Conference Care Newsletter

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"And went to him, and bound up his wounds . . . and took care of him" Luke 10:34
"But that the members should have the same care one for another" 1 Corinthians 12:25

Editorial

The Future of Elder Care

Sit up and dust off your visionary glasses. We are going to peer into the unknown a bit and, also, reflect on the past. Our objective is to obtain a clearer vision of where the path of elder care may be headed. Warning: Changes ahead!

What is "the state of the conference?" Collectively, the Church conference in North America is aging. This aging is in no respect negative, but it is driving the change of some dynamics. This aging truth means two things: (a) more elders in number and (b) the ratio of elders to general population is higher. Localities that were settled with young families years ago are waking up to the realization that they have elders needing care. Now what! Several localities are actively pursuing developing a care home in their areas. Other areas are wringing their hands and looking for viable options. We have heard of the "baby boomers." They are real. This generation will bring a significant bulge to the demand of elder care.

What is the responsibility of the Conference in terms of rallying and meeting the demand that is and will be increasingly bearing down on us? Is providing the necessary components of caring for our elders optional or a luxury? The answer is twofold: (a) the commandment by God to honor Father and Mother and (b) the mission side; helping our elders "keep the faith" to the end.

What is the state of our current homes? Visionaries decades ago led the way in giving birth to what we have today, our care homes. These homes were known as "nursing homes" and provided long-term care, For decades, they have served the supporting area and the conference at large. In time, independent apartments where added and in more recent years, assisted living has been added to some homes. Most of our homes are running at full capacity today. Our older homes are pulling back from serving the conference to serving their support congregations primarily. This shift is causing areas without homes to feel the need acutely to have a home. Almost no additional long-term care beds have been added within the conference for some time. What does more elders and the same amount of beds mean? It means that waiting lists in some of our homes are growing longer and longer. Some homes do not have the capacity today to care for their support congregations, much less the demand that is approaching.

Let's consider the trends of our homes. Independent living apartments are in high demand today. A number of homes are studying how to respond to this demand. All new localities entering into elder care are starting either at personal care or assisted living level. A facility-based home health (home care) is used by some homes. Hospice care (palliative care) is being used more. Today, the term "nursing home" is somewhat repulsive in the market place. Independent and assisted living are more appreciated terms. Years ago, we simply had nursing homes; today we have campuses which provide a continuum of care.

Are we on a collision course with reality? The looming baby boomer cloud is approaching, and our general aging and growing conference is setting the stage for some new dynamics. Coupling the numbers together with the changing trends and mind-set of the future market, we have a demand that will require preparation if we expect to meet it. While independent living is attractive to the market, it

is, also, attractive to our homes in bringing in vitality and revenue. However, it brings a responsibility to provide the subsequent care that will become necessary sooner or later. Are our homes keeping the long-term care in ratio to the amount of independent living on campus?

What is the emerging model? There are major roadblocks for new localities entering into long-term care through "nursing care." These roadblocks are regulatory and financial; coupled with public sentiment, the course is being redirected to independent/assisted living, or campus living. Other terms are "age in place, virtual communities, home services," etc. The industry is deducting that "nursing home" bed demand is decreasing. The mind-set of the baby boomers is more to "age in place." The ideal scenario would be to move into independent living and "age in place" and have care brought into the apartment. This approach provides serious questions to the traditional approach and it may not be possible to implement this widespread. However, this approach, howbeit in varied forms, is the appeal of the future market. While the modern terms of campus, independent, and assisted living sound attractive there is a financial component that will need to be reckoned with. Government assistance for assisted living, in some states, is in the beta stage, at best; others do not offer any assistance. This fact translates the financial burden back to private pay.

