Innovative Public-Private Models to Enhance Aging in Place in the United States

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As life expectancy has increased, families, communities, and societies alike are experiencing population aging. With advanced age, people are more likely to confront challenges to their physical health, mental health, economic security, housing, and access to supports. These challenges threaten people's ability to age in place, which is the preference of many older people. This paper examines innovative approaches to support aging in place in the United States, including public-private partnerships, integrative service models, and local community initiatives.

Introduction

Services for older adults are becoming increasingly important as the older adult population grows in size. The numbers of adults aged 65 and over in the United States increased from 35 million (12% of the American population) in 2000 and to 45 million (14%) in 2013 (Administration on Aging, 2015). The large baby boom generation began to turn 65 in 2011, and from 2011 through 2030, approximately 10,000 more will reach that age each day (Passel & Cohn, 2008). In fact, in 2030, about 73 million (20% of the population) will be 65 years-old and older and the numbers will increase to 84 million (21%) in 2050 (Ortman, Velkoff, & Hogan, 2014).

In addition to this "graying" of America, there is also a significant increase in racial and ethnic diversity among the U.S. population in general, as well as within the older adult population specifically. By 2030, older non-Hispanic white adults will decline from 80% in 2010 to 71.2% of the older adult population, while Hispanics will make up 12%, approximately 10.3% will be African American, and 5.4% will be Asian (Centers for Disease Control and Prevention, 2013). This trend will continue as it is estimated that by 2050, non-Hispanic white adults will continue to decline to only about 58% of the population aged 65 or older. During the same time, the Hispanic population of older adults is expected to continue to grow from 7% in 2010 to nearly 20%, African Americans from 8.3% to 11.2%, and Asian Americans from 3.3% to 8.5% (Centers for Disease Control and Prevention, 2013).

These population trends have implications for health and social service delivery systems. This paper reviews three innovative approaches to delivering services for older adults and their caregivers: public-private partnerships, integrative service models,

and local community initiatives. The public-private partnerships allow private sector companies to collaborate with the public sector, and integrative service models offer access to multiple types of services and providers in one place. Local community initiatives involve community community-wide efforts to change the physical and social environments of communities. We begin by providing an overview of aging in place, which these three approaches similarly seek to promote. We also offer an overview of health and economic challenges in later life that threaten aging in place, as well as traditional systems of social service delivery for older adults in the U.S.

Aging in Place

Aging in place refers to an older adult's ability to live within their own homes and communities, rather than relocating in later life, especially for reasons such as functional decline, widowhood, or financial constraints. Older adults express the goal of being able to age in place (AARP, 2005); in fact, 80% of older adults in the United States live independently in their own homes (Houser, Fox-Grage, & Gibson, 2006). Additionally, most older adults worldwide live in community housing, as opposed to supportive housing facilities such as nursing homes (Lipman, Lubell, & Salomon, 2012).

Environmental gerontology orients attention to aging in place as fundamentally involving both the older adult and their environments (Golant, 2003). A goal of aging-in-place services, therefore, can be framed as optimizing the interaction between older adults and their environments, including their immediate environment (e.g., dwelling) and broader environments (e.g., neighborhood or community) (Schwarz, 2012). For example, home modifications—such as installing grab bars in showers or placing ramps in entranceways—are enhancements to

an older adult's physical environment to increase the older adult's ability to perform activities of daily living.

Individual Threats to Aging in Place

Health

Cognitive Health

Declines in various areas of one's health can challenge an older adult's ability to remain in the home (Lien, Steggell, & Iwarsson, 2015). For example, a decline in cognitive functioning can lead to a declining ability to perform activities of daily living (ADLs), which limits an older adult's independence and therefore their ability to age in place (Holtzman et al., 2004). Biological aging impacts one's cognitive functioning, with attention and memory being the functions most impacted by age (Glisky, 2007). While the probability of being cognitively impaired at a given age has been decreasing since the mid-1990s, the growing number of older adults means that the absolute number of cognitively impaired individuals will continue to increase in the United States (Kerr et al., 2013). Cognitive impairment is defined as "confusion or memory loss that is happening more often or is getting worse during the past 12 months" (Center for Disease Control and Prevention, 2011).

