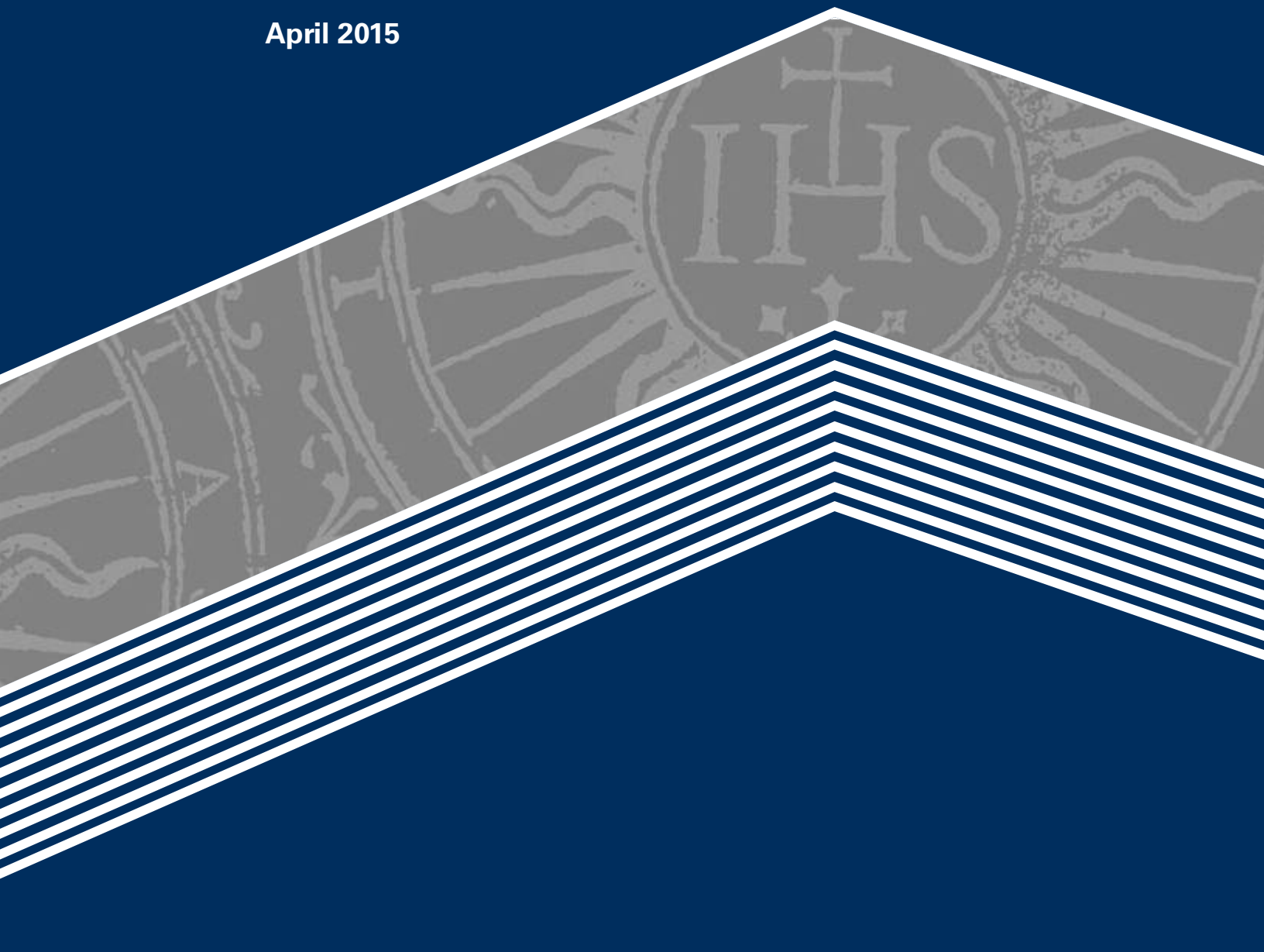
JESUITS®

Jesuit Health Care Handbook

for the Assistancy of Canada and the United States

April 2015



ACKNOWLEDGEMENTS (2014)

The 2014 revision of the Jesuit Health Care Handbook for the United States Assistancy was undertaken by a committee consisting of Arnie Shafer (CFN and ORE provincial assistant for health care), Paul Cochran, SJ (Superior of the Regis Community in Spokane, WA), Terry Kult (Health Care Coordinator for Omaha, NE) and David Godleski, SJ (Delegate for Formation and Jesuit Life – Jesuit Conference). The committee would like to thank Nancy Gallagher (Director, Manresa Hall, Philadelphia), Harry Geib, SJ (Superior of St. Claude La Colombiere Jesuit Community in Baltimore), Margaret Mary Monahan (Executive Director at Murray-Weigel Hall), Richard Twohig, SJ (former Superior of Colombiere Center in Clarkston, MI) and the other Provincial Assistants for Health Care (Deirdre Banscher (MAR), Ana Casey (MIS-NOR), Jane Glynn-Nass (CDT-WIS), Catherine Morency (NEN), Jacqueline Perez (NYK)) for their time, energy and diligence in their work on the revisions of the different sections of the Handbook. We also wish to express our gratitude to Ron Amiot, SJ, and Jane Ferdon, OP for their review of the updated drafts of the sections.

We are very grateful to Myles Sheehan, SJ, M.D., and Joseph Tetlow, SJ who contributed the original article entitled Spirituality and Aging.

The final editing of this Handbook could not have been accomplished without the assistance of Becky Sindelar and Doris Yu and we are thankful for the fine service they provided.

Should any part of this work be cited in scholarly material, the citation should read as follows: Provincial Assistants for Health Care of the Jesuit Conference of Canada and the United States, Washington, DC 20036.

©1997 by the New England Province of the Society of Jesus.
Revised 2006.
Revised 2014.
All rights reserved.

Printed in the United States of America.

No part of this book may be used or reproduced in any manner whatsoever except for brief citation or review in scholarly material without written permission of the New England Province.

Please contact the Jesuit Conference at 1016 16th Street, NW, Suite 400, Washington, DC 20036 for all inquiries concerning reproduction of any part of this material.

HOW TO SEARCH THIS DOCUMENT

PC users:

1. Press CTRL+F ("Control" and "F" keys).
2. Type your search term.
3. Hit "Enter."
4. Occurrances of your term will be highlighted in the text throughout the document.

   To the right of the search field are buttons to view the previous and next occurrances of your search term. Or you may press CTRL+G to see the next occurrance.

To bring up an advanced search function, hit SHIFT+CTRL+F ("Shift," "Control" and "F" keys).

Macintosh users:

1. Press ⌘+F ("Command" and "F" keys).
2. Type your search term.
3. Hit "Enter."
4. Occurrances of your term will be highlighted in the text throughout the document.

   To the right of the search field are buttons to view the previous and next occurrances of your search term. Or you may press ⌘+G to see the next occurrance.

To bring up an advanced search function, hit SHIFT+⌘+F ("Shift," "Command" and "F" keys).

To download the latest version of the free Adobe Acrobat Reader, visit **https://get.adobe.com/reader/**

CONTENTS

CONTENTS

FOREWARD

This handbook is divided into seven sections: Section One, *Conversation Guides for Superiors*, contains introductory comments and general directives for superiors in the form of questions and answers. Section Two, *An Annual Checklist for Superiors*, is offered as a practical tool for superiors to assess the health care needs and areas that may need attention in communities. Section Three, *Resources and Bibliography*, offers additional resources with added hyperlink/web page topics.Section Four, *Practical Guidelines for the Health Care of Jesuits*, provides a wide range of advice on quality of life questions and practicalities affecting community life. Section Five, *Ignatian Spirituality and Aging*, offers reflections on situating the aging process within the context of Ignatian and Jesuit spirituality. Section Six, *General Directives for Health Care in a Jesuit Retirement Facility or Nursing Care Center*. Section Seven, *Appendix*, which provides some samples of common forms as well as additional material.

It is the sincere hope of the American Provincials that the directives and advice contained herein will be of help to the superiors of the Assistancy as you endeavor to help the men entrusted to your care.

I. Conversation Guides For Superiors

The purpose of this section is to assist Jesuit superiors with some commonly asked questions about health care for the men in their communities. These questions and answers are an attempt to frame some of the common health-related questions that arise about the older men in our communities. Section Four, Practical Guidelines for the Health Care of Jesuits, contains concrete recommendations for superiors about a wide variety of community needs and items that affect the quality of life of individuals, and these are to be considered practical suggestions, which augment the general questions and answers contained in this section. It should be noted that superiors and all others involved in health care for Jesuits are strongly urged to consult a professional as appropriate for assistance with any of the items contained herein.

1. What sort of things can be done to encourage good health among the men of a community?

Recognizing the importance of cultivating healthy habits and encouraging men to take responsibility for maintaining their health is an essential part of the job of a Jesuit superior. At the same time, there is a limit to what a superior can do. Individual Jesuits need to take charge of their own health. There are three areas in which a superior of a community, in conjunction with the minister, can create the conditions in which good health is encouraged. First, encourage men to take care of themselves. This means inquiring into whether they have a physician and suggesting a reasonable frequency for these checkups. It is recommended that at least every two years younger men should see a physician to identify subtle changes in health.

A difficult task for the superior is to ask men about behaviors that are potentially self-destructive. Although an individual in the community may be a productive and good Jesuit, it is worth asking him about behaviors that suggest something is wrong. This requires the superior not to accept as the status quo behaviors that might be brushed over. Assume that a middle-aged professor in a university community has three to four drinks every night at pre-prandials. This is too much. The man should be confronted. He need not be an alcoholic to be using alcohol in a way that is unhealthy. The rector should ask him: "Why do you have three or four drinks a night? You become loud and gregarious after those drinks. Is your work going well? Is there something bothering you?" Another man may be noted by the superior to be rapidly gaining weight and eating large portions at mealtimes: "You have gained a lot of weight lately and seem to be eating heavily; what is that about? I am worried about your health with this weight gain. Could I help you in some way?"

Smoking is a difficult habit to stop and smokers are not pariahs. At the same time, heavy smokers may want to quit and find themselves unable to do so. There are medications and effective smoking cessation programs available. Encouraging a man to stop smoking may give him the push he needs to stop. "I have noticed that you find it hard to give up smoking; is there anything I can do to encourage you in this?" Second, create the conditions in the community where men are able to live a healthy lifestyle. Practically speaking, this means doing four things. First, provide meals that are nutritious and allow a choice for those who wish to follow a low-fat, low-cholesterol diet. Second, discourage smoking in common areas. Third, encourage reasonable exercise and opportunities for fitness. This can mean providing access to health equipment or a gym. Fourth, encourage shared leisure and opportunities for relaxation. Many Jesuits work too hard, and the potential for loneliness and isolation in our lives is real. Whether it is a special meal, a villa day, or some other opportunity to relax in each other's company, encouraging men to come together and have some fun is an important part of community health. Men who consistently refuse opportunities like these may be depressed, angry, anxious, or overly involved in work to the detriment of their overall well-being. Third, set an example by your own behavior. All your talk about good health to the community will be ineffectual if you drink too much, smoke like a fiend, eat to excess, and never take a day off.

2. As a Jesuit superior, what role should I play in the medical care of the men in my community?

This will be determined by a number of factors including your personality and the personality of the man, the size of your community, and the type of illnesses that come up during your period of governance. Some specific issues to consider for all superiors include:

- selecting a physician from a list of providers approved by your insurance company.
- normally, a Jesuit will choose his doctor like other Americans, deciding on the basis of a recommendation or a personal acquaintance.
- the choice of physicians used currently by men in your community
- positive interactions with physicians when you have questions about a man's condition
- dealing with specialty physician choices when a man is hospitalized

Superiors should make certain that the men in their community have a doctor and a dentist and have regular checkups. The superior should also be aware of the name of health care providers of his men, so he can contact them in the event of an emergency. The PAHC and/or local health care coordinator can assist in establishing this list.The choice of a physician is a highly personal matter and one that will usually be decided by the individual Jesuit. **Today the managed care network of many insurance programs may alter this individual choice.** In some communities, most of the men will see a few physicians. This has the benefit of dealing with physicians who are usually aware of the Jesuit community, are willing to help in emergencies, and provide faithful service to our members. At the same time, close relations between a Jesuit community and a physician or a group of physicians need periodic review. In caring for older men, the hallmarks of a good physician are a willingness to talk to the older man, parsimony with medications, careful investigation of problems rather than assigning them to "old age," and therapeutic efforts aimed at maintaining or improving function. Physicians who frequently prescribe tranquilizers, sleeping pills and excessive pain medication to older members of the community may not be the best choice.

Likewise, some physicians will show a misplaced respect for our men and not question or physically examine Jesuits as thoroughly as they would a lay person. It is wise for a superior to have a good relationship with one or two physicians who can assist in providing second opinions about men and arranging referrals. Occasionally a Jesuit will have a chronic problem and will benefit from a referral to a specialist. Ordinarily, the man's physician will arrange for a referral. From time to time, however, a problem may occur with a Jesuit that the man and/or his superior will feel needs further investigation. Particularly useful is obtaining a comprehensive geriatric assessment for older men who appear to be having difficulties. This type of assessment aims to look at the man from a number of perspectives in an effort to develop a care plan that will maintain or improve his functional abilities, as well as diagnose and treat any problems. If the Jesuit's physician is unable to recommend a referral for a comprehensive geriatric assessment, consult with the Province Health Care Assistant. Together you may need to call to a local university teaching hospital and the department of geriatrics for assistance.The normal channel of communication about a Jesuit's health should be between the Jesuit and his physician, with the Jesuit notifying his superior and the designated local health care provider of any significant change or problem. With some Jesuits, however, either because of an acute illness or frailty, there is a need for a member of the community, usually either the superior or the minister, to discuss the individual's condition with his physician. Such communication can be facilitated by accompanying the Jesuit to his appointment and, with the man's permission and in his presence, speaking with the physician. Doctors will not routinely answer questions about the condition of their patients to another person without the permission of the patient. **Federal legislation to protect patient privacy, known as HIPAA regulations (Health Insurance Portability and Accountability Act), can create some new barriers for Jesuit superiors trying to make sure that they are kept in the loop regarding health issues.** Practically speaking, the best way to make sure that a doctor will communicate with a Jesuit superior regarding the health of a Jesuit is to have the Jesuit provide a release to his

physician designating the Jesuit superior and his successors as an individual to whom the physician can speak (a sample *Consent for Release of Health Information* form can be found in the Appendix). Realize that no doctor is going to speak with a Jesuit superior if the Jesuit tells the doctor not to talk to the superior. Realistically, if you are the superior and you are concerned about a Jesuit under your care and you need health related information, and the man is not demented or unconscious, that Jesuit is going to have to tell the doctor to talk to you. If the Jesuit is demented, unconscious, or otherwise unable to participate in the decision making process, then the doctor will contact the person the Jesuit has listed on his advance directive (see below for a description of advance directives) or the Jesuit's next of kin. This makes it crucial that Jesuit superiors, probably with the help of the Provincial Assistant for Health Care (PAHC), be active in developing and keeping on hand a copy of the advance directive for each community member. When a Jesuit becomes ill and is transferred to a hospital, decision making may be difficult. Normally, it is the patient who is told about his condition and who consents or refuses to the plans of the physician. This may be problematic in the case of a frail, elderly Jesuit. First, most physicians will not think to call a Jesuit superior, and many doctors will not have the slightest idea what a Jesuit is, let alone a Jesuit superior. Second, with other older patients, physicians will routinely discuss the care of the patient with the patient's family, provided the patient agrees. Physicians may well speak with the relatives of a Jesuit rather than with a superior. Third, an older Jesuit may not be inclined to ask questions or disagree with the authority of a physician. Fourth, if the older Jesuit is too ill to participate in the decision-making process, physicians will look to the next of kin to assist in decisions. They will not think of religious superiors or ministers. When a Jesuit is admitted to a hospital, the superior or minister can do several things to avoid mishaps and poor communication. First, accompany the man to the hospital or emergency room and have the superior or minister listed as next of kin on hospital records. Second, if the man has made out an advance directive (living will, durable power of attorney for health care, or health care proxy), bring that document to the hospital so that it is available to the staff. Third, call the Jesuit's family members so they are informed. Make it clear that you are involved in caring for their relative and tell them to call if they have questions. Keeping family in the loop of information lessens the chance of a nasty conflict. Fourth, speak with the nurse and the physician of the Jesuit. Make it clear that you are the one to be called in the event of a problem. Show them a copy of the advance directive that designates you as the person to be contacted. Conflict can develop between family members and Jesuit superiors regarding decisions about life-sustaining care of critically ill Jesuits. A previously prepared advance directive is crucial in responding to this question. If a Jesuit names a family member rather than another Jesuit as his proxy, then the Jesuit community has no control over the decision-making process.

3. What sort of medical records should be kept on each man?

It is unreasonable to expect the superior to become a medical librarian. The PAHC has an electronic health record that provides critical information. In the event that you do not have regular access to the PAHC, an alternative form may be needed. The type of information that should be readily available in the event of an emergency includes: the name of the man's physician, a list of medications that the man takes, a list of any possible allergies, and the names and telephone numbers of family members who should be contacted. As important as collecting this information is, it is also important to provide a means for the information to be available when the superior's office is locked up on a night or on a weekend when the superior may be away. When the superior is away, another individual in the community should be responsible for providing emergency information. If your Province does not have a specific form, a sample is provided in this handbook in the Appendix or contact your PAHC for an electronic health record copy.

4. How do I know if an older man is doing well or not? If he is getting old, shouldn't I expect certain changes?

The most important piece of information for a superior in a community with older Jesuits is to recognize that changes in older Jesuits should not be chalked up to old age. Although it is true that with increasing age individuals experience decline, these changes are not the direct result of aging per se but represent illness. Memory loss, difficulty walking, depression, incontinence, personality changes, falls, and frailty are not normal. An older man in a community who seems not to be himself or who, for example, becomes forgetful, needs a medical assessment. Why bother with a medical assessment? Although decline does occur with aging, many of the changes that occur can be reversible. A sudden change in the status of an older person is often a sign that a serious illness is brewing. For example, an 80-year-old man who has been independent and does well in the community suddenly becomes confused over the course of 48 hours. He should be taken to an emergency room. This presentation of a sudden change in mental status may be the first sign of a drug reaction, a serious infection, a heart attack, a stroke, or other condition. It is not part of normal aging. Appropriate assessment and treatment can return an older person to his previous baseline. It is true, however, that many illnesses are chronic and not always curable with advancing age. Rather than simply assume that this is the case with an older individual, however, it makes sense to seek competent medical attention and establish a diagnosis. It may be that some treatment can be provided or interventions suggested that would improve function and increase independence.

5. How do I recognize and care for men who are showing signs of failing?

It is a common occurrence to be living with a man and be told by a visitor to the community that Father X seems to be doing poorly. The daily contact of community life can make it difficult to notice the changes over time that are readily apparent to an individual who has not seen the man for some time. Recognizing changes over time in older men requires paying attention to their functional ability. Functional ability describes how well a man is able to negotiate the common demands of everyday life. Some specific items, referred to as *activities of daily living* (ADLs), include his ability to bathe, dress, use the toilet, feed himself, groom, and walk independently. Other items, known as *instrumental activities of daily living* (IADLs), describe a man's ability to perform the tasks that make it possible to remain independent and include arranging for transportation and travel outside of the community, independent management of medications, using a phone, managing finances, shopping, and cleaning. Typically, instrumental activities of daily living are lost first in older individuals as a consequence of illness or dementia. Many will first note a problem with a parent because of a problem in paying the bills or running errands. But Jesuits in community, as opposed to lay people, often have many of the instrumental activities of daily living taken care of by the community. As a consequence, physical and mental problems with Jesuits are often relatively hidden until they present themselves at an advanced stage. The two key points for superiors who are in charge of a large number of older men are a discerning eye and a high degree of suspicion. Discernment is required in noting changes among the men in a community. A superior would do well to be concerned over a member of the community who, for example, begins to dress poorly or whose hygiene deteriorates. Likewise, problems with memory, continence, weight loss, and falls are signs of important changes. The high degree of suspicion requires that superiors not shrug aside changes in older men but pay careful attention and have a low threshold to refer to a physician. The superior should not be satisfied when he notices a functional change in one of his men and the physician brushes the concern off with a comment about the individual's age. It may well be that a competent physician will not find a specific explanation. He or she should still acknowledge the problem, discuss what has been done to investigate the problem, and share his or her thoughts as to what is the cause and whether or not further investigation is warranted. If a man continues to deteriorate and the man's physician does not seem to do much, then the superior may consider having the man see another doctor or arranging for a comprehensive geriatric assessment . Consult the PAHC or local health care professional for guidance in this referral.

6. Are there ways to structure a community to provide more support for some men without turning an apostolic community into a nursing home?

When an older man begins to have some functional declines and needs more assistance to live in the community, there are resources available to assist the man. The first place to begin is with the Provincial Assistant for Health Care (PAHC). Either the PAHC or the local health care professional can assist with arranging a home assessment or explain how to go about getting a referral for an assessment. The purpose of this assessment is to investigate the function of the man in his own setting, see what his needs are, and arrange for further services. The nurse may recommend a variety of services that will come to the community. The nurse, depending on the man's condition, can monitor his progress, check vital signs, change dressings, and provide other skilled nursing needs. Examples of other potential services include a home health aide who can help the man with bathing and grooming and a home physical therapist to assist the man in regaining strength and function and to train the man in the use of adaptive devices such as canes and walkers. Some services will be provided free of charge if covered under Medicare. Other services may be charged. Some communities with a large number of older men may consider providing more assistance for these men on a regular basis. Helping men retain their function and ability to live in community can often be a good investment for two reasons. First, it contributes to the man's well-being when he knows that help is available to him in the community and he need not fear a transfer to a retirement center or nursing home if a problem develops. Second, it can be less expensive to provide some help for a man in his own community rather than transfer him to another environment. The type of assistance that a community wants to provide will depend on a number of factors, including its finances, size, ability to recruit help, and the apostolate of the community. Some examples of help that should be considered include assistance with laundry and room housekeeping and hiring an individual to assist with bathing and grooming. In communities with relatively few members where older men may be isolated during the day, consideration should be given to obtaining some type of signaling device (e.g., Lifeline) that can summon help for a man should a sudden crisis, such as a fall, occur.

7. Is it worth confronting older men about smoking and drinking?

Older men who smoke and drink to excess should be confronted with their behavior for three reasons. First, there are health gains obtained by stopping drinking and smoking, even for old men. Second, the community usually will be relieved by the change in behavior. Third, it is the job of the superior to be concerned about the health and well-being of his men. Avoiding a discussion about smoking and drinking simply because the man is old is ageist.