Where are the visionaries today who will step up to the plate and offer solutions to the emerging need? The hierarchy of our homes leaves potential holes as we prepare for the future. The need is most acutely recognized by those closest to the need, administrators and boards. The funding is secured by those, for the most part, who are the least connected, deacons and general membership. The call for collaboration rings out today if we are going to ramp up and prepare for what is coming down the pike. The administrators need to be in touch "real time" with the market demands. They must convey to their respective boards the "lay of the land." It is squarely within the wheelhouse of the board to be looking ahead five, ten, fifteen years, drafting the future course of their home, together with the administrator. The board then carries the need, vision, and solution to the supporting deacons. At this junction is where collaboration becomes a key component. Unless the deacons buy into the vision, the vision will remain a vision and fail to develop into reality. The deacons hold the responsibility of securing funding, so it is imperative they are enthused with the project. The need and vision of our homes must then be conveyed to the people. The truth is that the money comes from the membership. There must be a shared vision between administrator, board, deacons, and membership.

The success of a project is directly related to the level of collaboration between the three groups. Who carries the vision? Yes, there are front runners, but the burden lies upon each one of us. Are we concerned for the welfare of our elders? Do I buy into the "mission of elder care?" If we choose to wait till the need becomes more evident, we will be woefully behind. And most distressing, there will be elders without a home to care for them.

Steve R. Koehn, Conference Care Committee

Care for the Caregiver

Patrick Hanes—Care Committee

I want to introduce a term and a concept, "vicarious trauma;" and try to not sound intellectual or turn the discussion toward an abstract diagnosis or self-diagnosis. Actually, I don`t think I had heard the term or understood the concept a year ago. It simply explains a certain idea that has come to be accepted as the reason that we sometimes struggle with our own emotional well-being while functioning as caregivers. It is good to learn that we are not alone and that there is hope.

It is not uncommon to find hospital workers, therapists, and parents who suffer emotionally and physically from continual exposure to trauma. We commonly call this "compassion fatigue" or "burnout." *Vicarious* means experiencing in the imagination the feelings of another. Here is how this relates to us. If we are a caregiver of someone who has experienced trauma, is disabled; has experienced suffering, pain, or abuse, accident, loss, or failure, we will have empathy with them to a greater or lesser degree. It is when it is in a greater degree that it can cause us problems. We, the caregivers, may be traumatized, also. Trauma may be said to be communicable or contagious. We absorb trauma.

A very effective method used in torture is to have the victim observe the suffering and torture of another. This is very traumatic in and of itself. It may be helpful to recognize the effect other people`s pain has on us.

The imagination and empathy are powerful. An illustration has been posited that suggests we think of a lemon. Notice that vibrant yellow color. Look closely at those little pores all over the surface. Squeeze it softly and smell that citrus smell. Slice it in half. Do you see the seeds and the dripping juice? Cut a small slice off, and take a bite. I would be surprised if you do not feel the sides of your tongue, in the very back, wanting to respond to that sourness; all by only thinking about it.

The only way to reduce the risk of vicarious trauma is to reduce the exposure. Different individuals will have differing levels of tolerance. We want to be sensitive to the suffering of others, but we must maintain our own health

and mental fitness. The world has its terms (e.g. "vicarious trauma"), and the world has its cures. There may be signs and symptoms that we are suffering. What can we do?

As caregivers, we need empathy and acceptance. We need understanding, and we need support. We need to share our burdens and our struggles. A support group may be beneficial.

We need an opportunity for respite; a time and a place of escape. We need to recognize our need for that escape and feel no guilt. Someone can accept the burden for us for a time. We must be able to turn to them in confidence.

We must learn our limits and be able to set boundaries and manage a healthy level of self-care. This would include diet, sleep, exercise, recreation, and social activity. These are all things that we know are essential to emotional health. When we fail in this, we need not be ashamed to admit it, "I am having trouble coping. Please help me."

Our point of reference can be disturbed to such a degree that it changes our view of other people and their motives. "Do my brethren care?" "Does anyone care?" Yes, we can be certain that our brethren care. Sometimes there is not a full understanding of our plight, but our brethren do care. Their support can help to hold us.

