Planning an Intercommunity Skilled Nursing Facility

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Many communities of men and women religious are currently weighing the benefits of intercommunity consortial models for providing skilled nursing care for their infirm members. Several intractable demographic, actuarial, and economic considerations accentuate these benefits. Many communities, for instance, have an increasing number of members with chronic conditions that jeopardize ability to perform basic activities of daily living. At the same time, most communities have fewer younger members providing income that could be used to build or convert facilities for skilled nursing care. Similarly, many communities have neither members professionally prepared to administer a skilled nursing facility, nor the accrued experience to utilizing them in a manner essential for sustaining their morale and minimizing burnout.

At a time of burgeoning health costs and declining community resources, these are meaningful considerations. This article, however, examines the less tangible benefits that occur when communities engage in an open, participatory process of fact-finding and discernment about inaugurating an intercommunity sponsored skilled nursing facility. Invariably this process surfaces three issues that initially disconcert many members. In confronting these issues collegially, however, the community empowers its members to transform them into occasions of personal growth.

First, the discussion about a facility for a community’s frailest mem-
bers highlights existing limitations in the community’s provision of long-term care. Second, the discussion about cosponsoring, sharing administration, and intercommunity use of a facility raises members’ concerns about the continued existence of their community. Finally, discussion about including both men and women religious in these facilities evokes unresolved family-based issues with their attendant anxieties. Nonetheless, when community members collectively address these issues, the process can become a graced moment sustaining members amid losses accompanying aging, emphasizing opportunities for mutual assistance, and affirming hope in the responsiveness of their communities to the need for as-yet-undiscerned structures.

The Provision of Long-Term Care

“Long-term care” aptly refers to interventions designed to compensate for the progressively inefficient functioning of biological systems, for example, cardiac, pulmonary, musculature, immune, and central nervous system. These interventions may include chauffeuring someone who no longer drives, introducing barrier-free architecture, using bright contrasting colors to alert persons to the presence of stairs, and providing technological devices like chairs which raise a sitter to a standing position. Even though these interventions may be needed indefinitely, they enable affected members to live in their customary community.

Members know, however, that there are limits to this prosthetic environment. A point comes when gradated interventions are no longer compensatory, and a protective environment, such as a skilled nursing facility, is indicated. This is a threatening transition for the persons involved for several reasons that they are not likely to articulate. For example, one of the features of community living that may have sustained them was the opportunity to avoid frequent or prolonged contact with certain other members. The skilled nursing facility may remove this option and thrust these very parties together in a constricted environment. Moreover, they have probably not familiarized themselves with the assets of the facility—and even avoided visits to colleagues who preceded them—because of a negative stereotype they hold, for example, that herein dwell those afflicted with Alzheimer’s, incontinence, and loss of autonomy.

Intercommunity sponsorship will not alter these fears and stereotypes, but community-wide discussion about such sponsorship is a forum to surface and confront them. The unprecedented nature of the topic under discussion, of its structural consequences for the communities involved, and its impact upon the personal future of all the members exclude no issues as too emotive to raise. The challenge for those facilitat-
ing the discussions is to sustain this candidness, to draw out both the un-
guarded and the informed opinions of the participants, and to com-
pplement those opinions with their own critique of the liabilities inherent
in a skilled nursing environment.

Discussion of the proposed model is an opportunity for videotaped
presentations about representative facilities, for site visits, and for the
insights of consultants to contrast negative preconceptions with facts. It
is an opportunity, too, to formulate a program of ongoing religious for-
mation that explicitly integrates participation in the community’s long-
term care program and residence in the skilled nursing facility into a
model of life cycle-relevant spirituality. ¹

Discussion of the proposed model is, of course, the forum for iden-
tifying the advantages of cosponsorship. Among these advantages, older
community members tend to focus especially upon structures that sup-
port their personal autonomy. ² The infusion of persons from other com-
munities because of cosponsorship provides this support. Residents can
choose to associate with their own colleagues, and/or discover new con-
fidants from other communities. They have access both to the facility ad-
ministrators and personnel from their own community and from other par-
ticipating communities.

