SPIRALS: THE JEWISH NURSING HOME DILEMMA

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Jewish nursing homes are in the throes of a series of death spirals — government cutbacks of Medicaid funding, outmoded buildings that thwart the provision of quality care, location in declining neighborhoods, and a lack of close ties with the families of their residents and with the federation. These spirals interact to threaten the existence of Jewish Homes.

The internal and external pressures that are building on Jewish nursing homes are neither a simple function of the idiosyncrasies of a particular community nor the management style of its administration. Rather, many of these pressures are *structural*; that is, they are the product of a set of dynamics that are held in place by a wide variety of factors. These dynamics can be viewed as systems and as such can be described, analyzed, and even diagrammed. This article analyzes the Jewish nursing home in terms of its systems.

Whereas there are few Jewish Homes in which all of these dynamics operate, few institutions do not grapple with at least some of them. Therefore, the total set of spirals elucidated herein does not describe a typical Home, but rather places interactive dilemmas into a theoretical framework.

GOVERNMENTAL EXODUS

In 1969, I was 22 years old and eligible to be drafted. The Vietnam War was in full bloom. To funnel young men into the Armed Forces, a draft and a draft board were established. In my district, the draft board was located in the Downtown Post Office. In a sense, this building became the center of my life. The decisions made there would dictate my age group's future: who would serve, for how long, and where — in a sense, who would live and who would die. There were an ever-evolving set of deferments, exemptions, priorities, and lotteries. The rules seemed to change continually. As is the case where the fate of thousands is controlled by a few, rumor, myth, and superstition abounded — stories of missing files, anomalies, being in an advantageous pool, and the like. The government had developed a whole new classification scheme, which took priority over all other life decisions.

Twenty years later, in 1989, I returned to that Post Office. The Draft Board was gone, as if it had never existed. The faceless bureaucracy that so controlled those earlier years of my life had vanished.

Interestingly, another government program also bloomed and withered within the same time frame. In the late 1960s, the federal government took control of the destiny of another age cohort. The bureaucracy developed an array of financial reimbursement systems to encourage services for the modern nursing home industry, the federal housing program, and the senior center movement. By 1987, Social Security accounted for more than one-fifth of the entire federal budget ($203 billion), with Medicare consuming another $78 billion and Medicaid a further $26 billion of federal matching funds.

Few in 1965 knew the extent either of the emerging demographic revolution or the programmatic stimulus that had been established. Now, almost three decades later, the government has initiated a set of

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Editor's Note: This article is the second in a two-part series on the state of the Jewish long-term care facility. The first article, "Why A Jewish Home?," appeared in the Fall 1992 issue.

downward spirals as it takes "corrective" action to reduce its expenditures on care for the aged.

The government's specific tactics are fourfold: (1) simultaneously raise the threshold levels at which an older person can gain access to government funds for services, (2) shorten the time during which services are available, (3) reduce actual reimbursement rates for services delivered, and finally, (4) institute rigorous surveillance and control measures. In effect, the burden is being downloaded and shifted financially, legally, and morally back onto the community while the government assumes the residual role of consumer protector.

Government cutbacks manifest themselves in a number of different ways. The government may hold rate increases below the actual wage increases experienced by Homes; it may impose more expensive standards/duties upon the Home; or it may continually change the regulations and reimbursement rules so that the Home must add (expensive) sophisticated services to receive its reimbursement, with that "indirect" additional expense not being reimbursed. A state may merely keep its already woefully inadequate reimbursement rate at the same level, forcing the Home to raise funds in a more difficult economic climate, hindered by changes in the Tax Code that reduce philanthropic incentives. Finally, a state, through its budgetary process, may so continually threaten draconian cuts or sweeping rule changes in its Medicaid program that the prudent Home board and administration is forced to act to reduce its reliance upon Medicaid reimbursement whether or not the draconion cuts are enacted. These changes, often in combination, create a climate in which the governmental exodus or cutback is palpable, even if not easily measured by simply looking at the Medicaid rate.

The relationship between nursing homes and state regulation makes "bureaucratization" a critical issue. Today, 60% of nursing home care is paid for by the government, primarily under the auspices of Medicaid. This makes the government both the nursing home's largest customer and its regulator. Reimbursement rates and regulations are intertwined, yet are often administered by separate, "autonomous" state agencies. This can result in an unfortunate downward spiral in which regulations set high standards for compliance but reimbursement rates are inadequate for the staff and program to meet those standards. Public outcry to exposure of this failure to care results in governmental inquiry, which in turn results in more onerous, higher standards and closer scrutiny. The irony is that new regulations with higher standards require even more money for compliance. Yet, public hearings often foster a hostile, unsympathetic environment that can result in even lower reimbursement rates. The disparity between standards, expectations, and reality becomes greater, which sets up the conditions for future abuse and continuation of the downward spiral. Periodically, descent down the spiral accelerates, reflecting society's ambivalence about aging, chronic disease, and paying for nursing home care (Figure 1). For the Home, the spiral creates pressures that may undermine staff morale and the continuity of the fragile support system that it attempts to build.