Our spirituality and sense of security may become weakened, but stability and security will be found in the same place we have always found it—at the foot of the cross. The uncertainties of life have brought us to a point that there is nothing we can do. We need to reach up to God—we are dependent upon his healing grace for our lives. We can do everything right in all of the practical and professional ways and yet not be healed. We want to be able to use the help that is available to us in a practical sense, but we will need Jesus. I am impressed with the thought that "underneath are the everlasting arms." When faced with our own emotional ills and discouragements, we must be willing to fall into those everlasting arms and let Him keep us. "Howbeit this kind goeth not out but by prayer and fasting" (Matt. 17:21).

A Review

Tim Penner—Care Committee

I have some memories from my school years. One is that we would need to do a review periodically. Something tells me I didn't like them. I'm not sure why not, but I'm imagining it seemed to be a waste of time. Let's do the test and get on with it. I probably didn't catch on that reviewing was to my advantage. I have fond hopes that I have caught on to this by now.

What follows is a review which will, hopefully, help prepare us for the tests ahead. Generally speaking, we know that tests will continue, and maybe increase, in our church community.

We can go back about a year and read the editorial "Glasnost and Perestroika" in the *Care Newsletter.* The Care Committee continues to promote openness. Even further back, there was an article that encouraged diagnosis by professionals. Conference Care continues encouraging early diagnosis by professionals—not self-diagnosis.

There is continued focus on cases where mental, emotional, and special needs circumstances are evident in children and teenagers. There are a variety of challenges in adults, as well.

The staffs in congregations counsel people who have spiritual and financial difficulties. When people are guarded and reluctantly say it like it is, the "what else" system starts playing a role in the counseling session. If a person with a difficulty of any type wants help, it works best if he or she comes clean. In financial counseling, it has been said that asking for help has more value than specific advice offered.

Considering the counselor side of the issue, and understanding that in spite of wanting to help solve a problem, the counselor needs to be careful not to make sweeping statements and conclusions.

Recently, a couple was asked if their child had ever been diagnosed. They indicated they had been advised to not seek professional help. They listened to that counsel. Today, they indicate that they feel they know what the child's problem may be, but since he has become an adult, jurisdiction is no longer in their hands and the child, together with the parents, continues on in turmoil. There is a chance that a lot of grief could have been avoided had early diagnosis been sought and treatment implemented.

The more complicated a problem becomes, the more expertise is needed in diagnosing and correcting the problem. Any vehicle operator can diagnose a flat tire and fix it or find someone else to fix it. Problems in the drive train become more intricate. Knocks and misses in the motor are best diagnosed with electronics operated by professionals. People who have been trained in vehicle mechanics are professionals. And different ones specialize in different areas.

When dealing with an individual who comes from hard places, when dealing with his heart, his brain, his emotional well-being, his mental state, his past experiences, and his hopelessness when there is damage, an area is being touched that is far more intricate than the drive train or the motor of a vehicle. The unprofessional person comes to sweeping conclusions like an unprofessional mechanic who recommends a new alternator when a broken tail light is shorting out the battery.

Not every emotional case is spiritual and not every case is medical or psychological. Truly, we need help in these areas. That is why pastors are sensitive and pray for wisdom to see the difference. We thank God for open-minded, humble people who labor professionally.

Professionalism

Tim Penner

Professionalism is expected of a professional. A professional is not an amateur. Some synonyms are *accomplished, skilled, proficient, experienced, trained,* and *businesslike.*

When people have problems with hearing or vision or have dental or medical needs, they use the services of qualified individuals to perform examinations. They generally feel comfortable with the assessments of their conditions, and follow the courses prescribed. This same principle is vital in the mental health, special needs and learning disabilities fields. Qualified assessments are needed. Treatment plans are needed as well; anything of lesser quality and competency will likely yield a less than desirable result. (Quote from a writing previously published in *Care Newsletter.*)

In our so-called advanced society, we depend on professionals to help us with our problems. A lot of alternative options to professional help are available. I am reminded of a claim that drinking tomato juice mixed with goose fat prevented or cured cancer. The Church of God in Christ Mennonite does express itself on unproven health theories and practices. Even though the quote below mainly addresses the physical, the Care Committee feels that it applies to the emotionally damaged and mentally challenged cases as well. Of special note is the statement, "strange and unproven."

