

GEORGE FOX UNIVERSITY

WHO CARES?

ESTABLISHING AND INTEGRATING CARE SYSTEMS WITHIN A
FRAMEWORK OF FAITH COMMUNITIES, MEDICAL CENTERS, AND
GOVERNMENT AGENCIES

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ELIZABETH T. BOATWRIGHT

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ABSTRACT

According to recent statistics, the accepted pyramid of age distribution will soon be inverted. People live longer, unaware that their resources may not outlast their lives. The unfunded liability of Medicare over the next 75 years is projected to be 32.4 trillion or \$201,000 per worker. The fastest growing demographic in our country will be 85 years and older, overwhelming the faith community with needs in medical services and costs, insufficient pension and retirement funds, government entitlements, food and transportation costs, and lack of family support. How will the faith community embrace the senior adult? This study addresses three specific areas of response: equipping staffs of church volunteers to assist the needs of elders, developing efficient and comprehensive care systems that cross-pollinate medical and community services with the faith community, and finding ways to integrate existing programs to avoid duplication of services, resulting in cost-effective, multi-generational, volunteer, compassionate care for the elderly.

Chapter 1 provides a basic overview of this problem and embraces it in the context of narrative. Biblical materials that demonstrate the basis for offering a care system, Christ's compassion for the ill, and stories relating to the apostles' post resurrection healing power, are found in Chapter 2. Chapter 3 will present materials from Christian history, demonstrating how the ancient practices of health and healing have been upheld or set aside. Chapter 4 will begin to address the missional solution to specific problems faith communities face concerning care for the elderly and how each church can begin to customize its plan to address those needs. Chapter 5 will present a practical

schematic for finding, equipping, monitoring, and maintaining a staff of volunteers to manage a program for the elderly. A final overview of the current challenges and the faith community's responses regarding care for senior adults is offered in Chapter 6.

CHAPTER ONE

INTRODUCTION

Remember the days of old; consider the generations long past.
Ask your father and he will tell you, your elders, and they will
explain to you. (Deut 32:7)

Taking Care of Lee, Dave, and Ellen

I was sound asleep when the call came in at 11:45 PM. Jane was distraught because one of our members called her crying out in distress. “Lee,” a divorced 84-year-old woman, was having a cardiac arrest and could not breathe.¹ Jane assured me she had called 911 and asked that Lee be taken from her home to Providence St. Vincent’s, a local hospital. Racing to get dressed, I made my way through the dark, early-morning highways to the emergency room and managed to find Lee’s curtained cubicle. Seated upright with a look of panic on her face, she was being attended by at least six medical professionals checking vital signs, all racing to keep her alive. Intravenous drips for hydration and antibiotics were started, blood-pressure medicine was ordered, an oxygen mask covered a good part of her face, and her hands grasped the rails of the bed, knees raised in a fetal position. Distress was a kind word to describe her state. Lee’s eyes met mine and her body shook in recognition as if to say, “Help me, I want out of here!”

A doctor pulled me aside and asked who I was. When I said I was a pastor at Lee’s church, he asked for contact numbers of family members to comply with HIPAA and PSQIA regulations.² I said I would quickly try to reach one of her daughters. Calling

¹ Although “Lee” is a fictitious name, all case studies in this dissertation are based on true stories.

² HIPAA stands for Health Insurance Portability and Accountability Act of 1992. The HIPAA privacy rule protects the privacy of individually identifiable health information and sets national standards for the security of electronic protected health information. The PSQIA (or The Patient Safety and Quality

Jane back, I found the numbers needed. “But don’t expect any help,” she said. “They don’t get along very well. They’re an Asian family with issues.”

I called the first daughter, who was away at Cannon Beach, Oregon, but she said she “didn’t have the time” and to tell the doctors her mother was not going to be a “good patient.” Then she hung up. Fortunately, Jane gave me the number for a second daughter who lived in Texas. That daughter was willing to offer a helpful history both of Lee’s reluctance to see a doctor, and the fact that she was in denial about her medical condition of congestive heart failure.

Lee had no advance directive for health care on file at the hospital and was in no position to offer direction whether curative or palliative care was appropriate. The daughter reluctantly agreed to speak to the doctor and offer what permission she could to continue the emergency triage. I stayed with Lee, holding her hand while she tried to grab the mask off and talk. Nearly three and one half hours later, and after much personal prayer and observation, I rejoiced when the emergency team found a bed on the eighth floor and she was admitted for further tests and medical procedures.

This was Saturday night. I had three hours of sleep before starting Sunday services. Follow-up included checking in with Jane to find out about Lee’s support system (only Jane and perhaps one other person), and calling our parish nurse to monitor the progress when Lee was discharged. In addition I needed to check in with the family for visits and care plans, obtain a phone number for Lee’s case worker, and then try to stay in touch with a friendship-visitation volunteer who was assigned to handle weekly

Improvement Act of 2005) Patient Safety Rule protects identifiable information being used to analyze patient-safety events and improve patient safety. <http://www.hhs.gov/ocr/privacy>, and <http://www.hhs.gov/ocr/privacy/psa/understanding/index.html>, accessed 10/18/10.

visits. I reminded myself that Lee is one of 515 members over the age of 65 in our parish. I was exhausted just thinking about it.

“Dave,” on the other hand, was a widower who lost his wife to cancer six years ago and was still grieving her death. His idea of recovery was typical of many men over 80 years of age. Simply move on. Don’t talk about it. To him, it is better to get together with some guys, over sack lunches, who like to go fishing and work in the garage. Then during a recent doctor visit, he was told he had cancer. We suggested a small group of men to get together and talk about where they were in their loss, but that didn’t work for him. In fact, he grew downright angry that someone wanted to help him get in touch with his feelings. For a child of the depression, getting in touch with feelings meant you were weak, unable to survive. He’d fought in World War II, and in the 30s stood in bread lines for his parents and managed the family rations. He didn’t need any help and resented that someone even brought up “getting in touch with himself.”

Then he tried finding a few lady friends to fill up the time and fill up his social calendar. Most of the women were flattered that someone noticed, and he would plan gourmet dinners and outings and concerts to have some fun. There was even one woman he wanted to marry, but she turned him down. Heartbroken, but maintaining their friendship, he kept searching for another, until his unrequited love interest had inoperable cancer. The only day Dave had been out in three months was to attend her memorial.

His long-distance children, all daughters, insist that he get some in-home assistance, but he is reluctant because, after all, “I’m able to attend to myself.” After having consulted with multiple oncologists, he now spends most of his days working out the rides for his radiation treatments and calling a few friends. We bring communion to

him once a month and a visitation volunteer is there with him once a week. But he won't move to an assisted-living facility. He will die at home with an in-home assistant.

“Ellen,” a widow of 92, lives in an adult foster home.³ Most of her days are spent maneuvering a small walker for her 4'11 frame. She has her Bible and photo albums in what she calls her “amen corner” (her recliner), and eats small nutritious meals prepared by her caregiver. One of Ellen's daughters' lives about 45 minutes away and her second daughter visits once or twice a year from San Diego. They had to sell their mother's home because she could no longer financially or physically manage by herself after the death of her husband five years ago. The monies from the sale of the home are in a special trust that pays for her care.

The greater concern, however, is her medications. About a year after her husband passed away, I got a call from Ellen, who was having what sounded like a panic attack. She couldn't breathe and was screaming into the phone that she was afraid to die. Calling 911 and two neighbors, I raced over to her home about ten minutes away. With the medics' assistance she was stabilized, but clearly frightened. Following her to the hospital, I called her daughter in Woodburn and she made her way up to Portland. Ellen had overdosed on painkillers, sedatives, and psychotropic drugs. As is true for many seniors, she was shuttled around to different medical specialists in emergency settings who handled her depression, anxiety, and the ever-present falls and collapses. Unfortunately, her primary doctor did not crosscheck the medications other doctors and hospitals were giving her, and she was taking multiples of the same prescription. I

³ Adult foster homes in the state of Oregon offer personal and health care to individuals in private residences. Licensed, inspected and monitored by the Department of Human Services, Seniors and People with Disabilities, and Agency on Aging Offices, a residence cannot house more than five patients/guests. “Choosing a Long-Term Care Setting: Facility Types - Review the Choices” Oregon Department of Health Services. http://www.oregon.gov/DHS/spwpd/ltc/ltc_guide (accessed 10/18/10).

quickly called our volunteer pharmacist, a member of our health and wellness team, who was able to line up the 19 bottles of medications and reveal the problem. Without a caregiver to assist her in her private residence, Ellen was not managing well.

The Problem

Lee, Dave, and Ellen represent only three in addition to the 512 other seniors over the age of 65 in our parish. On any given Sunday, a pastor can gaze into the eyes of a congregation and be reminded of a sea of need in the elder population. Consider the following statistics regarding the growing number of older Americans filling the pews. Most of these numbers, unless otherwise noted, are from the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics:

- The older population (65+) numbered 38.9 million in 2008, an increase of 4.5 million or 13% since 1998. That represented 12.8 % of the U.S. population, over one in every eight Americans. This is compared to an increase of 12.4 % for the under-65 population. However, the number of Americans ages 45-64 who will reach 65 over the next two decades increased by 31% during this period.
- Half of older women (50%) 75 years and above live alone.
- The 85 years-and-older population is projected to increase from 5.7 million in 2010 to 6.6 million in 2020.
- About 3.7 million elderly persons (9.7%) were below the poverty level in 2008.
- About 11% (3.7 million) of older Medicare enrollees received personal care from a paid or unpaid source in 1999.
- The median income of older persons in 2008 was \$25,503 for males and \$14,559 for females.
- In 2008 older consumers averaged out-of-pocket health-care expenditures of \$4605, an increase of 57% since 1998. In contrast, the total population spent considerably less, averaging \$2,976 in out-of-pocket costs. Older Americans spend 12.5% of their total income on health, more than twice the proportion spent by all consumers (5.9%).

- There were 92,127 persons aged 100 or more in 2008 (0.24% of the total 65+ population). This is a 147% increase from the 1990 figure of 37,306.⁴
- Mainline denominations are especially aware of aging members. In the United Methodist Church, 55% of its members are 55 years of age or older and nearly 30% of its members are 65 years of age or older.⁵ Presbyterian worshippers are older than typical worshippers, and getting older. The median age of Presbyterian worshippers in 2008 was 61, compared with age 58 in 2001. More than four in 10 of Presbyterian worshippers (43 %) in 2008 were age 65 or older, only 6 percent were ages 15 to 24, and just 15 percent were ages 25 to 44.⁶

Compounding these demographics are additional emotional, physical, and spiritual challenges for the elder members. The senior parishioner thinks about the family that isn't in town, and who, if anyone, will go to lunch with them after church because they can't go out at night. They worry about what will happen should they fall or find themselves in a life-threatening situation. They are concerned about their health benefits and cost of medicines. They track their possessions and daily routine carefully lest anyone detect they are in the beginning stages of dementia. They fear losing their eyesight and hearing. They are frightened about safety, loneliness and isolation, and find themselves depressed and at times unable to get up. They are stressed about the lack of resources that comes from living on a fixed income, and, they lack accessible support services. They worry about death, losing friends, and whether they will ever see their loved ones again. They feel useless and unable to contribute service to the church. And many find it hard to talk about a problem. Retaining the polite attitude their parents

⁴ Administration on Aging, "A Profile of Older Americans: 2009" (Washington, D.C.: U.S. Department of Health and Human Services, 2009), 2.

⁵ Richard H Gentzler, *Aging and Ministry in the 21st Century* (Nashville: Discipleship Resources, 2008), 26.

⁶ <http://www.pres-outlook.com/news-and-analysis/1.-news-a-analysis/10508-congregationalsnapshot>, 1 (accessed 12-13-10).

taught them, they contend they will be “all right.” In the end, they don’t want to burden anyone with their specific problems.

But their specific problems manifest themselves within the congregational setting whether they like it or not. While this façade of normalcy manages to work its way through the gathering areas and coffee hour of a faith community, the senior adult is hurting. Not only are they feeling the lack of support, but ageism, a prejudice or discrimination against people because of their age, is another stressor. Richard Gentzler offers the following observation:

Unfortunately, ageism is widespread not only in the marketplaces but also in religious circles. We hear words like, “The church is dying because we have so many old people in the church.” “If old people would just get out of the way...” “If older adults could just accept change...” “Either older adults should get with the program or they should leave the church.” As a result of such attitudes, ageism often causes congregations to neglect the spiritual and emotional needs of older adults.⁷

Many faith communities forget the parking space required for the wheelchair or walker. They assume amplification will manage the volume problem and neglect to provide hearing devices for the aging member. Church staffs have found the Internet a primary and economical source of communication, but have often forgotten the senior who doesn’t use a computer regularly and depends on hard-copy newsletters. Much of the programming for social activities and mission work is suitable for young families, but virtually impossible for the older adult suffering from severe arthritis and osteoporosis. An elevator for the second floor is too expensive to install.

The problem that exists in faith communities is that we are neither fully aware nor equipped to address the diverse needs of this aging population. Church staffs are

⁷ Richard H. Gentzler, *Aging and Ministry in the 21st Century* (Nashville, TN: Discipleship Resources, 2008), 20.

overwhelmed with the sheer volume and complexity of the physical, emotional, and spiritual challenges of the seniors in their home settings. Faith communities often abdicate or reassign their concerns to the government or medical institutions, who they assume will take care of “Lee,” “Dave,” and “Ellen.” An even deeper problem lies within the faith community’s lack of organization, recruitment, and equipping those volunteers who are able and willing to help, and the lack of coordination with outside professional and community resources that are already in place. This disorganization results in a form of “silo programming” or multiple services for seniors that function in parallel relationship without a point of intersection. A waste of time, resources, and gifting, silo programming only compounds the problem of services for seniors. This paper will offer a way to manage this difficult and growing problem of organization and duplication of services. It will propose a care system that integrates the church with the professional and community sectors and encourages multi-generational volunteers and families to reconnect with their elders and provide services that nurture and enhance the life of a senior adult.

Care System: A Working Definition

A care system creates an integrated design for services that address the needs of aging adult populations in the faith community.⁸ Tim Keller offers the following observation regarding ministries of mercy:

Every Christian family must develop its own ministry of mercy looking at the needs closest to it and meeting them through loving deeds and a spirit of encouragement....⁹ [T]he first

⁸ As a pastor of a large mainline-denomination church, I am aware that care of this depth and level of systemization may not be possible in a smaller congregation. I would encourage the reader to modify the model of a care system to the specific needs and resources of their congregation.

channel is the family itself. All individuals and families have a responsibility to develop their own ministries of mercy. Each congregation should develop programs and ministries of mercy that mobilize the gifts and resources of the congregation to aid the needy¹⁰

A faith community has, at its core, the family unit. But what if the family unit is divided and its members live thousands of miles away in other states? Then the church becomes the family to that isolated senior and programming reflects the volunteer and staff as the nurturing *first* support circle around that individual. This form of service involves one-to-one personalized ministry. This would include the prayer intercessor, the member who handles hospital visits, the crisis intervention counselor, as well as the pastor in charge of benevolence. Although these individuals would meet in teams for support, their work would be private with the member in need.

The *second* support circle in this care system moves from the individual to the internal volunteer support teams. These would be ecclesial members united in service to seniors who meet for equipping, accountability, and spiritual growth. This would include long-term visitation, socials and excursion teams, health and wellness teams, and repair and maintenance teams.

The *third* support circle in this model represents the professionals who provide medical, legal, psychological, and financial assistance in the context of a church setting. Many of the individuals in this tier are church members simply who have professional-level abilities and long to share that expertise as part of their service to the church. Other professionals appreciate the opportunity to travel to a church setting for a captive

⁹ Tim Keller, *Ministries of Mercy: The Call of the Jericho Road* (Phillipsburg, NJ: P and R Publishing, 1997), 123.

¹⁰ *Ibid.*

audience of people who want to be equipped with practical knowledge without a fee. This level of care would include care-giving seminars offered by a local hospital, grief seminars provided by a counseling office, and budget and credit classes created by a local financial planning society.

Finally, the *fourth* support circle represents community and government services. This would involve volunteers advocating for change at the city, county, state, and federal levels of government. Ministry at this level would include police services for safety, fraud prevention, transportation innovation and advocacy, and affordable senior housing.

But a care system cannot function in a vacuum. The faith community must have a foundation of leadership that believes the biblical mandate to seek justice and dignity for the elder, and also must have a method of recruitment, equipping, monitoring, and affirming the volunteers in their specific call for service. A care system works best when the services are cross-pollinated. For example, a fall-prevention seminar in the context of a luncheon, a prayer retreat held in a state park with ADA-compliant accommodations and a parish nurse in attendance, advocacy for affordable senior housing where the faith community provides socials, excursions, and grocery delivery.¹¹ This form of organization works toward a synergy of services, encourages shared goals and programming, and promotes healthier budgets.

Overview

If current statistics remain, the fastest growing population group in our country will be people 85 years and older. In the next 15-20 years, what was once a thriving

¹¹ The term “ADA” denotes The Americans With Disability Act of 1990. This was a sweeping reform package that created standards for accessible design for people with disabilities.

baby-boomer population will begin to overwhelm the already challenged churches attempting to meet the needs of this aging population. It is the intention of this dissertation to provide ideas for individualized care systems that facilitate meeting this enormous challenge, as well as offer practical applications that will help provide church staffs and volunteers with equipping resources that address the specific tasks of compassionate care.

Chapter 2 will present biblical materials that demonstrate the basis for such a care system, relating to the subjects of the Bible and health care, Jesus as healer, Christ's compassion for the sick, the Apostles' healing power and mandate, and implications of healing in the post-resurrection church.

Chapter 3 will present materials from Christian history demonstrating how the ancient practices of health and healing have either been upheld or set aside. This will include the various categories of care throughout history and the complex, nearly incomprehensible system of care that has developed over the last century now driven by cost and profit margins. Of special interest is the impact the current health-care reform proposals will have on the senior-adult population.

Chapter 4 will propose a missional solution to specific problems churches face concerning care for the elderly and infirm, and how each church can begin to customize its plan to address the needs.

Chapter 5 will present a practical schematic or care system for finding, equipping, monitoring, and maintaining a staff of volunteers to manage a program for the elderly. This will include examples of equipping classes, marketing and recruitment of new

programs, developing job descriptions for volunteer positions, and ways to retain vitality and vision for service teams.

Chapter 6 will offer the six major challenges seniors face in this century and six possible responses the faith community may wish to enact. In conclusion, the finished product is to act as a motivational tool for churches that feel overwhelmed with the imminent needs of an at-risk aging population that is underserved.

The challenges of serving this ever-growing population of aging adults will be great. J. Gordon Harris offers insight on one priority:

Overcoming the fears of growing old may be rated as a priority for dealing with aging issues. Growing old brings few dividends. Society remains ambivalent about aging. Becoming old no longer is prized and unique. A common impression of the aging process portrays it as fading into oblivion and dying. Little wonder that people want to live to a ripe old age but no one wants to grow old.¹²

Indeed, no one wants to grow old. But the faith community has a unique opportunity to serve and bring dignity to those elders who provide wisdom, mentoring, experience, and compassion to their church. The local church has the power to reverse the trend of disrespect and neglect, offer compassion and build self-esteem, and instill hope in this growing population. It is the intent of this dissertation to inspire and equip a new generation of intergenerational volunteers to nurture the aging adult to a place of honor and respect.

¹² J. Gordon Harris, *Biblical Perspectives on Aging* (New York: The Haworth Press, 2008), 149.

CHAPTER TWO

IMAGES OF HEALING AND CARING IN SCRIPTURE

The Spirit of the Sovereign Lord is on me, because the Lord has anointed me to preach good news to the poor. He has sent me to bind up the brokenhearted, to proclaim freedom for the captives and release from darkness for the prisoners, to proclaim the year of the Lord's favor and the day of vengeance of our God, to comfort all who mourn and provide for those who grieve in Zion. (Isa. 61:1-3a)¹

In the year of the Lord's favor, Isaiah proclaimed God's power would heal a fractured nation, "bind up the broken hearted" and "comfort all who mourn." And Jesus the Messiah declared in his earthly ministry, "the blind receive sight, the lame walk, those who have leprosy are cured, the deaf hear, the dead are raised and the good news is preached to the poor" (Matt. 11:4). Christ still cares for the broken and will perform miracles, and declare the impossible to the skeptical. However, finding a care system that can assess, administer and monitor situations of nurture and compassion is fraught with issues regarding family systems, the severity of the need, resources available, and willing servants. The purpose of this chapter is to construct a biblical foundation for healthcare. I will consider God's direct intervention as healer in the Old Testament, Christ as a healer and his remarkable compassion for the sick in the gospels, the apostles' healing power in the early church, and finally the implications of healing and care by means of the church. 2 Corinthians offers the caregiver encouragement from the God our comforter:

Praise be to the God and Father of our Lord Jesus Christ, the Father of all compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God. For just as we share abundantly in the sufferings of Christ, so

¹All scriptures used in this dissertation will be from *The Holy Bible*, New International Version (Grand Rapids, MI: Zondervan, 1984), unless stated otherwise.

also our comfort abounds through Christ. If we are distressed it is for your comfort and salvation; if we are comforted, it is for your comfort, which produces in you patient endurance of the same sufferings we suffer. And our hope for you is firm, because we know that just as you share in our sufferings, so also you share in our comfort. (2 Cor. 1:3-7)

God is a God of compassion and comfort who creates in us a patient endurance to survive troubles, distresses, and the sufferings of Christ. He does so for our comfort and salvation. After that distressed experience, we are to “pay forward” the comfort we have received to a new generation. Suffering, then, is a part of the Christian life, seen as a prelude to comfort. The care in the present is part of the greater legacy of the merciful comfort of God that someone else provided. Our work as caregivers is to take our own history of nurture and provide personal care for those who cannot care for themselves. And so we look to biblical examples as sources of vision and strength.

Pentateuch, Psalms, and Prophets

In the Old Testament, the concept of caregiving can be found in numerous passages in the Pentateuch, Psalms, the Prophets, and the Book of Ruth, and all reveal God as healer and as an agent of restoration. In Genesis chapter 20, Abraham tricked King Abimelech into believing his wife, Sarah, was his sister in order to receive favor from him. But God told Abimelech that he had taken a married woman and needed to return her to her husband or face the consequences. In carrying out the command, Abimelech continued to vent his anger, and Abraham placated the king, explaining that Sarah was his half-sister. But Abraham asked God for forgiveness for offering his half-sister to the king, and he prayed to God for healing: “Then Abraham prayed to God and God healed Abimelech, his wife, and his slave girls of barrenness, for the Lord had

closed up every womb in Abimelech's household because of Abraham's wife Sarah" (Gen. 20:17-18). Abraham repented for his sin through prayer and through God's forgiveness. In the end, health and the gift of future generations of the kingdom of Gerar were restored.

The book of Exodus also carries the promises of healing and childbirth. Under the laws of justice and mercy in Exodus chapter 23, God provides an angel to prepare the way to protect Israel and destroy their enemies as they travel to the place that is prepared for them. But they must destroy the sacred stones of the false gods and continue to worship Jehovah: "Worship the Lord your God and his blessing will be on your food and water. I will take away sickness from among you, and none will miscarry or be barren in your land. I will give you a full life span" (Exod. 23:25-26).

This promise corresponds to the blessing and curse of the covenant in Deuteronomy chapters 27-28 that also includes an angel to lead the Israelites into the land if they will be obedient, and is repeated in Judges 2:1-5.² Tainted water and food, and illness, were ever-present risks of the desert. But to lose a child was to lose one's future. Like the closing of a womb, miscarriage was feared as a sign of God's displeasure. The angel provides protection from such loss and humiliation.

The promise of healing and restoration is also restored in the book of Numbers when Moses's sister Miriam is stricken with leprosy. She and her brother, Aaron, refuse to confront Moses face to face regarding his recent marriage to a Cushite woman. To demonstrate his anger, God comes in a cloud, rebukes them, and Miriam turns "leprous, like snow." Incredulous, Aaron begs Moses, "Please my Lord, do not hold this sin we

² John W. Rogerson, R.W.L. Moberly, and William Johnstone, *Genesis and Exodus* (Sheffield, England: Sheffield Academic Press, 2001), 244.

have so foolishly committed. Do not let her be like a stillborn infant coming from its mother's womb with its flesh half eaten away" (Num. 12:11). Assuming the role of intercessor, Moses passionately petitions the Lord, ". . . 'O God, please heal her!'" And the Lord speaks directly to Moses. "If her father had spit in her face, would she not be in disgrace for seven days? Confine her outside the camp for seven days; after that, she can be brought back" (Num. 12:13-15). Despite the specter of death that leprosy imposes, the chosen people are inspired by the faith of their leader and his sister. They will wait the required seven days in obedience of God's covenant. God in His mercy delays the progress of a community—and as a result of their patience—grants healing to his chosen daughter who, in turn, will inspire a new generation of children.

The book of Psalms offers still another view of God as rescuer and healer. David cries, "O Lord my God, I called to you for help and you healed me, you brought me up from the realm of the dead. You spared me from going down to the pit" (Ps. 30:2). The pit described in this passage is *Sheol*, or "hell." David has known life in the pit of despair. A fugitive running from the mentally unstable King Saul, he hid in the caves of Adullam, and was rescued from death by the King's son, Jonathan. David feared for his life from the hands of the jealous and bloodthirsty King Saul and then put his trust in God in a Psalm of Adoration: "Praise the Lord, my soul, all my inmost being, praise his holy name. Praise the Lord, my soul, and forget not all his benefits—who forgives all your sins and heals all your diseases, who redeems your life from the pit, and crowns you with love and compassion" (Ps. 103:1-4).

Charles Spurgeon taught, “Forgiveness is the first order of our spiritual experience and in some respects first in value.”³ The greater reward for this internal emotional struggle is not the golden diadem that rests on a head, but the crown of God’s love and his compassion, his forgiveness of sins that transports us from death to life: “He sent forth his work and healed them. He rescued them from the grave” (Ps. 107:20). It is not just what God has done, but what he will do. In both of these Psalms, God reveals that he will intervene on our behalf. When God enters our lives as a healer, we are released from sin and sickness, and our health is restored. He offers more than benefits; he forgives and heals completely, forever.

But God also answered the cry of the prophets who begged God for mercy. In an entire set of prophetic images in Isaiah, Yahweh is the healer of a broken, wounded, fallen, and captive Israel. Isaiah tells of the Messiah to come, who will bear the transgressions of the sinful community:⁴ “But he was pierced for our transgressions, he was crushed for our iniquities; the punishment that brought us peace was upon him, and by his wounds we are healed” (Isa. 53:50). This prophecy reveals what God will provide to heal the nation—a Savior who will dwell among us. He will suffer before and during Calvary from beatings, the weight of the cross, the nail-pierced hands, and the sword in his side. In all of this brutality is atonement, his suffering for our forgiveness, and the healing of our souls.

³ Charles Spurgeon, *Psalms vol. 2 of Crossway Classic Commentaries* (Wheaton, IL: Crossways Books, 1993), 71.

⁴ Robert L. Hubbard, Robert K. Johnston, and Robert P. Meye, *Studies in Old Testament Theology: Historical and Contemporary Images of God and God’s People* (Dallas: Word Publishing, 1992), 177.

Jeremiah chapter 17 depicts a persecution and healing of another kind; it is the emotional deliverance from the enemies whom Jeremiah provokes by his faithful denunciations. And Jeremiah chose to be in intimate prayer directed to God. He lamented over the children of Israel who worshipped idols in high places with Asherah poles and trusted people more than they trusted God.⁵ The word Asherah actually means “grove” and the pole was probably a stylized tree form, representing the goddess of fertility by the same name. She was believed to be the mother of four children, including the infamous *Baal* (Lord), who was responsible for thunder, lightning, wind, and rain. Thus, the competition with Elijah and the priests of Baal was to prove the power of Yahweh against the God of the Canaanites who allegedly controlled the weather.⁶ Isaiah declared their hearts were deceitful and “beyond cure” usurping riches by “unjust means” (Jer. 17:9, 17:11). He begged God that they might be put to shame and that he might be released from this mission of despair: “Heal me O Lord, and I will be healed; save me and I will be saved, for you are the one I praise. They keep saying to me, ‘Where is the word of the Lord?’ Let it now be fulfilled!” (Jer. 17:14-15). Jeremiah begged that his persecutors be put to shame so that he might know emotional relief and witness their repentance. Despite the obstinacy of the Israelites and the ultimate earthly defeat of the nation at the hand of the enemy, God brought comfort to his faithful prophet, “But I will restore you to health and heal your wounds” (Jer. 30:17).

All of the passages previously cited offered insight about God who intervenes directly with his servants, his people, and prophets. But in the book of Ruth, he

⁵ Elizabeth Achtemeier, *Jeremiah* (Atlanta, John Knox Press, 1973), 56.

⁶ John A. Tvedtnes, “Bible Studies-Asherah,” All Experts, <http://en.allexperts.com/q/Bible-Studies-1654/Asherah.htm> (accessed June 23, 2010).

empowers a foreign woman as his agent to care for an elderly, destitute widow. And in his mercy, God honors the caregiver with a child, who is not only born into a family of wealth and love, but will also be an ancestor of the Christ.