JEWISH HOMES — THE TIME WARP

Jewish Homes for the aged have evolved out of a religious, philosophical, and historical tradition that promoted excellent psychosocial care. Yet, the environment that fostered our institutions has changed, and they are in danger of extinction if they cannot adapt to fit the world as it exists now.

To understand what the Jewish Home must become, it is useful to look at the assumptions and underpinnings that support its present form. This section examines the Home's financial and programmatic structure, as defined first by its "deal" with the

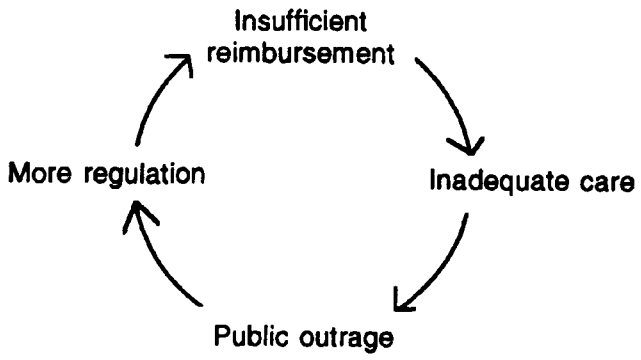


Figure 1.

government and how it has affected the actual and implied contract between and among the Home, the resident/family cluster, and the Jewish community.

In 1965, Congress created the Medicaid program, and for the first time the federal government took responsibility for the payment of direct nursing home care for indigent older Americans. Upon the creation of this "deep pocket," with its establishment of an assured steady reimbursement mechanism, the modern nursing home movement flourished.

The Jewish community was quick to recognize and seize this new funding opportunity. The federal government, in essence, was subventing our local communities' traditional and historical obligations to our poor, older family numbers. A "peace dividend" of the Eisenhower and Kennedy years, federal funding became the backbone of our Homes, housing, and aging services. Unlike many other religious, fraternal, and community groups who needed prodding to awaken and organize social service networks, Jewish communities already contained the requisite self-identity, vigilance, commitment, and sophistication.

Medicaid, the modern nursing home's foundation, is a program for the "indigent" and was designed to be a *last* resort. Yet, for the Jewish community, both individually and organizationally, it quickly became the program of *first* resort. As this 27-year Medicaid "experiment" is now being stripped away by a governmental exodus, we are faced with the shock that our Homes are not in touch with our communities. The Homes have been in a "time warp" for three reasons:

1. During the intervening 27 years, there has been an astounding rise in Jewish socioeconomic status. Yet, a corresponding gradual move from Jewish poor homes to upscale/mid-scale housing and campuses has been retarded by Medicaid.

   In the early 1960s and 1970s, government-sponsored buildings were adequate, particularly for our traditional mission of serving the poor, relatively well, old Jews. Yet, two factors changed. First, more and more older people lived longer and needed special living arrangements not because they were poor, but because they were frail. Second, older Jews, as a group, had more financial resources, in large measure because of Social Security cost-of-living-allowance increases, pension law reform, and inflation and the real estate boom that increased the values

of their homes. In sum, the Jewish community came to be caring for people in sickness and in wealth. As other organizations built new upscale facilities for their changed aged populations and their different expectations, many Jewish communities did not upgrade and reinvest in new physical plants, in large measure because of our perceptions. Residents continued to look poor, even if they actually had assets (which were transferred to their children). Continuing to serve our ostensibly traditional poor clientele, our facilities and their neighborhoods aged. Quietly, many wealthy Jews placed their parents in non-Jewish Homes, making the Jewish Home population less and less representative of its underlying community. With the recent marked change in the Home's ability both to meet expenses with government (Medicaid) revenues and to attract private-pay Jewish families who would help defray costs, many Homes awoke to the realization that their ability to address community needs and expectations had been compromised. In essence, the Medicaid program's logic encouraged us to pauperize our older people, which has in turn masked the upward mobility of the Jewish community.