8. What about odd and eccentric behaviors?

Many of our communities have men whose peculiar habits and behavior would not be possible in any other setting. Some of these behaviors represent long-term personality disorders that have never been confronted. Other problematic behaviors are the result of depression, obsessive-compulsive disorders, or chronic anxiety. It is very difficult for a superior to know how or when to confront individuals. Those who have a long-term history of problematic behavior may not respond favorably. Superiors, however, should try to assist men who are clearly acting strangely, even if this strange behavior has been ignored for years. Inquiring about the man's history among other community members and attempting to ascertain if any professional help has been given in the past are reasonable first steps. It is also reasonable to arrange for a conversation with the man and simply mention the behavior and ask the man why he does it. As an example: "Father Jones, I have noticed that you will not eat in the dining room with the rest of the community! Why is this?" A prudent superior would do well to make the attempt to get to know a man a bit first and make it clear that the man, despite his behavior, is a valued member of the community. Some behaviors create issues for the health and safety of the community and must be confronted, even if it

makes everyone very uncomfortable. As an example, most Jesuits are aware of an older man who will fill his room with artifacts and debris of his Jesuit life, creating a garbage dump. Behaviors like these, that create a problem where fire, vermin, and safety are real concerns, cannot be tolerated. In situations like this, contact the PAHC to develop a planned approach to carefully evaluate the room or identify if there is a mental health issue connected with this behavior. Some of the hoarding behaviors that are seen can be a manifestation of a personality style or downright disorder. Interventions have the potential to lead to tremendous disruption for a person who is at best fragilely balanced. Prior to making ad hoc interventions, it may be necessary to work in conjunction with a psychologist or psychiatrist to provide assistance to the Jesuit and the superior in interventions like these.

9. What should be done about meals?

Mealtime is an important part of Jesuit community. It provides an opportunity not only for obtaining nourishment but for conversation and relaxation. At the same time, proper nutrition is an essential part of fostering good health. Because meals are so important, and because many Jesuits have very strong feelings on what they like or what they feel is healthy, superiors often have a difficult task in making decisions about what will be served in the dining room.

Some suggestions may be of help: First, encourage choice and moderation. Some Jesuits will prefer meat and potatoes while others will opt for low-caloric, low-salt, and low-fat items. If possible, a choice of two entrees will help provide options that will keep the community well fed and content. Encourage the cook to cut back on salt, heavy sauces, and high fat items. Second, have the menus planned and reviewed with the help of a dietician. He or she can, in cooperation with the cook, make sure the choices available provide for a balanced diet. If you contract your food service, check into having their dietician assess the needs and choices of your community.Third, be cautious in cutbacks that involve meals. Many communities are forced to economize and can no longer afford meal service three times a day, seven days a week. In communities with older men, who may never have been in a kitchen since they entered the Society as teenage boys, it is unreasonable to expect that all will be able to fend for themselves. A particularly important mealtime for older men is breakfast. For many older persons, breakfast is the meal where they will consume the most of their calories for the day. Although abolishing meal service at breakfast may provide attractive economies, it may lead to nutritional decline among older men.

10. What should be done with men who appear to be having memory loss?

Although changes in memory are common with advancing age, they are not a part of normal aging. A gradual memory loss could be a sign of a number of conditions, including a problem with medications, misuse or abuse of alcohol, an underlying medical disorder like thyroid imbalance depression, or a dementing illness caused by strokes or Alzheimer's disease. Evaluation is crucial. Consult with the PAHC or the local designee to arrange for this consultation. There are reversible causes of memory loss, such as thyroid imbalance, adverse medication interactions, and some vitamin deficiencies. Second, even if a reversible cause is not found, establishing a diagnosis provides the opportunity for better planning for the man and his community. Although an individual may be diagnosed with Alzheimer's disease, it does not mean that a man is incapable of participating in and making a contribution to community life. When the diagnosis of a dementing illness is made, the superior should plan for the future, ideally with the help of the older man. First, the man needs emotional support in dealing with the diagnosis. Second, data concerning a living will and the appointment of a proxy decision maker should be reviewed or established while the man is still capable of understanding. Third, safety issues in the community need to be addressed. Most likely the man should no longer drive. If wandering is a concern, an identification bracelet should be obtained. Wandering and other behaviors may necessitate a transition plan to a safer Jesuit community. The diagnosis of a demanding illness, however, does not mean that the man must be moved. That should be

determined on the basis of his ability to continue safely in the community.

11. I'm concerned about the ability of some of the older men in the community to drive safely. What can I do about men who may be having problems driving a car?

Because the ability to drive is important for personal independence, it can be very tough for a superior to confront men in the community who may be having problems. Anyone can have an accident and older men should not be afraid they will be barred from driving because they have had a fender bender. At the same time, a laissez-faire attitude toward dangerous driving is not appropriate because of the risk to others. Less important than the chance that someone could be hurt, but not a trivial concern, is the fact that the community can be held responsible for the liability incurred by a community member who is at fault in an accident.

Superiors on occasion must order men not to drive. For the older man about whom there are concerns but real uncertainty, some hospitals offer driving testing programs through the occupational therapy department. Some auto insurance companies offer defensive driving courses and hands-on assessment as part of the policy services. Limiting a man's driving privilege need not be an all-or-nothing decision. Based on the advice of a physician and/or an occupational therapy driving evaluation, some compromises may be possible. For example, a man may drive to a parish a few miles away for supply work on Sundays. He has no problem with this route, but longer driving, night driving, or highway driving are all problematic. Limiting the man to driving within the neighborhood of the community may be possible. Such prudential decisions, however, are difficult and require balancing safety with the needs of the man to remain independent and not isolated. Men who drive drunk, habitually have accidents, or have serious vision problems must be ordered to cease driving. Driving guidelines are already available in many provinces. Additional conversation guides are available in section 4.21.

12. Are there ways to include older men more in community life?

Many communities find the older members are involved and active. In some settings, however, older men may not be fully integrated into the community and seem somewhat aimless and drift through the day. There are a number of possible explanations for this type of behavior, including boredom and a lack of stimulation now that an active career of teaching or pastoral work is over. One possible solution is to provide more structured activities during the day. Many of the older men will remember a regular order that provided a framework for their life. Now, however, the only order may be the times of meals. Providing some sort of scheduled activities may be useful. Suggestions would include communal liturgical events, daily videos, and occasional outings. Obviously, arranging for these activities can be difficult in a community where there are only a few older men and the rest of the community is working at the apostolate during the day. Part of regular order in the past included set times for prayer and group worship. Reviving such customs can provide the type of structure in life that some older men lack. Regularly scheduled times for visits to the Blessed Sacrament, meditation, and rosary are some examples. Other devotions, like Benediction, may well be popular among older men and encourage group participation. Community meetings can be another time when older and younger members can mingle. It is a reasonable idea to have some meetings devoted to outside speakers, media/slide shows of a recent trip of a community member, or other group activities that encourage companionship. Although it is important that a community be able to discuss difficult issues and speak frankly, many older men are very uncomfortable with faith sharing or open discussion of some issues. Taking care in planning meetings so that there is a balance in the type of formats that can create opportunities for everyone to come together as well as provide settings where frank discussions can be held.

13. What sort of health planning should I encourage in younger men?

In working with younger men, superiors can encourage the men to take responsibility for their health. Concrete suggestions include regular medical checkups and dental care, physical exercise, moderation in work and appropriate use of leisure time, cessation of tobacco use, and moderation in alcohol use. All men should be encouraged to develop an advance directive for health care. In addition, young and middle-aged men may need to be assisted in considering their own aging process and think a bit about what they would like to do in the future. The PAHC and/or local health professional can be excellent coaches in promoting healthy lifestyle choices.

14. What are advance directives?

Advance directives refer to a class of documents and statements whereby individuals attempt to direct the type of medical care they would want to receive in the event of a serious illness or accident and the individual is unable to participate in the decision-making process. Different states have different legal requirements about advance directives. In some states, a living will is allowed where specific treatments are mentioned. In other states, the legal method of establishing an advance directive is to appoint a health care proxy: a person who will act in the name of the patient should he be too sick to discuss with the physician and decide for himself. Some states allow a combination of living will and the appointment of a proxy decision maker. Other jurisdictions refer to appointing a durable power of attorney for health care decisions. This creates a role like that of the health care proxy. Advance directives are an important part of arranging for an individual Jesuit's health care. Given that many physicians will turn to the Jesuit's nearest living relative rather than a Jesuit superior, the appointment of a Jesuit as the health care proxy for another Jesuit provides a mechanism that ensures that the Society will remain involved in serious decision making.

15. What sort of things can be done to make a community more comfortable for older men?
Some attention to furniture, bathrooms, lighting, and other parts of the physical environment are useful in making a community an accessible and safe place for older Jesuits. (See section 4.22)

16. Are there some practical considerations that can be helpful in providing *cura personalis* for older men in a community?

Visiting a Jesuit in his room is an excellent way to get a better idea of what is going on with this man. Get a sense of what his living surroundings are like. Is the room a mess? Is the furniture comfortable and adapted to the needs of the older man? Are there hazards that can be corrected like electrical cords and clutter on the floor? Providing the man with some assistance to fix up the room as well as replace worn-out and useless furniture is important. Other things to notice include the types of belongings the older men may have. For instance, an older man may love classical music and have only an old radio. Without being extravagant, a modestly priced sound system and a few CDs might make the man's life that much happier. Likewise, see if the man has any hobbies. Provide some extra money to encourage him in pursuing these types of activities (of course that depends on the hobby!). Clothing and personal hygiene are other areas where men may need some help. Many older men pay little attention to their personal appearance. Occasionally, some of the clothing chosen by our men comes from their desire to model the vow of simplicity or poverty, since clothing may be taken from the common's table or closet it can make them appear slovenly or silly. Offer to take an older man shopping and get him clean, reasonable clothing, e.g., two or three pairs of pants, several shirts, and a week's supply of underwear.

Emphasize that it is important to the Society that he look neat and clean. If men have difficulty in matching clothing, or prefer not to wear casual clothes, it is reasonable to encourage the individuals to wear clean clerical clothing and replace old and threadbare clerics or cassocks. Some men may not be able to do their laundry. Finding a way to help a man out is important to

maintaining his dignity and appearance. Visiting the room of an older Jesuit can also give some early evidence of a problem that he may be able to disguise outside the room. The point is not to invade a man's privacy or embarrass him; it is to improve his ability to function and ensure that his dignity is respected. If there is an odor of urine in the room or, if there are other problems with hygiene, then this should not be left unattended. Neglecting an older Jesuit's decline is neither loving nor an example of personal care.

17. Are there specific policies a community should have on health care issues?

Communities need to consider two things. First, the appropriate Province policies can be obtained and reviewed. Keeping track of advance directives and permission to contact the Jesuit's physician are very important. Some Provinces have specialized forms for release of medical information referred to as consent for AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA. This consent form allows the superior or designated health care professional to participate in medical care discussion, discharge planning, and coordination of the plan of care. An example of such a consent form is included in the Appendix.

Second, the superior and his consulters can discuss problems that seem particularly common or distressing in the community, and then, perhaps with the advice of professionals, tailor a policy to the needs of the community. As an example, the various provinces have policies on dealing with alcoholism. Within the framework of those policies, a community may develop its own plan for aftercare and a list of resources and physicians with particular expertise in the care of men with alcohol problems.

18. When should men be referred to the Province health care center?

What options are there other than the health care center? An issue that needs to be considered by each community is the question of criteria for referral to the Province health care center. This must be coordinated with Province policy. At the same time, communities have varying resources to meet the challenges that may be posed by an older man with health problems and/or severe functional limitations. Likewise, it may be that a community can deal with one or two men with a variety of problems but any additional older men may overextend the personal or financial resources of the community. Ideally, the Provincial Assistant for Health Care, perhaps in conjunction with the director of the health care center, can assist superiors in planning for the care of older men. The PAHC may be able to supply the superior with a variety of resources to care for men outside of the health care center. Types of resources can include lists of physicians who can provide a second opinion; rehabilitation facilities; possible short-term nursing home stays; community-based adult day care programs, and professionals who will come into the community, like visiting nurses, home health aides, and physical therapists.

19. How can I help men prepare for transitions and retirement?

For many older Jesuits, aging is a particularly difficult time because they find themselves with little to do after a lifetime of busy apostolic work and have made no plans for the time when active work as a teacher or in a parish comes to an end. It is wise to begin discussing the transition process prior to the need. The point is not to make concrete plans for the future but to encourage men to begin considering possibilities for the future. Specific items to discuss include the use of leisure time, hobbies, and other ministries that may attract the man. As men become older, more concrete planning is necessary. The man should be encouraged to develop a specific plan or lists of possibilities that he would like to pursue upon retiring from an apostolate. Too often, men say they look forward to reading or doing some research but they make no concrete plans. When retirement comes, they are lost. Our spirituality has the potential to be a tremendous resource in planning for the transitions that aging will inevitably bring. Prayer, spiritual conversations, and devoting the annual retreat to asking the Lord about our desires, fears, and where the Lord is leading us as we age are all appropriate.

20. How can I attend to the spiritual needs of the men in my community?
Like most questions, this will depend on the men but some suggestions may be helpful. First, ask the older men what they want or if they feel anything is lacking. Second, review the opportunities available in the community for the spiritual needs of the men: availability of confessors, accessibility of the chapel for men with functional impairments, regular community Eucharist and prayer, and devotional opportunities from which all can profit but may be particularly appealing to older men, such as benediction and litanies. Third, consider an occasional day of recollection for the older men of the entire community so that they can come together. Group activities when the entire community can pray together can be an important way to bridge some of the occasional distance that may be felt.

21. How can I recognize men who might be depressed in the community?

Depression is a relatively common problem among people of all ages, not just the elderly. In older persons, depression can be neglected, as the changes due to this illness may be ascribed to aging or simply attributed to a change in personality. It should be emphasized that depression is a treatable illness. It does not represent a failure or weakness on the part of the person who is suffering. (Refer to section 4.13)

22. Should I involve the families/friends in the care of older Jesuits?

When a Jesuit becomes frail or ill, it is natural that his family/friends want to make certain that he is receiving good care and is being properly looked after. On occasion, some communities have had difficult problems with family/friends demanding certain treatments or being intrusive into the life of the community. It also is the case, however, that families/friends have properly identified areas of concern where their relative may not be well cared for and important issues are neglected. Hopefully, the community already welcomes family/friends in a variety of ways: special dinners during the year, liturgies, and get-togethers. It is much easier to deal with a crisis when there is a pre-existing relationship between the community, the community superior, and the family/friends of an older Jesuit. It is wise to ask a close family member from time to time how he or she thinks a relative is doing. This may provide a valuable insight into the man's condition as well as build a foundation for discussions if future problems occur. When there is a problem with an older Jesuit, the superior should notify the family. This is obviously the case in the event of an emergency hospitalization. In less urgent situations, however, it is wise to contact family. For example, a man may be having a slow decline in functional ability and generally not appearing to be doing well. The superior could initiate a conversation with a family member that reviews several points: first, that the changes in the older Jesuit have been noticed and are of concern; second, that the man has been seen by the doctor and the doctor's recommendations have been followed or another opinion sought; and third, that there are plans to care for the man in the future. Occasionally, family members can be extremely difficult. Approaching the family prior to a crisis may prevent some difficult behavior. In situations where the family appears unreasonable, the superior would do well to discuss the situation with his consulters for their support and advice.

In a hospital setting, it is essential that the superior do everything possible to be the contact person regarding issues in the care of Jesuits. Considerable confusion can exist regarding the issue of next of kin, and many nurses and physicians would look to a brother, sister, niece, or nephew rather than think to call a man's superior. Conflicts between family and religious superiors regarding care decisions in the hospital when the patient is unable to participate in the decision-making process can be very difficult and require legal consultation.

II. Annual Checklist for Superiors

A Jesuit is part of the one mission of the Society of Jesus regardless of his age, training, and locale. An integral part of participating in this one mission is the health (mind, body, and spirit) of the individual Jesuit and his community. The superior of the community is tasked with overseeing how each individual Jesuit lives out his mission, i.e., that he has the necessary health and support to labor with Christ in the Lord's vineyard.

It is highly recommended that the superior (or his delegate for health care) and PAHC meet yearly with each man in his community for a short colloquy regarding each Jesuit's health care. Preferably this would be separate from the annual colloquy that superiors conduct in their communities. This would allow the opportunity to review health care files as well as to have a conversation on health issues that are specific to the man but also include the community.

It is highly advisable for the superior and his consulters to have a yearly review of how the community enables the individual Jesuit to live out his mission. Sometimes called a "systems review," this process could help uncover strengthens and weakness in the community, e.g., kitchen and meal patterns, common areas of concern, transportation issues, safety in and around the community, and hospitality and support concerns of the vowed religious life.

Some items to consider as part of a health care colloquy (and annual colloquy):

1. How is the man's physical health at this time?

- Have there been significant changes in health? Hospitalizations?
- Does he have a primary physician? Is there a HIPAA waiver on file?
- Has he had age appropriate exams? Has he shared the results with the superior or health care delegate?
- Has there been unexplained weight loss/gain during the year?

2. How does the man take care of himself?

- Does he follow healthy patterns of eating/exercise?
- Does he take appropriate time away for rest, relaxation and renewal of his spirit and body?
- Does he have any hobbies or interests outside of his apostolic work?
- Does he read extensively, watch movies and/or sports or attend opera or symphonies?
- Does he maintain good relations with his family of origin? Does he have a network of friends to support him emotionally/spiritually?
- Are there concerns regarding food/alcohol consumption? Is he dressing and grooming himself appropriately? Does he wear clean and well-mended clothes, bathe regularly, etc.?
- Is he safely independent for his daily activities of living or does he need significant assistance from others?

3. How does the man relate to his community?

- Does he regularly interact with other community members? Or is he isolated and withdrawn?
- Is he present for community liturgies and meetings? Does he excuse himself for apostolic or personal reasons?
- Are there signs of memory loss, depression, anxiety or other tensions that affect members of his community?
- Are there issues of "commandeering" parts of the community, cars, TV rooms, etc., for his exclusive use?
- Does the community value the man and his mission—regardless of his age or type of assignment? And vice versa?
- Is the man able to live safely and comfortably in the community, i.e., is the furniture and lighting age appropriate, is healthy and nutritious food available at regular times, etc.?

4. What is the man's room like?

- Has the superior/health care delegate visited the man in his room?
- Is it clean and uncluttered? Appropriate lighting? No tripping hazards, i.e., extension cords, excess furniture, etc.?

- Is the room cleaned regularly? Are there smells that suggest health problems, e.g., urine or incontinence, rotting foods, etc.?
- Does the man need/want assistance with bed linens and laundry?

5. Is the man's health care file up-to-date?

- Is there a current Power of Attorney for him? Advance directives? Current list of medicines being taken and seeing his doctors as needed?
- Is there a list of nearest relatives/friends to be notified in case of a health care crisis?
- Is the health care file immediately available to the superior/acting superior/health care delegate when an emergency occurs?
- Has he been in contact with the PAHC?

6. How is the superior's relationship to the man?

- How well does the superior know the man and his physical and health care needs? His spiritual and emotional needs?
- Is there tension/avoidance on either person's part? Distrust that leads to breakdown in the relationship?

7. Some items for the community and consultors to consider:

1. Do members of the community feel safe and cared for?

2. Are community meetings always geared to younger members or are there a variety of topics and formats?

3. Do I make sure that older men have the same spiritual care as younger men?

4. What are the opportunities for spiritual direction, retreats, and access to Confession?

5. Do I encourage older men to attend community liturgies or do I avoid the topic?

6. Are there other devotions or liturgies that the community should have? (e.g., Benediction, communal Rosary?)

7. Do I make it clear I value the prayer life of men who cannot be physically active in the apostolate?

8. Do I have a plan to help the men consider transitions?

9. Am I a reasonable example of decent health habits?

10. Do I discuss with young and middle-aged members of the community their health and the need for them to take reasonable care of themselves?

11. Is there a policy about driving that considers what to do with men who should not be driving? Are there alternative transportation options in the area?

12. What are our hopes and dreams for the future?

III. Resources and Bibliography

Assessment Programs

Guest House Institute: Promotes expertise in the field of addiction to Catholic leadership, dioceses, orders, universities, and seminaries. It has a large expert speakers' bureau compromised of Catholic clergy, recovering lay and ministry professionals, and international academicians.
www.guesthouseinstitute.org

National Catholic Council on Addictions (NCCA): The NCCA, an affiliate of the USCCB, is an organization that promotes hope, healing, and reconciliation to those suffering from the disease of addiction; it also addresses the impact of addictions on family, society, and church. Spirituality and addiction resources. Services include educational workshops on Substance Addiction Ministries in local parishes.
www.nccatoday.org

Saint John Vianney Center: St John Vianney specializes in the treatment of behavioral disorders and psychiatric illnesses for Catholic clergy, consecrated religious, and clergy of other major Christian denominations.
www.sjvcenter.org

St. Louis Consultation Center: Comprehensive assessment and treatment services aim to aid an individual and his superior in understanding the nature of the individual's problems. Effective treatment begins with an accurate assessment of the individual's spiritual, emotional, and psychological state. It also is important to understand the impact of the individual's difficulties on the larger community of which he or she is a part.
www.Stlconsult.org

Saint Luke Institute: Brings the healing ministry of Christ to clergy and men and women religious through expert consultation, psychological/spiritual healing, and education.
www.sli.org

Servants of the Paraclete: Provide holistic, integrated programs devoted to the spiritual and vocational renewal of priests and religious brothers.
www.theservants.org

The Southdown Institute: Offers a five-day residential assessment program, a 14-week residential treatment program for religious and clergy suffering from a range of emotional/mental health concerns, and a two- year Continuing Care follow-up program and educational lectures, workshops, and consultation sessions.
www.southdown.on.ca

Healthy Celibate Living

Manuel, S.J., Gerdenio Sonny. (2012) *Living Celibacy: Healthy Pathways for Priests.* Mahwah, NJ: Paulist Press.

Amidst the Church's continuing clergy sex abuse crisis and the suspicions the public might have about celibacy and Catholic priesthood, Living Celibacy hopes to make what constitutes healthy celibate living.

Mental Health Resources

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: American Psychiatric Press.

A comprehensive clinical manual on mental health classifications and disorders, including treatment protocols and prognosis.

Midden, P. (2012). *New Creations: The Treatment of Priests.* St. Louis, MO: Wittmann Blair.

This book offers ordinaries and religious superiors a candid look into dealing with their problematic priests and religious. It describes time-tested approaches and strategies that are straightforward and respectful of the needs of the man, those around him, and the Church at large.

Patterson, K., Grenny, J., McMillan, R., Switzler, A. (2002). *Crucial Conversations: Tools for Talking When Stakes Are High.* McGraw Hill.

Real, Terrence. (2003). *I Don't Want to Talk About It: Overcoming the Secret Legacy of Male Depression.* New York, NY. Simon & Schuster.

Online Resources

Carlat Report: Behavioral Health Bulletin
www.carlatbehavioralhealth.com
Monthly topic on mental health therapy overviews.

Men and Mental Health: Depression, anxiety, bipolar, eating disorders, etc.
www.nimh.nih.gov/topics/topic-page-mens-mental-health.shtml

National Institute of Mental Health: Education outreach
/www.nimh.nih.gov

Aging & Spirituality

Bernardin, J. (1997). *The Gift of Peace*. Chicago, IL. Loyola Press.
He shares personal reflections and insights to the struggle to find peace in ministry as one stands on the threshold of eternal life.

Buchanan, Missy. (2008). *Living with Purpose in a Worn Out Body: Spiritual Encouragement for Older Adults*. Upper Room Books.

Callanan, M., Kelly, P., (1997). *Final Gifts*. New York: Bantam.
Hospice care and communication used by the dying to talk about their journey.

