellow church members they had spoken with about joining Mt. Vernon at Home had similar perceptions—Mount Vernon at Home seemed redundant to the services the church offered.

Local churches, however, did not consistently provide members with access to certain aging information and resources. Unlike the Village, and according to members, the church administrators and volunteers were not always able to offer their parishioner's expert- or professional-level information on how to navigate insurance concerns, where

to find advanced care, or always recommend professional in-home services. Florence
described the caring committee at the Unitarian Church:

> Well, we have a committee of about 12 of us. Really about nine are active. And
> we help out [parishioners who need help at home] by driving and checking in but
> they still have questions about healthcare we can't answer.

The Mt. Vernon at Home director was a licensed assisted living administrator
with professional and long-time knowledge of local aging resources. Additionally,
members described some churches as experiencing staff and pastor turnover. For non-
members, I surmised that they did not have consistent access to a person within the
church that knew the members' health or personal histories. Conversely, the Mt. Vernon
at Home staff had been in place for several years and was aware of the Village members'
backgrounds and needs.

According to members, churches were not able to provide guaranteed rides and
services to those who were in need of assistance. Coordinating church members' needs
sometimes proved difficult and often depended on the availability of volunteers. Mt.
Vernon at Home members were guaranteed assistance and scheduling was usually not a
problem due to the large number of volunteers. Members needed only to make a phone
call (with at least a day's notice), submit their request, and they would receive help. If
volunteers were not available, either the director or the office administrator would fill in.
Membership dues ensured a consistent level of service.

The Village director, in some cases, talked to members' adult children (or other
family) about their parents' situations (When members joined the Village they were
asked to provide names of individuals that could help them in the event of a crisis.). If a

member were having difficulty aging at home, the director would discuss the issue with the member's adult children (or emergency contact) and the member. The director often negotiated a solution (e.g., downsizing, moving to assisted living or an advanced care facility, installing home safety features) among the adult children and the member. To my knowledge, local churches did not engage adult children (especially those who did not live in the area) on their parents' care situations. The churches did not have the capacity to take on this level of oversight.

Churches in the study area did offer some transportation, in-home assistance, and social outlets. However, the churches' lack of consistency and levels of service coordination as described by the interviewees was perhaps enabling less than ideal situations. Non-members, who were under the impression that their church provided all the help they needed, may have been trying harder to achieve residential mastery. They did not have the same access to information or assistance that was available to the members. Access to information is an important aspect of maintaining residential normalcy and a large part of why Mt. Vernon at Home was valuable to the members. The quality of information received and its role in solving problems builds a sense of residential mastery and control.

All of the members and non-members expressed contentment with their homes and neighborhoods. None of the participants stated that they wanted to move away in the near future. However the non-members had to adopt several assimilative coping strategies (e.g., regularly check in with their adult children, depend solely on their friends, church, or family in a crisis, hunt for information regarding long-term care insurance) that could have been mitigated by joining Mt. Vernon at Home. The next

section provides an overview of what the members and volunteers found especially useful about their affiliation with Mt. Vernon at Home.

Research Question 3:

Which features of the Village contribute to Aging in Community?

I asked Mt. Vernon at Home members which features of the Village they used most. I asked volunteers what features of the Village they thought most helped members stay in their homes and community. Members and volunteers discussed what they thought was useful about what Mt. Vernon at Home offered. Both groups cited access to niche services, such as transportation, decluttering assistance, and home technology support as helping members age in community. Members emphasized the importance of receiving services and information not only for themselves, but how access to information helped other members. All members and volunteers spoke highly of the Village staff's competence and trustworthiness. The Village volunteers provided a majority of the services offered by the Village but also helped ensure, through communicating with the director, that members were aging in community safely and effectively.

Ready Access to Niche Services

Transportation. Members and volunteers consistently stated transportation was the feature that was not only the most frequently used but also the most helpful in allowing members to age in community. With one exception, all of the members interviewed were able to drive regularly, but they liked knowing that the Village was there for them in case of an emergency. Two members had begun changing their driving habits such as not driving at night or avoiding highways. Most of my volunteer work

consisted of driving members to medical appointments or the grocery store, and other volunteers stated driving was their most frequent volunteer assignment. A volunteer and member, Wes, regularly drove three members to the grocery store on Wednesday mornings and then another group of two or three in the afternoon. He helped some of them shop and carried their groceries into the house. He noticed that the members enjoyed seeing and talking to each other during the trip. The shopping run had become a social event, and members told him they appreciated the consistency of the service. As a volunteer, I observed that the ability to have regular access to transportation was crucial for some of the members to be able to age at home, as they had limited access to alternative forms of transportation. Not being able to drive while living in an automobile-dependent, low-density residential environment is perhaps one of the biggest threats to residential mastery and a predictor of moving (Lord & Luxembourg, 2007; Tang & Pickard, 2008). Toni, a 79-year old widowed member and volunteer, stated, "You have to be able to *get* around, or you're *going* somewhere else."

Decluttering. All of the study participants, including the volunteers, mentioned that they were either thinking about how to get rid of a large amount of items or actively removing belongings they no longer used from their houses. The process of getting rid of "stuff" was one of the first steps in considering downsizing or moving away. They realized that many of their belongings had outlived their usefulness and if they were to suddenly die or become incapacitated their adult children would be burdened with having to empty out their houses. Adult children's concerns about their parent's material belongings can extend to their parent's safety (e.g., compulsive hoarding) and how they will dispose of the items (Ekerdt & Sergeant, 2006) after their parents die. Additionally,

the presence of a large number of items in a home can leave an older adult "frozen" in place due being overwhelmed by the need to make so many decisions (Luborsky et al., 2011). Mt. Vernon at Home provided downsizing assistance referrals and volunteers helped members with reorganization tasks; this allowed members to feel more control of their surroundings and to prepare for a potential move.

Zora's adult daughter urged her to start giving away some of her extraneous possessions. Mt. Vernon at Home coordinated the use of two professional organizers for her:

> And Mount Vernon At Home has made it possible for me to stay... For example, I called them and they sent me two concierges, who helped me. Being a librarian, I had lots of books. Lots of books. And all these things had come into my house for 50 years but very little had gone out so the house was very, very full of stuff. And the two women who I got through Mount Vernon at Home came and helped me dig it out.

Zora was determined not to move but had negotiated with her daughter that if she was going to stay she had to start cleaning out her house so her daughter would not be overwhelmed with the task later.

Toni was determined to stay in her house for as long as possible. She too had been discussing possession reduction with her daughter and step-daughter but had not sought professional assistance:

> My daughter would kill me if I didn't clean this house up before I died. [laughter]. She said, "You can't leave the house like this!" I haven't had very much help cleaning out the house. My husband's daughter comes up once in awhile, and we

actually have cleaned out pictures. My husband was into photography and he saved all the outtakes. We had a dresser full of outtakes, so we got that... We had so much stuff in one time that they wouldn't pick up the recyclables because the thing was too heavy. A lot of stuff could get tossed. I don't think when I die, there's gonna be a lot of problems... I wanna try to get rid of some of the art work and some of the stuff, hopefully, while I'm still active and whatever. We had a man who is in an auction house in Falls Church, and I've forgotten offhand, but he talked about, "Anything that you have that's kind of a collection, enjoy it, because nobody else will want it."

Todd, a 93-year-old member, described his version of decluttering—slyly passing off items to his adult children:

I got stuff here and I'm thinking, "What am I doing with this?" I've found [my children's] graduation diplomas and everything; I think they should have it. And little by little when they do visit, I sneak it on them. I wrap it up in something. I put icing on it; make everything a "cake."

Volunteers stated their work with Mt. Vernon at Home had them thinking about their experiences with their parents and how they are going to handle downsizing when and if the time comes. Working with the members had volunteers evaluating their situations and aging strategies. Sarah, a 62-year-old Mt. Vernon at Home volunteer stated:

I think just, especially when my mom passed away, and had a house that she owned for 50 years, and all this stuff, of which we all have now... Five kids have

some of that stuff. But it's like, I really don't wanna leave that for my girls, and I'd

like to do it when I'm healthy enough, and have the energy.

Mt. Vernon at Home volunteers were asked to help members sort through

paperwork and help with light organization activities. Sarah continued:

I helped someone sort her papers, which I'm the worst person to do that. But it

was just kind of sitting there for a couple of hours, and that was really interesting

to see someone going through the stuff that we collect, and people our age do it

too and how hard that is to let go of that stuff.

Volunteer and member Wes commented:

Getting rid of stuff is hard. I don't want to get rid of my stuff. I cleaned out my

father's house, my parents' house. My father died...I cleaned out his stuff. My

mother was grateful for that. But when she died, we just hired someone to clean

out the house. There was nothing in the house I needed or wanted. But my stuff.

That's harder.

Technology support. Two members mentioned the importance of the technology

support Mt. Vernon at Home provided. A volunteer estimated about 80% of the members

used computers and the internet on a regular basis. Interview participants had rarely or

infrequently used computers earlier in their lives, but had now come to rely on

technology for communication with friends and family as well as a way to gather

information on everything from hobbies to healthcare. The volunteers assisted members

with mobile phones, computer software and hardware, fax machines, and printers. A

member, Claudia, commented how helpful the volunteers were with her technology

questions and they "didn't make me feel stupid." Boyd, an 87-year-old married member,

described his children trying to help him to learn how to use his computer and it did not

go smoothly. He did not want to burden his children and preferred to have one-on-one

help from Mt. Vernon's at Home's volunteers.

A Trusted, Knowledgeable Village Director

All of the Village members I interviewed and volunteered for praised the Mt.