2. Another contributing factor in the widening gap between the Jewish community and the location, physical plant, and program of Jewish Homes has been the age of the population served by the home. Because the average age of the residents is 85-90 years (and poorer), Jewish Homes are a generation behind other community agencies in terms of the amenities they offer.
3. The third factor that has made our traditional marketing approaches obsolete is that it is now the children of the aged residents who are making placement decisions. Twenty years ago we were serving a group of healthier old Jews from low socioeconomic backgrounds who made their own decisions. Yet, because today's cohort being served is so much older and more frail, their children are now making the placement decisions. Those children are 40-60 years old and are highly professionalized; they demand high levels of medical, psychosocial, and environmental services. Generally, they have very different expectations from the 80-year-olds of 1970. To the Home, the future shock of these demographic changes is suddenly apparent. Within a span of 17 years, the population who selects our services has changed by 40 years, or two generations. The result has been an increasingly visible attrition of middle- and upper middle-income Jews from Jewish facilities.

These three factors, when combined with government cutbacks, compromise the Homes' ability to be responsive to the needs of the Jewish community in the 1990s. Figure 2 graphically illustrates this phenomenon. In 1965, the Jewish Home (and federally sponsored housing projects) were within the mainstream of the Jewish community. Yet, as the Jewish community became more affluent (the socioeconomic status of the community is reflected by the shape defined by the curved lines), and simultaneously as the federal government changed its regulations to admit only poorer residents/tenants, the disparity between the institution/housing project and the mainstream Jewish community became greater.

Outdated Physical Plants

The historical, implicit contract of Jewish Homes with the families they serve is also being abrogated. Many Jewish Homes are old and are located in changing or declining neighborhoods. The Jewish community has

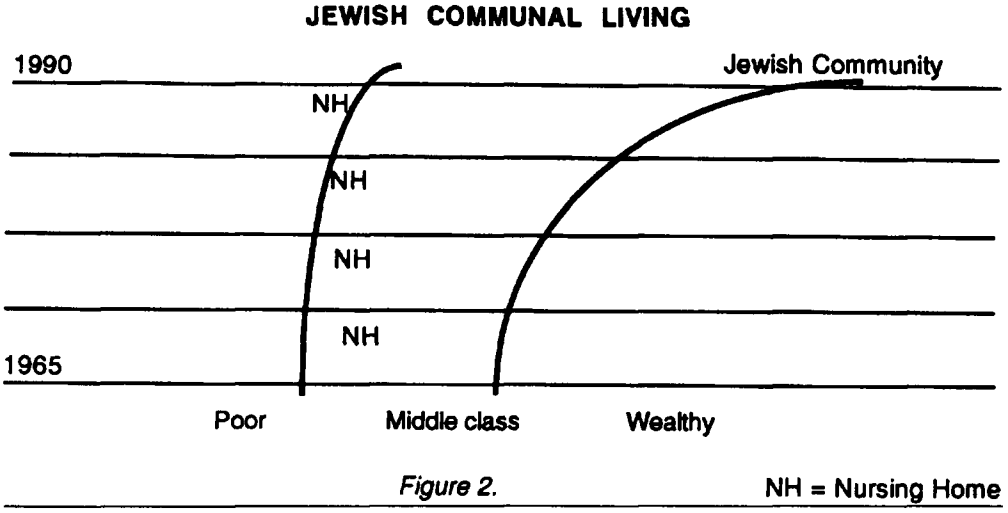


Figure 2. NH = Nursing Home

moved away, and for the present wave of residents and their adult children, the Home is an embodiment of the personal and collective past from which they have struggled for a lifetime to escape.

Many of these old physical structures are inappropriate for residents, staff, and family. The building no longer supports the programming that occurs there. For example, very few of today's extremely chronically ill residents can walk independently. Most are wheelchair-bound and have an array of sensory, gait, and physical decrements that make traveling about almost impossible. They cannot transport themselves, and other societal changes have resulted in insufficient numbers of volunteers or aides to transport them. The break-up of the traditional nuclear family, the Women's Movement, the economic necessity that both spouses must work, and the migratory workforce that places many adult children far away from their parents all have effectively depleted the volunteer workforce, at least as a reliable transportation system. And, the aides are now so involved with caring for the complex activities of daily living and the prophylactic and habilitative interventions for this new clientele that they have no time to transport them.

Even if there were sufficient transportation staff, most physical plants simply do not have the necessary numbers of elevators to transport, carry, and assemble 30-40 wheelchair-bound residents downstairs on a timely basis. Then, even if these clients were assembled downstairs, their sensory and attentional losses make large group gatherings inappropriate. The concentration of sights and sounds and the multiple stimuli make large groupings counterproductive.

