PROVIDENCE MANOR IS A PLACE TO AGE IN PLACE, OR IS IT?

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ABSTRACT

PROVIDENCE MANOR IS A PLACE TO AGE IN PLACE, OR IS IT?

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This project asks the question: Is Providence Manor a place to age in place? The notion of Aging in Place is essential for Providence Manor residents to remain in their apartments as they advance in the aging process. The U.S. Department of Housing and Urban Development (hereafter referred to as HUD) has defined Aging in Place as,

> The 202 program allows seniors to age in place and avoid unnecessary, unwanted, and costly institutionalization. With 38% of existing Section 202 tenants being frail or near-frail, requiring assistance with basic activities of daily living, and thus being at high risk of institutionalization, Section 202 residents have access to community-based services and support to keep living independently and age in place in their community. [1]

Providence Manor consists of forty-six one-bedroom units with a kitchen and living room. There are forty-six predominately African-American residents of various religious faiths whose ages range from sixty-two to ninety-two. Their median income is roughly $1100.00 a month from Social Security and SSI from which about 30% of the income goes to cover monthly rent. This Doctor of Ministry project uses qualitative research methods in order to gather data by means of informational interviews and directed interactions with the three stakeholders who are responsible for the wellbeing of these residents (myself and two others). Our goal was to take the HUD Mission

[1] Linda Couch, "Section 202: Supportive Housing for the Elderly," *2021 Advocates Guide – LeadingAge,* 2021, accessed July 5, 2024, https://nlihc.org/sites/default/files/AG-2021/04-13_Section-202.pdf.

statement, rendered above, and from it to craft a viable Vision statement to better enable our residents to overcome various barriers preventing aging in place and to identify the available resources so the residents can continue to live at Providence Manor for the foreseeable future. Part of the research involved exploring federal, state, and local government websites which helped to both define and speak to this issue.

This project has six chapters.

The Introduction presents us with the overarching narrative of "Miss B."

1. The Trauma of fear - the Root of fear, in chapter one, is the catalyst for the doubt some the residents have about aging in place. The history of the 1906 Atlanta Riots that caused many of their parents and grandparents to lose their homes, business and in some cases their lives helped to usher fear and doubt that lingers in their memories. Gentrification after the construction of the I - 75/85 interstate system and the Atlanta Beltline were a reminder that the fear of losing their homes could happen and so when they have to leave their apartment for health reasons, they fear they will lose it.
2. The original vision for Providence Manor and the realty of the structure provided the purpose and mission of Providence Manor, itself, as an affordable place to live and to age in place is highlighted in the second chapter, Meeting the fear.
3. Barriers affecting quality health care in chapter three – Care Issues – Dealing with the fear, is another issue that weighs heavily on the residents because they fear that voter suppression and the closing of trauma hospitals is another impediment to their ability to age in place.

4. Chapter four presents the project context (Understanding the fear) and introduces us to the stakeholders who will be the heart of the project. We also find a description of the overall project design along with Theological and Scriptural underpinnings.
5. Chapter five, Project Parameters – Calming the fear deals with various elements for the project and how it will come together as a plan of action.
6. Chapter six – Quelling the fear in conclusion we deal with a faith-based approach that is coming to the fore in Atlanta and may aid the full implementation of this - project. We also bring "Miss B's" narrative to a culmination.

DEDICATION

I dedicate this project to all the seniors who carry the fear of losing their apartments because of the aging process.

I want thank Dr. Daniel Kroger for the time and effort to help me with this project. He truly has a passion for what he does and it showed as he assisted me with this project.

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Dr. Riggins Earl, Professor ITC Atlanta, GA

Dr. Arthur Pressley, Advisor

Rev. Dr. Gerald Durley, Professional Advisor

Dr. Pat Weikart, Peer Advisor

My children, who reminded me of their love for me.

My Mother, Mrs. Margaret Butler

The Board, Management, Staff and Residents at Providence Manor

ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services
EHR	Electronic Health Record
FFS	Fee For Service
HMO	Health Maintenance Organization
HUD	The Department of Housing and Urban Development
LTSS	Long Term Services and Supports
MARTA	Metropolitan Atlanta Rapid Transit Authority
PRAC	Project Rental Assistance Contract
PQRS	Physician Quality Reporting System
SSI	Supplemental Security Income

GLOSSARY

202 PRAC	Project Rental Assistance Contract A project rental assistance contract, or PRAC, is an agreement between the Department of Housing and Urban Development and the owner of a property operating under HUD's Section 202 program for the elderly. This contract enables the owner to receive project rental assistance funds, which make up the difference between a community's approved operating costs and rents received from the property's residents. These agreements typically span three years and may be renewed depending on the availability of funding.
202/8 Section 8	is generally the name for HUD-subsidized housing programs. In Section 8, residents benefit from rents that allow them to usually pay 30% of their monthly adjusted income as rent, while HUD pays the difference between what a unit rents for on the open market (the contract rent) and what the resident can afford to pay (the tenant rent). These differences are paid to the landlord through a Housing Assistance Payment (HAP).
Age in Place	Seniors being frail or near-frail, requiring assistance with basic activities of daily living, Aging in place means a person making a conscious decision to stay in the inhabitation of their choice for as long as they can with the comforts that are important to them. As they age these may include adding supplementary services to facilitate their living conditions and maintain their quality of life.
Baby Boomers	those born between 1955 and 1964
The BeltLine	Twenty-two miles of historic rail segments that encircle Atlanta's urban core connects many of southwest Atlanta's neighborhoods including our Capital View, Capital View Manor, and Adair Park neighbors. With Sylvan Hills proximity to these neighborhoods and the Murphy Crossing node planned for the Murphy Avenue and Sylvan Rod intersection, Sylvan Hills cannot help but feel the positive impact of this transformative multi-modal transportation project. And the Ft. McPherson and Oakland City Marta stations give Sylvan Hills convenient connection points to the BeltLine and the new network of parks, residences, and business development around the city.
Homemaker\Home Health Aide	is a trained person who can come to a Veteran's home and

	help the Veteran take care of themselves and their daily activities.
HUD	The US Department of Housing and Urban Development
MARTA	The Metropolitan Atlanta Rapid Transit Authority,
MARTA Mobility	Is our paratransit service available to anyone unable to ride or disembark from our regular MARTA transit services.
SSI	Supplemental Security Income (SSI) SSI provides monthly payments to people with disabilities and older adults who have little or no income or resources.

INTRODUCTION – OVERHEARING STORIES OF THE FEAR

Over the course of my time spent in the affordable housing community[1] I have had many interactions with the residents. One of the residents with whom I have become acquainted is Miss B.[2] to say that Miss B is a very strong minded and determined person is an understatement; she will tell you like it is without any hesitation whatsoever. She moved to Providence Manor two years before I arrived as Compliance Manager.

Over the years, her mobility has started to decline and as a result she fell in her kitchen and in the process, broke her thighbone. She was rushed to Emory midtown hospital in order to determine the extent of her injury as well as to possibly undergo the procedure to set the bone. From Emory midtown she was transported to Emory Dunwoody where they actually did set the broken bone and, after a week of recovery, doctors recommended that she be sent to a rehab facility to fully recover from so she could return to her apartment. However, in the meantime, a family member made the decision to have her sent to a nursing rehab facility, which was a thirty-minute drive from her apartment which made it difficult for members of her apartment community to visit her. Needless to say, she found herself alone in an environment with which she was not familiar.

To Miss B's dismay, her stay stretched longer than she expected and as a result of the extended stay, her insurance coverage ended and the cost for her stay at the facility became her own responsibility which caused a rift between her and her relative. The rift

[1] The affordable housing community are apartments are construction funded and regulated by The Housing and Urban Development (HUD).

[2] Miss B is the name I have given to the resident to protect her true identity.

ended when Miss B asked her friend and trusted neighbor to handle her financial affairs until she returned home. This meant that she wanted her neighbor to pay her rent so she would not lose her apartment while at the same time paying for her stay at the rehab center. While this was going on, her relative made repeated attempts to end her apartment lease, but the relative did not know Miss B was still paying for the apartment. Because of all that happened, Miss B sent a request by that same neighbor who then asked me not to give her apartment away.

After Miss B's insurance lapsed, treatment to make it possible for her to return home diminished leaving her languishing in her bed. On many occasions Miss B made it known that she wanted to go home but the social worker told her and her neighbor that her apartment needed to be made ready before she could return home. Her neighbor was told that it was his responsibility to make the apartment ready with all the equipment and services required for her return to her apartment, before they would release her.

Miss B's situation is not a unique one. Many African Americans, especially those who are income challenged, who live in Housing and Urban Development (HUD) affordable housing communities experience the same fear of losing their apartments because of various health conditions. The first time I heard the plea to "not give my apartment away," was when I was the Site Manager at Friendship Tower Apartments. A resident suffering with terminal cancer and had to be moved into Hospice care. The last request the resident made to me was: "Mr. Hunter please don't give my apartment away." I knew since the resident required Hospice care and the illness was terminal, the resident was not coming back. That request was not the last time I would hear it. My interaction

with some of the residents also educated me about the profound depth of the fear they had about losing their home.

That fear is in the DNA of African Americans because it dates back to when they were kidnapped from their native homes and brought to this country as slaves who had no rights and were reduced to the status of mere property. As slaves, they experienced forced separation from their mothers and fathers and were sold as property to another slave owners for breeding purposes and mostly to work the plantations.

I was keenly aware of this particular DNA and the fear I mentioned above, that coursed not only through my blood, but more germanely, through the blood of the residents under my care. As a result, I began to have a notion both of concern for them as well as an opportunity to find a way to help quell that fear. I wanted to provide a way forward and began to consider a possible preferred future for them that became the purpose for this doctoral project.

Linda Couch is the Vice President for Housing Policy at *LeadingAge* which is a community of nonprofit aging service providers serving older adults; a kind of "think tank." The Mission for *LeadingAge* is succinct: "The Trusted Voice for Aging." Their Vision is just as brief: "An America that Values Older Adults and Those Who Serve Them." I quote both of these because they can serve as a model for what I propose to do in this project.[3] Later in this paper we will attempt to summarize the intricacies of US Housing Legislation, but here, suffice it to say that we shall take a look at the FEAR facing aging residents about the potential loss of their homes and their desire to "age in

[3] "Mission and Vision for LeadingAge," *LeadingAge.org*, accessed July 5, 2024, https://leadingage.org/about-us/

place." Ms. Couch has distilled Section 202 of the Housing act of 1959, specifically what is known by the acronym: PRAC: Project Rental Assistance Contract into what is in effect its purpose and could be taken as its "mission statement:"

> The 202 program allows seniors to age in place and avoid unnecessary, unwanted, and costly institutionalization. With 38% of existing Section 202 tenants being frail or near-frail, requiring assistance with basic activities of daily living, and thus being at high risk of institutionalization, Section 202 residents have access to community- based services and support to keep living independently and age in place in their community." [4]

I hope to take this mission and, in collaboration with on-site professional stakeholders at Providence Manor, create a vision statement that might better enable our residents to age in place with diminished fear of losing their homes.

This project will also continue to track the saga of Miss B as she fights to overcome the fear of losing her apartment while recovering from surgery and the unplanned confinement in a rehab/nursing home. Chapter One: the Trauma of FEAR: the Root of FEAR deals with background history regarding the DNA of fear mentioned above. Chapter Two: Meeting the FEAR deals with the History of Affordable Housing at the Department of Housing and Urban Development (HUD), specifically the Housing Act of 1959, Section 202 and the PRAC introduced above. Chapter Three: Dealing with the FEAR introduces us to a reference in popular culture and its implications. Chapter Four: Understanding the FEAR describes the Project Context. Chapter Five: Calming the FEAR deals with Project Implementation and Evaluation tools. Chapter Six: Conclusion -

[4] Linda Couch, "Section 202: Supportive Housing for the Elderly," *2021 Advocates Guide – LeadingAge*, 2021, accessed July 5, 2024, https://nlihc.org/sites/default/files/AG-2021/04-13_Section-202.pdf.

Quelling the FEAR deals with possible project aftermaths and the culmination of Miss B's story.

CHAPTER ONE

THE TRAUMA OF FEAR – THE ROOT OF FEAR

The story of Miss B which I recounted in the Introduction occurred during my time as the Property Manager at Friendship Towers, I am now the Compliance Manager of subsidized housing developments for senior citizens. My project's goal is to propose a way for senior citizens to live until they transition from this life with their dignity intact in their cherished homes; this is what *aging in place* means to me. [1]

As a result of my connections with various individuals in the senior community, who are predominantly Black, some have shared their stories of systematic abuses they have endured whether it was at the Federal, State, or Local level where they, their parents and grandparents resided. The abuses stemmed from denial of necessary services such as decent, safe, and sanitary living conditions, clean running water, to physical and sexual abuse and being denied the right to vote.

Their stories were very hard for me to hear and to accept. In some instances, the stories left me with a very bitter spirit. So much so that documentaries or movies depicting slavery and Black life continue to be horrendous to me. It caused me to turn away from watching or reading about the events. The abuse and death they suffered at the hands of their oppressors during the 1906 Race Riots was extremely hard for me to research, but I had to summon the courage to read two accounts of the event in order to better understand why the tenants harbored the fear of losing their homes along with the opportunity to live independently.

[1] Taylor Shuman and Scott Witt, "Aging in Place," *Seniorliving.org*, accessed June 3, 2024, https://www.seniorliving.org/aging-in-place/.

1906 ATLANTA RACE RIOTS

Hearing the stories of the 1906 Atlanta Race Riots served as the beginning of my understanding of why the former homeowners and apartment dwellers of Friendship Towers and Providence Manor considered finding a place to call home to live independently and to *age in place* was so significant to them. Gary M. Pomerantz in his book *Where Peachtree Meets Sweet Auburn, The Saga of Two Families And the Making of Atlanta* wrote about the horrific detail of the riots and the scars it left behind. He writes, "Over time, memories in Atlanta would prove segregated, too. The unspeakable horror of the 1906 riot lurked in the recesses of Black families in Atlanta for generations."[2]

To summarize the devastating effects of the 1906 Atlanta Race Riots would be like trying to sell an expensive automobile with no car body and tires as a luxury automobile. The Riots were the result of two white politicians who were vying for the office of Governor. They had exploited the issue of Black people gaining political power and wealth as a result of being successful businesses owners and enjoying home ownership as threats to white privilege. Their success had allowed them to live independently. Rather than share the details of this horrible time here, I refer the reader to Appendix I in this paper for more details and further reading. The account comes from an article found in The New Georgia Encyclopedia and the account is quite disturbing.

The trauma of the brutal acts perpetrated on Black people during the 1906 riots left a searing and indelible place in the memories of the Black community, but that did

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[2] Gary M. Pomerantz, *Where Peachtree Meets Sweet Auburn, The Saga of Two Families and the Making of Atlanta* (New York, NY: Penguin Books, 1997), 76.

not stop them from rebuilding what had been destroyed. However, the Interstate Highway construction project through Atlanta brought the fears that were once buried back to the surface. The loss of homes and the freedom to choose where to live were again taken away from the Black community because the interstate system divided the city of Atlanta into east and west. The division created another threat to losing the places they call home, their community, as well as their independence.

GENTRIFICATION OF COMMUNITIES

Some of the residents of Providence Manor and Friendship Towers who wished to rent apartments were from the surrounding neighborhoods of Capital View, Capital View Manor, and Adair Park along with The West End, Oakland City, and the Old Fourth Ward, where I now reside (the former home of Martin Luther King Jr.), as well as Peoplestown, Summer hill, Mechanicsville, Hunter Hill, and Washington Park communities in Southwest Atlanta. The construction of the I-75/85 interstate in the late 1950s is another example of agency being taken from those who lost their homes and independence. The event is so deeply seated in them because it was the beginning of gentrification, another challengingly horrific event that induce fear in the in the lives of the tenants. "Southwest Atlanta is the area between I-75 and I-20 along with the neighborhoods West of Grant Park. West End is the fastest gentrifying (area) in the Southwest, with both the affluent Cascade Heights district and downtown putting pressure on this area."[3]

[3] "Gentrification of Atlanta," *Wikipedia*, accessed July 5, 2024, https://en.wikipedia.org/wiki/Gentrification_of_Atlanta.

> Gentrification is defined as the process whereby the character of a poor urban area is changed by wealthier people moving in, improving housing, and attracting new businesses, typically displacing current inhabitants in the process.[4]

> It is also "the process of more affluent people and businesses moving into historically less affluent neighborhoods. While some urban planning professionals say the effects of gentrification are purely beneficial, others argue that it often results in harmful social consequences, such as racial displacement and loss of cultural diversity".[5]

Local construction of the Interstate system not only divided the city in two, but it also divided families and communities because it took homes either by eminent domain or high property taxes forcing the sale of their homes for less than their valuation.

Larry Keating, a professor of city and regional planning at Georgia Tech Research Institute, provided some insight into the devastating impact of gentrification. According to Professor Keating, "the project was designed to also create a buffer between the low-income Black neighborhoods and the central business district in one of many attempts to keep Atlanta's downtown a desirable location for middle-class white people by expelling Black residents from the area."[6]

> "Peoplestown's residents are all too familiar with the unjust patterns of urban development. When city officials wanted to link downtown Atlanta to the expanding white suburbs in the 1950s, three major interstates were constructed in Peoplestown, Summerhill and Mechanicsville, ripping through the heart of these long-established communities and separating the sister neighborhoods from each other.
>
> In 1957, the city conceived of another urban renewal plan and bought up about 600 acres of land in portions of Summerhill, Mechanicsville, and Peoplestown,

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[4] *Oxford English Dictionary*,, s.v. "Gentrification," accessed July 06, 2024 https://www.oed.com/search/advanced/Entries?textTermText0=gentrification&textTermOpt0=WordPhrase&dateOfUseFirstUse=false&page=1&sortOption=Frequency.

[5] Robert Longley, "Gentrification: Why It Is a Problem?," *ThoughtCo.*, April 23, 2021, accessed June 4, 2024, https://www.thoughtco.com/gentrification-why-is-it-a-problem-5112456.