Vernon at Home staff. They consistently expressed respect for the director and the office

administrator. None of the participants indicated that the staff was not helpful or

discourteous. I observed the Village director created an atmosphere of trust and concern

with the members. She took the time to talk to members about their daily lives when they

called the office to submit a request or when she saw them in the community. Members

appreciated not only the director's prompt replies to their requests but her ability to deal

compassionately and discreetly with crises. Florence described the director's role as

being that of "almost a priest". She continued:

> I think she does a pretty good job of knowing [about members who are struggling
>
> at home]. She knows [the members] pretty well and she knows when there's a fine
>
> line. [The volunteers] give her good information, as when somebody isn't
>
> managing at home. Although she's had some tough situations of people losing
>
> their minds or their abilities to function. She's very careful and discreet.

The members' ability to trust the Village staff contributed to feeling more in

control and perhaps buttressed their residential mastery. They had, "confidence that these

relationships will yield predictable and certain outcomes, that they will be treated

honestly, compassionately, and with dignity and they will not be abused." (Golant,

2015a)

This sense of trust also allows the director to serve the important role of confidant, someone for members to talk to outside of family and friends. Members may not have wanted to let friends and family know of their struggles to cope at home; some members were estranged from or had deeply ambivalent relationships with their adult children while others did not have family on which they could rely. I observed members calling on the director for advice before talking to their family members. I discussed this with the Mt. Vernon at Home director and she stated this gave the members a feeling of control and I surmised it improved their residential mastery. Members were not ceding control to a social service professional or their families. Instead, they discussed their options with a trusted, knowledgeable advisor who could suggest potential solutions to their dilemmas (Greenfield et al., 2013).

Part of the Village philosophy is not to operate like traditional social service agencies. Villages want to be perceived as membership-driven, neighbors-helping-neighbors organizations (Poor et al., 2012). Yet, some within the Village movement expressed concern that as their membership ages, Villages need to provide care coordination to meet the members' growing and changing needs (Lang, 2012). According to the director, approximately 25 percent of the Mt. Vernon at Home's staff's time per week is spent on assisting Village members with requests that do not involve transportation, help around the house, or referrals. These requests have to do with access to information and navigation regarding institutional care, health care, or other complex systems. Typical examples of questions were:

> *"Please help me contact the social security office. They won't return my calls."*
>
> *"I have a question about my long-term care policy."*

"My husband is being mistreated in his advanced care facility. What can I do?"

These "spur of the moment" care coordination types of requests were not officially quantified for reporting purposes (as volunteer hours and number of referrals are), yet they may be the most important of all the services to the members. The director described these requests usually taking place in person during impromptu meetings while running errands, at Village social events, or members calling her at the office or on her mobile phone. From my observation, the director was continually available to the membership to answer such questions and, to the best of her ability, followed through to resolve these issues for members. Although she was not a social worker, she provided an approach that combined aspects of case management.

Volunteers: The Village's Eyes and Ears

Volunteers are crucial to the Village model as they provide a majority of the services members use such as transportation and technology services (Greenfield, Scharlach, Lehning, et al., 2012). Because volunteers typically lived in the same community (service area) as the Village members, they were not perceived as "outsiders" (and perhaps able to more quickly build a trusting relationship). The important role of Village volunteers was not included in the Village literature. It was the volunteers' ability to provide not only services but also to report on the members' welfare that was integral to the aging in community process.

The volunteers spoke favorably of Mt. Vernon at Home, both about its mission and how it operated. None of the volunteers stated that they thought Mt. Vernon at Home could improve or that any crucial supports were lacking. The two individuals who served solely as volunteers joined for different reasons. One, Sarah, knew the director, who

convinced her to volunteer and the other, Elsa a 71-year-old married woman, read about

Mt. Vernon at Home in the local newspaper:

It was when they were in the planning stages, and I thought, "As soon as they get

going, I'm gonna volunteer." So as soon as they did, I called and said that I

wanted to volunteer, and [the Village administrator said], "Well, why don't you

come over right now and volunteer?" And I said "Nah, I'm gonna wait a little bit."

Before I knew it, she was in the front of my house. [laughter]

Elsa stated that she liked how proactive and engaged the staff is and spoke about

how integral they are to the success of the organization. Both Sarah and Elsa anticipated

eventually joining as members. They found satisfaction in not only volunteering but also

getting to know members of their community.

The Village director counted on the volunteers to act as her "eyes and ears"

regarding how the members are negotiating aging at home. Volunteers, who typically

spend at least one hour with the members and often enter their homes, were instructed to

notify the Mt. Vernon at Home staff if they observed a member having difficulty

physically, cognitively, or environmentally. Examples included hoarding, bruising,

mobility problems, falling, confusion, and depression. Members sometimes downplayed

obvious signs of difficulty and asked the volunteer not to mention anything to the

director. When I volunteered to give a member a ride to the grocery store I noticed that

she had a large bruise on her face and several on her arm. She told me she had fallen in

her backyard but asked me not to tell the director of Mt. Vernon at Home because she did

not want her adult children pressuring her to move. She said she had been to the doctor

(even though I was not sure how she got there) and she was fine. I contacted the Village

director out of concern and knowing it was something I was required to do. The director said she was aware the member had fallen. She indicated she would be contacting the member's adult children. Although she understood the members' need for control, the staff did not ignore members' being secretive about safety-threatening situations.

Volunteer and member Wes described an experience he had with a member who fell during a to the grocery store:

> Every time I report a mishap to the director. I had one lady fall at Safeway. I called 911. She was almost finished, and her cart was full of stuff. I went ahead after she went to the hospital, I paid for her groceries. Took them to her home. Her daughter and son-in-law lived nearby, [the member] gave me their names. The guy had a key to his mother-in-law's house, and we got the refrigerated stuff taken care of.

From what I observed, Mt. Vernon at Home did not enable dangerous aging at home. When members joined, they agreed not only to pay yearly dues but also acknowledged that the Village was there to encourage healthy, reasonable aging in community and to be aware that the volunteers assisting them would be required to notify the director of problems they observed. The director would, as warranted, discuss the issue with the members' preferred contacts (usually adult children or other relatives) and refer health care or social service professionals. Members were aware that Village volunteers and staff would not only be providing services but checking in on them. This community approach not only built relationships among the members and volunteers but also enabled the director to identify potential health or welfare problems early on.

Members acknowledged that they must eventually sacrifice some of their autonomy if they wanted to stay in their homes. Although non-members did not specifically mention it, this lack of privacy may be why some older adults declined to join Mt. Vernon at Home; they did not want "spies" reporting on their levels of incongruence. Some members tried to circumvent volunteers observing their living situations by waiting out front of their houses to be picked up or discouraging the volunteer from entering their homes. The director described a member who would go on mail order shopping binges and the packages were piling up around her house. In order to prevent the volunteer from seeing this hoarding behavior, the member would open her front door only a crack and slip out so the volunteer could not see inside the house. However, the volunteer reported this behavior to the director, who in turn visited the member to check on her well-being.

Community-based volunteers can provide a form of less emotionally charged caretaking separate from that supplied by family members. Sarah noted that visits with members can be positive, friendly, and have different expectations than when relying on family for support:

> I know from my own experience, my sisters took care of my mom when she was aging in Massachusetts and your kids treat you differently than someone that just kinda comes in and is happy to help and, just brings that sort of objective, positive energy into the house…an outsider is different than your daughter that's coming after they've worked 40 hours a week and is taking care of the kids and it's like, "Okay mom…" Or, "You have to do this, mom…" So I think that that... I don't

know whether members joined for that reason, but I think that's definitely a

benefit that they get, is just someone that really dotes on them in a good way.

Research Question 4:

What are the perceived challenges to the Village's sustainability?

Although Villages are rapidly being established nationally and in the Washington,

DC area, the ability of the model to become a long-term presence in communities has

been questioned by scholars and policymakers alike (Lehning et al., 2014). Villages are

usually self-supporting, have limited access to resources, and experience steady turnover

in membership. Several Villages in the Washington, DC area have had difficulty

becoming established or maintaining services due to a lack of coordination or leadership

deficits. The local nature of Villages is a source of strength but also a limitation. Villages

are increasingly reaching out beyond their service areas to find sources of financial or in-

kind support. The challenges Mt. Vernon at Home faced, according to members,

volunteers, and the director, were related to maintaining leadership, service limitations,

membership recruitment, and members' ambivalence towards attending the Village's

social functions.

Leadership

Mt. Vernon at Home's director's ability to build trust, supply crucial information,

negotiate solutions with members and their families as well as run the organization on a

day-to-day basis was a part of the members' satisfaction. The director also worked with

the board on various organizational challenges, fundraised, recruited new members,

attends Village social events, and participated in related local and national conferences.

Her responsibilities were numerous, but she maintained the members' loyalty. Three

members expressed concerns that the director was so integral to the success of the

organization that replacing her would be difficult, if not impossible. They stated finding

someone with the current director's knowledge, leadership abilities, community

connections, and engaging personality would be a challenge to the Village's

sustainability. One member, Florence, said that if the director were to leave, she believed

Mt. Vernon at Home might fail:

> They [the staff] work like dogs, and we need them badly. I don't know who else
>
> would take [the director's] place. I can't think of anybody. [laughter] And she's
>
> been doing it for, I guess, three years. Maybe more. So, the reality is I feel a
>
> certain tenuousness about it all, really. Yeah.
>
> Member Phillip commented:
>
> The Mt. Vernon at Home staff are extraordinary people. I think without them, the
>
> organization is going to collapse. It's sad, its really sad to see that, but I really
>
> don't know what drives the staff, but the director, has given this organization all
>
> she has, and more.