Because of these new realities, the corridor, really a hallway-highway, is now being used for a completely different purpose than was originally intended. The residents often live in line-ups along the hallway Interstate. They are lined up "to go," but in fact are going nowhere. They live in these long isolating line-ups, where, because of the width of the corridor and concerns over fire hazards, they sit front-to-back or side-to-side. In either instance, they have insufficient peripheral vision, hearing, and neck flexibility to engage in conversation with their neighbor. Most highway-hallways have insufficient windows for orientation and do not have as many air transfers in the heating and ventilating systems as do areas designed for congregate use.

The result is that the traditional hallway has become a gauntlet of wretchedness, a line-up of isolated, lonely, older people, disoriented by insufficient light for stimulation and by the accentuation of unpleasant odors.

This "deindividualizing" results in a marked increase in restlessness and acting-out from the residents and is an adverse stimulus to visitors. For visiting friends or family members, the anticipation of getting off the elevator and walking the gauntlet along the highway makes such visits less frequent. It is somewhat like a visiting dignitary who arrives to first review "the troops." In the Homes, this review is an invasion of privacy for both parties — both feel scrutinized. This in turn spirals into more isolation and more guilt-laden interactions between the resident, family member, and staff.

The final, logical, but saddest result is that the aide, the primary caregiver, delivers care in the isolated highway and consequently experiences this stranded resident not as a full person but as a series of deindividualized tasks. Daily routines are oriented around the batch-processing of those tasks. The fact that the residents look like they are in an assembly line suggests that they should be treated so. Frequently, the result is that residents exist in queues, waiting for ten o'clock toileting, eleven-fifteen nutrition, and twelve o'clock lunch. Everyone, aides and residents, performs each task together. This gang or batch-processing is the opposite of individualized attention, where residents eat, snack, read, toilet, and socialize within their own internal rhythms.

This example demonstrates that the physical design of a nursing home helps structure the movements, tasks, activities, and perceptions of resident, caregiver, and families. As each of those groups has changed — residents becoming more debilitated, staff less educated, and family less available — the old design often thwarts the new care needs and expectations. This results in a downward spiral: greater frustration, absenteeism, and turnover in staff, causing less productivity and quality of care; fewer volunteers to supplement that care; and residents living in inadequate environments. The downward spiral produces accentuated frustrations for residents, aides, and families (Figure 3).

The spiral manifests itself in many nursing homes nationwide because they were generally built along the hospital model to serve a more able profile of resident. Jewish Homes tend to be older than the norm; in a recent survey, 83% of the beds were 20 years old.

Changing Dynamics with Families of Residents

The experience of watching a parent fade is difficult at best, but these additional care- and building-based frustrations can severely accelerate the downward spiral. Historical "brakes" on the families' acting out have been eroded. Never having been volunteers and with no prior involvement with or commitment to the Home, the family may have little understanding or sympathy for the constraints placed on it. Rather than viewing the Home as a community service, an ally, a living extension of their values and resources, many families adopt the role of arms-length consumers — they are not involved, but are just purchasing services. The fact that it is often not their or their parents' money but government and Jewish community subsidies, exacerbates this hands-off posture.

In addition, families now recognize their strong bargaining positions. Because of the Home's ambiance, location, and lack of amenities, it is not "competitive." Therefore, the Home needs them more than they need the Home. In these circumstances, the role of parent advocate increasingly evolves into one of an adversary against the Home and its staff. Once family rage is engaged and existing guilt is activated, much time and energy are devoted to orchestrating

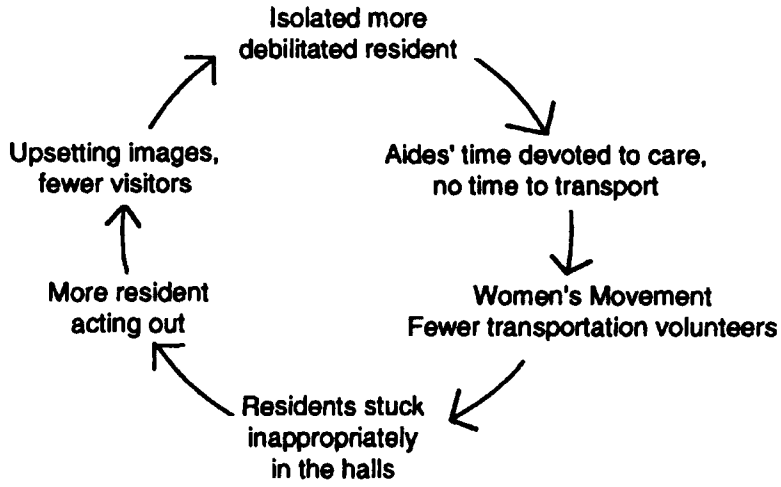


Figure 3.

pressure on the nursing home organization — through the board, through federation, or on staff directly. Often, the object of the pressure is unclear — to obtain some relief, to garner more attention for the parent, or to destroy the people who are "responsible" for the parent's condition and dying.