Chittister, Joan. (2008). *The Gift of Years: Growing Older Gracefully*. New York: Blue Bridge.
In *The Gift of Years*, Sister Joan Chittister describes the task of growing older gracefully through the three stages of being "old": "old" (age 65-74), "old old" (age 75-84), and "oldest old" (age 85 and over). Each of the 40 short chapters (averaging about five pages) starts with a quotation by writers ranging from Seneca to Carl Jung and ends with a brief summation of burdens and blessings of the relevant element in these later years. Some of the 40 topics seem negative, for example fear, ageism, sadness, and loneliness, but Chittister is able to draw positive results from them.

Griffin, Emilie. (2012). *Green Leaves for Late Years*. IVP Books.

Kidd, Sue Monk. (1990). *When the Heart Waits: Spiritual Direction for Life's Sacred Questions*. New York: HarperCollins.
Sue Monk Kidd's memoir *When the Heart Waits* views challenges in the transitional period commonly known as midlife. However, most of her reflections are relevant to any transitional period, including retirement.

McKevitt, Gerald. (2012). "The Gifts of Aging: Jesuit Elders in Their Own Words." *Studies in the Spirituality of Jesuits* (43/3) Autumn.
http://www.jesuit.org/Assets/Publications/File/Studies_Autumn_2011_43-3.pdf

Moody, Harry R., and David Carroll. (1997). *The Five Stages of the Soul: Charting the Spiritual Passages That Shape Our Lives*. New York: Anchor Books.
According to Harry Moody's underlying premise in *The Five Stages of the Soul*, not all people advance spiritually at the same pace, but spirituality does normally develop within the second half of life in the same sequence of stages: Call, Search, Struggle, Breakthrough, and Return. Moody exemplifies each stage by its effects on his own life and on the lives of acquaintances and varied public figures, past and future. The Calls that initiate the Search come in a wide variety of forms, for example vague feelings of emptiness, physical disorders, and beauties of art or nature, dreams, sudden spiritual insights, or near-death experiences.

O'Nan, Stewart. (2011). *Emily, Alone*. New York: Penguin Books.
The title of the novel highlights one key problem faced by elders like Emily, the feeling of "aloneness." Instead of a traditional plot, O'Nan has created a beautifully developed character study of Emily Maxwell, an 80-year-old widow who has settled into relatively passive old age, accepting dependency on others, bemoaning the infrequency of visits from her children and grandchildren, reliving scenes from her past, and living a routine life in the present. That is, until she finds independence by courageously driving her

new car around her Pittsburgh suburb. Later she drives home to visit her parents' graves, the first time in ten years. Here again O'Nan echoes a gerontological description of one stage of aging: the Return, with its internal reconciliation, its service, and its sense of peace.

Schacter-Shalomi, Zalman, and Ronald S. Miller. (1995). *From Age-ing to Sage-ing: A Profound New Vision of Growing Older*. New York: Warner Books.

Against a rich background of history and psychology, *From Age-ing to Sage-ing* traces attitudes toward old age in the past and then turns to ways in which modern retirees can find meaning, purpose, and a sense of completion in their later years. The book addresses a mixed audience, primarily elders and middle age adults planning for uncertainties of retirement, but health care professionals, nursing home operators, and family caregivers can also learn from it. Rabbi Zalman asserts that instead of producing depression and isolation, aging can be accompanied by positive effects when the aging person accepts the retirement years as a time for contemplatively "harvesting" the past, enjoying the present, and deepening a sense of oneness with the human and natural world.

Aging Topics

Sheehan S.J., RP Myles. (2012, September). *Aging Gracefully*, a production of Catholic TV. http://www.sjnen.org/news-and-events/aging-gracefully-catholictv-series-by-fr-myles-sheehan

Topics include: 1) Spirituality and Wellness of Aging, 2) Fear, Health Issues & Psychological Issues of Aging, 3) Talking to Your Physician, 4) The Gifts of Aging, 5) Thinking and Preparing for Death.

Adelson, Rachel. (2013). *Staying Power: Age-proof Your Home for Comfort, Safety and Style*. Thornhill, Ontario: Sage Tree Publishing.

Callone, Pat. (2007). *Alzheimer's Disease: The Dignity Within: A Handbook for Caregivers, Family and Friends*. Demos Medical Publishing, LLC.

Morris, Virginia. (2004). *How to Care for Aging Parents (3rd ed.)* New York, NY: Workman.

Radin, L., Radin, G. (2007). *What If It's Not Alzheimer's? Frontotemporal Dementia*. Amherst, New York: Prometheus Books.

Excellent resource on cognitive decline associated with executive function tasks and memory.

Online Resources on Aging

Alzheimer's Disease and Related Dementias: Learn about signs and symptoms, stages, diagnosis, research progress, treatment and care of Alzheimer's disease and dementia. www.alz.org

The Family Caregiver Alliance-National Center on Caregiving. San Francisco. http://www.caregiver.org/Fact-Sheets

Fact sheets on aging, caregiving, etc.

General Resources

CDC. Center for Disease Control and Prevention. Atlanta, GA.
Online resource for creditable resources on public health topics. Immunizations schedules, foreign travel vaccines, health promotion, and education, etc.
http://www.cdc.gov/

National Library of Medicine: Medline Plus.
8600 Rockville Pike, Bethesda, MD.
Online resource for consumer health information, including videos, illustration, and drug information. Search "Health Topics."
http://www.nlm.nih.gov/medlineplus

NRRO: National Religious Retirement Organization
Multiple resources on aging from the United States Conference of Catholic Bishops.
http://www.usccb.org/about/national-religious-retirement-office/

Elders & Driving Websites

http://www.seniordrivers.org - **Automobile Association of America** contains brochures, driving tips for seniors, video clips, and other helpful ideas from AAA.

http://www.nhtsa.dot.gov/people/injury/olddrive - **National Highway Traffic Safety Administration:** Research studies, booklets and materials, including Driving Safely while Aging Gracefully.

http://www.aarp.org/55alive - **AARP 55 Alive Mature Driving Site** to locate AARP Driver Safety education classes in your area; take the online Driver Safety course; other information on older drivers.

http://www.aging-parents-and-elder-care.com/Pages/Checklists/Elderly_Drivers.html - An article on driving by elders, which includes a checklist of telltale signs of decline in driving abilities; also includes ways for elder drivers to adjust to changing abilities.

http://driving.phhp.ufl.edu/ - **Website for the University of Florida National Older Driver Research and Training Center.** Their focus is on helping older drivers to maintain their safe driving ability as long as possible.

http://www.beverlyfoundation.org - The Beverly Foundation's mission is to foster new ideas and options to enhance mobility and transportation for today's and tomorrow's older population. The foundation pursues this mission through a specialized series of research programs, community demonstrations, and technical assistance products.

http://www.aota.org/olderdriver - The Older Driver Site of the American Occupational Therapy Association includes a link to find a driving specialist or program.

http://www.ama-assn.org//ama/pub/news/news/older-driver-safety.page- Website of the American Medical Association on Older Driver Safety.

www.seniordriving.aaa.com - Automobile Club of America

Disease-related Websites

Adult Immunization Recommendations:
http://www.cdc.gov/vaccines

Agency for Healthcare Research and Quality:
www.guidelines.gov

Alcoholics Anonymous:
www.aa.org

Al-Anon Family Groups:
www.al-anon.org

American Cancer Society:
www.cancer.org

American Diabetes Association:
www.diabetes.org

American Heart Association:
www.americanheart.org

American Lung Association:
www.lungusa.org

Parkinson's Disease Association:
www.parkinson.org

U.S. Preventive Services Task Force:
www.uspreventiveservicestaskforce.org

IV. Practical Guidelines for the Health Care of Jesuits

4.1 Taking ownership of one's own health care

Introduction

The Society of Jesus in the United States supports the promotion of health in each of its members in accordance with the teachings of St. Ignatius as found in the Exercises and the Constitutions. It is through the maintenance of optimum physical, mental, and spiritual health and well-being that each Jesuit can best be capable of effective apostolic ministry and be in the position to be missioned.

Each Jesuit has the primary responsibility for maintaining his own health and meets annually with the PAHC or the local health care coordinator. This affords an opportunity for health promotion and review of current health status.

General guidelines for taking responsibility for health care:

1. Each Jesuit should have a primary physician, dentist, or specialist as required who has access to his health history and to whom he can go for comprehensive health needs.

If you are in need of a new primary physician, dentist, or other specialist(s), Jesuits should ask either the superior or PAHC for professional referrals while remaining within the network of approved providers.

2. Any non-emergency surgery (necessary but not immediately so) should be discussed with the local superior or the superior who has the financial responsibility for health care needs.

3. Long-term treatments such as physical therapy, experimental treatments, extended psychiatric treatment, or experimental diagnostic testing should be discussed with your superior.

4. "Second opinions" may be initiated by Jesuits only after consultation with the local superior. Physician-requested second opinions may be made without further consultation with the local superior or the health care representative of the Provincial.

The following preventive health recommendations, which are age specific, should be used as guidelines to optimize the health of the Jesuit.

In addition, please be aware of the immunization guide from CDC. Their adult immunization recommendations can be found at http://www.cdc.gov/vaccines

Preventive health recommendations (Ages 19 – 39)

Schedule: Every 1 – 3 years

Leading causes of death and future chronic illness

- Motor vehicle crashes related to alcohol and cell phone use
- Heart Disease
- Obesity
- Injuries (non-motor vehicle)
- Suicide

Screening

- Diet behavior counseling – BMI 18-25, lifestyle choices, and stress management
- Physical activity
- Tobacco/alcohol/drug use
- Depression screening
- Sexual practices
- Use a helmet for some physical activities like biking

Physical exam

- Height and weight
- Blood pressure: 120/80 average – lower is better
- Complete skin exam
- Clinical testicular exam
- Family history of heart disease or diabetes: Lipid panel, glucose A1C

Preventive care

- Immunizations
- Influenza (Flu) Annual

- TD/Tdap: Give Tdap vaccine (adult booster) once. Td booster every 10 years.
- Measles, mumps, rubella (MMR): 1 – 2 doses
- Meningococcal: 1 or more doses
- Hepatitis A: 2 doses strongly recommended due to ministry assignments
- Hepatitis B: 2 doses strongly recommended due to ministry assignments
- HPV (Gardasil for men): speak with your physician
- Dental services every 6 months/yearly
- Eye exam
- Hearing screening (persons exposed to excessive noise)
- TB skin screening: risk related to unexpected exposure at homeless shelters, correctional institutions, nursing homes, substance abuse facilities, and immigrants/refugees centers

Remain alert for:

- Depression symptoms, poor sleep patterns, isolation
- Abnormal bereavement
- Sexual integration
- Suicide risk
- Malignant skin lesions

Counseling: "Healthy Eating and Living"

- Dietary choices: (1) 5 servings of fruit and vegetables a day, more is better; (2) Animal meat – 4-6 oz. daily; (3) Stay alert to our fast food society, especially saturated fats and processed foods.
- Daily exercise of at least 30-45 minutes a day. Walking is free, no excuses.
- Stress management skills: Yoga, meditation, group support, cognitive therapy for anxiety, days off, annual vacation, and retreat. Build friendships and use a spiritual director/guide.

Preventive health recommendations (Ages 40 – 64)

Schedule: Every 1 – 2 years

Leading causes of death and chronic illness

- Heart Disease
- Cerebrovascular disease – stroke
- Obstructive lung disease
- Cancer: colorectal cancer and lung cancer
- Pneumonia/Influenza

Screening

- Diet behavior and weight management: BMI under 27
- Physical activity: low impact exercise, core strength, and cardio exercise, 6 hrs./week
- Alcohol/tobacco
- Prescription drug abuse
- Travel-related illness
- Ergonomics of work environment
- Sleep apnea
- Safety helmets

Physical exam

- Height and weight
- Blood pressure: 120/80 or lower
- Blood test: comprehensive metabolic profile, lipid panel, TSH, B12, VitD3
- Complete skin exam
- PSA: age 50 for white males, 45 for African-Americans (www.guideline.gov)
- Review family history for heart disease, especially if incident prior to age 50.

Preventive care

- Over 45 yrs.: ask MD about daily low dose of aspirin
- Immunizations: Influenza: yearly seasonal vaccine
- Zoster (Shingles) age 60+ (Especially if you have already had an incident of shingles)
- Tdap: one booster shot as an adult; recommend a Td-tetatnus/diphterian every 10 years
- TB skin screening: related to ministry exposures and travel
- Dental services every 6 months
- Eye exam
- Hearing screening
- Colonoscopy screening: at age 50 and every 10 years to age 70

Remain alert for:

- Prescription drugs and driving impairments
- Mental health treatment and aftercare needs
- Midlife vocational/occupational unrest

- Depression/abnormal bereavement

Counseling: "Healthy Eating and Living"

- Diet and exercise: Time to take serious inventory of health choices and potential risk for future conditions that could limit one's availability for future ministry assignments. Seek assistance from a physician or life coach/personal trainer.
- Relaxation and hobbies
- Annual vacation and retreat/Spiritual direction

Preventive health recommendations (Ages 65 and older)

Schedule: Every 3 – 6 months depending on medical history

Leading causes of death and chronic illness

- Heart Disease, cerebrovascular disease – stroke
- Lung cancer, obstructive lung disease
- Cancer: Colorectal cancer, bladder cancer
- Pneumonia/influenza

Screening

- Diet behavior and weight management: BMI under 27 (over 30 is a diabetes risk)
- Physical activity: consider a personal trainer or local program to guide you in age appropriate activities, cardio exercise, core strengthening, gait, and balance. Goal: 30–45 minutes/day, 5 times a week.
- Alcohol/tobacco: limiting alcohol consumption and tobacco cessation programs
- Prescription drug overuse: request a complete prescription review annually with primary doctor.
- Driving assessment per Province guidelines
- Cognitive changes: appropriate screening for depression vs. memory disorders
- Functional status at home/work environment

Physical Exam

- Height and weight
- Blood pressure: 135/85 or lower (physician guidelines)
- Blood test: comprehensive metabolic profile, lipid panel, TSH, B12, VitD3, PSA
- Complete skin exam
- Hearing evaluation
- Bone density screening
- Electrocardiogram
- Urology: PSA and prostate care

Preventive Care

- Colonoscopy every 10 years
- Immunizations: Pneumonia, Shingles (Zoster), Tetanus/diphtheria, annual flu vaccine
- TB skin screening: related to ministry exposures and travel
- Hearing evaluation and interventions
- Dental services every 6 months
- Glaucoma testing by an eye specialist

Remain alert for:

- Changes in cognitive function
- Medications that increase risk of falls
- Signs of depression and personal neglect
- Abnormal bereavement
- Peripheral arterial disease
- Malignant skin lesions
- Tooth decay, loose teeth, and gingivitis
- Injury prevention: use of safety belts, smoke detectors, heating pads
- Fall prevention related to rugs and extension cords. Clothing that is oversized and worn out shoes.

Counseling: "Healthy Eating and Living"

- Diet and exercise: Be mindful of calorie balance, avoid fast food, high sugar dietary intake. Breakfast is important each day. Adequate water intake – 6 glasses/day. Age appropriate exercise program. Tai Chi or Yoga for balance and strength.
- Engage in hobbies and relaxation
- Annual vacation and retreat. Spiritual director and Jesuit delegate for Senior Formation.

4.2 Interactions with healthcare professionals

Superiors may find themselves at a loss in their interactions with health care professionals. The problems can include what sort of doctors to contact for problems in the community, dealing

with doctors and nurses in emergency situations, and negotiating a long-term relationship between health care providers and the community. Together with the assistance of the PAHC, strong liaisons can be developed.

In choosing a doctor for the community or helping men find an individual physician, one does well to choose either a family practitioner or a general internist. That individual can then serve as the gatekeeper for more specialized care should it be needed. Men should be discouraged from seeing a variety of specialists on their own.

Many Jesuits will have an old friend or student serve as their physician. This is not a good practice. Frequently the older Jesuit will not be receiving the professional care that he requires, but rather using this doctor as an excuse for not having comprehensive medical care. We are all familiar with the Jesuit who refers to an individual as his physician but it turns out that he only calls him to fill a prescription and not to seek a comprehensive medical evaluation or the preventive care he needs. Naturally, many Jesuits will turn to former students, or superiors may ask alumni or benefactors to our institutions to provide medical care for the community. In many cases this works well. There is, however, the potential for an unhappy relationship on both sides with the physician reluctant to send a bill, ill at ease in confronting unhealthy behaviors, not performing full examinations out of a misplaced fear of modesty, and in general not getting the good care that one would from a regular physician who is not "a friend." Professional relationships work best when they are conducted professionally and not on the presumption of friendship or obligation.

How can superiors find good doctors for the community?

One option is to ask the respected members of the community from whom they seek for their medical care. In other situations, superiors may wish to consult friends and colleagues as to who is good. Some special concerns involve accessing geriatric or psychiatric care. A good internist or family practitioner may well be able to meet the needs of an aging community. In choosing a physician, a superior may wish to ask if a physician has a certificate of added qualification in geriatric medicine. Another option is to review the network of physicians that are approved by your insurance carrier.
In finding psychiatrists, one would do well to seek the advice of an internist or family practitioner who provides care for Jesuits and ask her or him for a candid opinion on who would best meet the needs of Jesuits in your community. A problem for health care professionals in dealing with Jesuits is they do not understand our governance. The American health care system focuses on the patient, and physicians are reluctant to speak to other people about the health of a particular patient. Many doctors would not know what to do with a call from Father Superior or Father Minister because they do not understand what Jesuits are about. The issue is a delicate one and raises questions about a superior's style within the community. Men should be trusted to have a confidential relationship with their physician. It probably is unethical for a physician to speak about a man's health with a superior unless the man has given clear permission for that conversation. HIPAA regulations, discussed previously, can make this even more problematic. This can become particularly difficult if a man is ill and confused, and the superior has a real need to know so that the man can be helped in the community. Men should be encouraged to speak to their doctor about our governance system. Jesuits should discuss with their physician their advance directive for health care and make sure that she or he has a copy on file.

Emergency situations

When a Jesuit is admitted to a hospital, especially in an emergency situation, a superior or his designate must move quickly to make it clear to those providing care for the Jesuit that he is the one to be contacted for decisions if the man himself cannot participate in the decisions. Obviously the physicians will ask the ill Jesuit what he wants, but in many situations the Jesuit may be too sick to answer. Procedures to follow: 1. Make certain that a copy of the man's advance directive is placed on the chart and that the nurses and doctors know about it. 2. Make sure that the Jesuit superior is listed as the next of kin on the admitting information. 3. Once the man

goes from the emergency room to the hospital room, speak with the secretary on the floor and make sure that the records state that the person to be notified in an emergency is the superior or his designate. (Also make certain that the phone number given to the hospital is one where you can be reached and not the switchboard that closes at 8:00 p.m.) **NOTE**: Some communities have copies of the advance directives and the man's medical history by the car sign-out sheets in a community so that this information is readily available when an emergency situation occurs and the information is needed.

4.3 Specific steps to take in emergency situations

1. Planning for emergencies before they happen.

Community members should be encouraged to receive certification in basic life support from the American Red Cross. These classes provide instruction in basic life support for individuals who are choking, experiencing respiratory distress, or who have had a cardiac arrest. These classes are either free or have a minimal donation. One can find out more about these classes by calling the local branch of the American Red Cross. Alternately your local hospital probably provides training and certification in basic life support. Although it might seem obvious, having members of the community trained in maintaining an airway, restoring breathing, and assisting circulation can help an emergency have a positive outcome rather than become a tragedy. Evaluate the availability or purchase of an **AED** (*Automatic External Defibrillator*).

2. Dealing with the emergency.

Some emergencies are obvious and it is clear what should be done. In the case of someone who collapses, a person who is suffering a heart attack, or a person who falls with injuries, the only prudent course is to call 911 or the local emergency number and have the person transported to the hospital by paramedics.

3. Recognizing the hidden emergency.

What might be harder is to recognize what truly are emergency situations but may be hidden in the general hustle and bustle of community life. Some examples: a sudden change in a man's mental status where he becomes confused, belligerent, or angry. It could be the only sign of a serious life-threatening illness, such as a serious infection, a stroke, a heart attack, or some other dire process.

New onset of chest pain requires immediate assessment, as many heart attacks can be present with relatively few symptoms. Rapid assessment is essential. The person who is describing chest pain or indigestion should be taken by ambulance to an emergency room for assessment. Obviously individuals with a known medical history of angina or stomach upset who have been told by their physician to take medications should seek medical attention promptly if symptoms increase in severity or frequency. Falls and lack of consciousness are very serious. Although people do occasionally simply trip over a rug or lose their balance, one needs to have a high index of suspicion that, in fact, a person has fallen as a consequence of loss of consciousness. Similarly individuals who faint or pass out may have a serious condition and require immediate assessment by a physician. It is not appropriate after someone has "passed out" or had a serious fall to put them to bed and see how they are in the morning. They may be dead. Occasionally many older persons will complain of difficulty with breathing. The possible causes for complaint are multiple, yet require skilled assessment and should not be subject to self-diagnosis in treatment by our own members. Shortness of breath may be an indication of asthma, a heart attack, heart failure, a blood clot to the lungs, pneumonia, another infection, or the presence of other conditions that could have life-threatening consequences. It is impossible to provide a list of all the potential problems that could occur in a community. The key, however, is not to accept an approach that minimizes symptoms and avoids expert evaluation. Sudden changes in the health status of individuals require assessment and are not to be brushed under the rug. You are always wise to call 911 first rather than wait and regret your procrastination.

4.4 Communicable diseases

In the event that a community member has had exposure to a diagnosed communicable disease, the superior will need to contact the PAHC for appropriate suggestions on how to management the infectious disease.

A few such diseases are listed below and extensive information can be found on the CDC web site: www.cdc.gov

1) Tuberculosis
2) Hepatitis A
3) Hepatitis B
4) Hepatitis C
5) Influenza
6) Norovirus
7) Vancomycin resistant enterococcus (VRE)
8) Methicillin-resistant Staphylococcus aureus (MRSA)
9) HIV/AIDS

Key recommendations for limited medical supplies in each community in dealing with communicable diseases should include disposable gloves, alcohol-based hand rub, and face masks. Washing hands with soap and water routinely is always advisable.

Responsibility for routine cleaning and disinfection of environmental surfaces should be assigned using a bleach disinfectant. Dispose of trash in leak proof bags/containers.

4.5 Medical records

1. Community Medical Form.

An example of a possible basic medical form for your community is located in the Appendix (Section 7.3).2. Updating Medical Records. Since most Jesuit Communities are not health care facilities, only basic medical information is necessary to have on file. Realizing that, what is important for a superior to know about individual Jesuits residing in the community? Know the man's main conditions, his allergies, and any important highlights and main conditions in his medical history, as well as the name of his primary physician.

The Provincial Assistants for Health Care (PAHC) have developed a standardized document that can be used by all communities. If there is an infirmary in the community, then the health care professional and the appropriate staff should keep up those records on the members of the house. If a person is being moved to a non-Jesuit health care facility, it is strongly encouraged that the superior or PAHC facilitate communication between the man's primary doctor and the admission coordinator at the health care facility. The superior is strongly encouraged to obtain a typed discharge summary to accompany the hospitalized Jesuit on his way to the nursing facility.