Ruth and Naomi

The book of Judges ends with the phrase, “In those days Israel had no king; everyone did as he saw fit” (Judg. 21:25). Famine had debilitated the town of Bethlehem. At the beginning of the book of Ruth, Naomi; her husband, Elimelech; and their sons, Mahlon and Kilion, escaped from the starvation and chaos and settled in the land of Moab. After the death of her husband, Naomi’s sons marry two Moabite women, Orpah and Ruth. Ten years later, after the sons’ marriages prove unproductive and infertile, Mahlon and Kilion perish. Naomi was left without a husband, sons, or heirs to support her. Hearing that the famine was over in Israel, the women prepared to return home to the land of Judah. But Naomi had second thoughts. Knowing her daughters-in-law would have to compromise their cultural background to survive in a foreign land as she did in Moab—and fearing the purity of her grandchildren—she begged Ruth and Orpah to turn back and find suitable husbands out in despair and grief:⁷

Return home, my daughters. Why would you come with me? Am I going to have any more sons, who could become your husbands? Return home, my daughters. I am too old to have another husband. Even if I thought there was still hope for me—even if I had a husband tonight and then gave birth to sons—would you wait until they grew up? Would you remain unmarried for them? No, my daughters. It is more bitter for me than for you, because the Lord’s hand has gone out against me! (Ruth 1:11-13)

⁷ Jon L. Berquist, *Reclaiming Her Story: The Witness of Women in the Old Testament* (St. Louis, MO: Chalice Press, 1992), 143.

Orpah decided to leave for Moab, but Ruth clung to her mother-in-law.⁸ She would not abandon this widow, nor allow her to suffer as an elderly homeless widow without someone to support her. Ruth's response was sacrificial and compassionate:

Don't urge me to leave you or turn back from you. Where you go I will go and where you stay I will stay. Your people will be my people and your God my God. Where you die I will die, and there I will be buried. May the Lord deal with me, be it ever so severely, if anything but death separates you from me. (Ruth 1:16-17)

Not only would Ruth provide support and nurture for Naomi, she would embrace a God other than her own, and perish in a foreign land away from her own family. Despite this generous offer, Naomi remained despondent and, upon arrival in Bethlehem, told the townspeople to rename her *Mara*, a word that means "bitter" (Ruth 1:20). When she left the town, her heart was full, "but the Lord has brought me back empty" (Ruth 1:21). In the Jewish culture of this time, sons were considered "an inheritance from the Lord, children a reward from him" (Ps. 127:3). With the death of her husband and children, Naomi fell to the bottom of the social order, a category that includes the widow, the orphan, the resident alien, the debtor, and the slave.⁹ Naomi, as a faithful Israelite woman, must have a man to survive, for a man is required for economic survival.

Ruth is aware that Naomi will starve without a means of support.¹⁰ So she will need the strength of two attributes of a God she hardly knows, Yahweh Rapha, the God who heals, and Yahweh Jireh, the God who provides, to mend the broken, bitter heart of her mother-in-law. God does provide for these women in three

⁸ Berquist, *Reclaiming*, 144. The word "cling" refers to the male role in initiating marriage. See Gen. 34:3, Josh. 23:12, and 1 Kings 11:2.

⁹ Hubbard, Johnston, and Meye, *Studies in Old Testament*, 104.

¹⁰ Berquist, *Reclaiming*, 143.

very specific ways: protection from harm as Ruth labors in the fields, additional resources for their family, and a kinsman-redeemer who releases the Moabite from an uncertain future and grants her a place as the noble wife of Boaz.

Remembering that God commanded the Israelites to be merciful to the poor and leave the corners of their field for the gleaners to reap, Ruth begins this care-giving journey as a gleaner in the barley season in Bethlehem (Ruth 2:3). Boaz, a relative of Elimelech, notices Ruth's diligence. He allows her to stay close to his servant girls, away from the unwanted advances of the male harvesters. He has heard of her caring for her mother-in-law and affirms her sacrifice to leave her homeland, rewarding her kindness with extra portions of barley and a place at his table to eat. Ever Naomi's provider, Ruth saves a portion of food for her mother-in-law. Upon Ruth's return home, Naomi is overwhelmed at Boaz's generosity, knowing him to be one of their "kinsman-redeemers" (Ruth 2:20). A *Goel*, or "kinsman," is literally "one who redeems." When a Hebrew was obliged to sell his inheritance due to poverty, the nearest relative could redeem it for him. The *Goel* also received the property that had been unjustly kept from a deceased kinsman. The kinsman-redeemer was also to avenge the blood of his next-of-kin by seeking the life of the murderer.¹¹

But Naomi must plan strategically to regain her rightful place of honor in the community, and asks Ruth to complete one more task. She is to wait until Boaz has finished winnowing the barley, has completed his meal, and is beginning to sleep. Then Ruth is to uncover his feet, cover them with her skirt, and lie down (Ruth 3:9). This ritual was common practice in the Near East and was symbolic of protection, especially

¹¹ James M. Freeman, *Manners and Bible Customs* (Plainfield, NJ: Logos International, 1972), 129.

associated with marriage.¹² Ruth knows he can offer this safety as her next-of-kin. Disturbed in the middle of the night, Boaz awakes to find Ruth on the threshing floor, and she, in turn, asks him to spread the corner of the garment over her. Deeming her a woman of noble character, he complies. Boaz vows to handle negotiations with the kinsman-redeemer who is closer in the family than he is, and who could claim Ruth as his own. Not only does she stay the night, but Boaz also fills Ruth's shawl with six measures of barley for her mother-in-law. Already we can see God's hand in provision and reward for the sacrifice and labor to care for another. But the greater gift of healing and redeemed life is to come.

Boaz goes to the town gate, and gathers ten elders along with the kinsman-redeemer. Boaz then offers the land that belonged to Naomi's husband and sons to the kinsman-redeemer, who has the option to purchase the property. At first it appears that the unnamed kinsman will agree to purchase the land, but then he recants when Boaz notes the purchase includes Naomi, the dead man's widow, as part of the settlement. Fearing he might endanger his own estate, the kinsman withdraws his offer by removing his sandal to complete the transaction. He has relinquished his first right of refusal. This gives Boaz permission to purchase the land. But more than that, he has redeemed the lives of two women who are doomed to a hopeless life of poverty. In his purchase of the land, he claims Mahlon's widow, Ruth, as his wife to retain the name of the dead with his acquisition.¹³ As a result, she is raised to the status of a noblewoman.

¹² E.C. Rust, *Judges, Ruth, and 1 and 2 Samuel*, Layman's Bible Commentaries (London: SCM Press, 1961), 74.

¹³ Freeman, *Manners and Bible Customs*, 129. The irony in this story is that Boaz was not obligated to marry Ruth, as neither he nor the unnamed kinsman was a brother-in-law. The unnamed kinsman is not disgraced; he has only relinquished his right to the property. It is truly an act of grace that Boaz chooses to marry Ruth.

The elders of the town have witnessed more than a negotiation of land. They see this union as something miraculously tied to Rachel and Leah, women who bore the sons of the house of Israel. They have also witnessed the beginning of restoration and healing in the matriarch, Naomi. When Ruth and Boaz bear a son, Obed, he is laid in Naomi's lap as her own. Obed is not truly Ruth's son; he is Naomi's son, Elimelech's legal heir.¹⁴ Healed from the bitterness that nearly has destroyed her, Naomi hears a chorus of women rejoice in a song of praise:

Praise be to the Lord, who this day has not left you without a kinsman-redeemer. May he become famous throughout Israel! He will renew your life and sustain you in your old age. For your daughter-in-law who loves you and who is better to you than seven sons, has given him birth. (Ruth 4:14)

This is not just any child, but an ancestor in the genealogy of Christ. Not only have the destitute and barren conceived new life, but Obed will also be the father of Jesse, who will be the father of King David. This faith journey is in stark contrast to a previous recounting of the Levite who cut his concubine in pieces and sent the body to twelve different destinations (Judg. 19). In this narrative, God provides a story of restoration, protection, and provision to a foreign, overburdened Moabite woman who steps out of her traditional role as a woman without a future, and labors to care for the needs of her Israelite mother-in-law. But more than that, God's blessing on Ruth and Boaz reunites the pieces of Israel that are torn asunder in Judges. Through them, all the nations of the earth will be blessed and united. Ruth, as the new Abraham, has left her land in an act of faith and finds that God has provided an heir when all hope was lost.¹⁵

¹⁴ Berquist, *Reclaiming*, 150.

Instead of direct intervention and declaration, God has used Ruth, a non-believer, as an instrument of his healing for Israel.¹⁶

New-Testament Healing

In the New Testament, Christ is the primary instrument of healing in the Gospels. Not only does he set the captives free from physical and emotional limitations, his healing points to the greater power of God. In each instance, Christ assesses the situation, approaches the infirm with compassion and personal sensitivity, heals and restores the person, and offers care and comfort that leads to spiritual healing as a sign of his grace.

An example of this kind of healing and care is the story of the widow of Nain in Luke 7:11-17. The widow's son, the one resource she depended on, has died. As the funeral procession winds through the streets with a large crowd of people, the Lord responds:

“Don't cry.” Then he went up and touched the bier they were carrying him on, and the bearers stood still. He said, “Young man, I say to you get up!” The dead man sat up and began to talk, and Jesus gave him back to his mother. They were all filled with awe and praised God. “A great prophet has appeared among us,” they said. “God has come to help his people.” This news about Jesus spread throughout Judea and the surrounding country.
(Luke 7:13-17)

As revealed in the story of Ruth, a widow's only hope of survival is her family. She becomes a member of her eldest son's household, and he provides for his widowed mother until her death, at which time he inherits the property and possessions of the

¹⁵ John H. Walton, Mark L. Strauss, and Ted Cooper Jr., *The Essential Bible Companion: Key Insights for Reading God's Word* (Grand Rapids, MI: Zondervan, 2006), 29.

¹⁶ The story of Naomi and Ruth is indicative of those caregivers who are dedicated to a neglected sector of the population: the destitute and isolated senior. Subsequent chapters will address how twenty-first-century families have either embraced or abdicated from the responsibility of caregiving.

family.¹⁷ In the event she is left without an heir, a widow can gain assistance from a kinsman who makes his resources available or defends her in legal matters, such as land or inheritance. Without these safeguards in place, this widow's situation is desperate, and Jesus's heart goes out to her. As the widow relinquishes her son to him, Jesus's miraculous touch does more than restore her son's life; it grants grace and hope to a woman destined for the life of a beggar. Christ also was the son of a widow, and this allowed him to identify with her need.¹⁸ Those who witness this event are seized with amazement and praise God. They realize this to be more than a resurrected man coming back to life, but a mother coming to life as well. Townspeople witness the power of God through his son Jesus, who has come to "help his people."¹⁹ Loretta Dornisch says it well:

A great prophet—one who speaks for God—was raised (*egerthe*) among us (Luke 7:16). The raising, the resurrection, is first applied to Jesus, but then to the widow's son. (Jesus was also a widow's son). But each Christian also enters into this resurrection. The rising, the new life, is an energy that moves from one to another.²⁰

As a result, news of this healing spreads beyond the town into the surrounding country.

¹⁷ Trent C. Butler, ed., *Holman Bible Dictionary* (Nashville, TN: Holman Bible Publishers, 1991), 696.

¹⁸ Loretta Dornish, *A Woman Reads the Gospel of Luke* (Collegeville, MN: The Liturgical Press, 1996), 71.

¹⁹ Cleon Rogers, *The New Linguistic and Exegetical Key to the Greek New Testament* (Grand Rapids, MI: Zondervan, 1998), 124. In this passage from Luke 7:16, the phrase here actually means, "Used of God gracious visitation in bringing salvation." Or perhaps in more contemporary terms, the flesh of Jesus Christ is the new localization of God's presence on earth. "The word was made flesh and dwelt among them" (John 1:14).

²⁰ Dornisch, *A Woman Reads*, 72.

At another time Christ demonstrated love and compassion to a woman who had suffered from bleeding for twelve years.²¹ Drained of energy and resources, she was desperate, because “no one could heal her” (Luke 8:43). The Gospel of Mark notes that her condition actually has grown worse in the care of doctors (Mark 5:26). Crouching down in the middle of a crushing crowd, she comes up behind Jesus and touches the edge of his cloak, the tassel of the outer garment.²² Immediately, her bleeding stops. “Who touched me?” Jesus asks, and the crowd unanimously denies any involvement. Peter assumes the touch occurred when the crowd pressed up against Jesus. But Jesus is convinced that someone has deliberately and personally touched him. Christ replies, “I know that power has gone out from me.” The woman must reveal herself. Trembling before Christ’s feet, and in the presence of the people, she is no longer able to hide her identity. She pours out her story of prolonged illness and instant healing. Then Jesus says to her, “Your faith has healed you. Go in peace.” Like the widow of Nain, this nameless invalid is destitute, without resources. But Christ gives her new identity as a result of her faith. After she had given up all her resources, her faith and the simple touch of her hand on the Savior’s robe restore her to health.

In this same crowd, a synagogue leader named Jairus comes with news of his dying daughter. He, too, falls at Jesus’s feet, begging Jesus to heal his twelve-year-old

²¹ Catherine Kroeger, and Mary J. Evans, *The IVP Women’s Bible Commentary* (Downers Grove, IL: InterVarsity Press, 2002), 573. The word often used for bleeding was “discharge,” either as part of the woman’s monthly period, or a flow that occurred outside the time of the period. Lev. 15:19 and Lev. 15:25 declare this person unclean and anything or anyone coming into contact with the source unclean. In Jewish culture, this woman would have been completely isolated for twelve years.

²² Freeman, *Manners and Customs*, 345. According to Mosaic Law, every Jew was obliged to wear a tassel or fringe, *kraspedon*, at each of the four corners of his outer garment, with one blue thread per tassel. The tassels represented the law of God and the duty to keep it. The woman touched this “hem,” assuming some virtue was attached to the holy garment.

child. But Jesus continues on his way. After the woman, who has been subject to bleeding for twelve years, is healed, we learn that the delay has proved fatal to his child. But Jesus' words to Jairus echo the proclamation he has made to the healed woman. "Don't be afraid; just believe, and she will be healed" (Luke 8:50). Jesus goes to Jairus's house with Peter, James and John, and they enter the room, along with the child's parents. The professional mourners are already participating in shiva, wailing and moaning.²³ Assessing the situation, Jesus notes, "She is not dead but asleep," and the people laugh in disbelief. Once again, with a simple touch to her hand and the command, "My child, get up," her spirit returns. She stands up and Jesus asks that they give her something to eat. The child's parents are astonished that their little girl has come back to life.

Scholars suggest the two stories are juxtaposed for a purpose. In the same twelve years during which a little girl has filled her parents with joy and promise, a woman bearing a deadly and isolating disease has been drained of all hope. We witness the well-respected father risking his status approaching the controversial healer, and the disrespected outcast. These individuals form an interesting duo in the midst of a mob of people pressing to see the miracle worker.²⁴ As a prominent leader of the synagogue, Jairus makes an open request; the woman hides in the crowd, an unclean, untouchable pariah who is forced to declare her illness in public.²⁵ Blood, the source of life, is gone from her body. Spirit, the source of life for the little girl, has left her body.

²³ William Barclay, *Luke* (Philadelphia: The Westminster Press, 1975), 110. Shiva is a Jewish custom in which people mourn for the dead. In Jesus's day, it was the custom to hire wailing women as a token of respect.

²⁴ Catherine Clark Kroeger, and Mary J. Evans, *The IVP Women's Bible Commentary* (Downers Grove, IL: InterVarsity Press, 2002), 573.

²⁵ In Mark 5:23, Jesus and the woman share a private conversation.

Both are empty vessels until they have a personal encounter with the Savior.²⁶ The woman is restored to health; the little girl's spirit re-enters her body. The common denominator is faith. Jesus is not concerned about the bodily function that is common to women. He recognizes the woman's faith is strong enough to draw power out of him and calls her "daughter" (Luke 8:38, Matt. 9:20-22, Mark 5:34). In the midst of a crushing crowd, Jairus's faith boldly declares his need for the healing power of Christ. But these two stories offer more than a faith-and-healing connection. Christ is demonstrating that compassion and care for others is fundamental in the kingdom of God regardless of social status, financial resources, cultural differences, or religious taboos.

The story of the Good Samaritan in Luke 10 illustrates the responsibility to aid those in need of healing and to overcome the legalism of rigid temple rituals. The story seems simple enough until we understand the meaning behind the parable. Robbers attacked a man who was on his way to Jericho. They stripped him, beat him up, and left the man half-dead on the side of the road. A priest headed down the same road passed on the other side, around the man, and a Levite did the same. But a Samaritan saw the man and had pity on him. He bandaged the man's wounds, pouring on oil and wine, and took him to an inn to care for him. In an extreme act of generosity, the Samaritan paid for the man's stay and offered to reimburse the innkeeper for any extra expenses incurred. At the end of the lesson, Jesus asks the question, "Which of these three do you think was a

²⁶ Butler, *Holman*, 200. To the Jew, blood was considered the source of life, but it was also forbidden to touch. If someone touched a dead person or blood, they were considered unclean for seven days and forbidden to enter the synagogue until the priest declared them clean. Thus, with these two stories, Jesus performed miracles on people considered unapproachable.

neighbor to the man who fell into the hands of robbers?” The expert in the law replies, “The one who had mercy on him.” Jesus tells him, “Go and do likewise” (Luke 10:37b).

The road to Jericho was treacherous. Perched high on a cliff of narrow rocky paths and sudden turns, with a climb of over 3,600 feet over the 20-mile stretch, it was a fertile playground for the criminals of that day. People would pay and still do pay “safety money” to gain safe passage.²⁷ In the parable, a priest passed by and avoided the traveler, fearing he is dead, for to touch him meant being ritually unclean for seven days (Num. 19:11). To touch a dead man also meant losing his turn of duty in the temple.²⁸ He was not willing to risk his status for the injured man.

The Levites were the tribe chosen to carry out the responsibility of sacrifices. God chose them because they stood with Moses against the Israelites when Israel worshipped the golden calf.²⁹ So it is possible that given his priestly experience with blood sacrifices, the Levite in this parable realized the danger of robbers using decoys to entrap unsuspecting helpers, and so he passed by as well.

When Jews spoke of Samaritans, they accused them of being heretics and breakers of ceremonial laws. As part of the Northern Kingdom, their people intermarried with Gentiles. This, in turn, led to widespread worship of foreign gods.³⁰ Jews walked around the territory of Samaria to avoid any contact with the community. But Christ refused to do this. He walked through the land of Samaria to make a point, and later

²⁷ Barclay, *Luke*, 139.

²⁸ *Ibid.*

²⁹ Butler, *Holman*, 875. See Exod. 32:25-29 and Deut. 10:

³⁰ *Ibid.*, 1224-5.

demonstrated kindness to a woman no one else would acknowledge.³¹ Jesus made it clear that the disciples were obligated to love God and to “Love your neighbor as yourself” (Lev. 19:18), which included the Samaritans.³² Including a Samaritan in the story elicited immediate prejudice, but the Samaritan was the one who offered the most Christ-like response of mercy, compassion, and healing. His response pointed to the care God wants us to show for each of his children; this is in stark contrast to the legalistic attitudes of pious temple worshippers.³³

On the cross at Calvary, Jesus delegates the responsibility of care to his beloved disciple, John. Physically beaten and on the edge of death, Christ makes one last request for someone to care for his mother, Mary, knowing that she will become a controversial prophet’s mother, an isolated widow:

When Jesus saw his mother there, and the disciple whom he Loved standing nearby, he said to his mother, “Dear woman, here is your Son,” and to the disciple, “Here is your mother.” From that time on, this disciple took her into his home. (John 19:26-27).

So we assume John takes the role of kinsman and elder brother to Jesus’s mother, Mary, as none of the siblings of Jesus are mentioned in any of the Gospels at his death.

Although John is present at the crucifixion, Mary is the one who receives the body of Christ from the cross before she relinquished it to Joseph of Arimathea, a prominent member of the council to whom Pilate granted permission to bury the body (John 19:25-27, Matt 27:57). The only other time we hear of Mary is when she is present in an upper

³¹ Luke Timothy Johnson, *The Writings of the New Testament* (Minneapolis: Fortress Press, 1999), 528.

³² *Ibid.*, 523.

³³ The story of the Good Samaritan is indicative of those who care for people others often neglect: the isolated, the abandoned senior, the patient with AIDS, the mentally ill. Chapter 3 will address each of these categories.

room with John and the other disciples, a few days before Pentecost (Acts 1:14).

Tradition holds that Mary lived out her later years in Ephesus under the care of John, who was believed to have lived and preached in that city.³⁴

Healing and Care in the Post-Resurrection Church

After Jesus's death and resurrection, the mantle of healing and care was passed to the disciples. With the indwelling of the Holy Spirit, they continued the healing and preaching ministry of Christ. Peter was the first to take on this mantle on the Day of Pentecost (Acts 1:14).

The apostles devoted themselves to teaching and “. . . to the breaking of bread and to prayer. Everyone was filled with awe and many wonders and miraculous signs were done by the apostles” (Acts 2:42b-43). Thus, in Acts Chapter 3 we see the power of the Holy Spirit that, in turn, results in the healing.³⁵ One example is a crippled beggar, who was carried in and asks Peter and John for money. Men with disabilities, as well as women were banished from the court of Israel because something imperfect could pollute such a hallowed place.³⁶ Although there was no money to give, Peter declared a far more powerful solution: “. . . but what I have, I give to you; in the name of Jesus Christ of Nazareth, stand up and walk.” (Acts 3:6). The result was complete physical healing, along with exuberant praise and thanksgiving. For the first time in forty years, a man was not only able to walk, but gained access to the inner sanctum of the court of Israel. Like the woman with the flow of blood, Jesus gave him a new life of fellowship and access to the

³⁴ Butler, *Holman*, 804, 928.

³⁵ Johnson, *The Writings*, 229.

³⁶ Kroeger and Evans, *The IVP Women's Bible*, 610.

presence of God. More important, Peter used the miracle to point to Christ, the true healer. The result is nothing short of miraculous:

As a result, people brought the sick into the streets and laid them on beds and mats so that at least Peter’s shadow might fall on some of them as he passed by. Crowds gathered also from the towns around Jerusalem, bringing their sick and those tormented by evil spirits, and all of them were healed. (Acts 5:15-16)

Despite all the popularity and excitement of new converts, the exhaustion of traveling and healing took a toll on the disciples. They were criticized for not taking the time to care for the Greek widows through food distribution. The disciples, however, chose not to neglect the ministry of the Word of God in order to wait on tables. Instead, they selected seven men, believed to be “full of spirit and wisdom,” to accept the ministry to these honored Gentile women (Acts 6:3).

Seven men, Stephen, Philip, Procorus, Nicanor, Timon, Parmenas, and Nicolas, were presented to the apostles, who prayed for them and laid hands on them. In delegating and triaging these care responsibilities, two goals were accomplished: those with the appropriate spiritual gifts of compassion and wisdom were serving the needy, and those with gifts of teaching and preaching continued in their work to declare the Word of God.³⁸

In fact, the work and healing of these deacons was so powerful that jealousy and opposition arose from “members of the Synagogue of the Freedmen (as it was called)—Jews of Cyrene and Alexandria as well as the provinces of Cilicia and Asia” (Acts 6:9). They spread rumors accusing Stephen of blasphemy against Moses and God, calling in false witnesses to testify against him. Stephen defied the authorities with a bold declaration of faith, specifically the stories of Abraham, Joseph, and Moses and their

³⁸ For more on triaging care responsibilities, see Chapter 4.

encounters with the living God. Utilizing the stories, Stephen declared that the freedmen had resisted the Holy Spirit, their source of healing, and had betrayed and murdered the Righteous One, Jesus Christ. Unafraid, Stephen faced his accusers, and saw visions of heaven as he was stoned outside the city gates, forgiving his executioners. After godly men bury Stephen and mourn for him, Saul, who witnessed the murder, began his campaign to destroy the early church, dragging off men and women disciples and putting them in prison. Despite the persecution, men such as Philip in Samaria continued to spread the gospel through healing:

When the crowds heard Philip and saw the miraculous signs he did, they all paid close attention to what he said. With shrieks, evil spirits came out of many, and many paralytics and cripples were healed. So there was great joy in that city. (Acts 8:6-8)

Not long after the miraculous conversion of Saul on the road to Damascus, Dorcas, a much-loved disciple and compassionate social worker of her day “. . . who was always doing good and helping the poor,” died.³⁹ She was washed for burial and laid in an upper room. Peter heard of her death and altered his plans to travel to Joppa to be with her. Professional mourners were already present, and those she cared for gathered around her bed displaying the hand-made clothing she provided. Peter sent everyone away from Dorcas’s body so that he might be alone with the Holy Spirit. Peter prayed on his knees and called on the name of Christ, asking the woman to “get up.” The word here, in Greek, actually means sit up.⁴⁰ Dorcas opened her eyes, saw Peter, and sat up. The apostle took her by the hand and drew her to her feet; she was revived. Mourners, widows, family, and

³⁹ Kroeger and Evans, *The IVP Women’s Bible*, 612. This story is found in Acts 9:36b.

⁴⁰ Cleon Rogers, *The New Linguistic*, 124, 129, 263.

friends are called into the room to witness the miracle. Once again, the glory goes to Christ and people believe in the Lord.

The apostle Paul continued the tradition of healing and care in Acts 14 when a man in Lystra sat:

... crippled in his feet, who was lame from birth and never walked. He listened to Paul as he was speaking. Paul looked directly at Him, saw that he had faith to be healed, and called out, "Stand up on your feet." At that, the man jumped up and began to walk. (Acts 14:8-10)

An unexpected, nearly fatal reaction occurs, as the crowd believes that the "gods have come down to us in human form!" (Acts 14:11). Declaring Barnabas to be Zeus, and Paul to be Hermes, the crowd insists that sacrifices be given in their honor. However, Paul and Barnabas tear their clothes and rush out from the crowd, begging the mob to turn from their own way and consider the living God who has created the heaven and earth and sea and all the wonders contained in them (Acts 14:14-16). Despite their attempt to give the glory to the Lord, they barely escape the crowd. Fortunately, this does not end Paul's work as a healer.

Later in his ministry, while ashore on Malta on his way to Rome, Paul is the guest of Publius, the chief official of the island. Publius's father is ill and suffering from dysentery. After prayer, Paul lays his hands on the sick man and heals him. This act of kindness inspires the rest of the sick on the island to come to the home of Publius and be cured. Appreciative of this ministry, Publius furnishes Paul with supplies to send him on his way.

God's Call to Believers

Stories of healing in the Old and New Testaments share common elements. Those who are called to heal consider the need, family, and the resources available to the ill person. When healers understand the deep need and sense the care receiver's faith, they call on God to ask for intervention. God then intervenes, the patient is made whole, and all present are called in to witness the miracle. Glory is given to God for the miracle and those who witnessed the change come to a deeper knowledge and faith in God. We see healing in the stories of Miriam's leprosy, the woman with the flow of blood, and in the resurrections of the son of the widow of Nain and Jairus's daughter (Num. 12:11-15, Luke 8:43-48, 7:11-17, 8:40-56).

Caregiving centers on those who have been rejected, abandoned, or neglected. Consider Ruth and Naomi, who are destined for poverty and rejection. Boaz, in his mercy, witnesses Ruth's willingness to care, and he, in turn, protects her and Naomi from the harsh realities of poverty. The disciple John, in his love and dedication to Christ, is willing to be the son Mary needs at Jesus's death, so she may be properly cared for. The woman with the flow of blood is the recipient both of Christ's healing and the subsequent care of others. Cured of her bleeding, she can regain a place in the community as a healthy individual. Dorcas's care has come full circle. Those she cared for rejoiced in her resurrection from the dead, and were, in turn, motivated to continue her legacy of caring for others.

God's redemptive work is holistic in that he desires that all believers experience abundant life in body, soul and spirit. Included in that call is our dedication to advocate for healing and wholeness for all of God's children. That includes ensuring that people

have access to health care according to their needs and not dependent on their status, wealth, or position in society. Jesus had mercy on the lame, blind, poor, elderly, ill, mentally disabled, and the marginalized. In that same spirit, we ought to be advocates for those who struggle with mental and physical illness, valuing their needs and ensuring their care. If we truly love our neighbors as ourselves, our love should extend to their health and emotional stability. Caring for our neighbor is an extension of Christ's healing ministry and our care offers an otherwise forgotten witness to the community. Who would not be drawn to know more about those who volunteer to care for people, such as the neglected, abandoned, and isolated? Given the biblical examples we have discussed, the Lord is clearly concerned for those who are ill, and he equips those whom he calls, to be agents of his power to bring healing. If we refuse this call, we do so not only at their peril, but our own. Consider God's admonition in Ezekiel to those shepherds who take care of themselves:

Should not the shepherd take care of the flock? You eat the curds, clothe yourselves with the wool and slaughter the choice animals but you do not take care of the flock. You have not strengthened the weak or healed the sick or bound up the injured. You have not brought back the strays or searched for the lost. You have ruled them harshly and brutally. (Ezek. 34:2b-4)

And God's admonition continues in Matthew 25:34-41, when Jesus declares his judgment on those who would not take care of the hungry, thirsty, naked, ill or imprisoned:

The King will reply, "Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me." Then he will say to those on his left, "Depart from me, you who are cursed, into the eternal fire prepared for the devil and his angels. For I was hungry and you gave me nothing to eat, I was thirsty and you gave me nothing to drink, I was a stranger and you did not invite me in, I needed clothes and you did not clothe

me, I was sick and in prison and you did not look after me.” They also will answer, “Lord, when did we see you hungry or thirsty or a stranger or needing clothes or sick or in prison, and did not help you?” He will reply, “Truly I tell you, whatever you did not do for one of the least of these, you did not do for me.” Then they will go away to eternal punishment, but the righteous to eternal life.