[6] Jaclynn Ashly,"The Black Residents Fighting Atlanta to Stay in Their Homes,"*Aljazeera*, accessed July 6, 2024, https://www.aljazeera.com/features/2020/11/30/atlanta-gentrification.

> removing thousands of Black residents and closing more than 100 Black-owned businesses in order to make room for housing, businesses, schools, and parks that would attract middle-income – largely white – families."[7]

Another form of gentrification came about as a result of a twenty-two-mile bike and walking trail called *The Atlanta BeltLine*. "It was celebrated as the lift the city needed because of the declining tax base, abandoned homes and apartment complexes in ill repair. It also helped to increase the tax base and to revitalize the inner city."[8] The *BeltLine* was supposed to undo the harm caused by the divide created by the 75/85 Interstate construction. The existence of *The Atlanta Beltline* was not intended to harm the Black communities, particularly the elderly but the project had a devastating effect on the Capital View, Capital View Manor, and Adair Park along with The West End, Oakland City, and the Old Fourth Ward.[9] Gentrification under the name of *The Atlanta*

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[7] Ashly, "Black residents fighting Atlanta."

[8] "Atlanta Beltline," *2030 Strategic Implementation Plan FINAL REPORT*, accessed July 6, 2024, https://beltline.org/wp-content/uploads/2019/03/Beltline_Implementation-Plan_web.pdf. "It was an initiative that started with one graduate student's innovative vision, is coming to life. It is one of America's most ambitious urban transportation and redevelopment programs and is at its core a testament to public, private and community partnership. Grassroots advocates, business, civic, political and community leaders are driving the Atlanta BeltLine's implementation with their ideas and aspirations, inspired by a once-in-a-generation opportunity to renew our city and create a national model of healthier, more sustainable, interconnected neighborhoods with greater mobility and economic opportunity for all. Over the past several decades, cities have attempted to attract outside investment to transform urban neglect and decay into development and renewal by luring wealthier and predominantly white people to return to the inner cities in order to increase the city's tax base – especially in the form of sales and property taxes, which are major sources of revenue for local governments.

[9] Ashly, "Black residents fighting Atlanta." The BeltLine's 22 miles of historic rail segments that encircle Atlanta's urban core connects many of southwest Atlanta's neighborhoods including our Capital View, Capital View Manor, and Adair Park neighbors. With Sylvan Hills' proximity to these neighborhoods and the Murphy Crossing node planned for the Murphy Avenue and Sylvan Rod intersection, Sylvan Hills cannot help but feel the positive impact of this transformative multi-modal transportation project. And the Ft. McPherson and Oakland City Marta stations give Sylvan Hills convenient connection points to the BeltLine and the new network of parks, residences, and business development around the city."

BeltLine initiated opportunities for those seeking to take advantage of families and the elderly who were disadvantaged by the project. Homes considered inherited property as well as homes owned by those in their senior years of life on a fixed income found they were not able to maintain their homes up to the city code. In some cases, seniors were not able to keep up with the increased tax assessment and fell victim to delinquent taxes along with homes in need of repairs that led, once again, to foreclosure or residents being forced to sell their homes at less than market value.

In the article "Nowhere for people to go: who will survive the gentrification of Atlanta?" James Lartey wrote:

> Atlanta is also a special case in the history of housing in the US. It was the first city to develop public housing in 1936 and the first, early this century, to close it down completely, leaving all its housing subject to the invisible hand of market forces. Now, with rampant property speculation in black working-class areas, longtime residents are being priced out – and advocates say the racial dynamics are unsettling.[10]

One such study seems to confirm Mr. Lartey's assessment of Atlanta:

> A study says Atlanta is one of the nation's fastest gentrifying cities – the fourth fastest, in fact – which won't come as a surprise to anyone who lives here. All you have to do is walk the Beltline to see how areas from the Old Fourth Ward to the West End have been transformed by chic restaurants, boutique shops and high-end housing developments. It's a longstanding concern in the city, particularly in historically black communities where longtime residents have been displaced from their homes. Mayor Keisha Lance Bottoms' affordable housing plan, released last month, notes that "low-income residents of color and others" are at risk of "involuntary displacement from neighborhoods facing gentrification pressures.[11]

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[10]James Lartey, "Nowhere for People to Go: Who Will Survive the Gentrification of Atlanta?," *The Guardian (U.S.)*, October 23, 2018, accessed July 4, 2024, https://www.theguardian.com/cities/2018/oct/23/nowhere-for-people-to-go-who-will-survive-the-gentrification-of-atlanta.

[11]Jonathan Raymond, "Atlanta Is Rapidly Gentrifying. Here's Where.," *11 Alive*, accessed June 3, 2024, https://www.11alive.com/article/news/atlanta-is-rapidly-gentrifying-heres-where/85-2fee7faa-212d-4960-9c4e-5b4b95a7181f.

The Black community was not the only community impacted by gentrification. The Lindberg section of Atlanta, even though it is not a part of downtown, is located at the beginning of Buckhead and was the home of a Hispanics community. They lived in the area and shopped at the shopping center along Piedmont Road and Sydney Marcus Boulevard.

Cub Food store anchored the shopping center providing the community with quality low-cost foods and household items. The store, because of its low prices, brought other shoppers from all over Atlanta to take advantage of the low prices as well as the quality of the foods. However, Cub Food's closing in 2000 started the gentrification of the mostly Hispanic population in that area giving way for the planned MARTA (See Definitions: Metropolitan Atlanta Rapid Transit Authority) and BellSouth collaboration to build a new live and work community in that area:

> In the late 1990s, planning began between MARTA, the City, developers, and BellSouth to build a town center for the neighborhood in the area surrounding the MARTA station and renovate Lindbergh Plaza shopping mall. [12]

Black people, Hispanics, and other People of Color, particularly, those sixty-two and older have, at times, found themselves searching for a new place to call home. However, in today's market the cost to rent an apartment or house is out of the reach of most Black families and other People of Color.

The latest cost to rent in Atlanta is as follows:[13]

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[12] "Lindbergh, Atlanta," *Wikipedia*, accessed July 6, 2024, https://en.wikipedia.org/wiki/Lindbergh,_Atlanta.

[13] "Atlanta, GA Rental Market Trends," *Apartment List*, accessed July 6, 2024, https://www.apartmentlist.com/rent-report/ga/atlanta.

The average rent for an Atlanta studio apartment is $1,629 per month.

The average rent for an Atlanta 1-bedroom apartment is $1,862.

The average rent for an Atlanta 2-bedroom apartment is $2,431.

The average rent for an Atlanta 3-bedroom apartment is $2,882.

These rents are beyond the income of most seniors who are Black and other People of Color. Unfortunately, due to the lack of affordable housing in the inner city of Atlanta, it has become a place where low-income people cannot afford to live. Seniors are especially at risk because of the lack of convenient of transportation to the medical facilities and resources that are located in the inner city.

THE BARRIERS TO QUALITY HEALTHCARE

VOTER SUPPRESSION

Another attempt to take agency from seniors is through voter suppression enacted by voter restriction laws introduced after the 2020 election. The laws and voter suppression continued to stoke the fears of seniors due to efforts to repress their ability to participate in the Democratic process. When there is no one representing them then Blacks and other People of Color tend to become inaudible and invisible. The effort to make a certain voting group invisible and inaudible, and seemingly dispensable brings to mind James Cone, the author of Black Theology and his thoughts on the "in his works how traditional theology ignores the black experience and makes blacks invisible and inaudible."[14]

[14] Stephen B. Bevans, *Models of Contextual Theology* (Ossining, NY: Orbis Books, 2004), 9.

Voter Suppression and voter restriction was an attempt to hinder seniors from having representation on the state and federal level to advance their interests. The seniors living in 202/8 and 202 PRAC complexes cannot survive without their social security benefits, Medicare, rent subsidies and food stamps. If these benefits were eliminated or reduced, living conditions and medical services will be less than adequate for them to *age in place* not to mention having the ability to just stay in their apartments. They fear that if voting restriction and voter suppression are implemented no one will be there to advocate for them to fight for their funding needs. Their needs can best be described as need for care, with regard to both housing and health.

Since the 2020 general election, voter suppression, the gerrymandering of voting districts, and voter subversion in states like Georgia, and in particular, Fulton County has started the process of limiting and in some cases eliminating the voting privileges of People of Color, Black people, Women, and young first-time voters. These initiatives have begun by those who see a way to usurp the will of a certain voting group by turning the voters into an invisible and inaudible voting population. Fulton County was the focus of voter fraud allegations as a result of the 2020 Democratic sweep of the Senate and of Presidential election. These allegations led to a call for an audit and a recount of the votes in hopes of confirming that fraud had been committed. It was alleged that if it were not for the fraudulent vote in the state of Georgia and the alleged illegal votes from Fulton County, the other candidate would have won a second term as President.

Hence, the reason for the numerous voter restriction laws. These restrictive voting laws are intended to undermine the electoral process in the other states the other candidate lost, as well. The restriction on voting includes new barriers limiting

application for mail ballots and prohibiting sending unsolicited mail ballots or ballot applications. Restrictions on returning mail ballots, with limitations on who can vote by mail and new reasons for rejecting mail ballots were also implemented. In addition, stricter voter ID will make it difficult for voters with disabilities to cast a ballot. There was a bill introduced to erase the requirements to educate elderly voters on how and where to vote**.** These impediments to voting are designed to limit voter participation by the People of Color, Black people, women, and college age voters fit Cone's description of the invisible and inaudible.[15] If this is the case, then, by extension, how can care and affordable housing exist in the context of invisible and inaudible people?

HOSPITAL CLOSURE

The best example of health disparity/health inequity and the result of no representation on the state level was when the Governor of Georgia, Brian Kemp boasted of a six-billion-dollar surplus during the 2022 campaign for his re-election. His opponent pointed out that over the last ten years eight hospitals in rural Georgia and two hospitals in metro Atlanta closed.[16] Six of the ten were under his watch. The Atlanta Medical Center, known as WellStar, was one of two Trauma Unit to close in Atlanta and the other hospital to close was WellStar in the city of East Point.[17] The only Trauma Unit left in Atlanta is Grady Hospital.

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[15] Ibid.

[16] Andy Miller, "A Rural Georgia Community Reels After Its Hospital Closes," *KFF Health News*, accessed June 3, 2024, https://kffhealthnews.org/news/article/rural-hospital-closures-georgia/.

[17] Ibid.

Health care experts and their studies say Medicaid expansion helps keep hospitals afloat because it increases the number of adults with low incomes who have health insurance. None of the eight states with the most rural hospital closures since 2014, when Medicaid expansion was first implemented through the Affordable Care Act, had chosen to expand the insurance program by the start of 2021. In several of those states, including Georgia, Republican-led governments have said such a step would be too costly.

> "Georgia's inaction on Medicaid expansion hurt us probably more than anybody else," said Cuthbert Mayor Steve Whatley, a Republican who lost his reelection bid in the city of about 3,400 people in November.[18]

In a recent article, the Atlanta Journal-Constitution Editorial Board highlighted how the closure of the Atlanta Medical Center is one piece of Georgia's health care system appears to be failing under Gov. Brian Kemp and, as such, risks the health and well-being for all the people of Georgia:

> The Atlanta Medical Center is the sixth hospital to shut down under Kemp, but the governor still refuses to expand Medicaid, which prevents Georgia from accessing billions in federal funds to help support struggling hospitals and which also blocks 500,000 Georgians from accessing affordable health care. Georgia is one of just twelve states that hasn't expanded Medicaid. [19]

The situation is not relegated to urban areas. A recent article from KFF Health news that appeared in major USA Today newspapers on Sunday, July 7th highlighted the same situation wreaking untold damage in rural areas across the country. Some of these hospital closures are being repurposed which might alleviate some employment issues if

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[18] Ibid.

[19] *Sixth Hospital Closure under Kemp Hurts All Georgians,* September 13, 2022, accessed July 6, 2024, https://www.ajc.com/opinion/opinion-hospitals-closing-affects-us-all/L46RPDTRZBEOLPGAL3EQBKFX3M/

that were to take place in Atlanta, but that does not obviate the issue of a lack of health care for those most at risk.[20]

Kemp's lack of concern and effort to use some of his power to expand Medicaid and use some of the six billion to help stem the closure of the hospitals has left many Blacks and other People of Color without adequate health care services. They were left with only one Trauma One facility to treat seniors with high blood pressure and the potential for heart attacks and strokes.

Despite all the laws implemented to impede People of Color, Black people, Women and first-time young voters, Care in the broader sense still can exist. There are people willing come together, as volunteers, to demonstrate Care Responsibility by continuing to assist the invisible and the inaudible with voter registration, filling out voter registration forms, transportation to the voting precincts and aid those who want to vote by mail.[21] The act of Care Responsibility has led to better Healthcare as a result of the tireless effort to promote Care, and, as such, the invisible and the inaudible might become visible and audible. Their effort paid off when Rev. Dr. Raphael Warnock was elected to a full six-year term as the US Senator from Georgia after defeating the Republican candidate. His election gave new life to the effort to provide Affordable Housing and Quality Health Care to Georgians by giving a voice to the invisible and inaudible.

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[20] Taylor Sisk, "Closing of Rural Hospitals Level Towns with Unhealthy real Estate," *KFF Health News,* June 26, 2024, accessed July 9, 2024, https://kffhealthnews.org/news/article/rural-hospital-closures-unhealthy-real-estate/

[21] Joan C. Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York, NY: New York University Press, 2013). Once needs are identified, someone or some group has to take responsibility to make certain that these needs are met.

CHAPTER TWO – MEETING THE FEAR

"In some homes, the soul of the space has been lovingly crafted over time. The memories we make there, bit by bit, laugh by laugh, with some heartache thrown in for good measure, make it seem inconceivable to ever abandon the house itself. We say that it's the memories and people that make a home, not the things in it or the structure itself, yet when we're forced to leave a treasured home behind, it doesn't merely tug at the heartstrings — it damn near severs them." [1]

THE VISION

The faith community has stepped up to provide Affordable Housing for seniors, People of Color and Blacks. The faith community could be the answer for seniors aging in place when it comes to providing care to the senior communities. Friendship Towers and Providence Manor are representative of affordable housing complexes in Atlanta which successfully provide affordable housing to seniors. It was the vision of Rev. Dr. Gerald Durley, Pastor Emeritus of Providence Missionary Baptist Church, who made it possible for a man who had an income of $100.00 a month to live rent free at Providence Manor.

In an interview I had with Dr. Durley, I learned that the vision for Providence Manor came about because his elderly parishioners needed a place to call home. He went on to say that "when he heard the testimony of a man living rent free at Providence Manor from the time it opened, it was at that point he knew he had fulfilled the vision God had given him."[2].

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[1] "Moving on Is Simple. It's What We Leave behind That's Hard," web log, *Artmechanic* (Wordpress, August 20, 2016), accessed July 7, 2024, https://artmechanic.wordpress.com/.

[2] Rev. Dr. Gerald Durley, interview by author, Atlanta, December 10, 2021.

His dream not only made it possible for the man to have a home, but it also made it possible for anyone who qualified to make Providence Manor their home. Some of the residents have come from as far as Guyana, Trinidad, and Panama. Various religious faiths are also represented among the residents as well. These include Muslims, Seventh-day Adventist, Baptist, and Catholics. The one factor they all have in common is they are people of color, and all needed a place to call home so they could live independently and, of course age in place.

Dr. Durley shared this with me, "I like what you said", this was in reference to my ministerial calling that I shared with him:

> it gets to the point when it gets time to pass it off to the next person in order for the next group to carry it on to the next phase and on to the next phase. So often, there are times when we really don't know what the end looks like, but we do know what we did. And what we did was, we did what was required of us to do and now the time to pass it on and pass it on to someone else and allow it to go to the point the personalities and talents come into play.[3]

He was referencing his understanding that the issue of affordable housing had been met and now was the time to implement aging in place for seniors. Once again, the context of my ministry is providing Affordable Housing for people sixty-two years and older so they can maintain their independence while aging in place. I had the pleasure of serving the communities of Friendship Towers, sponsored by Friendship Baptist Church, and Providence Manor, sponsored by Providence Missionary Baptist Church, in Atlanta for over twenty years. Seventeen of those years were spent at Friendship Towers Apartments, which opened in 1977, and seven years to the present at Providence Manor,

[3] Durley, interview.

which opened in 2010. Friendship Towers is a HUD Section 202/8 Program[4] and Providence Manor is a 202 Project Rental Assistance Contract (PRAC) [5] property that is governed by an independent board separated from the church. The 8 in 202/8[6] and PRAC in 202 PRAC[7] indicates the type of rental assistance available from HUD to the qualifying tenants.

THE VISION BECAME A REALITY

The vision of aging in place through rental assistance became a reality because the 202 program for supportive housing was enacted by congress under the 202 Supportive Housing program[8] for very low-income elderly with options that allow them to live independently but in an environment that "provides support activities such as cleaning, cooking, transportation," etc. so they can *age in place*.[9] The program is similar

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[4] "Housing: Housing for the Elderly (Section 202)," *Department of Housing and Urban Development (HUD),* pg. 25-5, accessed July 7, 2024, https://www.hud.gov/sites/documents/28-FY16CJ-HousingElderly.pdf&ved=2ahUKEwihgrqVhpaHAxUOQjABHTJzAREQFnoECBgQAQ&usg=AOvVaw1VyFNol4qdq6bwDPooOKfR.

[5] Linda Couch, "Section 202"

[6] Wendy Fitzhugh, "Section 8 vs. Section 42," *National Center for Housing Management - Compliance*, accessed July 7, 2024, https://www.nchm.org/section-8-vs-section-42/0

[7] Jeff Hamann, "HUD Project Rental Assistance Contracts (PRAC)," *Janover - HUD Loans*, December 8, 2022, accessed July 7, 2024, https://www.hud.loans/hud-loans-blog/hud-project-rental-assistance-contracts-prac/.