When a Jesuit is being moved to a Jesuit-managed facility, similar documentation and transfer information is critical. Please consult with the PAHC for a checklist of discharge information, diagnostic testing results, labs, and therapy notes.

Organ Donation: One of the difficulties with Jesuits for organ donation is that in much of, if not all of the United States, the person's legal next of kin, e.g., sister, brother, niece, etc., (not religious superior) has the authority to grant permission for donation. Given that many Jesuits have expressed a preference for organ donation, they need to speak with their family as well as their superior regarding their preference in the event that in sudden death it may be difficult for a superior to really do much to facilitate an organ donation. The double tragedy of a sudden death, especially in a younger person, is the loss of multiple organs that could provide life for many people, which makes this issue especially important for younger members of the Society.

Special Burial Requests: Men should be told to bring these to the attention of the superior in order to avoid difficulties at the time of death. Often men who are suffering from a terminal disease assemble detailed burial requests. This should be seen as a way of getting some control over the chaos of illness. As in many cases of this nature, pastoral care should dictate any conversation about this.

Advance Directives: Advance directives are documents that provide for the health care of an

individual if he is not able to speak for himself because of illness, accident, or some other catastrophe. Advance directives can take multiple forms ranging from verbal statements to formal documents. In most states, however, the best way for an individual to secure his wishes in the event of serious illness is accomplished by the completion of a relatively simple form. Depending on the state, advance directives will either consist of a living will format or the appointment of an individual to speak for the person. This latter option can either be a durable power of attorney for health care or a health care proxy. In many states, features of a living will and a proxy can be provided in the same document. It is important not to confuse durable power of attorney with power of attorney. The former remains in effect if the person is incapable of making medical decisions. The latter ceases to remain in effect just when you need it! It is customary for a Jesuit to designate the superior to speak for them. If the superior is not chosen, it is imperative for the superior to know who the proxy is so that the individual can be located when a crisis occurs. It is best to avoid lengthy living wills or various statements made in writing by the Jesuit, as these are often subject to considerable interpretations and confusion due to the lack of clarity in the language or when the person's seemingly clear wish becomes hopelessly muddied. Especially to be avoided are vague documents such as a "Catholic Living Will" or statements as "I desire to be treated in accord with the teachings of the Catholic Church." Although such statements are laudable, they cause great confusion among physicians of very good will who wish to take care of the Jesuit but lack training in what those statements mean. It is also to be noted that the magisterium's competence does not extend to purely medical decision making in the provision of therapies in a specific medical condition. Superiors should consult their Province for forms that are applicable in the state in which the community lives. This will ensure that the right document is being used. In Provinces with many states, it is important that either different forms are provided for each state or a competent lawyer has drafted a document that will be honored in several jurisdictions. A final issue that should be decided on the Provincial level, and usually with legal counsel, is whether Jesuits can simply designate the superior (rather than a named individual) or his successor as the proxy decision maker. If that is not the case, a mechanism in the community should be operative to attend to this when the superior is changed. The real issue with these documents is that an individual Jesuit and his superior speak honestly about what the man would want in the event of a life-threatening illness. This conversation should take place in the context of the superior's concern for the individual Jesuit and his desire to make sure that he receives good medical care. Also, this conversation is an opportunity to express the superior's concern about reasonable stewardship over medical resources, avoiding unnecessary pain and suffering, and the witness of Christian faith in the Resurrection in a society where many do not believe in eternal life. This conversation may be more crucial than any written form in that it provides the superior (or some other proxy) with real knowledge about what the man would want if he cannot speak for himself. It is not the proxy's job to make life and death decisions. It is the proxy's job to provide what he feels is the most likely response of the sick Jesuit in this situation so that the doctor can make treatment decisions accordingly. Although the communication between proxy and Jesuit is essential, it is equally important that the Jesuit let the physician know his wishes prior to a health care crisis. Such communication prior to a crisis can guide the physician in his or her approach to an illness and provide for much better care than would be the case if the physician is uncertain, afraid of legal reprisals, and essentially "doing everything" out of a misguided feeling that this is necessary.

Community held medical records

As indicated above, a model form for brief record keeping purposes within your community can be found in the Appendix (Section 7.3). You may wish to add certain categories, but this one is probably sufficient for emergency situations.

Another option is to work with the Province Assistant for Health Care. The Assistancy has invested in an electronic database containing the health care record for Jesuits in the U.S. This database is HIPAA compliant and can only be

accessed by authorized Province health professionals. These records are encrypted and password protected. Page one of this form can be printed for your emergency file use, and a blank copy of this can be found in the Appendix (Section 7.7).

Medical forms such as this should be completed and easily accessible during an emergency. Some communities keep a copy of each Jesuit's completed form in a sealed envelope in the same binder as the car check-out sheets. This way the information is accessible if a superior is not available at the time an emergency occurs. Obviously once the forms are returned, they are once again sealed in a new envelope.

4.6 General principles for community record keeping

The following pages provide recommendations concerning the record keeping process/protocol for the health care records on individual Jesuits.

General principles for community record keeping

It is recommended that the following record keeping process be established for the health care records on individual Jesuits:

Types of records	Paper copy	Computer	Who has access	For what purpose?	Disposition
Medical (updated after medical change/ yearly physical)	Rector's/superior's/minister's office (to be forwarded to any new community for filing)	If community has a system for this	Superior Province Health Care Assistant or coordinator Hospital/physician	Legal/Reference	Archival decision at death
Advance Directive	Province Offices, Local Superior	No	Superior Province Health Care Assistant or coordinator Province Office	Legal/Reference	Accession to Archives at Death
Organ Donor/Body Donor to Science	Local Community	Yes	Superior Province Health Care Assistant or coordinator	Information	Accession to Archives at Death
Special Burial Requests	Province Offices/Local Superior (exists in written form)	Yes	Province Office Local Superior In certain States family and close friends (.e.g, Texas)	Information	Accession to Archives at Death
Will (Original and Copy)	Finance Office of Province	No	Province Treasurer	Legal/Reference	Original must be filed in Office of Clerk of County in which Jesuit died. Copy Accession to Archives at Death
Death Certificate	Finance Office of Province	No	Province Treasurer	Legal/Reference	Accession to Archives at Death

It is recommended that all of these records should be retained permanently.

4.7 Funeral preparations

Some superiors have reported experiencing difficulties and discomfort before the tasks of arranging a fellow Jesuit's funeral and dealing with other concerns subsequent to his death. This is especially true when that Jesuit's specific wishes have not been reliably determined. The following generic checklist is offered as an instrument for local adaptation as a means of addressing these concerns, minimizing ambiguities, and resolving questions that may arise after a Jesuit's death. What follows on pp. 62 - 67 is a possible instrument you may wish to reproduce within your community. It is offered as a sample worksheet; feel free to make your own modifications to suit the needs of your particular community. You might also check with your Province office to see whether another instrument is available.

Individual circumstances will, of course, suggest how this instrument, formatted as a questionnaire, might best be employed: as a structured interview in fraternal dialogue between superior and subject, perhaps, and/or as a prayerful exercise in which a Jesuit might engage in solitary reflection.

Sample Letter to Jesuits about Funeral Preparations

Dear Brothers: Peace to you

Death and disabling incapacity are not topics that invite easy reflection or conversation. Prompted, however, by the frequent experience of ambiguities generated by the absence of documentation, my consultors and I are trying to establish, for those individuals who wish to supply one, a record of preferences and other information that might otherwise be neglected or overlooked at the time of your death. Thus, you are invited to review the following checklist, indicating your wishes in regard to these various matters.

Funeral preparations

Medical directives

1. Are Health Care Proxy and Durable Power of Attorney for Health Care documents on file with the local superior?
    a. ☐ Yes
    b. ☐ No

2. What directions, if any, are in place for:
    a. Organ donation:
    b. Donation of my body to science:

Memorial card

1. Do you wish the customary photograph of yourself on the card?
    a. If yes, where is there a photo available for such use?
    b. If no, what would you prefer instead of your photo?

2. What text would you like to appear on the card?
    a. ☐ *Suscipe*
    b. ☐ *Anima Christi*
    c. Scripture Passage:
    d. Other:

3. Other places (besides the usual houses of the Province) to which I would like cards to be sent (e.g., persons listed in your address book, if we can find them):

4. The death notice and obituary will be sent to newspapers in various cities. Please list the city/cities to which the death notice and obituary should be sent.
    a.
    b.
    c.
    d.

Wake

1. I would prefer the casket to be:
    ☐ Closed
    ☐ Open

2. Any additional instructions (e.g., Scripture passages to be used)

Funeral

1. Name of person you'd like to have preside at the funeral Mass:

2. Name of pallbearers (if any)
   a.
   b.
   c.
   d.
   e.
   f.

3. Names of priests you'd like to have concelebrate, if they are available:
   a.
   b.
   c.

4. Homilist (please indicate two or three choices in order of preference)
   a.
   b.
   c.

5. Music preferences – music you would strongly desire to have or have a strong desire NOT to have. Please be specific.
   a.
   b.
   c.
   d.
   e.
   f.

6. Any specifics regarding the General Intercessions?

7. Gift bearers (please indicate their names)?
   a.
   b.
   c.
   d.

8. Preference for Eucharistic Prayer:

9. Eulogist:

10. Any other issues:

Burial

1. What type of burial would you prefer?
   a. ☐ Traditional
   b. ☐ Cremation
2. Burial will, of course, be in one of our usual Jesuit plots. I prefer that the burial be
   a. ☐ where the death occurs
   b. ☐ Elsewhere – please specify:
   c. ☐ I am indifferent regarding the place of burial

Other

Please specify any other matters that need to be addressed (e.g., flowers, needs of family members, etc.)

Matters relating to personal effects

1. Have you made a last will and testament or prepared any similar document that will facilitate the final disposition of your effects?
   a. ☐ Yes. If so, where is this to be found? _____ (It would be good for your local superior to have a copy of this document)
   b. ☐ No. Please consider creating such a document.

2. If you do not care to be that formal, please take the time to identify articles (books, papers, photographs, audio tapes, CDs, DVDs, etc.) which should not be discarded but should be passed along to a specific person. ***Please identify that person in writing and also specify the exact location of these articles.***

3. If there is a bank account (savings, checking, or other) under your name, please provide the information necessary to close the account.
   i. Name of bank:
   ii. Name of account holder:
   iii. Account number:
   iv. Address of account holder:
   v. Other persons on this account:

   i. Name of bank:
   ii. Name of account holder:

iii. Account number:
iv. Address of account holder:
v. Other persons on this account:

i. Name of bank:
ii. Name of account holder:
iii. Account number:
iv. Address of account holder:
v. Other persons on this account:

4. If you have a safe deposit box(es), please provide the following:
   a. Name of location where the box(es) are held:
   b. Where are the keys to the box(es):
   c. Other persons who have access to the box(es):

5. If you have other materials in containers (e.g, suitcases, safes) with combination locks, please provide the combinations so that we can retrieve the materials:

6. Please provide all user names and passwords on any electronic or Internet account (e.g., Google, online banking, Netflix, Facebook, etc.):

Name of account	User name	Password

7. Please provide the physical location of all credit cards/debit cards:

8. Please provide the following information for ***each*** credit card or debit card account:
   i. Name of bank/credit card company:
   ii. Name of account holder:
   iii. Account number:
   iv. Expiration date on card:
   v. Address of account holder:
   vi. Other persons on this account:

4.8 Transitions

It is very difficult to give clear-cut criteria for transition from an independent community to a community that provides more assistance, e.g., a Province health care facility. Normally a move is considered when a person needs assistance in the activities of daily living. These include the following: being able to move around from bed to chair without a problem, dressing oneself, using the toilet, maintaining continence throughout the day, bathing, grooming, and feeding oneself. When a lay person has problems with these activities, he or she needs either assistance at home or placement in a nursing facility. What about Jesuits? As an example, an older Jesuit who was formerly doing quite well and then had a stroke now needs help with dressing. It makes no sense to send him to the nursing community when a member of the community can help him button his shirt and fastens his belt without great fuss. This is part of the ordinary care, which we owe each other. Another Jesuit, however, may have problems with making it to the bathroom, in dressing, showering, and falling frequently. In this case, provided the man has had a thorough evaluation by a physician and these deficits cannot be remedied, then it is appropriate that he move to a community with assisted living or a nursing home. Issues like these raise the question of transitions in Jesuit communities. There are a number of reasons why it might be necessary for an aging Jesuit to leave a community that has been his home for many years. These transitions are never truly easy, but in many cases there are ways to think and plan that may help both the man and the community during the transition process.

For temporary assistance while a man is still in an active community, Medicare Home Health Compare (www.medicare.gov/homehealthcompare/) is a good resource.

How should a superior approach the subject of transitions?

1. Transition is a part of every Jesuit's life, and it is not part of our vocation to become rooted in a place. In community meetings, superiors might wish to emphasize this topic and provide opportunities for both younger and older

members to discuss transitions in their life. In individual conversations with older Jesuits the superior should ask open-ended questions such as: "What do you think the future holds for you? Have you thought about what you want for the future?" Some Jesuits will likely spontaneously discuss their fears and their hopes for the future. Others may avoid the topic or announce their plan to stay in a specific community until they are carried out. Although there is no way to deal with every possible problem, the superior should early on move beyond the superficial and encourage the man to think about what transition will be like and how when the time comes for this transition, the superior will be most helpful for this man. In some ways there will be an element of preaching to the converted because it is likely that the man who thinks seriously about his life and where God is calling him will have both an easy transition and serve as an example to the community. The cranky or difficult Jesuit, or the Jesuit who simply refuses to look beyond the surface, will probably have a difficult transition. There is little that the superior can do except provide a conscious effort for planning and providing a context for transitions.

2. Discussions about transitions should be part of all Jesuit life as they are something that we all experience frequently. Men in a community for a long period of time should be challenged to consider their next step and urged to think, pray, and discuss with the superior their hopes, fears, and expectations regarding this move.

3. Difficulties in transitions can be eased if those who remain behind in a community make the effort to keep in touch with the man who has been moved. (How would you feel if you moved and none of your friends called, wrote, or visited?)

Options in transitions

Skilled Nursing Care

Why does an older Jesuit have to move on sometimes? The most obvious reason is an overwhelming illness that requires skilled nursing care that can be found in some of our health care facilities. As an example, the transition is very hard for a Jesuit who has had a stroke, a heart attack, or a major surgery and cannot come home. When an illness like this occurs suddenly, very little planning can be done. This transition happens to many older Americans. The best that can be said is that as Jesuits we are relatively privileged, for the most part, by having facilities where we will be cared for by Jesuits and those who work with us in this health care ministry.

Assisted Living Community

Another more difficult transition is when a Jesuit simply appears to be increasingly incapable of independent living. His capability to remain in the community depends on three factors: (1) The ability of the community to provide safe and responsible support 24/7; (2) The type of function limitations experienced by the older Jesuit; (3) Possible resources available to keep the man in community.

1. The ability of a community to provide safe and responsible care.

This is a particularly neuralgic issue because transitions will work well in a community where the older Jesuits are loved and cared for in contrast to communities that look at the care of older people as a potentially difficult responsibility. In the former community a transition may not be easy, but there is a far better chance that it will be done well rather than in the latter type. Younger Jesuits need to consider aging apartheid that promotes separation of Jesuits rather than a *cura personalis* that is the tradition of the Society or the lived experience of many middle-aged Americans that struggle to combine career and family as they provide care for aging parents. Transitions are best when there is a place of hope to which a person can move. Thus, it may be necessary to create a community for older members of another community because their collective infirmities do truly limit the apostolic availability and potential of the few young men who are working in a specific apostolate. In a case like this, the new community should be one that

combines a physically attractive setting, a warm atmosphere, and an appropriate environment that will make it easy for the older man to maintain his level of functional ability.

The other part in assisting older Jesuits with transitions is that either health care communities or communities designed for older Jesuits should be visited by younger Jesuits and not kept in a cordon sanitaire situation. What will make any transition easier is to make a man know that those with whom he has lived care for him and will demonstrate that care by driving to visit him in his new community.

2. The type of function limitations experienced by the older Jesuit.

What indicates the need for a possible transfer for health care support?

1. Difficulties with hygiene that impact negatively on the man and the community.

2. Irascible behavior that creates an unpleasant environment for other community members.

3. A gradual deterioration of function and behavior that has received adequate medical evaluation and is not chalked up to functions of old age.

Probably the key is the individual's ability to care for himself in a manner that is safe and dignified and does not create an excessive difficulty for other generous community members. The kinds of problems that can happen include great instability in walking, frequent falls, bowel and bladder incontinence, inability to dress oneself, and inability to shower or bathe on a very regular basis and take prescription medication accurately. Many of these problems may be hidden by an individual out of fear that he will be forced to move.

What is especially difficult is that early recognition may reveal a treatable medical problem that can be reversed through preventative medicine. For those individuals whose growing infirmities do, however, clearly limit the man's ability to contribute to community or truly have a negative impact on the community, then the individual or individuals in question must be moved. It would be hoped that the community would see the man becoming frail over time and have the good sense and inquire how he is doing, take him to the doctor and tell the doctor what is wrong, and try to get him better. It is important that the superior not let this slide. If he does not have the courage to talk about these changes, then one can guarantee tension within the house and a difficult transition.

3. Possible resources available to keep the man in community.

Another issue in considering transitions is how much support should a community provide to a man who is failing. Everybody needs help from time to time and communities should be able to give a man some help with dressing, provide for assistance with transportation, and, in a charitable manner, help with means of hygiene and personal care. The difficulty facing a community is men who are clearly holding on in a desperate effort to avoiding moving. A number of men can have a number of needs that may not be big individually but collectively are too much for a community to bear. There is no way to establish a clear calculus for when an individual is too much or the community is overburdened. People need to be honest and caring, but critical of ageist attitudes and assumptions. At the same time, a community must realize that our apostolic communities are not nursing homes. A superior who finds himself burdened by these decisions might seek the guidance of either a physician with special expertise and qualification in geriatrics or a nurse geriatric practitioner who can come into the community, perhaps share a meal or two in the community setting, and gain a sense of who truly seems to be failing. Specific assistance that may be available to communities includes homemaking and home health aide services that can be privately contracted or maybe, in some cases, reimbursed by Medicare. Such services include assistance with bathing, dressing, help with medications, and simple actions like assistance with laundry and light housekeeping in a man's room. You can find the services in your area by calling the local hospital, asking to speak with the social work or social service department,

and asking them to provide a list of home care or home nursing organizations. Another option is to call the visiting nurse association listed in your phone book and ask for a listing of their services. A final note about the transition process, which again may prove difficult, but may help ease transitions: One should be critical of those Jesuits who continually complain about older Jesuits and are too self-absorbed to participate in the care of their older brothers. One also needs to confront an attitude that will occasionally be found in an older Jesuit that the community is his, and that he has the license to continually criticize the Church, the apostolate, the community, and other Jesuits, and that he is not accountable to normal Jesuit governance. Unfortunately there will be difficult cases in which the main issue is control and a fight over power in a man who is unwilling to recognize that he is no longer capable of living independently or that his behavior poisons the community. Regrettably, in such situations, the superior, perhaps with the help of the Provincial, has to exercise the authority of his office in what might seem to be a heavy-handed manner.

N.B. For some communities and Provinces, if the man's health care needs cannot be met in the Province-supported facility the transition to a non-Jesuit facility is a reasonable option. This consideration may be due to psychological and physical needs beyond the scope of care at the Province health care facility. Consultation with the PAHC is strongly recommended.

4.9 Personal belongings

Jesuits transitioning and their personal belongings.

It can be difficult when Jesuits leave a community where they have lived for many years to go to another community or health care facility and they must reconcile the need to leave some belongings behind. Although there is no reason why a Jesuit cannot bring a modest amount of personal items to the health care facility, extensive personal libraries, knick knacks, and other clutter sometimes cannot make the move with the man. Another problem is that some Jesuits are collectors of newspapers and magazines. Unless these are of some particular value or unusual magazines, then the man will need to discard them. On occasion one can be struck by the starkness of the rooms of some of our men in our health care facilities. This may reflect the austerity of their lives, or it may be a sign that no one took the trouble to make sure that the man had those few belongings that are important in his new setting. When a man moves to a new community, there should be coordination with the new superior as to what constitutes a reasonable amount of personal belongs in this new setting. Especially important would be photographs, picture albums, and perhaps other cherished mementos.

4.10 How to make older men feel valued in community

Jesuit superiors face the challenge of making all in their care feel appreciated and valued. This can be a challenge with some men! As men age they may have particular vulnerability to feeling that they are unimportant, not valued, and apostolically worthless. There is no magic way to counter this attitude except the ongoing care and concern of a sympathetic superior who is willing to listen, encourage, and, from time to time, be firm with older Jesuits.

What are some practical suggestions?

If the community is not very large, the superior should make a point on occasion of taking an older man out to lunch or for some outing where he can talk and have a pleasant time. This social encounter may lead to more real exchange of information than would be the case with a formal account of conscience where an older Jesuit may hide his feelings of sadness under the cloak of traditional religious language. Another thing for a superior to do is to ask older men about their hobbies, encourage them in the pursuit of these hobbies or to take one up, and to provide the men in question with reasonable financial support. A third possibility is to visit the man where he lives, i.e., in his room. Take a look at the surroundings or furnishings for their comfort and safety. See what mementos and pictures the man has and engage him in conversation about these memories. The superior can also ask the entire community to take part in caring for older

men. Some of the practical items just suggested can be done by any Jesuit with a heart. As an example, if you notice one of the older men is not dressing well or looking a bit shabby, suggest to one of the younger men to take him shopping and give him some money to outfit the older man in an appropriate manner. The particular outing does not matter so long as the older Jesuit has a sense that someone cares that he is alive. Older men should be encouraged to attend community socials and especially liturgical functions. All too often some older men will celebrate a private mass early in the morning and then feel excused from the community celebration late in the afternoon. Tell him he is a valued member of the community and that in addition to his private mass, he belongs in prayer with his brothers even if he does not wish to concelebrate at that time. Community meetings can often be an awkward time with younger men more facile in discussing feelings and emotions whereas older men can feel embarrassed or simply confused by topics like intimacy, sexuality and ministry, appropriate relations with lay people, etc. Not every community meeting need be an exercise in self-revelation. Instead, a meeting might focus on a topic in liturgy or Scripture or history or travel that does not present obvious possibilities for division and could be enjoyed by all. Men who are eating at meals that minimize their time with the community are Jesuits who may be feeling lonely and otherwise disturbed. The superior should discus with the man the behaviors he notes and ask what is going on. For other Jesuits loneliness is a persistent feeling, despite their efforts to throw themselves into work and community. It can be a trial of one's vocation that a particular Jesuit is lonely because he is away from good friends, family, and other connections that give support to his life. Helping members of a community through this transition time requires that other members of the community reach out and notice that the other person is there and efforts should be made to make him feel wanted. This need not be elaborate, but involves simple and repeated offers to share a meal, go to a movie, share a walk, etc. With older men as they retire and physical infirmities multiply, lack of contact with the surrounding world and loss of peers because of death and illness can create a situation where loneliness is a clear and reasonable response. Again, probably the best way to help in situations like these is to keep one's eyes open, notice them, and ask the man how he is doing, if is he lonely, and what he or other community members can do to help with this loneliness. Many Jesuits have created a barrier around themselves to privatize their life in community. These barriers should gently but firmly be knocked down so that these men cannot retreat into intractable loneliness and depression.