If the care of the sick will have significance in the final judgment, can we wait any longer as believers to fulfill this call? Are there ways to educate faith communities to explore new avenues of advocacy and care? Are believers motivated and prepared to serve the elderly as the new health plan goes into effect? As we explore the history of caregiving in the next chapter, some of these questions will be addressed.

CHAPTER THREE

A BRIEF HISTORY OF HEALTH CARE

“He led me back and forth among them and I saw a great many bones on the floor of the valley, bones that were very dry. He asked me, ‘Son of Man, can these bones live?’” (Ezek. 37:2-3a)

As Ezekiel walked the valley floor, all he could see were decaying bodies and dry bones. There was little hope that the disobedient Israelites would ever revive. And so it is with our current health care system. The crisis of health care in this country continues to confront and to confound our legislators in Washington. As of the date of this writing, even with the passage of the new health-care law in 2010, there is still no definitive consensus on a plan that will work for everyone.¹ This new health-care bill will not fully take effect until 2014. In the meantime there are still huge chasms of mistrust to bridge and questions regarding the \$940 billion price tag. There are insurance mandates and fines for employers, and taxes that need to be addressed.² And in the interim, insurance premiums are on the rise. The current federal administration estimates the new benefits based on no-cost preventative health services alone may push up premiums an average of 1.5 percent.³ Based on town-hall meetings with representatives from Congress, it seems that there is a huge disparity between the perception of citizens, and those of lobbyists.

We are in a crisis of communication, care, and compassion. Sixty-two percent of the

¹ David M. Herszenhorn, “Health Care Figures Match Obama Wish List,” *The Oregonian*, March 19, 2010. The bill will be \$940 billion over 10 years, according to the Congressional Budget Office.

² Ibid. The costs for the new health-care program over 10 years is estimated to be \$940 billion, affecting 95 percent of eligible Americans when fully phased in, including 32 million uninsured. High cost insurance plans will be taxed starting at \$10,200 for individuals and \$27,500 for families. There will be a higher Medicare payroll tax on investment income and wages for individuals earning more than \$200,000 or married couples earning more than \$250,000. Businesses will be hit with a \$2,000-per-employee fee if the government subsidizes their workers’ coverage. Only companies with 50 or fewer workers are exempt from this plan.

³ R. McClatchy, “Specifics Explain New No-Cost Preventative Health Services,” *The Oregonian*, July 16, 2010.

bankruptcies filed in this nation are due to overwhelming costs of medical care, up twenty percent from a pool of respondents in 2001.⁴ Children continue to remain uninsured and vulnerable to viruses, diseases, and abuse—without a safety net—and many seniors face a decision on whether or not they can afford the forty-four percent increase in the cost of drugs.⁵ It seems that we are wandering the valley floor begging for signs of life in a care system so irretrievably broken, we wonder if it can ever be revived. This chapter will offer some insight on how we got into this situation, examine a few of the present crises we are facing, particularly with seniors, and offer some ideas on how we may begin to innovate with plans to care for our elders. Our desire is to give them “a future and a hope,” (Jeremiah 29:11) and to take care of God’s children with simplicity and compassion.

Humble Beginnings

So how did we find ourselves in this valley of despair and destruction? William Bynum, author of the book, *A History of Medicine: A Very Short Introduction*, categorizes medical history into five major phases: Bedside, Library, Hospital, Social, and Laboratory.⁶

⁴ Sarah Lovenheim, “New Study: Bankruptcy Tied to Medical Bills,” *Washington Post*, June 4, 2009, http://www.voices.washingtonpost.com/health-care-reform/2009/06/new_study_shows_medical_bills.html (accessed December 3, 2010).

⁵ Allen Rubin, “Prescription Drugs and the Elderly,” website for senior citizens, <http://therubins.com/geninfo/eldpresc.htm> (accessed December 10, 2009). This increase in cost occurred from 2000-03.

⁶ William Bynum, *The History of Medicine: A Very Short Introduction*, (Oxford, England: Oxford University Press, 2008), 2.

Bedside

The bedside phase of medicine involved the whole patient. The training for the caregiver was very much like a modern day apprenticeship program consisting of a teacher/mentor and student/apprentice. An example of this method was Hippocrates (460-370 BC), who was considered the father of naturopaths, chiropractors, herbalists, and osteopaths—and the founder of ideals in health, disease, and healing. His was a holistic approach to the patient.⁷ As there were no hospitals, care was done at the bedside in a patient's home, and students who wished to be doctors learned at their master's side. The Hippocratic doctor knew his patients thoroughly, not only in their social, economic, and familial context, but how they lived, what they ate or drank, where they traveled, what the family history of disease had been—and whether they were slave or free. As the medical systems adapted to the prevailing Greek culture, doctors were free to combine theology and healing, so the priest-physician was a common trade. Healing temples emerged dedicated to the Greek god Asclepius.⁸ If the gods were displeased, or there had been transgressions or magical forces at work, the priest-physician was available for prayer and interpretation. What resulted were physicians who interpreted illness on the basis of dreams reported to the doctor. The doctor in turn would dispense magic potions and spells to ward off what the priests felt were evil spirits.

Healing in early centuries of Christianity could be categorized into three areas: miraculous or religious/ritual healing, magical healing, and healing by natural means. Miraculous healing was an extraordinary event that resulted from intervention of a divine

⁷ Ibid.,6.

⁸ Ibid.,7.

power beyond the normal course of nature.⁹ Pagans, Jews, and Christians all shared a universal belief that intervention in nature was possible, and we are aware of the miraculous healing in the New Testament—not only by Christ but by Peter, Paul, and other apostles. The second form, magical healing, involved the employment of amulets, incantations, or occult objects such as herbs and gems. These objects supposedly manipulated hidden preternatural forces within nature, but outside its normal course.¹⁰ These magical practices were condemned by Christian leaders and were considered the work of evil forces. Psalm 121:1 declares, “I lift up my eyes to the hills, where does my help come from? My help comes from the Lord, the maker of heaven and earth.” The hills housed the charlatans and occult practitioners who sold their potions and lotions, and cast spells on an unsuspecting public, especially the pilgrims headed to Jerusalem. The final area of healing was by natural means, encompassing the physician’s repertoire of folk remedies, home cures, traditional treatments, and herbal recipes.¹¹

Libraries

From the bedside and the temple grew a new phase of medical care based on compilation or the library. The physician model Bynum cites is Constantine the African, who died sometime before 1098. The objective of this style of medical care was no longer the whole patient but the written text (posed in a scholastic, linguistic, university setting). Recovery and commentary were the goals. The library of knowledge was contained in the manuscripts of the master teachers, copied by hand, and often housed at

⁹ Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Baltimore: John Hopkins University Press, 2009), 4-5.

¹⁰ *Ibid.*, 5.

¹¹ *Ibid.*, 5.

the great library and museum in Alexandria, Egypt. These ancient manuscripts provided the formal foundations of medical practice well into eighteenth century.¹² Within this library of medicine were commentaries dating from the fall of Rome in 455 to what we call the Renaissance period. A veneration of the medical wisdom of the Greeks with added medical theories and practices developed in subsequent centuries; this collection of observations and notes was considered a treasure. Very few literate doctors could access the fourth-and fifth-century writings of Caelius Aurelianus. Aurelianus painstakingly produced a compilation of writings on acute and chronic diseases based on an earlier physician, Soranos. Within these collections were summaries on migraine, sciatica, and other common diseases.¹³ By the eighth century, a major translation movement made its way into the Islamic countries.¹⁴ In fact, the medieval Islamic medical tradition was often seen as a conduit for the preservation and transmission of ancient Greek texts, which were translated into Middle-Eastern languages, then back into Latin, and finally into modern European languages.

Hospitals

During this same era of the eighth and ninth centuries, the institution known as the hospital had its beginning. Romans used special buildings called *valetudinaria* (from the root *valere* meaning to be strong or well) to house and care for sick soldiers, with one building dating back to 9 AD.¹⁵ Even slaves were being housed together when they were sick, reflecting the value they had in society. Most of the *valetudinaria* contained a

¹² Bynum, *History of Medicine*, 20.

¹³ *Ibid.*, 21.

¹⁴ *Ibid.*

¹⁵ Bynum, *History of Medicine*, 23.

number of beds. In general these were for the sick, but they were also set aside for outbreaks of specific illnesses that required quarantine. In either case, they were never considered a place of permanent residence.

The word for hospital comes from the same root as the words hospitality, hostels, and hotel, for it was a place of rest and charity. In Christendom, early hospitals followed this tradition of offering a safe place to stay and meals. Religious establishments maintained by religious orders were perceived both as a place of refuge or hospitality for pilgrims, but also available for the needy. Although not initially built for the sick, they contained an infirmary where the needs of the ill could be served. Many of the famous European hospitals date back to medieval times, including Hotel Dieu in Paris, St. Bartholomew's in London, and Sta Maria Nuova in Florence.¹⁶ Some of the great Renaissance artists depict this benevolent care of the church, particularly as seen at the deathbed. Examples would include the following portraits: Giotto's "St. Francis Appearing to Gregory IX," 1300,¹⁷ Gentile da Fabriano's, "The Crippled and Sick Cured at the Tomb of Saint Nicolas," 1425,¹⁸ El Greco's "The Burial of Court Orgas," 1586,¹⁹ and Dominico Ghirlandaio's, "The Funeral of Saint Fina," 1475.²⁰

Hospitals in the Islamic world of the Middle East were of considerable size by the eleventh century, divided into specialty wards for eye diseases and the insane. They were quite appealing to students of the day wishing to learn the practice of medicine. Like their

¹⁶ Ibid.

¹⁷ Rosa Georgi, *The History of the Church in Art* (Los Angeles: J. Paul Getty Museum, 2004), 313.

¹⁸ Ibid.,197.

¹⁹ Ibid.,76.

²⁰ Georgi, *History of the Church*, 35.

Christian counterparts, both institutions shared the same range of philanthropic or charitable funding and the most prominent causes were two diseases in particular, “the plague” and leprosy. The *lazaretto* (from Lazarus, the poor man whose sores the dogs licked) was a Christian-sponsored hospital that quickly adapted its care for the Black Death of the fourteenth century. Leprosy was the lightning rod for social ostracism and often-legal death. The diseased victims were condemned to lives of begging and humiliation, with their familiar rattle shaking before them. Sisters of Charity, monks, and others freely lived among these people and dedicated their lives to them.

Medical Schools and Doctors

With the increased populations in these hospices and institutions, the need for trained doctors grew and the university, with its specific training curriculum, met this need. The medical school at Salerno was built simply to train doctors, and nothing else.²¹ Later, medical schools were begun in Bologna (1180), followed by Paris (1200), and Salamanca (1218). By the late fifteenth century there were 50 schools for the training of doctors.²² Thus, the university-trained physicians were launched to complement the already established *library medicine*. Much of this training was based on the ancient texts and disputation rather than practical training. A byproduct of this lengthy and expensive university degree was the gentlemanly status that physicians acquired. Manual work was beneath them and was bequeathed to the surgeon and apothecaries who were trained the Hippocratic way, in apprenticeships. Those of a lower status were unable to read Latin and dispute the theories of the ancient doctors, Galen and Avicenna. Still, many of the

²¹ Bynum, *History of Medicine*, 26.

²² *Ibid.*

university-trained physicians acted as general practitioners, compounded their own drugs, and performed surgery. And urban surgeons established guilds on a par with the butchers and bakers. This tradition of separation of professional specialty and/or status remains to this day, with board certification and specific hierarchal licensing.

Social

By the early nineteenth century, the shift was made to the fourth phase of medicine, social. The object of inquiry was now the population and statistics, and the site of education was the community. As the industrial revolution and population boom in urban centers grew, the community hospital and clinic were the norm, with the primary goal of prevention. Public-health services were to maintain health and to contain disease, placing a greater emphasis on the practice of hygiene. Before the dawn of the industrial era were the horrific “plague years” with the particularly grim “Black Death” wiping out between one-quarter to one-half of the population of Europe from the mid-fourteenth to the mid-seventeenth centuries.²³

Prevention and containment of disease were the goals of hospitals, especially in light of the first major health challenge of the nineteenth century, the cholera pandemic. And the poor were targeted as part of the problem. T.R. Malthus, in his *Essay on the Principle of Population* (first edition, 1798; sixth edition, 1826), pointed out the double-edged sword of poor relief: “. . .keeping the poor alive could simply compound the misery of penury in later generations, when breeding paupers reproduced yet more dependency.”²⁴ His law of population stated that throughout nature, the capacities of organisms to reproduce always outstripped the number of offspring that could actually

²³ Bynum, *History of Medicine*, 69.

²⁴ Bynum, *History of Medicine*, 79.

survive. Diseases, misery, war, vice, and want kept human populations down, and interfering with the system by keeping the poor alive did no good in the long run.²⁵ Clearly, a form of rationed care based on social status was alive and well in the eighteenth and nineteenth centuries.

Laboratory

The final phase of medicine, and one that continues to this day, is the *laboratory*, with the object of inquiry the animal, the site of education the lab, and the goal to understand. From the early modern period of the late nineteenth century, experiments were often performed in home laboratories. This was the age of the microscopes of Leeuwenhoek and Robert Hooke, the cell theories of Theodor Schwann, and the “germs of disease,” the research studies on anthrax and rabies by Louis Pasteur, and the cholera studies of Robert Koch.²⁶

The medical community embraced this research and lauded these men as the heroes of their day. Similar to our modern-day specialists who discovered a polio vaccine or cancer-treatment drugs, the scientists of the microscope received worldwide recognition from the medical establishment.²⁷

Present Crises

“I said, O sovereign Lord, you alone know” (Ezek. 37:3b).

So what does our medicine in the modern world look like? How did we arrive at the present state of over-management and overspending for patient care? Somewhere on

²⁵ Ibid., 60.

²⁶ Ibid., 94

²⁷ According to Bynum, page 112, Louis Pasteur’s 70th birthday in 1892 was the focus of international acclaim with thousands in attendance.

the path—from the bedside to the library to the university to the laboratory, and then on to the huge institutional research center and hospital—we lost our way. Even though we called it “caring” via research and development, is it possible that Rousseau’s philosophy of the hypocrisy of others made us lose hope?²⁸ Quite simply, the driving force behind modern medicine is cost.²⁹ We continually ask, “Is it affordable?” The more that is available, the greater the demand, and spiraling medical costs have shaped modern medicine. Medicine is now big business and relies on the structure of an international corporation. And much of the cost-cutting motivation is aimed at the senior adult. In a now famous article titled, “The Case for Killing Granny,” *Newsweek* writer Evan Thomas notes the following:

Our costs have grown nearly 50 percent in the past decade, and we haven’t found a way to stop over treating patients. In his address to Congress, President Obama spoke airily about reducing inefficiency, but he slid past the hard choices that will have to be made to stop healthcare from devouring ever-larger slices of the economy and tax dollar. A significant portion of the savings will have to come from the money we spend on seniors at the end of life because—that’s where the money is.³⁰

If a third of the money spent by Medicare, about \$66.8 billion a year, goes to chronically ill patients in the last two years of life, Congress will inevitably dissect this kind of spending. The problem lies in the geographical spending patterns. For instance, the average cost of a Medicare patient in Miami is \$16,351; in Honolulu it is \$5,311. In Bronx, New York, it is \$12,543 and in Fargo, \$5,738. Manhattan hospitals retain a

²⁸ Mark Lilla, *The Stillborn God: Religion, Politics, and the Modern West* (New York: Vintage Books, 2007), 150. Rousseau suggests in his book, *Emile*, that it is the hypocrisy of others that makes us lose hope, which must be restored through the idea of God.

²⁹ Bynum, *History of Medicine*, 118.

³⁰ Evan Thomas, “The Case for Killing Granny,” *Newsweek*, September 21, 2009, 34.

Medicare patient for 21.9 days for end-of-life treatment, and in Mason City, Iowa, that same treatment is done in 6.1 days.³¹ Recently, this kind of disparity in payout and efficiency came to light when a fragile compromise regarding the current health-care bill came to the attention of our Oregon senators and representatives in Congress. They stressed concern that their payout, based on efficiency and cost-of-living under Medicare's complex formula of reimbursement, would be too low. Instead, a compromise was reached three days before the health-care reform bill was passed. Two years would be spent studying the 40-year-old formula of Medicare reimbursement rates to recommend more permanent solutions to geographic payment disparities.³² Much of the problem lies in the way doctors order tests and procedures, for their inclination is to do all they can to cure the patient. If Medicare pays according to procedure, test, and hospital stay, there is an incentive to do more. So the questions remain: What do you take out? What is unnecessary?

In his 2011 State of the Union speech, President Obama acknowledged that the 2010 Affordable Care Act is still in debate. But he was also clear that he will not “go back to the days ...of denying someone coverage because of a pre-existing condition,” or “tell a brain cancer patient from Texas that his treatment might not be covered.” He noted two positive innovations: cheaper prescription drugs for seniors and giving uninsured students a chance to stay on their parents' coverage.³³ To further reduce health-care costs,

³¹ Evan Thomas, “The Case for Killing Granny,” *Newsweek*, September 21, 2009, 34.

³² Charles Pope, “Medicare Deal Reached, Clearing Way for Oregon Democrats to Vote for Health Care Reform,” *The Oregonian*, blog entry posted December 12, 2009, http://blog.oregonlive.com/politics_impact/print.html?entry-2010 (accessed November 11, 2010).

³³ President Barack Obama, “State of the Union Speech 2011” <http://www.washingtonpost.com/wp-srv/politics/documents/state-of-the-union> (accessed 1/31/11).

the President is proposing cost reductions in Medicare and Medicaid, combine to form the single biggest contributor to the long-term deficit:

Health insurance reform will slow these rising costs, which is part of why nonpartisan economists have said that repealing the health care law would add a quarter of a trillion dollars to our deficit. Still, I'm willing to look at other ideas to bring down costs, including one that Republicans suggested last year: medical malpractice reform to rein in frivolous lawsuits.³⁴

It all comes down to cost. Cost to run the medical center and clinic, cost for reimbursement, costs to purchase insurance and pay out settlements, cost for rehabilitation and home care, surgery, and administration. With the major components of this health care reform due by 2014, we have about three years to unravel the mystery and put the care innovations in place.

Innovating Care

This is what the Sovereign Lord says: "Come from the four winds O breath and breathe into these dead that they may live."
So I prophesied as he commanded me, and breath entered them; they came to life and stood up on their feet, a vast army.
(Ezek. 37:9b-10)

The best way we can tackle our national health crisis is to stop living cautiously. If we tiptoe our way around the insurance, medical, and pharmaceutical industries hoping we will not wake the sleeping giants and force them to be accountable to their profits, we will continue the cycle of abuse of power and coercive tactics in lobbying. With all due respect to Congress, the current health-care bill may be yet another Band-Aid for an already hemorrhaging system of care. Medical doctors will continue to make their patient quotas, drug companies will continue to overprice their products—making us a nation of

³⁴ Ibid.

pill-popping, dependent consumers—and insurance companies will continue to pursue their margin of profit, a 400-percent profit increase over the last eight years.³⁵ Did we really think the international conglomerates would take this health-care bill sitting down? We have simply put the elephant in a new dress and called it a compromise. And seniors, with their fixed incomes and rising needs in medical care, stand to lose.

Instead, it is time to begin with a new attitude of caring for one another. Despite the trend of “radical independence” of health savings and pension accounts, and the “ownership society” during the presidency of George W. Bush, it is time to analyze why the current system of private pay isn’t working.³⁶ Could it be the commissions that drive the insurance companies to sell and reap the benefits of risk? Or could it be the pharmaceutical industry’s desire to please stockholders with revenues of \$315 billion in 2007 in the United States alone, and another \$65.2 billion for research and development?³⁷

I would suggest at least five different solutions to ameliorate this decline in care. First, wherever possible, put doctors on salary. Mayo Clinic has already done this and, for many, their results are considered far superior to the community-hospital paradigm. This would be a radical change since the majority of doctors in this country are either self-employed or in small group practices. Many loathe working for someone else. But if

³⁵ Nicolas Ballsy, “400 Percent Profit Increase for Health Insurers Cited by Health Care Bill Backers is Selective, ‘Meaningless’ Number, Say Analysts,” *CNS News Online*, <http://www.cnsnews.com/news/article/52745>, (accessed December 13, 2009).

³⁶ Bill McKibben, *Deep Economy: The Wealth of Communities and the Durable Future* (New York: Henry Holt and Company, 2007), 118.

³⁷ US Pharmaceutical Industry Report, posted June 2, 2009, <http://www.reportlinker.com/p0118600/US-Pharmaceutical-Industry-Report.html> (accessed December 14, 2009).

everyone is paid the same respectively and merit-pay increases are based on care efficiency and costs, why not put some burden on those who make the charges and order the procedures?

Second, as per President Obama's suggestion, put a cap on settlements and limit malpractice suits with ceilings set by communities, not by national conglomerates. There is no doubt that limiting settlements would cut costs. According to various studies, defensive medicine—or medicine that requires the aid of lawyers for lawsuits—adds 2 percent to the total cost of care. When one considers that bill to be \$2 trillion, it is a significant number.³⁸ Although tort reform that would limit the size of damage awards has been proposed, Congress has thus far been influenced by trial lawyer lobbies, which has stopped this reform in its tracks. Consider instead medical courts run by medical experts with no punitive damages. Consumers win, but insurance companies with incentives for high payouts and competitive rates based on deductions and co-pays lose.

Leonard Sweet, in his new book *Nudge: Awakening Each Other to the God Who is Already There*, notes that to be a Christian is to be a “watchman.”³⁹ In the spirit of watchful stewardship then, I would propose a third reform: Offer medical students free tuition with the promise that the same number of years spent in class will be given back to the community *gratis*, plus a stipend for living expenses. Doctors would have the opportunity to work with the poor and marginalized, and the government would have excellently trained professionals who (hopefully) would be thankful to start their careers without overwhelming debt to pass on to their clients. And there would be no shortage of

³⁸ Thomas, “Case for Killing Granny,” 34.

³⁹ Leonard I. Sweet, *Nudge: Awakening Each Other to the God Who's Already There* (Colorado Springs, CO: David C. Cook Publishing, 2010), 18.

doctors for government-sponsored programs to serve those patients who desperately need the care and rarely obtain it, seniors, children, the disabled, and the uninsured. Recent surveys reveal that one in eight children has no insurance, with the majority of these living in low-income working households with barely enough money to meet the rent and pay for groceries.⁴⁰ If the medical school loads an average debt of \$154,607 on each doctor before he or she graduates, one can assume that some of that debt is passed on to the client in billing.⁴¹ Why not learn from the ground up with people who are in need?

The fourth reform would consolidate costly medical procedures. Two examples come to mind: innovations at Massachusetts General and consolidating rehabilitation services in the National Health System, United Kingdom. Physicians at Massachusetts General are experimenting with a kind of universal care, assigning nurses to the hospital's 2,600 sickest and costliest Medicare patients. Nurses provide basic care, develop plans for people to take their medicine, act as gatekeepers, and decide if a visit from the doctor is really necessary. This innovation cut 5 percent out of the costs and provided the elderly with what they needed the most, caring human contact.⁴² This program is similar to those under the National Health Service (NHS) in England, where there is no insurance premium to pay, no co-payment, no fee at all, whether you drop by the general practitioner's office with a cold, or receive a quadruple bypass from the top cardiac specialist.⁴³

⁴⁰ Maggie Mahar, *Money Driven Medicine: The Real Reason Health Care Costs So Much* (New York: Harper Collins, 2006), 198.

⁴¹ Association of American Medical Colleges, "2008 Graduation Questionnaire," AAMC questionnaire, <http://www.aamc.org/gq> (accessed December 12, 2009).

⁴² Thomas, "Case for Killing Granny," 34.

⁴³ T.R. Reid, *The Healing of America* (New York: The Penguin Press, 2009), 103.

Christchurch Hospital (NHS) located near Bournemouth, England, offers another form of consolidation of services for pensioners. In their orthopedic and rehabilitation wards, patients come to the center one or two days a week, avoiding costly intermediate care of rehabilitation hospitals. The patients are given four-hour blocks of time in the facility with a team composed of a physical therapist, occupational therapist, psychological counselor, doctor, and nurse/case manager who all have one-on-one time with them. This saves an enormous amount of resources spent in sending specialists on separate appointments to the home. It also allows the team of professionals to observe and consult with one another on site. As well, patients enjoy a support group of peers at the end of each four-hour session.⁴⁴

Legacy Salmon Creek Medical Center in Vancouver, Washington, is also beginning to adopt a more coordinated care model called Medical Home. Guided by patient need, this program would put one physician in charge of the patient's care and encourage supporting physicians to function in a team. In addition, high-need patients would receive extra assistance from a health coach or nurse case manager, coordinating not only clinical health care, but connecting outside organizations and agencies to the patient. Currently this is in five pilot clinics and will soon be placed in all the primary-care clinics.⁴⁵

If it were true that 70 percent of people want to die at home but about half die in hospitals, an additional part of health-care reform would be to encourage people to

⁴⁴ Interviews/surveys of patients, interviewers Margaret Inchley and Sharon Hall, Christchurch Hospital, Bournemouth, England, November 20, 2010.

⁴⁵ Melinda Muller, "Legacy to Adopt a New Model of Care", <http://www.columbian.com/news/2011/jan/23/legacy-salmon-creek-medical-center-local-clinics-t/> (accessed 1/26/11).

consider hospice or palliative care, the fifth reform. This practice allows people to be comfortable and clean and manages their pain as they live out the last six months of their lives.⁴⁶ The founder of the modern hospice movement was Dame Cecily Saunders, a nurse and devout Anglican, who worked as a medical social worker in a London hospital in the years immediately following World War II. Her life project, St. Christopher's Hospice in London, England, was established in 1967 as a "personal calling, underpinned by a powerful religious commitment."⁴⁷ She once cared for a Jewish immigrant named David Tasma, who escaped the Warsaw ghetto only to lie dying in a London hospital at the age of 40. Sanders made a special point to visit him every day, and he in turn inspired her to begin a new kind of palliative care. She noted, "We do not have to cure to heal."⁴⁸

I realized that we needed not only better pain control but better overall care. People needed the space to be themselves. I coined the term 'total pain' from my understanding that dying people have physical, spiritual, psychological, and social pain that must be treated. I have been working on that ever since.⁴⁹

"The St. Christopher's project was divinely guided and inspired," Saunders noted, raising the consciousness of the medical establishment, and creating a sequestered religious community solely concerned with caring for the dying.⁵⁰ But the idea soon expanded from a purely religious commitment into a broader secular application; a medical project acting in the world.

⁴⁶ Thomas, "Case for Killing Granny," 34.

⁴⁷ Wesley J. Smith, "Dame Cecily Saunders The Mother of Modern Hospice Passes On," *Weekly Standard*, July 19, 2005, 1. http://www.weeklystandard.com/Utilities/printer_preview.asp?(accessed March 30, 2008).

⁴⁸ Hospice of Michigan, "Brief History of Hospice Movement," Hospice of Michigan, <http://www.hom.org/movement.asp> (accessed July 24, 2010).

⁴⁹ Smith, "Dame Cecily Saunders," 1.

In 2008, an estimated 1.45 million Americans were treated in 4,850 hospice programs—up from only 25,000 patients in 1982, according to the National Hospice and Palliative Care Organization (NHPCO). NHPCO estimates that nearly 40 percent of U.S. deaths in 2008 were in a hospice setting, usually at home. As baby boomers age, “the demographics are going to explode,” says Naomi Naierman, president and CEO of the American Hospice Foundation (AHF).⁵¹ The more that people buy into this type of death-defying act of curative care in the emergency room, the more costs and anxiety regarding care go up. Instead, in the hospice setting, the patient is offered pain management, a comfortable and clean environment, and, as they request, spiritual care.

Tom Gordon, chaplain at Marie Curie Hospice in Edinburgh Scotland, has been an innovator in providing spiritual care for the terminally ill. In 2004, he developed “A Competency Model for the Assessment and Delivery of Spiritual Care,” declaring that both the National Health Service (NHS), the National Institute for Clinical Excellence (NICE) and the World Health Organization (WHO) definitions of palliative care have ensured that spiritual care is firmly on the current healthcare agenda.⁵² Chaplain Gordon distinguishes religious care as care given in the context of the shared religious beliefs, values, liturgies and lifestyle of the faith community—versus spiritual care that is given in a one-on-one relationship, is person-centered, and makes no assumption about personal conviction or life orientation. “Spiritual care is not necessarily religious,” Dr. Gordon continues, but “Religious care, at its best, should always be spiritual.”⁵³

⁵⁰ Ibid.

⁵¹ Sean Flynn, “At the End of Life, They Offer Comfort,” *Parade Magazine*, June 20, 2010, 6.

⁵² Tom Gordon and David Mitchell, “A Competency Model for the Assessment and Delivery of Spiritual Care,” *Journal of Palliative Medicine*, no. 18, (2004): 646.