Recruitment of New Members

Five of the interviewees stated that finding new members was a challenge for the

organization. Wes, a volunteer and member, commented:

> [Non-members] don't see the social aspects or they don't want it. "I don't need
>
> driving." "I can pay for a whole lot of taxis with the membership fee that is
>
> charged." They don't see anything beyond that. That is the challenge we have in
>
> soliciting new members. They don't see a value to it.

Similarly, Toni, a member and volunteer stated:

And so, the other thing that's kind of scary is, of course, we lose members, so it's a struggle to keep getting members as we lose members, you have to try to keep that balanced, and loss of people that, I'm not necessarily really close with, but still I knew them well enough to feel really sad about it.

Member Phillip said:

I think, from a kind of sociological point of view, it's a very difficult organization to maintain because of the attrition. We all are mortal. We depart from the organization and so the recruitment has to be very, very intensive.

The number of members has grown steadily over the years, but members were also leaving the organization. According to the director, they had very few dropouts and the majority of the members stopped participating due to death, moving away from the area, or needing higher levels of care. As the organization primarily relies on membership dues, maintaining or increasing membership levels is essential to building services and not raising fees. However, Mt. Vernon at Home cannot accept individuals who have high levels of care needs or have expectations that exceed what the organization offers.

Service Limitations

Mt. Vernon at Home offered a variety of services, but these services were bounded. Membership did not guarantee that one would be able to stay at home until death. The Village, in this case, was not a replacement for long-term care. Instead, it was a supplement to existing resources that gave older adults time to make informed decisions about where and how they will live.

The volunteers reported that members sometimes asked them to perform duties that were beyond basic home repairs or transportation such as moving furniture, pulling

weeds, or driving the members more than a few miles. Volunteers usually refused. The

director was supportive of the members' needs but did not want to alienate the

volunteers. The Village could not be "everything" to the members and the director

"worked to keep expectations reasonable".[6]

None of the members I interviewed indicated that they experienced service

limitations. All of the volunteers mentioned experiences with service limitations. A

member had started to use a wheelchair and she was not able to receive transportation

from Mt. Vernon at Home volunteers. Wes explained:

> We don't go beyond certain limits...sometimes people ask for stuff and [the
>
> volunteers] are not capable of...for example we have one lady who is not very
>
> mobile anymore. If they require a wheelchair, we can't take them anymore. Even
>
> if they call for help, we have to say no. I don't have the capability of taking a
>
> wheel chair. I can take a walker in my trunk but I can't take a wheelchair.

Although there was not an age requirement for membership, the director

interviewed potential members in person to determine the level of services needed. Those

who struggled with multiple ADLs and in need of higher levels of care were referred to

local providers instead. Members were limited to how many requests they could make;

those who requested more than three rides per week were encouraged to use a discounted

taxi service as a supplemental form of transportation.

Socializing within the Village was not a Priority

Two main purposes of a Village are providing members with a) direct assistance

(e.g., transportation, technology support) and b) social opportunities that prevent

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[6] Interview with the director of Mt. Vernon at Home, October 1, 2015

isolation. The social aspect of Villages was widely cited in the literature as an integral and important component of the model (Davitt et al., 2015; Greenfield, Scharlach, Lehning, et al., 2012; Poor et al., 2012). Surprisingly, participating in Village social events was not a primary reason for joining or sustaining membership according to most members. Although two of the members (a married couple) I interviewed cited the Village's social events as the primary reason they used Mt. Vernon at Home (but not why they joined). They participated in Mt. Vernon at Home's events although they emphasized that they already had active social lives. Merrill, the 87-year-old wife, stated Mt. Vernon at Home supplemented their social activities:

> You see, there's one thing I just really need to say is, that when I read about the Village in *The Washington Post*, I assumed that it was helping you get a ride to the hair dresser, a ride to the doctor's office, a ride to the airport, they certainly don't do the airports. And after we were members for about a month, I discovered that it was social. We were not looking for a social life…[laughter] because we already had that, we had a tremendous social life, I thought… And so we discovered that there were lots of parties, "Cheers", which ended up being a cocktail party, trips to the museum. Trips to the museum, I really like. And there were luncheons, and dinners, and teas.

Merrill and her 87-year-old husband Boyd joined Mt. Vernon at Home because they knew one of the founding members through their church. They liked the idea and joined even though they perceived the Village as primarily providing transportation assistance, which they did not need. They stated they did not use many of the supportive services and did not volunteer, but they, for the most part, enjoyed the social events.

Participating in Mt. Vernon at Home's events widened their social network and increased their access to information regarding aging resources.

Other members expressed ambivalence about Mt. Vernon at Home's social events. A majority of the members, including the founding members, stated they only occasionally attended Mt. Vernon at Home's social functions as they were active in their churches or already had a wide network of friends outside of the Village. All of the members I interviewed or volunteered for had attended some of Mt. Vernon at Home's social functions but did not mention them as being important at that time. They either expected to use more of the assistive services, such as transportation or referrals, in the future or were using them at that time. A 93-year-old member, Todd, attended a luncheon in a large group but was frustrated by the amount of time he had to spend at the event:

> One of the local restaurants we went in, I guess there were about nine of us. We were all sitting around just talking which was fine, but we were all sitting around talking for over an hour before anybody even came to take our order. And I thought, "They've gotta be able to do better than this." While we are retired, you do have things you want to do and you figure if you're going to go to a luncheon, if it's at noontime, you should be able to make an appointment for doing something at 2:30 in the afternoon, but here we [were] approaching 2:30…

He stated that the luncheons were a great idea but his time was valuable and this experience had him rethinking participating in another. Todd knew other members and they socialized outside of the Village occasionally. He appreciated that he had the option of going to Village social events but often did things on his own, such as visiting the senior center on a regular basis.

Other members stated that they were uncomfortable during some Village social events either due to existing cliques or by other members who were displaying physical or cognitive disabilities. Boyd expressed some discomfort when he described a recent Mt. Vernon at Home social event where he was surrounded by widows:

And at that same time there were only two, maybe there were three men there. And there must have been 20 [people in attendance]. And a lot of 'em, at least a half a dozen of 'em, were new to me, I didn't know them, and they were older widows. You know, walking with canes, and gray hair, and lots more wrinkles than I have.

Georgia, a member in her 80s, described her experience at a Mt. Vernon at Home social event:

And all the seating was taken and the tables, except this one table, and we didn't know anybody there, and there was not much in common with any of them there. It's a pretty…um, diverse bunch of people. And I didn't enjoy it at all.

Georgia described the dinners as not something she enjoyed but did like attending lectures and volunteering occasionally. I interpreted Georgia's use of the term "diverse" as meaning people with a range of disabilities and personalities, as the Village demographics were homogenous.

Wes described his wife's view on participating in Mt. Vernon at Home socially:

She's a pediatric nurse. She likes pediatrics. Not geriatrics. She wants nothing to do with old people. She had to deal with old people when her mother was alive. Her mother was old and got old slowly. She had to deal that, but she doesn't like to deal with old people. She wants nothing to do with them. Socially, if I go to a

picnic [at Mount Vernon at Home], she doesn't come. She doesn't want to. Which

is fine with me. She has her life, and I have my life.

These members expressed they felt discomfort around those they perceived as

frail and this led them to avoid certain social events. Member/volunteers did not cite this

discomfort when they were volunteering for other members.

During my volunteer work, I informally asked members if they attended Mt.

Vernon at Home's social events. Most responded that they attended a few per year but

what they valued other aspects. Socialization in the Village may combat isolation and

foster connections within the community, but was not cited as important by a majority of

members in this study. Members I interacted with tended to bring their social networks to

the Village and continued to participate with them. The social events were a supplement

to their current or future relationships; this perhaps contributed to their feelings of

residential mastery and that the Village was "insurance" against not only crises but also

changes in their social networks, such as friends dying or moving away.

Summary

Participants in this study were demographically homogenous. Nine (60 %) were

living alone in large single-family homes and a majority of all Mt. Vernon at Home

members are women living alone in single-family homes. Volunteers and volunteer-

members were younger than those who were members only. All of the members and non-

members experienced some levels of residential incongruence, although none reported

facing a crisis necessitating a higher level of care. Participants had changed their driving

habits, felt overwhelmed by their material items, and sought out information on aging-

related services. The use of various forms of support buffered the community residents

from setbacks ranging from surgical recovery to finding improved advanced care for a spouse.

The themes of access to information, role of social networks, Village services, and the importance of trusted guidance were evident in the findings to each research question. Village members were able to access information from a centralized source whereas non-members had to seek out answers to health care on their own. Social networks helped determine if someone was going to join a Village and how they felt about participating in Village events. Village services such as transportation, decluttering assistance, technology support, and access to information directly assisted members in their goals to age in community. The volunteers said that the service of checking in and their ability to report issues to the director were primary forces in helping members age in community safely. The director's trusted guidance was critical to members' ability to effectively use Village services. However, despite the director's trustworthiness and dedication, the Village's ability to adapt to changes in leadership and the needs of its members may affect its sustainability.

CHAPTER VI

Discussion, Implications, and Future Research

This study explored how suburban older adults were residing in their homes and long-occupied communities with or without the use of a Village, an emerging form of supportive service. I used the experiences of older adults and community-based volunteers to gain insight into not only what strategies older adults employed but also what types of aging in community services they found useful. The limited nature of the research on Villages, despite the rapid proliferation the model, led me to investigate the following questions:

1. What are the primary reasons older adults join or do not join the Village?

2. What sources of support do non-members use in comparison to Village members?

3. Which features of the Village contribute to being able to age in community, according to the volunteers and members?

4. What are the challenges to the sustainability of the Village?

Addressing these questions within the context of the theory of residential normalcy revealed findings that have not been previously discussed in the Village research literature. Specifically, the members' relative indifference to the social aspects of the Village, the importance of access to high-quality information on complex issues such as health insurance and advanced care, and the Village as a form of anticipated support that informed members' feelings of residential mastery. In this chapter, I discuss the empirical findings within the context of my research questions and conclude with a final section on policy implications and future research.