"Believers should shun strange or unproven health theories and practices. These usually are accompanied by a certain amount of fanaticism, which is not characteristic of a Christian's inward rest and peace. Health fads may easily become an obsession that distracts from the quiet rest and security which faith in the Great Physician provides. Christians should scrupulously turn away from all health crazes and unexplainable cures. Some of these may border on or lead to occult involvement. Others are based on deceptive and ungodly philosophies and practices" (*Bible Doctrine and Practice,* p. 410).

It seems that when dealing with mental issues like depression, trauma, and diagnosed syndromes like autism and FASD, guards go up when help is looked for in the medical field. There may be some justifications for that, because in past decades professional psychiatry performed procedures that were pretty harsh. There are instances where counselors derailed individuals, keeping them from dealing with problems that were spiritual and needed the Lord's help. However, the main fear is that professional medicine, especially as it relates to the psychological part of man, messes around with the mind in using pills and therapy and that this may hinder individuals from dealing with the spiritual condition of the heart. If this is true, then the indication is that mind or brain sickness is not a medical condition but a spiritual one.

If the above is true, then what is to be done with autism, FASD, clinical depression, depression that develops from serious physical health issues, imbalanced chemical issues, inherited mental disabilities, and a host of other issues that are becoming more known, not because they did not exist previously but are understood today because of developments in scientific research.

The above reasoning seems to fall short of finding solutions. The endeavor in almost any dilemma is to find solid answers. Experience indicates that this is most often outside the realm of possibility, and so a group maneuvers through challenges, trying many options that offer help; counsel and prayer, hopefully, being close to the top in the list of options.

God created the world and everything in it. He has given mankind minds that have successfully delved into the function of the human body, have discovered remedies and cures, but have not succeeded in making a complete human without problems. Seemingly, on the grand scale of things, it is only becoming more complex. However, on the average, people are living longer in spite of the hype that so much of what we eat and how we live is unhealthy. And many diseases have become a thing of the past because of scientific research and knowledge. We thank God for this.

More so than ever, wisdom is needed to find a way through the maze of challenges facing us today. Prayers should be offered to the One who controls the universe—prayers for wisdom to understand how to help those who hurt, prayers for those who face futures with no relief in sight, prayers for those among us who have physical and mental issues and special needs, prayers for leadership, prayers for soft hearts to understand the pain in the hearts of people because of serious issues in their personal lives, prayers for open minds to accept reality, and prayers to know what to do.

The Samaritan saw the man beside the road. He stopped and helped him. The priest and the Levite took note but walked around on the other side of the road. Who was the professional?

Why Hospice?

John Ensz—DON Grace Home

Death is inevitable—we are all heading that way. When an elder at Grace Home appears to be nearing the end of life, we offer hospice services [Palliative Care in Canada] to them and their family. Most families choose hospice care—after many questions have been answered. There are a lot of myths regarding hospice care, so I thought I would address them in this newsletter.

One of the first myths is that hospice care is about death. It's not—it's about life. This may seem like a paradox, so let me explain. The criterion for admission to hospice care is a life expectancy of six months or less. However, we have had elders who have been on hospice much longer than that, as well as some who are discharged from hospice. Several years ago, we had an elder here who was admitted to hospice three times before going "home." Hospice is about recognizing that a disease process is no longer curable and that comfort is the new goal. It treats the person and not the disease. Comfort, not cure, pain, and disease symptom control, and physical, emotional, and spiritual care are all components of hospice that allow elders to live what life they have left to the fullest and with dignity.