[8] "Section 202 Supportive Housing for the Elderly Program," *U.S. Department of Housing and Urban Development*, accessed July 7, 2024, https://www.hud.gov/program_offices/housing/mfh/progdesc/eld202.

[9] Taylor Shuman and Scott Witt, "Aging In Place," *Seniorliving.Org*, accessed June 3, 2024, https://www.seniorliving.org/aging-in-place/. Aging in place means a person making a conscious decision to stay in the inhabitation of their choice for as long as they can with the comforts that are important to them. As they age these may include adding supplementary services to facilitate their living conditions and maintain their quality of life.

to Supportive Housing for Persons with Disabilities (Section 811) and provides funding for the procurement of property and construction through The US Department of Housing and Urban Development (HUD).

In essence and to recap what we have noted earlier, the Project Rental Assistance Contract (PRAC) is HUD funded and provides rental subsidies to the elderly residents living in the 202 units.[10] The funding combined with the resident's rent covers operational expenses. Applicants have to be sixty-two years old or older and fall inside the income limits set by HUD annually in order to qualify for occupancy.

The 202 PRAC program was established in 1990 to help address the affordable housing crisis for seniors. Before 202 PRAC, seniors were relegated to poor living conditions, inadequate plumbing, and poorly insulated housing. The cost of housing was usually beyond their financial means. Many seniors apply to 202 PRAC properties because they are affordable, safe, secure, sanitary, and are supposed to offer a chance to be independent and experience a level of dignity and self-respect.

In addition to affordability, the 202 PRAC project was designed to enable seniors to age in place the same way 202 Supportive Housing is designed.[11] 202 Supportive Housing has resources and staff on site to serve the needs of its residents. However, the 202 PRAC community does not have the staff, resources nor funding to accomplish the goal of assisting seniors to age in place. To respond to this problem, Congress created the

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[10] Hin-Kin (Ken) Lam, Jill Khadduri, and Judy Weber, "Section 202 and 811 Operating Costs Needs ,"July 16, 2010, accessed June 4, 2024, https://www.huduser.gov/portal/publications/pubasst/Sec_202_811.html.

[11] "FY 2020 Section 202 Supportive Housing for the Elderly Program," *U.S. Department of Housing and Urban Development*, accessed July 7, 2024, https://www.hud.gov/program_offices/spm/gmomgmt/grantsinfo/fundingopps/fy20_section202

Service Coordinator's position,[12] with the hope that this position might assist seniors to age in place. In reality, due to the high turnover rate associated with the position and frequent mission changes for the position, it remains difficult for seniors to age in place.

[12] Judith Chavis, "HUD-Funded Service Coordination Programs: ROSS, Family Self-Sufficiency, and Service Coordinators in Mutifamily Housing for Elderly and Disabled," *National Low Income Housing Coalition*, 2018, accessed June 3, 2024, https://nlihc.org/sites/default/files/AG-2018/Ch05-S05_HUD-Funded-Service-Programs_2018.pdf.

CHAPTER THREE

CARE ISSUES – DEALING WITH THE FEAR

I LISTEN TO YOUR SILENT CRY.

So that you don't get tired in a lost corner of your heart
Through the cracks in the door of that poorly closed space called 'you'
There is a silent cry that only I can hear
The silent cry that you've been hiding for a while[1]

The recent movie *I Care A Lot* centers on the lead character, Marla, played by Rosamund Pike, who satisfies her greed for money and power at the cost of the elderly living alone with no immediate family.[2]

Marla built a network to take control of her victim's independence as well as financial assets. The network consists of a research division to determine who is vulnerable to her plan, a court that is favorable to grant her partitions for guardianship over elderly victims, and a nursing home willing to do her bidding to essentially hold the victims captive.

The nursing home that houses Marla's victims in effect, becomes a prison. This becomes evident in the scene when Jennifer Peterson, who tries to leave the community room at the nursing housing home and Marla is seen closing the door to prevent her from leaving. In another scene, Mrs. Peterson's son, Peter Dinklage as Roman devises a plan

[1]NCTIFY, "Stray Kids Lyrics (#7 - Silent Cry)," *Wattpad*, accessed June 4, 2024, https://www.wattpad.com/1114001614-stray-kids-lyrics-stray-kids-%E1%A8%80-silent-cry.

[2] *I Care a Lot, directed by J Blakeson* (United States: STXfilms, Black Bear Pictures, Crimple Beck, 2020), Netflix and Amazon Prime.

to free his mother and she is caught attempting to escape and later heavily sedated to prevent her from future attempts.

The reason why Marla was successful in getting custody over Mrs. Peterson and her estate was Roman changed his identity to hide his connection with the mob and when Marla did her research, she was led to believe that Mrs. Peterson had no living relative. Through a series of crosses and double crosses, Marla eventually joins forces with Roman and they build a huge empire of stolen assets and captive elderly patients One of them, whose son is Feldstrom eventually proves to be Marla's undoing, not to be a spoiler here!

The nursing home was a villain like Marla. When they called Marla to tell her one of the patients died, they were bent on keeping the beds filled to keep their revenue stream going. When the patients did not have any financial resources and their Medicare benefits ended, the patients were converted Medicaid resulting in the nursing home becoming their permanent home.

I decided to include this reference to popular culture because the movie, fanciful as it is, does touch upon issues that intersect with this project. Our Ms. B found herself in a similar situation with regard to keeping a bed filled because the truth was being withhold from her when she said she wanted to go home. The truth was also withheld from her care-giving neighbor. Recall that they were both told that before she could be released her neighbor had to arrange for everything that she required for her at home care to be in place before she could return to her apartment.

Despite the nursing home attempt to withhold vital information from Miss B in order to keep her at the nursing home, she like Mrs. Peterson in the movie, had hoped to

return to her apartment by keeping her rent current. Remember, each month Miss B had authorized her neighbor to dutifully pay her rent on the first of every month.

Finally, the move showed that nursing homes and rehab centers that are for profit can seem at times not necessarily consistently for the patients. Residents like Ms. B have to be very careful who is advising them as to what nursing home and rehab is best to administer the type of care they need and if they truly need to go to a nursing home or rehab for rehabilitation treated. They also need information about how to keep the door open for them to be able to return home and age in place for as long as possible.

As stated above, I have heard the cries of the residents living at Providence Manor saying they want to age in place where they live and not have to end up staying in a nursing home after receiving rehab or being released from the hospital for various reasons – they want to return home.

In addition to the fears that the residents experienced which I recounted in chapter one, the residents of Providence Manor experience many more barriers preventing them from aging in place. The decrease in doctor-patient consultation, cooperation and participation and the reality ever-increasing health care costs are of course key factors to consider in this field of study. More to the point of this project is lack of knowledge as to viable options on the part of the residents or the withholding of knowledge pertaining to the available resources on the part of some individuals or entities involved in some of the health care bureaucracy, possibly unintentionally (more on that later in this paper). An aspect of the latter could lead to a possible death knell to aging in place by means of practice of Ageism when paternalistic decisions are made about the type of treatment and even medication prescribed for an elderly patient without their informed input.

There was a time when aging parents lived in the same household with their adult children and family. Therein, the entire household contributed to the care of the aging parent by helping them keep medical appointments, meal preparation, and cleaning up after them as best they could. However, because of career moves and advancement that required relocation to other cities, states and even countries, families have become separated. These events in the lives of many senior citizens have caused them to make decisions to give up the old homestead and move into affordable care communities. They have been compelled to forge new relationships while adjusting to living alone and doing for themselves. They settle into their new affordable housing like Providence Manor in order to age in place.

Seniors living in Providence Minor tend to remain at Providence Minor for as long as their health will permit. The average age of the residents is seventy-three years old, however the age ranges from sixty-two to ninety-four who live on a fixed income, Social Security and or SSI.[3] Some already have health issues or will have them as they age, but they are able to maintain their routine day to day without any assistance. If they do not own their own car, they are able to arrange transportation with the public transportation system known as the Metropolitan Atlanta Rapid Transit Authority (MARTA).[4] The transportation system is key for them to keep their medical appointments, grocery shopping as well as conducting other business matters. For those who cannot ride the regular buses, MARTA mobility offers a service that will pick them

[3] The age data was taken from the Providence Manor Resident Birthday file.

[4] The Metropolitan Atlanta Rapid Transit Authority, known as MARTA, provides bus and rapid rail service to the most urbanized portions of the Atlanta metropolitan area. The eighth-largest transit system in the United States, MARTA serves nearly 400,000 passengers a day. The transit agency was established in 1971 with the passage of an authorizing referendum by voters in Fulton and DeKalb counties and the city of Atlanta.

up from the building and return them to the building.[5] Residents who are not able to leave the building for whatever reason can have their groceries and prescriptions delivered to them.

When residents need extra assistance with transportation to shop or keep medical appointments or just to run errands other residents will offer their assistance to meet their needs. When this happens the true example of community is on display.

There are times when some residents are not able to do some things for themselves, for example, needing assistance with bathing, cooking, and cleaning their apartments. When these limitations happen, a decision has to be made whether or not they can stay in their apartment with the help of family members or acquaintances or be moved to an assisted living community. However, most of the residents want to remain where they are so they can maintain their agency, but in some cases, there is a conflict with family members who want to place them in a facility against the resident's will.

The resident's desire to stay in place falls in line with a survey published in AARP in November 2010. The survey results showed that an estimated two thirds of the participants wanted to remain where they lived, and two thirds wanted to remain in their community.[6]

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[5] MARTA Mobility is our paratransit service available to anyone unable to ride or disembark from our regular MARTA transit services. "MARTA - System Information: Accessible Services - Mobility," *MARTA (Atlanta Mass Transit)*, accessed June 4, 2024, https://ww.itsmarta.com/marta-mobility.aspx.

[6] Teresa A. Keenan, "Home and Community Preferences of the 45+ Population," *Home-Community Services 10-4*, November 2010, accessed July 9, 2024, https://assets.aarp.org/rgcenter/general/home-community-services-10.pdf.

The decision to stay in place or go to a nursing home is a decision that should not be made lightly. For some seniors, nursing homes and rehabilitation center stories make for a horrific experience. The horrifying stories of mistreatment and poor medical care bring up the fears of the past about losing their home.

The Vantage Aging organization, an advocate for senior independence, lists six reasons for senior independence. The character for senior independence consists of the ability to make choices, be in control of their physical ability, the sense of accomplishments, activities that stimulate memory, a sense of self-worth and maintaining relationships. Vantage explores these characteristics in detail as follows:

> Everyone should have the opportunity to live independently with dignity – especially our senior populations. While aging can sometimes make independent living difficult, small supports, such as home wellness solutions and home-delivered meals, can help seniors maintain independence in their own homes.
>
> Independence is important to the physical and mental well being of older adults. As a provider of wraparound programs and services that help older adults stay at home and active in their communities, we want to share some insights with you about how independence and activity benefit us as we age.
>
> Loss of independence can be discouraging to older adults. They have spent their entire lives living independently, working jobs, raising families, and making decisions.
>
> The natural effects of aging can sometimes make independent living harder than it once was. Difficulties with mobility, behavioral health conditions such as isolation and loneliness, and financial strains are just some of the contributors to a loss of independence in aging adults.
>
> While we cannot avoid some barriers to independence, we can take the time to understand the importance of independence in seniors and look for ways to increase opportunities for independent living. The following benefits are common results of senior independence and demonstrate how important it is to empower older adults to live independent lives.
>
> 1. **Feel like an individual**

The ability to make choices throughout the day has a big impact on how you feel about yourself. When you are no longer managing the decisions in your life, you might feel like less of an individual.

Older adults have lived their whole lives with their own personalities and beliefs. If they reach a point when they cannot express themselves, they won't feel like themselves. These feelings can lead to depression, anger, or destructive behavior, which are damaging to both the senior and their caregiver.

Make sure you or your loved one is able to maintain their sense of self in the environment they live in. They should be able to personalize their space with photos and items that reflect the things they care about and enjoy. It's also beneficial for them to make choices in daily living, like the clothes they wear and the food they eat.

2. Maintain balance and strength

Retaining balance and strength is a huge determining factor in someone's ability to stay independent. It also motivates older adults to stay active, which may result in health benefits that foster independence.

If strength is not routinely worked on, it's likely an aging individual will lose muscle mass and core balance. Loss of strength and balance can lead to dangerous falls that leave a senior in a hospital or assisted living facility for a long time. Injuries also make it hard to maintain independence.

Maintaining physical ability is a great way to prevent falls that lead to a long-term loss of independence. Evidence-based prevention programs like Steady U Ohio's Matter of Balance teach older adults how to manage falls while building up strength, balance, and confidence. There are also mobility devices that provide support for seniors who need help walking, such as walkers and railings.

3. Sense of purpose

Loss of independence can be isolating. Seniors who are isolated often develop feelings of hopelessness and depression, and the negative effects on their mental health can lower their quality of life.

Independence gives seniors a sense of purpose. They have opportunities for achievement, can contribute to the lives of their family, friends, and neighbors, and enjoy activities that they've always done.

The chance to set and reach goals has a big impact, even if they seem small. Independence allows older adults to take on the unique challenges of aging head on and overcome them with a sense of accomplishment.

Even if a senior is limited by mobility, they can still gain a sense of purpose through involvement in volunteer activities. For example, VANTAGE RSVP offers a Telecare program. Volunteers provide friendly, reassuring calls to homebound seniors to address social isolation. Volunteerism provides a sense of purpose and involvement in the community.

4. Aids with memory skills

The effects of independent living can contribute to improved health conditions in some older adults. Increased memory skills are just one to name, and an important factor in living a fulfilling life.

Memory loss gradually happens as we age, but independence and activity boost memory skills. Higher activity levels increase blood flow to the brain and using the mind often helps to preserve memory. Daily routines help promote both memory and independence.

5. Gives a sense of control

Sometimes, independence may be the only thing seniors feel that they control. The ability to live independently empowers seniors and reinforces that, though some factors, such as health or financial stability, may prevent them from carrying out some activities they once did, they still have a hold on many aspects of their life.

A sense of control also promotes a feeling of achievement and self-worth. And, feeling in control over their actions, choices and situation can have a positive effect on a person's mental health.

6. Develops positive relationships

Good rapport can stem from a senior-caregiver relationship built on promoting independence. Caregivers can provide seniors with the tools and resources they need to maintain independence, such as helping them set up their home in a way that promotes fall prevention and helping them navigate digital devices to stay connected with family members".[7]

The residents of Providence Manor organize and participate in weekly bingo games that enable them to exercise their memory by keeping in mind the numbers called

[7] MT, "Six Reasons Independence Is Important to Seniors," web log, *Vantage Aging*, March 5, 2021, accessed July 9, 2024, https://vantageaging.org/blog/independence-is-important-for-seniors/.

and the numbers needed to win the game as well as the game they are playing, for example, cover four corners, to coverall. Bingo offers them self-worth, exercising their memory and comradery in the Providence community.

The Tuesday night get-together also provides the residents with the opportunity to come together to dance and, if they choose to do so, they can play a game of "bid whist." Dancing is a great exercise activity and card playing satisfies the need to stimulate the mind as well as satisfy self-worth.

However, the rising cost of health care, the decline in doctor patient interaction and being discriminated upon because of age can prevent them from receiving the quality of health care they need to age in place. These barriers contribute to the fear that they might lose their home because they would have to move into a nursing home.

THE DECLINE IN PATIENT HEALTH CARE AS COST RISES

The article written by Arthur Gale MD (the bulk of which can be found in Appendix II of this paper) shares how doctor and patient participation has declined since he started practicing medicine in 1963. It is his contention the FFS (Fee For Service) worked better to keep Medicare cost was under control while maintaining the quality doctor patient participation because:

> For the first twenty to twenty-five years Medicare worked well with regard to cost to the taxpayer and the quality of care rendered to patients. Journalist Steven Brill showed in a landmark Time magazine article how Medicare brought under control the main driver of high health care costs: the hospitals. In contrast to private commercial health insurance companies, Medicare accomplished this feat with very low administrative costs.[8]

[8] Arthur Gale, "Fifty Years of Medicare: The Good and the Bad," *Missouri Medicine* 112, no. 4 (2015): 252–257.

Medicare Advantage changed Medicare causing the cost of healthcare to increase while doctor patient participation declined leaving patients dissatisfied with the quality of care. "However, when patients have a serious illness, nursing home and rehabilitation benefits are usually less than in standard Medicare FFS benefits."[9]

Dr. Gale draws attention to the excessive cost of health care as a result of HMOs (Health Maintenance Organizations) and those in congress who contributed to the rising costs. Dr. Gale also takes issue with Accountable Care Organizations when he compares FFS with ACA. Part of his argument deals with

> The most controversial aspect of ACOs is that doctors will be at financial risk. Financial risk pits the financial incentives of physicians against the medical interests of patients. The more physicians do for patients the less they get paid. The less doctors do for patients the more they get paid. The physician is no longer the patient's advocate. These financial incentives violate the Hippocratic Oath which states: 'I swear...that I... will follow that system which, according to my ability and judgment, I consider for the benefit of patients, and abstain from whatever is deleterious...'[9]

Relating to Quality of Care, Dr. Gale points out:

> The government, through CMS (Centers for Medicate/Medicaid Services), is using its new gimmick - the electronic health record (EHR) - to measure quality through the Physician Quality Reporting System (PQRS). This is being done in all three modes of health care delivery: Fee-For-Service, Medicare Advantage, and Accountable Care Organizations. By checking boxes on patients' blood pressure, weight, exercise, smoking cessation, cholesterol, LDL, hemoglobin A1C, etc., quality is improved. And physicians are rewarded financially if they check all the boxes correctly. It's as if physicians were not discussing these issues with patients before these EHR metrics were introduced. This payment model for improving quality does not consider that many, if not most patients, are non-compliant with their physicians' recommendations no matter how many boxes are checked.[10]

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[9] Gale, "Medicare."

[9] Ibid.

[10] Ibid.