4.11 Spirituality and aging in community

Ignatius' vision of people created to praise, reverence, and serve our Lord is especially important during the later stages of life in the Society. Since much of our spiritual life is privatized, little can be said here beyond a few practical suggestions. This presupposes daily Mass and regular structured community spiritual exercises.

1. Ask them what religious practices are important to them and try to provide these practices. Although benediction may not be the form for most of the community, do realize that this may have been an important part of the spirituality of older Jesuits.

2. Try to provide regularized options for the Sacrament of Reconciliation, etc.

3. Continue to stock the house library with good religious reading material. It may be helpful to survey your house as to the desires of your men. If biographies of the saints are important to many in your house, focus on that as an area of spiritual reading that needs augmentation.

4. St. Ignatius wished that each house have a garden for the sake of reflection. Try to keep your garden up to some standard of pleasantness and provide seating for community members.

5. Encourage annual retreats and provide the transportation an older man needs to a place conducive to his annual reflection and renewal. Some older men opt for a "house retreat" so as not to appear a burden to the superior or

put the community out because of a mobility problem.

6. Encourage men to exercise their priestly sacramental life in a parish setting or other religious context.

7. Have spirituality as a topic for a community meeting, though be careful not to focus on this as a sharing of emotions, which can confuse many of the elderly not used to communicating in this way.

8. Organize some lectures on a topic of Jesuit history, Jesuit spirituality, or theology.

9. Encourage growth in companionship among community members and use creative means to evoke a sense of "friends in the Lord."

10. Call on the elderly to speak to the community on parts of the heritage of the Society that come from the time they entered.

11. Organize times for common prayer for those who prefer it.

4.12 Loneliness

This topic cannot be addressed in any comprehensive form. What can be said is something about how to notice this internal psychological state when it surfaces in your community. Some of this topic has been touched on in the discussion of transitions, personal belongings, hobbies, and making older men feel valued in community. Loneliness often coexists with depression and one should have a high index of suspicion that the man who is withdrawn and lonely is suffering from a major depressive illness and needs help and perhaps medication. There are other situations when men rightly or wrongly feel themselves alone; their Jesuit brothers can ameliorate that. Among any Jesuits, individuals who seem reclusive, avoid community gatherings, spend excessive amounts of time in their rooms and develop a style of eating at meals that minimizes their time with the community are Jesuits who may be feeling lonely or otherwise disturbed. The superior should discuss with the man the behaviors he notes and ask what is going on. For other Jesuits loneliness is a persistent feeling, despite their efforts to throw themselves into work and community. It can be a trial of one's vocation that a particular Jesuit is lonely because he is away from good friends, family, and other connections that give support to his life. Helping members of a community through this transition time requires that other members of the community reach out and notice that the other person is there and efforts should be made to make him feel wanted. This need not be elaborate, but involves simple and repeated offers to share a meal, go to a movie, share a walk, etc.

With older men as they retire and physical infirmities multiply, lack of contact with the surrounding world and loss of peers because of death and illness can create a situation where loneliness is a clear and reasonable response. Again, probably the best way to help in situations like these is to keep one's eyes open, notice them, and ask the man how he is doing, if he is lonely, and what can he or other community members do to help them with their loneliness. Many Jesuits have created a barrier around themselves to privatize their life in community. These barriers should gently but firmly be knocked down so that these men cannot retreat into intractable loneliness and depression.

4.13 Ways to recognize depression

Although some individuals may be chronically depressed and down in the dumps, true depression represents an observable change in the behavior of most people. Recognizing that may sometimes be very easy. An individual who has previously been active, friendly, and a good community member suddenly becomes withdrawn and moody and avoids people in the community. He also has difficulties with work and outside friendships. Depression may well be the cause. Occasionally depression is more subtle, and there are a variety of symptoms that may be helpful in recognizing depression. Here is a list of some of the more common symptoms:

- A change in sleep patterns, frequently manifested by early morning awakening with an inability to fall asleep again;

- Lack of interest in normal activities, work, friendships;
- Anger;
- Persistent guilty ruminative thoughts, or as may be the case among Jesuits, severe scruples and persistent "desolation";
- Lack of energy, feelings of persistent fatigue, unable to do regular duties because of this fatigue;
- Changes in concentration, which may manifest as memory loss, mild confusion, and even among older men as to be thought of as Alzheimer's disease or other dementing illnesses;
- Changes in appetite, weight loss or gain may be seen;
- Abuse or overuse of alcohol to medicate lonely feelings;
- The signs of psychomotor slowing are often seen with depression and include: listless appearance and a shuffling gait. (Some individuals rather than having psychomotor slowing will exhibit psychomotor agitation with pacing, hand wringing, weeping, and other high-energy agitating manifestations.)

Depression may well be the common factor behind many problems seen in community life. Reclusive behavior, individuals who act strangely, and people who seem angry and bitter all of the time could well have a depressive component to their illness. Superiors should have access to a good psychiatrist for consultation (and for themselves) and advice on community members. Superiors should have a low threshold to contact the primary care physician when depression is suspected. He or she may institute treatment or refer the man to a psychiatrist. Always take seriously any suicidal desires or behaviors of community members. This does require an emergency assessment through the emergency room of your local hospital.

4.14 Utilization of local resources

Each superior is strongly encouraged to have regular conversations with the PAHC and the local health care coordinator. By working together, these groups can discuss and plan options to meet the specific needs of your community. A variety of resources may be accessible depending on the town or city where the community lives. One way to start is to ask a doctor or nurse with whom one has a good relationship and see if he or she can make a referral to an appropriate agency. Another resource, which can be invaluable, is to contact the local social work department of your local hospital and make an appointment with one of the social workers, recognizing that you will probably need to pay for their time and to ask her or him for advice for referrals for needed resources. A third option is to look in the phone book and find a council on aging. Many local areas have these councils, which serve as a clearing house for information for resources and activities for older individuals. A fourth option would be to call the local visiting nurse association and to ask for advice on these issues. They will likely be able to give you some good leads. Consider a small high school community where an older man may be going blind and is alone for a significant part of the day. Contacting a social worker can lead to a referral for Talking Books, which are provided free of charge for the visually disabled, as well as applications for other special services that are available in many states. Other problems in living experienced by community members may also have local community resources available to help them. The key to finding these resources is the willingness to spend some time networking and looking beneath the surface at what is in many cities and towns a fairly extensive network of social services. Likewise, many of the older men in the community who feel they have nothing to do and little work can be valuable resources by agreeing to do volunteer help in a variety of tasks. Look in your phone book or you can call RSVP (Retired Senior Volunteer Programs). They will provide a list of volunteer activities that desperately need the skills and services of many Jesuits. Older Jesuits may also help you to surface opportunities and services in your area, thus giving them a sense of investment and responsibility in their own care.

4.15 Families and friends of Jesuits

The relationship between a Jesuit's family of origin, their friends, and his Jesuit brothers can be summarized by the following statement:

It is the conviction that life as a religious continues to have meaning and value to the Jesuit. The decision to join the Society of Jesus was a free choice and is one that has been constantly reaffirmed over the years by the decision to continue living the religious life in the Society of Jesus. It is expected that choices made by a Jesuit and the decisions made by a Jesuit's religious superiors should be honored and upheld. A third party may be consulted but should not be looked to for final decisions regarding a Jesuit. The Society of Jesus takes very seriously its responsibility for and role in providing *cura personalis* for its members.

Jesuits are expected to inform and consult a family of origin during an illness. But, the Society of Jesus has final responsibility for decisions about a Jesuit's health, and the hope and desire is that family and friends will honor decisions without interference. This desire in no way manifests a lack of love for family and friends, but it does recognize the desire of a Jesuit to entrust decisions about his care to the Society of Jesus. It is expected that the usual presumptions found in civil law that look to the family for decisions should be put aside in favor of the wishes of the Society of Jesus.

How can a Superior communicate well with friends and family?

The best way to communicate well with a family is to create an ongoing relationship with families. It may be worthwhile to consider an annual gathering where families are especially welcome. The community should welcome families, recognizing the occasional need to set some boundaries.

How to deal with challenges?

When a superior is confronted by a situation that appears to be difficult either for the superior himself, the Jesuit, or the community, it is wise to obtain some professional advice. These types of problems frequently involve long-standing psychological issues in the family or friends' circle. An excellent resource can be a social worker skilled in family therapy. The Provincial Assistant for Health Care can also be an advocate for you.

4.16 Overview on professional counseling and psychotherapy

In our life together, we Jesuits provide mutual support, encouragement, and love through community life and friendship, spiritual direction, community prayer, retreats, and efforts toward personal and theological renewal. Yet we know well that these ordinary means of growth and healing are sometimes not sufficient to help some of our men to continue their development as persons and as Jesuits.

When stress, anxiety, or depression begin to burden or incapacitate, a Jesuit should feel invited, in consultation with his superior, to seek the aid of trained counselors. While our culture sometimes views such assistance as a sign of weakness, let us enjoy a quiet confidence based on the experience of many of our men who have gained useful insight into their own situations and burdens through the help received from a trained therapist. Counseling is not a panacea, but it is one more gift from God to us in our journey to him.

Occasionally a man may not realize that his behavior is manifesting extreme tension or anxiety. It is difficult for many of us to admit that we need help, not only to increase our apostolic effectiveness but also to remove the obstacles blocking our own growth. Knowledgeable and trustworthy Jesuits with whom we live and work may help us to gain a realization when we are in this need. More ordinarily, superiors are requested to deal with the suggestion from a community member that a particular Jesuit may need professional counseling help when other means have proven ineffective. ***We therefore have provided some guidelines in the next section to assist in a superior's deliberations about counseling for a member.***

When full confidentiality permits it, the process may involve a community, insofar as we may in our different ways assist a companion in need of professional help. The guidelines do look toward the role of the local community — superior, consultors, and members — in the process of affecting individual members of their community. But in order for all of us to be entirely trusting of the full confidentiality we are meant to have from

our superiors, these guidelines pertain especially to local superiors.

These guidelines do not address preventive means, or those ordinary means which the Society and our wider culture usually provide for our continual personal development in living and serving together. Rather, these statements focus on those already existing situations of distress or unfreedom in our lives that may be proving unresponsive to more customary help.

4.17 Guidelines for counseling and psychotherapy

1. In a spirit of brotherly love, when a Jesuit learns in a non-confidential way that a fellow Jesuit is in need of professional help and is not receiving it, he should discuss the matter with the individual's superior. Should wise and careful reflection indicate it would be helpful, the Jesuit should broach the subject, perhaps with the individual himself, and encourage the individual to take appropriate steps for recovery.

2. Members of the Jesuit community, but especially the superior and community consultors, should accept it as part of responsible community life that we give appropriate assistance and encouragement to a community member who needs to receive or who is already receiving counseling or therapy. The two key words here are "responsible" and "appropriate." Responsible: We are profoundly covenanted and mutually involved. We are a Society, a companionship, called to communion, to be friends in the Lord. Appropriate: Let realism be a central element of our love and care and also reverence: a fine sense of the feelings, reputation, and privacy of one another.

3. Where serious problems arise the superior should be in continuing contact with the appropriate Provincial Assistant and when necessary with the Provincial. Should any community involvement be appropriate in the process, care should be taken by all that confidentiality is preserved.

4. The local superior should have a list of recommended psychiatrists and psychologists in his area. Jesuit psychiatrists and psychologists in the Province are available to give advice when requested by superiors, e.g., as to when to seek professional help in particular cases, what kind of help, etc. Local superiors should also have adequate information about hospitalization facilities and procedures in their area. Furthermore, communities should see the financial costs involved in counseling or therapy as a wise and important apostolic investment.

5. Superiors should not feel unduly burdened. Their task is to decide whether professional evaluation is appropriate or necessary. The further decision as to whether (and what kind of) treatment would be appropriate lies primarily with the professional. Furthermore, wherever initial evaluation is not done with a psychiatrist, at least a psychologically-minded doctor should be part of the evaluation, so that general medical conditions are evaluated along with emotional ones.

6. When a community member leaves the house for a time, for counseling or therapy purposes, community members, with the approval of the superior, should maintain good personal contact with the individual and actively seek his return to community and to his former work.

7. When someone in the course of counseling or therapy needs to live, whether briefly or at length, in a Jesuit community where he has not previously been residing, superiors and members of the host community should welcome him in a full spirit of brotherly love, generously offering any assistance that may help return him to full health and to his former work and/or community.

4.18 Guidelines for longer-term therapy at a treatment center

As we become more knowledgeable about severe mental illness and its ramifications, we have come to realize that short-term treatment on an outpatient basis, or, worse, ignoring

aberrant behavior, serve neither the individual involved nor the community in which he resides. Jesuits who could be absorbed in larger communities in the past and were considered to be merely eccentric are now understood to suffer from mental illness and to be unhappy in their plight. For the welfare of both individuals and communities, these needs must be met in the future. In exploring possible structures to address this problem, other Jesuit resources have been contacted, but no combination of such resources seems feasible at this time, for example, if a Province does not have the financial or personnel resources on its own to respond to this need. Hence, it is clear that such a Province must use a non-Jesuit resource as its principal health care agency in this area. It is the practice of the USA Jesuits to provide for the medical, spiritual, and fraternal care of the mentally or emotionally impaired members in religious houses administered by competent and experienced religious communities. The local superior, together with the Provincial Assistant for Health Care, will be the principal advisors to the Provincial and his consultors on whether an individual is in need of a residential program to deal with his mental or emotional problems. The superior will carefully document the individual's behavior patterns that appear to be aberrant. It is expected that the superior will have professional evaluation reports from qualified medical persons and evidence that all other alternatives and medical procedures have been tried. Funding will be determined by the insurance program of the Province (or where applicable, the local community) and the economic situation of the community in which the man resides.

4.19 Overview on alcoholism

The Society of Jesus in the U.S. recognizes and accepts alcoholism as a disease. This disease generally manifests itself as a threefold illness of body, mind, and spirit. Unless arrested, alcoholism leads to irreparable damage or premature death.

In fraternal charity and in varying degrees of competence, all Jesuits have an obligation in conscience to help the suffering alcoholic to obtain adequate treatment. This obligation is just as urgent as that of securing adequate treatment for any serious disease.

Clinical experience shows that persons afflicted with the disease of alcoholism need help and professional treatment. They are rarely able to help themselves effectively. Finally, because of the addictive nature of the disease, they are incapable of a sound and realistic judgment as to whether or not they need treatment.

The provincial assistant for health care should be consulted about a Jesuit with a drinking problem. He or she can offer information and make recommendations about the available and necessary treatment options for the Jesuit.

4.20 Guidelines to address alcohol issues

Introduction

The purpose of these suggestions is to help a superior bring a problem drinker in his community to the point where the man is willing to accept help in seeking a solution to his problems.

It's not always easy to see when the man's drinking has crossed the line from moderate or social use to problem drinking. But if he consumes alcohol to cope with difficulties or to avoid feeling bad, he is in potentially dangerous territory.

Alcoholism and alcohol abuse can sneak up on the man, so it's important to be aware of the warning signs and take steps to encourage the man to cut back if you recognize them. Understanding the problem is the first step to addressing it.

Understanding the Problem

Alcoholism and alcohol abuse are due to many interconnected factors. People who have a family history of alcoholism or who associate closely with heavy drinkers are more likely to develop drinking problems. Finally, those who suffer from a mental health problem such as anxiety, depression, or bipolar disorder are also particularly at risk, because alcohol may be used to self-medicate.

Indicators the man may have a drinking problem. Does he:

- Feel guilty or ashamed about his drinking?
- Lie to others or hide his drinking habits?
- Have community, friends, or family members who are worried about his drinking?
- Need to drink in order to relax or feel better?
- "Black out" or forget what he did while he was drinking?
- Regularly drink more than he intended to?

The bottom line is how alcohol affects the man. If the man's drinking is causing problems in his and the community's life, then he may have a drinking problem.

Alcohol abuse - signs and symptoms

Substance abuse experts make a distinction between alcohol abuse and alcoholism (also called alcohol dependence). Unlike alcoholics, alcohol abusers have some ability to set limits on their drinking. However, their alcohol use is still self-destructive and dangerous to themselves or others.

Common signs and symptoms of alcohol abuse include:

- Repeatedly neglecting his responsibilities in community and/or at work because of his drinking.
- Using alcohol in situations where it's physically dangerous, such as drinking and driving or mixing alcohol with prescription medication against doctor's orders.
- Experiencing repeated legal problems on account of his drinking. For example, getting ticketed for driving under the influence or for drunk and disorderly conduct.
- Continuing to drink even though his alcohol use is causing problems in his relationships.
- Drinking as a way to relax or de-stress. Many drinking problems start when people use alcohol to self-soothe and relieve stress. Getting drunk after every stressful day, at social, dinner, and/or haustus.

Not all alcohol abusers become full-blown alcoholics, but it is a big risk factor. Sometimes alcoholism develops suddenly in response to a stressful change, such as new or loss of ministry, retirement, or another loss. Other times, it gradually creeps up on the man as his tolerance to alcohol increases. If he is a binge drinker or drinks every day, the risk of developing alcoholism is greater. This is a critical moment; early intervention can prevent development of full-blown alcoholism.

Alcoholism (alcohol dependence) – signs and symptoms

Alcoholism is the most severe form of problem drinking. Alcoholism involves all the symptoms of alcohol abuse, but it also involves another element: physical dependence on alcohol. If you rely on alcohol to function or feel physically compelled to drink, you're an alcoholic.

Commons signs of withdrawal symptoms may include:

- Anxiety or jumpiness
- Shakiness or trembling
- Sweating
- Nausea and vomiting
- Insomnia
- Depression
- Irritability
- Fatigue
- Loss of appetite
- Headache

Rationalizations you may hear from the man about his drinking:

- I can stop drinking anytime I want to.
- My drinking is my problem. I'm the one it hurts, so no one has the right to tell me to stop.
- I don't drink every day, so I can't be an alcoholic. OR I only drink wine or beer, so I can't be an alcoholic.
- I'm not an alcoholic because I have a job and I'm doing okay.
- Drinking is not a "real" addiction like drug abuse.

Denial is one of the biggest obstacles to getting help for alcohol abuse and alcoholism. The desire to drink is so strong that the mind finds many ways to rationalize drinking, even when the consequences are obvious. By

keeping the man from looking honestly at his behavior and its negative effects, denial also exacerbates alcohol-related problems with work and relationships.

Toward a solution*

Intervention by a superior

1. Documentation is important. Gather information, i.e., eyewitnesses, complaints or concerns from co-workers or community members.

2. Promptly undertake an informed, planned, one-on-one brotherly intervention. The aim is to lead the man to make his own decision to accept help. The superior can stress to the man that he is following his obligation to respond to this serious health problem and to provide treatment options. It is important for the man's sense of support, hope, and love that this be done in a spirit of fraternal love and concern.

3. If the man agrees to accept help, the superior should contact the Provincial Assistant for Health Care to identify the best treatment option for the man. See additional resources in Section 3: Assessment Programs.

4. If the man is resistant, plan for a group intervention.

Intervention by group

1. Identify key support people, i.e., Provincial, his Assistant for Health Care, Prefect of Health, minister, personal doctors.

2. Have a clear plan for referral/intervention. Again, documentation is important.

3. Direct Provincial involvement may be needed – communication between superiors and Provincials in the man must be moved.

Provincials/Leadership cannot let addictions go untreated.

Follow-through (aftercare)

After the intervention, the problem is not completely solved, so the superior cannot dismiss it from his mind when the Jesuit brother agrees to accept help. That is the best beginning. A superior needs to continue contact with the man while he is in treatment. Moreover, he must maintain this close follow-up when the man returns to the community. The superior is encouraged to provide the necessary supports to enable the man to continue with his recovery program.

1. Support for aftercare.

2. Foster small groups within the community or local area, where the man with addiction problems can share with other Jesuits, as in AA, SA, etc.

The recovery program will engage him for the rest of his life.

4.21 Suggestions for a driving conversation

Starting the conversation

This guide provides some suggestions for a conversation about driving. Local superiors are encouraged to seek professional assistance in those situations when concerns arise about the driving skills of their community members. Your Province may already have guidelines in place; please check with the assistant for health care in your province.

Ten questions for the individual Jesuit driver to ask himself about his ability to drive:

1. Have you noticed a change in your driving skills?

---

* This material was adapted from two sources: (1) Challenges to Healthy Jesuit Living: RECOMMENDATION MATRIX in Jesuit Conference of the United States Task Force on Challenges to Healthy Jesuit Living and (2) National Clearinghouse for Alcohol & Drug Information.

2. Do others honk or show signs of irritations when you drive?

3. Have you lost confidence in your driving ability, leading you to drive less often?

4. Have you ever become lost when you are driving?

5. Have you ever forgotten where you are going?

6. Do you think at present you are a safe driver?

7. Have you had any car accidents in the past year?

8. Have you had any minor fender benders with other cars or objects in parking lots?

9. Have you had any recent traffic tickets?

10. Have others criticized your driving or refused to ride with you?

If you answered YES to any of the above questions, you may need to have your driving skills screened. Seek further consultation with your local superior. A physician order would be needed for further assessment.

Ten questions your local superior or other Jesuits might ask about your driving:

1. Do you feel uncomfortable riding with the individual Jesuit driver?

2. Have you noticed any abnormal or unsafe driving behavior?

3. Has the driver had any recent crashes?

4. Has the driver had any near misses that can be attributed to mental or physical decline?

5. Has the driver received any recent traffic tickets?

6. Are other drivers forced to drive defensively to accommodate the individual Jesuit driver's errors in judgment?

7. Have there been times when the individual Jesuit driver has become lost or confused?

8. Does the individual Jesuit driver require many cues or directions from passengers?

9. Does the individual Jesuit driver need a co-pilot to alert him to potentially dangerous situations?

10. Have others commented on the individual Jesuit driver's unsafe driving?

If you answered YES to any of these questions about the driving skills of the individual Jesuit driver, then an assessment and functional screening by a physician is appropriate. A medical order would include a hands-on driving assessment by an occupational therapist and, if indicated, a neuropsychological screening (usually not covered by medical insurance).

Key points:
Conversation
Clinical Evaluation
Behind the Wheel Evaluation
Rehabilitation through on the road instructions, adaptive driving equipment, community accessibility options.

The driving conversations: 5 stage talks with older drivers

To understand the 5 Stages of The Driving Conversation, click on the links to the pages below:

Stage 1. Rethinking the driving conversations - Ideally you begin this conversation before any issues have presented themselves. Establish your concern for the future and align yourself with being on the same team as your aging community member.

Stage 2. What to do at the first signs of change - What to look for as early signs of change in driving habits. Self-assessment tools offered. Providing support to preserve maximum freedom.

Stage 3. The warning bells - Learn the signals that there are more serious concerns. What professional medical assessments could be

suggested? Referrals to Driving Rehabilitation Specialists and adaptive devices for the car are discussed.

Stage 4. When it's time to retire from driving - Critical questions to know when it's time to hang up the keys. Methods to ease the transition are discussed. Alternative approaches if driving cessation will not be voluntary.