Discussion

Villages, through their services and programs, attempt to enrich older adult members' coping repertoires to renegotiate residential normalcy. Village services may boost assimilative strategies that allow a member to age at home. When a member could no longer drive, Mt. Vernon at Home provided transportation to the grocery store, social events, and medical appointments. When getting in and out of the shower became hazardous, Mt. Vernon at Home gave the member names of vetted contractors who could install grab bars at a pre-negotiated discounted rate. Services such as these may support a member's feelings of residential mastery.

Additionally, Villages aim to assist residential comfort through offering social support, volunteer opportunities, and recreational events. When the time comes for a member to move away from home, the Mt. Vernon at Home staff can provide guidance on various appropriate housing choices within the Village service area (i.e., familiar community surroundings) in an attempt to alleviate feelings of residential discomfort.

These forms of efficacious assistance and the nature of the member's relationship with Mt. Vernon at Home provided the members with a sense of residential mastery knowing that assistance is "just a phone call away" as several members stated; the Village provided a safety net or "insurance" in case members had a crisis or quickly needed information.

After my analysis of the data I collected, I discovered four main themes relative to the participants' experiences with aging in community:

- access to information;
- the role of social networks;

- the services Villages offer; and

- the importance of trusted guidance.

Members and non-members had somewhat similar coping repertoires but differing ideas about the mission of the Village. The difference in coping repertoires was particularly apparent in discussions why certain individuals did not join Mt. Vernon at Home. Both groups relied on their social networks for support, but members had access to a centralized source of information and services that the non-members did not. The members' trust in the director was essential to their satisfaction and how they used the organization. Volunteers played a critical role in not only providing services to members but also ensured that members were aging at home safely.

Joining a Village: Value Added

The decision to join Mt. Vernon at Home was influenced by social networks, perceived aging needs, and perceptions of the organization. The members joined Mt. Vernon at Home for primarily two reasons: either because they anticipated using more of the services in the future or because they were out of their residential mastery zones (e.g., overwhelmed by clutter or seeking critical health care information). The older adults that joined for anticipated reasons were either impassioned founders or were recruited through their social network.

Participants in the study area who did not join Mt. Vernon at Home cited a combination of three reasons: (1) they were not aware of what the organization actually did; (2) they thought it was redundant to their existing social networks; and (3) as part of an accommodative strategy they differentiated themselves from an organization that was perceived as helping only the "old." Non-members did not express interest in joining the

Village although they anticipated needing assistance through their adult children, paid help, or having to move to assisted living.

However, Mt. Vernon at Home representatives, to help change the perception of the organization and recruit new members, could emphasize to non-members the Village is a form of anticipated support. Non-members could join before experiencing a crisis, receive access health care information, be provided transportation in case of emergency, and receive discounted referrals for services they may have not previously used, such as installing safety features and decluttering assistance. Non-members were proud of their achievements and ruggedly self-determined but could have benefitted from membership in the Village even if the support was mostly anticipated or perceived as "insurance" (Krause, 1997a). Additional forms of support and the ability to access information before a crisis arose would most likely increase older adults' abilities to adapt and maintain residential normalcy, which would further their abilities to age in community. Additionally, Villages need to continue to promote awareness of the value (e.g., referral discounts offsetting costs of membership fees) and utility (e.g., access to a consistent and expert level of information) of the Village to potential members. The Village offers more than transportation and social events; non-members who consider themselves "not ready yet" can benefit from the information and discounts it provides.

Participants in this study emphasized the importance of staying in their homes and neighborhoods as they aged. They did not describe themselves as "old" or needing high levels of assistance; they perhaps conflated the concept of "old" with frailty, decrepitude, and other ageist labels. Non-members equated joining Mt. Vernon at Home with being old and therefore undesirable. Their perception of the Village revealed ageism among

older adults and the pervasiveness of stereotypes related to growing older (Hurd, 1999).

Mt. Vernon at Home and other Villages will need to overcome these perceptions by

emphasizing that they are a component of an "all age-friendly" community and

participation benefits people of different ages, not just the "very old."

Members and Non-Members: Sources of Support

Research questions 1 and 2 were more closely linked than I had anticipated. Non-

members did not perceive the Village as of any added benefit because they could rely on

other sources of support that were familiar and perhaps more trusted. They did not see the

use in paying fees for what they could get for free. Family, friends, and churches were the

safety nets for non-members who wanted to continue to age at home and in their

communities. This strategy, when considered from the perspective of residential

normalcy, can be problematic. It may have taken the non-members longer than the

members to renegotiate residential mastery as the non-members were (a) relying on

friends and family who were not always available or felt burdened by requests and (b)

counting on their churches to provide a consistent level of support. Churches may not be

able to offer the levels of assistance non-members needed. Members had access to a

centralized and expert information source, which could increase an individual's ability to

adapt in times of environmental stress. Mt. Vernon at Home could work with religious

organizations in the service area to emphasize to non-members the utility of Mt. Vernon

at Home membership.

The results regarding this question also reinforced the academic literature on the

importance of social networks and anticipated support. All of the participants mentioned

their social networks as being important to them, but the members had an expanded

social network through the Village. As those members' knew died or moved away, they could use other social and supportive experiences within the Village, fostering residential normalcy through connectedness and purpose. Social relationships do not necessarily guarantee social support (Tang & Lee, 2011), but Village membership provided guaranteed assistance.

Additionally, this study found that it is important for a Village, or any community-based organization to confirm that their services are not redundant with existing options, but also how their services are differentiated from those of other organizations. For example, religious organizations may provide transportation, but Mt. Vernon at Home offered guaranteed rides on a flexible schedule and aging-related information may be available on various websites, but the Village provided tailored personalized guidance.

Village Features Contributing to Aging in Community

The features of the Village that allowed members to age in community were what was missing from the non-members' repertoires: (1) access to high-quality information from a skilled, trusted party, (2) consistent levels of service, and (3) flexible caretaking not provided by adult children, neighbors, or friends. When compared to non-members, members' access to these features may lead to increased capacity to age in community for a longer period. When residential normalcy is lost, it may cause older adults to be at much greater risk of having to relocate from their homes.

Member's access to niche services such as decluttering (surprisingly, a topic mentioned in all of the interviews) can help retain feelings of residential mastery. Decluttering is an assimilative act for older adults who are attempting to maintain or regain residential normalcy. They can have a feeling of control over their material convoy

(G. V. Smith & Ekerdt, 2011) while perceiving that they are taking steps towards moving away, even if they have no immediate plans to do so. Reducing their possessions also alleviates feelings of guilt about being a burden to their adult children and reinforces feelings of responsibility and independence. Mt. Vernon at Home's ability to refer vetted professional organizers and volunteers aided in this process and enabled a negotiation process between older adults and their children. Other services such as IT assistance and transportation allowed the members to not only accomplish basic tasks but helped keep them connected to their communities.

Additionally, the expert assistance offered by Villages was not emphasized in either the academic literature or the Mt. Vernon at Home marketing materials. In both cases, the social and transportation assistance aspects were emphasized, and that is how some non-members perceived the organization: as a group that provides transportation and social events for those who are aged and isolated. What non-members might not realize is that they as members would have consistent access to a knowledgeable advisor. They would have access to a type of information that goes beyond referrals regarding home repair services and professional organizers. The director provided "concierge" level access to information in the confusing and ever-changing health care landscape.

Village volunteers were integral to the organization not only because they provided transportation, the most used service, but also because they provided a failsafe for those who were in denial about or in the midst of losing their residential mastery. Without the input of volunteers, those who insisted on aging at home outside of their residential mastery zones and without consistent assistance were risking their health and

safety. Additionally, volunteers were important connections from the community for members, especially if members did not put an emphasis on attending social events.

The director, volunteer, and member form a feedback loop (Figure 8), wherein all parties provided information or services allowing the member to adapt during times of environmental incongruence. If the volunteer observed the member exhibiting physical, cognitive, or environmental issues, he or she then notified the Mt. Vernon at Home director of the problem, which prompted the director to discuss the issue with the member, usually in person. This process (known to the member, volunteer, and director) ensured that when residential mastery significantly decreased, other residential options (e.g., remodeling to accommodate a disability, downsizing, moving to assisted living) were discussed among the director, the member, and their families (if applicable). A situation that is agreeable to all parties was not always reached, but the members were not aging in isolation or in complete denial of problems, due to the volunteers' and director's involvement. This approach was a combination of intervention strategies that are informal (neighbor-volunteer) and formal (Village director) and may prove an effective tool in the support networks of families in community context (Mancini, Bowen, & Martin, 2005).
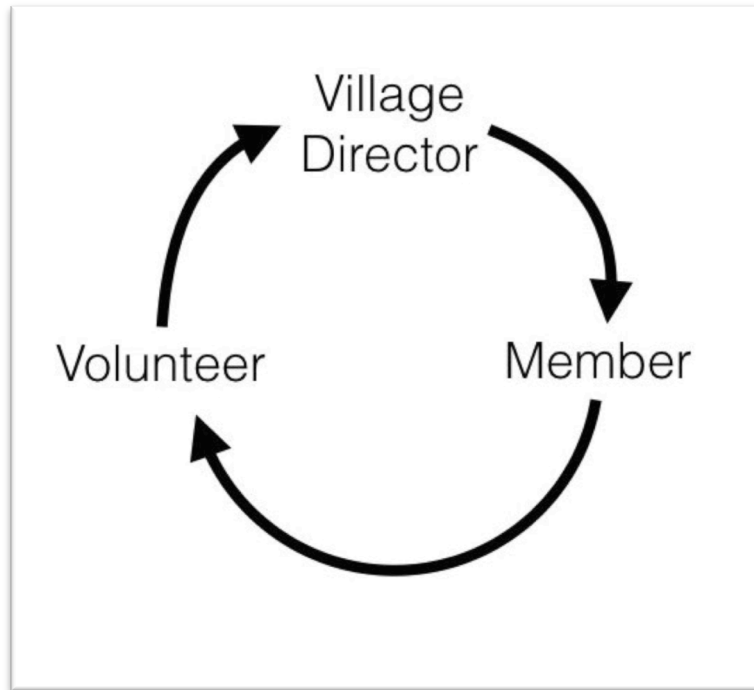
Figure 8. Feed back loop among volunteer, member, and director when a volunteer observes environmental incongruence.