All of this activity antagonizes staff, making staff retention more difficult, and the spiral continues its downward plunge (Figure 4).

Changing Financial Assumptions

A third assumption that calls for review is the set of financial assumptions and underpinnings of the Medicaid program.

A fundamental principle of Medicaid is that the child assumes responsibility for neither the sins nor the financial obligations of the parent. This honorable motive is squarely in line with Judeo-Christian principles, particularly for a group that was genuinely indigent in the era before Medicare, Social Security, and sophisticated pension growth, reform, and protection.

The Jewish nursing home itself is built on the principle of nonfamilial responsibility. We pride ourselves in caring for the indigent, and the percentage of Medicaid clients we serve and our financial statements reflect this commitment. Yet, a number of environmental changes demand that we rethink our position.

As background, Medicaid generally pays less than the actual cost of care, and Medicaid rules basically forbid the Home from even requesting supplemental income from families. Ironically, even the resources from Jewish older people and their families that might help support our critical services under Medicaid are generally inaccessible under the Home's current configuration of programs and services. Older people and their families engage lawyers and accountants to transfer the residents' assets before they come to the home.

Medicaid law states that such transfer within 30 months of entering the home is presumptive evidence of intent to defraud Medicaid, and the state will look to those assets before reimbursing the Home for care provided to Medicaid patients. Yet, transfers made prior to 30 months before entering are rarely scrutinized, and worse, families, out of ignorance or avarice, sometimes make such a transfer after the resident is already in the Home! As a consequence, the Home may have provided

months of service (at $2,000-$3,000 per month) while the Medicaid application is pending, only to be told later that Medicaid has been rejected.

The Home's only recourse is to discharge a destitute, often confused resident who often knows nothing of the transfer and to institute a cause of action against the family. And if the latter is successful, a merry chase ensues to find the assets. Even when this unfortunate scenario does not unfold (and it generally does not — Jewish Homes are loathe to discharge a frail, confused old person in such circumstances or to take such actions against a family), this set of arrangements and expectations inhibit the development of a strong, trusting relationship between the surrogate family (the caregivers) and the traditional family.

In earlier days, when Medicaid paid the actual cost of care, the transfer of assets was a winked-at practice. There was an implied agreement to maintain the next generation's inheritance. Yet, now that the Home no longer receives sufficient government reimbursement, it is subsidizing the wealthy with assets it does not have, assets the community is not raising (Figure 5).

Despite the high socioeconomic status of the Jewish community, our Homes have percentages of Medicaid clients unheard of by other groups, and consequently, they experience higher deficits. These deficits threaten, on an ongoing basis, the survival of our Homes, the continuity of staff positions, the comfort and pleasure of serving on the board, the jobs of the executives, and the continuity of their mission and philosophy.

In light of the Jewish lay and professional expertise in financial and operational matters, it is clear that the problem is generally not simply one of absentee or sloppy management. The issue is not tactical. The problem is strategic and structural. The government and federations cannot or will not pay. Overall, the families and residents can. Yet, they are not asked to do so. Our organizations are not set up to obtain adequate reimbursement on a fee-for-services basis from many clients we serve. We have become confused in our mission. We were not established to protect the inheritances of middle-income families, to take from the community, to absolve families of their responsibilities.

By lacking foresight, by displaying an unwillingness to invest in the correct buildings and programs, we are now caught in a trap. It is time to question the policy of allowing healthy people to come into our housing, to care for them there, and then to