Medical professionals' (doctors, nurses and chaplains') instincts and experience are the essential components for spiritual assessment, and spiritual need must be discerned before it can be assessed.⁵⁴ The spiritual-care model works on four levels:

1. Casual contact with patients and their families (understanding that all people have spiritual needs, distinguishes spiritual and religious needs, basic skills of awareness)
2. Staff and volunteers whose duties require contact with patients and families/caregivers (enhance competencies developed at level 1, increased awareness of spiritual and religious needs and response)
3. Staff and volunteers who are members of the multidisciplinary team (moves into the area of assessment of spiritual and religious need, developing a plan for care, recognizing spiritual, religious, and ethical issues)
4. Staff and volunteers whose primary responsibility is for the spiritual and religious care of patients, visitors and staff (existential and practical needs arising from issues in illness, life, dying and death, liaison for external resources, support training, and education for health care-professionals).⁵⁵

All of this training and assessment for spiritual care would take place in the context of a residential hospice setting.

But what if the patient is at home? The hospice client could be integrated into the church's care system, with home-visitation volunteers, parish nurse and pastor all working together with the patient's family to help the patient die a "good death," or to serve as a team of encouragement and motivation in the rehabilitation process. This coupled with a church's health-and-wellness volunteer team—consisting of a social worker, pharmacist, occupational therapist, physical therapist, and emotional counselor—would round out the comprehensive compassionate care a church can provide. Unlike the sovereign rule of a king whose touch was said to enact miracles on earth, the trained

⁵³ Gordon and Mitchell, "Competency Model," 647.

⁵⁴ Ibid.

⁵⁵ Ibid., 647-648.

hands of a willing commoner would have the opportunity to declare Christ's grace in the privacy of a home.⁵⁶

Fortunately for Ezekiel, the bones did not lie on the valley floor for long. God had a plan to bring to life the dead nation of Israel. And the Creator's plan was to grow an immense army strong enough that it would open the graves and revive the nation by putting His spirit into it (Ezekiel 37:14). Former Secretary of Health, Education and Welfare John W. Gardner once said, "What we have before us are some breathtaking opportunities disguised as insoluble problems."⁵⁷ A health-care system is not an insoluble problem. The task before this nation will be to pump revival and spirit into a care system that was dead on arrival and has been in the morgue for years because many cannot access even the basics of simple medical care.

The affordable care system we need should look more like Hippocrates at a bedside with a hospice patient than a scientist hovered over a lab table who discovers a cure for Acquired Immune Deficiency Syndrome (AIDS) or Methicillin-Resistant Staphylococcus Aureus (MRSA). And while Congress continues to draft the provisions and penalties for the health-care bill while posing for photos, churches can begin to formulate a mission statement committing them to care for the ill of their congregations and communities. They may choose to work within the political and legal systems to propose changes that bring the doctor more in touch with the patient and make the care affordable. But the church does not have to filibuster so it can visit an aging parishioner, nor need it debate about whether a nutritious meal ought to be brought to someone who is rehabilitating at

⁵⁶ Jean Bethke Elshtain, *Sovereignty: God, State and Self* (New York: Basic Books, 2008), 62.

⁵⁷ John Gardner, 1965 speech, "PBS-John Gardner-Engineer of the Great Society" "<http://www.pbs.org/johngardner/chapters/4.html>, accessed 1/31/11.

home. And it is unlikely that a committee is needed to decide whether someone ought to visit a family who is grieving over the loss of a child. Instead, we have the adroitness of a family of believers who can respond, encourage inter-generational involvement, and equip those who wish to care for those in need. In short, we have the ability to create care systems that integrate the church, community and professional medical professions. The bones may live yet.

CHAPTER FOUR

**INTEGRATING A MISSIONAL ATTITUDE
OF CARE GIVING INTO THE CHURCH**

It would not be right for us to neglect the ministry of the word of God in order to wait on tables. Brothers, choose seven men from among you who are known to be full of the Spirit and wisdom. We will turn this responsibility over to them and will give our attention to prayer and the ministry of the word (Acts 6:2b-4)

Religion that our Father accepts as pure and faultless is this: to look after orphans and widows in their distress and to keep oneself from being polluted by the world. (James 1:27)

The post-Pentecost disciples in Jerusalem were overwhelmed with their labors. Not only were these men the primary source for planting churches, preaching, teaching in the synagogue, comforting those who mourn and healing in the name of Christ, they were also called on to manage the distribution of resources for Jewish widows. This included setting tables and serving food (Acts 6). Given the explosive response to Peter's inflammatory sermons against the established religion, and the exponential growth of the church which incited the Sadducees to jealousy, the disciples faced persecution as well as the additional burden for a growing number of believers.¹ But their call was to obey God rather than human authorities (Acts 4:19; 5:29). Even though there was fear of judgment, their faith grew and the numbers of followers continued to increase—so much so that their next challenge came from within their ministry instead of outside.

Even though there was a well-established tradition of caring for widows and other marginalized people, it was not always executed successfully.² Jerusalem attracted

¹ Catherine Clark Kroeger and Mary J. Evans, *IVP Women's Bible Commentary* (Downers Grove, IL: InterVarsity Press, 2002), 612.

² Kroeger and Evans, *IVP Women's*, 613.

widows and widowers since it was the custom of elderly Jews of the Diaspora to return to the city of their faith. At Jerusalem they could identify with their families of origin as they awaited their own death.³ Isolated from their other families of support and friends, the majority of them were beyond the capacity to earn resources, and their safety net was gone. And so they lived on the fringes, often unnoticed by the community.

By Acts chapter 6, there was tension in the ranks of the apostles, who were simply unable to do it all. They realized that they could not neglect the needs of their widows, yet needed to maintain their efforts “to prayer and to serving the word.”⁴ Seven men were called to offer the best, most appropriate care. These were people of “good standing, full of the Spirit and wisdom” (Acts 6:3). Those chosen were Greek, due to their strong links with the Diaspora community, and were sympathetic to the specific culturally sensitive needs of these widows. This plan proved successful and served both the widows and ongoing apostolic ministry. Luke records, “The word of God spread. The number of disciples in Jerusalem increased rapidly and a large number of priests became obedient to the faith” (Acts 6:7).

The purpose of this chapter will be to follow the same course of reasoning as the first-century apostles: Discern and assess the ministry need in a faith community regarding care for senior adults; discover the perceived needs of the elderly in that community; motivate church leadership to see that need; consider staff and volunteer support; and adopt and integrate a missional statement regarding the care of the elderly within the governance of the faith community. If these steps are diligently followed, it is hoped they will lead to a specific, personal-care system for the elderly that church

³ Ibid.

⁴ Ibid.

leadership can manage regardless of church size, specific needs, or staff dedicated to the ministry.

Assessment of the Individual Church

So what are the questions we should be asking a church in order to assess their ability to serve the elder members? Begin with a simple demographic inventory of the church. Due to the transitions that take place in retirement, a benchmark many churches use is retirement age. How many members are over 65 years of age? How many are over 85, an age when many people cease to drive? What percent of the total church population do these numbers represent? What compassion/care ministries are currently in place to serve these populations? How does the church embrace or engage the seniors? What programs are working well and what programs need help? What is the greatest need for these programs? Is there a need for more volunteers, resources, training, supervision and ongoing oversight? Are there ways to integrate multi-generational activities to encourage youth and families to get involved? Is the church working with any community, civic, county organizations, or professional medical groups to assist in their programs?

When these kinds of questions were posed in a recent survey of thirty-two diverse churches from all over the United States and a few from the United Kingdom, it became clear that the numbers and needs of elder believers are growing.⁵ Like the first-century church leadership, church/faith community staff and volunteers are concerned with how compassionate care can be distributed fairly. A simple demographic illustrates

⁵ From September to November 2008 and from March 15 to October 10, 2010, I distributed a survey to 32 geographically diverse churches in the United States and the United Kingdom asking those serving in pastoral care and senior ministries about their elder populations, needs, successes, and important future trends in caring for their members. Nineteen responses were returned. Although this was not a scientific study, the information proved invaluable for national and international trends in ministry. The survey with results is listed in Appendix 2.

this point: Of the churches surveyed, all but nine of the churches had 35% or more of their congregation over sixty-five years of age. In 2008, the older population (65+) numbered 38.9 million, an increase of 45 million or 13 percent since 1998.⁶ The population 65 and over will increase from 35 million in 2000 to 40 million (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade).⁷

What were the perceived needs of the elderly in this sample of churches? The greatest recognized need in these faith communities was counseling for grief and clinical depression. Such issues as loneliness, job loss, and family conflicts were major contributors. Additional needs were visitation for the homebound, hospital-patient and post-surgery care, benevolent funds for national and international elderly, transportation, finding a parish nurse for assessments, and helping the transition of baby boomers into senior adulthood.

Given the difficulty with loss and depression, it is no wonder that suicide rates increase with age and are highest among the elderly aged 65 and older. While this age group accounts for only 13 percent of the population, Americans 65 years or older account for 20% of all suicide deaths, and 84% of these suicides are men.⁸ This suicide rate is attributed to the following factors: social isolation, divorce or death of the spouse (2.7 times higher than for married men and 17 times higher than for married women), and

⁶ Administration on Aging, "A Profile of Older Americans, 2009," U.S. Department of Health and Human Services, http://www.aoa.gov/aoaroot/aging_statistics/Profile/index.aspx > (accessed October 21, 2010).

⁷ Ibid.,3.

⁸ Office of the Surgeon General, "The Surgeon General's Call to Action to Prevent Suicide 1999," U.S. Department of Health and Human Services, (accessed October 15, 2010).

access to firearms. One of the most alarming factors is that 70 percent have visited their physician in the month prior to their committing suicide.⁹

Inventory of Perceived Needs/Care Systems for the Elderly

So how do we motivate the leadership of faith communities to see the need and encourage their support? Three things come to mind. First, begin by building on what is already in place. Second, choose a vision committee comprised of those presently in the trenches and add new members with a passion for senior ministry. And finally, carefully craft a new plan to present to leadership for approval. In countless situations, faith communities begin by throwing out the entire existing program and starting over. This is a poor solution for two reasons. Every church/faith community generally has some source of pastoral care, whether it is a solo pastor or a few volunteers who visit the ill. These need to be encouraged and affirmed in their work and motivated to think about how they can create a vision to grow the ministry, not dismissed. As well, the existing plan should not be thrown out because we can learn from it. Often it can be reshaped into something that is specific to the need.

It is important to have multiple voices speaking to the need of the elderly. By listening to a carefully selected committee of people with experience in pastoral care as well as those who represent the governance of the church and still others who are younger, though less experienced but passionately engaged, we get a trove of history and perhaps a few good ideas to move forward.

There are many stories of some new chair of a deacon board who decides he or she will start a “new era” of care by “firing” all the volunteers and bringing in some

⁹ Ibid.

packaged program from a mega-church because it was advertised in a seminar. The cost of such a program, in addition to alienating the volunteers who have served faithfully, can inspire a perfect storm of resentment and confusion. Instead, begin with some specific questions: What are the church's values? What is its mission statement? Are seniors/the elderly a part of that statement? Do we honor the elderly with clergy/staff support, or is ministry to them primarily volunteer-driven? Where is our church strongest in caring for the elderly? How can we build and strengthen our ministry to the elderly? Where are our areas of weakness and why? What programs would enhance the ministry? Are there people with a passion for this ministry who can take the reins of leadership? Do we need to invest in different forms of training such as Stephen Ministry, or specific seminars such as grief care and care-giving, and are there resources to pay for them? Finally, once we know what ministries need to be developed, where will we find volunteers and who will train them?

The study of churches in 2008-2010 recognized multiple other concerns of seniors. These include: isolation; mental incapacity and emotional imbalance; physical immobility; lack of family support; lack of resources/income; confusion about medical, financial and Social- Security matters; inability to drive a car; transportation for appointments; pharmaceutical issues; hygiene and general housekeeping; home maintenance; preventive medicine; and the senior's hoarding/unsafe living situations. In addition to these there were cultural considerations, such as celebration of holidays and milestones in their cultural group (e.g. Cinco de Mayo, saints' holy days, festivals, and special birthday and anniversary milestones).

Once the vision group understands the perceived needs of their congregation, they can begin to form an individual “care system” of response. This response needs to reflect the sensitivity of their church/faith community in demographics, size of volunteer bank, and cultural distinctives. Perhaps the best way to demonstrate this theory is to create a graphic that depicts a variety of responses at different levels of service (see page 132). Level one, or the center of this progression of concentric circles, represents the “core issues” of compassionate ministries. This includes prayer (prayer teams, telephone prayer teams, internet prayer requests), visitation (pastoral and volunteer), emergencies (family crisis, hospitals, hospice, end-of-life situations), and necessities (food bank, housing referrals, shelters, benevolence).

Level Two integrates the internal support teams of family/church volunteers into the care system. At this level there are independent (but accountable to the Congregational Care Pastor) visitation volunteer teams. These would include Stephen Ministers who volunteer to travel to assisted-living facilities and senior residences where members reside. These volunteers can offer community worship, senior-activity groups (monthly or more frequent gatherings), transportation to appointments, medical equipment, maintenance help, clean-up, and follow-up meal programs for those who are hospitalized or are in bereavement situations. Support groups can be formed for the following: dementia (separate groups for Parkinson’s, Alzheimer’s), cancer, grief/loss (separate men’s and women’s groups), and teaching appropriate care-giving skills to care for a spouse or a loved one. In addition, a church may want to consider a health-and-wellness team comprised of members who are doctors and nurses and who provide flu shots and blood-pressure checks, emergency procedures in the event of a crisis, walking

programs, and contact lists for those seniors who live alone. A parish nurse would be in charge of this team.

Level Three integrates medical and legal professionals. It would also include seminars with physical therapists (fall prevention, bone and joint maintenance and exercise, physical transfer issues during the rehabilitation process), occupational therapists (managing living alone, rearranging the home for mobility issues), doctors (when to call for emergency, stroke, heart-attack signs, etc), nutritionists (diet plans, nutritious meals on specific plans such as diabetic or cancer concerns), pharmacists (mixing medications, overreactions to medications, Medicare plans and how to select generics versus name brands), counselors, and therapists (to address depression, aging, mental health, and empowerment). Finally, legal seminars can be arranged on such topics as wills, trusts, probate, guardianship, and transfer of wealth, taxation and, with the aid of a clinical social worker, advanced-care directives and organ donation.

Level Four integrates civic and government resources with the church/faith community. These include the following:

- Contacting and working with local adult community centers to provide transportation and excursions
- Providing resources on special housing programs such as affordable housing under HUD Section 202 of the Federal government
- Contacting county services including case-management social workers, adult protective services, county medical and mental-health services, meal programs, and respite programs for caregivers.

The church or faith community may wish to create:

- A job-support/career-support group for those who wish to continue working
- Safe driving classes and assessments through the American Association of Retired People and the Department of Motor Vehicles
- Safety and Fraud prevention plans through local police services
- Support programs to assess Social Security, Medicare and Medicaid needs through programs like SHIBA (State Health and Insurance Benefits Association)

- Banking and personal-assistance programs from a local financial-planning society, adult day-care programs, home-care agency seminars, and invite representatives from assisted-living centers, memory-care centers and rehabilitation programs.

Health-care fairs may be another way to integrate the county health services on the church grounds for an afternoon or weekend. All of these agencies could be contacted to work alongside of and integrate their programs into preexisting ministries in the faith community. (Please note Illustration 1 on page 132).

It is important to note that there must be a theme for each level of the care system that “cuts across” each ring of services and forms a cohesive support band around the entire program. The ministries cannot and should not “fly alone” and should be encouraged to work together. For example, a seminar might incorporate a low-cost lunch and feature a medical professional from the local hospital speaking on prevention of falls and a local government agency social worker educating on respite programs in the area. In the end, the elderly will receive multiple levels of ministry from both the professional and faith community.

Motivating Church Leadership to Adopt Plan and Budget

Once the vision committee is aware of the possibilities for care, they need to take a break for prayer and discernment, then resume their work with a short inventory of what programs could be added given the perceived needs and potential volunteers. This is not a one-size-fits-all approach, or a pre-packaged kit solution. It takes patience and wisdom to decide what each church can handle, and more important, whether or not the church will approve or attempt the task. Whatever programming comes out of this vision

committee, the ideas may or may not be adopted by the governing board of the church, so gradual modules of change, perhaps two programs at a time, are recommended.

The process begins with a look at the mission statement of the church and the various departments/ministries where the compassion ministries reside. At Lake Grove Presbyterian Church in Lake Oswego, Oregon, the mission statement reads as follows:

Our Mission is to be a group of people who desire to:

Get Changed through their commitment to Jesus Christ

Get Connected through their commitment to the people of Christ

Get Going through their commitment to the work of Christ.

We seek to accomplish this mission by being a church that:

Exalts God in inspiring worship

Encourages one another in supportive fellowship

Equips our people for ministry through ongoing learning

Extends the love of Christ here and throughout the world.¹⁰

We understand from these statements that the church is highly committed to Jesus Christ through fellowship, equipping, encouragement and caring, and exultation in worship. Whatever proposal is made, this mission statement is the foundational starting point for senior programs and must be accepted by the leadership of the church.

Second, it is important to understand that not all ministries for seniors are created equal. Some programs are tucked away in adult ministries, and some ministries to seniors dwell in a department known by their caste of age including “seniors,” “boomers,” or “second-half singles.”¹¹ Some programs, due to the over-abundance of widows and widowers, are even sandwiched into a multi-tiered singles ministry.¹² And a few programs for senior adults are “orphans,” without a director, home, or program area.

¹⁰ Lake Grove Presbyterian Church, *Mission Statement*, Lake Grove Presbyterian Church, Lake Oswego, OR, 2004

¹¹ Gary Stabberd, survey/interview by author, Bothell, WA, October 3, 2010.

These ministries are simply delegated to the pastor, deacon, or leader who has the time to supervise, and they are usually lost on the internet home page of general ministries.

Careful study of where the ministry will fit into the life of the church may dictate whether or not the program will survive. It is important to look at any current trends in downsizing, personnel changes, and cutbacks. Will the ministry survive given the present-day administrative changes and budget reductions? Who will supervise the ministry, and who will advocate for the ministry on the leadership board of the faith community or church?

Consider an example of a church that presently has pastoral care for hospital visitation and emergencies, a prayer team and a food closet, but that perceives the need for a benevolence fund and a handyman/woman team for repairs. These proposals will incorporate both level-one and level-two needs into the care-system model. To introduce these needs, a series of questions should be posed to the vision committee.

First, do these new ministries fulfill the mission statement of the church or do they depart from the mission statement? Will these programs burden or lighten the load of the pastor or staff person presently handling benevolence needs of individuals? Would the mission statement to assist the poor be any less effective if a member of the care team was appointed to manage the benevolence fund, instead of a pastor?

Second, who will handle the administration of the benevolence fund and how will people be chosen and approved as recipients for the resources? How will referrals be made? Will these be made by a pastor, a member of the church, or by self-nomination? Who will administrate and keep records to avoid fraud, embezzlement, or frequent and inappropriate requests?

¹² Gary Winkelman, survey/interview by author, Springfield, IL, October 1, 2010.

Third, what will be the budget impact on the total budget of the church? What are the limits of such a fund and how will the availability of resources be communicated to the congregation? Will there be a third-party payment to the recipient's billing company or will it be a reimbursement for monies already spent? How will monies be raised for this fund and how will the funds be replenished? As you can see, there are multiple questions for just this one ministry. And yet, this example speaks to the level of detail that may need to be presented to church leaders. When a proposal of this importance is before the governing board of the church, a comprehensive, documented plan must be provided. The governing board is financially bound to the budget of the church and given the confidentiality of the program, the stewardship of the benevolence fund should be delegated to only the most trusted of servants.

A handyman/woman team, however, is a volunteer-intensive program with additional concerns for liability. This also involves budget considerations for materials and intense administration. The purpose of this team is to assist members who are seniors, home-bound, and physically disadvantaged, as well as community members, with basic home and auto repairs that have been neglected due to the physical or financial limitations of these individuals. The team may be made up of professional carpenters, plumbers, roofers, painters, electricians, car mechanics, and general cleaning helpers who are available for on-call work throughout the year.

Like the previous proposals, the same mission/governance, administration, and budget concerns need to be addressed:

- How does this program fit into the general mission statement of the church, and what kind of governance structure is in place for support?

- Who will administer the program, taking referrals, setting up dates, gathering volunteers, making sure liability forms are signed by both parties, and handling follow-up calls and thank-you notes?
- What kind of budget will be expected for each project?
- Will the budget be used for materials, equipment rental, truck and gas rental, and food for breaks/meals?
- Will these expenses be paid by the recipient of the services, the faith community, or the volunteers?
- How can we set a budget with the variable amounts of work that need to be accomplished?

Once these questions are answered, the proposal needs to be written for the governing body of the church. An example follows:

Ministry Proposal

Handyman/Woman Team – “Movers and Shakers”

Department: Encourage-Congregational Care

Reports to: Deacon in charge of Movers and Shakers/Pastor for Congregational Care

History/Background: For many months, seniors and many single parents have found themselves unable to attend to the repairs and general maintenance of their properties, apartments, and cars. Some face immediate eviction, and many church members and their extended families have called the church and asked if there was someone who could help. They simply cannot afford the repairs and often go without heat in the winter or ventilation in the summer for fear of open windows and theft..

Purpose/Reflection of Mission of Church: The purpose of this ministry team is to provide general home repairs, furniture movers to carry furniture to a new home or a donation center, cleaning, mechanical work, and referrals as a statement of getting connected through a commitment to the people of Christ; services will be provided to church members and long-term visitors. Second priority will be given to referrals from outside the church or from community agencies. It is the intent of this ministry to assist the financially and physically disadvantaged of our faith community and to help them avoid costly repairs and furniture moving.

Personnel required/hours needed and special considerations –

Volunteer recruitment/database: Twice a year, bulletin announcements and newsletter articles will be submitted for publication with specific volunteer openings and requirements for training, as necessary. A database of names and specific areas of expertise and training will be maintained. Because of the

physical nature of the work, we ask that volunteers be at least 14 years of age, with parental consent required for those under 18.

Each member of each team and the service recipient will be required to sign a liability waiver provided by the faith community/church before the volunteer shift begins.

General Handymen/Women: Carpenters, plumbers, electricians, masons, painters or people skilled with home-repair work will be asked to work a four-hour volunteer shift in a private home under a professional supervisor/foreman, and with a volunteer. Most of the work will be of a specific nature such as rewiring a home, fixing leaky faucets, putting in a wheelchair ramp, painting, repairing furniture or cabinets, or building or removing a wall.

General Cleaning Volunteers: General cleaning is often needed to avoid eviction or to meet health and sanitation codes, particularly in federal and state-sponsored housing. Frequently, seniors are no longer able to handle the deep cleaning required to keep a home healthy. This team will work in four-hour shifts to assist with cleaning kitchens, bathrooms, floors, windows, as well as doing laundry, and preparing a senior to move to another facility.

Car Mechanics: Certified auto mechanics willing to give their time will be sought for work to be done on their time in their car shops. However, weekend car enthusiasts who change oil and tires and check fluids and who wish to teach others good car maintenance will also be welcome.

Furniture Movers: The last Saturday of the month will be set aside for moving furniture, unless other arrangements can be made. Volunteer teams of four will be available for multiple homes of donated furniture, or one home move on that day. Most of these moving parties are designated for down-sizing and excess furniture will be donated and hauled to a charity of the resident's choice. Single parents who are moving from a domestic-violence situation may choose furniture as part of a "fresh start" program and will need to move that furniture from an agency warehouse to their new home.

Administrator/Dispatcher: He or she is in charge of all intake calls and referrals. This person or persons will gather volunteers for specific dates and times, will handle all liability forms, and will make follow-up calls to the recipient of services.¹³

Budget Considerations: It is requested that the recipients of the services purchase the materials for the repair or move. However, if they cannot afford this,

¹³ In some churches, there may be a volunteer coordinator who handles teams, such as the movers and shakers, but also all volunteers—care teams, prayer teams, etc. The administrator/dispatcher model is recommended in this case due to sensitivity of emergencies, timeliness of furniture moves in crisis, confidentiality matters, and evictions.

the faith community will bear the cost. Please consider the following amounts for a specific line item in our budget:

Cost of gas and truck for one day/month	(\$75 x12) \$ 900
General cleaning materials	\$ 150
Food/Snacks for workers/water	(\$25 x 12) \$ 300
Misc. tools/materials/parts	<u>\$ 700</u>
Total for the year	\$2050

It is the intention of this ministry that materials be donated. However, should there be any funds left over at the end of the year, we ask that the amount be rolled over into that designated account for the following year. In the event the cost of materials or parts exceeds \$100 for any one incident, the deacon in charge will consider the benevolence fund. Any member of the faith community is welcome to contribute to this fund, but due to tax limitations, specific and/or personal designation for any one project is prohibited. All services are a gift from the faith community and not a loan.

Supervision/Monitoring: The deacon in charge of this ministry will supervise the dates chosen for work and will assist the administrator or dispatcher with a calendar that meets the needs of the faith community and does not overtax the bank of volunteers.

Follow-up Evaluation: Every six months the deacon in charge of this ministry will report to the Board of Deacons and Associate Pastor for Congregational Care with a report for evaluation and suggested adjustments to the program.

Additional Questions: Please contact chair of vision committee, _____

Given the current budget restraints of the Federal government and the elimination of cost-of-living increases from Social Security, seniors are living on less and costs have not declined.¹⁴ However, when a church reaches a budget crunch, regardless of the need of the program, it may be turned down. It is important to be able to flex the budget needs to fit the bare minimum. Whoever presents the budget needs to be ready with creative ways either to save or to obtain other resources in order to make the budget acceptable.

¹⁴ Stephen Ohlemacher, "No Social Security Increase for 2011," *The Oregonian*, October 11, 2010.

This kind of program also encourages the professional and spiritual gifts of the total membership of the faith community. Seniors will be grateful because they can call on the church and someone will be scheduled to help them. And volunteers, particularly young adults, will be exposed to a world they rarely see in their workplace: that of the physically challenged senior adult. This cross-pollination of generations is a healthy alternative to what is now the “ghetto” feeling we have in churches where certain ages are steered away from the modern-music service and young people do not feel welcome or do not respond to the “organ concert” on Sundays in “big church.” In addition, there are people reticent to teach a Bible class or to facilitate a small group, but who are delighted to wield a hammer or paint a wall, especially if the time required will fit into an already over-taxed schedule. The volunteer is not forced to work any one scheduled work party and is free to decline the offer, letting the dispatcher know when he or she is available for the next opportunity.

Adoption of the Plan within the Governance of the Church

How would this program go from a written proposal to the integrated ministries of the church? There are at least three steps: Observation and participation, evaluation and presentation, and finally accountability and vision. Before the proposal goes to the governing body for budget and adoption, I would encourage an observation-and-participation demonstration. Find those people who are the decision-makers for ministries of the church, and more specifically those individuals who will eventually be the supervisors or provide staff oversight for such a program, and encourage them to assist in a move for a senior or in a home-rehabilitation project. Once on-site, it is important to encourage leaders to speak to the senior recipients and ask multiple questions regarding

their present situation and how long they have waited for the service to happen. The leader might also ask: “Who else have they asked for help?” and “What was the result?” Instruct the leaders to ask questions about the recipient’s ties to the church and if they have transportation to get to church and any other appointments. Ask if a friendly volunteer can assist with these weekly tasks. This interview technique allows the leaders to speak from first-hand knowledge about the needs of the seniors in the church and serve as an advocate for their needs.

Once the *observation-and-participation* period is over, the vision committee should meet with the leader, ministry proposal in hand, and ask for an evaluation and proposal strategy. There are several issues that would be considered. Does this ministry conform to the mission and strategy of the church? What are the proposal’s strengths and weaknesses? Are there pieces of the written proposal that need revision? Is the proposed budget within what the church can afford? Once the revisions are made, the proposal is readied for the leadership meeting and members of the vision committee should be encouraged to attend and even make the presentation, if allowed. The committee should be available for questions from the floor and be ready to affirm the proposal to the leadership body. The vision committee needs to be clear about who will be their supervisor on budget, liability issues, changes to policy, and personnel matters, as some of these areas may spill over to administration and other departments. Once the proposal is accepted, accountability to supervisors, adherence to policies of the faith community, and additional vision work begins.

Accountability to the authorities of the faith community is important, and a plan that prevents any potential lawsuit is essential. Volunteers who are free to do as they

please are often caught in a web of their word against another's when there is a liability issue, accusation, or conflict. For instance, given the intimate nature of a friendship visitation volunteer scheduled to visit a homebound senior once a week, federal and state background checks are mandatory. Should there be any question about the nature of a visit, the church or faith community can prove that they properly screened the volunteer. This will be especially critical for visitors to the homebound, as they are out of the purview of their immediate supervisor and in an individual's care facility or home.

Reports of a friendship visitation volunteer's individual visits can be part of a database file on the assigned senior for future reference. Using a similar example of the repair and moving teams, a supervisor will report about the task performed, who was involved, what went well, and include proposed areas for improvement. The individual volunteer is asked to make a personal evaluation of the project for the file. This evaluation not only facilitates better ideas for projects in the future, but also documents an exact record of activities accomplished on any given day. It is recommended that composite reports/evaluations on any given ministry, such as the "Movers and Shakers," be requested twice a year for review and evaluation. Once the composite reports have been collected, the leadership and, if so designated, the original vision committee can be called together to decide on future ministries. These ministries can either grow out of the present core programs or be new projects created within the care-systems model.

The next chapter will explain the process of organizing and initiating volunteers for the faith community's care system and the integration of the ministries into the life of the church.

