THE JEWISH NURSING HOME IN THE YEAR 2000

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Changes in the demographics of aging, the nature of the Jewish community, and governmental involvement will dramatically alter the Jewish nursing home of the future. The key challenge is to create broad conceptual frameworks that can respond effectively to these multifactorial changes. Building new homes that follow the movement of the Jewish community to the suburbs and adapting facilities to meet the heightened expectations of future generations of the elderly will be essential.

Projecting the future of the Jewish nursing home is a treacherous business. The forces acting on Jewish homes are powerful and interactive, and even if we begin to understand these forces of change, how they interact can produce widely different scenarios. Yet, if the Jewish nursing home is to respond effectively to these changes in demographics, the nature of the Jewish community, governmental involvement, and challenges to sectarian institutions, it is necessary to put them in a framework from which a model of the Jewish home in the year 2000 can be derived. This article presents such a framework and model as a basis for recommendations for the future evolution of the Jewish nursing home.

FORCES OF CHANGE

Demographics

The size and nature of two demographic cohorts—(1) the generation that will reach old age in the 1990s and the first part of the next century and (2) the "Baby Boomers"—are key determinants shaping the Jewish nursing home of the future.

Between 1920 and 1935, there was a 15-year dip in fertility that produced the smallest percentage increase in population in American history. After World War II, this generation went on to build an unprecedented level of sustained prosperity. It now moves toward retirement age with enormous financial assets. Sociologist Charles Longino has found that nearly 60% of retirees aged 55 to 64 and just over 50% of those aged 65 to 74 are financially comfortable. In addition, 12.3% of the younger group are the "pension elite," with income from three sources: Social Security, pensions, and assets (Longino, 1988, p. 23).

In contrast to that earlier generation, the "Baby Boom," which lasted from 1946–1958, produced the largest cohort in this country's history. In 1964, four out of ten Americans were baby boomers, and today, that generation is 75 million people strong (Longino, 1988).

Figure 1 shows the impact of cohort size on the future nursing home population. It makes two assumptions: (1) nursing homes serve those aged 80 years and older and (2) there will be no further increase in life expectancy. Figure 1B, which shows the population of nursing homes in the future, is divided into four time periods. The first, from the present to the year 2000, is termed *Before Chaos Erupts (BCE).* During this period, Jewish homes will be losing their immigrant cohort, as 1921 was the last year of large-scale immigration by European Jews. The second period, from 2000–2015, is *Chaos Erupts (CE).* The chaos will stem from two sources: the increased longevity and radically different

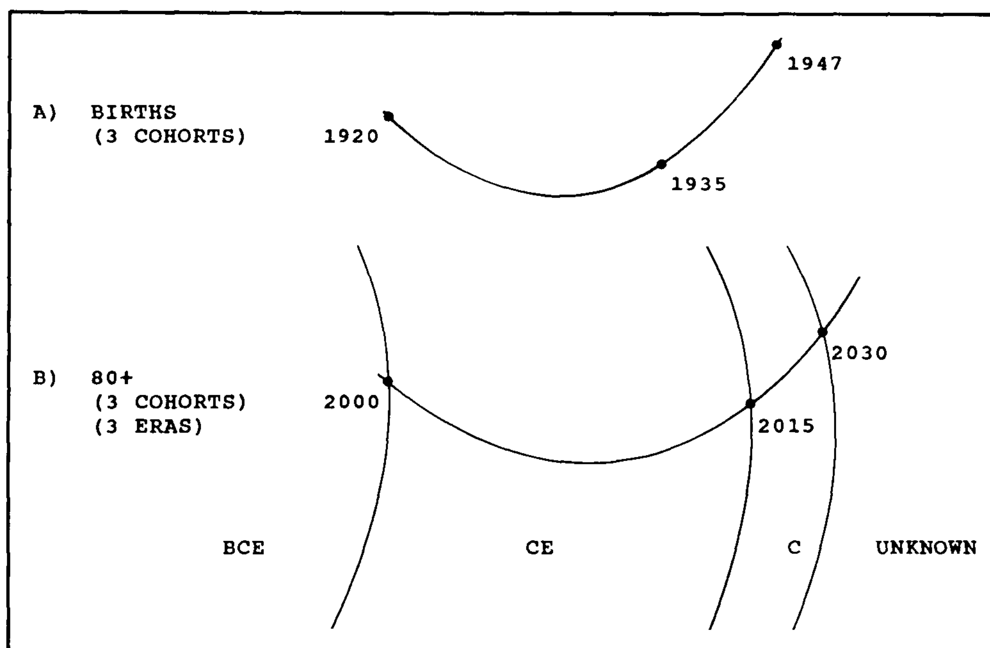

Figure 1. Impact of cohort size on the future nursing home population.