Finally, discussion of the proposed model enables the several admin-
istrators of the long-term care programs in the corresponding communi-
ties to articulate their own undermet needs. Many communities have iden-
tified only a small number of members to assume the emotionally and
professionally demanding responsibilities of developing and coordinating
their long-term care programs. These members often find themselves with-
out knowledgeable colleagues within their communities who can empa-
thize with their situation. They must advocate continually on behalf of
staffing and resources for their programs, while at the same time partici-
pating in support groups and conferences that enhance their professional
competence. ³ Under stress they sometimes derogate trou-
blesome individuals under their care, categorizing them as “maligners-
ers” or “manipulators,” and are undoubtedly counter-labeled by these
others in turn. Cosponsorship introduces new personalities who are un-
known to one another, a “breather” for all concerned, and a freshness
that enhances individuality.

The Continued Existence of the Community

The novelty of several communities sharing a skilled nursing facil-
ity often dramatizes to members that the ongoing existence of their com-
munity may be in jeopardy. The problem that ensues is not a failure to
trust in a gracious providential design or a resistance to the community’s new corporate and individual ministries. It is, rather, the need to grieve for the loss of familiar structures members had expected would support their own older years. As the community responds to economic constraints, older members sometimes feel a corresponding inattention to the founding charism that had identified them. They may feel, too, a discontinuity between their own ministries and their current distance from the ministries of many younger members. Now, while they are trying to pursue their grief work, their community proposes a residence in which they appear to be living with strangers!

Facilitators of the discussions need to assist members in recognizing the multiple discontinuities that they have already negotiated so fruitfully and the flexibility and courage they characteristically bring to this latest challenge. They can also help prospective residents of the skilled nursing facility to view the similar issues which confront each community as a common ground for conceiving anew the ministries and structures needed in the twenty-first century. Indeed, after the current cohort over sixty-five years of age has died, the remaining members may face the most severe discontinuity in the community’s history. Rather than being discounted, then, members of the older cohort can use their experience and wisdom to serve in the community as catalysts of evolution and transition.

Facilitators can be especially helpful to those members whose communities are preparing to close. Since their communities are probably the smallest, it is essential that the consortial model specify the procedures that will support the traditions cherished by each community. These members of the final cohort are simultaneously mourning the demise of their community, the expectations they held about the institutional context of their later years, and the personal losses accompanying their own aging. One of their challenges is to draw upon their situation as an incentive to prepare, record, and catalog a detailed oral history of their community.

**Gender Integrated Facilities**

Inevitably male communities will reach out to female communities to participate in the planning of consortial facilities. The numbers of men are small by comparison with women religious, and make even cosponsored facilities exclusively for men prohibitively expensive. Moreover, male communities generally recognize that female communities have established eminent positions in planning and conducting skilled nursing facilities for their members.
The objections which members raise about residing in a skilled nursing facility for both men and women are usually expressed in terms of maintaining privacy, familiar routines, and ease of interaction. These considerations need to be taken at face value and examined at length. On another level, however, many of these objections arise from problematic dynamics unresolved from the members' families of origin. Matters of gender evoke issues involving grandparents, parents, siblings, family lore, and the allocation of role prerogatives. Even though older members have been ameliorating these issues for decades through ongoing life review, the anxiety aroused by discussing both the skilled nursing facility and the gender integration of community life in the facility tends to elicit powerful family-related reminiscences.

Community living of the vowed life offers many opportunities for sponsoring groups devoted to life review. Members who already participate in such groups can bring their revivified reminiscences to these meetings. Others will find in these discussions incentive to begin life review programs both in the larger community and in the skilled nursing facility.

Finally, the convergence of experiences of life review with discussions about the proposed skilled nursing facility often encourages members to raise questions about the admission of family members to the facility as well. However communities respond to these questions, gratifying relationships of members with their kin as they confront such emotionally laden issues together can be a key component of members' life satisfaction.

Conclusion

Communities of religious are increasingly involving their members in discussions about the feasibility of cosponsoring and administering a skilled nursing care facility serving several communities. These discussions engage participants in difficult issues about health maintenance expenses and community resources. No less important, however, these discussions can lead members to attend to issues associated with their own aging, with the content of their life review, and with the contributions they can make to their community, however frail their health.

NOTES

187-192.
3 The National Association of Church Personnel Administrators and the Third Age Center at Fordham University provide pertinent consultation for religious responsible for long-term care in their communities.

Weathered Treasures

When cast by life’s waves upon
The coast of old age,
Shall we, like rough driftwood, be—
Splintered, shattered, tossed
Ashore—left unsought? Or, like
Sea-scattered shells, shaped
And painted by the deep, come
Beautified by tides
And, like rare shells, treasures be.

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