Some older adults may prefer to have their friends and family provide assistance rather than "strangers." However the positive, light interaction among members and volunteers built social connections and reinforced the members' senses of residential normalcy. They did not feel they were burdening their adult children. Instead, they bonded with someone who lived a community in which the older adults had staked so much emotional and financial investment.

The members' ability to trust the volunteers and director was an important aspect in allowing aging in community. Without trust and the guidance the director provided, the Village could not have continued to operate and perhaps would have caused more stress to the members. However, the sense of trust led to some overdependence on the director, which is described in the next section.

Challenges to the Village's Sustainability

All of the older adults interviewed wanted to stay in their homes for as long as possible and avoid the stress of involuntary relocation. Neither the volunteers nor the members indicated any Village services were lacking. However, the organization faced challenges on several fronts. The membership was changing; members were dying or moving away yet it was growing. Therefore membership recruitment and fundraising had taken on a higher importance. The director assumed a large share of the organization's duties and was being pulled in many different directions. Older Villages are most likely experiencing similar problems as members age out and the newer members, who may only join during a crisis, demand more services.

The organization's increasing reliance on its director indicated that it could become managed in a top-down manner rather than horizontally or wholly collaboratively. The board was active in fundraising and membership recruiting, but the director and her administrator were expected to implement member's ideas (e.g., activities, recruiting speakers) in addition to their day-to-day duties and growing the organization. If they did not have time to see the ideas through, the suggestions were usually dropped. Members suggested for activities but did not always want to take the initiative in seeing the ideas to fruition. The director stated since the founding members had rotated off from leadership positions, board meeting attendance had been spotty, and she was trying to find more engaged participants. The Village members' trust and reliance on the director had become a double-edged sword. The director's competency and trustworthiness provided the members with increased senses of control and

satisfaction, yet they were becoming increasingly dependent on her to manage and grow what had been established as a collaborative organization.

Key Person Risk (also known as "Key Man Risk") is a reliance on one core person and can leave an organization vulnerable to collapse if that person were to resign (Ardiphine, 2015; Vickers, 2015). Mt. Vernon at Home's relatively small operating budget limited the number of staff and reinforced the importance of the director's role. As risk and responsibility are shifted from governments to private providers and communities, these organizations, some with limited capacities, must devise ways to mitigate the associated complications inherent within their structures. To this end, the Village could benefit from succession planning, a process that identifies and develops new leaders. Succession planning can increase an organization's ability to adapt successfully during leadership transition and keeps an organization in a preparedness state if there should be a leadership vacancy (Lubar Price, 2006).

The "early adopter" members were four to eight years older than when they joined. They expected to use more of the organization's services and to volunteer less frequently. If members volunteer less and use services more, Mt. Vernon at Home may have fewer charismatic "booster" members, fewer volunteers, and more demand for its assistive services. The lack of member boosters is an issue facing Villages nationally as their original leadership turns over (Lehning et al., 2015). The Village model was not developed to serve only those who are in crisis or be a conduit for services. Members were expected (but not required) to be active in the organization, initially as volunteers, and age into needing higher levels of support. Therefore the Village must be regularly recruiting new, younger members and volunteers to serve the members with the most

needs. There was a tenuous balance between those who had lighter demands on the organization and those who had heavier demands. Members who join Mt. Vernon at Home earlier in the aging in community process had access to information resources they would not otherwise had, and they could have been active participants in the organization's leadership.

The members' ambivalence towards the Village's social aspects could also be a potential difficulty. Members' reasons regarding the social activities had to do with not feeling comfortable around "old" people, cliques, and inefficiencies. Although members acknowledged that they attended events and realized the social aspects were an important component of the Village, they preferred to rely on their current groups of friends and pursue activities on their own. The reliance on existing social networks could lead to the Village being perceived and used as a service-providing organization rather than a collaborative effort that broadens social networks and supports healthy aging. The members' reluctance to participate in social events most likely does not apply to all of Mt. Vernon at Home members, but it may be a natural part of aging for some adults. Carstensen (1995) posited that as adults reach old age, they winnow their social connections to only the ones they perceive as the most important. The members interviewed for this study may view Village social events as extraneous to their current wants and needs. The mixed feelings regarding social events may not be an issue in other Villages, but Villages should regularly survey members regarding their preferences for social activities.

As the number of older adults in the community increases along with demand for assistive services, Mt. Vernon at Home may have to widen its service capacity. It may no

longer be enough to offer social activities, assistance with ADLs, and information. All assimilative coping solutions have, "implementation costs and usability barriers" (Golant, 2015b, p. 4). Mt. Vernon at Home's service limitations may become too onerous for members, which may lead them to make other choices in their goals to age in community. For example, a member could drop out of the Village because it cannot accommodate his or her needs and remain at home without assistance. Those who refuse to or cannot adapt (e.g., move from their homes, seek higher levels of care) may come to see the Village as irrelevant to their needs.

As the membership ages and demands for different or more intensive services increase, Villages will need to leverage a variety of partnerships. Joining with other non-profits, religious organizations, and aging service programs may be a relatively straightforward process as Villages, and these types of organizations share similar missions. One of the Village's assets, its membership's consumer power, may be key in partnerships with market-rate providers. A Village's pre-negotiated fee structure with vetted contractors is one example. However, exclusive partnerships with large, competitive companies such as insurance or housing providers may prove problematic. Continuing Care and Retirement Centers (CCRCs) are interested in working with Villages to form efficiencies, gain exposure to potential clients, or to generate their version of Villages ("CCRCs without Walls") (J. Graham, 2012). Villages may not want to become beholden to a single CCRC to recommend its services solely to the membership and, similarly, members may not want to be pressured into such an arrangement for their needs. Ideally, Villages will provide their members with an array of recommended housing providers so that they may make an informed decision when the

time comes to move from their homes. Members could reveal their preferences for

market-rate services through Village coordinated surveys and participation in community

planning forums (Warner et al., 2016).

Residential Normalcy and Village Membership

Figure 9 illustrates data derived from my analysis that most likely contributed to

the members' and non-members' feelings of residential mastery and comfort. Although

this study did not demonstrate that Mt. Vernon at Home members aged in community

more effectively over time than non-members, members may be more able to adapt to

environmental incongruence due to their increased feelings of residential comfort and

mastery derived from access to services and information. For example, non-members

may gain residential comfort from thinking that they can rely on friends and family if a

health crisis should arise. Members may also have friends and family on whom they can

rely, but they have the added resource of Village services to assist them during periods of

illness or incapacitation when they are out of their mastery zones. The supplemental

assistance of the Village may help them return to their residential mastery zones, albeit

renegotiated ones, and a congruent living environment.

	Members	Non Members
Study observations contributing to feelings of residential comfort	Established social network consisting of friends, family, and churches; expanded social network; trusted guidance	Established social network consisting of friends, family, and churches
Study observations contributing to feelings of residential mastery	Access to centralized, expert-level information regarding complex systems; volunteers checking in; consistent access to services such as transportation, information technology support, vetted referrals, and decluttering; proactively thinking about aging issues due to availability of information; not burdening friends or adult children with caretaking requests; Village as anticipated support	Not needing Village services; availability of friends, family, churches for immediate or anticipated support; ability to find aging-related information and services on their own

Ability to retain or renegotiate residential normalcy while aging in community

Figure 9. Study observations contributing to aspects of residential normalcy and the potential ability to retain or renegotiate residential normalcy while aging in community.

Village membership was not necessary to age in community. Non-members were satisfied with where they lived and were experiencing relatively minor levels of environmental incongruence. However, Mt. Vernon at Home provided services and trusted leadership that buttressed the members' feelings of residential normalcy. Feelings of residential normalcy will most likely assist them in staying in their homes and gave them the resources to make informed decisions about any future moves, whether involuntary or voluntary. If older adults' can stay in their homes satisfactorily and safely while engaging in their communities for a longer period, this could have a variety of implications such as lowering medical costs, avoiding premature institutionalization,

improving mental and physical health, and bettering service delivery. However, Mt. Vernon at Home must be able to effectively deal with its challenges to maintain operations and continue to assist older adults in adapting to a "new normal."

Theoretical Implications

Applicability

This study demonstrated the empirical applicability of residential normalcy theory to a community-based support organization. The two main functions of the Village model: (1) providing members social supports, activities, volunteer opportunities, and recreational activities and (2) helping older adults remain as autonomous and independent as long as possible through assistive services, align with the dual concepts of residential comfort (e.g., social support) and residential mastery (e.g., assistive services). Using residential normalcy as a framework or sensitizing concept while studying Villages or other aging in community programs may prove to be useful as empirical findings could be matched to the theoretical concepts of residential normalcy. How older adults adapt to their environments using community-based supports will become an increasingly important research focus as more Americans choose to age at home. Studying only the objective aspects of older adults' homes does not predict residential satisfaction. Older adults' relationships with their homes and community are a meaningful way to interpret how they adapt to their environments and make use of resources.