expectations of this American-born, well-educated, and financially comfortable generation. In the third period, from 2015–2030, occurs *Chaos (C),* which will be caused by the interaction of the heightened expectations with the increase in cohort size. The time after 2030, when the Baby Boomers will be requiring nursing home beds, can only be called *Unknown.*

Two other demographic issues are relevant to the future of the nursing home. First, the women's movement has dramatically changed the nature of the family and the workforce. Traditionally, it has been women—daughters and daughters-in-law—who have been the primary caregivers for the aged. Yet, recent surveys indicate that some 90% of women aged 18 to 49 are in the workforce (Jones, 1980). In our highly mobile society, fewer and fewer children live in the same community as their aging parents. Those women who do take on the obligation of caring for their parents form what is called the "sandwich" generation. Already beginning to suffer their own age-related decrements, these women in their forties to sixties are juggling demands of child care and working while simultaneously assuming the enormous burden of caring for their parents.

The other relevant demographic factor is the decrease in the number of births in the 1960s and 1970s, which has produced a much smaller cohort. This generation will live in the shadow of the Baby Boomers, whom they are destined to support in their twilight years (Naisbitt & Aburdene, 1986).

Nature of the Jewish Community

The interaction of several trends has made the universal problems of aging especially difficult for the Jewish community. As a result, Jews have a greater need for formal gerontological services than the general population.

Jews as a group are older than the general population for a number of reasons. Because of their high socioeconomic status, most Jews have had lifelong exposure to good nutritional and medical care and consequently have increased longevity. In addition, the Jewish population is not being replenished at a replacement rate. Fertility

is low because many young Jews seek advanced education and have career aspirations, thereby marrying late and producing fewer children. As a group, therefore, Jews have a high proportion of older to younger persons.

Another striking characteristic of the Jewish community is its upward mobility. Today, 41% of Jewish households have incomes of $50,000 or higher, which is four times the rate of the non-Hispanic white population (Dychtwald, 1989). Expectations have been heightened accordingly, both of the lifestyles to which Jews have become accustomed and the services that they demand.

The nature of Jewish identity is changing as we move toward the 21st century. The practice of formal religious rituals has declined, particularly among the Baby Boomers (Cohen, 1983). Yet, cultural identification and traits remain strong, as does the desire to associate with other Jews (Silberman, 1985). As noted by Patai, Jews continue to be characterized by "intensity, sensitivity, and impatience" (Patai, 1977, p. 405).

In order to thrive, Jewish facilities must deliver care that is responsive to these cultural characteristics. The observance of Kashrut and the provision of religious services will no longer suffice to attract Jews. Jewish clients will expect nothing less than a supportive environment that delivers a continuum of excellent psychosocial medical care.

Governmental Involvement

Historically, caring for the infirm, sick, and aged has been seen as a responsibility of the religious sector, not the government. This tradition shaped the American attitude toward care for the aged until 1935, when the economic and social order had so deteriorated that federal intervention was mandated in the form of the Social Security Act. The passage of Medicare in 1965 marked a further shift from the policy of minimal federal involvement in care for the aged. Since 1965, governmental involvement has grown by accretion around these two primary vehicles for intervention.

Clearly, today's fragmented structure of federal involvement is no longer responsive to the sheer numbers of elderly and the complexity of their needs. Yet, in our current political culture, it is unlikely that we can reasonably anticipate an integrated federal aging policy. As Hedrick Smith states in his recent book, *The Power Game* (1988), "One of the paramount problems facing American public life is the fragmentation of power. . . .Fragmentation often leaves our politicians wallowing in deadlock because the government lacks the cohesion to form durable coalitions needed to resolve the nation's most demanding problems."

One result of this fragmentation has been the increased role of the administrative branch of government. The burgeoning of administrative law is the most notable feature of post-World War II American public life. The legislative branch of government develops only the most rudimentary legal frameworks and thus delegates to the bureaucracy the task of translating often conflicting and vaguely written compromises into social policy. Policy therefore develops on a case-by-case precedential basis.

In recent years, administrative and bureaucratic policy has also been driven by the need to contain costs. The percentage of the gross national product (GNP) devoted to health care more than doubled between 1960 and 1983, when it reached 11%, and by the year 2000, it is projected that 15% of the GNP will be spent on health care. The huge cohort that will reach old age after the year 2000 will undoubtedly produce an even greater increase in health care costs.

Ironically, even while the bureaucracy attempts to reduce its financial responsibility for care, it has extended its jurisdiction and control over caregiving institutions. Administrative law is now dictating decisions formerly made by lay

boards and professionals in nonprofit nursing homes. For example, the new wave of Do Not Resuscitate (DNR) orders moves the family, physicians, and professionals from the role of decision makers to the role of enforcers of state procedures and regulations.