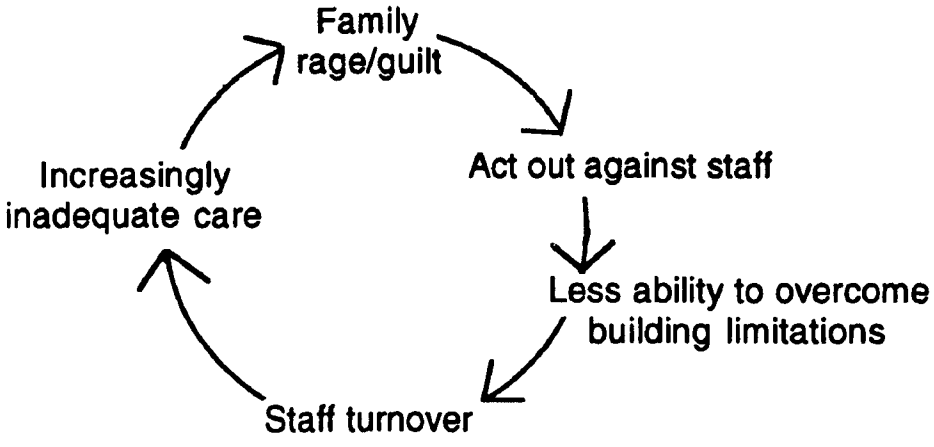


Figure 4.

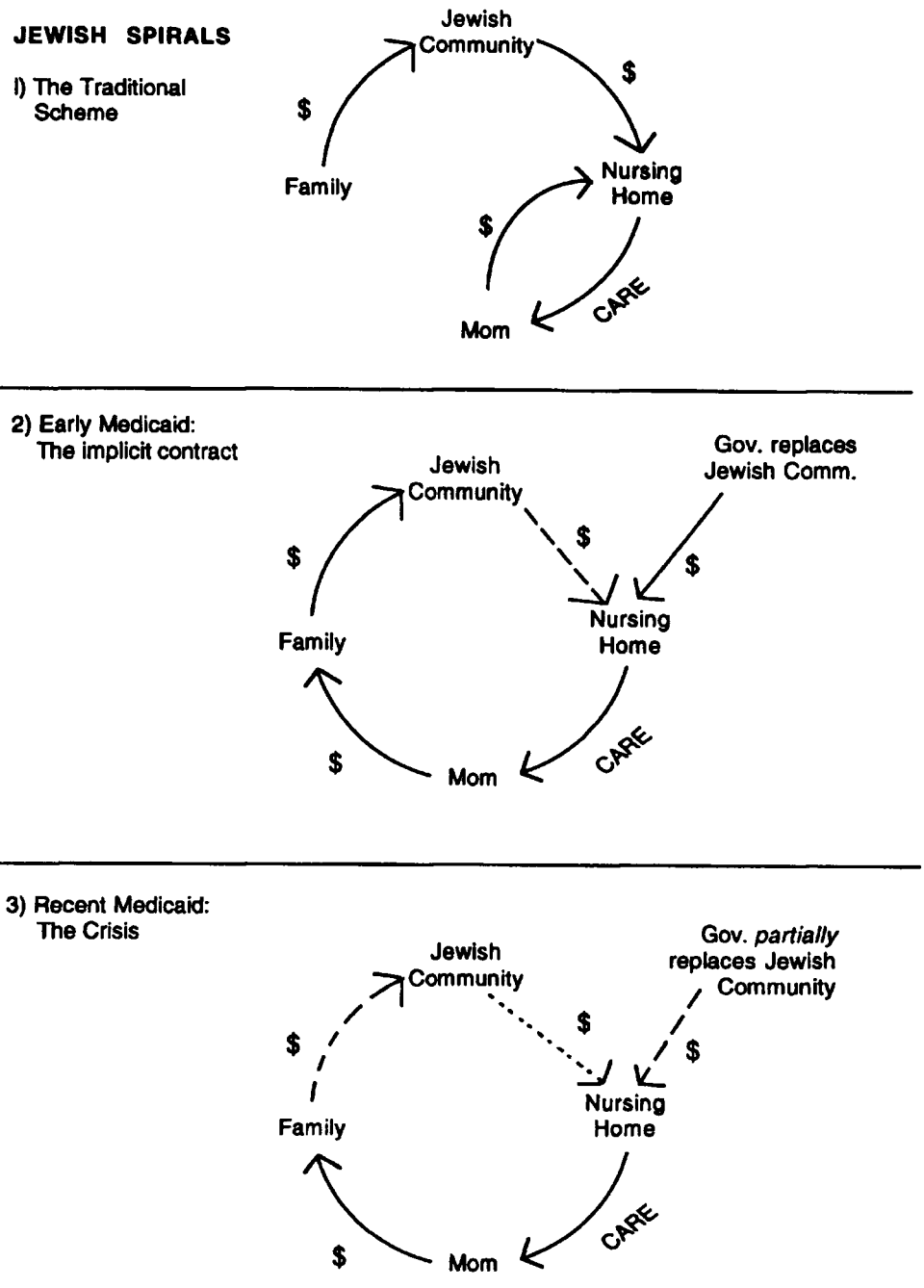


Figure 5

allow their families to abscond with their assets and have the parent receive the community subsidy available to Medicaid recipients.