Dr. Gale also draws attention to the deficiency of Medicare Part D when comparing it with Veterans Administration to negotiate pharmaceutical costs as opposed to Medicare beneficiaries.

> Part D does not allow Medicare to directly negotiate drug prices with health plans as it does with the Veterans Administration. Veterans pay much less for pharmaceuticals than Medicare beneficiaries. Medicare members must pay a price for drugs that is a result of negotiations between drug companies and insurance plans. As a result, the cost of drugs to a Medicare patient may be up to 80% more than what a veteran pays for the same drug.[11]

As we will see in this chapter there is a connection Dr. Gale's essay on the true reason for the rising cost of healthcare and the attempts reduce the services administered to seniors because of their age.

The Rising Cost of Health Care

Health care cost is expected to rise exponentially according to the Peter G. Peterson Foundation an organization that tries to curtail the growth of Social Security and Medicare. Their concern is of the growing number of aging seniors requiring health care services.[12]

The foundation researched the United States healthcare spending from 1962 to 2022, and they project that the number of aging seniors will increase to 21% by 2032. Exhibit III in the Appendix provides in-depth information from the Center for Medicare and Medicaid Services, The United States Census Bureau, and the U.S. Bureau of Labor Statistics along with the Organization for Economic Co-operation and Department. This

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[11] Ibid.

[12] Why Are Americans Paying More for Healthcare?," weblog, *Peter G. Peterson Foundation*, January 3, 2024, accessed June 5, 2024, https://www.pgpf.org/blog/2024/01/why-are-americans-paying-more-for-healthcare.

research opens the door for ageism in healthcare for seniors. Their argument is centered on the rising cost on the flood of Baby Boomers entering into the Medicare system to 2032.

LOBBYING COST IS ANOTHER FACTOR IN RISING HEALTHCARE COSTS

The *JAMA Network Forum* is an outlet for critical analyses to be submitted for publication along with citations. In an article entitled: "Lobbying Expenditures in the US Health Care Sector, 2000-2022," William L. Schpero, PhD, Thomas Wiener, Samuel Carter and Paula Chatterjee presented charts documenting the contributing factor lobbying has had on the rise of healthcare costs.

As health care services are becoming increasingly profit-oriented, the rise of lobbying on behalf of the health care providers, pharmaceutical and health product industries have also increased. This has added to the cost of healthcare which results in the cost of services, prescriptions, and out of pocket costs being passed down to the consumers, especially seniors like those living in Providence Manor.

> Lobbying activities in the US health care sector have drawn increasing public scrutiny over concerns that some firms may be wielding an outsized influence on policy making. However, little is known in the health policy literature about the amount spent on health care lobbying outside the pharmaceutical and health products industry. Other health care stakeholders, such as hospitals and insurers, have faced regulatory scrutiny and may be investing in lobbying activities to represent their interests.[13]

See Appendix IV for more details about this issue.

AGEISM IS NOT THE CURE FOR RISING HEALTH CARE COSTS

[13] William L. Schpero et al., "Lobbying Expenditures in the US Health Care Sector, 2000-2020, *JAMA Health Forum* 3, no. 10 (October 3, 2022), Accessed July 09, 2024, https://doi.org/10.1001/jamahealthforum.2022.3801.

The political debate today is whether an eighty-year-old man is too old to serve a second term as President of the United State. The premise is he may not live long enough to serve out his term in office and, or he may not have the proper cognitive mind to make good decisions with regard to the welfare of the country. The odd thing is if he does win a second term, he will have the best medical care while in office as opposed to a tendency to limit health care services to seniors because of age.

If Daniel Callahan, the author of *Setting Limits*, quoted by Claire Andre and Manuel Velasquez in "Aged-Based Health Care Rationing," has his way, the eighty-year-old President will be limited to palliative care.

> Perhaps the most prominent advocate of aged-based rationing is Daniel Callahan, author of *Setting Limits*. In this book, Callahan proposed that the government refuse to pay for life-extending medical care for individuals beyond the age of 70 or 80, and only pay for routine care aimed at relieving their pain.[14]

In that same journal article, authors Claire Andre and Manuel Velasquez discuss the pros and cons of Aged-Based Health Care Rationing. They wrote that Dr. Callahan professed the following:

> Those, like Callahan, who support proposals to ration life-extending medical resources on the basis of age maintain that such a rationing system would bring about the greatest good for the greatest number of people. While the health of the young can be ensured by relatively cheap preventive measures such as exercise programs and health education, the medical conditions of the elderly are often complicated, requiring the use of expensive technologies and treatments -- and often, these treatments are ineffective in providing any tangible benefit for either patient or society. In short, the costs that arc incurred to prolong the life of one elderly person might be more productively directed toward the treatment of a far

[14] Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* in Claire Andre and Manuel Velasquez, "Age-Based Health Care Rationing: Challenges for an Aging Society," *Issues in Ethics* 3, no. 3 (Summer 1990), accessed July 09, 2024, https://www.scu.edu/mcae/publications/iie/v3n3/age.html

> greater number of younger persons whose health can be ensured by less costly measures.[15]

In response to Dr. Callahan's writings Dr. Christina Harris, the chief health equity officer at Cedars-Sinai Medical Center, Los Angeles, as quoted by Victoria Pelham wrote:

> Age-based prejudice leads to serious inequalities, including missed or delayed diagnoses and less information about medical decisions and treatment side effects. Many people are also denied critical healthcare or given improper treatment. And older adults are largely left out of clinical trials, which could be lifesaving, showing how drugs affect people differently with age.
>
> Ageism gets less attention, but treating everyone fairly throughout their lives is part of providing equitable care. Further, it overlaps with racism and other forms of discrimination, making accessing healthcare even harder for certain individuals as they get older."[16]

Andre and Velasquez go on to write about the debate whether to ration health dollar for seniors in favor of serving the needs of others who are not in their senior years while others argue meeting the needs of everyone, treating everyone as equals.

> Advocates of health care rationing also argue that issues of justice are at stake in this social debate. It's estimated that the government now spends more than $9000 per elderly person and less than $900 per child each year. The skewed distribution of health care resources, they say, is not only detrimental to the overall health of the society; it is also unjust, because the elderly receive a disproportionately large piece of the health care pie, while a far greater number of younger people are deprived of an equal share of the nation's health care resources. Moreover, "need" should not be a fundamental criterion for determining how much health care the elderly (or others) are allotted. In the context of constant technological innovations to prolong life at all costs, the "needs" of the elderly know no bounds and drain the pool of resources that ought to be made available to all age groups.

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[15] Claire Andre and Manuel Velasquez, "Age-Based Health Care Rationing: Challenges for an Aging Society," *Issues in Ethics* 3, no. 3 (Summer 1990), accessed July 09, 2024, https://www.scu.edu/mcae/publications/iie/v3n3/age.html

[16] Victoria Pelham, web log, *Confronting Ageism in Healthcare*, (Cedars-Sinai Medical Center, October 16, 2023), accessed July 09, 2024, https://www.cedars-sinai.org/blog/confronting-ageism-in-healthcare.html.

Others who oppose rationing health care on the basis of age argue that a mere consideration of benefits and costs fails to give due weight to other more important moral considerations, such as justice and rights. Justice, they argue, requires that people be treated similarly unless there are morally relevant reasons for treating them differently. In determining who should or should not receive health care, it is relevant to consider a person's need for health care, the likelihood of recovery, or the likelihood of improving a person's quality of life. Age, however, reveals little about a person's medical need or prognosis, and should no more influence the distribution of health care than race or sex. It is the medical liabilities we often associate with old age, not age itself, that count as relevant reasons for treating people differently. If our aim is to use costly resources more effectively, then we ought to deny treatment to all patients whose prognosis indicates a short life span, chronic illness, or little likely improvement in the quality of life, rather than denying treatment simply on the basis of age.

Moreover, it is argued proponents of age-based rationing try to pit the young against the old as if providing benefits to one group means unfairly taking them away from members of the other group. But, this is mistaken. We don't claim that it is unjust to spend more educational dollars on children than on adults. Similarly, it is not unjust to spend more medical dollars on the aged than on the young, so long as every individual has the same access to medical care over a lifetime.

Those who oppose rationing health care by age argue that such a policy would violate our moral sense of respect for persons. Embarking on age based health care rationing in order to cut health care costs or to increase productivity treats the elderly as a mere means to economic ends, failing to respect the fundamental dignity of persons.

Furthermore, to claim that it is better to preserve the lives of the young than those of the aged is to assume that the lives of the aged have less value than those of the young. In fact, many opponents of age-based health care rationing argue that in modern society, all people have a fundamental right to the medical care they need to maintain good health and a reasonable quality of life, regardless of any characteristic, be it race, religion, sex, socioeconomic class -- or age. Assuming that an elderly individual no longer has this right, or that an elderly person's right is diminished, is just wrong. To claim that the elderly's right to health care must be restricted because they have achieved a "natural life span" -- that they have no life goals or possibilities -- is simply erroneous. In fact, their major life achievements may still be ahead of them. The right to health care does not diminish with age. An aged person has as much of a claim on medical resources as the young person, and consequently age-based rationing is an unequivocal violation of this basic right."[17]

[17] Andre and Velasquez, "Age-Based Health Care Rationing."

As the debate whether to ration health care to seniors as opposed to making health care funding available to other age groups, discrimination enters the picture. Seniors who are Blacks and other People of Color become the true victims when it comes to rationing health care. Per the 2020 census, Baby Boomers are aging as well as other individuals who are living longer due to better health care.

> As boomers age through their 60s, 70s, 80s and increasingly beyond, the 'big bulge' of the boomer generation will contribute to the overall aging of the U.S. population in coming decades," said Stella Ogunwole, a demographic statistician with the Census Bureau.
>
> "The older population is becoming even more significant," she said.
>
> The number of people aged 65 and older in the United States has grown rapidly over most of the 20th century, from 3.1 million in 1900 to 35 million in 2000.
>
> In 2018, there were 52 million people age 65 and older, according to the Census Bureau's Vintage Population Estimates. Their share of the population grew as well, from 12.4% in 2000 to 16.0% in 2018.
>
> But aging boomers are not the only reason the nation's population is getting older overall. Longer lives — in part due to better health care — and record low birth rates among young women are also major factors, according to Haaga, (John Haaga of the National Institute on Aging).[18]

Better health care is not experienced when it comes to Blacks and People of color who are seniors. Black seniors alone are 9% of the seventy-eight million Baby Boomers.[19] Seniors like those living in Providence Manor experience less doctor to patient participation than their Caucasian counter parts. Ageism affects the doctor-patient interaction and the resulting impact on the quality of health care which seniors receive.

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[18] America Counts Staff, "By 2030, All Baby Boomers Will Be Age 65 or Older," *United States Census Bureau*, accessed July 9, 2024, https://www.census.gov/library/stories/2019/12/by-2030-all-baby-boomers-will-be-age-65-or-older.html.

[19] Ed Gordon,"Blacks Face Challenges as Boomers Turn 60," audio blog, *News and Notes* (National Public Radio (NPR), April 26, 2006), accessed July 9, 2024, https://www.npr.org/2006/04/26/5363453/blacks-face-challenges-as-boomers-turn-60.

Khiara M. Bridges is a professor of law and anthropology at Boston University. Her article for Human rights Magazine published by the American Bar Association, Implicit Bias and Racial Disparities in Health Care, gives a different perspective pertaining to the quality of health care and impact it has Blacks.[20]

> Why are black people sicker, and why do they die earlier, than other racial groups? Many factors likely contribute to the increased morbidity and mortality among black people. It is undeniable, though, that one of those factors is the care that they receive from their providers. Black people simply are not receiving the same quality of health care that their white counterparts receive, and this second-rate health care is shortening their lives.
>
> In 2005, the Institute of Medicine—a not-for-profit, non-governmental organization that now calls itself the National Academy of Medicine (NAM)—released a report documenting that the poverty in which black people disproportionately live cannot account for the fact that black people are sicker and have shorter life spans than their white complements. NAM found that "racial and ethnic minorities receive lower-quality health care than white people—even when insurance status, income, age, and severity of conditions are comparable." By "lower-quality health care," NAM meant the concrete, inferior care that physicians give their black patients. NAM reported that minority persons are less likely than white persons to be given appropriate cardiac care, to receive kidney dialysis or transplants, and to receive the best treatments for stroke, cancer, or AIDS. It concluded by describing an "uncomfortable reality": "some people in the United States were more likely to die from cancer, heart disease, and diabetes simply because of their race or ethnicity, not just because they lack access to health care."

Some of the residents at Providence Manor talk among themselves about how they are treated by their doctors and nurses when they go to their appointment. They complain about doctors not hearing their concerns and staff treating them like they are too old to know what they are talking about.

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[20] Khiara M. Bridges, "Implicit Bias and Racial Disparities in Health Care," *Human rights Magazine* 43, no. 3 (August 01, 2018), accessed July 10, 2024, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/.

One resident shared the experience of being prescribed the wrong medication for breathing problems and was rushed to the hospital emergency every other month. The resident changed health care providers. The new provider ran tests and prescribed a new dosage of medication. The resident has not had to return for emergency care for treatment.

Seniors living at Providence Manor as well as other 202 PRAC properties are already fearful of losing their apartments due to no fault of their own, but now they are dealing with the way doctors and hospitals decide on the quality of health care they will receive.

THE QUALITY-OF-CARE SERVICES

The care services or lack thereof is another barrier seniors face. In order for the residents of Providence Manor to age in place they must have access to the services and information they need to stay in their homes. The problem they face is income eligibility for the services they need. The care services they need are short-term and expensive because of their financial situations. Medicaid does not offer aid to those who do not qualify.

There are some seniors living in Providence Manor who have very large savings. The reason for these large saving is to provide for their burial arrangements; many of them do not believe in life insurance policies. As seniors age, they spend less and save more. Over a period of time, they amass large savings, and they feel secure because they have done so. The consequence they face is if they become ill for whatever reason, all but $2000.00 in savings has to be exhausted to qualify for Medicaid long term coverage.

Because of the Medicaid requirements they are then left with nothing for their burial arrangements.

Providence Manor has two residents who are exceptions to the income limitations; one is a veteran and the other receives Social Security in addition to an accident settlement. Home health services for veterans goes beyond the services afforded to non-veterans.[21] They both require round the clock care seven days a week that provides them with cooking, cleaning, dressing, and feeding. See Exhibit V in the Appendix for more information on Long Term Services and Supports (LTSS).

In general, LTSS consists of a broad range of assistance for people with chronic conditions and functional limitations. This can include support for activities, such as bathing and dressing, that people need to function in their own homes, as well as services provided in institutions. Importantly, and contrary to what many consumers may assume, Medicare does not cover the costs of LTSS. The need for affordable options is increasing, as more people are aging and living longer and there is a declining pool of family caregivers available and/or willing to assist.

[21] "Geriatrics and Extended Care," *Veterans Administration*, n.d., accessed July 10, 2024, https://www.va.gov/GERIATRICS/pages/Homemaker_and_Home_Health_Aide_Care.asp.

CHAPTER FOUR

CONTEXT FOR THE PROJECT – UNDERSTANDING THE FEAR

In the previous chapters, we have dealt with many of the issues that have led to many individuals at Providence Manor and other housing entities having the fear that they might not be able to return to their homes in the aftermath of health issues. This chapter will detail how we plan to design and implement this Doctor of Ministry project to come to terms with this concern and opportunity. Recall that there exists a kind of mission statement summarized earlier that can function as such for our purposes. Before we can finalize the project plan, we must first deal with the three main stakeholders among the leadership that exists at entities such as Providence: the Compliance Officer, the Property Manager and the Service Coordinator. Let us review each in turn.

PROJECT STAKEHOLDERS

COMPLIANCE MANAGER

At present, I serve in this capacity at Providence Manor. My role includes the following:

- Manage and direct marketing, application & screening processes for compliance activities.
- Prepare certification related analyses and reports as required.
- Ensure that processes, tools, trainings and systems are developed and maintained to support the division.
- Administer housing policies and procedures, transfer policies, tenant selection plans and grievance procedures.
- Conduct and coordinate investigations with staff regarding potential lease violations and fraud issues.
- Maintain updated knowledge of housing programs regulations, obtaining necessary certifications and ensuring that staff is appropriately trained and certified as necessary.
- Identify, analyze and develop recommendations to address problems and issues, and communicate issues and concerns to the Owners.

- Monitor adequacy of a central pool of applicants for placement in affordable housing programs in relationship to Project-Based Rental Assistance.

PROPERTY MANAGER

This individual is responsible for maintaining the standards for the entity set by HUD which includes the following:

The property management standards should set reasonable performance standards reflecting the results that competent management agents can be expected to achieve. MAHRA requires that property management standards be consistent with industry norms and HUD requirements. HUD requires that the property management standards include at least the following:

A. *Major Repairs and Replacements*. A provision requiring the owner and manager to develop and utilize effective programs for:

1. preventive maintenance, so that major building systems remain serviceable for as long as practicable; and
2. capital replacement, so that major buildings systems are repaired or replaced at the end of their useful lives, in a cost-effective manner.

These programs must be consistent with the OAHP-approved Restructuring Plan, in particular with the PAE's Physical Condition Assessment (PCA).

B. *Physical Condition*. A provision requiring the common areas and all units in the property to comply with HUD's *Uniform Physical Condition Standards* (published in the *Federal Register* on September 1, 1998) and with applicable local codes.

C. *Compliance with Other HUD Requirements*. A provision requiring the owner and manager to comply with other HUD requirements applicable to the property, including:

1. Governing Documents. Compliance with the requirements of any Regulatory Agreement and/or Section 8 Contract. Compliance with applicable portions of HUD's Handbooks and Notices (including the *Occupancy Handbook 4350.3, Management Handbook 4381.5,* and *Loan Management Handbook 4350.1*), regarding the management and maintenance of the property and relations with tenants.
2. Required Reports. The timely and complete submission of all required reports and information requests (including audited financial statements, inspection review responses, management certifications, and other data).
3. Project (Housing entity) Records. Project records that provide a complete and accurate account of operations, and that are readily available and suitable for review by HUD.
4. Inquiries. Responsiveness to inquiries and requests from residents, HUD and local governments in a timely and appropriate manner.