It is estimated that at least 5.1 million Americans aged 65 years or older currently have Alzheimer's disease, which is the most common type of cognitive impairment (Hebert, Weuve, Scherr, Evans, 2013). Furthermore, it is estimated that the number of older adults with Alzheimer's disease may rise to 13.2 million by 2050 (Hebert, Scherr, Bienias, Bennett, & Evans, 2003). This cognitive impairment can make it more difficult for an older adult to live independently in the community, therefore requiring additional support. There are now over 10 million family members providing unpaid

support to a person with a cognitive impairment, a memory problem, Alzheimer's disease or another form of dementia (Alzheimer's Association, 2010). However, older adults who do not have access to a family member may need to rely on paid in-home support. If this is not accessible in their community, or affordable for the older adult, they may need to leave their home for care in a facility.

It is important to note, however, that cognitive decline is not inevitable with advancing age. Cognitive training interventions, for example, have been found effective in improving older adults' cognitive abilities and their ability to perform activities of daily living such as driving, medication use, and financial management (Ball, Berch, Helmers, et al. 2002). These interventions can delay or even prevent the need for nursing homes, home care, and hospital stays, which reduces healthcare costs while increasing the independence and dignity of the aging population (Ball, Berch, Helmers, et al. 2002).

Mental Health

Mental health is another important area of consideration for the older adult population. In 2008, approximately 14% of adults aged 65 and older and 18% of adults aged 85 and older had symptoms of clinical depression (Federal Interagency Forum on Aging-Related Statistics, 2012). Furthermore, older adults suffering from mental illnesses such as schizophrenia, bipolar disorder, and recurrent depression are predicted to increase both in total numbers and in relative proportion to the overall American population (Jurdi, Rayan, Rej, & Sajatovic, 2014). It is estimated that 20.4% of adults aged 65 and over met criteria for a mental disorder, including dementia, during the previous 12 months (Karel, Gatz & Smyer, 2012). Furthermore, older adults with symptoms of mental illness are less likely than adults of other

ages to receive mental health services and for the older adults that do, they are less likely to receive care from a mental health specialist (Karel, Gatz & Smyer, 2012).

Depression is a leading cause of suicide among the older adult population, as it often goes untreated. In fact, older men have the highest suicide rate of all age groups. In 2013, 18.6% of suicides were committed by those ages 85 years and older (Centers for Disease Control and Prevention, 2015). Also according to the CDC, an estimated 10,189 older Americans (ages 60 and older) died from suicide in 2013. Suicide is particularly high among older, white males (32.74 suicides per 100,000 people). Additionally, the rate of suicide in the oldest group of white males (ages 85+) is more than four times higher than the national suicide rate of 11.01 suicides per 100,000 people (Centers for Disease Control and Prevention, 2015).

Therefore, the mental health field is faced with many obstacles to appropriately serving older adults with mood disorders, including: a workforce that may be too small to meet growing needs, cost constraints, access issues, and a lack of reliable research data on specific treatments for this population (Jurdi, Rayan, Rej, & Sajatovic, 2014). There is a need to increase education and awareness regarding mental health for older adults themselves, their families, and mental health professionals. Furthermore, there are growing calls for more programs within community agencies to provide both medical and mental health care, as well as the necessary educational, social, and outreach services to geriatric patients with severe mood disorders. For example, for older adults who struggle to get to a community agency on their own, it is essential to develop in-home mental health services, so that the clinician can go to the older adult client instead of

vice versa. This would increase the likelihood of older adults receiving the mental health services that they need, and thus combating the depression that often goes untreated among this population.

Physical health

In terms of physical health, more than 75% of older Americans have multiple chronic conditions, and treatment for this population accounts for 66% of the country's health care expenses (Centers for Disease Control and Prevention, 2013). Heart disease and cancer pose the greatest risks as people grow older, as do other chronic illnesses, such as: strokes, chronic lower respiratory diseases, Alzheimer's disease, and diabetes. Additionally, despite the availability of vaccines, the flu and pneumonia also continue to contribute to death among older adults. Chronic illness may negatively impact a person's ability to perform instrumental activities of daily living (IADLs), such as managing money, preparing meals, and taking prescribed medications (Centers for Disease Control and Prevention, 2013). This is a significant concern for older adults and their families as it threatens their ability to age in place. Disabilities related to chronic illnesses are a large reason for older adults needing to leave their homes for care-based residences.

America's spending on health care, which is the highest of all developed countries, is expected to continue growing since chronic diseases impact an increasing amount of older adults. Of the health care expenditures spent on the older adult population, 95% are for chronic diseases (Centers for Disease Control and Prevention, 2013). It costs three to five times more to provide health care for older adults (aged 65 or older) than for someone younger. By 2030, it is expected that health care expenses will rise by 25%, mainly due to the population aging that the U.S. is

experiencing. Additionally, Medicare expenditures are estimated to rise from $555 billion in 2011 to $903 billion in 2020 (Centers for Disease Control and Prevention, 2013).