Some respond that the Jewish community would not allow the status quo to be

challenged. The underlying assumption here is that Jews are so imbued with money-lust, with the *need* to get something for nothing, and to use their professional and political sophistication to transfer all responsibility for their parent's care to some outside governmental/institutional organization that any reasonable demand for participation and sharing in the struggle will evoke great rage and furor.

The response to these concerns is twofold. First, we have set up systems that encourage this cynical and destructive behavior. We have not developed appropriate housing and services with the proper incentives to create a financially feasible, secure approach to older people's care. The second and stronger response is that the above assumption contains more than a hint of anti-Semitism. Jews have historically been defined by their enormous sensitivity to suffering and commitment to ideas larger than themselves.

Do our community leaders and benefactors *really* want to protect family inheritances, or do they wish to build the proper service-based campuses that serve the entire community, expecting those to pay who can and saving the hard-earned contributions and surplus for those who are truly indigent?

The Changing Community

The downward spirals ripple forth beyond the four walls of the nursing home and begin to affect the future viability of the organized community itself. The Jewish federation is an idea — a rallying point around which Jews form associations and ventures for collective action. To the degree that those ventures address ever-shifting needs, federation is recognized as an effective vehicle for collective action, and the potential of "community" is energized. Federation must adapt to address each generation's unique style, experience, and priorities.

For the Baby Boomer generation, the most direct need that requires collective action is the care of their parents. For a variety of reasons, Israel, the Holocaust, and anti-Semitism no longer galvanize this generation to collective action (see the author's article, "Why a Jewish Home", in the Fall 1992 issue of the *Journal of Jewish Communal Service*). Yet, a combination of factors are inhibiting the natural, easy evolution of the federation to address and meet this generation's needs.

The first inhibition is the relationship between nursing home and federation professionals. The modern nursing home industry has virtually sprung into existence in the last 21 years. After Medicaid was created in 1965, the government very quickly assumed a substantial portion of the financial responsibility for the Jewish aged, allowing federations to turn their attention to other issues and agencies.

During this same interval, support for Israel has grown as a major agenda item for federation. The Yom Kippur war of 1973 was a watershed event, riveting Jewish concerns and energies on Israel and correspondingly reorienting the priorities of federation. To some degree, this reorientation was facilitated by the historical coincidence of the passage of Medicaid. By 1973, Medicaid was in youthful full bloom and promised to substantially unburden the Jewish community of the care for its elderly for the future. Now that governmental undertaking seems to have ended. At the same time, the U.S. government is supporting Israel as never before. The result is that over the past 21 years the federations and the U.S. government have reversed roles in supporting domestic programs for older American Jews and foreign programs for Jews in Israel.

Other Jewish agencies have remained much more closely allied both to federations and to the demographic changes and market trends over the past few decades. Those agencies have served a younger generation, whose demands for upper-middle-class facilities and programming have been

recognized and met over the intervening 20 years.

As this generation ages and calls for the amenities to which they have grown accustomed, three facts become clear. First, over the past 27 years, a whole generation of federation leadership has matured without deep experiential relationship with the government-subsidized nursing homes. Second, now that the government is cutting back, the Homes are turning to their federation. These federation leaders suddenly face a sophisticated nursing home industry laced with intricate regulations and overlapping programs serving a frail population whose profile is relatively foreign. Third, because of the size, complexity, and specialized nature of the long-term care industry, a new hybrid Jewish administrator has evolved, with professional training and experiences dissimilar to those of the traditional Jewish communal service worker. With the government changes, these groups, federation and nursing home professionals, somewhat autonomous for 27 years, are now pushed together.