Stage 5. Preserving independence after driving - Planning ahead to maintain freedom. What are some creative transportation alternatives to driving?

What NOT to do

The decision to retire from driving is NOT an ultimatum. It is not a single conversation. Ideally this conversation takes place in a way in which the individual and superior create a plan. The superior has the final decision concerning driving. Check with your Province office for specific driving policy.

4.22 Furniture and furnishings for a community

When should a superior be concerned about the personal belongings of a man? The superior needs to be concerned when there is an excessive amount of clutter that may cause a safety hazard or certain devices that may run the risk of fire, electrical shock, or other hazard. Superiors should know their house and have a sense of clutter or hazardous devices that individual Jesuits keep in their rooms.

General Principles:

When considering furniture and the furnishings for a community, take into account older men and those with physical limitations, either temporary or permanent. Furniture needs to be safe, comfortable and easy to use.

Particularly for older men, many of whom have some problem with leg weakness or arthritis, it is important to avoid low chairs that make it almost impossible for them to get up once seated. Ideally, furniture should have relatively high seats with good arm supports, so the man can steady himself getting down or getting up. Regrettably, the overstuffed lazy boy type chair favored by many men is usually too low, quite difficult to get up from, and encourages immobility rather than functional independence. With regard to safety, an excessive amount of furniture is a hazard, as is too many furniture groupings.

The issues of clutter and fire safety may become obvious with men who have a propensity for "saving" many items like newspapers, letters, and other materials that may be painful for them to discard.

Lighting:

Loss of visual acuity caused by cataracts and other changes in the eye is common to older people. Good lighting is an important way to avoid accidents. Overhead lighting casts fewer shadows and can help increase the safety of the Jesuit Community for its older members. In consultation with someone skilled in lighting design or interior renovations, light fixtures that are aesthetically pleasing and functional can be chosen.

Hallways:

Hallways pose special challenges because of carpeting, lighting, and the need some older men have for support in navigating down their length. Carpeting should be relatively light and a sharp distinction should be made between hallways and stairways so that men will have visual clues and not fall down the stairs. Likewise, hallways should be well-lit at all times, and all members of the community should be made to realize that it is false economy to shut the lights out for the evening when an older man may wander and fall. Carpeting should be well-maintained and without scatter rugs or potential barriers that could lead to falls. Particularly useful for some older men may be the addition of a hallway railing that could provide them with support as they walk down the corridor.

Bathrooms:

Consider installing ADA height toilets and grab

bars. Shower stalls that require a high step for a man to enter should be renovated. Consult a contractor or medical equipment vendor to change the shower pan to entry-free access. Consider purchasing temperature sensitive faucets and hand-held shower nozzles.

Flooring:

Consider non-skid flooring material.

4.23 Food preparation considerations

Community meals provide a special challenge for superiors who need to juggle four sometimes mutually exclusive goals: 1. Provide adequate nutrition; 2. Discourage food faddism both for the young and the old; 3. Maintain peace in the community; 4. Stay within a budget. Despite passing fads and dire warnings about fat and fiber from various quarters, moderation both in choice of foods and amounts is reasonable. Although they can be a source of problems when eaten in excess, a dash of salt, an occasional egg, a bit of butter, and red meat are not poisonous. It should not be the case, however, that every meal be laden with fat, salt, gravies, rich sauces, and fatty meats. In seeking help in planning a menu, a dietician could be consulted. A professional can usually be found through a local hospital or clinic. Ask your chef to prepare a list of typical menus and, ideally, the superior, the dietician, and cook can meet to formulate a healthy plan. It is extremely important for superiors not to be swayed by well-meaning if over- zealous members of the community who feel obliged to impose strict diets that may represent their own idiosyncratic views on nutrition rather than true scientific knowledge. A special problem that many younger Jesuits do not seem to recognize with older men is that the elderly may have diminished appetites and weight loss. Although an overweight older Jesuit with a history of heart disease needs to be strongly counseled about his diet, do not overlook the thin older man who is losing weight.

Special diets and food fads:

Rectors are often faced with community members requesting special diets. Obviously it is the responsibility of the community to meet the needs of those with special problems, e.g., diabetes, hypercholesterolemia, or specific conditions indicated by their doctor as a genuine health problem. One needs to consider budgetary constraints and a reasonable regard for poverty in dealing with Jesuits who seek diets for unproven or faddish reasons. (If a person is a vegetarian, then it is appropriate that the vegetables already planned for the community meal are well-prepared. If however, someone suddenly announced that he felt a need for a brown-rice diet, one could question whether this is a reasonable request.)

Rules of thumb:

1. Make sure the men's calorie requirements are being meet. Some men can benefit from high-calorie drinks like Ensure or Boost.

2. A daily ingestion of fast foods should be avoided due to the excess intake of salt, sugars, fats, and processed additives. 3. Don't give in to fad diets.

4. For men with limited cooking experience who have to prepare their own meals, provide a healthier choice such a frozen entrée like "Smart Ones, Healthy Choice." The recommended entrée guidelines are at least 300 calories per serving with sodium between 600-800mg and 10 grams of protein.

V. Ignatian Spirituality and Aging

5.1 Spirituality and aging

In these pages, the Jesuit Health Care Handbook focuses on Jesuit spirituality and the ageing Jesuit. The pages aim to help superiors in their *cura personalis* and *cura apostolica*. They also mean to offer support to those who give our aging men health or other professional care.

The guiding perspective throughout can only be that aging is a time of opportunity and new possibilities. Both Jesuit spirituality and gerontology urge seeing it that way. Although the challenges are real and not to be disguised by Pollyanna like sentiments, aging presents older Jesuits real possibilities for human growth and holiness.

Jesuit spirituality and aging

Our spirituality begins in the Principle and Foundation, the authentic experience of God creating and caring for us all our life long. Aging with this foundation, we continue aware that God is with us and loves us, providing us grace to move toward the goal of our existence. Hence, we are free to take each day of our age as a gift. We reject the view that getting old is a negative experience, a view frequently bruited in the United States today, and that the elderly are somehow less alive or vital than the young.

Not all Jesuits take age as a gift, as anyone can see. Some ignore the reality of their aging. Some effectively deny it by continuing in work – work that may no longer be especially productive. A Jesuit can keep engaging in a plethora of tasks that keep him from integrating into his later years his long experience of everyday life and of grace.

But as a rule, Jesuits not only adapt but find new depth as we age. We find spiritual consolation even in our last years. These are proving longer than most of us expected, an added time to find getting old challenging. As one asked, not without humor, "What do you do when you find yourself in a marathon you didn't sign up for?" We have been men who said the "Suscipe" anticipating to be put to work. We gave ourselves to God precisely by giving ourselves all our lives long to often arduous work for others. From this active life, we come to a time when we may well be able to give more time to prayer, reflection, and spiritual reading. To prayer in our aging, we bring a rich variety of experiences.

Aging Jesuits are generally aware that, as we can be less active the way we were when younger, we need to experience a greater givenness to contemplative action. We can experience this even in debilitating illness: Fr. General Nicolás said to a man – paralyzed but clear-minded – who regretted that he could not pray: "Your body prays all day long." For many, though not for all, this change to a more contemplative life comes to prove satisfying.

Living the Spiritual Exercises

A Jesuit will manage this shift better if he has let the *Spiritual Exercises* keep informing his appreciation of his life and vocation as he ages. We must again and again rediscover that we are loved as we are, even though we have to live ongoing conversions, as flawed as any man and as prone to habits of sin. A man who seems clinically depressed may actually rather be spiritually desolate, giving himself to serious sin or to blatant spiritual or religious negligence. None of us lives a celibate life for long without having to choose again and again to follow Christ and make our own his affections and desires.

We are, however, notably pragmatic men. We are eager to put our imitation of Christ into action. With the onset of age, we confront the unappetizing need – the unaccustomed need – simply to *wait*. Americans are not good at waiting, and we are Americans. In old age, our experience seems to be inflicted on us and we must accept much more than in earlier years. If we are open to it, we are graced with a deeper understanding Jesus Christ in His Passion. Humanly, He failed, and older Jesuits are readier to empathize with Him in the human failure he accepted. Looking back over our years, enough of us are tempted to feel that they have been empty. We watch this feeling lead some men to living a closed-in life of practical despair. But generally, Jesuits come to appreciate that God has been with us all along, His passionate, infinite love present at every stage of our life

here, and waiting for us beyond it.

The ages of Jesuit life in the Constitutions

The *Constitutions* also give a lens to focus the Jesuit's aging and spirituality. In this perspective (as suggested by Fr. Pat Lee, Oregon Provincial (2008-2014)), the succeeding sections of the Constitutions mark out a path from early fervor, to education and training for mission, to deciding the best way to proceed in work in the Kingdom. Then, in Part VIII, the process of Jesuit development comes to its fruition with the older Jesuit who now can give to God totally through prayer. The mission to pray for the Society and the Church is not a euphemism for being put out to pasture, but a valuable mission entrusted to a man who is now beyond inordinate affections and excess self-love, self-will, and self-interest and can truly communicate with God in prayer, lifting up the needs of our Society, the Church, and the world.

Does Pat's vision match the reality of what we experience in our encounters with aging Jesuits or in our own lives as we age in the Society?

The aging Jesuit and humane gerontology

One of the truisms from gerontology is that the older people get the less alike they are. There is tremendous variability from one older Jesuit to another. And thinking about this man as a person, it is useful not to have stereotypical views of what older Jesuits are supposed to be like, but view aging for each individual holistically. This means considering men from a variety of perspectives: biological, psychological, social, spiritual, community life, and apostolic life. The goal of health for Jesuits is not physical and psychological perfection but integration to be the most effective apostle possible. Each of the perspectives is interwoven. When we think about the spiritual life of the older Jesuit, there remains the goal of availability for the apostolate that is possible, with each of the different parts of the man that make him who he is at that moment coming to bear.

- Thus, although aging should not be equated with illness, illness is a common part of aging and that affects a man's spirituality, sometimes shaking him with deep questions of personal meaning.
- Likewise, psychological aspects of a personality, deeply rooted through the years, will be part of how a man approaches prayer, his relationship with God, his interactions with others, and his ability to cope with the challenges of aging.
- The social history of a Jesuit includes what he has done during his life, his friendships, successes, failures, and ability or lack of ability to adapt to change that inevitably occurs with aging. The man who is clinging on to work, feels that a particular apostolate absolutely depends on him, views himself as irreplaceable, and who cannot appreciate who he is separate from what he does or has done may well have a very challenging time spiritually when change is forced either by illness or the order of a superior.
- Community life is part of Jesuit life, and many men as they age have had a variety of experiences, some very good and some not so good. For some, aging may be a time of withdrawal and, without the stimulus of work and an active ministry, real isolation as there is a lack of experience in relating to other Jesuits in ways that are personal and based on deep friendships.
- Again, the spiritual life of an older Jesuit who has been engaged in community life, open to the variety of personalities, accustomed to sharing his life and presence with his Jesuit brothers will have a depth and richness that may be lacking in men who have never fully accepted Jesuit community as a place for the heart and spirit to reach out and flourish.

The aging Jesuit and illness

Spiritual and physical illnesses can reinforce each other at any time of life. But with decreased independence these interactions become more obvious and problematic. Illness, with decreased personal freedom, can constitute a real spiritual crisis for Jesuits as much as for any person. The Jesuit who faces these challenges with a history of regular prayer, spiritual direction, openness, and a real desire to find God in the midst of their problems will discover how God loves them in new ways. But the man who is rooted in his own desires, who is caught in his own self and

sinfulness, can find illness shattering. For men bring their habits, fears, joys, and ways of relating to others to their older years. Men who have been immersed in Jesuit spirituality and truly find the meaning and love of their lives in their relationship with Jesus may well know hard times, but will also likely be more resilient.

It is not infrequent that an older Jesuit is deeply problematic and creates chaos around himself, disturbing other Jesuits and presenting challenges for those who care for them, particular for staff in our health care facilities. Men like this require compassion, because not every problem of distressing behavior has a spiritual source. Men who have lived deeply spiritual and wonderful Jesuit lives can develop tough behaviors related to dementing illnesses and the like. Some may have to struggle with depression and can be tough to deal with.

But there are a few older Jesuits who are just plain mean, inappropriate, and difficult. Chances are they have been this way for most of their lives and with aging their disturbed personality has no outlet other than those around them and those who care for them. These are tough cases, and pious admonitions will not do too well. But the real love and care shown by brother Jesuits and health care providers can provide the opportunity for grace to be real, immediate, and received by men who may well have not had much affection or happiness in their lives.

Summarizing: Jesuit spirituality and aging

One of the dangers in considering aging is to simply reduce it to managing a collection of problems. That would be wrongheaded and ignore the reality that God's grace is as available to an old Jesuit as it is to a novice on the thirty day retreat. It is too easy to think that men are simply set in their ways and avoid encouraging and facilitating real spiritual growth. Probably even more important for superiors is helping men in middle age and older to think and pray seriously about what they want and what God seems to be offering them as they age. Just as men as they age are encouraged to consider their diet, exercise, and appropriate preventive health care practices, Jesuit superiors should think about encouraging men to develop a deeper and more intimate spiritual life and friendship with Jesus.

What sort of ways can a superior show care and assistance for the spiritual depth and life of Jesuits as they age? Likely, many superiors have a variety of experiences and ways of proceeding, so what follows is only meant to assist in considering the question, and is not any sort of definitive answer.

1. Make sure the yearly fraternal conversation includes discussion about prayer, attendance at Eucharist, spiritual direction, and a yearly retreat. Markers for concern would be the man who does not have a director, does his own retreat, is vague about prayer, and attends Eucharist only when convenient.

2. Spiritual life is not separate from the other perspectives mentioned above in considering a holistic view of aging. The physical, psychological, social, community, and apostolic elements of a Jesuit life are supposed to be all part of spiritual life, and likewise, it is hoped that a Jesuit's spiritual life will influence these other elements. Be ready to ask or encourage discussion about these different elements of a man's life and how they are finding, or not finding God.

3. Be ready to challenge men as they age who hold on to positions of influence or who are keen to view their presence as irreplaceable and essential. In this, also be aware that many Jesuits with age bring a perspective and wisdom that can be very beneficial in an apostolate and this is very different from a failure to appreciate that they are aging and that the contributions best made are not the same as when they were younger. Wisdom and grace look different than fear, rigidity, and controlling behavior.

4. Use community meetings as an opportunity to discuss aging, especially by allowing older men to tell their stories and be open to sharing their hopes and fears. Silence is a great way to make sure that isolation and the evil spirit can hurt us at any time in our lives. With aging, the enemy of human nature has a number of tricks to encourage us to feel alone, unappreciated,

and tempted to despair.

5. Make sure that community members visit men who are in the province health center, or if that is not geographically convenient, that regular communication is encouraged. It can be hard for an older man spiritually who finds himself in the health center and whose previous community, where he may have lived most of his lifetime, does not visit, call, or provide any evidence of care and concern.

6. Encourage men who are in their middle age and early older years to consider a thirty day retreat that will ask God to reveal how best to face aging and death.

7. Share with older Jesuits who need more care that giving up some degree of independence, that may be already threatened by illness and frailty, can be a much needed gift that will allow more freedom for Jesuit caregivers as well as those who work with us to provide care. Just as an elderly family member who stubbornly clings to a home or refuses help, and thus exhausts their children with added work and worry, so an older Jesuit can control a community or be a source of disruption that detracts from apostolic and community energy, activity, and life. (This idea suggested by Kate Morency, RN)

8. At superiors' gatherings, ask your peers for their best ideas on encouraging spiritual depth and growth with age.

5.2 Ignatian spirituality and the aging, sick and dying Jesuit

William A. Barry, S.J.
Nov. 12, 1993

It is a great pleasure to welcome all of you to the New England Province and to Campion Center. This is the first meeting of its kind, I believe, bringing together men and women from all our provinces who have a care and concern for elderly, sick and dying Jesuits. I hope that this weekend will be very profitable for all of you and for the continuing work of providing quality care for our elderly, sick and dying Jesuits.

I have been asked to focus my remarks this evening on Jesuit spirituality and the aging, sick and dying Jesuit and those who care for him. As I thought about the topic, I ran through a number of possible starting points. I recalled how Ignatius cared for his sick companions. Once, when Simon Rodrigues was sick, Ignatius walked miles to comfort him, a deed that Simon remembered later in life when he had so badly treated Ignatius the General. Or I could speak of how Ignatius, in spite of his insistence on strict poverty, wanted everything done for those who were sick in the house. Indeed, he made sure that the Roman house had a villa house outside Rome so that his men could get away from the pestilential air of Rome where they often got sick. But finally I came back to the heart of Ignatian spirituality, the **Spiritual Exercises** and to the very beginning of them, the "Principle and Foundation." There we ponder God's dream in creating the world and each one of us. Let me, therefore, begin my presentation here.

Why did God create a universe with people in it? It certainly was not because God was lonely and needed company. God, we believe, is the perfect community of Father, Word and Holy Spirit who needs nothing else to be fulfilled. Then why create a universe and us? It is as if the three Persons said to one another, "Our community life is so good; why don't we create a world where there will be other persons whom we can invite into our community life!" In other words, God desires our world and us into existence so that we might enjoy the Trinitarian life of God. We are made for God, and, as Augustine says, we shall be restless and frustrated until we attain union with God. In creating us God has implanted in us a deep desire for union with God, a desire that we often experience as a welling up of a desire for "we know not what," for the "All," for union with the Mystery we call God. When that desire wells up in us, we feel a deep joy and a wholeness that is hard to explain or describe. We are, as C. S. Lewis puts it, "Surprised by Joy," and this "Joy" is the desire for God.

Let me give you a concrete example of the welling up of such a desire. It comes from Frederick Buechner's autobiographical memoir **Sacred Journey**. After his father's tragic suicide

his mother took him and his brother to Bermuda. Near the end of his stay he was sitting on a wall watching ferries come and go with a girl who was also thirteen. Quite innocently, he says,

> our bare knees happened to touch for a moment, and in that moment I was filled with such a sweet panic and anguish for I had no idea what that I knew my life could never be complete until I found it... It was the upward reaching and fathomlessly hungering, heart breaking love for the beauty of the world at its most beautiful, and, beyond that, for that beauty east of the sun and west of the moon which is past the reach of all but our most desperate desiring and is finally the beauty of Beauty itself, of Being itself and what lies at the heart of Being.[1]

Buechner himself acknowledges that there are many ways of explaining this experience. However, he goes on to say that "looking back at those distant years I choose not to deny, either, the compelling sense of an unseen giver and a series of hidden gifts as not only another part of their reality, but the deepest part of all."[2]

When I have the experience of desiring "I know not what," I am experiencing God creating me **now** in all the particulars of my present existence. While I am caught in that experience, I do not worry about my past failures and sins or about what the future might hold. I feel at one with the universe and as whole as I could possibly be. Moreover the desire I experience is the deepest desire within me. That desire is in tune with God's one intention in creating the universe, and that desire can become the ruling passion of my life, if I let it. When we experience this desire, it is God's Holy Spirit drawing us into the community which is the Trinity. While we are in the power of this desire, everything else becomes relative before the absolute Mystery we desire. Moreover, insofar as this desire reigns in our hearts, we desire to live out our lives in harmony with this desire and want to do whatever will more readily bring us to the object of our desire. Hence, we want to live in harmony with God's creative purpose in creating us, to choose what will be more in tune with our desire for union with God. Ignatius spells out the implications of the foundational experience of God's creative touch in the Principle and Foundation.

Ignatius, too, experienced this "Joy," this desire for "he knew not what," and he reflected on this experience a long time. He distilled the results of his reflection and his study of theology in the "Principle and Foundation" which, in somewhat dry language, expresses why God made us. Here is the text:

> Human beings are created to praise, reverence, and serve God our Lord, and by means of doing this to save their souls.
>
> The other things on the face of the earth are created for the human beings, to help them in the pursuit of the end for which they are created.
>
> From this it follows that we ought to use these things to the extent that they help us toward our end, and free ourselves from them to the extent that they hinder us from it.
>
> To attain this it is necessary to make ourselves indifferent to all created things, in regard to everything which is left to our free will and is not forbidden. Consequently, on our own part we ought not to seek health rather than sickness, wealth rather than poverty, honor rather than dishonor, a long life rather than a short one, and so on in all other matters.
>
> Rather, we ought to desire and choose only that which is more conducive to the end for which we are created. (The Spiritual Exercises, n. 23)

---

1 Frederick Buechner, **The Sacred Journey**. San Francisco: Harper & Row, 1965, 52.
2 **Ibid**., 56.

Because God is God and because our only ultimate happiness lies in living in harmony with God's intention for the universe and for each one of us, Ignatius calls upon us to be "indifferent" to all created things. In his recent translation Ganss notes that the term is a key technical term in Ignatian spirituality. However, "(I)n no way does it mean unconcerned or unimportant. It implies interior freedom from disordered inclinations."[3] Because I am made for union with God and with all other creatures, I want to treat other creatures in accordance with God's intentions, and not abuse them for a purpose contrary to or different from what God intends.

I believe that you can now see where I am heading in this talk. If the deepest desire of my heart (and of anyone's heart) is union with God, then everything else pales to insignificance in comparison with God. Hence, it is a matter of "indifference" whether I am successful in my career or not, whether I am rich or poor, whether I am sick or healthy. Ignatius and those who have imbibed his spirituality expect to find God in all things, in every circumstance of life, in sickness or in health, in a long life or in a short one, and so forth. Ignatian spirituality draws a person toward the realization that the "pearl of great price," namely God, is worth more than anything else that he or she possesses; to buy that pearl one would, indeed, sell all that one has. Thus, we who follow this spirituality beg God to help us to the "indifference" Ignatius speaks of. We want to be "indifferent" to sickness or health, to a long life or a short one. But only a bit of self knowledge reveals to each of us how far from this ideal we are. The mere repetition of the words of the "Principle and Foundation" will not make us indifferent, will not make us accepting of our lot in life when sickness, old age and dying stare us in the face.

The attainment of the ideal of Ignatian indifference toward sickness or health is a life long process. Moreover, it is not attained by the force of will power alone; in fact, unaided attempts to attain indifference by will power alone will only bring us to despair or to a joylessness that is totally foreign to Ignatian spirituality. The only pathway to the attainment of Ignatian indifference is a life long commitment to prayer, to the relationship with God which will gradually rub away all our disordered inclinations through a growing love for God above all things. Ignatius himself did not easily attain to this indifference in the face of illness and death. Let me give you some examples from his **Autobiography** which indicate a growing change in his image of God and in his love for God.

After his initial conversion Ignatius went to the small town of Manresa where he spent almost a year in prayer and other spiritual exercises. Prior to going on the journey to Manresa he says of himself that he considered entering the Carthusians. However, his ardor to enter cooled, as he says, because "he feared that he would not be able to give vent to the hatred that he had conceived against himself."[4] This self hatred tells us much about his image of God at this time. If Ignatius hates himself so violently, we can speculate that he harbors an image of himself before an implacable God. Not long after his arrival in Manresa he begins to attack his body and his former attitudes toward ambition and vainglory by terrible fasts and penances, to the point that he did permanent damage to his health. Moreover, he began to have great swings of mood which led him into terrible bouts of scruples. The agony of his struggle with these scruples can be seen in this paragraph from the Autobiography.