D. *Anti-Crime Programs*. A provision encouraging the owner and manager to use available programs to the extent that such programs are reasonably likely to reduce drug activity and other crime and that the cost, if any, of such programs is reasonable in relation to their likely benefits. Such programs may be offered by the police, local schools, community groups, resident associations, and other local organizations. *Accessible Property Records*. A provision encouraging the owner and manager to maintain well-ordered offices with easily accessible records that provide a complete and accurate account of operations.[1]

SERVICE COORDINATOR

HUD suggests that Service Coordinators are primarily involved with the following types of activities:

- Provide general case management and information and referral services
- Establish provider directories and linkages with community agencies

[1] "The Management Agent Handbook (4381.5)," *U.S. Department of Housing and Urban Development*, accessed July 10, 2024, https://www.hud.gov/program_offices/administration/hudclips/handbooks/hsgh/4381.5.

- Educate residents on available services and benefits and on tenancy issues
- Monitor provision of service
- Advocate for residents
- Educate housing management staff*
- Work with resident organizations
- Help residents set up informal support networks
- Educate housing management staff*
- Set up volunteer programs

*Service Coordinators are considered part of a property's management team and should meet regularly and communicate with the property manager, maintenance staff, and other personnel about situations that arise that affect residents.[2]

This position is the most critical of the three for the sake of the residents in that it is governed by a lot of regulations. The position was established to provide information to the seniors so they can age in place. The Service Coordinators is supposed to pull together the health care resources in the community and make them available to the seniors living in Providence Manor.

The Service Coordinator position was created by Congress and design "assist elderly individuals and persons with disabilities, living in federally assisted multifamily housing, to obtain needed supportive services from community agencies" such as those in the metro Atlanta community.[3] However, that will not happen if there is no one to fill that position. Providence Manor, like other 202 PRAC properties has experienced a high

[2] "15k. Overview of Service Coordinator Activities, Quality Assurance, and Training Requirements," *Multifamily Housing Program Financial Management Toolkit*, n.d., accessed July 10, 2024, https://www.hudexchange.info/programs/multifamily-housing/financial-management-toolkit/15-service-coordinators-in-multifamily-housing-scmf-program/15k-overview-of-service-coordinator-activities-quality-assurance-and-training-requirements/.

[3] "Multifamily Housing Service Coordinators," *U.S. Department of Housing and Urban Development*, n.d., accessed June 3, 2024, https://www.hud.gov/program_offices/housing/mfh/progdesc/servicecoord.

turnover rate in the Service Coordinator position because for profit organization have been successful in luring Service Coordinators away with the promise of better salaries and fringe benefits. In an effort to prevent the continued turnover, three congresspersons have introduced a new bill called the *Expanding Service Coordinators Act* to stave off the revolving door of exiting Service Coordinators. If this bill passes, hopefully Providence Manor will be able to attract and retain Service Coordinators along with their talent restoring stability, resident security, and continuity. In addition, the position will be able to provide real accurate information to the resident so they can decide whether to move or age in place. Providence Manor does have such a person in place at present.

However, the Service Coordinator position needs to be reevaluated to determine if the position truly meets the needs of the Providence Manor community to facilitate aging in place. The position does a fairly respectable job advising the seniors about healthy living but when they need information about the availability of resources to move beyond the various barriers so they can return home from rehab, or a nursing home, these same seniors are often left in the dark.

These three stakeholders will function as the cornerstone for this Doctor of Ministry Project.

PROJECT PROPOSAL – WRESTLING WITH THE FEAR

I have already alluded to what I intend to accomplish in this project: to begin with the mission statement about ageing in place that came from Linda Couch's take on Section 202 in the 2021 HUD Advocates Guide from which I quote once again for the convenience of the reader:

> The 202 program allows seniors to age in place and avoid unnecessary, unwanted, and costly institutionalization. With 38% of existing Section 202 tenants being

> frail or near-frail, requiring assistance with basic activities of daily living, and thus being at high risk of institutionalization, Section 202 residents have access to community- based services and support to keep living independently and age in place in their community.[4]

Loughlan Sofield and Brenda Herman are nationally recognized experts in the field of interpersonal collaboration. Their work focuses on collaboration among churches who are interested in bettering the flow of communication among the various entities involved therein. I believe their tools shared in their book *Developing the Parish as a Community of Service* might be fruitfully adapted for this project. In that book they highlight both Mission Statements and Vision Statements as well as their inherent differences:

MISSION STATEMENT:

- Is developed by the entire parish (here: organization – HUD)
- Is objective (developed after collecting and studying data)
- Is specific – includes a plan for implementation
- Gives direction to the entire parish (or organization, here: HUD)

VISION STATEMENT:

-Is formed by a small group (here: the Three Stakeholders)
-Is subjective (developed after a dreaming session)
-Is General
-Gives direction to the core group (which, in our case is the residents)[5]

In our case, we hope that the Vision Statement will be able to become a way to better inform the residents of Providence Manor (and, by extension, hopefully other HUD

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[4] Linda Couch, "Section 202."

[5] Loughlan Sofield and Brenda Hermann, *Developing the Parish as a Community of Service* (Cambridge, MA: LeJacq, 1984). Pg. 17.

Entities) so they could be better able to understand how to keep their homes (if able) and to be able to successfully age in place.

PROJECT SUPPORT

DEFINITION OF CARE AND CARE EQUALITY - THEOLOGICAL UNDERSTANDING ABOUT HEALTHCARE

To understand why care is needed to help seniors in the Affordable Housing community it requires understanding of the definition of care. Care researchers Joan Tronto and Bernice Fischer's definition of care underlines five elements of care:

> One of the most popular definitions of care, offered by Tronto and Bernice Fischer, construes care as "a species of activity that includes everything we do to maintain, contain, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment". This definition posits care fundamentally as a practice, but Tronto further identifies four sub-elements of care that can be understood simultaneously as stages, virtuous dispositions, or goals. These sub-elements are: (1) attentiveness, a proclivity to become aware of need; (2) responsibility, a willingness to respond and take care of need; (3) competence, the skill of providing good and successful care; and (4) responsiveness, consideration of the position of others as they see it and recognition of the potential for abuse in care .[6]
>
> In 2013, Tronto added a fifth phase of care: *Caring with.* Caring with occurs when a group of people (from a family to a state) can rely upon an ongoing cycle of care to continue to meet their caring needs. When such patterns become established and reliable, they produce the virtues of trust and solidarity……. While it is true that some are more vulnerable than others, all humans are extremely vulnerable at some points in their lives, especially when they are young, elderly, or ill. Human life is fragile, and people are constantly vulnerable to changes in their bodily conditions that may require that they rely on others for care and support. Third, all humans are at once both recipients and givers of care. While the typical images of care are that those who are able-bodied and adult give

[6] Maureen Sander-Staudt, "Care Ethics - 2. Definitions of Care," *Internet Encyclopedia of Philosophy*, n.d., accessed July 10, 2024, https://iep.utm.edu/care-ethics/#H2.

> care to children, the elderly and the infirm, it is also the case that all able-bodied adults receive care from others, and from themselves, every day.[7]

Professor Inge Van Nistelrooij of the University of Humanistic Studies in Utrecht, Netherlands goes further when she states:

> If responsibility is not taken or accepted, caring does not occur. Responsibilities to care are taken by certain groups of people, making caring practices into moral and political practices in which responsibilities are assigned, assumed, or implicitly expected, as well as deflected. Responsibilities to care are however taken by certain groups of people, for else nobody and nothing would be taken care of. Despite the lack of political and ethical attention for this everyday practice, our society would not exist without care.[8]

Epidemiologists John Wright and Rhys Williams along the Public Health advisor John Wilkerson, writing in the journal BMJ are helpful in their assessment of the differences between health care needs and health needs; an issue that speaks to the quality of care needed in order to age in place:

> When it is in the context of *health-care need and health needs. Healthcare need* is the capacity to benefit from healthcare services, such as disease prevention, diagnosis, treatment, rehabilitation, and terminal care. However I choose to focus on health needs; *Health needs*, for example, the need for social and environmental supports for health, such as housing, food security, education, and employment. *Health needs* incorporate the wider social and environmental determinants of health, such as deprivation, housing, diet, education, employment. This wider definition allows us to look beyond the confines of the medical model based on health services, to the wider influences on health. Health needs of a population will be constantly changing, and many will not be amenable to medical intervention.[9]

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[7] Joan Tronto, "There Is an Alternative: *Homines Curans* and the Limits of Neoliberalism," *International Journal of Care and Caring* 1, no. 1 (March 1, 2017): 27–43, https://doi.org/https://doi.org/10.1332/239788217X14866281687583.

[8] Inge van Nistelrooij and M.A. Visse, "Me? The Invisible Call of Responsibility and Its Promise for Care Ethics," *Medicine, Health Care and Philosophy* (October 16, 2018): 1–11, https://research.uvh.nl/en/publications/me-the-invisible-call-of-responsibility-and-its-promise-for-care-.

[9] John Wright, Rhys Williams, and John R. Wilkinson, "Development and Importance of Health Needs Assessment," *National Library of Medicine*, April 25, 1998, accessed June 5, 2024, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113037/.

In *Toward Equity in Health: A New Global Approach to Health Disparities*, edited by Barbara C Wallace., PhD, Dr. Wallace provides a broader understanding of the importance of care needs and the broader implication that will exist if the responsibility to offer care needs affect the very being of seniors.

> Health disparity/inequality is defined as a particular type of difference in health (or in the most important influences on health that could potentially be shaped by policies); it is a difference in which disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups."[10]

The question in my mind is how can anyone disregard the need to provide care to the elderly living in affordable housing? Let us now have a look at a Theology of Care as well as how Sacred Scripture provides insight into Care for Others as a way of coming closer to an answer to my question through this project.

THEOLOGY of CARE

THEOLOGY of CARE can best be defined by the example shared by Dr. Gabriella Woo, MD the executive director of Amos Health and Hope when she was one of the presenters in the April 6, 2022, Webinar CCIH (Christian Connections for International Health) Integration of Faith and Health. She started her presentation by saying, "the scriptures are full of emphasis on healing and the integration of faith and health. One example in Mark (5:36) is when Jesus said, 'your faith has made you whole'. The way that Jesus healed both body and spirit is a perfect example of where faith and

[10] Barbara C. Wallace, ed., *Toward Equity in Health: A New Global Approach to Health Disparities* (New York, NY: Springer Publishing Company, 2007).

health intersect and of Amos health and hope this is a fundamental value for the work that we do."[11]

The word intersection or intersect symbolizes the Divine God, the vertical alignment and the horizontal alignment is the Divine God intersecting with humankind. As a result of the two axes intersecting the commands from God to care is received by humankind requiring them to act. That intersection happened to me when I read a book title "Moore by Todd Wilson".

SCRIPTURE

> The Hebrew definition of care: שׁמר - shâmar -To take care (watch over) v.-to be in charge of or deal with something, implying responsibility for management.[12]

Eric W. Adams, contributed an article on Care to the *Evangelical Dictionary of Biblical Theology* and goes further:

> In the Old Testament several Hebrew words are translated as "care" or a similar word (e.g., "worry" or "anxious"). In 1 Samuel 10:2, when Samuel anoints Saul as king, a series of signs are predicted by Samuel to prove God's favor on Saul, culminating in the indwelling of God's Spirit. The first sign is that two men will say to Saul, "The donkeys that you went to seek are found, and now your father has stopped worrying about them and is worrying about you.[13]

In the following, excerpt, from blogger Tom Carlton of *Ethnos 360* found in his blog entitled: *Orphans, Widows, the Poor and the Bible,* Carlton first talks about

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[11] Gabriella Woo, MD, "What Is the Theology of Health and How Does It Apply to Global Health?" (Webinar), *Christian Connections for International Health*, accessed July 14, 2024, https://www.youtube.com/watch?v=CsMYZiG6p_c.

[12] *Strong's Hebrew Lexicon*, n.d., s.v. Shamar, accessed July 14, 2024, https://studybible.info/strongs/H8104.

[13] Eric W. Adams, "Care," in *Evangelical Dictionary of Biblical Theology 3rd. ed*, ed. Daniel J. Treier and Walter A. Elwell (Grand rapids, MI: Baker Academic, 2017), pg. 82.

systematic theology and its intersection with scripture as we have attempted to do above; he says:

> …each one of us 'does' systematic theology without realizing it. We say things like, 'Throughout the Bible God is always…' Or 'The Bible teaches that…'and then we fill in those blanks with some action on God's part or a topic on the Bible's part that we see as general truths…So we systematize, summarize, synthesize, generalize, emphasize…but when we place ourselves under the Scriptures as students willing to be corrected…it corrects our imbalances; it confronts our lives and our theology.[14]

Carlton continues as he describes God through Moses, makes it abundantly clear how the widows, orphans, and foreigner were to be treated and the consequences for not doing so for those who violate His commands.

Moses makes this statement about God in Deuteronomy, *"He executes justice for the orphan and the widow, and shows His love for the alien by giving him food and clothing."* (Dt. 10.18) And later he instructs them, *"At the end of every three years, bring all the tithes of that year's produce and store it in your towns, so that the Levites (who have no allotment or inheritance of their own) and the aliens, the fatherless and the widows who live in your towns may come and eat and be satisfied, and so that the LORD your God may bless you in all the work of your hands."* (Dt. 14.28-29) He makes provision for the poor living among them, *"For the poor will never cease to be in the land; therefore I command you, saying, 'You shall freely open your hand to your brother, to your needy and poor in your land."* And finally we see His concern again when He says, *"Cursed is he who distorts the justice due an alien, orphan, and widow…"* (Dt. 27:19) [15]

Given the secular and biblical definition of care, those who are determined to reduce or eliminate resources for health needs for the elderly are deflecting care. This can result in health disparity/health inequity which can affect seniors who cannot age in place in order to live independently.

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[14] Tom Carlton, "Orphans, Widows, the Poor & the Bible," web log, *Ethnos 360*, September 5, 2015, accessed July 15, 2024, https://blogs.ethnos360.org/tom-carlton/2015/09/05/orphans-widows-the-poor-the-bible/.

[15] Carlton, "Orphans, Widows."

God had a plan to create everything for the existence and survival and of humankind. Everything that God created is designed to meet the needs for all creatures to exist in the created order and humankind can survive. God was so concerned for what He created that He gave instruction for all He created to be cared for, plants, animals, birds, sea creatures and humankind. Grace Ruiter comments on this from her post at the Reformed Church of America:

> Within this ecosystem, from the start, God assigns humans special responsibilities. In Genesis 1, God gives humankind dominion over other living things. In Genesis 2, God puts humankind in the garden of Eden to "till it and keep it." However, God also instructs them not to eat from one particular tree: the tree of the knowledge of good and evil. The story of Adam and Eve's eating the forbidden fruit doesn't just represent human rejection of God's way. It represents the fracture of both humanity's relationship with God *and* God's creation. The reverberations of human sin disrupt shalom across all of creation.[16]

He was so concerned that he also revealed the consequences if His command was not obeyed (Amos 5:10–12).

RESPONSIBILITY TO CARE

In other scriptural references, the nation of Israel had experienced war and experienced loss, as seen in Exodus 17:1-14 when they fought against the Amalek, resulting in the survival of widows, orphans, and the foreigners who would give their lives to God. In Deuteronomy 14:27-29 God set funding and distribution in place to care for those in need. Funding existed for the purpose of distribution; how and when to share with those who did not have it, and it was the responsibility of those who did have to share. God's activities demonstrate care, God is Care and Care is God. The story about

[16] Grace Ruiter and RCA Commission on Christian Action, "Why Care for God's Creation Matters: A Biblical Perspective," *Faithward*, 1982, accessed June 5, 2024, https://www.faithward.org/why-care-for-gods-creation-matters-a-biblical-perspective/

the Good Samaritan demonstrated the commands God gave the Israelites in Deuteronomy 14:27-29. The Priest and Levite passed a man who was beaten and left for dead without rendering care to him. They willingly ignored the command in Deuteronomy, but when the Samaritan saw the man, he stopped to exercise the command to care. A practical outworking of loving vigilance, efforts, and tenderness. God perfectly shows care. People should imitate God's care, but human care is often limited, faulty or misplaced in self-centered ways.

Going further, care is:

"A practical outworking of loving vigilance, efforts, and tenderness, God perfectly shows care. People should imitate God's care, but human care is often limited, faulty or misplaced in self-centered ways." [17]

[17] Martin H. Manser, *Dictionary of Bible Themes: The Accessible and Comprehensive Tool for Topical Studies* (London: Martin Manser, 2009).

CHAPTER FIVE

PROJECT PARAMETERS – CALMING THE FEAR

The purpose of this project is to develop a vision statement by means of a collaborative effort on the part of the stakeholders to help with the process of Calming Fear many residents experience about being able to age in place and retain their place of residence, if they are able to do so.

It is the stakeholder's (mentioned and described in the previous chapter) whose individual and collective (read: collaborative) insight that will hopefully result in a vision statement that is based on HUD's Mission Statement for people sixty-two years and older to age in place. It is also our intent to share that vision statement with our residents to determine if, in fact it attains the desired effect

The definition of Collaboration comes to us from Loghlan Sofield, mentioned in the last chapter:

> The identification, release, and union of all the gifts in ministry for the sake of mission. The essence of collaborative ministry of gift. Second, collaboration is never and end in itself: it is a vehicle for ministry.[1]

While the context for this project does not find itself in a church, we still view our efforts on behalf of our residents to fall with the realm of ministry because both Providence Manor and Friendship Towers originated under the auspices of churches. With that in mind, we (meaning both me and the stakeholders) are well aware of the need to separate the entities with which we are dealing from the laws, regulations and guidelines of the Federal Government (HUD, specifically.

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[1] Loghlan Sofield and Carroll Juliano, *Collaboration: Uniting Our Gifts for Ministry* (Notre Dame, IN: Ave Maria Press, 2000), pg. 17.