CHAPTER FIVE

**ORGANIZING, INITIATING, AND MONITORING
VOLUNTEERS FOR CARE SYSTEMS**

Moses listened to his father-in-law and did everything he said. He chose capable men from all Israel and made them leaders of the people, officials over thousands, hundreds, fifties and tens. They served as judges for the people at all times. The difficult cases they brought to Moses, but the simple ones they decided themselves. (Exod.18:24-26)

Moses struggled with delegating leadership. As the undisputed leader of a sprawling but still young nation estimated at 600,000 men between the ages of 20 and 60 and considerably more women and children, he was the sole judge for all the disputes for those seeking God’s will¹ His father-in-law, Jethro, was aware that Moses was overwhelmed in his role as adjudicator and it was wearing him out.² So Jethro’s plan was to come up with a system that would equip capable people who were otherwise “unemployed,” those who were God-fearing, trustworthy, and hated dishonest gain. These would have jurisdiction over specific modules of people, in the thousands, hundreds, fifties and tens. These would form an organized army of spiritual leadership to “serve as judges for (the) people at all times.” Moses would address only the more difficult cases (Exod.18:26).

¹ Dick Harfield, “How Many Israelites Come Out of Egypt with Moses?” http://wiki.answers.com/Q/How_many_Israelites_came_out_of_Egypt with Moses (accessed October 4, 2010). In this same online article, Harfield notes that Donald Redford, author of *Egypt, Canaan and Israel in Ancient Times*, interprets Numbers 1:46 to say that the total number of Israelites who fled Egypt was 2.5 million. This is based on 600,000 men over the age of 14, probably as many women, and—as it was the Jewish tradition to have seven children per family—the number could have been more than 2 million.

² Exod. 18:13-16.

Jethro understood that the proper people with the right training in the best ministry scenario was vital for this system of leadership to work. Though this system of discerning, training and delegating seems relatively simple, it is a challenge to many leaders in pastoral and senior-adult care. Like Moses, they are called to lead a flock, yet they struggle with delegation, assuming they are the only persons appointed by God to handle every case for those in need. And yet in many circumstances, such as Peter and the other disciples in Jerusalem appointing new deacons, or Paul and his instruction to Timothy in Titus 1:5-9 to choose and appoint elders where he was not able to, the Bible teaches that delegation of leadership is core to the success and growth of a ministry (Acts 6 and Acts 15:22, 39-40). For me, the greatest single error faith communities make is to keep volunteers from serving in their areas of giftedness. This can occur due to ageism, or judging someone who doesn't fit the "profile" of the "normal" church member. Further, churches fail to write detailed job descriptions, which makes it difficult, if not impossible, to find the proper leadership fit. Sadly, their goal may be no deeper than getting a willing body to fill a desperate need. Simply stated, there are likely countless volunteers who desire to serve if we, as leaders, create the organized matrix of job descriptions, training, supervision, and accountability to help them do so. The words of the Apostle Paul in I Corinthians 12 and 14 remind us,

...the body is a unit, though it is made up of many parts; and though all of its parts are many, they form one body. So it is with Christ... But in fact God has arranged the parts in the body every one of them, just as he wanted them to be. If they were all one part, where would the body be? As it is, there are many parts but one body (I Cor. 12:12,18-20).

It is my belief that many members of any faith community are untapped gifts waiting to be discovered and used for the glory of God. As spiritual leaders, we owe it to

our flocks to assist these members in finding their gifts and encouraging them to function in the same roles, as they are led by the Holy Spirit. This chapter will propose a system to organize those gifts into specific ministry areas to senior adults, define leadership roles, inventory the church resources for volunteer involvement, and discover ways to take the care-system ministry into the community.

Organization, Recruitment, and Requirements for Volunteers

So where do we begin to organize the ministry? We start by assessing the present care system and decide what kind of leadership will be required for each ministry and whether or not tiers of accountability will be required. We ask such questions as, where are the members being served? Are they being visited, fed, with their real needs met? Does the church have moving services, a parish nurse, a prayer ministry, emergency services, or leaders in a Stephen Ministry? If so, could we classify areas that could be clustered together? Could we group homebound friendship visitors, home communion, and parish nurse together and call it “visitation services”? Could food, counseling, and job and career services be grouped together and labeled “outreach to the community?”

An informal survey taken of churches in 2010 confirmed that most churches group their ministries in the following fashion: prayer, visitation, care ministries (including recovery services and support groups), community outreach or local missions, spiritual encouragement, and social activities.³ Each category of ministry had either a lay supervisor, director, or pastor who managed the day-to-day operations of that ministry.

³ From September 2008 to November 2008 and from March 15, 2010 to October 10, 2010, I distributed a survey to 32 geographically diverse churches in the United States and the United Kingdom to ask those serving in pastoral care and senior ministries about their elder populations, needs, successes and important future trends in caring for their members. Nineteen surveys were returned. Although this was not a scientific study, the information proved invaluable for national and international trends in ministry and where the perceived needs lie for the future. The results of this survey are listed in Appendix 2.

Also, each ministry under that category has a team of volunteers to assist the faith-community members in need. For many seniors, it is overwhelming to navigate the different departments to find assistance. But, what if seniors could find the information in a more user-friendly organized system? If multiple ministries could be blended together into a single brochure that would include all relevant contact information, this single resource would include contact telephone numbers, e-mail addresses and web sites. The next important step for a faith community would be to cluster similar ministries for their seniors.

Spiritual life: prayer teams, prayer chain and telephone chain, Bible studies, small groups, prayer retreats and services, and chapel services for senior residences.

Visitation, Health and Home Ministries: Friendship Visitation (visiting home-bound seniors, and those in assisted living, long-term rehabilitation, and memory-care centers), home communion, parish nurse services, medical equipment, care team (follow-up for hospitalization and medical procedures), transportation services, follow-up calls for absenteeism, delivered meals, and respite care.

Community Services/Local Missions: care and share food delivery (monthly boxes and holiday boxes), deacons' food pantry (emergency boxes), manna ministries (gleaning bread and staples for distribution to affordable senior housing residences), job and career ministries, mentor programs, benevolence fund, financial/ budget and credit counseling, free health fairs and health screenings, SHIBA (Medicare and Social-Security counseling), and helping-hands ministries (moving, repairs, car maintenance, cleaning services).⁴

Support Services/Recovery and Healing: memorials, grief recovery, dementia and Alzheimer's support, cancer support, Parkinson's support, counseling services, health and wellness seminars.

⁴ The term "affordable housing" is a reference to a specific type of housing available through HUD Section 202. Qualifying income levels are based on half of a person's median income in the city where the apartment is located. Residents must be 62 or older and are required to pay 30 percent of their adjusted income for rent.

Social Activities: parties, anniversaries, excursions, luncheons, and holidays.

Once the clusters are established, the supervisors of each ministry need to agree on a way to communicate with each other and to share volunteers to execute the tasks. With many churches, most ministries are spread over multiple departments. Spiritual-life activities are regularly found in “Adult Ministries;” visitation and home ministries are normally under the banner of “Pastoral Care.” Community services are likely to be found under “Local Missions,” social activities normally reside in “Community Life” departments, and support services are likely to be found in “Recovery Ministries.” Thus, it is imperative that departments agree they are part of the greater whole of this care system for seniors and will have specific contact people available to assist the elders when they call the ministry office. On the rare occasion that a faith community has established all these ministries under one department, one coordinator would be the point person to triage the services. Would these organizational clusters work for a solo pastor and a few dedicated volunteers? On a smaller scale, the answer is “yes.” Ministries, such as a visitation team, can combine with the follow-up team for emergencies and meal services as one group. And a single coordinator could merge adult activities to include both spiritual-life programs and social interaction. A lay leader who is willing to coordinate the services under the supervision and approval of the pastor can manage this kind of consolidation.

A strategic key to any care system is to know how many volunteers are required for the ministry and then recruit and find volunteers who know their spiritual gifts and professional skills and are passionate about the specific area in which they wish to

volunteer. August and March are two strategic times that emerge as the best to call for volunteers. August allows enough time for people to be interviewed and to have a background check completed by the beginning of the school year. March is readying people for the Easter season and summer and is not in competition with May and June graduations and weddings, holidays, or major family events such as Mother's or Father's Day.

It is helpful for a faith community to schedule a spiritual-gifts assessment at least twice a year to follow the recruiting season. Two of the most popular workbook programs for this task are called *Network* and *S.H.A.P.E.*⁵ Both affirm the need for people to see themselves as unique, wonderful, and gifted vessels for God's use and, more importantly, as a fit for an area of ministry in the body of Christ. *Network*'s "servant profile" depends on three areas of study: spiritual gifts (what ability you have been given by the Holy Spirit), passion (where or who you will serve), and style (how you will use the tools you have).⁶ *S.H.A.P.E.* is an acronym that stands for the five components of their *kingdom purpose*: spiritual gifts, heart, abilities, personality, and experiences.⁷ Whatever system of personal inventory a faith community uses, it needs to remain consistent throughout volunteer recruitment. Job descriptions should reflect the components of the *Network* or *S.H.A.P.E.* course requirements and include a detailed description of the volunteer position, expectations, delegation, equipping and certification or background for every job opportunity. Consider the following volunteer position based on the *Network* model:

⁵ Bruce Bugbee and Don Cousins, *Network* (Grand Rapids, MI: Zondervan, 2005); Eric Rees, *S.H.A.P.E.: Finding and Fulfilling Your Unique Purpose for Life* (Grand Rapids, MI: Zondervan, 2006).

⁶ Bugbee and Cousins, *Network*, 26.

⁷ Rees, *S.H.A.P.E.*, 22.

Position Title: Friendship Visitation Volunteer

- Requirements: Once a week (or more) visitation for homebound person or elder living in assisted-living, memory-care, or hospice facility. Must take caregiver training course and have a background check. A car is helpful for errands and short drives, but not required. May be asked to facilitate and/or arrange transportation to church or activities. Attend the volunteer team meeting on first Thursday of the month at 3 PM. Any costs for gifts, cards, and background check will be assumed by the church.
- Servant Profile: Gifts - *mercy, shepherd, encouragement, helps, intercession.*
Passion - *elderly, disabled, or medically institutionalized individuals.*
Style - *people-oriented*
- Hours: Flexible - *normally 2-4 hours a week plus monthly meeting.*
- Contact: Mary Smith X 107.

The *S.H.A.P.E.* version of this volunteer position would adhere to the *kingdom purpose* format:

Position Title: Friendship Visitation Volunteer

- Requirements: Once a week (or more) visitation for homebound or elder living in assisted-living, memory-care, or hospice facility. Must take caregiver training course, and have a background check. Car helpful for errands and short drives, but not required. May be asked to facilitate or arrange transportation to church or activities. Attend the volunteer team meeting on first Thursday of the month at 3 PM. Any costs for gifts, cards or background check will be assumed by the church.
- Life Profile: Spiritual Gifts - *mercy, encouragement, helping, pastoring.*⁸

⁸ It is important to note that while *S.H.A.P.E.* utilizes 20 spiritual-gift definitions, *Network* uses 23—thus, the discrepancy in spiritual gifts for these job descriptions.

Heart - elderly, physically and medically disadvantaged individuals.

Abilities - communicating, counseling, encouraging, serving

Personality - reserved, self-controlled, cooperative, prefers to work with people rather than program organization, data.

Experiences - understand grief, and medically fragile situations, caring for an elderly person, patient listening, talking with isolated, lonely people.

Hours: Flexible - 2-4 hours a week, plus monthly team meeting

Contact: Mary Smith x107.

(For a sample listing of job descriptions in the care-system model, please refer to the Appendix 3).

Once the job descriptions are prepared, members of the faith community are recruited, and the servant profile or life profile is completed, each participant should be interviewed. Sadly, many faith communities skip this step. Instead of honoring the specific gifts of each individual, they simply assign people where they believe they should serve or plug people into random tasks for a specific need. This is a waste of resources and time. People who want a quick resolution to the need discover later on that the person they coerced into a position will often be frustrated and ready to quit—and the process starts all over again.

In stark contrast, trained consultants from the spiritual-gifts assessment program can sit down with candidates and personally interview each person for suitability. The consultant can discern from the interview the candidate's heart, find out where their central passion is, and match them to a "unique ministry opportunity" where their spiritual gifts, central passion, abilities, personality, and experience fit.⁹ The candidate will feel the position is important enough that other resources are employed to ensure a

⁹ Bugbee and Cousins, *Network*, 143.

good match, which can bring additional validation to their role as a volunteer. Including the interview process may mean the program will not have the perfect number required to carry out the ministry, but those who are called and passionate about that area will serve well. Is it possible that a person will not be placed? Absolutely. The right fit takes time, and as soon as an opening is available for that particular profile and position, the volunteer will be called and matched.

Occasionally, there are more volunteers than ministry opportunities. One of the most serious offenses we can make as faith leaders is to call a group of volunteers and not put them to work. A church would be wise to have a few auxiliary ministries available, such as assisting with luncheons for seniors or being a chaperone or driver for an excursion. This kind of activity would allow the volunteer to experience some of the scope of the ministry before a specific placement is made.

Once the person is assigned to a specific volunteer position, it is recommended that there be a commissioning or, at the very least, an affirmation in a public setting. A church worship service, or part of a larger ministry meeting of department leaders with senior pastoral staff present, would be best. This acknowledges the importance of the volunteer's work in the church, affirms the ministry's place in the mission of the church, and allows senior leadership to know the volunteers who are now serving with them. A set calendar of important dates should be organized as follows:

- February and July:** Marketing for positions in newsletters, e-mails/ home page, church bulletins.
- March and August:** Recruiting, gift assessment, consultant interviews.
- April and September:** Commissioning, name recognition in public meetings and bulletins.
- May:** Celebration banquet/annual affirmation with church leaders present.

Although background security checks and gift assessments are important, training is essential for the success of volunteer ministry. This training can be achieved through apprenticeships. In the churches that were interviewed in the spring and fall of 2010, it was noted that the success of their ministries rested in seasoned volunteer supervisors who were equipped to train their volunteers on the job.¹⁰

Examples of equipping programs are: *Called to Care*, *The Stephen Ministry Program*, and *Redeemer Diaconate Manual*.¹¹ Each of these programs offers its own signature approach to training the volunteer. *Called to Care* addresses both the small- and-large membership churches and organizes an applicable plan for care giving. In the small church the primary supervisor is the pastor, who engages managers to run the volunteer programs. In a larger setting a complete stand-alone ministry is created, with directors, managers, supervisors and volunteers. Each is accountable to the staff, elders, deacons, or accountability officers.

Popular in the *Called to Care* program are the role-playing case studies. The program utilizes “care cards” which are one-to three-page portable summaries addressing issues from abortion to advance directives for widows.¹² As volunteer equipping classes

¹⁰ Rev. Sim Fulcher, associate pastor, First Presbyterian Church, Honolulu, 45-550 Kianaole Road, Kaneohe, HI, interview/survey by author, October 7, 2010.

LeRoy Casey, pastor and care ministry leader, Longmont Christian Church, 10345 Ute Highway, Longmont, CO, interview/survey by author, October 8, 2010. Rev. Fulcher leads a church where 30 percent (or 450) of his 1,500 congregants are over 65, and Pastor Casey’s church has 12.9 percent (or 370) of his congregants over 65.

¹¹ Office for Church Life and Leadership, United Church of Christ, *Called to Care*, (Cleveland, OH: The Pilgrim Press, 1991 and 2008). *The Stephen Ministry Handbook* (St. Louis, MO: Stephen Ministries, 2000). Timothy Keller, *Redeemer Diaconate Manual: Handbook for the Diaconate Mercy Ministry*, 9th ed. (New York City, RPC Press, 1998).

¹² *Called to Care*, tab section titled “care cards,” 1, 2, 52.

involve training in real-life scenarios, these cards are an excellent way to introduce the various personalities and environments of marginalized citizens.

In *The Redeemer Diaconate Manual*, however, the emphasis is more on the connection between counseling and scripture, and it provides a sample organizational structure to use. The manual takes considerable time walking the volunteer through caregiving. It addresses such issues as protection and burnout avoidance, client assessments, crisis management, and accountability. It also provides a comprehensive section on the psychological needs of the emotionally troubled and even instructs in creating budgets for the underemployed. The main emphasis is on the members of the diaconate serving not only their congregation but as well the community-at-large as their extended congregation.

One of the most popular equipping pieces is the *Stephen Ministries Training Manual*, taught over an initial period of fifty hours with seventeen and a half additional hours of continuing education. Not only does it contain comprehensive training in caregiving and counseling practices, but it strives to integrate the program into the larger mission of the church with “Christ Care” groups (small groups with healing and accountability components). The Stephen Ministry program requires a manager/director be trained in a central location, normally St. Louis, Missouri, in order to equip the volunteers.

All three of the programs encourage practice with case studies and on-the-job training with a seasoned volunteer as supervisor. If there were a drawback to any of these packaged programs, it would be that none of them concentrates on the specific needs of a senior adult, but instead they work to form a diverse care ministry that touches all facets

of a congregation or faith community. Each of these programs will help the volunteer in their overall counseling skills. However to learn more, they will need to select specific areas of each manual that are pertinent to aging populations, such as: care giving, dementia, Alzheimer's disease, depression, and palliative care. Likewise, training participants may want to forgo sections covering abortion, understanding adolescents, and child abuse—though any of these issues could touch the life of a senior.

Complementary to studying pastoral-care ministry components is practical equipping in the field. An example may be an experienced volunteer or manager who will walk alongside a new volunteer who wishes to visit a homebound senior. After an initial training session on rules, precautions, legal issues and ideas for meeting the needs of a senior who is homebound, a new visitation volunteer would visit an elderly person with someone who has served in that capacity for at least one year. While visiting the senior together, the experienced person could demonstrate the proper attitude and approach, routine and observations, to be made for each visit. On the subsequent visit to the same homebound senior, the new volunteer would demonstrate what he or she learned by taking the lead for that visit, while the more experienced volunteer observes. If the more experienced volunteer is satisfied with the progress, the new volunteer may be given an individual assignment. This approach can work for making hospital visits, delivering food, providing transportation, giving assistance through helping-hands ministries, grief counseling, and a variety of other services that might require on-the-job training. Each month, when the volunteer attends the team meeting for visitation volunteers, reports are made on progress and/or problems that were encountered. The team acts as both

encourager and coach to the newer volunteers. It provides a safe environment where they can share frustrations and fears about their service.¹³

Leadership Roles

One of the more difficult tasks in care teams is leadership organization. Because churches often divide their senior ministries between multiple departments, it is often difficult to strategize the management of volunteers and maintain accountability. The answer lies with the coordination of four different tiers of leadership: director/supervisor, manager, volunteer, and apprentice. The director/supervisor is in charge of all senior-adult ministries. This can be an ordained staff member, non-ordained staff person, or a volunteer lay person who oversees the ministry, manages and supervises the counseling/client work, and is in charge of training and accountability for managers. In the event there is no assistant director, a person should be appointed to oversee the manager's meeting (for some organizations this might be the Board of Deacons). This would entail scheduling monthly meetings, creating the agenda for the meetings, and assume the role of liaison to the governing body of the church (elders/session, deacons, or vestry, for example). Also, this person will be responsible for maintaining the vision for the ministry.

The second significant tier is the managers or "middle-management" people who supervise their assigned area of service. In the care-system model this will include management of medical equipment, food closet and distribution, home visitation, hospital and rehabilitation visitation, memorials, job and career assistance, and financial

¹³ Bambi Encarnacion, director of Senior Adult Programs, Evangelical Free Church of Fullerton, 2801 Brea Ave., Fullerton, CA., Survey/interview by author, October 13, 2010. This church sponsors a program called 4LOVE Ministry, an outreach to assisted-living centers and skilled-nursing facilities. The team of facilitators for the Bible study gather regularly for prayer and accountability.

budget/credit counseling. These managers are in charge of the organization and administration of the volunteers assigned to their ministry and accountable to the director and assistant director. They may, along with other seasoned volunteers and former managers, maintain the role of mentors to the volunteers, particularly those volunteers in their first year. Once a month, the managers will meet with the director and assistant director to report on the progress of each ministry and to discuss issues of concern. These would include accountability in terms of areas of need or discipline and planning any needed plenary sessions to inform the participants of new laws and procedures. The managers would also model and encourage prayer for one another, affirm the volunteers' labors and allow them to share what God is doing both in their own lives and in the lives of those who receive their care.

The third significant tier of service in this care system consists of the volunteers. They are accountable to the managers who assign them to their roles/positions and who are responsible for background checks, equipping, certification, and accountability.

Apprentices, the final tier of service providers, serve under the supervision of a volunteer and/or manager, and gain on-the-job training to learn the skills required for the positions assigned. In some faith communities, "huddle groups" of six to eight volunteers and apprentices are formed for Bible study and prayer, and meet on a weekly or bi-weekly basis for a year or more.¹⁴ At the end of the year, the volunteers and apprentices are free to form two or more huddle groups out of the original group and grow the ministry. An important component of these teams or groups is flexibility, so that people have the opportunity to join at any time in the life of a group, as long as they are willing

¹⁴ Group Life Resources, "ReGroup: Training Groups to be Groups," Willow Creek Association, <http://willowcreek.com/grouplife/resources> (accessed October 15, 2010). Willow Creek Resources has developed "ReGroup," the equipping curriculum for training new leaders, both online and in book form.

to be trained and catch up to the current level of equipping. It is recommended that each team of volunteers writes a report to their manager once a quarter, which, in turn, is forwarded to the managers' team, who then create an annual report for the church. Some might question the rigidity of this structure or find it too "corporate" in nature. However, the inter-connectedness of the care system and the liability and legal ramifications of such a ministry requires a structure that facilitates both accountability and mutual encouragement. If left to random management or occasional check-ins with a supervisor, the ministry may have a heart of encouragement, but fall apart in the follow-through for each care-receiver. For instance, a person may be suitable as a volunteer on paper, but prove to be a less-than-sympathetic visitor with appointments. Each church needs to check back with the care-receiver or family to see if the relationship is going well.

Inventory of Church Resources

Up to this point, this chapter has concentrated on recruiting, equipping, and commissioning those interested in becoming volunteers to senior adults. But what about those professionals who may want to serve in their professional capacities that are unaware of the need? This would include members of the faith community in the medical professions such as nurses and doctors, physical therapists, occupational therapists, exercise therapists, psychologists, nutritionists, and cancer case workers/specialists. For the practical issues of retirement and fiscal health, the ministry can call on financial planners, social workers, Social Security and Medicare consultants, insurance agents, and lawyers. Dramatists and musicians can provide entertainment for luncheons, special events and chapel services at nearby senior residences. Genealogists and historians might be called upon for family-history and personal narratives. Counselors, memory specialists

(“memerobics”), psychologists, and job and career specialists, along with life coaches, can provide emotional and practical insight on depression, working after retirement, goal setting, and understanding the social security and Medicare matrix and enrollment periods.

The question is, how do you ask a busy person to come alongside the ministry? The simple answer is just to ask. Begin by deciding where these professionals can serve, and create a campaign for them to come alongside the volunteers already in place. An example of this would be a health-and-wellness ministry, with a registered nurse assuming the role of a parish nurse. Within the team are doctors, nurses, physical, occupational, and exercise therapists, nutritionists, pharmacists and optometrists—those who are interested in maintaining not only the health of seniors, but that of the church-at-large. The parish nurse sets the agenda for the meetings, and decides on the kinds of services that would be helpful, based on his or her observations and assessments during home visits. For instance, if in a one-year period a church had a considerable number of people falling and breaking limbs, it might be a good time to do a seminar on preventing falls. In other years when the threat of H1N1 or Norovirus looms, the health-and-wellness team could become educators and create a program aimed at preventing viruses and unwanted illness, as well as provide flu vaccinations at reduced or no cost to the recipients.¹⁵ Additional seminars might include emergency procedures in case of disaster,

¹⁵ National Center for Immunization and Respiratory Diseases, Division of Viral Diseases, “Norovirus,” <http://www.cdc.gov/ncidod/dvrd/revb/gastro/norovirus.htm> (accessed October 11, 2010). Noroviruses are a group of related single-stranded RNA, non-enveloped viruses that cause acute gastroenteritis in humans. H1N1, also known as the “swine flu,” is an influenza-causing illness. People are infected through coughing, sneezing, or talking with people who have the influenza. Senior adults in foster-care centers, assisted-living residences, or any multi-family dwelling with common areas are particularly susceptible to these viruses. Also, see Centers for Disease Control and Prevention, “Questions and Answers: 2009 H1N1 Flu (“Swine Flu”) and You,” <http://www.cdc.gov/h1n1flu/qa.htm> (accessed October 11, 2010).

how to talk to your doctor to translate a diagnosis or treatment, deciphering medications and prescriptions with a pharmacist, and exercising the brain to keep the memory fresh. A nutritionist could program specific cooking classes for cancer and diabetic needs, and an optician could offer suggestions for healthy eye care and understanding cataract surgery.

Two problematic areas for seniors are finance and legal issues. Engaging professionals to address these needs is becoming more problematic with the recent financial disasters of 2008.¹⁶ Faith communities are wise to avoid any kind of specific investment advice. However, it can be very helpful to provide advice that assists in budget planning and fraud and scam avoidance. It is also important to teach seniors how to choose a resourceful advisor, how to compare funeral plans and costs, how to read a medical billing statement, and how to discern whether a will or trust would be a preferred estate plan.

Two ministries that have trained budget and credit counselors are free-of-charge programs through *Crown Financial Ministries* and *Financial Peace University*.¹⁷ *Crown Financial Ministries* counselors are “Money-Map Coaches,” who facilitate the budget process with a scriptural foundation and are restricted to finding ways for people to get out of debt and create and work within a budget that matches their income.¹⁸ These coaches are not permitted to give financial advice on any marketable security or insurance product, or to offer their private services. The work of Crown Ministries is done through small-group video seminars, small-group Bible studies, live all-church

¹⁶ Bureau for Consumer Protection, Business Center, “Churches Cheated in Opportunity Scam,” Federal Trade Commission <http://business.ftc.gov/print/92>, accessed October 13, 2010.

¹⁷ Larry Burkett, *Journey to Financial Freedom* (Gainesville, GA: Crown Financial Ministries, 2003, 2005), 3; Dave Ramsey, *Financial Peace University* (Brentwood, TN: The Lampo Group, 2006), 34.

¹⁸ Burkett, *Journey*, 7.

seminars, and one-to-one coaching. *Financial Peace University*, on the other hand, utilizes video classes, large stadium events, and limited one-on-one counseling with online facilitators. Both are alternative ways to engage the financial professional's expertise through coaching without compromising the church's integrity with unwanted sales or marketing pitches.

One of the most successful classes at Lake Grove Presbyterian Church in Lake Oswego, Oregon is a class entitled, "The Last Things We Talk About."¹⁹ Over 250 people have taken the course. It engages professionals from the financial, legal and medical professions, as well as pastors who speak on spiritual matters. The faculty is comprised of ordained staff and members of the community and a variety of contributing professionals. As an example, we offer a class on preparing for death. Subjects include advance directives, taught by a licensed clinical social worker; organ donation, wills, trusts, endowments, and estate taxes, taught by a lawyer; a seminar on what the Bible says about heaven taught by the senior pastor; and planning the memorial, inventories, and communicating wishes to the family, taught by the associate pastor who is also a Certified Financial Planner. Additional information regarding funeral/cremation costs is included, along with memorial planning outlines, POLST and advance directives, and newspaper obituary forms.²⁰ What seems like a grim topic is handled with sensitivity and care, and members' private information is locked away in a filing cabinet until their deaths occur. This class offers the opportunity to work on matters normally left to the

¹⁹ Elizabeth Boatwright and Bob Sanders, "The Last Things We Talk About," Lake Grove Presbyterian Church, Lake Oswego, Oregon, 2005.

²⁰ POLST stands for Physician Orders for Life-Sustaining Treatment. This form must be signed by a physician, and is normally posted in a prominent place in the resident's kitchen for emergency personnel to read in case of a crisis. In Oregon, the POLST takes precedence over an advance directive that is normally on file with the health-care representative, lawyer, doctor, and hospital.

bereaved and unprepared family. By personalizing their needs and wants in areas such as arranging for the disposition of the body and stating what music and scriptures will be in the memorial, class participants have made a loving gift to their families leaving them one less thing to worry about.

As churches are looking for ways to engage young people in meaningful service and encourage dialogue between the generations, one of the newest areas of ministry involves intergenerational programming with youth and senior adults. Amy Hanson, in her new book *Baby Boomers and Beyond*, notes, “We live in an age-segregated society...the assumption has been that it is easier to meet the specific needs of people if they are grouped by age....”²¹ Because so many senior adults are detached from their family of origin and extended family, this kind of ministry provides a way for elders to “adopt” and nurture a younger generation and for the younger generation to appreciate the wisdom and experience of the elder generation. Gordon McDonald, in his book *Who Stole My Church?*, spends a great deal of time working through this issue with a group of disgruntled older adults who loathe change, and a modern-music team of young adults eager to hear from the older generation. In time, they realize each group has something to offer. They begin to spend time together to mesh ideas, and ultimately realize that it’s not their church, but God’s. God is doing the changing.²²

In a survey of churches conducted in the spring and fall of 2010, the majority of the churches noted that their youth were assuming the traditional roles of resident weed-pullers or seasonal yard-maintenance workers for the physically impaired and seniors.

²¹ Amy Hanson, *Baby Boomers and Beyond* (San Francisco: Jossey Bass/Leadership Network Publication, 2010), 169.