The model, however, does not account for how the presences of community-based services, such as Villages, contribute to feelings of residential comfort. The presence of aging-related resources in a community can influence the decision to stay in that community (Tang & Lee, 2011) and can have a direct impact on a person's feelings of

not only residential mastery, but also residential comfort. Members described how they were pleased with what the Village offered and these feelings most likely contributed to positive feelings about the community—they were glad that they lived in a place that had such a resource. Conversely, a poorly run organization or one they felt they did not fit into could have the effect of causing the member additional stress and conjure negative feelings about his or her community. I argue that it is more than the social components of Villages that lead to feelings of residential comfort—the presence of the organization may lead to positive feelings about the community.

Adaptation versus Transformation

The Village is an organization that contributes to members' resilience through adaptation rather than transformation. The current ecology theories applied to gerontological issues often do not include recent developments in the SES literature that distinguish between adaptation and transformation. Adaptation changes a system to a new equilibrium, but the structures and the goals of the system remain the same (e.g., able to stay at home rather than move to assisted living). Transformational change involves creating a fundamentally new system (Walker et al., 2004) when the previous system becomes untenable (e.g., moving to a nursing home). The person's search for residential normalcy then begins again in the new environment as he or she restructures his or her life around new activities and norms.

The older adults interviewed in this study were adapting to changing circumstances in their environments. Mt. Vernon at Home not only mitigated residential incongruence through providing access to resources and services but also helped the members adapt to experience a new rather than original equilibrium. For example, a

member had difficulty driving, but she did not have to move away because the Village provided her with transportation. To stay in her home, she adapted to a "new normal," but her environment remained the same. Also, volunteers providing feedback to the Village director was a factor in members' adaptation, as the director would intervene if she learned the member was experiencing incongruence. Mt. Vernon at Home's strategy maintained adaptation by keeping members' lives in a relatively constant state. Members would be faced with transformative decisions once their living environments became untenable, but they had access to information to assist in the transition that perhaps the non-members did not. The distinction between adaptation and transformation in the gerontological literature on resilience and aging in community initiatives could provide a finer point on how older adults negotiate their environments.

Policy Implications and Recommendations for Future Research

Policy Implications

It is critical that educators and policymakers examine aging in community strategies, considering the increasing population of older adults in need of supportive services, to determine if these strategies will support older adults living in homes and neighborhoods that were chosen during a different stage of life. Under the mantle of age-friendly communities and the increase in the number of older adults, local governments and non-profits are increasingly working together to avoid duplication of aging services while expanding social services, civic engagement, access to information, and social opportunities. However, this coming together will most likely be a slow process, as local municipalities and community-based aging programs may have differing priorities. Community-based programs such as Villages target middle-income populations, but local

policy makers may view their mission as assisting only the most physically and economically vulnerable residents.

Villages are described in the literature and media as primarily social organizations that provide transportation and referrals. However, this research demonstrated Mt. Vernon at Home provided more than social opportunities, transportation, and names of vetted contractors. The Village filled a gap by providing information and support to older adults who did not qualify for low-income programs. The access to trusted, centralized information regarding complex systems helped members adapt to a new form of residential normalcy and perhaps kept them from having to make sudden, costly transformative decisions. Local policies could support and promote Villages to provide targeted aging-related information to older adults. The benefits of the Village are not singular (e.g., social or transportation) or intended for solely "old people." Instead, the services and supports the Village offers apply to anyone who needs aging-related information. Additionally, local government support of and coordination with Villages changes the adaptive capacities (or resilience) of the communities by providing opportunities that support the comfort and mastery zones of residents. Community support of older adults in multiple ways then transcends caring only for the most vulnerable. Informational and anticipated support helps create resilient communities wherein older adults can adapt safely and in an informed manner. Villages, as well as other community-based support programs, can assist localities in prioritizing and identifying needs among a diverse population of residents (Golant, 2014).

Future Research

As the empirical research on Villages is limited, there are numerous opportunities

for future research. The rapid growth in the number of Villages nationwide indicates there is a demand for their services, but how are they impacting their communities and is the model sustainable? This study's results may apply to other Villages and could be the basis for studies that compare Villages, measure outcomes, and examine how community-based services aimed at the middle-class fit into the age-friendly community rubric.

Longitudinal studies of Villages (with a control group of non-members) are necessary to identify what are the factors determining the members' ability to stay at home (or in community) or having to make a transformational change, such as moving away. How does a Village's service limitations impact member's ability to age in place? Studies such as these could address how Villages foster adaptation and mitigate residential incongruence, leading to a deeper application of residential normalcy theory. Additionally, and importantly, these studies could focus on outcomes such as health and health care costs to help determine if Village membership affects personal and community-level financial costs. Measuring outcomes and quantifying benefits has become increasingly important to non-profit organizations that are seeking outside funding and identifying effective practices.

This study of Mt. Vernon at Home confirmed the literature finding of Villages facing long-term sustainability issues. Consumers of aging services expect programs to operate continuously and in a consistent manner (Golant, 2014). Future research is needed to examine Villages' and other community-based aging programs', such as NORC-SSPs, abilities to maintain operations. The sustainability of community-based organizations is becoming an increasing concern to non-profits in a climate of scarce

funding. A potential future research question could be, why do some organizations with similar missions or clients, fail while others succeed and what are the variables involved? As part of this research, the establishment of databases or publications containing best practices could be created to disseminate the information to community-based service organizations, funders, and policy makers.

Villages are a part of a wider network of agencies and organizations contributing to age-friendly communities. What other community planning efforts are supporting existing social organizations and membership associations in age-friendly initiatives? New York City's Aging Improvement Districts, for example, are bringing together community stakeholders to coordinate age-friendly initiatives (New York Academy of Medicine, 2012). Villages can heighten their visibility and go beyond serving their members by connecting community groups to contribute to wider goals.

Conclusion

Older adults in Fairfax County have more choices than previous generations regarding how and where they will live as they grow older. However, many prefer to stay in the homes and the communities with which they have become familiar. The average length of residency for participants in this study was 41 years. During that time, the county became bigger, poorer, older, and more diverse. Not only have the residents aged but so have their housing, the infrastructure, and many of the amenities they use. Fairfax County is making strides to accommodate its aging population, but the solutions may come too late for many.

The older adults interviewed in this study were frustrated by the lack of information on aging services and benefits. This frustration was also echoed on a national

level during the 2015 White House Conference on Aging, where it was agreed more had to be done to help older adults across multiple scales and income levels. Age-friendly community initiatives are also an attempt to assist older adults and neighborhoods in adapting to changing realities. However, the progress has been slow, and a majority of localities have yet to integrate these ideas into policy and practice fully.

Villages are a direct, consumer-led response to the frustration and confusion experienced by older adults and their families. Mt. Vernon at Home did fill an information and services gap for its members. Without the Village, older adults would have to have relied on inconsistent levels of support, most likely experienced residential mastery issues, and moved away from their homes sooner. Sudden transformative changes can have long-reaching financial and emotional effects for those involved and may place burdens on public resources. However, Villages such as Mt. Vernon at Home, are dependent on the communities they serve. Their futures rely on the willingness of the community to continue to provide support. Therefore Villages must be flexible, inventive, and seek out collaborations to leverage funding sources and opportunities.

Aging in community is not a blanket solution, and it can be difficult for those with limited physical, social, and economic resources. As environmental incongruence increases, older adults have to seek out other options beyond their homes. Community-based interventions, such as the Village model, can offer appealing solutions to those who want to remain independent and in their homes. Villages provide useful services and encourage autonomy and self-determination, which in turn enriches older adults' coping skills. These organizations, although they need further research regarding their effectiveness and replication, are important as they treat older adults as active participants

in their futures while also attempting to improve the resilience or "staying power" of communities and individuals. Social workers, gerontologists, and urban planners will continue to need to work together to ensure that communities adapt to accommodate the needs of older adults.

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APPENDIX A

Interview Recruitment Materials

Jennifer LeFurgy
PhD Candidate, Planning, Governance, & Globalization
Recruitment Materials

Email/telephone recruitment for **Village Members and Volunteers**

Dear Mr./Ms._____,

My name is Jennifer LeFurgy and I am a PhD student in the department of Urban Affairs and Planning at Virginia Tech in Northern Virginia. I live in Alexandria and have been a Mt. Vernon at Home volunteer for 3 years. I am now conducting research that focuses on the experiences older adults are having in this community and the services, if any, that they use. I am contacting you because [NAME], the director of Mt. Vernon at Home, [or other referring party] suggested that you might be interested in participating in the interviews I am collecting from Mt. Vernon at Home members and volunteers.

Participation in this study involves a one-hour interview with me at the location of your preference or over the telephone. My questions will focus on how you became involved with Mt. Vernon at Home and your experiences in this community. **The information will be recorded and used for my dissertation that will be publicly available, but all participants will be anonymous and your name will not be used in the study.** I would like to assure you that the study has been reviewed and received ethics clearance through the Virginia Tech Institutional Research Board. The final decision about participation is yours and you may withdraw from the study at any time.

I am performing the interviews this summer and plan to have them completed by the end of August. Would you be available during the next week for an in-person interview either at your home or at a location convenient for you? Or, if you prefer, we can talk over the telephone.