> Once, being very disturbed because of them, he set himself to pray and with great fervor he cried aloud to God, saying, "Help me, Lord, for I find no remedy among men, nor in any creature. No task would be too irksome for me if I thought I could get help. Lord, show me where I may get it, and even if I have to follow after a little puppy to get the remedy I need, I will do it."

---

3 George E. Ganss, *The Spiritual Exercises of Saint Ignatius: A Translation and Commentary*. St. Louis, MO: The Institute of Jesuit Sources, 1992, 151.

4 **A Pilgrim's Journey: The Autobiography of Ignatius of Loyola**. Introduction, Translation and Commentary by Joseph N. Tylenda. Wilmington, DE: Michael Glazier, 1985, n. 12.

> Taken up with these thoughts he was many times vehemently tempted to throw himself into a deep hole in his room which was near the place where he used to pray.[5]

The self hatred has taken a very violent turn, indeed, to the point where he was tempted to suicide. What kind of image of God lies behind such scruples? It has to be a God who is relentless in his pursuit of every last detail of the sinner's faults, indeed, a God who will never be satisfied with any examination of conscience the sinner has so far done. God must be a terrible judge ready to pounce on every sin or sinful tendency. Unless this image of God changes, suicide is the only out. As you care for us Jesuits, be aware that some, hopefully very few, still live as though this were the real image of God.

Fortunately, Ignatius kept on praying to God for deliverance. After a couple of days free from scruples, they returned. Ignatius says:

> But on the third day, which was a Tuesday, the remembrance of his sins returned to him while he was at prayer, and as one thing leads to another, he thought of sin after sin from his past life and felt obliged to confess them again. After these thoughts, there came upon him a loathing for the life he was then living and he had a strong temptation to give it up. In this manner the Lord chose to awaken him as from a dream.[6]

Ignatius, we can speculate, has realized that the image of God with which he has operated thus far in Manresa was a product of the demon and not an image of the true God. He goes on to say:

> Now that he had some experience with the different spirits through the lessons that God had given him he began to think about the way that that spirit had come to him. Thus, he decided, and with great clarity of mind, never to confess his past sins again and from that day forward he was free of his scruples, and he held it for certain that our Lord had desired to set him free because of His mercy.[7]

God is not implacable, but merciful, and Ignatius can count on this God. Thus he need not continually grub around in his mind for possible unconfessed sins.

What I want to emphasize is that this change in Ignatius' image of God did not come about through theological argument or through preaching, but through experience and reflection on experience. Ignatius experienced different moods and thoughts; he reflected on these differences; finally he came to the point where he realized that some thoughts and emotions came from God and some did not come from God. The encounter with God in prayer and in life changed his image of God. Gradually the experience of God transformed his image of God and his image of himself in relation with God. Such a transformation is, Ignatius believed, open to anyone who gives God a chance, to anyone who pays attention to his or her experience, reflects on it and discerns what is of God from what is not of God in his or her experience. Ignatius believed that at every moment of our lives we are in the presence of God, we are encountering God, and that, if we pay attention to our experience with the expectation of knowing God, we can gradually be weaned from our false images of God, from our inordinate attachments that keep us from recognizing the "pearl of great price," and from our fears of sickness, old age and death. If we are faithful to such attention to our experience, Ignatius believed, we would quite literally find God in all things, in good times and in bad, in sickness and in health, in success and in failure. Through his own faithfulness to the practice of such discernment of spirits Ignatius was brought to such a state of indifference that he could, he says, come to peace in fifteen minutes if the Society of Jesus were to be dissolved. In

5 **Ibid**., 23 24.
6 **Ibid**., 25.
7 **Ibid**., 25.

addition, people who describe him in his later years as General of the Society speak of his sense of humor and his ease with others, a far cry from the man tortured by scruples in Manresa.

In his *Autobiography* Ignatius describes three instances when he was threatened with death. The differences in his reactions to the thought of imminent death tell us a great deal about how a lifetime of paying attention to God changed his image of God and his attitude toward death. The first occurred at Manresa when a fever brought him to death's door. He was convinced that he was about to die. He says:

> At that instant the thought came into his mind that he was numbered among the righteous, but this brought him so much distress that he tried everything to dismiss it and to dwell on his sins. He had more difficulty with that thought than with the fever, but no matter how he toiled to overcome it, he was unable do so. When the fever lessened and he was no longer in danger of death, he loudly cried out to certain ladies who had come to visit him that the next time they saw him at death's door they were, for the love of God, to shout aloud that he was a sinner and that he should be ever mindful of the sins he had committed against God.[8]

Some of the Jesuits who are in your charge may still be in this stage of fear of God. Pastoral care of them would include help to experience God as merciful and kind to all.

Contrast this last experience, where Ignatius is still caught up in terror of God, with the next one he describes. He was on ship from Spain to Italy, and in a storm everyone on board was convinced that death was inevitable.

> Thus, making use of his time, he made a careful examination of conscience and prepared himself for death, but he felt no fear because of his sins nor was he afraid of being condemned, but he was especially disturbed and sorry, knowing that he had not put to good use all the gifts and graces that God our Lord had granted him.[9]

Notice that Ignatius knows that he is a sinner and that this knowledge saddens him. But it does not frighten him as it did before. Because of his further experiences of God he now trusts in the mercy of God. He seems now to believe that he is a sinner loved and forgiven by an all merciful God. This experience reminds us of the description of the Jesuit from GC 32: "What is it to be Jesuit? It is to know that one is a sinner, yet called to be a companion of Jesus as Ignatius was." It is to be hoped that most of the sick and elderly Jesuits we care for have reached this level of intimate knowledge of God.

Finally Ignatius describes a time in the year 1550, just six years before his actual death, when he and everyone else were convinced that he was about to die of a fever.

> Thinking of death at the time, he experienced such joy and so much spiritual consolation in the thought of having to die that he burst into tears. This came to be of such frequent occurrence that many times he stopped thinking of death just so as not to have so much consolation.[10]

Now Ignatius seems to be so in love with God that the thought of death and complete union with God overjoyed him. Thoughts of his sins do not seem to arise. The self God image seems to be that of beloved to lover. God has taught Ignatius the ultimate lesson of who God really is for Ignatius, and for all of us, Lover **par excellence**. Fidelity to the relationship with God has changed Ignatius' image of God as well as his image of himself.

Ignatius urges the one who directs the Spiritual Exercises to "allow the Creator to deal

8 **Ibid**., 32.
9 **Ibid**., 33.
10 **Ibid**., 33.

immediately with the creature and the creature with its Creator and Lord" (n. 15). In that encounter with God each of us can be freed of those attachments that make us inordinately afraid of sickness, old age and death. In our care for our elderly and sick brothers in Christ we can continue this Ignatian direction with the sure hope that God can be found in all things, even in sickness and diminishment. Death itself is, we believe, only the door that reveals fully what God desires for all of us, namely union with God and with one another forever.

So as we ponder the central principles of Ignatian spirituality with regard to the care of sick, elderly and dying Jesuits, we can well remember that Ignatius would have us take good care of our elderly and sick brothers; but even more we need to remember that even these days of diminishment and sickness and dying are times for encountering the living God, are, indeed, times for helping our brothers to say again in a new and deeper way the prayer of Ignatius:

> "Take, Lord, and receive all my liberty, my memory, my understanding, and all my will, all that I have and possess. You, Lord, have given all that to me. I now give it back to you, O Lord. All of it is yours. Dispose of it according to your will. Give me love of yourself along with your grace, for that is enough for me." (n. 234)

VI. General Directives for Health Care in a Jesuit Retirement Facility or Nursing Care Center

While it is important to retain the unique quality, traditions, and Province identity that exist in each Province's retirement or nursing care centers, certain standards should be consistently upheld throughout the Assistancy. This section outlines those best practices and expected policies that should be implemented, if necessary, and upheld if already in place. Those centers that are state-licensed may have additional requirements.

Each health care center or Province should have a written plan for ongoing QA (Quality Assurance) and QI (Quality Improvement). Ideally there should be regular reviews conducted by an outside party or team; inter-Province cooperation may be employed in this regard.

Further, it is recommended that a plan be established to see that these areas are addressed in a timely fashion. Finally, there should be a Province strategy for the regular improvement of these areas. This may be best achieved by the formation of a quality assurance committee that meets regularly to discuss quality measures. These measures may include review of falls and other incidents, medication errors, in-house wound development, etc. In the Appendix can be found a sample tool that may be of use for tracking and trending quality measures in a health care facility.

I. Mission statement

A mission statement should be drafted for each facility. It should be specific to the level of care provided (independent, assisted living, and/or infirmary or skilled level of care) and placed within the context of Ignatian spirituality and a Jesuit vision of mission.

II. Retirement/Nursing care centers policy

A. Transition process

1. There should be anticipatory discussions with the Jesuit before the move, with his immediate superior and the Assistant for Health Care to the Provincial, about the demonstrated change in his health care needs that require a move to a facility that can better meet his needs. During the discussions every effort should be made to help the Jesuit understand the decision and feel that he is a partner in the decision.

2. The determination of the center/facility that the Jesuit will move to will be determined by the medical, functional, and/or cognitive needs of the Jesuit (a tool should be developed by each unique venue to make this assessment uniform and as objective as possible). Each care facility should have written criteria on the levels of care provided and available services.

3. If at all possible, the Jesuit should receive a visit from the care facility to which he will be moving. During this visit a medical, functional, and cognitive assessment should be done (a tool should be developed by each unique venue to make this assessment uniform and objective as possible).This time can also be used to address any concerns the Jesuit might have and also allow for discussion on the space limitations of the facility (if there are any) as well as the daily routines of the center/facility.

4. The superior of the Jesuit's current community should inform the man's family and, when appropriate, his friends about the changes in the Jesuit's condition that necessitate the need for a move to a higher level of care.

5. Medical records should be requested and sent to the receiving facility before the Jesuit moves to the new facility.

6. A medical history, a list of medications, and other pertinent medical information should be transmitted to the receiving facility. Each province should develop a tool to facilitate seamless transitions. (A sample copy of a new resident intake form is included in the Appendix in Section 7.6.) A copy of the Jesuit's Advance Directive should be sent to the receiving community so they can prepare for the man's admission.
7. When possible a celebratory party/dinner should be held for the Jesuit before leaving his

current community and the receiving community should provide a clear welcome.

8. On admission to the new facility, a complete nursing assessment is done and a plan of care is initiated. Regular assessments and follow-up are done according to the facility's protocols.

B. Assessment

In each care facility, a formal system to establish a thorough profile of each arriving Jesuit should be in place. In most cases a portion is done by the PA for health care or charge nurse of the facility while the other section is done by the superior of the community. It should include, but not be limited to, the following:

- Acuity levels/ROM
- Interests and Hobbies
- Family/Friends
- A discussion with the new resident of the assets of the place
- A two-month plan for incorporation into the new residence (special attention during this time)
- Staff introductions and interaction as to how the staff may be helpful
- A comprehensive functional assessment of a person's needs and exactly what he can and cannot do; activities of daily living
- Complete medical physical
- Activities the man did and did not do in the past
- Work history
- Fears, anxieties, hopes, wishes
- Spiritual needs
- Development of a nursing care plan
- Required activity care plan
- Spiritual care plan (sacrament of the sick, confession, breviary, etc.)
- Medical care plan from the physician
- Make sure documents exist on advance directives, living wills, etc.
- Plan for records transfer
- Mental status exam
- Physical assessment
- Immunization screening
- A problems list for all of the above
- A primary care physician and dentist should be obtained
- Often an initial screening by a psychiatrist is helpful
- Facilities that have a dietician should also have the new resident screened
- Each facility should establish its own plan for periodic re-evaluation of the person.
- The Provincial, the local superior, and the superiors of the Province should share a clear understanding as to a facility's areas of competence.
- A system should be established whereby an ongoing evaluation of each Jesuit is communicated to the Jesuit superior of the facility.
- A system should exist that informs a Jesuit's previous community of his state.
- The man's family should receive regular evaluation updates.

C. Safety

1. Environment

A disaster plan (for earthquakes, tornadoes, etc.) should be in effect. The plan should be tested at regular intervals.

Many facilities have created Safety Committees that meet at regular intervals to discuss issues regarding safety.

2. Environmental Integrity

The following areas should conform to safety for Jesuits and staff. An outsider should mandate an assessment of each care facility. If any area is found to be in need of repair, updating, or replacing, then a schedule should be developed to address the need(s) based on high-to-low priority.

- Electrical
- Tub, bathroom, shower
- Night lighting
- Carpet edges
- Floor coverings
- Step edges
- Call bells
- Side rails when needed
- Furniture should be adequate
- Cleanliness; a policy needs to be in place for hygiene standards
- Policy on regular evaluation for the environment
- Scheduled maintenance

- Good functioning equipment
- Variety in diet, especially for those following special diets
- House transportation should be accessible to residents
- Is the house accessible for those who reside there?
- Safe food handling standards, including temperature of foods, should be monitored regularly

3. Infection Control

Policy should exist based on Standard Universal Precautions. Good medical policy should be developed for the following:

- Contaminated waste disposal
- Laundry sanitation
- Health care standards for employees (TB testing, etc.)
- Needle/Stick Protocol for Staff
- MRSA/CDIFF (Nursing Home)
- A procedure for Quality Assessment and Risk Management
- A system for incident reporting and systematic reporting of errors
- A plan for total quality control should be established to address problems and how to solve them, i.e., falls, medical errors, employee injury, misdiagnosis, etc.
- A policy on the use of restraints (who and why) and a policy on review
- A policy on medical restraints (who and why) and review to assess the need for this over time
- Protocol for Patient Abuse (a policy on how to handle this and training to understand when it is happening)
- Policy that coincides with state law on protocol for reporting incidents

D. Staffing

Professional (licensed) and certified care (C.N.A., M.A., caregivers, etc.) must be administered in a caring, supportive environment that helps create a family, community atmosphere, while maintaining as much independence as possible. Generally, an RN needs to be on the staff or at a minimum an RN must be available and clinical responsibilities delegated according to the nurse practice acts of the states in which the facilities are located. Additional regulations may apply if the facility is licensed.

The following items should be made clear:

- Job descriptions
- A clear Personnel Policy Manual
- Levels of pay should conform to the area of the country in which the facility is located.
- Generally, an activity director is needed; again flexible based on the level, people, etc.
- Personnel files should be maintained for each employee, which includes annual reviews, disciplinary concerns, and, when appropriate, copies of verified licensure.
- Background checks where appropriate/required

Site specific, general principles for staffing minimums should be established for all levels of care.

Retired:

Assisted:

Full Nursing:

E. Jesuits and care givers:

A clear understanding should exist between the Jesuit superior and the facility's health coordinator and/or clinical director. Maintaining a good working relationship will beneficially impact the Jesuits and the community as a whole.

The superior should not make decisions independently of the health care coordinator or clinical director; rather, he should enter into regular conversations with the health care coordinator and/or clinical director about the men and the facility. The superior should make every effort to ensure that the above mentioned guidelines are incorporated. Regular face-to-face meetings are beneficial.

A new superior should begin his work by respecting the continuity that exists in a place and the good program the coordinator has established. The coordinator needs to have the flexibility required to work with a variety of

superiors. The ideal situation is one in which a team approach is taken.

Each facility should have a written chain of command and policies in place regarding supervision of staff, as well as general guidelines for communicating with the men about their care needs. Specific areas to keep in mind include responsibility for hiring and firing of staff; informing men of a need to stop driving; transitioning to a different level of care; non-compliance; refusal of care; and accepting needed assistance with hygiene, etc.

F. Medications

Each facility should have written policies and procedures regarding:

- Medication orders
- Administration control
- Error reporting
- Refusal of medications

VII. Appendix

7.1 "Challenges to Healthy Jesuit Living" from Community As Mission: Jesuit Life Now and Into the Future (US Jesuit Conference, 2012)

Challenges to Healthy Jesuit Living

Recommendation Matrix

One of *GC35*'s most striking statements is found in Decree 3, #41: "Thus, Jesuit community is not just for mission: it is itself mission." Community as mission implies a transformation of Jesuit culture with a new grace, and members of the Society being transformed by this grace as well.

The key framework of such a transformation is Mutual Relationship, and understanding of our lives in common as built on mutuality and best expressed in "covenant" terms: the Society (in its unity, as the province, represented by the provincial), a local community, and its individual Jesuits have a commitment to one another to support and develop the mission of Jesuit community. Covenant, rather than "policies," "programs," or "tools," stresses mutual responsibility and accountability to others: The Society, a community and an individual Jesuit all have specific contributions or investments to make, and all are answerable to one another for the fulfillment of community as mission.

This covenanted interplay touches our deepest desires for wholeness and holiness, evoking possibilities of hope, healing and love in the experience of Jesuit life. The Task Force was convinced that the desire for such a change or transformation in community culture already exists among brother Jesuits, and needs only to be awakened and structurally encouraged.

How do we make this happen? The matrix which follows looks at the roles of leadership (at both the province and local level) and individual members in making such a transformation take place. The matrix presumes a less institutional, more covenantal way of looking at Jesuit community, especially in dealing with some of its particular challenges. The matrix seeks to incorporate the reality of difficulties into the deeper expression of community life. Rather than exclude and isolate "difficult people," this is an opportunity to incorporate healthier models of Jesuit life across all dimensions and develop ways of supporting and engaging those with difficulties as members of the community's mission.

Challenges to Healthy Jesuit Living - Recommendation Matrix

Issue/Value	Leadership Best Practices	Individual Best Practices
Health Care	• Provide community resources to sup- port healthy diet and exercise (e.g., gym in community or access to gym; personal trainers, as appropriate) • Use health care coordinators well (e.g., consulting on medications) • Be clear about role of prefect of health in local communities. • Medical record of medications and conditions on back of the door to an individual's room for ready access in emergency situations Nutrition consultation for kitchens, pro- viding cooks who take proper responsibility for the nutritional needs of the community • Regular health updates (e.g., newsletter) • Attractive alternatives to alcohol-based social hour • Attention to strategic investment in health care across the spectrum from proactive to crisis • Who gives attention to the physical and emotional health of a provincial and his socius?	• Personal attention to diet and exercise • Regular medical attention: check-ups for PSA, blood pressure, cholesterol levels, etc. • Self-monitoring of cholesterol, salt and sugar intake, blood pressure, weight, factors within one's control. • Awareness of alcohol and food intake • Be compliant with medicine and see benefit of medicine • Individuals become more aware of and take responsibility for health costs and providers. • Individuals understand insurance coverage that is provided by the province
Toxic Behaviors: (narcissistic; grossly insensitive; self-protective; avoid responsibility; isolated; source of disharmony and fragmentation of community) The man who "doesn't need help".	• Acknowledge that we have people with these behaviors • Listen to and understand the concerns of the community • Identify and document problematic behavior • Develop incremental interventions, beginning with common norms of the gospel and religious life. • Confront and set boundaries (not adapting to the individual, giving him too much informal power) • Need a plan to deal with the individual that is supported at all levels of governance; consider group intervention at times (rather than one-on-one) • Provincial needs to take direct responsibility at appropriate moment • The individual must be made aware that continued disruptive behavior will have serious consequences. These consequences must be clear and made clear. • Communication between superiors and provincial in cases where an individual must be moved • Realize that some men cannot live life in community • Develop criteria and accountability for men living outside community	• The community is ready to take part in interventions for the man's sake and their own. • The man must gain awareness and under- standing of his personal anger and resentment. • He must be shown the documented ac- count of his destructive behavior. • He ultimately needs to be given a plan for which he is responsible. • He must acknowledge the consequences if he does not change his behavior ("Toxic" members may not become an- gels, but may become more responsible if confronted with the truth in love.)

Issue/Value	Leadership Best Practices	Individual Best Practices
Difficult Transitions	• Identify, acknowledge and help normalize stressful transitions • Encourage men in transition to share experience with one another and with superiors • Provide workshops for cohort group transitions (e.g. newly ordained) • Life-coaching in 50's; promoting re-training; how to live with leisure. • Facilitate transitions to new province structures, encouraging: "Open Houses" across "borders"; visiting and getting acquainted with other regions and personnel; erasing caricatures and old images; one Society • Handle transitions to health care facilities with "intentionality" and care. • Engage in early identification and dialogue. • Superiors encourage move to health care when appropriate and not just wait until a crisis. (cf. Wisconsin Province policy) • Health care facilities provide intellectual stimulus; good books; connection to current events and people; "Elder Hostel" type experiences. • Develop contact with the outside world in health care facilities: readers for the sightless; companions outdoors for the immobile – balancing need with reasonable "boundary" measures. • Do "dying" better; (e.g., talk; missioning letter; vigil with dying; men intentionally reflect on reality of death; booklet/journal on one's Jesuit life)	• Potentially stressful transitions - Post-ordination - Loss of parents/siblings - Change in assignment - Loss of Jesuit friends (death/departures) - Job loss and failure & loss of satisfaction - Mid-life issues - Diminishment • Older Jesuits in places have begun to form groups to reflect on the end of life and/or the end of life as they have known it. A spirituality for aging. • One doesn't let his mind or interests dry up with aging. • In health care facility TV does not replace books, while one still has sight. Options for the sightless. • The man in transition does not lose initiative.
Spiritual	• Consistent use of the spiritual resources of the Society of Jesus - Spiritual direction - Annual retreat - Continuing formation - Prayer/liturgy - Manifestation of conscience in which provincials and superiors build a trusting relationship that is not one-sided or "institutional", and allows for the one accepting the manifestation to share his own inner life and experience as a brother; a form of transformative experience that leadership can provide to elicit trust. • Promote education and development of competent spiritual directors • Promote open conversation to bridge and respect divergent ecclesiologies or politics that can perpetuate splits. • Adaptive use of spiritual resources in times of crisis (e.g., hospitalization, collective "crisis") • Foster creative, culturally responsive spiritual expression communally and individually. • Attention to people who feel marginalized by the Church • Recognize that the men themselves have desires for change; ride their energy; sharing of dreams.	• Consistent use of the spiritual re- sources of the Society of Jesus - Spiritual direction - Annual retreat - Continuing formation - Prayer/liturgy - Open manifestation of con- science • A spirit open to cultural change in its many aspects; a spirituality of "desires" • Able to deal with feelings of shame and humiliation, collectively and personally, and move on. • Identification with "sinners" vs. dissociation from them. • Proactive hospitality toward other Jesuits, and toward colleagues and friends, men and women; expanding the notion of Jesuit community.

Issue/Value	Leadership Best Practices	Individual Best Practices
Crisis Management	• National referral directory of therapists, treatment programs, etc. • Mandate integrated approach especially in regard to faith • Seen as part of a proactive incremental process – programs, etc., are steps after other alternatives have been explored • Leadership develops crisis management teams to support superiors • Companionship for man in crisis	• Community awareness of the "signs" of physical and psychological crises (e.g., suicidal tendencies, conduct in ministry) -- and call attention, ask for help. • Community discretion and confidentiality; respects privacy.
Environmental	• Build structures that promote social interaction • Public spaces that promote appropriate family and colleague hospitality/interaction. • Private spaces for community interactions. • Demonstrated commitment to environmental sustainability (clean air; recycling; energy conservation) • Separation of living and working situations • Create incentives for sustainability (e.g. paying public transportation costs)	• Attentiveness to one's own living space • Personal responsibility for environmental sustainability • Investment in design and care of communal space. • Concern for creation on all levels; conservation • Uses public transportation; shares rides, etc.