Moreover, people 65 years old and older have the smallest percentage of people with proficient health literacy skills and the largest percentage with "below basic" health literacy skills (Kutner, Greenberg, Jin, & Paulsen, 2006). If older adults lack the knowledge and comprehension regarding their health, there is a decreased likelihood of them receiving important medical tests and preventative care. Therefore, they also become more likely to receive emergency health services and have difficulty with chronic illness (Rudd, Anderson, Oppenheimer, & Nath, 2007). Furthermore, increasing health literacy and understanding of preventative health measures among the general American public also benefits the health of older adults so that when individuals do become a part of the older adult population, they will have been more likely to have made more health-conscious decisions throughout life that will continue to benefit their long-term health.

Economic Security

Lacking the financial resources to live independently also threatens aging in place. In 2014, the rate of poverty among those aged 65 and over was 9.0%, and among those aged 85 and above, about 12% (Federal Interagency Forum on Aging-Related Statistics, 2012). Poverty rates are much higher among particular subgroups of older adults; for example, about one-fifth of African American adults aged 65 and above had income levels below the federal poverty line (Federal Interagency Forum on Aging-Related Statistics, 2012). Economic insecurity of older adults comes from a widening gap between their housing, health care, fuel and utility expenses and shrinking assets (New Jersey Founda-

tion for Aging, 2012).The weakened economy has also negatively impacted the economic security of older adults, as the value of their assets has declined.

The Elder Economic Security Standard Index (Elder Index) summarizes senior's expenses associated with living independently in the community. Closely related to ''family budget'' estimates (Johnson et al. 2001), the Elder Index is based on the expenses encountered by older adults living on their own or as a couple. Similar to family budget measures, the Elder Index utilizes geographic specificity for appropriate measurement. However, unlike family budget measures, the Elder Index is designed to measure expenses specifically for individuals and couples who are aged 65 and older (Johnson et al. 2001). This makes the Elder Economic Security Standard Index more effective in measuring the economic well-being of older adults rather than analyzing older adults solely based on the federal poverty line.

Especially in metropolitan areas, housing costs threaten older adults' ability to age in place. Advocates in the U.S. are increasingly calling for the development of additional federally subsidized housing options that are appropriate for older adults with supportive service needs. Subsidized housing refers to government-supported housing for people with low to moderate incomes who pay rent based on their income (National Association of Area Agencies on Aging, n.d.). Local governments are also utilizing innovative affordable housing options in order to meet the increasing housing needs, which include the use of housing vouchers, low-income tax credits, and mixed-income public housing developments (McFadden & Lucio, 2014). Currently, approximately two million low-income adults aged 62 years and older live in federally subsi-

dized housing, which is greater than the number of older adults who live in nursing homes (Wilden & Redfoot, 2002). Moreover, in 2012, older adults aged 62 years and older comprised the second largest percentage of public housing residents (31%) (McFadden & Lucio, 2014). Some reports indicate that older adults face long and even closed waiting lists for affordable housing (New Jersey Foundation for Aging, 2012).

Furthermore, a large number of older adults in affordable housing have chronic health issues and other health needs, which may require accessible units, supportive services, or transportation to health care facilities (McFadden & Lucio, 2014). Older adults in subsidized housing have been found to be in poorer health than older adults in unsubsidized housing (McFadden & Lucio, 2014). Specifically, studies report that older adults in subsidized housing have more difficulty performing basic activities of daily living (ADLs) and instrumental activities of daily living (IADLs) than other older adults (McFadden & Lucio, 2014). Therefore, it is critical that affordable housing options for older adults be available near services they may need, such as health care facilities, senior day programs, and in-home health workers. Without access to these supportive services within the community, an older adult is at greater risk of not being able to live independently, and thus being forced to move into a more costly nursing home (McFadden & Lucio, 2014).

Traditional Service Delivery Approaches

The aging network includes state aging offices, 665 area agencies on aging, approximately 240 tribal organizations, thousands of nonprofit, in-home and in-community and residential service provider organizations, as well as various advocacy groups (Polivka &

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Zayac, 2008). These are in accordance with The Older Americans Act, enacted in 1965, which provides a framework for the delivery of services aimed to support older adults. For example, state and area agencies on aging, at a state's option, administer Medicaid LTSS programs as well as services funded by the Social Service Block Grant (SSBG), the State Health Insurance Program (SHIP), and the Public Health Service Act Alzheimer's Disease Supportive Services Program (Polivka & Zayac, 2008).