Another myth is that admission to hospice is "giving up on them and just letting them die." Nothing could be further from the truth! Hospice care is an acceptance of the inevitable and a shift from frequent unpleasant visits to the hospital to remaining in familiar surroundings, being cared for by people they know and love, caregivers who are using a wide array of treatments and medications to keep them comfortable and pain free. Many previously used medications and treatments may be stopped, but only ones that no longer provide any benefit to the elder.

Speaking of medications raises the specter of another myth, probably the one I'm asked about the most: "Will my loved one be drugged into unresponsiveness and given medications that will hasten their death?" The drug everyone seems to be most concerned about and scared of is morphine. Morphine is one of the chief "go-to" drugs in hospice care, but it is only given when needed and in doses that provide pain relief and comfort. The dying process is often accompanied by rapid breathing, which increases discomfort and anxiety. Morphine relaxes the body and slows the breathing. The elder may sleep more, which is fine, as comfort and decrease in anxiety is being achieved. Many studies have been done over the last several years that have shown that using morphine near the end of life actually prolongs life by several days. The body is relaxed and not fighting the dying process. Sometimes the morphine is given as often as every two hours, and an elder passes a few minutes after a dose has been given. This may be why some think the morphine caused the elder's death, but the reality is it had nothing to do with it. The morphine doses given in hospice care are small and do not cause a person to die.

A third myth involves eating and drinking. Elders on hospice are offered food and liquids on a regular basis until it is obvious their bodies no longer need or want them. Feeding an elder whose body no longer wants food causes intense discomfort. The elder is not being "starved" to death; their physical bodies no longer need or want food or liquids. Sometimes an order is given by the doctor to hold food and liquids at this point as it is no longer needed.

While we as humans tend to dread and fear the dying process, it is as much a part of life as birth. At Grace Home, we strive to provide our elders with "a good death" when they reach that time of life. This is not an oxymoron. It is a death where they are comfortable and relaxed and can cross over in peace and quietness. We support the use of hospice for those who desire it as they provide us with many of the protocols and tools to make this happen.

2018 Care Meeting Report

Ida Klassen

The Crooked Creek congregation did a wonderful job of hosting our Care Meeting this last August. This was the first time we had a two-day meeting, and it was well attended.

Registration began at the Debolt Community Center Thursday morning where we listened with interest to Eric Osborne, a TBRI parent trainer from California who presented at the meeting in Glenn last year. Trust Based Relational Intervention is an attachment-based intervention designed to meet the needs of children from hard places who often are in the foster or adoption populace. Eric is an inspirational and informative speaker who knows what he is speaking about since he has several of these at-risk children in his own family. Eric spoke about "felt safety." This is different than the adults knowing that these children are safe. The child needs to feel safe. This can take much time and persistence until the child learns that he can trust the people around him. Because of this lack of trust, traditional methods of discipline often are not effective for these children. When dealing with these children, it is important to remember that the change must start with us.

Penny Rose, a representative of the public school district, spent the last part of the morning telling us about services that may be available through our local school districts. Various kinds of assistance are available for con-

ditions that are above and beyond the capabilities of our church personnel. Each district has programs available that can be accessed through the public school or health care systems.

Our breaks for meals and snacks fill a valuable part of these meetings as the sharing and networking that takes place are vital to helping people understand that they are not alone in their journeys.

Eric again presented, in the afternoon session; this time more specifically on FASD. Again, this was very informative, explaining some of the whys behind the behaviors of this disorder and giving advice and experiences on how to deal with these challenges in real life situations.

Helmut Herrmann shared personal experiences about his daughter who has special needs. He spoke of how he learned to access funding for various needs. There are organizations that can assist with helping people get started with a child who has special needs. It takes a lot of effort, and these families are often hurting. It is important to be connected to someone who can help.

We continued the afternoon with breakout sessions. There were four groups, and everyone could decide which their area of interest was. The topics were special education, challenges of adoption, dealing with developmental disabilities, and support groups. We had short discussions in each group, and then one person was selected to report back to the main group when we reconvened.