²² Gordon MacDonald, *Who Stole My Church?* (Nashville, TN: Thomas Nelson, 2007), 23.

Although these roles are noble and necessary, in the end, the amount of time the senior actually spends face-to-face with the youthful volunteer is minimal. Fortunately, there are more creative cross-generational activities. Rev. Dr. Beverly James of First Presbyterian Church in Bakerstown, Pennsylvania, noted that their grade-school children visit one senior-care center per month and share snacks, games, crafts, and songs. Children bake desserts for Meals on Wheels and assist in the deliveries, and their youth offer snow shoveling, yard work and some housework.²³

Barbara Gaddis, Associate Pastor at Collegiate Presbyterian Church in Ames, Iowa, encourages “Caring Connections,” nine groups made up of people of a variety of ages, overseen by two deacons. “In times of joy or crisis for members, these deacons enlist members of the caring connection to minister via visitation, prayer, food, delivery, rides etc.”²⁴ For a faith community of 458 people with two pastors, this kind of care system grants permission to the laity to handle many of the ministries normally handled by a Board of Deacons and/or an overwhelmed pastoral staff. It allows diverse ages to dwell together in fellowship, provides accountability in the emotional seasons of life, and allows them to celebrate within a smaller congregation given the opportunity to “love one another” in tangible ways.

Dann Ragan of Council Road Baptist Church in Bethany, Oklahoma noted that still another way to approach an intergenerational ministry is to encourage their youth to serve on food-distribution teams. They also encouraged their grandparents to serve as

²³ Dr. Beverly James, associate pastor, First Presbyterian Church, Bakerstown, PA, interview/survey by author, April 30, 2010.

²⁴ Rev. Barbara Gaddis, associate pastor, Collegiate Presbyterian Church, 159 N. Sheldon Ave., Ames, IA, interview/survey by author, April 28, 2010.

tutors to children by participating in after-school programs. He also recommends mentoring programs. These help prepare high school and middle school students, as well as seniors (intergenerational) to be servers for the “soup for supper” ministry. He also started a program called “Grand Room” where senior adults mentored children.²⁵

Edd Spurlock of First Baptist Church of Mountain Home, Arkansas creates intentional mission work through his GLOW (Go Love Others Weekend), with both young and senior-adult members. These service teams also assist single-parent moms and widows.²⁶ These examples of multigenerational service and support allow generations to serve side by side and exchange wisdom and energetic ideas.

But how do we bring the professional and the need of the faith community together? One way is to stay in contact with federal, state, county, and city/community agencies on aging, local adult community centers, and all the major medical centers in the area. Most of these groups have a newsletter, or some form of e-mail or electronic communication, that informs the public on the latest changes in government policy and healthcare issues. Some also offer seminars with guest lecturers, health fairs, and professionals who may be available to come and speak to a faith community. A master calendar of these activities would be set up on a computer generated grid that could act as a clearinghouse where leaders could either have access through the internet or be sent a monthly update by mail.

It is highly recommended that the senior-adult leadership gather this information well in advance for calendaring and begin to think of their future programming twelve

²⁵ Dann Ragan, Pastoral Care-Community Team, Council Road Baptist Church, 2900 N. Council Road, Bethany, OK, interview/survey by author, October 30, 2010.

²⁶ Edd Spurlock, executive pastor, First Baptist Church, Mountain Home, AR, interview/survey by author, September 30, 2010.

months in advance. This exercise will facilitate the on-site programs already in place and illustrate where there are “holes” in the calendar that may be filled with “outside” experts who can offer their time. As a reciprocal resource, the calendar will assist leaders in the faith community who wish to stay current on who may be available at a certain time of the year so the leaders may contract their services. Likewise, community groups can be apprised of the programs the faith community has to offer and post them on their websites or calendars. Hopefully, this will avoid duplication of services and seminars, and provide a diversity of topics for seniors to enjoy.

Excursions can also be a part of this cooperative calendar. They might be built around a special medical-center lecture with a lunch date, or medical professionals can utilize a church site as part of their roving lecture series, holding the program on a Sunday after a specific worship service. This eliminates the need for additional transportation and can be coupled with a luncheon for much-needed fellowship. An example of this is a recent lecture series from Providence Medical Foundation for grieving persons, entitled, “Getting through the Holidays.” Because many senior members are unable to get out at night, Deacon Jane Sparks of Lake Grove Presbyterian suggested to Providence they could do a separate presentation at our church for our widows’ group and make it a community event. Providence was able to add this to their calendar and we have the benefit of reaching more seniors in our geographic area with a seminar and a nourishing, affordable lunch.

Another popular course, offered through our local Legacy Medical Centers, is “Powerful Tools for Care Giving.”²⁷ This curriculum, offered in two four-hour segments, trains both the in-home caregiver and the long-distance family member in how to advocate for services, handle delicate matters such as tasks of assisted daily living and transfer, gain insight in how to work with hospice personnel and, most importantly, how to care for the caregiver. It is a grim statistic that due to compassion fatigue many care receivers outlive their caregivers, as caregivers are often the second victim of the disease.²⁸ Not only does the class equip the loving family member or friend who is caring for the patient, but it grants them time to be with kindred souls who understand their commitment, compassion, and fatigue.

Another community equipping class offered by SHIBA (State Health Insurance Benefits Association) educates people on retirement benefits.²⁹ This volunteer organization equips financial and social work professionals to be volunteer counselors in matters of Social Security, Medicare, Medicaid, enrollment periods, veterans’ benefits, insurance and optional medi-gap and prescription plans. Providing a comprehensive book that outlines the details of each federal and state program, this free seminar comes with toll-free numbers to set up one-to-one counseling appointments for specific questions on coverage. Not only does this class address the needs of retired seniors, but it provides a

²⁷ Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *Powerful Tools for Caregiving* (Portland, Oregon: Legacy Health System, 2002).

²⁸ Schmall, *Powerful Tools*, 1.

²⁹ Senior Health Insurance Benefits Assistance, *Oregon Guide to Medigap, Medicare Advantage and Prescription Drug Plans* (Salem, OR: SHIBA, 2010). Perhaps one of the greatest advantages of this volume is demystifying the differences between the Medicare and Medicare Advantage programs, reciprocity among the states, and the pitfalls and penalties of enrollment periods for both Medicare, Medigap and prescription plans.

much needed seminar for pre-retirement adults who are concerned about forced retirement issues, layoffs, and when to retire.

Launching New Ministries

Psalm 82 admonishes the reader to “Defend the cause of the weak and fatherless; maintain the rights of the poor and oppressed. Rescue the weak and needy; deliver them from the hand of the wicked.”(3-4). One of the final frontiers in senior adult ministry is to send mission-minded people into the community to initiate change in civic policy. One of the most effective ways to accomplish this task is to encourage members to be advocates for community initiatives and programs when a senior’s livelihood is at risk. In a recent study sponsored by Partners for Livable Communities and the National Association of Area Agencies on Aging entitled “A Blueprint for Action: Developing a Livable Community for All Ages,” the most common issues for the aging are the following:

- A lack of affordable and appropriate housing options,
- Few opportunities for walking, bicycling, or other forms of physical activity, making it more difficult to remain healthy and engaged
- Inadequate mobility options
- Limited information about available health and supportive services in their community
- Concerns about the safety and security of the community
- Limited opportunities for meaningful, challenging, volunteer service.³⁰

A faith community can prayerfully decide if one of these areas is a suitable match to the mission statement of the church. Two of the greatest needs for seniors at the present time are affordable housing and supportive services. As rents continue to rise, and the Social Security COLA (cost of living average) remains capped at January 2009 rates, 58.7 million Social-Security recipients without the safety net of fully paid-for homes are

³⁰ National Association of Area Agencies on Aging and Partners for Livable Communities, *A Blueprint for Action: Developing a Livable Community for All Ages* (Washington, DC: MetLife Foundation, 2010), 2.

at the mercy of market-rate rents.³¹ With an average Social-Security payout of \$1072 per month, this entitlement sum is the primary source of income for 64 percent of recipients.³² Is it any wonder seniors must often make the difficult decision between food and medicine?

To counter this trend in potential homelessness for seniors, a faith community may wish to consider what effort it would take to create affordable senior housing under the Federal Tax Code Section 202, within their city limits. This particular Housing and Urban Development grant is open to non-profits, including faith-based organizations, who may partner with a development company for the sole purpose of providing affordable dwellings for people over the age of 62 who fall within certain income limitations.³³ Funding would come from federal grant monies, state tax credits, and private investors. The benefits to the renters, particularly if the housing development is located on or near the church grounds, are the following:

- Affordable dwelling based on personal income
- Exercise rooms
- Walking paths within the grounds and landscaped areas
- Seminars and lectures by physical and occupational therapists
- Health-and-wellness teams, based at the church, to support the residents.

There are multiple other benefits as well.. Seniors are provided a locked and fully secured residence with an on-site manager. The church can partner as the service arm of

³¹ Stephen Ohlemacher, “No Social Security Increase for 2011,” *The Oregonian*, October 11, 2010, A1, A4.

³² Ohlemacher, “No Social Security,” A4.

³³ “Data Sets, 50th percentile Rent Estimates” *HudUser*, <http://www.huduser.org/portal/datasets/50per/html> (accessed October 14, 2010), U.S. Department of Housing, “Section 202 Supportive Housing for Elderly Program, <http://www.hud.gov/offices/hsg/mfh/grodesc/eld202.cfm> (accessed October 14, 2010). Income limitations are based on federally established income levels, normally 50 percent of the median income for the specific city where the property is located. About 30 percent of an applicant’s adjusted income is considered as “rent.” The minimum rent payment allowed is \$75 per month.

the designated development company, providing resources such as transportation and shuttle services, health and wellness activities and prevention programs, visitation, food distribution and grocery delivery, as well as holiday activities and seminars.

It is important to note that under HUD regulations, such a facility has a forty-year life span before it can be sold to another party. Therefore, there is incentive to establish a consistent policy and to retain a management company that will screen applicants carefully for long-term affordable housing. I recommend that rents be periodically re-evaluated based on a change in a renter's personal income, not market conditions. In the end the program survives financially due to state and federal subsidies that off-set the deficits from affordable rents.

Once housing issues are resolved, the next concern is "support services." Where does a senior who is mobility-impaired begin to find assistance with government programs, food, medical services, medication assistance and emotional counseling? Many churches can provide this through their own internal teams and ministries, but if the church has fewer than 150 members, how will they provide for these diverse needs and services within the smaller congregation? The answer lies in one of two areas: advocating for people utilizing the county services or encouraging the faith community to form a ministry clearinghouse. County offices normally have an office on aging, or a social-services department with a person handling adult services. A coordinator or manager-level volunteer in the faith community can be assigned to be a liaison for the menu of services offered at the county level. In Clackamas County, Oregon, which includes the cities of Tualatin, Lake Oswego, Oregon City, West Linn, and the unincorporated areas of Clackamas and Milwaukie, there is a staff of twenty-three persons available to assist

with transportation, medical supervision and home-care services. They also provide case workers, adult-protective services, food distribution, and respite care.³⁴ If the visitation volunteer can work with the county liaison and find the appropriate services for a home-bound senior who has no family nearby, it is possible that the senior can retain his or her independence and avoid the high cost of alternative residence care.

Another way to engage the smaller church in a variety of assistance for seniors is to join a Community Clearing House, such as Love INC (Love In the Name of Christ). Love INC is a consortium of churches that provides a variety of ministry offerings that comprise the greater central depository of services. For instance, one church might contribute its clothing bank and tool inventory, another church car repair, and another medical equipment and financial budget planning as well as job and career counseling. When a senior advocate or liaison calls the Love INC office, the dispatcher at the clearinghouse can direct the caller to specific churches that can meet the need. This avoids the time consuming task of calling multiple churches or agencies for assistance.

Organizing, initiating, and monitoring volunteers for care systems requires administration, leadership and continued accountability. Moreover, the volunteers need equipping, nurturing, coaching and affirmation for a job well done. For the smaller church, it may be necessary to find specific resources for health and social services through the county or other government organizations. For that reason, faith-community liaisons must communicate with county case managers who are willing to fill the gap to facilitate a senior's independence. In either case, the ministry must remain senior-centric. The next chapter will discuss multiple ways to advocate for the needs of seniors and how

³⁴ Clackamas County Social Services and Information Referral (Clackamas County, OR, Clackamas Co, 2010), 2.

the church can, by integrating them into their mission, establish ministries for this specific demographic.

CHAPTER SIX

WHO CARES?

When Jesus saw his mother there and the disciple whom he loved standing nearby, he said to his mother, “Dear mother, here is your son.” and to the disciple, “Here is your mother.” From that time on, this disciple took her into his home. (John 19: 26-27)

As he suffered on the cross, Jesus remained concerned about both his earthly family and his spiritual family of disciples. Without a son to provide for her, his mother Mary was destined to live the life of a poor widow. Jesus delegated his beloved disciple, John, as the one who would care for her, and Mary was taken into John’s home. In the ancient world it was a common practice to reserve a room for the parents to reside in the home of the eldest son until their deaths. It was a practical means of handling the change in ownership of possessions from the parent to the child.¹ Once the parents settled into the home, they were considered a welcome addition to the community, honored in their home and revered by members of the temple.² But without a family member to offer this kind of provision, Mary would be ostracized, given the political nature of her son’s message. This same kind of compassionate oversight was illustrated in Ruth’s care for Naomi in the Old Testament where elders were given a place of honor. Leviticus 19:32 instructs us to “Rise in the presence of the aged, and show respect for the elderly.” To honor our father and our mother was considered glorifying to God. Geriatrics researcher J. Gordon Harris explains:

¹ Trent C. Butler, Ed., *The Holman Bible Dictionary* (Nashville, TN: Holman Bible Publishers, 1991, 475.

² Ibid.

The word used for honor your father and mother comes from the root *kabad*. Its intensive form (*piel*) used here, emphasizes the giving of “weight” to prominent people. It commonly refers to glorifying God. The commandment states that children must grant full significance to parents even when they may be losing physical and economic indicators of importance. Honoring your father and mother includes making them feel important for what they have achieved as parents and for what they have accomplished as the instructors of younger generations (Deut. 6:7, 20-21, 11:19).³

Despite this rich biblical history, respect for the elder has diminished in the 21st century. And as a result, seniors are in distress over at least six major issues: the changing face of family care; confusion and complexities in health care/medical systems; the silo effect of programming in the service industries of law, social work, and health care; lack of housing, transportation, and resources to live; end-of-life decisions; and seeking independence and aging-in-place resources. The purpose of this chapter will be to examine these six areas of distress and the potential impact on our aging population and how to move forward with six responses from the faith community.

First Challenge: The Changing Face of Family Care

The multiple-generational living scenario has been a road of hairpin turns in the twenty-first century. The biological children of the elderly predominantly live elsewhere and subsequently, the senior experiences isolation and loneliness. Currently, about 31% (11.2 million) of non-institutionalized older persons live alone (8.3 million women, 2.9

³ J. Gordon Harris, *Biblical Perspectives on Aging: God and the Elderly* (New York: The Haworth Press, 2008), 106.

million men).⁴ The majority of these are trying to live alone in the home where they raised their children, or are confined to senior housing developments and/or assisted-living arrangements. These provide what the family formerly managed: meals, activities, social work, transportation, and assistance with daily living tasks.

A newer trend, based on economic need, is the *homing together* model, where a referral agency matches people seeking homes with those who have rooms to rent. Seniors Homing Together, a housing agency in Milwaukie, Oregon, provides this service.⁵ With rents climbing well past the recommended 30-40 percent of net income and one-bedroom apartments averaging \$700/month and up, seniors are looking for inexpensive alternatives. In 2006, when applications opened up for HUD housing, there were 10,000 applications in the Portland Metro area.⁶ The waiting list is not due to open for another two to three years.⁷ In this economic and social scenario, family members are often individuals whom you choose, not the ones you brought into the world.

In some instances, seniors do not even get to choose who will become “family” for them. When younger parents can no longer care for their children, or children are court-ordered to live with the next of kin, often the grandparent steps in. As the recession has begun to take its toll, the number of U.S. children being raised by their grandparents has increased sharply. Roughly seven million U.S. children live in households that

⁴ Administration on Aging, “A Profile of Older Americans: 2009,” (Washington D.C., U.S. Department of Health and Human Services, January, 2010), 1. http://www.aoa.gov/aoaroot.aging_statistics/Profile/index.aspx (accessed October 21, 2010).

⁵ Merry MacKinnon, “‘Homing Together’ Responds to Senior Housing Needs” *Boom!* November 2010, 12.

⁶ HUD stands for Department of Housing and Urban Development. Housing provided under this federal program is subsidized for low-income families, seniors and disabled, and special needs situations. It also provides grants for home ownership. More information can be found at www.HUD.gov.

⁷ Ibid.

include at least one grandparent.⁸ Of that number, 2.9 million are being raised primarily by their grandparents, up 16 percent from 2007 to 2008.⁹ The reasons for this increase include the following: single parents who are overwhelmed financially or are incarcerated; a parent who has succumbed to illness or substance abuse; high rates of divorce and teen pregnancies; and long overseas deployment in the military. And the children grandparents care for are often riddled with pre-existing conditions due to abuse, neglect, prenatal exposure to drugs and alcohol, or loss of parents.¹⁰ It is a huge burden for grandparents to give up their retirement lifestyle to be responsible for a child who is experiencing the emotional loss of their parents in the home.¹¹

In addition, the senior experiences a lack of time and money, declining health, unfamiliarity with existing community resources (especially in the areas of medical care and education), and confusing legal problems, often combined with grief, guilt, and stress. The combination of these factors can result in depression.¹² And if things are not complicated enough, there is the possibility that the grandparents may become ill or disabled, or may die and no one will be left to care of their grandchildren. It is almost more than a senior adult can bear.

However, since the financial downturn in 2008, the housing landscape has returned to some of the old intergenerational models. Due to advancing age, health

⁸ David Crary, "More Kids Are Being Raised by Grandparents," *The Oregonian*, September 9, 2010, A1, A6.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid. 34 percent of grandparent caregivers are unmarried and 62 percent are women.

¹² Richard Gentzler Jr., *Aging and Ministry in the 21st Century* (Nashville: Discipleship Resources, 2008), 78.

issues, financial instability, inability to afford senior housing, and subsequent loss of independence when the car is taken away, seniors not moving in with their children. And adult children are moving back to the family homestead, more for economic than for compassionate reasons.¹³ The new family is called to house three generations.¹⁴ What was a commonplace living arrangement as late as the mid-1960s is now the new trend in housing. As Lindsay Chapman notes, “One of the side effects of the economic contraction is that America is about to rediscover the virtues of three-generation households.”¹⁵

According to the Des Moines Register, 2.3 million parents lived with their adult children in 2000, compared with about 3.6 million in 2007. Joshua Coleman writes, “...there is high potential for conflict, but there is also a good potential for increased closeness.”¹⁶ Very often emotional issues such as accessibility and discipline of grandchildren, and who controls the household, are potential conflicts in the living situation. In response, Terry Hargrave’s book, *Boomers on the Edge*, offers three principles to bear in mind when a senior welcomes their adult children and grandchildren back into the home: responsibility, patience, and boundaries. Hopefully, these principles are foundational to avoiding additional conflict.¹⁷ Even though some families are

¹³ Lindsay Chapman, “When Parents Move In With Adult Children, *Finding Dulcinea*, available from <http://www.Findingdulcinea.com/features/home/When-Parents-Move-In-With-Adult-Children>; accessed 8 December, 2010.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ This quotation is taken from the book *When Parents Hurt: Compassionate Strategies When You and Your Grown Child Don't Get Along* by Joshua Coleman, PhD, (New York: Harper Collins, 2007), 5.

¹⁷ Terry Hargrave, *Boomers on the Edge* (Grand Rapids, MI: Zondervan, 2008), 142, 146, 150.

returning to a model of inter-generational living, the emotional baggage they bring through the front door is often too heavy to take upstairs.

Second Challenge: Confusion and Complexities of the New Health Care System

As of the writing of this paper, the Health Care Reform Act of 2010 is still meeting opposition in at least 20 states.¹⁸ With a new Republican-led House of Representatives and a Democratic-led Senate, senior adults are only beginning to absorb the confusion and potential changes. Consider the following factors in this ongoing drama: As of December 13, 2010, mandatory insurance has been ruled illegal in Virginia. Judge Henry Hudson of U.S. District Court in Richmond, argues that the Health Care Reform Act exceeds the regulatory authority granted to Congress under the Commerce Clause of the Constitution. This suit is one of 25 legal challenges to the Health Care Reform Act making their way through the federal courts in our country.¹⁹

Added to these woes are the changing schedules of applying for Medigap and Medicare options (this year November 15-December 31, next year beginning in October), and a shortage of primary-care doctors who will take Medicare patients.²⁰ The rising costs of non-generic medicines and a three-year wait for covering a pre-existing medical condition are also mounting concerns. Insurance plans in Oregon will drop 25,000 retirees and others with Medicare coverage by 2011, due to the phasing out of private fee-for-service plans. These plans were to meet the same requirements as health-maintenance

¹⁸ McClatchy Tribune, "Virginia Allowed to Fight Health Care Law," *Oregonian*, 3 August 2010, p. A2.

¹⁹ New York Times Service, "Mandatory Insurance Ruled Illegal," *Oregonian*, 14 December 2010, p. A2.

²⁰ Rita Rubin, "Glimpse The Future of Primary Health Care," *USA Today*, 16 August 2010, p. A1, A2.

and preferred-provider organizations serving Medicare enrollees. Everyone affected by this change will have the option of enrolling in another private health plan, but monthly costs are predicted to be substantially higher and options limited. This year in Malheur County, Oregon, seniors on Medicare could choose from 16 health-care plans offered by six companies with premiums from \$0 to an average of \$84.00/month in addition to the Medicare Part-B premium. In 2011 the option narrows to one company, ODS, offering two benefit designs; a PPO plan at \$127.00 per month and a non-PPO plan (with no drug coverage) for \$64.00 per month. Under this same plan, seniors can purchase a stand-alone prescription drug plan for about \$30.00 per month. And all of these options come with additional paperwork and ever-changing regulations. The glossy brochures the Centers for Medicare and Medicaid Services issued in May 2010 are at risk of being overhauled.

Third Challenge: Silo Programming

Silo programs, as the name implies, are independent services for seniors that are not connected or related to any other organization. Components of each program stand alone and there is no cross-pollination within the faith community, local community/civic services, or medical affiliations. In a recent interview at Lake Grove Presbyterian Church with Ann Adrian, Director of the Lake Oswego Adult Community Center, we were amazed to discover the many duplicated programs for seniors.²¹ Both of our organizations have a social worker, a mid-day meal program and special luncheons, lecturers from the local hospitals, health assessments, SHIBA seminars, grief-and-loss groups, fall-prevention classes, and caregiver equipping seminars. Duplication of

²¹ Ann Adrian, Lake Grove Presbyterian Church, Lake Oswego, Oregon, interview by author, October 10, 2010.

programs is not necessarily a detriment in a large community, but it is a comfort to know that we can work together and avoid this kind of parallel programming. In addition, we are comforted that the Adult Community Center also has separate programs we can share: a Loaves and Fishes program (meals on wheels), foot care, stores, banks, medical transportation, sports instruction, painting/art classes, memory care respite hours, and computer instructor. Our specific faith community can provide “beat the heat” days with a cooling center, vaccinations, blood pressure checks, blood-bank days, walking programs, concerts, extended weekend excursions, memerobics (memory training), and now affordable housing through a new project, Oakridge Park.

As we shared our lists, we were ready to make up a master calendar to initiate an integrated program of services. The Adult Center will provide a daily shuttle to the senior housing, Oakridge Park, and we, in turn, will provide a meeting center with our community room. Plans are being made for classes to be held in the community room for residents on the west side of the city. This will save the Adult Center additional fees and will allow Westside residents to walk to day classes without taking the shuttle. Lake Grove Presbyterian has four trained financial planners who can travel to the Adult Center to offer one-to-one counseling to those seniors who may have budget and credit problems. In addition, the church has an inventory of nearly 200 pieces of medical equipment available for lending. This medical equipment includes shower chairs, raised seats, canes, crutches, wheelchairs, and walkers.

In an interview with Program Coordinator and Social Worker Mary Ann Hard of Lifespan Respite Care in Multnomah and Clackamas Counties, she noted that very few churches are training or encouraging home visits by church volunteers. She added that

churches are either too small to form a team or too busy trying to survive cutbacks in staff who normally train the volunteers. She is a trained instructor for the class “Powerful Tools for Care Giving” sponsored by Legacy Hospital. If a faith community or civic group wants to receive this free training for volunteers and family care givers, there are over 10 trained instructors available for classes. A church can sponsor the dates for the class and inform the county and state offices. Legacy can publicize the class to their patients’ families who need it, and encourage participation. This kind of cooperative thinking as a community of health care, social work, adult centers, and faith communities counters the silo system of programming.

Fourth Challenge: Lack of Housing, Transportation, and Resources to Live

Experts note that keeping the aging *boomer* (and older) driver safe and mobile is a profound challenge. Within fifteen years, more than one in five licensed drivers will be 65 years or older.²² That number will nearly double from 30 million today to about 57 million, according to the Government Accountability Office.²³ Men will outlive their driving ability by an average of six years and women by an average of 10 years. Many will choose to remain in their suburban homes even after the keys to the car are taken away. Because 75 percent of older drivers live in suburban or rural areas where there are few alternatives to driving, public transportation is not a realistic option.

Scientists at Massachusetts Institute of Technology’s Age Lab are developing technologies aimed at keeping older people active and driving. There is a tremendous

²² Joan Lowy, “Aging Baby Boomers Face Driving Skill ‘Mobility Gap,’” *The Oregonian*, November 10, 2010, A4.

²³ *Ibid.*

need because the number of fatal crashes for older drivers begins to rise at 75 years of age and increases more significantly for drivers over 85. The fatality rate for drivers 85 and older is worse than teenagers and drivers in their early 20s. A large proportion of these crashes come from something as simple as negotiating a left turn.²⁴ Unfortunately, taking the keys away from a senior causes both a physical and an emotional crisis.

For what some hold as the greatest American generation (born between 1919 and 1946), survivorship and independence are as basic as breathing. Their self-reliance and resilience helped them survive the Great Depression and one world war. Taking away that independence can result in depression and lack of motivation, not to mention lack of mobility. Without a car, they are at the mercy of walking on uneven surfaces, challenging bus routes through less-than-safe areas of town, and unguarded waiting platforms.

To complicate matters, many communities are not adequately mitigating these issues. In Multnomah County in Portland, Oregon, the 65-and- older population is projected to soar by 43 percent from 2015 to 2025, while the total county population of all ages during that time is expected to grow by only six percent.²⁵ Unfortunately, a bond measure that was placed on the November 2010 ballot to increase accessibility to transit for the growing elder population was defeated. This shortsightedness may be attributed to a lack of awareness for both the growing population and the need for safe, affordable transportation for those unable to drive.

²⁴ Ibid.

²⁵ Merry MacKinnon, "Aging Population Means Greater Public Transportation Demand," *Boom!*, October, 2010, 7, 13.

Fifth Challenge: End-of-Life Decisions

One of the most avoided and yet pertinent concerns for the senior adult is end-of-life-decisions. This is especially relevant in light of the controversy over the politically and emotionally charged so-called “death panels” discussed at length in 2009. The original premise for end-of-life discussions with a doctor was to allow seniors to make choices about what will happen in the event of a long-term illness or death. Incorporating the advance directive and POLST forms, senior adults would make their wishes known to their physicians who would then chart their preferences. However, in states such as Oregon and Washington which already have assisted-suicide provisions in place, what will stop a physician from counseling seniors, as a matter of convenience for the medical institution, to end their lives?

With the move from managed care to rationed care looming in the not-too-distant future, who will be able to stop the case manager or doctor from making decisions based on what the institution can afford versus what the patient wants? And when individuals are too frail to answer for themselves, and family members are not there to advocate for them, who speaks for these ailing seniors? There are some on the other side of this end-of-life concern who question that excessive treatment may be wasted on a treatment for terminal lung cancer, when the money can be spent on other patients with a chance to live. I believe ultimately the concern is not so much the expense, but what patients want, versus what they are forced to do against their will or even without their knowledge.

An example of the expendability of seniors was the recent case of a 48-year-old caregiver son who left his frail 78-year-old mother in a bathtub for 18 hours while he watched T.V. Douglas Noah Marcks then called emergency dispatchers to their home

where they found her unconscious in the bathtub of a deplorable house with feces in the bedroom.²⁶ The woman was removed from his care and she died a year later. “She had medical issues and was deteriorating,” noted prosecutor Amy Holmes Hehn. “We believe he simply neglected her to the point where she became very ill and died of complications.”²⁷ After authorities discovered he was living with his girlfriend and her aging mother, he was arrested on suspicion of abuse. Mr. Marcks was indicted in January 2010 on 20 counts of first-degree criminal mistreatment under allegations that he failed to care for his mother and used her Social Security and pension payments for himself. For that offense, Mr. Marcks was sentenced to five years in prison.²⁸ Without specific plans in place for her care, his mother’s wishes were unknown. This vulnerable woman was at the mercy of her abusive son. Instead of receiving the care she may have hoped for, she was the victim of fraud, deception, and mistreatment.