Since I have identified the aforementioned stakeholders, Sofield and Juliano next suggest that "the stakeholders review the four levels of collaboration: co-existence, communication, cooperation, and collaboration." The writers further suggest, after reviewing the four levels, the stakeholders should decide if they want to move to the next level. Once done the stakeholders decide whether there is a desire to grow, they will move to that next level.[2]

The fourth level, collaboration, is called the true collaboration, described in the "Characteristics of Achieving Level Four of Collaboration".

> This level is characterized by a number of realities. First, the group acknowledges, articulates, and experiences ownership of a common mission. Second, there is a desire to work together for a common goal. 'Turf' issues are relegated to a lower status. The desire to collaborate, rather than compete, arises as the driving force. Turf and competition are replaced by a spirit of mutuality and partnership. Third, there is a decision to identify, value, and unite the various gifts that each possesses. Individuals and groups acknowledge the gifts they bring to the common mission and are able to affirm the gifts that others bring. Collaboration occurs when all the different gifts are freely joined together in ministry…[3]

The level for the stakeholders then moves to is The Practical Steps to Collaborative Ministry:

> The Practical Steps to Collaborative Ministry" are the four Cs consisting of clarification, conviction, commitment, and capacity/capability. "Any group who wishes to become more collaborative must first spend time discussing what the term means to each of the individuals within the group or unit. After the initial sharing, there is need for the group to determine a corporate understanding of collaboration. Failure to arrive at a common understanding of collaboration will result in frustration and inevitable conflict.[4]

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[2] Sofield and Juliano, "Collaboration," 18.

[3] Ibid., 19.

[4] Ibid., 20.

It should become obvious when moving from one level to deeper levels, that the stakeholders would become more intentional with their gifts to arrive at the essence of collaborative ministry (Gifts-Ministry-Mission) to eliminate any misunderstanding about their purpose as they move toward creating a vision statement that will connect with the HUD mission statement as well as setting and adhering to an agreed-upon timetable for scheduled meetings. The following quote will necessarily be adapted for usage in our decidedly secular setting:

> The essence of collaborative ministry is the identification, release, and union of all the gifts in the … community. This statement emphasizes the fact that 100 percent of the people of God are both gifted and called. Any collaborative project must develop a process for clearly identifying the gifts of the individuals or groups involved. Next, a frank and candid exploration must be undertaken to determine what, in the individuals or in the system, is preventing the gifts from being placed at the service of the gospel. Finally, there is need to determine how the gifts can be joined together to accomplish the mission.[5]

After a so-called dream period of brainstorming, the stakeholders will develop a series of evocative questions to meet the objective of informing residents about aging in place. The answers to the question will be analyzed for the purpose in developing the vision statement and guide to be share with the residents, relatives and family members as well as other caregivers. This would be the beginning of developing a viable commitment of the vision statement to the HUD mission statement. From there, we would eventually move to the implementation phase, to offering support to the residents, relatives, family and caregivers. The last phase is the evaluation phase which would be a continuing cycle in order to gauge effectiveness first of the project itself and then of the process we envision.

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[5] Ibid., 21.

PROJECT PLAN OF ACTION SCOPE

The project will gather the stakeholder once a week for 2.5 hour Zoom sessions for the purpose of sharing everyone's own personal origin stores regarding issues arising from the Miss B narrative. Using the Miss B narrative, I will ask everyone to share their experiences with the resident's fear about losing their apartment and the desire to age in place as well as their own personal fears or concerns about this issue, perhaps arising from their own life experiences. As a result of these meetings, we shall hopefully be able to craft a vision statement based on the HUD mission statement utilizing the tools described earlier in this chapter. Research narratives collected from residents, reading books, journals, found documents, will also be included. The project will be designed to take place within a time frame of a four-month period. It will also consider carefully the best dates and times for gathering and listening, and the reasonable amount of time necessary to process and reflect on the mass of material collected from the stories. One obstacle that may arise in this project is the confidentiality that should exist in sharing personal information shared with the Service Coordinator with the other two stakeholders as mandated by HUD regulations. Some other obstacles that may occur from low self-esteem, arrogance, hostility, inability or unwillingness to deal with loss, termination, and separation some of which are mentioned by Sofield and Juliano.[6]

TIMELINE

Meeting on ZOOM once per week for 2.5 hours over four weeks.

METHODOLOGY

> (Qualitive) Methodological research involves the utilization of a variety of methods and approaches which enable the researcher to explore the social world

[6] Ibid., 24-25.

> in an attempt to access and understand the unique ways that individuals and communities inhabit it. Like Practical Theology, qualitative research is essentially interested in situations and practices. Like Practical Theology, qualitative research is essentially interested in situations and practices… A simple way to conceptualize good qualitative research is like a detective story without a fixed ending… However, unlike a detective, the qualitative researcher does not seek to *solve* the problem or 'crack' the case…The evidence can tell many stories, and all of them may contain truth.[7]

By now, I think the reader can see that the Narrative of Concern regarding Ageing in Place is multifaceted. I hope this project might help both stakeholders and residents see how complex their fear has become, and in some way our efforts might help quell those fears.

EVALUATION

This evaluation emphasizes the aspect of storytelling that is informative, but as we know, in its very telling story (narrative) may also be transformative for the reader as well. Carl Savage and William Presnell have developed their own methodology in *Narrative Research in Ministry*. They also help to provide a fitting context for Project evaluation:

> We see a form of evaluation that consists of two distinct parts. One part is observing change. This first part is fairly straight forward; you compare the state of the context prior to a new ministry intervention and afterward. In a sense, this part of evaluation is only a measurement process. Has there been change in activity, habits, stories told, etc.? The second part is discerning transformation. The definition of transformation is "a marked change, as in appearance or character, usually for the better." (The American Heritage Dictionary of the English Language. (Boston: Houghton Mifflin, 2000)).The latter part of this definition is critical in this understanding of the purpose of evaluation—discerning transformation… [8]

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[7] John Swinton and Harriet Mowat, *Practical Theology and Qualitative Research*, second. (London: SCM, 2016). 28-29.

[8] Carl Savage and William Presnell, *Narrative Research in Ministry: A Postmodern Research Approach for Faith Communities* (Louisville, KY: Wayne E. Oates Institute, 2008). 124.

Of the five different choices for evaluation, presented by Savage and Presnell, I believe the Functionalist perspective would provide a good fit for this project:

> This perspective seeks to discern how parts of a context might fit together differently now. It builds on the sense that if one component system is changed, that change affects the whole. While this perspective can be used in a deterministic way, it also allows for the researcher to discern 'unintended' consequences that may have emerged by the programmed initiatives.[9]

The reason that evaluation is important in Project research, according to Savage and Presnell, is that the end result does not exist in the realm of success or failure, only in discernable results which they claim can lead to a preferred future that can be markedly different from the present situation:

> Instead, we describe the new orientation to the realities present at the end of the process that sought to empower a preferred future. We may ask (even in a secular setting – emphasis mine): What is the Spirit doing? What is emerging? What has been called forth?... Again, this is discernment, not measurement…you have moved your ministry perspective from a 'now' to a new 'now;' from one emerging future to another. The preferred story is future as preferred relationships.[10]

[9] Savage and Presnell, "Narrative Research," 128.

[10] Ibid., 125.

CHAPTER SIX – CONCLUSION – QUELLING THE FEAR

FAITH BASED COMMUNITY, THEIR ROLE

When the need to provide affordable housing for seniors came to light originally, it was the Faith Community who started what was then called The Old Folks home. They used a house to provide shelter for the senior members of their congregation who needed a place to live. Later with the help of the federal government they were able to take advantage of funding from HUD to build and manage affordable apartments for seniors.

Now the Faith Based Communities in collaboration with the Service Coordinator are being called upon to minister to those who need quality health care to fulfil the prayer David prayed on behalf of Solomon when he ascended to the throne. Psalm 72:12-14.

> **12** For he will deliver the needy when he cries for help,
> The [q]afflicted also, and him who has no helper.
> **13** He will have compassion on the poor and needy,
> And the [r]lives of the needy he will save.
> **14** He will [s]rescue their [t]life from oppression and violence,
> And their blood will be precious in his sight;

David prayed as Solomon ascended to rule over Israel. David remembered God's instructions to the Priest and Levites, therefore they were the only ones to touch and carry the art of the convent when he returned it to Jerusalem; because he obeyed God's command his endeavor was successful. David wanted to remind Solomon about the obligation he had to care for the orphans, widows, foreigners as well as the Levites that is recorded in Deuteronomy 14:27-29. David did not want Solomon to not forget all that God had commanded.

The Atlanta Journal-Constitution published in its Sunday, February 11, 2024, edition how the Faith Based Community is tackling health equity in the Atlanta metro

area by setting up mobile clinics to serve some of the underserved communities, leasing space on church campuses for free clinics to administer urgent care as well as primary care, while others setup community gardens to help others learn how to grow nutritious food. [1]

These endeavors should continue to provide every resident with the information and services they need. However, in addition to what is already provided. Residents need to know what to expect as well as their rights if they have to go to a nursing home or rehab center after a medical procedure.

Education seminars for seniors as well as printed media is needed to inform the residents and seniors in general of their rights, proper nutrition, and proper medication dosage. The following are some of the topics to cover.

1. Their right to return home with the assistance from PowerLine to continue with their healthcare.
2. How to cook nutritional meals from the gardens.
3. Invite a pharmacist to advise seniors on when and how to take their medication and medication not to mix.
4. Invite attorneys to educate senior about Miller Trust.
5. Invite a Social Workers to explain Medicare and Medicaid benefits

The objective of this project was to provide residents of Providence Manor with the knowledge to overcome the barriers preventing them from aging in place by exercising faith to overcome the barriers that are preventing quality healthcare and enjoying social equity so they can age in place.

As seniors get older, they have trouble getting in and out of the bathtub. Another issue revealed some family caregivers are not prepared to handle the responsibility of

[1] "Faith Based Community Tackles Health Equality Issues," *Atlanta Journal-Constitution*, February 11, 2024, sec. B-7.

being a caregiver for their loved ones. There needs to be more research to address these concerns. This is the gist of what this project hopes to accomplish

You have heard the saying, “a little bit of knowledge will take you a long way,” or something to that effect. Such was the case with Miss B, she found herself growing despondent and depressed because she did not see a way she could return to her apartment. Every time she thought she was going home the social worker told her she ran the risk of falling at her apartment and no one will be there to assist her let alone not having a caregiver to see to her needs. Nor will she have everything she needed to be in place at the apartment before they will release her. This was the same excuse that was given to her on three different occasions. She and her neighbor were told it was left up to her neighbor to arrange for everything she need which left them both at the point of confusion and frustration.

It was not until someone outside of the facility told Miss B, she could be transferred to another facility, but it had to be a written request from her. At that point the door of opportunity started to open. When Miss B made the request, in writing, for a clinical to be perform in order for her to be transfer to another facility the facility had no other choice but to grant her request.

As a result, Miss B was transferred to a facility that was close to her apartment which meant her neighbors and friends could visit her. At the new facility she learned from someone outside of facility that there was a nonprofit organization who specialized in transferring patients from nursing homes to their home if it was in writing. So, her had her neighbor to check into it to see if they will offer her the assistance she needed to return home.

Miss B was told that all she needed to do was to put it in writing using the name of the organization, that she wanted to return home to continue with her rehab and therapy. The new nursing home had no other choice but to honor her request. As a result, she was able to return to her apartment to continue her treatment. Our project will hopefully derive a vision statement that can help facilitate the process whereby Miss B and others can return to and keep their homes where they might be able to successfully age in place.

The question asked in the title "PROVIDENCE MANOR IS A PLACE TO AGE IN PLACE, OR IS IT? Miss B has provided the answer to the question when she returned to her apartment to receive the assistance and resource she needs to facilitate her rehabilitation.

In addition to Miss B's determination to return home, HUD issued a Notice[1] in February 2023 authorizing the owners through the Service Coordinators of 202 PRAC properties to facilitate whatever services and resources needed so the frail and near frail can age in place.

[1] HUD Notice H-2023-02

APPENDIX I

Exhibit I The 1906 Atlanta Race Massacre

"On the afternoon of Saturday, September 22, Atlanta newspapers reported four alleged assaults on local white women, none of which were ever substantiated. In a series of extra editions published throughout the day, the papers added lurid details and evermore inflammatory language, and soon thousands of white men and boys gathered downtown in protest. City leaders, including Mayor James G. Woodward, sought to calm the increasingly indignant crowds but failed to do so.

By early evening, the crowd had become a mob; from then until after midnight, they surged down Decatur Street, Pryor Street, Central Avenue, and throughout the central business district, assaulting hundreds of Black people. The mob attacked Black-owned businesses, smashing the windows of Black leader Alonzo Herndon's barbershop. Although Herndon had closed down early and was already at home when his shop was damaged, another barbershop across the street was raided by the rioters—and the barbers were killed.

On Sunday, September 23, the Atlanta newspapers reported that the state militia had been mustered to control the mob; they also reported that Black people were no longer a problem for whites because Saturday night's violence had driven them off public streets. While the police, armed with rifles, and militia patrolled the streets and guarded white property, Black people secretly obtained weapons to arm themselves against the mob, fearing its return. Despite the presence of law enforcement, white vigilante groups invaded some Black neighborhoods. In some areas African Americans defended their homes and were able to turn away the incursions into their communities. One person who described such activity was Walter White, who experienced the riot as a young boy. The incident was a defining moment for White, who went on to become secretary of the National Association for the Advancement of Colored People (NAACP), and he later described the event in his 1948 memoir A Man Called White.

On Monday, September 24, a group of African Americans held a meeting in Brownsville, a community located about two miles south of downtown Atlanta and home to the historically Black Clark College (later Clark Atlanta University) and Gammon Theological Seminary. The group was heavily armed. When Fulton County police learned of the gathering, they feared a counterattack and launched a raid on Brownsville. A shootout ensued, and an officer was killed. In response, three companies of heavily armed militia were sent to Brownsville, where they seized weapons and arrested more than 250 African American men. Meanwhile, sporadic fighting continued throughout the day.

Aftermath

On Monday and Tuesday, city officials, businesspeople, clergy, and the press called for an end to violence, because it was damaging Atlanta's image as a thriving New South city. Indeed, the massacre had been covered throughout the United States as well as internationally. Fears of continued disorder prompted some white civic leaders to seek a dialogue with Black elites, establishing a rare biracial tradition that convinced mainstream northern whites that racial reconciliation was possible in the South without national intervention. Paired with Black fears of renewed violence, however, this interracial cooperation exacerbated Black social divisions as the Black elite sought to

distance itself from the lower class and its interests, leaving the city among the most segregated and socially stratified in the nation.

Newspaper accounts at the time and subsequent scholarly treatments of the riot vary widely on the number of casualties. Estimates range from twenty-five to forty African American deaths, although the city coroner issued only ten death certificates for Black victims. Most accounts agree that only two whites were killed, one of whom was a woman who suffered a heart attack on seeing the mob outside her home.

There were other consequences of the riot as well, both locally and nationally. Its aftermath saw a depression of Atlanta's Black community and economy. The riot contributed to the passage of statewide prohibition and Black suffrage restriction by 1908. It discredited for many Black leaders the accommodationist strategy of Booker T. Washington among the leadership of Black America and gave new legitimacy to the more aggressive tactics for achieving racial justice epitomized by W. E. B. DuBois, who wrote a powerful poem, "The Litany of Atlanta," in the riot's wake. Although it had a profound effect on many of those who experienced it, the riot was forgotten or minimized for decades in the white community and ignored in official histories of the city.[1]

[1] Clifford Kuhn and Gregory Mixon, "Atlanta Race Massacre of 1906," *New Georgia Encyclopedia* (A More Perfect Union - National Endowment for the Humanities, November 14, 2022), accessed June 3, 2024, https://www.georgiaencyclopedia.org/articles/history-archaeology/atlanta-race-massacre-of-1906/.

APPENDIX II

Exhibit II, Arthur Gale, MD, Fifty **Years of Medicare The Good and the Bad** Articles from Missouri Medicine are provided here courtesy of **Missouri State Medical Association**.

Contributing Editor Arthur Gale, MD, renders his personal opinion about half a century of Medicare and looks into its troubled and uncertain future.

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The Good of Medicare

July 30, 2015, marked the fiftieth anniversary of Medicare. President Harry Truman first enunciated the need for health insurance for the elderly. President John Kennedy was working on a plan before he was assassinated. Medicare was enacted in 1965 during the Lyndon Johnson administration. The bill was signed by Johnson in Independence, Missouri, the home of Harry Truman who became the first person enrolled in Medicare.

I started practice in 1963, a year and a half before Medicare began. I recall a patient about 65-years-old who came to my office with chest pain. I hospitalized him at a private hospital. He had a myocardial infarction from which he recovered. Several months later he again came to my office with complaints of chest pain. His major concern was not his chest pain but that he had run out of insurance and could not afford private hospitalization.

I arranged for him to be admitted to St. Louis County Hospital. In those days when patients had no insurance, they were admitted to a ward service at St. Louis City or St. Louis County Hospital. Medicare was a godsend for patients like the one I just described.

For the first twenty to twenty-five years Medicare worked well with regard to cost to the taxpayer and the quality of care rendered to patients. Journalist Steven Brill showed in a landmark Time magazine article how Medicare brought under control

the main driver of high health care costs-the hospitals.[1] In contrast to private commercial health insurance companies, Medicare accomplished this feat with very low administrative costs.

The Fee-For-Service (FFS) method of payment under which Medicare operated during this time allowed doctors to act as advocates for patients. Doctors were able to give patients enough time during office visits to express all of their complaints and concerns. The quality of care was good. Until the 1990s most patients were satisfied with Medicare and almost all physicians accepted Medicare.