Many states have improved their long-term-care systems for older adults by funding private and public nonprofit aging organizations to provide in- home and community-based substitutes to nursing facility care (Polivka & Zayac, 2008). However, many states are still spending 70% to 80% of their long-term-care funding for the older adult population on nursing home care (Kaiser Family Foundation, 2006), even when most older adults prefer to remain in their own homes and communities. This is a large problem for older adults, their families, as well as the general public as it is neither cost effective nor the preference of older adults. Furthermore, continued reliance on nursing facility care will make Medicaid's long-term-care costs increasingly less sustainable (Polivka & Zayac, 2008).

Scholars have characterized traditional aging services providers as "less concerned about innovation than survival, particularly in a period of economic uncertainty" (Niles-Yokum & Wagner, 2015, p. 201). However, there is growing national support to assist entities that are part of the Aging Network with thriving in the shifting landscape of healthcare, as influenced by the Affordable Care Act and other new policies. For example, the Linkage Lab is an organizational development program which aims to assist community-based organizations in expanding partnerships with health care entities (health plans, hospitals, etc.) in order to more effectively coordinate services for older adults (The Scan Foundation, n.d.).

Social Innovation and the Older Adult Population

Social innovation is significant change in social practices and structures that create social change (Choi & Majumdar, 2015). Social innovations offer unique solutions to today's societal problems, which neither classic government policy nor market solutions are able to solve. Examples of popular and effective social innovations outside of the field of aging specifically include: micro-financing, fair trade, and emission trading (Choi & Majumdar, 2015). Kesselring and Leitner (2008) add that social innovation influences the behavior of individuals or specific social groups and align it with accepted – not primarily economic rationality following – goals, which emphasizes the goal-oriented character of social innovations.

Given the complexity of the aforementioned challenges facing the older adult population, social innovations may provide effective responses to the challenges older adults face when aging in place. The growing prominence of integrative service models, local community initiatives, and public-private partnerships reflect innovative approaches to better meeting the demands of population aging. We discuss each of these approaches below.

Public-Private Partnerships

Public-private partnerships (PPP) allow government agencies to implement public infrastructure and services utilizing the resources and knowledge of the private sector (World Bank Corp, 2015). Essentially, a public-private partnership is when one or more private sector companies collaborate with the public sector in order to provide a public service. It should also be noted that in these partnerships, the private party assumes the financial risk. The PPP Knowledge Lab defines a public-private partnership as "a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance" (World Bank Corp, 2015).

Public-private partnerships in aging services have received significant attention, as the collaboration with private companies allows for increased investment of time, money, and focus to address the challenges of aging. Herr, Sloan, and Siva (2006) depict the importance of partnerships with private sector businesses since there are limited public resources available to invest in aging services. Public-private partnerships received discussion at the 2015 White House Conference on Aging, as it was exemplified that the involvement of the private sector in aging services can assist the public sector in addressing complex issues faced by seniors, such as healthy aging and long-term services and supports (White House Conference on Aging, 2015).

Studies have found that public-private partnerships can improve service delivery and quality of life for older adults and families (Galvin, Tolea, George, & Wingbermuehle, 2014). For example, the Dementia Friendly America Initiative formed a partnership with US Against Alzheimer's, the National Association of Area Agencies on Aging, and Blue Cross Blue Shield of Minnesota to support dementia-friendly communities across the country. This is based on a model implemented in Minnesota, which aims to increase dementia awareness and better support both individuals with dementia and their families within their own communities (White House Conference on Aging, 2015). As

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another example, Jones-Davis and Buckholtz (2015) found that public-private collaborations in the field of Alzheimer's disease research yields higher research productivity, reduces research risk, and increases innovation by including a diversity of perspectives, expertise, and resources.

An important area of long-term services and supports is in the area of supporting caregivers. Reducing caregiver stress not only benefits the caregivers of older adults, but also can help the older adults to whom they provide care. Given this knowledge, the SCAN Foundation, a private company, is investing $2 million to assist community-based aging networks with building collaborative partnerships with the healthcare sector (White House Conference on Aging, 2015). Furthermore, The John A. Hartford Foundation plans to invest $3 million to support the Area Agencies on Aging's delivery of evidence-based services and programs, which support older adults and their caregivers in their communities (White House Conference on Aging, 2015). These investments from the private sector enhance the public sector's ability to support the older adult population while aging in place.