The other concern is people assuming consent for life decisions. A recent case involved a husband who said his ill wife, Virginia, who was suffering from amyotrophic lateral sclerosis or Lou Gehrig’s disease, wanted to end her life. John Roberts killed her on February 2, 2008. This ending of life was not based on the Death With Dignity Act. He simply, as Judge Jerome La Barre noted, “...took the law into his own hands,” and shot her as she slept.²⁹ He claimed that he loved her so much that it was the right thing to do.

²⁶ Aimee Green, “Caregiver Son Accused of Leaving Mother in Bathtub is Given 5 Years,” *The Oregonian*, August 5, 2010, D1.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Holly Hottle, “Husband Gets Life Sentence in Killing,” *The Oregonian*, July 16, 2009, B1, B2.

Does love or devotion to another's care allow a person to take another's life? And what consent, if any, must be required for such an act? What if the senior is unable to speak for themselves or is in a vegetative state? Who makes that decision? Central to these concerns is the registry for medical order/advance directive forms. This digital registry gives emergency medical workers immediate access to the patient's wishes.³⁰ For some it eliminates the difficulty of finding family members to grant consent on medical procedures. For others, there is concern as to how these forms are managed and if any of the answers are coerced or answered under duress, or simply misunderstood. In the coming years there will be exponential growth in our fragile senior populations. The problem of consent, particularly in light of provisions within the Death with Dignity Act, will continue to be an area of conflict.

Organ donation has become the recommended treatment of choice for many patients with end-stage organ failure. However, the controversy remains heated over the number of organs available and the solutions required for addressing the shortage of these organs for those on waiting lists. Solutions include payment for organs, denial of organs to certain patients, or changing consent practices. The most delicate of situations is denying the person who is deemed too sick, often the aging senior, the option to even make the donor list. Jennifer Lahl, National Director for the Center for Bioethics and Culture Network, offers some insight:

Think about it. We already have bioethicists advocating for futile care theory, that is, the right to refuse wanted life-sustaining treatment based on quality of life judgmentalism, resource allocation, or both. Add in the motive for taking organs to this volatile field—and wary families will become even less trusting, and medical issues will become even more likely to end up in

³⁰ Bill Graves and Charles Pope, "End of Life Claims Pull the Plug on the Facts," *The Oregonian*, August 10, 2009, A1, A2.

court. Square that if we ever enact explicit health care rationing, or redefine death to include a diagnosis of PVS—as many luminaries in the transplant field advocate.³¹

Seniors are already frightened that they will not have a say in their medical care as they age. As this quotation implies, we are in a managed-care health system headed for rationed care. Who will speak for the frail senior who has no family nearby? Can the church step in as an advocate? More important, does the church have a mandate to protect the senior when we believe there is potential fiscal, physical, or emotional neglect on the part of a medical institution?

We need to ask some basic questions of all our seniors. Do we know their wishes regarding end-of-life decisions? Are we aware of their opinions about curative or palliative/hospice care or minimal treatment? Do they desire care at home until their death? Have they signed a POLST or Advance Directive to let their family know their wishes? These are all queries that could be handled within a faith community at a seminar or in the privacy of a home with a visitation volunteer and the individual's family.

Sixth Challenge: Aging-in-Place Resources and Care Options

Terry Hargrave, in his book *Boomers on the Edge*, calls aging baby boomers the “Care-giving Generation.”³² Not only are they welcoming the wayward young adult home, but they are also caring for their aging and fragile parents. With this sandwich generation overwhelmed with the responsibilities of caring for their children and their aging parents, they begin to look for other alternatives. This may include senior-housing

³¹ Jennifer Lahl, “Presumptuous Consent,” available from The Center for Bioethics and Culture Network, <http://www.cbc--network.org>; accessed 16 June 2010. PVS means Permanent Vegetative State.

³² Terry Hargrave, *Boomers on the Edge* (Grand Rapids, MI: Publisher, 2008), 27.

complexes, assisted-living facilities, and, on their doctor's advice, a memory-care residence. However, costs for these facilities can be exorbitant.

The Portland metro-area senior apartment buildings vary roughly from \$700-\$1000 in rent. Independent-living retirement communities with meal plans cost approximately \$1400-\$3500 per month. Assisted-living communities with some services for assisted daily-living can range from \$2300-\$6000 per month. Care homes, also known as adult foster care, range from \$2300-\$5000 per month. Dementia/Alzheimer's communities cost \$3500-\$6000 and nursing homes are \$6000-\$9000 per month.³³ Is it any wonder people on fixed incomes are looking to their families and their churches to bail them out of this nightmare of costs?

It is my observation that seniors prefer to retain their dignity and choose to remain at home rather than be subjected to a pre-determined meal plan and social calendar. When they become frail, or lose mobility options, then they will look to agencies or friends to provide in-home care. However, in-home care costs \$18-30.00 an hour, and adult day services are \$50-75.00 per day, which translates to \$1500-\$2250 per month. With hourly home care, 5 hours a day ranges from \$2700-\$4500 per month and at 10 hours a day, this would be \$5400-\$9000 per month.³⁴

Another rising trend is elder caregivers subsidizing their fixed incomes by caring for other elders. Home Instead Senior Care notes that the average caregiver in their

³³ Brent Brokaw, "A Place for Mom," pamphlet/chart, 2009. A Place for Mom is an agency that facilitates housing options for seniors in the Portland, Oregon. As with most agencies of this kind, the consumer is able to find a home without a fee. The agency charges a finders' fee to the foster home, assisted-living facility or memory-care center.

³⁴ Ibid.

agency is 60 years of age.³⁵ Many of these senior caregivers have already cared for their aging parents and spouses and understand the stresses the family experiences. They bring a wealth of knowledge and compassion and are willing to take about half of what the agency charges as wages.³⁶

This is where the faith community has an opportunity to engage and equip seniors in their choices. We can offer our own seminars on the subject of remaining in their neighborhood or city as they age with experts from local agencies, or simply direct them to housing brokers. Most of the senior housing brokers with whom I have met are anxious for families to help their parents make the right choice. And like any other commissioned worker in this housing industry, they make their income when they properly place someone in the right facility or home.

What Will It Take For the Church to Respond?

Response Number One: Biblical Justice

The first response to the desperate need of our elderly is to motivate missional churches to form an organized intergenerational volunteer base to seek biblical justice for the senior. The primal motivation for this action is biblical justice. Deuteronomy 24:17 - 24 commanded Israel to do the following:

Do not deprive the foreigner or the fatherless of justice, or take the cloak of the widow as a pledge. Remember that you were slaves in Egypt and the LORD your God redeemed you from there. That is why I command you to do this. When you are harvesting in your field and you overlook a sheaf, do not go back to get it. Leave it for the foreigner, the fatherless and the widow, so that the LORD your God may bless you in all the work of your

³⁵ John Leland, "Elderly Increasingly Care for Elderly," *The Oregonian*, May 2, 2010, A6.

³⁶ *Ibid.*

hands. When you beat the olives from your trees, do not go over the branches a second time. Leave what remains for the foreigner, the fatherless and the widow. When you harvest the grapes in your vineyard, do not go over the vines again. Leave what remains for the foreigner, the fatherless and the widow. Remember that you were slaves in Egypt. That is why I command you to do this.

Tom Davis reminds us in his book *Fields of the Fatherless*, “When it comes to caring for the people on God’s heart, indifference is a sin.”³⁷ He goes on to confirm the role evil plays in indifference: “The definition of evil in the world is when good men and women see injustice and do nothing. Indifference means people can’t hate or love, they simply don’t care, a greater sin.”³⁸ The Apostle James reminds us that “Pure and faultless religion is this; to look after orphans and widows in their distress.”(James 1:27). Is the church looking after widows? Are we offering blank stares and indifference when an elderly person asks for a ride, a weekly visit or companionship, or some activity that accommodates their disability? In his book *A Church for the 21st Century*, Leith Anderson notes the following about a healthy church:

Healthy churches are also incarnational. They are well informed and involved with the world. This means knowing what is going on, spending time with people unlike ourselves, finding ways to serve others, risking accusations and misunderstanding in order to be with those who are sinners.³⁹

Let us consider spending time with people unlike ourselves. Is it possible we find ourselves walking away from a senior because we do not have the time to listen to that same story another time? This indifference is a sin of omission. Leaving seniors out of

³⁷ Tom Davis, *Fields of the Fatherless* (Colorado Springs, CO: David C. Cook Publishing, 2008), 32-33.

³⁸ Tom Davis, *Fields*, 34. Mr. Davis is using a quotation from Edmund Burke.

³⁹ Leith Anderson, *A Church for the 21st Century* (Minneapolis, MN: Bethany House Publishers, 1992), 133.

the life of the church and relegating them to the corners of the building in wheelchairs is only creating more distress. Consider the parable of the Good Samaritan. A lawyer sought to trap Jesus into saying something derogatory about the law. However, Jesus showed him that these same Jewish leaders were the ones who did not really keep the law at all.⁴⁰ In fact he accused them of protecting themselves from the needs of others.

We are called, as the Good Samaritan was, to care for the physical and economic needs of the man in the road, in this case the isolated senior. Yes, there will be ridicule and hardship when we carry the elderly woman from the sanctuary with soiled pants and a puddle in the middle of the pew. And yes, there may be some embarrassment when, in the middle of the sermon, a hearing-impaired senior blurts out, “I still can’t hear you!” as he or she drops the sound-aid device on the sanctuary floor. There will be embarrassment when we financially assist the senior who cannot pay rent because the non-generic medication has doubled in price. And there will be moments when a visitation volunteer will enter a home where there is no food in the refrigerator because the resident’s caregiver did not make a trip to the grocery store. None of these inconveniences matter. It is part of our call as believers to care for the elderly. It is respect for the God of justice. We need to incorporate the isolated senior into the family of God. J. Gordon Harris

notes:

Respect for the God of justice therefore motivates respect for an older person. The Holiness Code characteristically reinforces such statutes with a formulaic self-revelation of Israel’s God: “I am the Lord.” For example, it has already been noted how such a refrain reinforces the honoring of the elderly: “You shall rise up

⁴⁰ Timothy Keller, *Ministries of Mercy* (Phillipsburg, NJ: P and R Publishing, 1997), 11.

before the white head, and honor the face of an old man, and you will fear your God. I am the Lord.” (Lev.19:32).⁴¹

Response Number Two: Adopt Seniors into the Family of God

The second response to the need of the elderly is to re-evaluate the expectations of the nuclear family and adopt the senior member into the greater family of God. To ensure that we honor the senior, we need to take a closer look at who is available to care for the elder in the family of God.

Our nuclear family was once the source of our name and our identity. And many people believe one of the church’s primary responsibilities is to strengthen that family. Sadly, the “traditional” two-parent household with one or more children is on the decline. The US Census Bureau shows that the percentage of married people has been in sharp decline for the past decade. The percentage of married people has dropped from 57% in 2000 to 52% in 2009 (the lowest since information on marital status was first collected over 100 years ago). Factor in our young unmarried adults, and the percent of two-parent families is even lower, around 44 %.⁴² These related-by-blood two-parent households should form the core of those who would take the senior into their home.

However, with such dramatic changes in the families of origin, *home* is redefined. Now home, as Robert Frost puts it, “is the place, when you have to go there, they have to take you in.”⁴³ When seniors can no longer care for themselves, they find a facility, an

⁴¹ J. Gordon Harris, *Biblical Perspectives on Aging: God and the Elderly*, 2nd ed. (New York: The Haworth Press, 2008), 104. Leviticus 17-26 has been called The Holiness Code. Scholars suggested it was an ancient collection of laws that had circulated independently before being placed in its present location in Leviticus. For more on this code, see *Old Testament Survey* by William Lasor, David Hubbard, and Frederic Bush (Grand Rapids, MI: Eerdmans Publishing Company, 1996), 89.

⁴² Population Reference Bureau, “In U.S., Proportion Married at Lowest Recorded Levels,” accessed 15 December 2010, available from <http://www.prb.org/Articles/2010/usmarriage Decline.aspx>;

⁴³ Robert Frost, “Death of a Hired Man,” 1915.

unrelated family, or a foster home that “will take them in.” Is it any wonder that seniors flock to a faith community as a haven of people who are caring and compassionate?

With estranged and overextended boomer children living in all parts of the United States, seniors see their local faith communities as adopted families, places where they feel safe. There it is hoped they can find a ride, be invited to a meal, enjoy a lunch with a lecture on health care, hear from a parish nurse about measures to prevent high blood pressure, be greeted at the door on a Sunday by name, engage in a multi-generational activity or service project, find a Bible study, and be affirmed for just being around.

Churches, in their quest for biblical justice, can develop intentional activities that incorporate seniors into every facet of their mission. Mentoring, teaching, prayer, maintenance, office work, social activities, service programs, correspondence, and short-term mission work are just a few of the areas in which seniors can thrive and pour themselves out into a younger generation. The purpose for all of this intentional visioning is to declare to the faith community that older adults are a resource and have the potential to pass on knowledge for the benefit of future generations.

Response Number Three: Integrating Ecclesial and Social Programs

The third response to the needs of seniors is to integrate and triage services between the churches, governmental agencies and medical programs. Recent reports regarding city revitalization are beginning to address the integration of services for seniors. Both the May 2007 report from National Association of Area Agencies on Aging and the 2008 report from Multnomah County, Oregon, are proposing ways to incorporate aging populations into city planning: housing; health and supportive services;

employment; civic engagement; transportation; culture and lifelong learning; public safety, and volunteer opportunities.

Why not include spiritual and emotional wellness? What is to keep the faith community from cross-pollinating its services with these programs to avoid duplication? Housing is an excellent example of how a care system can provide a diversity of services. First, a city must be able to find land within its boundaries for a Section 202 housing project to provide affordable housing for people over the age of 62. Because the nature of the grant requires a non-profit or faith-based partner, would not a church with services for seniors be a good candidate? While the state provides tax credits, and the federal government provides the initial capital for construction and maintenance, the local church can provide volunteer medical staff for health assessments and wellness checks. The faith community can also provide volunteers for food distribution, visitation, social activities, multi-generational programs with children and youth, budget and credit counseling, and volunteers to maintain the property.

Another area for potential integration and cross-pollination of services is in providing care. The AARP recently published a research report that noted a caregiver's wish list. With nearly 65.7 million Americans assisting family members, the diversity of needs within the care-giving population is great. Over 66% of these care-givers with jobs have arrived late, left early, or taken time off during the day to attend to their care-giving issues. What will ease the burden for millions of families? Here is their list: 15% need a partially paid, six-week leave of absence from work; 56% need a caregiver's tax credit of \$3000; 29% want a voucher program to get paid minimum wage for some hours of care-giving; 26% want respite care with a qualified person to take over for a while; 21% desire

a driver service to help with transportation chores; 18% desire an assessment of needs to connect to needed services.⁴⁴

A faith community's care system has the ability to step in and address these needs. Financial planners and tax professionals working pro-bono can assist care-givers with applying for tax credits and can offer seminars on how to access and communicate their wishes to human resource people. The resource officers can, in turn, suggest lawyers who can interpret labor laws. If a church chooses to initiate a respite program, they may be able to train volunteers to provide a weekend break for a caregiver at no charge. Transportation services should be available within the faith community. A list of qualified licensed drivers with weekdays and/or weekends free can be available to those seniors who need a ride to the doctor or who need to run an errand. A health and wellness team at a church can provide one-on-one assessment visits and referrals for housing placement, social services, and federal and state medical programs, pro-bono clinics, and senior-friendly legal assistance. In short, the wish list can be fulfilled with volunteers organized in a faith community that utilizes a care system of services.

Response Number Four: Holistic Ministry

The fourth response to the need of the elderly is to establish holistic ministries within the church that meet their social, emotional/psychological, physical, spiritual and financial needs. In chapter 5 of this paper, a care-system model was identified. Beginning with a core group of ministries (prayer, visitation, emergencies, care team and follow-up calls, food/nutrition and shelter), the system moves into the first of a series of concentric

⁴⁴ AARP, "Caregivers' Wish List," *AARP and You*, Research Report, accessed 10 October 2010. Available from <http://www.aarp.org/cargivingus>;

circles of church-based support. The first tier could encompass many of the resources and services provided within a faith community. These could include medical equipment, a long-term visitation team, cancer support, health and wellness check-ups and vaccinations, equipping classes for caregivers, and grief care for loss.

The next tier would incorporate the use of medical professionals who offer pro-bono services within the church setting. Medical institutions are encouraged to see the faith community as a center for learning and they, in turn, could provide instruction in following areas: fall prevention; physical and occupational therapy classes; a pharmacist offering classes on medicines and prescription drugs; memory classes; mobility and agility classes; and hearing and foot care.

Finally the last of the concentric circles embraces civic and community resources. This could include such things as safe-driving programs, caseworkers from the local county offices for environment assessments, Adult Protective Services, Adult Community Centers, Fraud and Safety classes taught by instructors from the American Association of Retired Persons (AARP), and SHIBA seminars which instruct individuals on Medicare and Medigap policies as well as applying for grants under HUD Section 202 programs for affordable housing. All fall under this category of civic/community resources.

This tier of services is where professionals may wish to offer their time for lectures and workshops. *The Last Things We Talk About* seminar engages the services of a lawyer for estate and elder law. The same lawyer may also wish to cover topics such as guardianship, wills and trusts, titling assets, and banking. A class on fraud and criminal activity can involve the police and members of an investigative unit. This same tier in the

care system will also incorporate advocacy for seniors, such as bus lines, transportation services, and program services within a city's boundaries.

Response Number Five: A Biblical Model for Caregiving

The fifth response to the needs of seniors is to return to the first-century caregiving model. In chapter 3 of this paper, it was noted that we have an opportunity to care for our seniors with simplicity and compassion. In the first century, this meant that the senior-adult patient remained in the home as an extended-family member. Other members of the family cared for the elder, even at their bedside, because it was their cultural obligation. The eldest son was responsible for the parents—it was part of his responsibility for his inheritance.

Given the present costs for elderly care, even with the subsidized medical plans, many families are returning to this model. They are no longer willing to pay outrageous costs for a pill, or a pillow. Nor are they willing to have their wages garnished or their fixed income diminished to pay down the mortgage on overpriced and over-the-top medical care. Instead the trend is to return home. And potentially, the church has a huge role to play in this scenario. By piecing together the work of an in-home services agency, weekly visitation volunteers, and re-engaging the family to take part in this holistic care scenario, the costs may become affordable.

The hardest issue is caring for a parent from a distance. A church simply cannot expend its volunteer force to assume the role of the primary caregiver. There is no substitute for a child or family member who cannot live near his or her loved one. The family member, however, can have conferences with the faith community's assigned visitation volunteer and pastor when he or she is in town, to receive reports of progress or

decline in a senior relative's health and to make suggestions for care. It is often during this time of consultation that the family decides on a move to a lower cost foster home and/or hospice care when elders are no longer able to care for themselves.

The doctor's role in this foster care/ hospice environment will change radically. In a home setting, curative care is no longer the driving force for the patient. Instead, palliative/comfort care is the norm. It is a return to the bedside physician who is there for pain management and maintenance. Patients have the choice of whether they will go to the hospital, based on their own or the family's wishes. In the later stages of illness and decline, the heroics of saving a life are gone. The more important goals are comfort care, pain management, and a self-directed home-going to eternal life.

Response Number Six: Give Seniors Hope

The final response to the needs of seniors is to give them hope that there will be someone who will care for them. In chapter 2 we were introduced to two images of caring for the aging adult; The illustrations of Naomi and Ruth and the calling of the first deacons in Acts 6. Seniors can be assured that the God of all comfort and his follower would not leave or neglect them. The Apostle Paul's first letter to Timothy addresses the issue of the aging and their families. J. Gordon Harris notes the following:

Timothy deals with aging issues by discussing giving support to widows. Widows living with children should be taken care of by them. Adult children should support their widowed mother motivated by religious duty and a sense of gratitude. Such care pleases God. (1Tim. 5:3-4). A person who does not care for such dependents denies the faith and is "worse than an unbeliever" (1 Tim. 5:8). When does a widow without any children qualify for church support? She must be sixty years old, have been married only once, be a good mother, possess a reputation for good deeds, and have performed many services (1 Tim. 5:9-10)...The ideal situation however, is for believers (male and female) themselves

to take care of a widow and not burden the church (1 Tim 5:16). Such care indicates that at this stage in the life of a church a concern for social structures like that of the common theology of aging now dominates church practices.⁴⁵

This same theology needs to permeate our own faith communities. A primal role as believers is to embody God's promise that we will never leave nor forsake our seniors. But how do we accomplish that in a world filled with *me* and *mine* thinking? How do we redeem the wisdom of our elders so that they may be the peacemakers, those who pour their lives into a future generation? We accomplish this when we find people who are willing to take responsibility for seniors within their congregation. In taking responsibility for our elders, we provide them transportation, a Sunday dinner, an outing, a connecting call to a long-distance child, and a willing hand when the repairs need to be done. We stay in touch with their health needs and get involved with their diagnoses, illnesses and hospital stays. We find like-minded people who want to socialize with them and carry on a conversation that is sensitive to their generation and values. We care about laws and regulations that affect their lifestyle and budget. We get involved when there is confusion in a billing, a relentless creditor, or a fraudulent salesperson. We are there when they need us. In short, we take away their fears about dangers, emotional depression, immobility, and pennilessness.

Richard Gentzler offers what should be the purpose of every older adult ministry:

- To nurture faith by acknowledging both the blessings and losses of later life and recognizing that interdependence, not independence, is of greater value.
- To build Christian community by developing a structure in our churches that encourages and facilitates intentional ministry, by, with, and for older adults.

⁴⁵ J. Gordon Harris, *Biblical Perspectives*, 133.

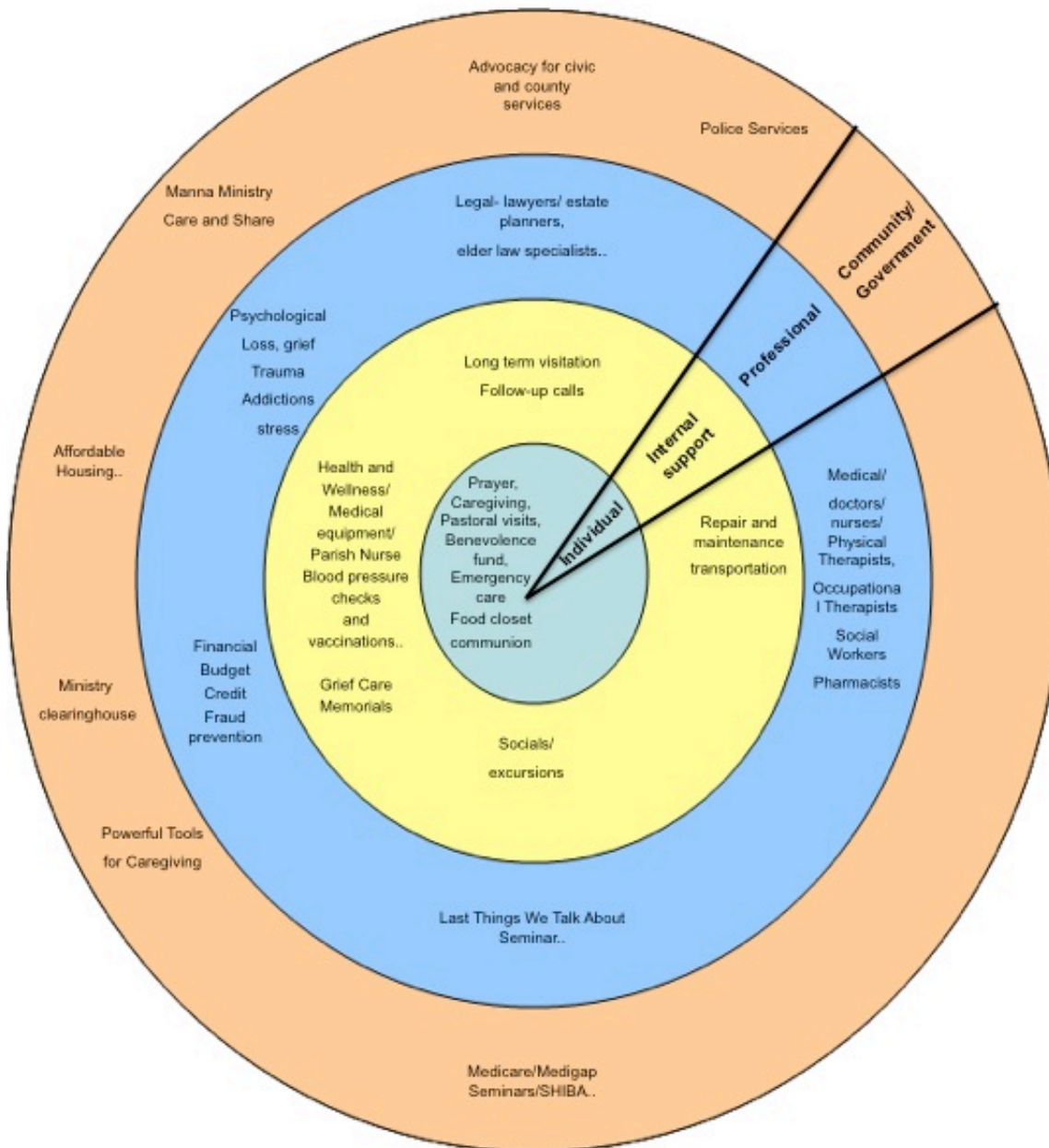
- To equip older adults for faithful living and serving by offering a fresh perspective that sees older adults as active participants in contributing to the church's life and mission and in meeting the spiritual needs of its members⁴⁶

Who cares? As the body of Christ, as a faith community alive in Christ, we must care. The appendices to follow will provide practical tools for faith communities to begin the journey.

⁴⁶ Richard H. Gentzler, Jr. *Aging and Ministry in the 21st Century* (Nashville: Discipleship Resources, 2008), 91-2.

Illustration 1

Care Systems



Appendix 1

Assessment Tools for Churches

Church Assessment Form

Name of Church/Location-

Senior Pastor

Person being interviewed/ Position Title/ Brief Job Description

Basic Demographics of the Population in your church over 65

of persons over 65= _____=% of total church population _____

of persons over 85= _____= % of total church population _____

of persons under 40 _____=% of church population of _____

What are the major ministries that embrace pastoral care/care systems in your church?

Spirituality

Nutrition/Wellness

Legal/Financial

Enrichment

Outreach/Mission/Service

Recreation

Mental Health

Church Assessment Form, p. 2

What percentage of the work described above is done by ordained/clergy persons/retired clergy persons and what percentage is done by volunteers?

____ Clergy/ retired clergy

____ Volunteers

Where is the greatest need for pastoral care in the church?

What are some of the successful programs currently in place to meet that need?

Have you worked with intergenerational programs (i.e. youth serving elders over 65) in any of your programs? If so, what were the activities? Were they helpful?

If you were able to equip and put into place additional pastoral care programs what would they be?

Are you at present working with any federal, state, local program or local medical center, private agencies to integrate care? If so, what are the advantages? Disadvantages?

Assessment Tools for Churches

Senior Adult Survey Form

Name _____

Address _____

Phone# _____

E-mail Address: _____

Male ___ Female ___ Date of Birth _____

Birthplace _____

Marital Status: Married ___ Single ___ Never Married ___ Divorced ___ Widow ___

Do you live alone? Yes ___ No ___

If no, whom do you live with?

Emergency Numbers _____ (Family Member)

_____ (Neighbor)

_____ (Friend)

During the past week, how many times did you:

_____ Go shopping

_____ Talk with a friend or a relative

_____ Do errands

_____ Go on a short trip/visit

Any concerns about where you live?

Specifics? _____

Please rate your health: excellent, ___ very good ___ good ___ fair ___ poor ___

Are you able to get to worship services on your own? Yes ___ no ___

How often do you attend? ___ Times a month

Do you need a ride to church? ___ What service do you attend? _____

Would you like to receive any of the following services in your home?

_____ Pastoral visitation

_____ Care team visitation

_____ Devotional/Bible Study materials

_____ Communion

_____ Worship service CD

Do You Need?**Can You Provide?**

Transportation
 Home Repairs
 Housekeeping Chores
 Minor Plumbing Repairs
 Minor Carpentry Repairs
 Legal Counsel
 Income Tax Preparation
 Financial Counsel
 Medical Assistance-pharmaceutical
 Medical Assistance- second opinion
 Medicare/Medical counseling (SHIBA)
 Meals/Meal Preparation
 Reading Materials
 Support Group (Grief and Loss, AA, etc.)
 Fellowship Group/ Prime/Time
 Bible Study Group
 Prayer Group
 Caregivers Support Group
 Respite Support
 Travel Opportunities

Any other needs not covered above?

Other ministry you can provide?

Please identify or list any program or idea you have for older members of this church:

For Office Use Only

Care Team and Deacons
 Helping Hands
 Communion Team
 Meal Team
 Parish Nurse- Health and Wellness Team
 Transportation Team
 Community Life
 Equipping Team
 Prime Time Fellowship
 Heart to Heart- Grief and Loss

Assessment Tools for Churches

Senior Adult Ministries Volunteer Application

Name _____

Address _____

Phone# _____

E-mail Address: _____

Male ___ Female ___

Date of Birth _____ Birthplace _____

Marital Status: Married ___ Single ___ Never Married ___ Divorced ___ Widow ___

Member of this church since _____

Member of Bible study/fellowship? ___ Yes ___ No

Reference Name _____ phone number _____

Driver's License

Number _____

Have you ever been convicted of a federal or state crime? Please describe details/penalty?