The Bad of Medicare:

Medicare Advantage, Medicare Accountable Care Organizations, and Medicare Part D

Medicare Advantage

A revolutionary change in Medicare occurred in 1973, during the Nixon administration when the federally-backed Health Maintenance Organization (HMO) Act was passed. This law provided grants and loans to HMOs and required employers with 25 or more employees to offer federally certified HMO options if they offered traditional health insurance to their employees. This law gave HMOs access to the private health insurance market and ultimately to the Medicare population.[2]

This law is, in my opinion, the primary cause of America's problems with cost and quality in health care. The bill was supported by both Republicans and Democrats as a strategy to lower rising health care costs. This was a cruel joke because health care costs in the United States at that time were not out of control and were similar to costs in other Western industrialized democracies.

Caught on Tape

The ostensible reason for introducing HMOs into health care was to lower costs. The real reason was to increase corporate profits. This is borne out by an excerpt from the Nixon tapes in a transcript of a 1971 conversation between President Richard Nixon and his aide, John D. Ehrlichman, that ultimately led to the HMO act of 1973. There are some gaps in these tapes:

Nixon: ... "You know I'm not too keen on any of these damn medical programs"

> **Ehrlichman:** ... "Edgar Kaiser is running his Permanente deal for profit...And the reason that he can do it...I had Edgar Kaiser come in...talk to me about this and I went into it in some depth...All the incentives are toward less medical care, because...the less care they give them the more money they make"
>
> **Nixon:** "Fine..."
> **Ehrlichman:** ..."and the incentives run the right way..." **Nixon:** "Fine..." [3]

This excerpt neatly sums up the purpose of HMOs from its earliest origins. Nixon told his friends who supported and initiated this law that they could make a lot of money from HMOs. And HMOs have lived up to this expectation in spades. It also explains why health care costs are now so much higher in the United States than in other industrialized nations. Health care costs in the United States were about the same as other industrialized democracies until the 1980s. Then managed care and HMOs took off and so did America's health care costs.

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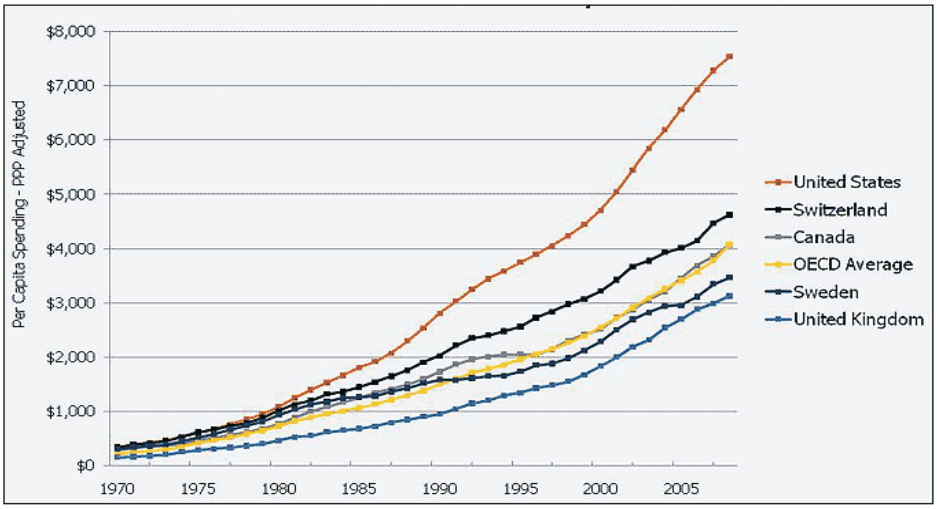
Figure 1 clearly documents this. Health care per capita spending in the United States was about equal to other OECD (Organizations for Economic Cooperation and Development) countries like Canada, the United Kingdom and Switzerland, etc., until about 1980. Then the graph shows a steep rise in health care costs in the USA compared to other countries, which has persisted to the present day. This steep rise coincides with the advent and takeover of the USA health care delivery system by commercial and Medicare managed care.[4]

Figure 1



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).
Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. Break in series: CAN(1995); SWE(1993, 2001); SWI(1995); UK (1997). Numbers are PPP adjusted. Estimates for Canada and Switzerland in 2008.

In the 1980s and 1990s corporate managed care stepped in and "fixed" a system that was
not broken. In an Orwellian twist, Medicare policy makers now blame FFS for the high cost of health care despite the fact that standard Medicare which is also known as Medicare FFS annually costs the American taxpayer about $14 billion less than Medicare Advantage, which is Medicare's managed care commercial private for profit plan.[5] It has been estimated that Medicare subsidies to Medicare managed care insurers over the past three decades have amounted to over $280 billion.[6]

Blaming FFS for the excessive cost of health care is nonsense. Yet everyone involved in health care today, including not just government bureaucrats, policy makers and self-serving insurance cartels, but Congress, hospitals, academics, practicing physicians, residents, medical students, and the general public, all believe this nonsense. Albert Einstein reputedly said any nonsense can attain importance by virtue of its being believed by millions of people.

Medicare Advantage plans are growing and constitute about 30% to 40% of all Medicare enrollees. The public likes them because they get freebees like spectacles, some drug benefits, and gym memberships, and enrollees often do not have to buy a supplemental policy. However, when patients have a serious illness, nursing home and rehabilitation benefits are usually less than in standard Medicare FFS benefits.

Consumers are mainly concerned about how much they pay out of pocket - not what it costs the government and ultimately the taxpayer. So, they think that Medicare Advantage is a good deal. The big health insurance companies like UnitedHealth Care and Humana love Medicare Advantage because it is their most profitable product. The corporate executives who run these insurance plans often complain about getting the government out of their lives, but they have no qualms about gouging the government and ultimately the American taxpayer so long as they can make a good profit. Medicare Advantage is a prime example of corporate welfare. The insurance company executives have taken to heart Nixon and Ehrlichman's message about how profitable HMOs can be, "the less care you give them the more profitable they can be."

Accountable Care Organizations

Accountable Care Organizations (ACOs) are the newest government program designed to lower health care costs under Medicare. The easiest way to understand ACOs is to acknowledge that they are just another form of HMO using capitation instead of FFS. Fee-For- Service again becomes the scapegoat for high health care costs even though, as noted above, Medicare FFS on an annual basis is $14 billion per year less expensive than the Medicare HMO, Medicare Advantage. Under ACOs doctors and hospitals will be financially rewarded if they meet certain goals or benchmarks. This is called "shared savings."[7]

The most controversial aspect of ACOs is that doctors will be at financial risk. Financial risk pits the financial incentives of physicians against the medical interests of patients. The more physicians do for patients the less they get paid. The less doctors do for patients the more they get paid. The physician is no longer the patient's advocate. These financial incentives violate the Hippocratic Oath which states: "I swear...that I... will follow that system which, according to my ability and judgment, I consider for the benefit of patients, and abstain from whatever is deleterious..."

These perverse financial incentives were tried in the 1990s under the old gate keeper HMOs. Younger doctors probably don't remember gatekeeper HMOs. Under this system the primary care doctor acted as a "gatekeeper" for ordering tests and procedures. For the short time gatekeeper HMOs were in force they did lower health

care costs. However, when the public found out what actually was going on with their health, i.e., some doctors were padding their own pockets by denying needed care, their fury knew no bounds.

This is best exemplified in the 1997 movie "As Good as It Gets," starring Jack Nicholson and Helen Hunt. In the movie Helen Hunt, a single mother, voices her dissatisfaction in no uncertain terms with an HMO's treatment of her son's asthma. When she says that she is going to obtain the services of a good non-HMO doctor, spontaneous cheering and applause broke out in movie houses all across the nation. These spontaneous public outbursts to "As Good as It Gets" were as bad as it gets for the HMO industry. That movie, like no other event signaled the end of gatekeeper HMOs.

I thought that the perverse financial incentives involved in gatekeeper HMOs were gone for good. But I was wrong. The insurance companies apparently never give up on their assumption that doctors are no different from Wall Street traders and that their behavior in treating sick patients can be controlled with financial incentives. Now the same financial incentives they used with gatekeeper HMO are back again under ACOs but with a new name: risk contracts. Because of the bad publicity they received with gatekeeper HMOs the insurance industry wants to conceal its role in developing risk contracts from the public. This is revealed in a recent document released by the American Hospital Association: "One lesson learned from the HMO experiment noted earlier is that providers and patient communities will not accept a system with medical management from the insurance entity. Consequently, there has been an emphasis on physician leadership even when the sponsoring entity, in terms of contracting and investment, is considered the hospital."[8]

What this means in plain English is that now the government and third-party insurers with the
acquiescence of hospitals and some physicians are going to impose through ACOs physician
financial incentives which the American public overwhelmingly rejected in the past. Physicians, unlike insurance companies, are still trusted by the public and they have been chosen to assume a leadership role in ACOs.

This new form of rationing care won't work because ultimately the public will find out what risk contracts really are and again will reject them as they did with old gatekeeper HMOs. And when the trial lawyers find out about them, watch out. It won't be the hospital or insurers or CMS that gets sued. It will be physicians. When a CEO of a hospital network was explaining how risk contracts work to a group of doctors a physician asked, "What if I get sued?" The CEO's response was, "Deal with it," which is another way of saying "it's your problem, not mine."

There is another lesson to be learned about this unholy alliance between commercial health insurance companies and hospitals. In the so-called competitive free market under which our health system operates, hospitals and insurance companies are supposed to be competitors. Now, under ACOs, they are colluding to promote risk contracts. I believe this is a flagrant example of 'crony capitalism.'

By law under Medicare, commercial insurance companies are allowed to skim 20% off the top for administrative costs. And the hospitals will take their cut for administrative and other costs, too. This leaves physicians holding the bag rationing health care to patients. If they don't, their income will suffer. Despite all of the positive hype put-out by CMS, hospitals, and insurance companies, ACOs like all HMOs in the past, will fail in their mission to lower costs. HMOs and capitation have been studied since the 1970s. They have never lowered health care costs. And they never will.

Source: TruthinAccounting.org

Quality of Care

What about the quality of care in Medicare today? The government, through CMS, is using its new gimmick - the electronic health record (EHR) - to measure "quality" through the Physician Quality Reporting System (PQRS).[9] This is being done in all three modes of health care delivery: Fee-For-Service, Medicare Advantage, and Accountable Care Organizations. Supposedly, by checking boxes on patients' blood pressure, weight, exercise, smoking cessation, cholesterol, LDL, hemoglobin A1C, etc., quality is improved. And physicians are rewarded financially if they check all the boxes correctly. It's as if physicians were not discussing these issues with patients before these EHR metrics were introduced. This payment model for improving quality does not consider that many, if not most patients, are non-compliant with their physicians' recommendations no matter how many boxes are checked.

Quality of care should be equated with time spent with patients - not box checking. This is especially true in elderly patients with multisystem diseases who have many concerns and need time to express them. I know of an internist who works for Kaiser Permanente, a staff model HMO, who must see 30 patients per day. He is allotted 10 minutes for each patient. He comes home every night to spend several hours going over lab tests and doing other medical related work. This is not quality care. He advised his children not to go into medicine. In the brave new world of managed care and government edicts, the physician, a once proud professional, has been transformed into an assembly line worker.

Medicare Part D

Medicare Part D is the Medicare drug program passed by Congress. It might be considered
an example of padding the bottom line of the pharmaceutical and insurance companies at the expense of Medicare beneficiaries and ultimately the taxpayer. Part D does not allow Medicare to directly negotiate drug prices with health plans as it does with the Veterans Administration. Veterans pay much less for pharmaceuticals than Medicare beneficiaries. Medicare members must pay a price for drugs that is a result of negotiations between drug companies and insurance

plans. As a result, the cost of drugs to a Medicare patient may be up to 80% more than what a veteran pays for the same drug.[10]

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One of the coauthors of this giveaway bill was Representative Billy Tauzin (R-La.), Chair of the House Commerce Committee. After the bill was passed, Tauzin quit Congress and took a job as chief lobbyist for Big Pharma at $2 million per year. The head of CMS at the time, Thomas Scully, defended the giveaway and deliberately understated the cost. He then returned to the private sector and resumed his career as a health care lobbyist. One Congressional representative called it the worst example of lobbying at the expense of the public interest in her 25 years as a member of Congress.[11] Medicare pays physicians directly. Why should the pharmaceutical companies be paid differently? Doctors would be paid far more than they are today if they were allowed to negotiate their reimbursements from Medicare with insurance companies. Right now the doctors can't negotiate and are forced to accept Medicare reimbursement on a "take it or leave it" basis.

Conclusion

If the government, through CMS. was serious about lowering Medicare costs and improving quality, it would stop focusing on physicians and blaming FFS for all of the ills of our health care system. Instead of relying on Medicare Advantage and ACOs, it would eliminate them entirely. The Federal government should also cut out the insurance company middle men in Medicare Part D and purchase drugs directly from the pharmaceutical industry for its Medicare beneficiaries. And of course the hospitals, the main driver of high health care costs, must be reined in. As noted above by Brill, only Medicare has the power to lower out-of-control hospital charges.

None of this is likely to happen, at least in the near future, because our dysfunctional Congress is dominated by the special interests that profit from maintaining the status quo. The non-partisan Congressional Budget Office (CBO) predicts that the Medicare Trust Fund will run out of money in 2030 or in about 15 years.[12] A true financial crisis might force the government to make some of the necessary changes described above. Whether the government and the American people have the will to make these changes remains to be seen.

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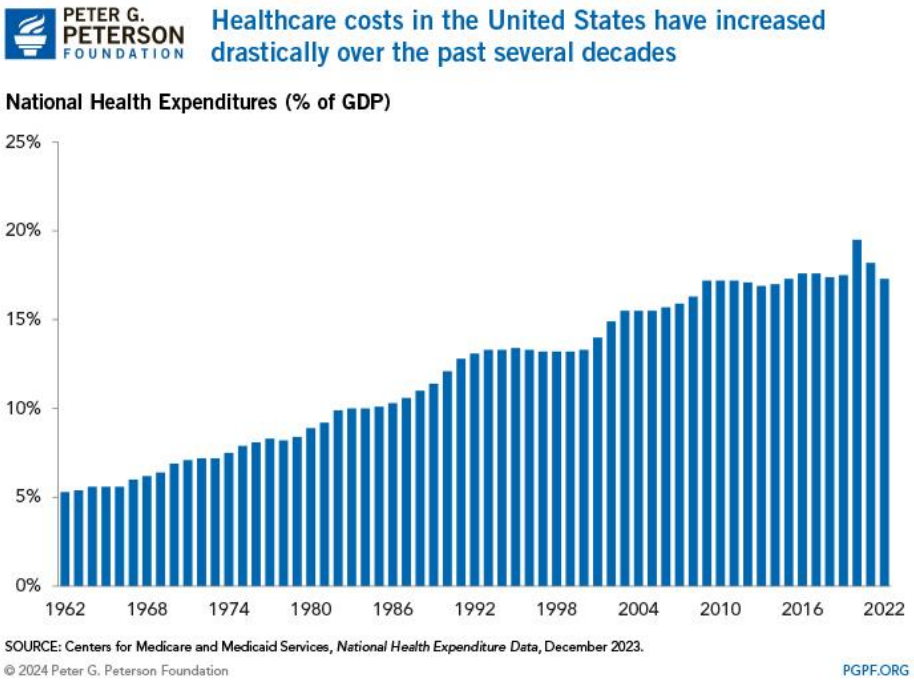
APPENDIX III

WHY ARE AMERICANS PAYING MORE FOR HEALTHCARE

" The United States spends significantly more on healthcare compared to other nations but does not have better healthcare outcomes. What's more, rising healthcare spending is a key driver of America's unsustainable national debt, and high healthcare costs also make it harder to respond to public health crises like the COVID-19 pandemic. Below is a look at the increasing healthcare costs in the United States, what is causing that rapid growth, and why it matters for public health and our fiscal outlook.

HOW MUCH DOES THE UNITED STATES SPEND ON HEALTHCARE?

The United States has one of the highest costs of healthcare in the world. In 2022, U.S. healthcare spending reached $4.5 trillion, which averages to $13,493 per person. By comparison, the average cost of healthcare per person in other wealthy countries is less than half as much. While the COVID-19 pandemic exacerbated the trend in rising healthcare costs, such spending has been increasing long before COVID-19 began. Relative to the size of the economy, healthcare costs have increased over the past few decades, from 5 percent of GDP in 1962 to 17 percent in 2022.



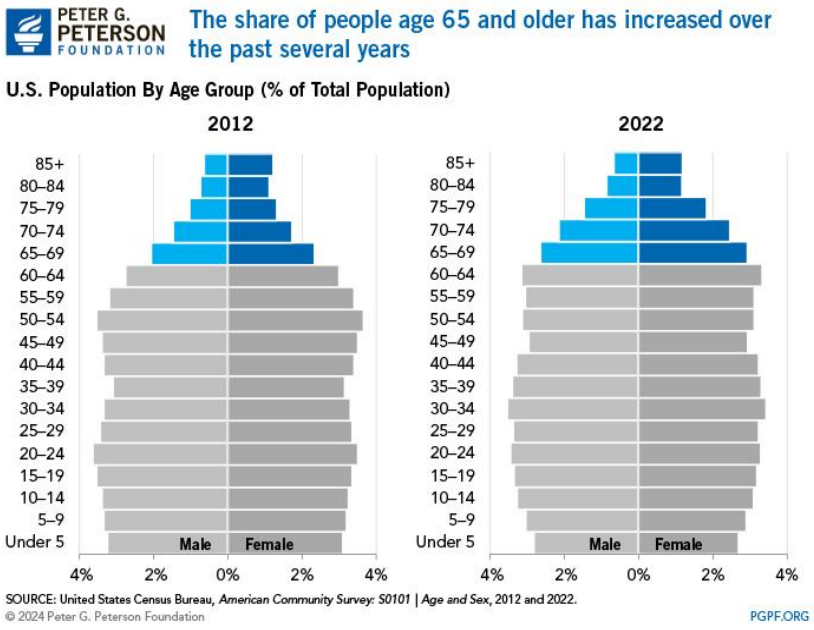
WHY HAS HEALTHCARE SPENDING RISEN IN THE UNITED STATES?