If you are interested in participating, please contact me at *jlefurgy@vt.edu* or *703-965-7993* to let me know your availability and to schedule a time for an interview. If you respond by email, I will send you a confirmation email.

I look forward to hearing from you and I hope you can participate.

Sincerely,
Jennifer LeFurgy
PhD Candidate
Planning, Governance & Globalization Program
School of Public and International Affairs
Virginia Tech - National Capital Region
703-965-7993 mobile

Email/telephone recruitment for **Non-Village members**

Dear Mr./Ms._____,

My name is Jennifer LeFurgy and I am a PhD student in the department of Urban Affairs and Planning at Virginia Tech in Northern Virginia. I live in the Hollin Hills neighborhood of Alexandria. I am now conducting research that focuses on the experiences of older adults in Alexandria and the aging-related services, if any, that they use. I am contacting you because [NAME], director of Mt. Vernon at Home, [or other referring party] suggested that you might be interested in being part of the in the interviews I am collecting from local residents.

Participation in this study involves a one-hour interview with me at the location of your preference or over the telephone. My questions will focus on your experiences with growing older in this community and you will have opportunity to give feedback on current aging services. **The information will be recorded and used for my dissertation that will be publicly available, but all participants will be anonymous and your name will not be used in the study.** I would like to assure you that the study has been reviewed and received ethics clearance through the Virginia Tech Institutional Research Board. The final decision about participation is yours and you may withdraw from the study at any time.

I am performing the interviews this summer and plan to have them completed by the end of August. Would you be available during the next week for an in-person interview either at your home or at a location convenient for you? Or, if you prefer, we can talk over the telephone.

If you are interested in participating, please contact me at *jlefurgy@vt.edu* or *703-965-7993* to let me know your availability and to schedule a time for an interview. If you respond by email, I will send you a confirmation email.

I look forward to hearing from you and I hope you can participate.

Sincerely,
Jennifer LeFurgy
PhD Candidate
Planning, Governance & Globalization Program
School of Public and International Affairs
Virginia Tech - National Capital Region
703-965-7993 mobile

APPENDIX B

Informed Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants
in Research Projects Involving Human Subjects

Title of Project: Staying Power: Aging in Community and the Village Model

Investigator(s):   **Jennifer LeFurgy**   **jlefurgy@vt.edu/703-965-7993**
                          Name   E-mail / Phone number

I. Purpose of this Research Project

The purpose of this study is to explore the role of the Senior Village, or "Village", a volunteer network that aids older adults who are aging at home rather than moving away. The investigator will interview members and volunteers from Mt. Vernon at Home, an established Village in Fairfax County, Virginia and older adults residing in the community who chose not to belong to the Village. Findings may reveal the strengths and weakness of the community's Village model and aging services. Moreover, this study will contribute to research on developing age-friendly communities. Approximately 15 people (5 village members, 5 volunteers, and 5 non-village members) will be interviewed. All participants will remain anonymous. Excerpts of the interviews and an analysis will be used in a dissertation and will be published in academic journals.

II. Procedures

This study will focus on the experiences older adults living in the Ft. Hunt, Belle View, and Mt. Vernon areas of Alexandria. Members and volunteers from Mt. Vernon at Home (a Village) will be interviewed along with older adults in the community who do not belong to Mt. Vernon at Home. The investigator is interested in comparing experiences of those who are Village members and those who have chosen not to join. Village volunteers will be asked about their experiences with Mt. Vernon at Home. Therefore, the investigator would like to include you in this study so that you may offer your experiences and opinions about living and growing older in this part of Fairfax County.

Participation in this study is voluntary. Should you agree to participate, the investigator will interview you for approximately *one hour* (60 minutes). The interview will to take place in a mutually agreed upon location. The investigator will ask you some general questions about your background and several open-ended questions about your recent experiences.

You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the investigator. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, I may contact you by telephone to give you an opportunity

to confirm the accuracy of our conversation and to add or clarify any points that you wish.

III. Risks

There are no known risks associated with participation in this study.

IV. Benefits

Although no tangible benefits accrue to the individual in this study, there may be larger societal benefits to be gained from participating in this study. It is the investigator's expectation that this project will inform urban planners, policy makers, and community advocates of the vital role older adults play in sustaining the livability of our communities. Moreover, it is the investigator's intention to encourage urban planners, policy makers, and community advocates to consider and actively engage older adults in the policy making process at the local level of government.

No promise or guarantee of benefits has been made to encourage you to participate.

Study participants may contact Jennifer LeFurgy at a later time for a summary of the research results.

V. Extent of Anonymity and Confidentiality

Interviews will be audio recorded. However, anonymity of study participants will be assured through the use of pseudonyms (false names) when their stories are related in the text. Your name will not appear in any thesis or report resulting from this study; however, with your permission anonymous quotations may be used. Data collected during this study will be retained for *one year* in a locked storage area and all audio recordings will be deleted after the transcription is complete (within 3 months of interview). Jennifer LeFurgy will only have access to the tapes and transcribed records.

The Virginia Tech (VT) Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

VI. Compensation

There is no compensation to be earned for this study.

VII. Freedom to Withdraw

It is important for you to know that you are free to withdraw from this study at any time without penalty. You are free not to answer any questions that you choose or respond to what is being asked of you without penalty.

Please note that there may be circumstances under which the investigator may determine that a participant should not continue in the study.

VIII. Questions or Concerns

Should you have any questions about this study, you may contact the research investigator whose contact information is included at the beginning of this document.

Should you have any questions or concerns about the study's conduct or your rights as a research subject, or need to report a research-related injury or event, you may contact the VT IRB Chair, Dr. David M. Moore at moored@vt.edu or (540) 231-4991.

IX. Subject's Consent

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

_____ Date_____
Subject signature

_____
Subject printed name

(Note: each subject must be provided a copy of this form. In addition, the IRB office may stamp its approval on the consent document(s) you submit and return the stamped version to you for use in consenting subjects; therefore, ensure each consent document you submit is ready to be read and signed by subjects.)

APPENDIX C

Interview Protocols

Interview Protocol – Village Members

Introduction:

Thank you for meeting with me today. As I mentioned on the telephone, I am completing my graduate studies project.

Let's talk about what it's like to live in this community, how Mt. Vernon at Home helps you get along, and a little about your background. I am interested in how Mt. Vernon at Home helps you meet your needs and what other services or assistance you might use. Your identity will not be used and only I will have access to the audio recordings and transcripts. If I use your story as an example, I will not use your real name. You may decline to answer any of these questions.

Before we begin, I need to ask you to review and sign an "Informed Consent" form that indicates you agree to do this interview and possibly a follow-up phone interview of 15 minutes to confirm or add material. [HAVE PARTICIPANT SIGN TWO INFORMED CONSENT FORMS, LEAVE ONE COPY WITH THEM].

1. To begin, how long have you lived in this part of Fairfax County?

   a. If fewer than 5 years, from where did you move? When?

2. How did you come to live in this community?

3. Do you live by yourself?

   a. If yes, for how long?

   b. If no, whom do you live with?

4. Do you have children?

   a. If yes, do they live in the area? [PROBE: for where if not in area] How often are you in contact with them? Do they provide you with any assistance?

   b. Do you have other family living in the area? How often do you have contact with them? Do they provide you with any assistance?

5. Please describe your current housing situation. How long have you lived there? What aspects do you like the most about your house? [PROBE: own or rent, what makes them want to stay or move]

6. What do you like most about your community? Least? [PROBE: also ask about what they like or dislike about region.]

7. Do you have immediate plans to move someplace else?

   a. If yes, may I ask why and where? [PROBE: type of living arrangement, when, why]

   b. If no, why not? [PROBE: to see if they would like to move but preference does not exist or too expensive or if they are unable to sell home.]

8. How long have you been a member of Mt. Vernon at Home?

9. What were your reasons for joining Mt. Vernon at Home? Which of these were most important to you?

10. What type of assistance, if any, did you rely on before joining Mt. Vernon at Home? [PROBE: friends, neighbors, family, county or paid help? How long?]

11. What Mt. Vernon at Home services do you use the most? The least? [PROBE: What services are making a difference/keeping them from having to move].

12. How satisfied are you with the services Mt. Vernon at Home offers? Why? [PROBE: not only types of services but quality of interactions with staff and volunteers]

13. What other types of assistance beyond Mt. Vernon at Home do you use? [PROBE: church, neighbors, family members, community services, or health aides?]

14. What other types of aging services would you like to see offered by Mt. Vernon at Home? By other local organizations? [PROBE: Do you have any unmet needs related to your current environment?]

Thanks, those are my main questions. I'd like to ask a few details so I can compare the people in my study with people in other studies. I'll never use your name, I'll just combine your answers with everyone else's.

15. Please tell me the year you were born.

16. How many years of schooling did you complete?

17. What kind of work did you do for most of your life?

18. Are you still working? Full or part time? [If not] When did you retire?

19.   Are you married or not?

20.   And you are a [woman/man] right?

Finally, here's a card with some numbers related to annual household income. Just tell me the letter that's closest to the yearly income for your household.

Before we end, I would like to remind you that your individual responses will not be identified in my report. I would like to ask you a final question regarding your income. On this card I have written some numbers with some annual household income categories [SHOW CARD]. Can you tell me the letter that best represents your annual household income?

A. Less than $15,000 per year
B. $15,000 to $24,999 per year
C. $25,000 to $34,999 per year
D. $35,000 to $49,999 per year
E. $50,000 to $74,999 per year
F. $75,000 to $99,999 per year
G. More than $100,000 per year

Those are all of the questions I have for you. Do you have any questions for me?

I will call you if I have any additional questions, such as clarifying comments from our discussion today.