Thursday evening, Danny Toews had a very inspiring message. A brief overview is difficult, but we heard about various types of pain and how we need to help each other bear pain and learn to manage our own pain. Pain is intensified by fear, guilt, loneliness, and anger. Walking in truth is important. If there is a why, there will also be a how. A group of local couples presented a few lovely songs of comfort and hope, pointing us to the Lord and the refuge we can find with Him.

Friday morning, we reconvened in the Crooked Creek church. We spent most of the morning listening to parents who opened their hearts, shared hurts, struggles, and battles without fear of censorship. We heard of victories and stories of help and blessing. As is usually the case at these times, there are many tears shed as people feel free to spill it out in a safe place. We trust this is part of the healing process and gives courage to families who are struggling.

After lunch, we heard a short report from Roger Loewen, one of the Conference Curriculum board members who is on their special education team. Their work is not completely defined at this point, but they are interested in helping in school settings.

Paul Regehr's family told the story of their journey with a son with high needs. Although there was much hard work involved in caring for Kyle, there were many joys as the family and their community worked together.

Patrick Hanes gave a presentation on vicarious trauma and how we need to be aware of caregivers becoming traumatized by others' trauma. Caregivers need acceptance and a chance to escape without feeling guilty. Their own spirituality can be weakened. The world offers us a lot of solutions, and we don't want to ignore that; however, we need Jesus and His everlasting arms.

Marcus Durley gave a short talk on "diagnosis." He encouraged us to remember to train the trainable. Burdens are lifted at Calvary; we need to bear each other's burdens. The correct diagnosis is that we are all sinners and Calvary is the cure. That is where we start.

Ida Klassen read a success story written by a mother of a child with special needs and the challenges faced in school. The child was expelled from school, but after an assessment and a proper diagnosis, there was some good communication established between board and family. The child returned to school successfully after a correct diagnosis, prescribed meds, a lighter workload, and an experienced teacher who wanted the child in her class.

Colleen Wohlgemuth, a special education teacher, brought some of her thoughts on school issues. We need to ask for help. Teamwork is vital for success. If there are issues at school, there are often issues in the home.

Tony Isaac, a teacher, brought some of his thoughts. Everyone craves acceptance. The golden rule is important. Students can be reached, but it may not be easy. Sometimes we, not the slow learner, need to change.

Lawrence Penner brought encouragement and advice for the various types of support groups and care groups.

The Care Committee and Resource Team plan to continue these meetings.

An Urgent Plea

This is a plea to those who have a heart for children; especially children who have come from hard places in life—children who deep down want to have a chance in a loving family like most of us have had.

There is a huge need for homes that can take in children in emergency situations, on a moment's notice, and give them and their parents a chance to catch their breath and make some decisions for the future.

There are times when things like threats, attempts of suicide, sexual abuse, or violent behavior can cause disruption in a home, and with there being other, younger children in the home, a need is created for an immediate, different place for them to stay for a short time. No matter what these children have done, the parents love them like you love your children and can hardly bear the thought of

sending them to a children's home, a psychiatric ward, or other non-Christian institutions where about anything can happen.

We currently have brothers and sisters among us who are working with these children and developing facilities and programs to help with this need. However, vacancies are few and waiting lists are long, therefore the need for emergency homes.