Generally, healthcare spending can be thought of as a function of price (dollars charged for healthcare services) and utilization (the amount of services used).

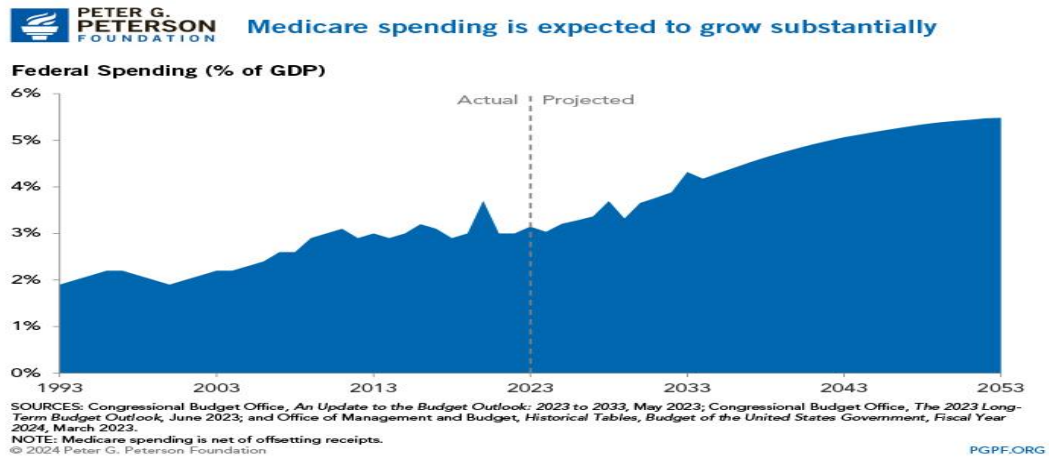
There are several underlying factors that can increase price and utilization, thereby boosting spending on healthcare. The most notable of those factors are an aging population and healthcare prices.

An Aging Population

The share of the U.S. population age 65 and over has increased over the past several years, rising from 14 percent in 2012 to 17 percent in 2022. Furthermore, that number is projected to continue climbing – reaching 21 percent by 2032. Since people age 65 and over, on average, spend more on healthcare than any other age group, growth in the number of older Americans is expected to increase total healthcare costs over time.

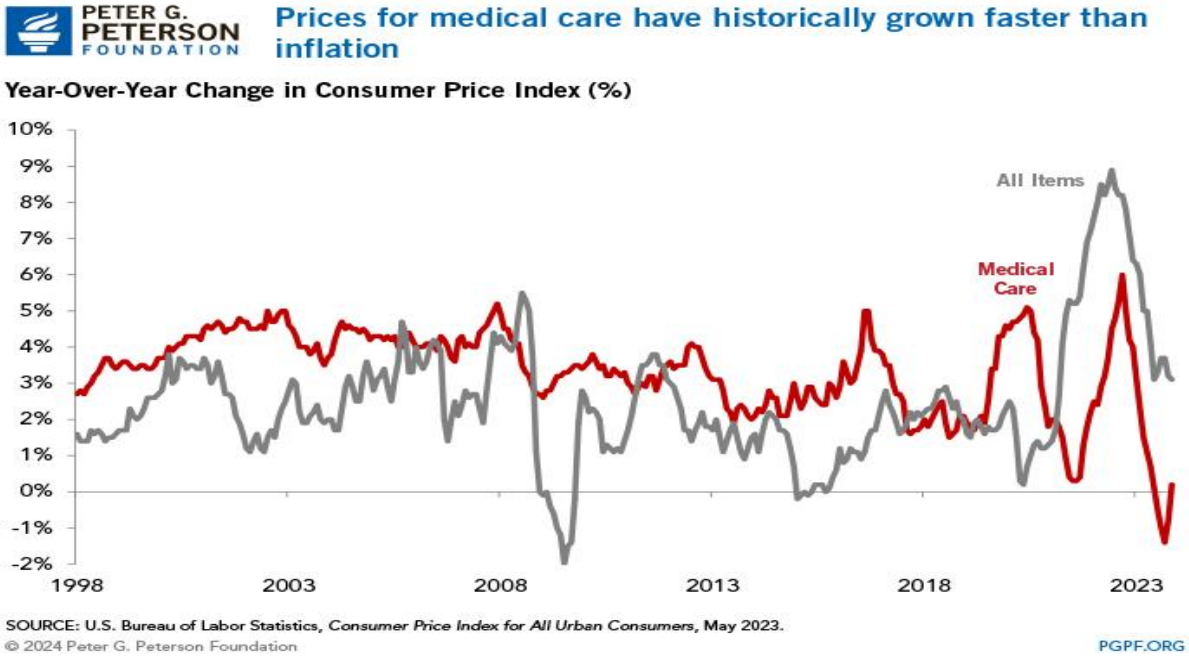


Furthermore, as individuals turn 65, they will become eligible for Medicare, and the number of enrollees in the program — 65 million in 2022 — will grow substantially. The increase in enrollment is expected to significantly increase the cost of Medicare over time. In fact, the Congressional Budget Office projects that Medicare spending will nearly double over the next 30 years relative to the size of the economy — growing from 3.1 percent of GDP in 2023 to 5.5 percent by 2053.



The Increasing Cost of Healthcare Services

Prices are another significant driver of healthcare spending in the United States; the cost of healthcare services typically grow faster than the cost of other goods and services in the economy. In the past 20 years, the Consumer Price Index for All Urban Consumers (CPI-U) for all items — the average change in prices paid by urban consumers for various goods and services — has grown at an average of 2.6 percent per year while the CPI-U for medical care has grown at an average rate of 3.1 percent per year. Over the past two years or so, however, the CPI-U for medical care has been lower than the overall CPI-U. In addition to historically high levels of overall inflation, analysts point to wage increases for health workers and delays in observable price increases, due to healthcare prices being set in advance, as possible reasons for that trend.



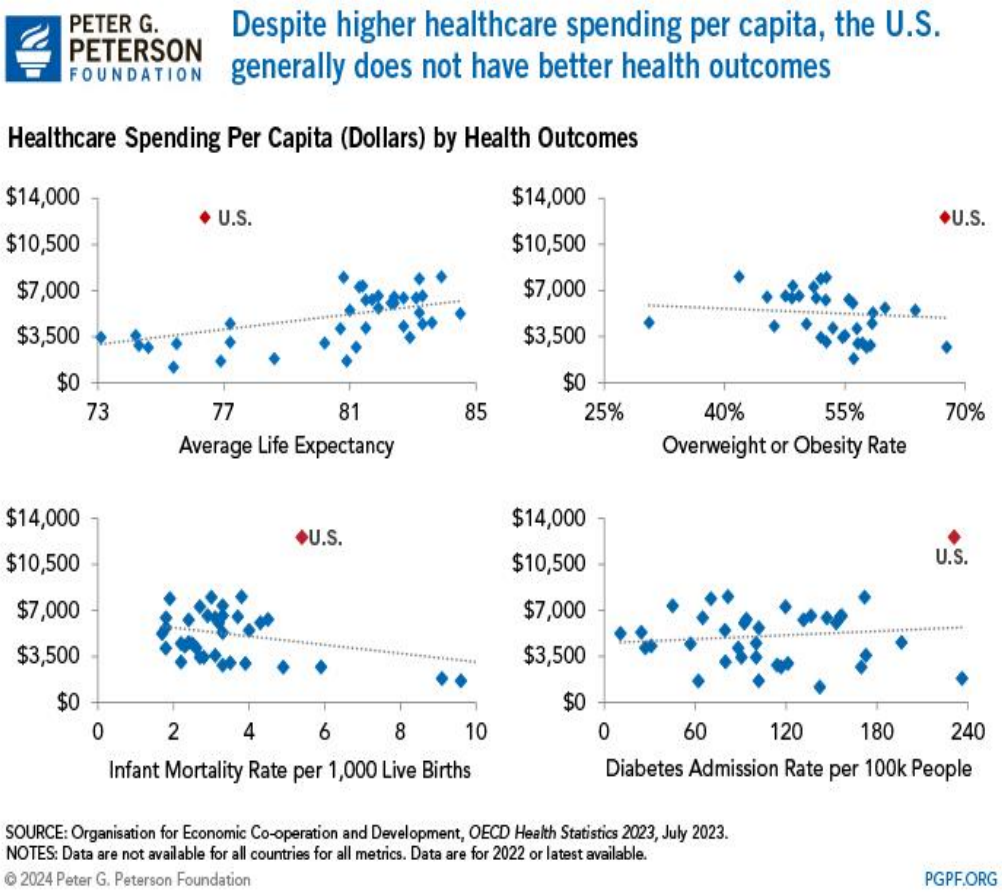
There are many possible reasons for that increase in healthcare prices:

- The introduction of new, innovative healthcare technology can lead to better, more expensive procedures and products.
- The complexity of the U.S. healthcare system can lead to administrative waste in the insurance and provider payment systems.
- The consolidation of hospitals can lead to a lack of competition or even a monopoly, granting providers the opportunity to increase prices.

More research needs to be done, though, to confirm the reasons that healthcare costs grow so quickly.

WHY INCREASING HEALTHCARE COSTS MATTER

It would be one thing if high healthcare spending led to better health outcomes. However, that is not the case in the United States. When evaluating common health metrics, the United States lags behind other countries despite spending more on such goods and services.



CONCLUSION

High healthcare costs put pressure on an already strained fiscal situation and are one of the primary drivers of the long-term structural imbalance between spending and revenues that is built into the country's budget. Containing high healthcare costs is important for our nation's long-term fiscal and economic well-being. For ideas on how to solve some of these issues, visit our Solutions page and the Peterson Center on Healthcare." [1]

[1] "Why Are Americans Paying More for Healthcare?," weblog, *Peter G. Peterson Foundation*, January 3, 2024, accessed June 5, 2024, https://www.pgpf.org/blog/2024/01/why-are-americans-paying-more-for-healthcare.

APPENDIX IV

"Lobbying expenditures grew by more than 70% across all 4 categories from 2000 to 2020, with higher levels of growth before 2010 (Figure 1). In 2020, US health care lobbying expenditures totaled $713.6 million vs $358.2 million in 2000. In 2020, pharmaceutical and health product manufacturers spent the most on lobbying activities ($308.4 million), followed by providers ($286.9 million), payers ($80.6 million), and other firms ($37.7 million). Spending was highly concentrated, with the top 10% of firms responsible for 70.4% of spending among payers, 69.0% among manufacturers, and 59.0% among providers (Figure 2). Spending among other firms was less concentrated, with the top 10% responsible for 37.7% of spending.

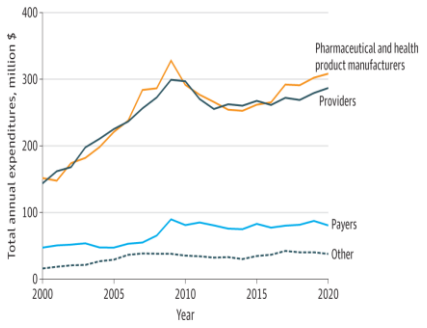


Figure Legend:

Trends in Federal Lobbying Expenditures Across US Health Care Industries, 2000-2020All spending adjusted to 2020 dollars using the Consumer Price Index. Providers are defined as health professionals, hospitals, nursing homes, and associated trade organizations; other, as health care consultants and policy organizations.

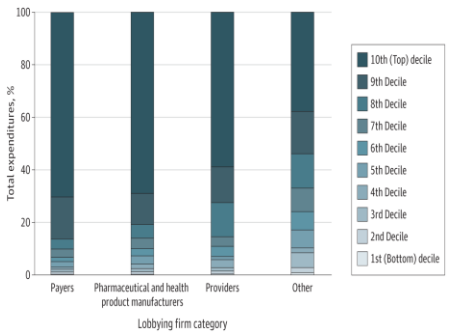


Figure Legend:

Concentration of Lobbying Expenditures Across US Health Care Industries, 2020Providers are defined as health professionals, hospitals, nursing homes, and associated trade organizations; other, as health care consultants and policy organizations.

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APPENDIX V

Exhibit V, Long-Term Services and Supports (LTSS)

LTSS consists of a broad range of assistance for people with chronic conditions and functional limitations. This can include support for activities, such as bathing and dressing, that people need to function in their own homes, as well as services provided in institutions. Importantly, and contrary to what many consumers may assume, *Medicare does not cover the costs of LTSS*. The need for affordable options is increasing, as more people are aging and living longer, and a declining pool of family caregivers is available to help.

- **New financing options are needed to make LTSS affordable.** The cost of LTSS exceeds what families can afford. A social insurance solution can best meet this growing need. Everyone should contribute if they can, and everyone should have the security of good coverage. A social insurance system is the best option, because the need for LTSS is unpredictable while the costs can be catastrophic. In the meantime, innovations in private coverage that create valuable, financially sustainable products should be encouraged.

- **LTSS should be coordinated and person- and family-centered.** To ensure the best outcomes for people in need of LTSS, family caregivers must be acknowledged as part of the care team, and service providers must coordinate their activities and share information across settings. Individual caregiver circumstances, abilities and needs must guide all treatment decisions.

- **More top-quality services should be available to help people remain in their homes and communities.** The federal government should eliminate Medicaid's bias favoring nursing facilities by mandating the provision of home- and community-based services (HCBS) for everyone who meets Medicaid eligibility criteria and chooses to receive services in HCBS settings. Services should be available in a range of settings, including supportive housing and adult day centers.

- **Family caregivers need more support for their crucial, unpaid efforts.** Unpaid caregiving has become increasingly complex for the relatives, friends and neighbors who provide it, often at significant emotional, physical and financial cost. Federal and state governments can empower caregivers by ensuring that LTSS covers services, such as respite care and adult day services, that supplement their efforts and help them endure. LTSS programs should also allow for family caregivers to be paid in certain situations, such as when a paid worker would otherwise be needed. Medicaid and other programs should include assessments of

family caregivers' needs. Employers should allow greater accommodations for the many employees who also provide family caregiving.[1]

[1] "What Is Homemaker Home Health Aide Care?," *Geriatrics and Extended Care*, October 18, 2023, accessed June 4, 2024, https://www.va.gov/GERIATRICS/pages/Homemaker_and_Home_Health_Aide_Care.asp

APPENDIX VI

Empowerline is a service that assists the elderly to assess the possibilities for returning home after a medical situation that had required a stay in the hospital, rehab center or nursing home. The following is an excerpt from their website:

- ask the nursing home social worker to make a referral to Empowerline to learn about your options in metro Atlanta.
- during the assessment, the nursing home should ask whether you would like to receive information about returning to the community.
- If you say "yes," they are **required** to contact Empowerline so that we may provide you with that information.
- After Empowerline receives a referral, one of our Certified Options Counselors will visit you or your loved one in the nursing home to discuss options and services that can help you move back into the community.
- The counselor will discuss available long-term service options and help you determine the most appropriate services to meet your needs and preferences so that they may help you successfully move back home.
- the long-term supports and services listed above, there are several programs that nursing home residents may be eligible for to support them during a transition out of the nursing home.
- Empowerline helps individuals transition from nursing homes to community settings through two programs:
- If you are a Medicaid eligible nursing home resident who has been living in a nursing home for at least three months,

    - Empowerline can help you to transition through a program called Community Transitions, also known as Money Follows the Person (MFP)
    - We use Community Transitions to pay for your expenses involved in any move, such as acquiring furniture and household items, assisting with moving costs. home modifications, and utility deposits for up to 365 days after your transition.

- Visit Georgia's Department of Community Health for more information about the Money Follows the Person program.
- See Exhibit VII, EmpowerLine[1]

[1] "EmpowerLine," *Empowerline*, accessed July 14, 2024, https://empowerline.org/resource/long-term-services-supports-planning/#jump.

Exhibit VI, https://www.empowerline.org/resource/long-term-services-supports-planning/#jump

I'm already living in a nursing home, but I want to move back into the community. What services can help me?

Being in a nursing home doesn't always mean you or your loved one needs to live there permanently. Maybe you were admitted after a stroke or an accident, and with rehabilitation complete, you feel that you can successfully move back home. Or maybe your mother has been living in a nursing home, but now that you're retired, you feel you can take care of her in your own home.

At any time during a nursing home stay, you can ask the nursing home social worker to make a referral to Empowerline to learn about your options in metro Atlanta. In fact, during your assessment, the nursing home should ask whether you would like to receive information about returning to the community. If you say "yes," they are **required** to contact Empowerline so that we may provide you with that information.

After Empowerline receives a referral, one of our Certified Options Counselors will visit you or your loved one in the nursing home to discuss options and services that can help you move back into the community. The counselor will discuss available long-term service options and help you determine the most appropriate services to meet your needs and preferences so that they may help you successfully move back home. In addition to the long-term supports and services listed above, there are several programs that nursing home residents may be eligible for to support them during a transition out of the nursing home.

Help to transition out of a nursing home

Empowerline helps individuals transition from nursing homes to community settings through two programs:

Community Transitions
If you are a Medicaid eligible nursing home resident who has been living in a nursing home for at least three months, Empowerline can help you to transition through a program called Community Transitions, also known as Money Follows the Person (MFP). We use Community Transitions to pay for your expenses involved in any move, such as acquiring furniture and household items, assisting with moving costs, home modifications, and utility deposits for up to 365 days after your transition. Visit Georgia's Department of Community Health for more information about the Money Follows the Person program.

Nursing Home Transition Program

If you have been in a nursing home for at least 30 days and are at least 55 years old, you may be eligible for the Nursing Home Transition program – whether or not you are eligible for Medicaid. Like Community Transitions, the Nursing Home Transition program will help you return to the community: either in your own apartment, a personal care home, or at home with loved ones. Empowerline can help you transition under this program and connect you to other services to help you to live in the community.[1]

[1] "Empower Line," *Empowerline*, accessed July 14, 2024, https://empowerline.org/resource/long-term-services-supports-planning/#jump.

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