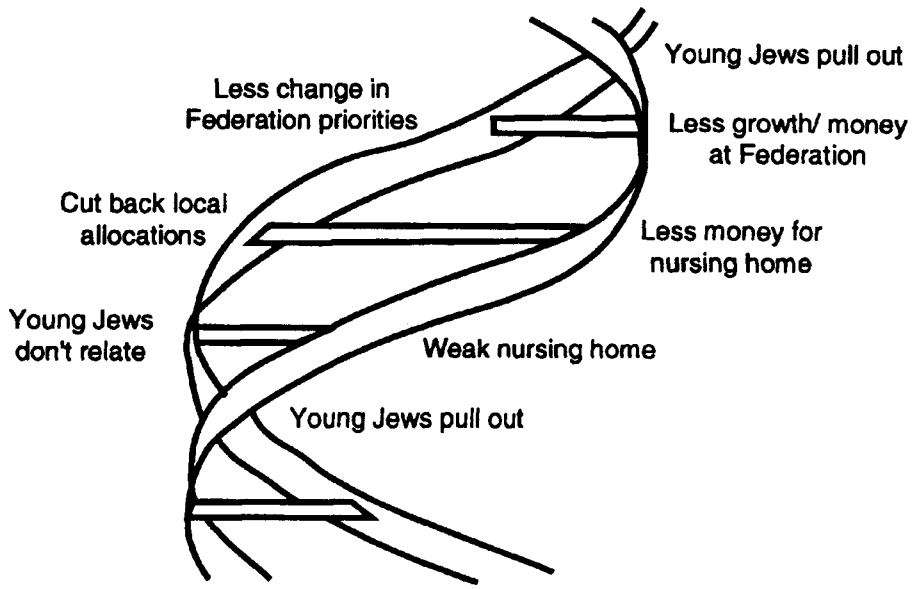
The other set of inhibiting factors revolve around the community's new generation of leadership. The Boomers' generational experience makes them suspicious of organizations. With their heterogeneity and their finely honed analytic skepticism, they approach cautiously — quickly reading both de facto power structures and the operating style of the organization. All too often, the federation's top-down control and its historical "predetermined" allocations process effectively turn off this new "power" generation. The consequences are diagrammed in a double helix in Figure 6. The young generational pullout results in less growth, involvement, and money for federation, which in turn leases less money for Jewish Homes to reconfigure themselves to meet the expectations and needs of the younger generation. Parents are therefore placed in non-Jewish Homes, "proving" that the organized Jewish community is *not* a vehicle to meet contemporary needs. At best, it is a place for the poor "others" and pointedly not for me, and at worst, it is an anachronism.

Simultaneously, as young Jews pull out, they withdraw from the battle to change historical community priorities, their parents' priorities. The future becomes merely a projection forward of the current status quo. As a result, existing resources are invested in areas that do not foster growth in the overall communal enterprise, which in turn causes further frustration, disillusionment, and abandonment. Figure 6 is a double helix because, like DNA, it is the genetic code for the community. It is the process by which communal values and belongingness are transmitted to the next generation. Its current structure, as expressed in Figure 6, is a frightening "double downward spiral" for the Jewish communal enterprise.

CONCLUSION

This article describes a series of death spirals for the Jewish Home. In a number of communities, the Jewish Homes are functioning in old modes of expectations and approaches: they are not structured to take action, to move, to strike. Proprietaries and other nonprofit organizations, however, have taken action. They have built newer physical plants, in locations closer to the Jewish community in more secure and familiar neighborhoods, with more sympathetic labor forces. They can skim the private-pay residents and the "desirable" Medicaid clients (i.e., those who pay more than the actual cost of care), and if a resident becomes difficult, the contractual arrangement is easily severed. Jews will accept this because they are familiar with such contractual arrangements and adjust their expectations accordingly.

So the pressure builds on the Jewish Home. Executive time is devoted less to program and more to cash flow, to direct or indirect fund raising, and to dealing with federation politics. This requires lobbying



Double Helix
Figure 6.

through complex and entangled layers of generally well-intentioned laypeople who often have relatively little understanding of the unique nursing home industry, yet may have intense emotional sentiment about the Jewish Home simply because of the nature of our special services and prior personal experiences, i.e., the death of a parent.

In a related phenomenon, in a number of communities, proprietary operators attract upscale Jews through focused nursing home or congregate housing developments and then involve themselves with federation and nursing home boards by donating expertise and management "overview." They position themselves to "scope" the competition, to keep abreast of developments in the field, and to guide policy. It is hard to imagine such a conflict of interest being tolerated in other fields. Yet, despite this "help," the Jewish Home remains in the residual position, servicing the people nobody else wants and with programs that are too expensive and difficult for others to operate; in essence, allowing the community to support the burdensome so that the "skimmers" can retain the profitable pockets (and can literally make a fortune).

Meanwhile, the pressures in the home's financial, political, and administrative environment rise to an intolerable level...and stay there. We scrape for community funds, compete for staff, watch our assets diminish, constantly fear for the survival of the Home, and after years in crisis, the mode, the aim of just surviving becomes institutionalized.

And all this time the Home's position dissipates. Wealthy and powerful Jewish families no longer view it as the right place for their parents — one that offers guilt-free care. This creates its own downward spiral in federation, where there are fewer well-positioned insiders who can translate the story of the Home or feel a deep emotional commitment to its mission.

At the end, the community asks, Why can't we do it well? Why is this such a struggle?