In addition to public and private entities collaborating for individual projects or issues, there are also public-private partnerships that have formed to address older adults at a more local level. The Westchester Public/Private Partnership for Aging Services exemplifies this, as this partnership includes multiple government agencies, businesses, voluntary service agencies and consumers collaborating in order to assist older adults in the Westchester County community (The Westchester Public/Private Partnership, 2016). This partnership saw the need to collaborate in aging services since there are 191,000 adults aged 60 and over in Westchester County, and that is pro-

jected to increase by as many as an additional 63,000 older adults due to the baby boomers entering the older adult population (The Westchester Public/Private Partnership, 2016). The Westchester Public/Private Partnership for Aging Services depicts the significance of utilizing private corporations in aging services, as these entities are able to contribute unrestricted funds or also donate in-kind services that significantly expand important services for older adults (The Westchester Public/Private Partnership, 2016).

Integrative Service Models

An integrative service organization utilizes a patient-centered integrated care model to provide continuous and coordinated care by considering all of the needs of each individual patient (Spoorenberg, Wynia, Fokkens, Slotman, Kremer, Reijneveld, 2015). This is in contrast to the usual fragmented system of care delivery, in which older adults rely on several different healthcare professionals for service in various domains. This fragmented care may have negative consequences, including misunderstanding by the patient, adverse drug interactions from multiple providers, impaired treatment participation, lack of communication among service providers at different locations, and even treatment errors (Spoorenberg, Wynia, Fokkens, Slotman, Kremer, Reijneveld, 2015). Research has found that the currently fragmented system of health care delivery and financing does not appropriately meet the needs of older adults, who are especially likely to have more complex healthcare and social service needs than younger populations of adults (Gross, Temkin-greener, Kunitz, & Mukamel, 2004; Naylor, Kurtzman, Miller, Nadash, & Fitzgerald, 2015). With an integrative service model, older adults can have all of their needs met in one place, as these entities provide older adults with a variety of services and providers.

This makes health service delivery simpler for older adults who may struggle with the fragmented system of care, while also increasing the likelihood that they will have all of their health needs met.

An example of a significant integrative service model for the older adult population is the Program of All-inclusive Care for the Elderly (PACE). PACE is a Medicare- and Medicaid-managed long-term care program for adults aged 55 and older who chose to live in the community despite being certified as nursing home eligible by the state (Fretwell, Old, Zwan, & Simhadri, 2015). PACE utilizes comprehensive medical and social services, integrated and coordinated care by an interdisciplinary team, and an adult day center supplemented by in-home and referral services (Fretwell, Old, Zwan, & Simhadri, 2015). Each older adult's care plan is created by the interdisciplinary team, which includes at least a primary care physician, a nurse, a social worker, physical and occupational therapists, a recreation therapist, and health aides; and may also include a pharmacist, a nutritionist, a psychiatrist, a transportation coordinator, and other health care workers (Gross, Temkin-greener, Kunitz, & Mukamel, 2004). Since PACE has seen many successes since it was initially developed, President Obama signed the Program of All-Inclusive Care for the Elderly (PACE) Innovation Act in November 2015, which expands this model of care to serve high-cost and high-need populations (Cortes & Sullivan-Marx, 2016). For example, the PACE Innovation Act provides the Centers for Medicare and Medicaid Services to include younger populations with disabilities and older adults who do not yet meet Medicaid clinical eligibility requirements for skilled nursing facilities (Cortes & Sullivan-Marx, 2016).

In addition to integrating various types of care, PACE also integrates

Medicare and Medicaid funding for services through monthly capitated payments (Eng, Pedulla, Eleazer, McCann, & Fox, 1997; Fretwell, Old, Zwan, & Simhadri, 2015). This combination of Medicare and Medicaid funding better allows PACE to individualize its services based on the needs of each participant (Gross, Temkin-greener, Kunitz, & Mukamel, 2004). In addition, PACE programs have succeeded to attract startup funding from national foundations, such as the John A. Hartford Foundation and the Robert Wood Johnson Foundation, which also has promoted the programs' financial viability, especially in the early phases of development (Gross, Temkin-greener, Kunitz, & Mukamel, 2004).