Thank you for your time today. I very much enjoyed meeting you.

Interview Protocol – Non-Village Members

Introduction:

Thank you for meeting with me today. As I mentioned on the telephone, I am completing my graduate studies project.

I would like to spend about an hour discussing your experiences living in this community. I am interested in your story and what services or assistance you use or could use as you grow older in this community. I'm going to ask you questions about your experiences and then some background questions. Your identity will not be used and only I will have access to the audio recordings and transcripts. If I use your story as an example, I will not use your real name. You may decline to answer any of these questions.

Before we begin, I need to ask you to review and sign an "Informed Consent" form that indicates you agree to do this interview and possibly a follow-up phone interview of 15 minutes to confirm or add material. [HAVE PARTICIPANT SIGN TWO INFORMED CONSENT FORMS, LEAVE ONE COPY WITH THEM].

1. To begin, how long have you lived in this part of Fairfax County?

   a. If less that 5 years, from where did you move? When?

2. How did you come to live in this community?

3. Do you live by yourself? If yes, for how long?

4. Do you have children?

   a. If yes, do they live in the area? [PROBE: for where if not in area] How often are you in contact with them? Do they provide you with any assistance?

   b. Do you have other family living in the area? How often do you have contact with them? Do they provide you with any assistance?

5. Please describe your current housing situation. How long have you lived there? What aspects do you like the most about your house? Least? [PROBE: own or rent, what they appreciate/dislike about house]

6. What do you like most about your community? Least? [PROBE: ask about what they like or dislike about region.]

7. Do you have immediate plans to move someplace else?

   a. If yes, may I ask why and where? [PROBE: type of living arrangement]

      b. If no, why not? [PROBE: to see if they would like to move but preference does not exist or too expensive or if they are unable to sell house.]

8. What type of public or community assistance, if any, do you receive in your current living situation? [PROBE: e.g., meals on wheels, transportation assistance]

      a. If yes, are you satisfied with the assistance you receive? Why?

9. Do you belong to a church or any social or community organizations?

      a. If yes what kind? [PROBE: Is this used for support/assistance?]

10. Are you aware of Mt. Vernon at Home?

      a. If yes, how? What do you know about it?

      b. [If no, explain Mt. Vernon at Home mission and membership fees].

11. Why is it that you do not belong to Mt. Vernon at Home? Have you considered joining?

12. Are there other types of aging services you would like to see offered in this community? [PROBE: do you have unmet needs related to your current environment?]

Thanks, those are my main questions. I'd like to ask a few details so I can compare the people in my study with people in other studies. I'll never use your name, I'll just combine your answers with everyone else's.

13. Please tell me the year you were born.

14. How many years of schooling did you complete?

15. What kind of work did you do for most of your life?

16. Are you still working? Full or part time? [If not] When did you retire?

17. Are you married or not?

18. And you are a [woman/man], right?

Finally, here's a card with some numbers related to annual household income. Just tell me the letter that's closest to the yearly income for your household.

Before we end, I would like to remind you that your individual responses will not be identified in my report. I would like to ask you a final question regarding your income.

You may choose not to answer. On this card I have written some numbers with some annual household income categories [SHOW CARD]. Can you tell me the letter that best represents your annual household income?

    A. Less than $15,000 per year
    B. $15,000 to $24,999 per year
    C. $25,000 to $34,999 per year
    D. $35,000 to $49,999 per year
    E. $50,000 to $74,999 per year
    F. $75,000 to $99,999 per year
    G. More than $100,000 per year

Those are all of the questions I have for you. Do you have any questions for me?

I will call you if I have any additional questions, such as clarifying comments from our discussion today.

Thank you for your time today. I very much enjoyed meeting you.

Interview Protocol – Village Volunteers

Introduction:

Thank you for meeting with me today. As I mentioned, I am completing my graduate studies project.

I would like to spend about an hour discussing your experiences volunteering with Mt. Vernon at Home. I'd like to talk about how you have observed and interacted Mt. Vernon at Home members during your volunteer time. I am also interested in how Mt. Vernon at Home has affected members' ability to stay in their homes or impacted them, positively or negatively. I'm also interested in how those in the community you may know who do not belong to Mt. Vernon at Home are managing to stay in their homes. Your identity will not be used and only I will have access to the audio recordings and transcripts. If I use your story as an example, I will not use your real name. You may decline to answer any of these questions.

Before we begin, I need to ask you to review and sign an "Informed Consent" form that indicates you agree to do this interview and possibly a follow-up phone interview of 15 minutes to confirm or add material. [HAVE PARTICIPANT SIGN TWO INFORMED CONSENT FORMS, LEAVE ONE COPY WITH THEM].

1. How long have you lived in this community?

2. How long have you been a volunteer with Mt. Vernon at Home?

3. How did you become a volunteer?

4. Do you volunteer with other organizations? If yes, which ones?

5. Are you also a member? Why did you join Mt. Vernon at Home? [PROBE: social, volunteering]

6. Taking into account your experiences with Mt. Vernon at Home members, why do you think older adults join Mt. Vernon at Home?

7. Why do you think older adults do NOT join Mt. Vernon at Home, even though they may be in need of some assistance?

8. According to your observations, what aspects of Mt. Vernon at Home contribute to members being able to stay in their homes? What types of services or features are lacking? [PROBE: Any anecdotes about how Mt. Vernon at Home helps or doesn't help its members]

9. What are the differences you have observed between how Mt. Vernon at Home members are able to remain in the community as they grow older and how non-members you may know are able to remain in the community as they grow older? [PROBE: Do those who don't use Village move sooner, use different services?]

10. What are other types of services for older adults you would like to see offered by other local organizations?

11. Do you know someone who does not belong to Mt. Vernon at Home but would be eligible to join? Would you be willing to refer them for an interview?

12. May I ask the year you were born?

Those are all of the questions I have for you. Do you have any questions for me?

I will contact you if I have any additional questions, such as clarifying comments from our discussion today.

Thank you for your time today. I very much enjoyed meeting you.

APPENDIX D

IRB Approval Letter

Office of Research Compliance
Institutional Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE:	June 17, 2015
TO:	Jim Bohland, Jennifer Beth LeFurgy
FROM:	Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)
PROTOCOL TITLE:	Staying power: Aging in community and the Village model
IRB NUMBER:	15-494

Effective June 17, 2015, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 5,6,7**
Protocol Approval Date:	**June 17, 2015**
Protocol Expiration Date:	**June 16, 2016**
Continuing Review Due Date*:	**June 2, 2016**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Date*	OSP Number	Sponsor	Grant Comparison Conducted?

* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this IRB protocol is to cover any other grant proposals, please contact the IRB office (irbadmin@vt.edu) immediately.

APPENDIX E

Categories and codes

Category	Codes
Activities/Social	
	Activities
	Advocate
	Assistance not provided by Village
	Attached to neighborhood
	Belonging to a church
	Can do things on my own
	Church services
	Cultural events
	Doesn't belong to church
	Enjoy wild life and gardens in yard
	Keeping busy
	Like area
	Like neighbors
	Neighborhood social support
	Schools
	Seeking out support
	Similar to Neighbors
	Social Network
	Socializing through Village
	Transportation
	Travel
	Using community resources
	Volunteering
Background	
	Career
	"Depression Era Mentality"
	Divorce
	Education
	Exciting living somewhere else
	Health and wellness adherent
	House
	Independence
	How long lived in house
	Living in single family home
	Powerful memories
	Retirement
	Romantic partner
	Trauma survivor

Category	Codes
Category	**Codes**
Background (cont'd)	Why they moved to area
	Widow
Challenges	
	Adaptation
	Alzheimer's disease
	Becoming emotional (during interview)
	Companionship
	Cost of advanced care
	Cost of moving
	Crime Fears
	Denial
	Depression
	Disabled parent living with them
	Disabled spouse
	Dislike Neighbors
	Downsizing
	Driving
	Emergencies
	Estate planning
	Failing health
	Falling
	Feeling like a burden
	Feeling safe
	Health care aides
	Health care assistance
	Health care costs
	House improvements
	Isolation
	Item not easy for older adults to use
	Lack of information
	Living alone
	Living on a single floor
	Long Term Care
	Managing finances
	Mortality
	Moving from area
	Negative experiences with aging resources
	Organizing/Decluttering
	Overlooked middle class
	Pressure to move

Category	Codes
	Scams
	Self esteem
	Staying at home despite obstacles
	Staying in area
	Stress
	Struggling at home
	Stuff
	Taxes
	Thinking about moving to assisted living
	Time to move
	Unsure about moving
	Vulnerable
	Why I don't want to move
Family	
	Adult Children
	Extended family
	My parents' experiences
	Spouse
Observations about Village	
	Ambivalence towards Village
	Assistance around the house from Village
	Checking in
	Crisis prompts joining Village
	Dropping out of Village
	Founding of Mt. Vernon at Home
	How they found out about Village
	Intrusive
	Joining Village
	Limits on what Village offers
	Multi level involvement
	New member
	Non-member
	Other Villages
	Praise for Village Staff
	Reason for not joining Village
	Someone outside your network helping

Category	Codes
	Tech support
	Transportation
	Village programs
	Village director as ombudsperson
	Village fees
	Village finances
	Village helping with spouse
	Village is for 'Old People'
	Village is redundant to existing network
	Village issues/challenges
	Village programs
	Village volunteers as extra eyes and ears
	What Village could offer
Organizations	
	AARP
	Area Demographics
	Hollin Hall Senior Center
Residential Options	
	Paul Spring (Assisted Living)
	Montebello (Multi family)
	Porte Vecchio (Multi family)
	Goodwin House (Assisted Living)