This needs to be considered with a lot of prayer, conviction, and support from staff and congregation. So if you feel a stirring in your heart to help broken children and stressed parents, contact the Conference Care Committee

Twelve Commandments for Parents of Children with Disabilities

"The Exceptional Parent;" by Virginia Richardson.
Submitted by Denver Wiebe

1. Thou art thy child's best and most consistent advocate.
2. Thou hast valuable information about your child. Professionals need your input.
3. Thou shalt put it in writing and keep a copy.
4. Thou shalt try to resolve problems at the lowest level, but do not hesitate to contact a higher authority if the problem is not resolved.
5. Thou shalt keep records.
6. Thou shalt seek out information when needed.
7. Thou shalt take time to think through information before making a decision.
8. Thou shalt have permission to be less than perfect. Important lessons are learned from both successes and failures
9. Thou shalt not become a martyr. Decide to take a break now and then.
10. Thou shalt maintain a sense of humor. It is great for your emotional well-being and that of your child.
11. Thou shalt always remember to tell people when they are doing a good job.
12. Thou shalt encourage a child to make decisions because one day he or she will need to do so.

Conference Care Newsletter is published when possible by the Conference Care Committee to share concerns, inspirations, and ideas among the care facilities of the Church of God in Christ, Mennonite. Articles and suggestions should be sent to Tim Penner, editor, 64 First Street, Steinbach, MB R5G 2B6; Ph./Fax 204-346-9646; Cell 204-346-4048; e-mail: timbrenda@live.ca.

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2018 Care Conference Report

Tim Penner

The annual Care Conference convened October 18 and 19 in southern Idaho. It was well attended by administrators, DONs, board members, and dietary and activity directors from the fourteen care facilities in the conference.

Thursday morning the group listened to Robert Vande Merwe, a representative from elder care in the state of Idaho. He spoke on the future of elder care. His presentation was very informative. He stated that good caring is the future of elder care. Good staffing is the future of good health care. He touched on the challenges of technology. He mentioned that the baby boomers were not preparing for their Medicaid needs in the future. He encouraged managers to motivate their team members to shepherd. He stated that top down leadership, for example, "I say, you do" was not accepted in the long run. People remember how you made them feel and not what you said. His presentation was inspirational.

Thursday afternoon was designated for the different departments to spend time in their own sessions. The departments summarized the contents of their discussions Friday morning.

Thursday evening, the administrators reported on projects they had initiated in their facilities the past year. This gave everyone a picture of what had transpired and what could be accomplished with good team work and vision. It was especially useful for newer facilities working at becoming established. However, older facilities benefited, also. Experiences and initiatives by newer facilities give new impetus to the old.

On Friday, all attendees met together. After introductions the departments reported. A few points covered were:

a. Relationship skills should be encouraged.
b. Residents are often unable to verbalize pain.
c. Marijuana is an issue.
d. No one has a plan developed for the coming baby boom surge.
e. Breakfast buffet.
f. How to maintain enthusiasm.

After lunch, the future of elder care was addressed again, more as it related to the church conference. A few points addressed by the speaker were:

a. We have an aging conference; what is our responsibility?
b. How much mission is embodied in the care of our elders?
c. Are we on a collision course with reality?
d. Does the need have to become acute before we act?

Two agenda points related to leadership. Think about the worst boss you have had. Think back to the best boss you had. Take the bad points out and put the good points into your leadership effort. Embrace conflict as a source for growth. Christ taught a servant-leadership role.

Relationship caring is trust based. The human touch is important. There is a difference in saying, “I appreciate you,” or “You are appreciated.” God is a God of relationships.

Another aspect of caring covered was “end of life care.” It was stated that a lot of ignorance exists about end of life care. Encouragement was given to train families and employees in the end-of-life process.

An aspect that is often overlooked in a care facility is the care that caregivers need. Suffering and struggling with aging affects the individual directly and can easily affect the caregiver. Who will care for the caregiver? Administration needs to be conscious of this, and the caregiver needs to look after herself.

There is continued talk about retirement plans. Prospective employees are asking what facilities are offering. It is difficult to find direction.

There was general support for the way the conference was structured. There was special appreciation for the hospitality and services. Next year’s conference will convene in Mississippi.

Announcement

Care meetings in 2019 will convene in Walnut Hill, Florida, April 4 and 5, and in Sinclair, Manitoba, August 8 and 9.

More details will follow in the *Messenger of Truth* and via Conference Services.