Frequent staff contact combined with an integrated care delivery system and funding system allows PACE to better monitor chronic conditions, which enhances older adults' ability to avoid hospitalization and institutionalization (Gross, Temkin-greener, Kunitz, & Mukamel, 2004). This is exemplified by the Elderhaus PACE Program in Wilmington, North Carolina, which reduced the use of acute hospital care and nursing home care while 46% of their participants improved and 20% of participants maintained their level of functional independence (Fretwell, Old, Zwan, & Simhadri, 2015). Research has found the outcomes of PACE programs to be positive, with consistent growth, good consumer satisfaction, reduced rate of institutionalization, and cost savings to public and private payers of care (Eng, Pedulla, Eleazer, McCann, & Fox, 1997; Fretwell, Old, Zwan, & Simhadri, 2015). This integrated approach to health care delivery combats many of the aforementioned health challenges faced by older adults, as they can have their cognitive, mental, and physical health all addressed in one place.

Local Community Initiatives

There are innovative ways in which communities can become aging-friendly, which enhances an older adult's ability to age with dignity in their own communities. These initiatives involve community-wide efforts to change the physical and social environments of communities in order to assist older adults, while also eliminating barriers to social participation for older adults (World Health Organization, 2007). The social participation piece can be as important for older adults as assisting with their potential physical needs, as many older adults face social isolation or feel excluded from their long-time communities. Therefore, these aging-friendly community initiatives encourage active aging, which is described as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organization, 2007).

The WHO Global Network of Age-Friendly Cities and Communities program identified several domains contributing to age-friendly localities, including: social participation, civic participation and employment, community support, access to health and social services, communication and information, provision of transportation, and access to outdoor spaces and safe buildings (World Health Organization, 2007). Examples of age-friendly community initiatives include the WHO Global Network of Age-Friendly Cities and Communities program, the Visiting Nurse Society of New York's AdvantAge Initiative, the U.S. Environmental Protection Agency's Building Healthy Communities for Active Aging initiative, AARP's Livable Communities initiative, and the Villages movement (Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014). While the various community initiatives differ in their approaches, they share the common objective of enabling a community to meet the physical and emotional needs of older adults, enhance the social participation of older adults, promote civic engagement, and reduce the need for older adults to relocate to nursing home care (Scharlach, 2009).

"Villages" are associations in which older adults pay a membership fee to receive social, educational, recreational, and supportive services in order to enhance their quality of life and ability to age in the community (Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014). A Village typically utilizes very few paid employees, which mainly serve as liaisons between the older adults and other service providers, including volunteers. In many Villages, much of the direct support comes from other Village members and younger community volunteers (Thomas, 2011). Villages also typically provide their members with contact information for vetted service providers (Thomas, 2011). This direct provision of services and contacts eliminates the barriers that older adults sometimes face when caring for themselves and their own homes in the community. In addition to utilizing older adults as providers of supportive services, the Village model often engages older adults in governance roles within their communities (McDonough & Davitt, 2011). This involvement of older adults can be empowering to them, as they are able to assist each other with remaining in their communities, instead of only relying solely on paid formal support.

A 2014 study conducted by Scharlach, Davitt, Lehning, Greenfield, and Graham utilized data from a 2012 national organizational survey to observe the extent to which Villages help their members access support and services aligned with the World Health Organization's aforementioned eight domains, while also bettering the age friendliness of the community

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(Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014). These researchers found that most of the Villages in the study provided supports and services consistent with the eight domains identified by the WHO Global Network of Age-Friendly Cities and Communities program (Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014). In fact, 85.5% of the Villages in this study provided assistance with at least six of the WHO domains, while traditional aging service providers typically only provide assistance with one or two of the domains (Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014).

As individuals advance in years, they are increasingly likely to face challenges that impact their well-being and their ability to age in place. The issues surrounding older adults are becoming increasingly significant as the population continues to grow. With the rapid population aging occurring within the United States, social institutions have not been able to respond to older adults' needs as quickly as the population has been growing. Significant areas where older adults face barriers include cognitive functioning, mental health, physical health, and economic security. In addition to these areas in which all older adults may face challenges, there are also vulnerable groups of older adults, such as minorities and those who are economically disadvantaged, who may face increased hardship during their later years.

With all of that in mind, it is essential for policymakers within the municipal, state, and federal government levels to take note in the areas where older adults are not being effectively served, so that appropriate policy changes can be initiated. Social workers, other medical professionals, caretakers, families of older adults, and older adults themselves should also remain informed on these challenges to older adults so that they can advocate for beneficial changes. Socially innovative ways to address challenges in aging services include public-private partnerships, integrative service models, and local community initiatives. Further research on social innovation is important since social innovation research sheds valuable insight on social change as well as ways to solve pressing social problems and to better capitalize on social opportunities, including those associated with population aging.

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