Have you been in an accident or moving violation in the past three years?

What has motivated you to work with senior adults?

What Areas of this ministry interest you the most?

What is your experience working with senior adults?

Do you see any areas of service we could add to this ministry? Be specific.

I declare that the above information is true and correct.

X _____ Date _____

You will be notified once the background check is completed. Thank you.

Assessment Tools for Churches

Ministry Proposal Form

Name of Ministry:

Department:

Reports to:

History/Background. Why is this ministry needed?

How does this ministry reflect mission of the church?

Personnel required, hours needed and special considerations:

Volunteer recruitment and marketing:

Description of volunteers needed:

Budget considerations:

Supervision/Monitoring/Accountability:

Follow-up evaluation:

Additional Questions: Please contact Chair of vision committee: _____.

Appendix 2

Results of Church Survey

Using the Church Assessment Form in Appendix 1, here are the results of the church survey conducted in 2010.

Church and Interviewee Data

Church Name	Interviewee Name	Interviewee Title
Cedar Mills Bible Church, Portland, OR	Dave McElheran	Pastor to Seniors and Pastoral Care
Collegiate Presbyterian Church, Ames, IA	Barbara Gaddis	Associate Pastor
Community Bible Church of San Diego, CA	Scott Lowther	Staff Director, Counseling and Youth Ministries
Council Road Baptist Church, Bethany, OK	Dann Ragan	Minister of Pastoral Care
First Baptist Church, Mountain Home, AR	Edd Spurlock	Executive Pastor
First Baptist Church of Indianapolis, IN	Frederick Lewis	Senior Minister
First Evangelical Free Church of Fullerton, CA	Bambi Encarnacion	Director of Senior Adult Programs
First Presbyterian Church Bellevue, WA	Colin Robeson	Pastor Associate
First Presbyterian Church of Honolulu, HI	Sim B. Fulcher	Associate Pastor
First Presbyterian Church Bakerstown, PA	Beverly W. James	Interim Associate Pastor
Grace Presbyterian Church, Houston, TX	Michael Fry	Associate Pastor for Congregational Care
Green Acres Baptist Church, Tyler, TX	Darryle Dunks	Minister of Pastoral Care
Lake Grove Presbyterian Church, Lake Oswego, OR	Libby Boatwright	Associate Pastor Congregational Care
Longmont Christian Church, Longmont, CO	LeRoy Casey	Director, Pastoral Care Ministries
Northshore Baptist Church, Bothell, WA	Gary Stabbert	Pastor of Prayer and Care
Peninsula Covenant Church, Redwood City, CA	Todd Gumbrecht	Connection Pastor
West Side Christian Church, Springfield, IL	Gary Winkleman	Minister of Pastoral Care and Singles
Westlake Hills Presbyterian, Austin TX	Peter Haas	Associate Pastor for Community
Westminster Presbyterian, Medford, OR	Lori Boehning	Associate Pastor/Congregational Care Pastor

Table 1- Question- What is the size of your church?

Church Membership Size	Number of Respondents	% of Respondents
<= 500	5	26.3%
501-2000	5	26.3%
2001 +	8	42.1%
Size Not Reported	1	5.3%

Table 2- Question-What is percentage over 65, over 85, under 40?

Membership Age Proportion	Percent
> 65 years old	47.4%
>85 years old	6.8%
< 40 years old	37.6%

Table 3- What are the major program/ministry areas for seniors?

Major Program Type	Number of Responses	% of Responses
Enrichment/ art, music etc.	2	1.8%
Legal/Financial	18	15.8%
Mental Health Wellness	19	16.7%
Outreach/Mission/Service	18	15.8%
Physical Wellness/Nutrition	19	16.7%
Recreation	19	16.7%
Spirituality	19	16.7%

Table 4- Break down program areas by size of church

Major Program Type	<= 500	501-2000	2001+
Enrichment	0.0%	3.8%	0.0%
Legal/Financial	0.0%	1.9%	7.1%
Mental Health Wellness	10.3%	9.6%	21.4%
Outreach/Mission/Service	10.3%	13.5%	21.4%
Physical Wellness/Nutrition	34.5%	30.8%	21.4%
Recreation	3.4%	5.8%	2.9%
Spirituality	41.4%	34.6%	25.7%

Table 5 What are some of your successful program areas?

Successful Programs	Number of Responses	% of Responses
Enrichment	1	1.5%
Legal/Financial	4	5.9%
Mental Health Wellness	16	23.5%
Outreach/Mission/Service	11	16.2%
Physical Wellness/Nutrition	14	20.6%
Recreation	6	8.8%
Spirituality	16	23.5%

Table 6- Break down successful programs by size of church

Successful Programs	<= 500	501-2000	2001+
Enrichment	6.7%	0.0%	0.0%
Legal/Financial	6.7%	10.0%	3.1%
Mental Health Wellness	13.3%	20.0%	31.3%
Outreach/Mission/Service	26.7%	20.0%	9.4%
Physical Wellness/Nutrition	20.0%	30.0%	15.6%
Recreation	13.3%	0.0%	12.5%
Spirituality	13.3%	20.0%	28.1%

Table 7 How much of pastoral care is done by clergy?

Proportion Clergy vs. Volunteer	Number of Respondents	% of Respondents
>50% Clergy	7	36.8%
<50% Clergy	8	42.1%
Not Reported	4	21.1%

Table 8- Break down in ministry areas with clergy/non-clergy

Successful Programs	>50% Clergy	<50% Clergy
Enrichment	0.0%	3.3%
Legal/Financial	7.1%	3.3%
Mental Health Wellness	21.4%	26.7%
Outreach/Mission/Service	14.3%	16.7%
Physical Wellness/Nutrition	21.4%	20.0%
Recreation	10.7%	10.0%
Spirituality	25.0%	20.0%

Table 9-Where are the greatest needs in pastoral care?

Greatest Need	Responses
Benevolence support	1
Community building	1
Counseling	7
Crisis care	2
Fall prevention	1
Financial counseling	1
Funerals/memorials	2
Grief	2
Hospital and home visitation	9
Meals	1
More support staff	1
More volunteers at higher level	1
Non-member issues	1
Parish Nurse	1
Prayer—needed across full spectrum of age ranges	1
Reaching out to the Community	1
Senior Adults Services	3
Spiritual guidance	1
Support groups	7
Transportation	2
Weddings	1
Working more in nursing homes	2
Community building	1
Counseling	7

Table 10-Do you have intergenerational programs at your church?

Have Intergenerational Programs	Number of Respondents	% of Respondents
Yes	12	63.2%
No	7	36.8%

Table 11-Break-down of intergenerational programs by church size

Have Intergenerational Programs	< = 500	501-2000	2001+
Yes	80%	80%	50%
No	20%	20%	50%

Table 12-What are the types of intergenerational programs offered.?

Intergenerational Program Type	Number of Responses	% of Responses
Mental Health Wellness	2	4.7%
Outreach/Mission/Service	26	60.5%
Physical Wellness/Nutrition	5	11.6%
Recreation	8	18.6%
Spirituality	2	4.7%

Table 13- Are there additional programs you would like to see?

Additional Programs
Adding a clinic on campus for community as well as seniors
Additional visitation ministry
Assistance from life stage pastors
Assistance from small group leaders
Class to equip people in prayer ministry
Classes on how to train visitation ministry
Commit for a year to volunteer to serve a certain population
Congregational/geographical models to oversee all needs
Continue to improve all our programs
Divorce recovery
Expand counseling
Extend the effectiveness of existing ministries
Grief mentors for men
Have a professional in residence, less lay-based
Helping families with caring for aging parents
Helping families with parenting
Job/career counseling
Make deacons the real ministers
Marriage tune-up/divorce prevention
Mentoring of boomers by successfully retired people
More follow-up care
More grief seminars/grieving techniques
More organic care, less programmatic
Organized home communion
Parenting classes and support
Parish nurse
Regular visits for discharged hospital patients
Resume/interviewing skills
Special classes for grieving and children of divorce
Visitation ministry
Visitation ministry mentoring
Willing Hands group - do small odd jobs for those in need

Table 14 -Are you currently working with any federal/state/local agency?

Work with Federal/State/Local Agencies?	Number of Respondents	% of Respondents
Yes	9	41.4%
No	9	41.4%
No Response	1	5.3%

Table 15-Break-down of response by church size

Work with Federal/State/Local Agencies?	< = 500	501-2000	2001+
Yes	40%	60%	50%
No	60%	40%	50%

Table 16- What are some of the federal/state/and local programs you participate in?

Federal/State/Local Programs
ACCESS-inc
Baptist Home for Children
Baptist Retirement Center
Community food assistance for disadvantaged
Community groups that assist with moves, repairs, home assessments
Community promotions
Community service projects
Discharge planners
Eastside academy, working with at-risk youth
Heart and Hand (women's ministry)
Help Now
Hopelink -- partner agency that provides resources for people who call into church
Hospital for lectures/seminars
House of Healing (girls' ministry)
Letter ministry
Local counseling center/referrals
Meals on Wheels
Multidisciplinary Youth Assessment Team (at risk youth)
Oil changes for single parents
Powerful tools for care giving with Legacy Hospital
Reaching Our City (clinic, food, and thrift centers)
Ready Wheels
Regional Food Bank
Resources for tax returns
Salvation Army
Senior Housing Project with HUD
Senior Placement for Housing (Senior Living Options)
Serve the Peninsula
Shelters
Substance abuse programs
Third Left Turn Ministry
Traveling Nurses
Widows luncheon tea
Working with Adult Community Center—transporting to center and classes
Working with city for career counseling
Working with impoverished part of city

Appendix 3

Sample Job Descriptions Senior Adult Ministries

Care System Tier One-Individual

Position Title: **Barnabas/Benevolence Interviewer**

Requirement: Must have good listening/counseling skills, Stephen Ministry training (or equivalent), financial/budget skills. People will be required to interview potential candidates who request aid from benevolence funds.

Servant Profile: Gifts- *mercy, pastoring, counseling*
Passion- *marginal persons, single parents, homeless people, unemployed*
Style-people orientation

Hours: Varies, based on need. Usually 2-5 hours per week.

Contact: Congregational Care Pastor _____.

Position Title: **Care Team (Could also be Stephen Ministers)**

Requirements: Ability to discern needs for any of the following people: ill or recovering from illness, involved in therapy/procedures; unemployed; grieving; mentally and emotional fragile; in financial and legal distress; or working through family concerns (divorce, separation, child custody, domestic violence). Individuals from team are assigned and responsible for follow-up, counseling/mentoring and finding resources as needed.

Servant Profile: Gifts- *discernment, mercy, helps, encouragement, faith, intercession, shepherding,*
Passion-*people who need listeners/support people/advocates*
Style- *people orientation*

Hours: 1 hour per week for team meeting. As needed for follow-up calls and meetings with individuals.

Contact: Pastoral Assistant _____

Position Title:**Communion Server**

Requirements

Serve communion once a month in homes, institutions, senior residences, and memory care centers. Volunteers will work in pairs to visit assigned home-bound members with scripted communion service and sacraments. Short training course required.

Servant Profile:

Gifts-*shepherding, counseling, mercy, faith*
 Passion- *elderly, disabled, mobility-impaired.*
 Style- *people orientation.*

Hours:

1-2 hours per month.

Contact:

Communion Chair _____

Position Title**Food-Closet Volunteer**

Requirements:

Willingness to sort donated food on a weekly basis. Monitor stock levels and notify faith community when certain items are needed. May be called upon to purchase key items for food closet.

Servant Profile:

Gifts- *helps, mercy, administration*
 Passion- *homeless, marginalized, seniors, single parents, unemployed/underemployed*
 Style-*program orientation*

Hours:

One day per month. Two hour shift.

Contact:

Food Closet Coordinator _____

Position Title:**Prayer Team**

Requirements:

One hour of group prayer per week in one of the following time slots: Tuesday mornings at 8:30 or Sunday morning at 8, 9:30 and 11:00 at the church; throughout the week on the electronic prayer chain (e-mail or fax). National Day of Prayer/prayer retreat.

Servant Profile:

Gifts-*intercession, mercy, helps, faith, shepherding*
 Passion-*people in need of intercession*
 Style- *people orientation*

Hours:

As available for times listed above.

Contact:

Prayer team coordinator _____

Care System Tier Two- Internal Support

Position Title: Follow-up-call Volunteer

Requirement: Pleasant telephone voice. Willingness to speak to people who have been absent from the faith community. Make follow-up reports for Directors/Pastors.

Servant Profile: *Gifts-administration, helps, mercy, faith, discernment*
Passion-people who are unsure of commitment to church,
people who may have unrevealed needs and concerns.
Style-people-orientation

Hours: 3 hours per month plus report time.

Contact: Pastoral Assistant _____

Position Title: Friendship-Visitation Volunteer

Requirements: Perform once-a-week (or more) visitation for homebound person or elder living in assisted living, memory care, or hospice facility. Must take caregiver training course and have a background check. A car is helpful for errands and short drives, but not required. May be asked to facilitate and/or arrange transportation to church or activities. Attend the volunteer team meeting on first Thursday of the month at 3 PM. Any costs for gifts, cards, and background check, will be assumed by the church.

Servant Profile: *Gifts-mercy, shepherd, encouragement, helps,*
intercession.
Passion-elderly, disabled, or medically institutionalized
individuals.
Style-people-orientation

Hours: Flexible - normally 2-4 hours a week plus monthly meeting.

Contact: Friendship Visitation Volunteer Coordinator _____

Position Title: Grief-Care Coordinator

Requirement: Experience in counseling or in grief/loss seminars. Willingness to work with people who are experiencing all levels of loss. Coordinates program, place of event, food and follow-up for resources and additional counseling. In charge of master calendar

of events for widows/widowers.

Servant Profile: Gifts-*mercy, encouragement, administration, helps, leadership*
 Passion-*working with families who are in grief*
 Style-*people orientation*

Hours: First-Friday-of-the-month dinner and follow-up planning time.

Contact: Pastoral Assistant _____

Position Title: Handyman/Woman Helpers “Movers and Shakers”

Requirements: **Recruitment/database Volunteer-**Twice a year, bulletin announcements and newsletter articles will be submitted for publication with specific volunteer openings and requirements for training, as necessary. This person will be in charge of the database of names and specific areas of expertise and training will be maintained. Because of the physical nature of the work, we ask that volunteers be at least 14 years of age with parental consent required for those under 18.

Each member of each team and the service recipient will be required to sign a liability waiver provided by the faith community/church before the volunteer shift begins

General Handymen/Women- Carpenters, plumbers, electricians, masons, painters or people skilled with home repair work will be asked to work a four-hour shift in a private home with a professional supervisor/foreman in charge. Most of the work will be of a specific nature such as rewiring a home, fixing leaky faucets, putting in a wheelchair ramp, painting, repairing furniture or cabinets, or putting up or taking down a wall.

General Cleaning Volunteers- General cleaning is often needed to avoid eviction, or to meet health and sanitation codes particularly in federal and state-sponsored housing. Frequently, seniors are no longer able to handle the deep cleaning required to keep a home healthy. This team will work in four-hour shifts to assist in kitchens, bathrooms, floors, windows,

doing laundry, and preparing a senior to move to another facility.

Car Mechanics- Certified auto mechanics willing to give their time will be sought for work to be done on their time in their car shop. However, weekend car enthusiasts who change oil and tires and check fluids and who wish to teach others good car maintenance, will also be welcome.

Furniture Movers- The last Saturday of the month will be set aside for moving furniture unless other arrangements can be made. Volunteer teams of four will be available for multiple homes of donated furniture, or one home move on that day. Most of these moving parties are designated for down-sizing and excess furniture will be donated and hauled to a charity of their choice. Single parents who are moving from a domestic violence situation may choose furniture as part of a “fresh start” program and will need to move that furniture from an agency warehouse to their new home.

Administrator/Dispatcher- In charge of all in-take calls and referrals. This person or persons, will gather volunteers for specific dates and times, will handle all liability forms, and will make follow-up calls to the recipient of services.

Servant Profile: *Gifts-helps, creative communication, administration
Passion-disadvantaged, mobility-impaired, disabled, seniors
single parents,
Style-people and/or program orientation*

Hours: Normally 1 four-hour shift per month except for emergencies.

Contact: Chair, Handyman Helpers _____

Position Title: **Health and Wellness Volunteer**

Requirement: Needs to be member of faith community and medical professional i.e. doctor, nurse, physical therapist, occupational therapist, speech therapist, pharmacist, social worker, marriage and family

counselor, psychologist, orthopedic specialist and others. Members will meet monthly to plan out health and wellness programs such as vaccinations, blood pressure checks, health fairs, special seminars.

Servant Profile: Gifts-*encouragement, teaching, mercy, helps, faith.*
 Passion-*Elderly and medical fragile people, mobility impaired persons.*
 Style-*people or program orientation*

Hours: Regular meeting once a month. Weekends as needed for seminars, workshops, vaccination clinics, blood pressure check-ups, and health fairs.

Contact: Parish Nurse _____

Position Title: Home Cooked Meal Volunteers

Requirement: Willingness to provide and deliver a home-cooked meal for a family who has suffered loss, or has an ill member.

Servant Profile: Gifts-*helps, mercy, encouragement*
 Passion-*medically fragile families, cancer patients, children with chronic conditions*
 Style-*people orientation*

Hours: As needed. Generally one meal a month is the average.

Contact: Home Meals Coordinator _____

Position Title: Medical Equipment Volunteer

Requirements: Sort, clean, and inventory donated medical equipment for storage and loan closet. Follow-up on non-returned items.

Servant Profile: Gifts-*administration, helps*
 Passion- *elderly, disabled/mobility impaired, children with prolonged illness*
 Style-*program orientation*

Hours: One three-hour shift per month.

Contact: Friendship Visitation Volunteer Coordinator _____

Position Title: Memorial Coordinator/Volunteers

Requirement: Work as reception volunteers, setting up tables and chairs, setting up and serving food, clean-up.

Servant Profile: Gifts- *helps, administration, hospitality, creative communication.*
 Passion-*assisting the bereaved with hospitality for their guests.*
 Style- *people or program orientation.*

Hours: As needed. Schedule varies, normally Thursdays and Fridays.

Contact: Pastoral Assistant _____

Position Title: Transportation Volunteer

Requirements: Current driver's license and insurance; access to private car that is insured. Volunteer will drive elderly/mobility-impaired people to appointments, doctor's offices, and on general errands.

Servant Profile: Gifts- *helps, administration, mercy.*
 Passion-*elderly, mobility impaired, disabled people.*
 Style- *people orientation.*

Hours: Varies with appointment. Generally two hours per appointment.

Contact: Transportation chair _____

Position Title Van Driver- "Sunday Drivers"

Requirement: CDL license (for larger van), current insurance coverage, background clearance. Volunteer will assist elderly and disabled into and out of van and drive to destination/senior-housing facility.

Servant Profile: Gifts-*helps, administration, mercy.*
 Passion- *elderly, disabled, mobility-impaired people.*
 Style-*people orientation.*

Hours: Worship days ½ hour before and ½ hour after service.

Contact: Transportation Chair _____

Care System Tier Three- Professional

Position Title: Budget/Credit Counselor

Requirements: Training in Money Map Coaching or Financial Peace Seminar for Budget Counselors. Professional work in finances and banking helpful, but not required.

Servant Profile: *Gifts-administration, mercy, encouragement, discernment.*
Passion-people with financial difficulties, people with emotional distress about money.
Style-people orientation.

Hours: Usually 1-2 hours per appointment. Most coaching is once every two weeks for up to six months.

Contact: Pastoral Assistant _____

Care System Tier Four- Community/Government

Position Title: Care and Share Volunteer

Requirements: Must be a licensed driver and have an insured car. Shoppers coordinate menus of food based on seasonable availability of goods. Packers sort and box perishables and staples on the night before delivery. Delivery people take packed boxes and distribute to pre-determined list of disadvantaged families the following morning (Saturday).

Servant Profile: *Gifts-mercy, administration, helps, faith, hospitality, discernment*
Passion-under/unemployed, seniors, single parents, disabled.
mobility-impaired people, emotionally and mentally ill.
Style-people orientation (delivery), program orientation (shoppers/packers).

Hours: Shoppers- 2-3 hours on third Friday of the month.
Packers-1-2 hours on third Friday of the month.
Delivery People- 2 hours on third Saturday of the month.

Contact: Care and Share Coordinator _____

Position Title: Job and Career Mentor

Requirement: Business experience in human resources work a plus, but not required. Must attend a training course and apprentice for three weeks with another mentor. Communication skills in resume building and interviewing.

Servant Profile: *Gifts-discernment, helps, administration, shepherding, mercy, teaching, encouragement.*
Passion-people in need of career change or unemployed,
Style-people orientation.

Hours: Mondays, 8-10 AM, plus group meetings and training times.

Contact: Job/Career Ministries Coordinator _____

Position Title: Manna Ministry Volunteer

Requirements: Provide transportation of donations from local bakeries, supermarkets, and specialty cafés to church; sort donated bread products and perishables; redistribute goods to local agencies and food banks serving the poor and marginalized. Licensed driver and insured car required.

Servant Profile: *Gifts-helps, administration, hospitality, mercy.*
Passion-elderly, single parents, unemployed, marginalized peoples.
Style-people and program orientation.

Hours: Hours available seven days a week. Most shifts are two-hour pick-up and drop-off.

Contact: Chair, Manna Ministry _____

Appendix 4

Sample Volunteer-Training Outlines

Friendship Visitation Volunteer

- I Purpose of the Ministry-to serve the homebound member with the hands and feet of Christ

- II Liability and Legal Matters
 - Application and background check procedures
 - Initial training
 - Contacts and family members-overview of homebound member grid
 - Safety and emergency situations
 - What is not permitted

- III Who Do We Serve
 - Data base information-history and background on member
 - Basic areas of need-dementia and memory loss, immobility, loneliness, depression, lack of family support, loss of purpose.

- IV How Do We Serve
 - Weekly visits
 - Reports to database
 - Case studies and monthly meetings- additional training

- V Anatomy of a Visit-Home or Hospital
 - Blocking out time
 - Calling ahead
 - Preparing your heart and mind- what to bring
 - Entering the a room
 - The value of presence
 - Interruptions and silence
 - Short excursions and errands
 - Knowing when to leave
 - Homework and details for next visit

- VI Special Circumstances
 - When to call the church
 - When to call the family
 - When to call the hospital/911
 - When to call Adult Protective Services

- VII Additional Questions

Sample Volunteer-Training Outlines

Communion Server

- I Purpose of the Ministry-to bring the worship service and communion to the home-bound member.

- II Liability and Legal Matters
 - Gain permission to enter home or facility
 - Assistance matters-transfer, comfort
 - Value of second person, guest in home
 - Safety and Emergency procedures
 - What is not permitted- any handling of bodily fluids

- III Common issues to remember with visit
 - Time allotted
 - Flexibility- asleep or not asleep, supervised or non-supervised
 - Rules of the house- what is common practice for anti-bacterial hygiene?
 - Hint: Take your own bottle of Purel on every visit.

- IV What to Bring
 - Your time
 - Communion kits
 - Worship bulletin/ CD of service
 - Any seasonal gift (Easter, Christmas, Thanksgiving)

- V Anatomy of a Visit
 - Blocking out time
 - Calling ahead
 - Preparing your heart and mind
 - Entering the a room
 - The value of presence
 - Interruptions and silence
 - The program
 - Song, Apostles' Creed, invitation to the table, prayer of thanksgiving, words of institution, distribution of elements, closing prayer and The Lord's Prayer, benediction.
 - Knowing when to leave
 - Submitting notes to office regarding visit and returning communion kits.

- VI Additional Questions.

Appendix 5

Sample Seminar Outlines

Last Things We Talk About- Two Sessions Week One

Speaker One-Senior Pastor

- I What Does the Bible Say About Heaven?

- II Planning the Memorial
 What is the purpose? Who is involved?
 Scripture
 Music
 Obituary
 Eulogy-who will provide?
 Speakers
 Special music/pictures
 Memorabilia
 Reception- time/details.
 Plan now and set aside.

Speaker Two- Associate Pastor or Director for Senior Ministries

- III Notes from the field
 How do we communicate our wishes to the family?
 Your wishes vs. the family's wishes
 Financial/Estate concerns/Costs
 Blended family concerns
 Putting your house in order-organization

- IV Working with a mortuary/cemetery
 Cremation/ casket burial
 Dying out of state/in a foreign place.
 Interment/internment
 Pre-arranged plans

Last Things We Talk About p. 2**Week Two**

Speaker One- Licensed Clinical Social Worker

- I Advance Directive/ POLST-physician signed
Filling out the forms/where to file
Organ Donation
Working with Doctors/Nurses
- II Living Will- Five Wishes

Speaker Two- Estate Attorney/Elder Law

- III Things to consider at time of death-legal and practical
- IV Wills and Trusts
 - Estate Taxes and Final Returns
 - Endowments/Gifts
 - Deductions/Costs of Burial
 - Where to File Information

Sample Seminar Outlines

Care Giving Basics

- I What is Caregiving?
- II Who is the identified patient? What is their history of activity/achievement?
- III Taking care of the caregiver. When does a spouse cross the line into a care-giving role? The emotional rollercoaster.
- IV Lifestyle changes, social situations, hospitality for visitors
- V Setting the schedule of the day-routine vs. special events.
- VI The Basics
 - a. Transfer for chairs, shower, and car.
 - b. ADL- assisted daily living tasks (feeding, toileting, dressing, bathing, and transferring etc).
 - c. IADLS- instrumental activities of daily living (shopping, handling finances, preparing meals etc).
 - d. Appetite
 - e. Exercise
 - f. Activities
 - g. Transportation-adaptation?
- VII Where do I look for help?
 - a. Agencies and brokers
 - b. Hourly wage/ private pay vs. agency hired
 - c. What are the questions to ask?
 - d. Costs/ affordability
 - e. Legal matters-hiring and firing-eligibility.
 - f. Family members-availability?
 - g. What is covered by Medicare/Medigap programs?
 - h. What is covered by special insurance-/long term care?
- VIII “Asking for help is a sign of strength”
Taking respites- Lifespan Respite Agency.
- IX Finding a support system for the caregiver- no translation required.
- X When to make the transition from home to a facility?
- XI Hospice/palliative care vs. curative care.
- XII Questions?

Sample Seminar Outlines

Pre-Retirement Seminar

- I Introduction

- II What the Bible says about retirement (hint: very little)

- III Inventory
 - A. Highlights in your life

 - B. Mistakes/ lowlights

 - C. Where were the greatest lessons learned?

 - D. If you had to do it over again, what would you change?

 - E. Who are/were your heroes? Mentors?

- IV What is Your Passion in Life (where or who you would serve if there were no obstacles).

- V Mapping Out Goals After Retirement
 - A. Spiritual Growth

 - B. Family Commitments

- C. Health- Medicare/Medigap/Medicare Advantage planning
- D. Travel
- E. Professional Work
- F. Volunteering
- G. New Things/Training/Education
- H. Time Management- How would I structure my time differently?
- I. Financial/ Pensions/Gifting
- J. Investment of Time and Resources
- K. Missions/Partnerships

VI What's the Timeline? How/When will this be accomplished? Are there any restrictions or concerns that would get in the way of your goals?

VII Other Dreams?

VIII What is your final legacy? What do you want people to know about you? What is your final word?

Appendix 6

Additional Resources for Senior Adult Ministries

AARP- American Association of Retired Persons: www.aarp.com
601 E. Street, Washington, DC 20049 (888)687-2277

AARP is a non-profit organization dedicated to enhancing the quality of life for all as well as those over 50 years of age. Included in their services are two publications. The bi-monthly AARP Magazine and the AARP Bulletin offer insight on a variety of subjects including insurance, travel benefits, volunteering, advocacy, financial services, discounts, health products and services, and programs and events. In addition they have compiled statistics and reports on timely subjects such as health care reform, financial scams, mental health, and public policy.

CASA-Christian Association Serving Adult Ministries: www.gocasa.org
13646 NE 24th Street, Bellevue, Washington, 98005 (888) 200-8552 (425) 460-3709

CASA is a network of pastors, directors, and volunteers dedicated to serving the senior adult in churches and faith communities. Their website features resources, church and ministry trends, news, advocacy, and an online partnership directory. The staff is also available for consultation regarding a specific church's needs. The online Adult Ministries Resource Center has valuable articles, free downloads and useful resources for review. In addition, CASA also has an E-newsletter and yearly international leadership conferences.

Center for Bio-ethics and Culture <http://www.cbc-network.org/about/>
130 Market Place, San Ramon, Ca. 94583 -no phone listed.

CBC is about shedding light on the bioethics issues within our culture that most profoundly affect our humanity—especially among the most vulnerable. The CBC exists to accomplish the following: collaborate in providing resources and a public forum; educate the culture about the impact of biotechnologies; engage in dialogue about what it means to be human; challenge those who influence our culture to use science that is grounded in moral responsibility. Excellent articles are available regarding recent trends in legislation, health-care reform, and organ donation.

U.S. Administration on Aging: <http://www.aoa.gov>; aoainfo@aoa.hhs.gov
One Massachusetts Avenue, Washington, DC. 20001 (202) 401-4634, (800) 677-1116.

US Administration on Aging is a national network of federal and state agencies that assist the senior adult over the age of 62. Resources include emergency preparedness, aging statistics, health, prevention and wellness programs, advocacy for elder rights protection, and community based long-term care. Their website features a special state/federal office finder for local agency offices.

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