7.2 Jesuits Aging 2006 – A Presentation by Myles Sheehan, S.J., M.D.

Over the next ten years or so, the Society of Jesus in the United States will decrease in size, and then, if current predictions are accurate, be constant at about 1000 members.

Diminishment is not something that is easy to view with excitement and consider an opportunity. But I do. I believe that the current time in our Church gives American Jesuits an opportunity similar to that of Ignatius and his first companions. It is a time of turmoil and change where we can labor along with Christ. That may seem like pious delusional thinking. And it would be delusional if I thought that we would recognize new opportunities without changes, choices, uprooting, and opposition. Realizing some of our future opportunities requires us to be much more creative about aging in the Society in the United States. Creativity about aging for American Jesuits has several components. The first is to re-consider what we mean by health in the Society of Jesus. With a better understanding of health in the context of our charisma and mission, then I believe we will have the chance to look with optimism and excitement at some of the challenges we face. Reconsidering what we mean by health as Jesuits requires thinking about health from more than a medical perspective. Health in the Society of Jesus is not an end in itself: our health is part of our ability to fulfill our mission. In my 21 years in the Society, I have been struck that we talk a lot about the problems associated with poor health and the infirmities that old age can bring. Part of this is a commendable desire to make sure that our men receive excellent care and are treated appropriately. Indeed, in the past two decades I have been gratified by improved standards of care, better staffing and facilities, and, in general, a much improved approach to some of the medical problems of aging. But being a healthy Jesuit is not defined by infirmity or illness, or even the absence of medical problems. Health has a variety of components. Those in health care may well be familiar with the model of George Engels that looks at health as having biological, psychological, and social components. It reminds physicians and other providers that the people for whom we care are not just diseases or bodies, but they are people whose health includes a variety of psychological and social factors.

When we think about health for Jesuits, then I believe we need to add some other dimensions to Engel's bio psychosocial model. Let me suggest six, acknowledging that none are mutually exclusive and there is a fair amount of overlap: Apostolic, biologic, psychological, social, community, and spiritual. In what follows, I am giving some rough outlines, not attempting definitions that are perfect. What is the apostolic dimension of Jesuit health?

The basic question is whether or not a man is ready for mission and has the necessary qualities and skills to work and be with people, sufficient prudence to deal with work related issues, and the freedom to be available for the missions that the Society proposes as part of a discernment process. What about the biological dimension of health?

I would emphasize the prevention of disease, care for existing conditions, and a habitual pattern of living that avoids fads and extremes but attempts to minimize risks to health and emphasizes reasonable exercise and a prudent diet. The psychological dimension of health for a Jesuit is clearly related to all the others?

It would certainly include the balance and psychological health to live the life of the vows without anguish, to reflect on experience and ponder the best course, and the maturity to avoid both an obsessive need to placate authority or an immature failure to deal with unresolved authority issues. Psychic health for a Jesuit includes responding to the challenges of community living, having the ability to maintain good relations while not being afraid of honest discussion and fair disagreement. The social dimension of health includes both the person's place in the larger society and the network of relationships in which a person lives and works?

Social health for a Jesuit would certainly include the ability to engage and work with others in an apostolate. But in our current society, it also includes the ability to function to interact with individuals where there is a loss of previous respect and regard for Jesuits and priests, and

where sometimes one can run into overt hostility. The community dimension of health for Jesuits is often critical and frequently overlooked.

The community aspect of health would include being able to live with others in a way that allows interaction, maintains reasonable hygiene in personal quarters, and engages with other community members at meals, recreation, worship, and meetings. A Jesuit who is disruptive in community, absent, or otherwise weird is not a healthy Jesuit. Spiritual health should be central to our understanding of what it means to be a healthy Jesuit.

The characteristics of spiritual health would include the ability to pray, a regular prayer life, regular conversation and direction about one's spiritual life, and the use of prayer as a strength and guide for behavior and interactions in the apostolate and in the community. In other words, a healthy spiritual life will be made manifest by its fruits in community and in apostolic work. Appropriately, superiors and others have been increasingly insistent that Jesuits see physicians and that attention be paid to their medical care. It is not my impression that superiors are as direct about requiring individuals to have a spiritual director and to take a yearly retreat. You might have a Jesuit with great blood pressure, fantastic lab results, and a colon as clean as a whistle on colonoscopy; but without a spiritual life you have an unhealthy Jesuit. Looking at health for a Jesuit from a perspective that is bigger than just medical diagnoses and idiosyncratic behaviors, suggests that health for Jesuits depends on the individual but it also depends on the health of communities, the nurturing and maintenance of a spiritual life, and committed superiors who know their men well and are willing to have sometimes difficult conversations. Perhaps a more sensitive indicator of health in the Society is not the list of diagnoses of the individual Jesuits, but the "mission ability" of the men. Part of the difficulties with mission may be a failure to look holistically at Jesuits as individuals who are meant to be on mission. A Jesuit is not really healthy unless he is engaged in a mission. How does a more expansive definition of health directed at mission allow us to face the challenges of the next few years? I believe it allows us to face an incontrovertible fact with flexibility and a recognition that God is presenting us with an opportunity. The fact is that as the Assistancy drops from a bit under four thousand currently to around 1000 men in ten to fifteen years, we cannot continue financially to maintain our current structure of health centers and infirmaries. There are too many beds for the future needs of Jesuits, although the next few years will be busy ones as we reach the crest of the aging wave of American Jesuits. Healthy aging for older Jesuits can include a variety of futures that will allow mission directed involvement. Mission directed life is not about sitting around until one is sent to the province infirmary. Non-Jesuit American men as they age move in a variety of ways to a variety of different futures. They move geographically, they have a set of other interests, some develop second or third careers, and, in what may be called retirement settings, they have new friendships and live in new communities. I worry that in comparison far too many Jesuits stay put at an apostolate for decades. Some of them truly are wisdom figures who continue to provide enormous service. But let us be honest. There are other men who have no idea where else to go and who do not have the support and encouragement, or even the challenge, to move to a new kind of future. At any given time, this may only be a handful of men. But over the years, this wasted potential becomes substantial. Our Jesuit rhetoric about not retiring is not helpful. It creates an incentive to hang on in a setting when there are other good opportunities beyond the confines of where one has spent most of one's adult life. Quite frankly, there are men who are too frightened to move out of their communities. Some hide behind a feeling that they are irreplaceable or that the Catholic and Jesuit character of an institution is somehow dependent on their ongoing presence. Thus they putter about in their community, generously trying to do the best they can but, perhaps, missing the much greater apostolic fruit that could be available in a new apostolate. Recognizing a new stage in life with different possibilities is part of what healthy aging is about. So what's the opportunity?

The opportunity is to develop a plan for aging in the Society that shows the same kind of awareness of God's Providence that Ignatius

showed in the Constitutions. It means less focus on institutions and more on individuals coming together on mission. And it is directed at maintaining and directing zeal for souls rather than allowing the enemy of human nature having us settle for hanging around a recreation room when there is so much need. Let me outline four suggestions before finishing on changing demographics and the meaning of health in the Society. First, the cornerstone of new opportunities for Jesuits is always their experience of prayer and the Spiritual Exercises interwoven with their experience of life. Although Tertianship is the definitive close to Jesuit formation, it should not be the end of Jesuit spiritual growth and change. I would suggest that the Assistancy create opportunities for men in their late middle age to spend serious time with God, and with each other, praying about where God is leading them as they grow in years. This would mean developing retreats as well as get-togethers similar to what is now done for men in formation.

At a recent meeting of our health care coordinators, this idea received much attention and support. No doubt there would be some resistance in the beginning. That will change if the programs are done well, with care, and with obvious respect for the needs and hopes of the men involved. It also is an immediate response to the feelings of neglect that some older men may be having in the midst of planning for the future. Some of the current Assistancy planning can leave older Jesuits thinking that their time is past. Many of the health care coordinators expressed concerns that older men felt left out. Change in institutional commitments, communities, and patterns of living may create a sense that the contributions of the past are not valued. Attending to the more holistic health needs of older men now, rather than simply waiting until they become sick or infirm, is a way to combine both *cura personalis* with attention to apostolic needs.

Second, Jesuits who are aging and want to move on in ministry should not find themselves "all dressed up and nowhere to go." We can create frustration by having nothing available apostolically as men look to their future. I would suggest that the Assistancy look to a set of ministries that are appropriate for older men and both meets real needs as well as provides good community life in a setting that is congenial to men who may face some physical challenges. We need to avoid isolated locales or sticking Jesuits alone as they age in rural parishes or other sites where there will only be a disaster if they become frail. We need to be much more creative about mission. Although Provinces have attempted to look at new career positions, this would be an ideal place to look beyond Provinces and across the Assistancy. Third, thinking about mission concretely means to dream about the kind of opportunities that might be available for older Jesuits. In considering the future of our current health facilities we must recognize their tremendous apostolic potential. It may be that the facilities, some of which have substantial surrounding land, could be converted into a mixed retirement community, a place that would allow older persons from a variety of backgrounds to come together. Using some of this resource to provide housing for people of low income is a way to combine our desire for justice with our recognition of the needs of older persons. Ministry for older Jesuits in such a setting could include work in direction, retreats, pastoral care, and other possibilities. Imagine developing a community for older persons that includes Jesuits, alumni from our institutions, and housing for low and middle income elderly in a setting that allows recreation, conversation, and friendships. Not only would the Jesuits have a number of pastoral opportunities, it could well be that there would be work that the other older persons could do that might benefit a school, or provide assistance to others in need, etc. Indeed, one can think of partnership with a Jesuit university and the creation of some type of courses, activities, and immersions that could allow the wisdom of older Jesuits, and older lay people, to come forth in new ways. We also need to realize the tremendous potential of a group of Jesuits who would live in an adult community not owned or operated by the Society. (I hesitate to use the word retirement community because of the baggage associated with the word in Jesuit circles.) The lay people in this setting might think of themselves as retired. Jesuits, however, would be involved in the lives of other people and thus would find themselves busy and active. There will be the need to create an appropriate community

structure for the Jesuits and think a bit about how to work issues of governance. But the potential outweighs the problems. The fastest growing segment of the American population are those 85 years of age and older. Those are a lot of souls that need care, and conversion, and the grace of Christ. And we have Jesuits who are their contemporaries and who could provide extraordinary apostolic service. I would suggest the signs of the times point in an obvious direction. Something less obvious to consider as well. If older Jesuits are working with grandparents, they may well find themselves serving as advisors and trusted mentors to the grandchildren! Again, Ignatius found himself overwhelmed by opportunities in a time filled with change and confusion. Are we holding on so tightly to past models that we are missing God's call? A fourth, and fairly obvious consideration, is that there are many other possible models for ministry as Jesuits get older. Frankly, the potential is only limited by our fear of doing something different and by the logistic needs to have organization and care given to developing these new apostolates. This speaks to a need for the possibility of someone at the Assistancy to help coordinate these ventures across provinces. This individual would be available to help provincials and superiors think about the apostolic uses of older men rather than simply deal with problem cases. He (or she) would look to organizing retreats and other gatherings for Jesuits in their late middle age and older. And she (or he) would have responsibility for considering how best to work with superiors in considering the apostolic potential of older men. In other words, this individual would be helping us consider the future and the resources of healthy Jesuits, men who want to be on a mission, rather than our current somewhat obsessive focus on the personal care of men who are sick or our sometimes seeming over solicitude for maintaining institutions. I have mentioned challenges of caring for our older men as we face a period of change. There are challenges in considering a more holistic understanding of health for Jesuits, and challenges in developing new opportunities for men in the Society in the United States as they age. The fundamental challenge is to take God's action across the lifespan seriously and, both as individual Jesuits and as friends in the Lord united in mission, to make sure that as we age we are led by the Spirit, deepening our relationship with Jesus and further progressing in our love of the Father. Ignatius' ideal of the man with Final Vows remains an ideal that we are blessed to see instantiated in many fine Jesuits. For the rest of us, however, time and other concerns can take us away from prayer, regular spiritual reading, and a habit of encouraging healthy relationships with superiors who really know us well. Human nature is such that for many Jesuits the period after Tertianship can be a time when they may not make progress personally and spiritually. This can be especially the case given that many people will live for four or five decades after Final Vows. And for some these four or five decades will be living in a manner that is privatized, isolated, and not fully engaged with the community. What a waste of the graces that we have received! Ignatius was almost obsessive in his detailed prescriptions for those in formation. Perhaps part of his reticence about the life of those after Final Vows was that in the sixteenth century there were not that many years left for most men after they finished formation. Men usually died in their forties, fifties, and sixties. Happily, that is not the case today. Don't you think Ignatius would have been excited by the opportunity for many more years of fruitful ministry for himself and his companions? Why should we be so dull as not to take advantage of this gift? We are being forced for a variety of reasons to think about our present and our future. There is so much that is exciting and filled with opportunity. The prospect of a healthier Society of Jesus, with health defined broadly and directed toward mission, is something that fills me with hope. The dark spirit makes me worry that people will not have the courage to change, that we are so stuck in nurturing institutions rather than individual Jesuits it may be too late, and all our rhetoric can tie us up in knots rather than set us free. But that's the dark Spirit. Not the Spirit of God. And I truly believe that the Spirit is speaking something very important for us to attend to at this time.

7.3 Sample of community health care information form

Community Medical Information Form

Community Medical Information Form

The following information is requested in case of an emergency. Please feel free to provide all or as much information as you think would be helpful in case you are not able to speak for yourself. Please return to my box as soon as possible.

Date completed:_____
Name:_____
Hospital of Choice:_____
Name of your Current Physician:_____
Name of the Office/Clinic:
_____
Do you have any pre-existing conditions an emergency room should be aware of?
Yes____ No ____
List medical diagnoses:
_____
_____
Allergies (e.g., medications, latex, or foods):
_____
_____
Are you taking any regular medications? Yes____ No ____
Please list your medications below, including dosage information:
_____
_____
_____
_____
_____
Person to be notified in case of emergency (include telephone #):
_____
Have you granted durable power of attorney? Yes____ No ____
If yes, where is that document located?
_____
Are you an organ donor? Yes____ No ____
If yes, where do you keep the document indicating this?
_____

7.4 Sample of Authorization for the Release of Medical Information Form

HIPAA Medical Records Authorization
Authorization for the Release of Medical Information

I, _____, date of birth _____, hereby authorize my physician and consultant physicians, health care professional, hospital, clinic, laboratory, pharmacy or health care insurer to release information concerning my health condition, either in writing, telephone or facsimile to:

Arnie Shafer, NHA
California Province Assistant for Health Care
PO Box 519
Los Gatos, California 95031-0519
Telephone: 408 884-1619
Facsimile: 408 884-1666

Lisa Bishop-Smith, RN
California Province Health Care Coordinator
P.O. Box 45041
Los Angeles, CA 90045-0041
Telephone: 310 338-5886

I request that my information be released for the purpose of assisting my religious Superior, the California Province Assistant for Health Care and the Health Care Coordinator in being informed on my current medical conditions and treatments and/or the California Province Treasurer or his designee having access to billing information regarding my treatments.

The type and amount of information to be used or disclosed is the patient's entire medical file including but not limited to: Billing Records, Medical History, Consulting Reports, Clinical Notes, Diagnosis, Prognosis, Evaluations, Clinical Testing/Laboratory Reports, Mental Health and Rehabilitation Records, Neuro-Psychological Testing and Management, Pharmacy, Allergies, Immunization records and Correspondence.

I understand that the information in health records may include information relating to behavioral or mental health testing and/or services and treatment for alcohol and/or drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to used or disclosed. I understand that my disclosure of information carries with the potential for unauthorized re –disclosure and the information may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing

A photocopy or facsimile shall be as valid as the original.

Authorization signature: _____ Date: _____

Witness signature: _____ Date: _____

7.5 Sample Quality Improvement Report

Jesuit Health Center Name (Quarterly or Monthly)
Quality Improvement Report
Date__/__/__

Data Source	Acceptable	Outside Acceptable Parameters	If outside acceptable parameters, note action(s) taken
1. Internal Tracking of Quality Measures including: Falls Weight Loss Pain Management Hypnotic Use Pressure Ulcers	X		• Falls with Major Injury: • Residents who have moderate to severe pain: • Prevalence of hypnotic use more than two times in last week: Residents with pressure ulcers:
2. Quality Dashboard	X		• Hand hygiene: • Mortality Nursing Facility: • Presence of Advanced Directives:
3. Resident Council Meeting Minutes	X		• No issues identified at this time.
4. Safety and Environmental	X		
5. Dietary Services	X		• Temperatures at the point of service are monitored monthly. They continue to be satisfactory. • Diet order audits are conducted on a quarterly basis to ensure the accuracy of diets being served. • Monitoring of 5% or more weight loss continues on 1st and 2nd floors.
6. Pharmacy Report			
7. Infection Control Reports			
8. MMDS			
9. Rehabilitation			
10. Reportable Accident Data		X	• There were (#) SNF resident incidents/accidents, which is a decrease from last quarter. • There were (#) ALF resident incidents/accidents, which is a decrease from last quarter. One of these incidents resulted in a DPH reportable. • Number of reportable incidents.

Data Source	Acceptable	Outside Acceptable Parameters	If outside acceptable parameters, note action(s) taken
11. Employee Incidents/ Accidents		X	• There were (#) employee incidents/accidents this quarter.
12. Policy and Procedure Changes	X		
13. Staff Development /Turnover	X		• The turnover rate (%) • Alzheimer's and Dementia training • Blood Borne Pathogens training • Fire Safety and Disaster training • MSDS training • Employee Handbook/Policies

CURRENT QUALITY IMPROVEMENT PROJECTS:
- 2nd floor main shower rooms
- Updating the Infection Prevention Policy and Procedure Manual
- Maintenance/Housekeeping checklist audit for vacant rooms
- 2013 Action Plan
- Organize and review the medical record filing system
- Audit of HIPAA Privacy and Security

COMPLETED QUALITY IMPROVEMENT PROJECTS:
- Implemented the MOLST/POLST for all Jesuits
- All Health Center employees completed the Alzheimer's Habilitation Training
- Empty Room Audit for Maintenance and Housekeeping
- 2013-2015 Strategic Plan
- Implementation of Consistent Assignments (3 months and Jesuits did not like it)
- Employee Satisfaction Survey

7.6 Sample of New Resident Intake Form for Health Care Facility

New Resident Intake Form

Demographic Information	
Last Name	
First Name	
Middle Initial	
What would he like to be addressed as?	
Birthdate	
SSN	
Medicare # (attach copy of card, if possible)	
Secondary Insurance (attach copy of card, if possible)	
Secondary Insurance ID#	
Primary Physician	*(Per Request of our Doctor)*
Primary Physician Phone Number	*(Per Request of our Doctor)*

Cognition	
Orientation (Person? Place? Time?)	
Are there any mental health concerns?	
Is there a history of Alzheimer's or dementia?	
Is there a history of anxiety?	
Is there a history of dementia? *(If yes, please attach any pertinent paperwork so that we have a baseline.)*	
Is there a history of drug or alcohol dependency?	

Current Medical Information	
Medication List – Please attach copy	I am attaching the most current medication list & the patient will be sent with a 2-3 week supply of medications *OR* I do not have a current medication list. I will inform the Jesuit to bring all of their medications to St. Camillus, in addition to a 2-3 week supply of medications
Medication Administered by: (please circle one)	Self-Administered Medications *OR* Staff Administers Medications *OR* RN sets up in Mediset and Patient administers to self
Medicinal Allergies	
Food Allergies	
Current Height & Weight	_____ Inches & _____lbs.
Driving	Able to safely drive & has a current driving license Or Does not currently drive
Medical History – Please attach copy	*Please send with paper copies of Jesuit's medical history for our doctor to review*
Surgical History – Please attach copy	*Please send with paper copies of Jesuit's medical history for our doctor to review*
Special Diet?	
Does he have an Advance Directive? If so, please attach copy	Yes & it will be sent with the Jesuit *OR* There is no Current AD on File
Is he a DNR? If so, please attach copy	Yes, he is a DNR and a copy will be sent with him *OR* No, he does not have a DNR order on file

Personal Care/Mobility Information	
Bathing & Frequency	Is able to bathe self *OR* Requires some assistance with bathing *OR* Requires total assistance with bathing
Oral Care	Independent *OR* Requires some assistance with oral care *OR* Requires total assistance with oral care
Shaving	Independent *OR* Requires some assistance with shaving *OR* Requires total assistance with shaving
Toe Nail Care	Independent *OR* Requires some assistance with nail care *OR* See's podiatrist on a regular basis
Dressing	Independent *OR* Requires some assistance with dressing *OR* Requires total assistance with dressing
Mobility/Transfers	Independent Or Stand by assist for transfers Assist of one with transfers Or Max assist of two with transfers Other:_____
Assistive Equipment Needed	Hospital bed Wheelchair Walker Reacher Shower chair Shower Bench Call Light (necklace to call for assistance) Single Point Cane Quad Cane Side Rails on Bed Commode Toilet Seat Riser No equipment needed Other: _____
Elimination Status	Continent of Bowel & Bladder *OR* Continent of Bowel, Incontinent of Bladder *OR* Incontinent of Bowel & Bladder Other:_____
Dentures	No Dentures *OR* Partial Dentures (upper or lower) *OR* Full Dentures
Hearing Status	No Hearing Impairment *OR* Hard of Hearing – will need a Hearing Aid Evaluation *OR* Currently has Hearing Aids (R or L)
Vision	No visual Impairments *OR* Wears Glasses *OR* Wears Contacts *AND/OR* History of Glaucoma? *AND/OR* History of Cataracts? And/Or Will need to establish care with Ophthalmologist upon arrival
Respiratory Equipment	Currently does not use any respiratory equipment *OR* Currently using oxygen (please attach orders and company used) *OR* Currently uses Nebulizer (please bring all equipment and contact information from the rental company) *OR* Currently uses a CPAP/BiPap (please bring all equipment and contact information from the rental company)

7.7 Sample of Health History Form for Jesuits

Society of Jesus Health History Form

Preferred Hosp. _____
Primary Doctor _____
Phone _____
Office _____

Last Physical _____
Last Dental Exam _____
Last Eye Exam _____
Record Updated _____
Blood Pressure _____ / _____
Blood Type _____
Height, inches _____
Weight, pounds _____

Medicare Qualified Programs — Effective Date
Medicare A _____ _____
Medicare B _____ _____
Medicare C _____ _____

State Medicaid _____
Prov. Medical Plan _____
Other Medical Plan _____

Current Presciption Meds

Current Non-Presciption Meds

Birth Date _____ Age _____

Emergency Contacts: Name / Phone / Relationship

1. _____

2. _____

Allergies and Reactions

Major Diagnoses

Immunizations	Date
❑ Childhood	
❑ Cholera	
❑ Flu	
❑ Hepatitus A (1) (2)	
❑ Hepatitus B (1) (2) (3)	
❑ Meningococcal	
❑ Pneumo Vac	
❑ Shingles	
❑ TB	
❑ Tdap	
❑ Tetanus-Diptheria Booster	
❑ Typhoid	
❑ Other	

Jesuits.org