The most visible form of governmental involvement with nursing homes is the survey process. The survey is the periodic in-house review by state inspectors to assure that the nursing home is complying with government regulations. The adversarial, police-like posture taken by the government in this process is largely shaped by the widespread public perception of a predatory industry that needs close scrutiny. That perception is in large measure a product of nursing home scandals in the early 1970s.

This adversarial process creates a bureaucratic posture in which regulators attempt to maintain distance from the regulated. The government's goal is to develop a survey in which facts and statistics speak for themselves, yielding automatic verdicts and penalties and thereby avoiding the legal jeopardy of complex appeal processes.

There are a number of problems with this approach. First, the ripple effects of the regulations themselves are so complicated that they often require an interactive alliance between the nursing home industry and regulators to ensure that they operate for the good of the client, and this alliance is difficult to forge and maintain in an adversarial environment. Second, the multidisciplinary nature of chronic nursing home care does not make it amenable to a clear, statistical, formula-like reimbursement and regulatory system. Gerontological research has shown that the number of variables that influence the quality of care and of life—physical, psychological, nutritional, familial, etc.—are not easily reduced to a simple formula. The attempt to do so leads to an ongoing succession of reformulations and modifications. And each change creates a new cycle of turbulence and disruption in an already fragile system.

Governmental Challenges to Sectarian Facilities

Governmental support for programs that serve old people within unique religious and cultural milieus has become increasingly more difficult in today's complex regulated environment. The First Amendment itself is unclear on this subject. It states that "Congress shall make no law respecting an establishment of religion *or* (emphasis added) prohibiting the free exercise thereof." As a result, there are different bodies of precedents. On the one hand, the government desires that institutions be color-and creed-blind and have an absolutely democratic admission process. On the other hand, it wants each institution to meet the unique needs of its population.

The major bodies of First Amendment case law are actually a series of discrete structures sharing common themes but each taking its own shape from its particular legal terrain, i.e., welfare, busing, or education. Consequently, the Jewish nature of our homes is in constant jeopardy from interpretations in somewhat unrelated fields, the precedents of which threaten to "bleed through" and affect our ability to deliver Jewish programming in various aspects of our government-sponsored care delivery systems.

THEORETICAL MODEL

As we enter the 1990s, the Jewish nursing home is experiencing nothing less than a *Perestroika*, a fundamental restructuring. Everything is changing at once: the number of old people, the nature of Jewishness, the expectations and styles of new generations of the elderly, the foundations of reimbursement systems, government models and expectations, and the locus of control under an increasingly dense cross-hatching of bureaucratic regulations. The effects of all these changes are being accelerated and reshaped by advancements in technology. How can we find sufficient coherence in all this change to prepare for its effects?

A simple cause-and-effect model is inadequate. The challenge is to understand the multiplicity of interacting variables, the ramifications of which threaten to overwhelm our organizations and their administrators. In our organizations we are experiencing *multifactorial* changes. For example, a regulatory change requiring a change of procedure in one department of a facility will affect the work of many other departments. The interaction of the variables is often reflexive, meaning that a change in one component is itself affected by the change it has induced in other components. In other words, the ripple effects caused by one change not only affect other components but also return to affect and demand change of the original component. And in an environment of constant regulatory change, every department in a facility is likely to be in flux with ongoing changes interacting throughout the organization. Changes will have multiple effects; effects will have multiple causes.

Multifactorial analysis helps explain the complexity of the changes in our professional world. For example, changed career aspirations stimulated by the women's movement have led to a nursing shortage. Simultaneously higher governmental expectations and regulations (i.e., the number of tasks required to be performed in a given time period), combined with reimbursement systems that wring out much of the interpersonal pleasure that previously existed in nursing, have left nurses with a deadingly mechanical job and thus less satisfaction. The resulting burnout exacerbates both the difficulties of recruiting new nurses and attrition in the ranks of experienced nurses. Facilities are forced to use more nurses from outside agencies who have less commitment to the residents and less sense of responsibility, which translates into less organizational control. As a consequence, there is pressure to change regulations in order to allow persons with less training to deliver care—a relaxation in standards that has the direct opposite effect of what was originally intended. And the need to correct this unforeseen and unintended result, that of actually lowering standards of care, must be translated back to and through a governmental bureaucracy that is at once ponderous and suspicious of the regulated industry's motivation in recommending changes.

From a multifactorial analysis of these changes can be derived a model of the Jewish nursing home in the year 2000.

The New Resident

The new residents will be frailer, will have higher expectations of care, and will be desirous of more privacy, consistent with there pre-institutionalized lifestyles. In addition, the populations in the nursing home will be increasingly segmented. For example, Alzheimer's and other diseases and conditions will be broken into a number of different discrete diagnoses. Chronological age will become less relevant, and there will be a move toward services based on functional assessment of residents. And there will be constant, ongoing, unsatisfying recategorizations of populations upon which to measure and reimburse the residents.

Interventions

The traditional role of the professionally trained caregiver, the clinician, will change. The restrictive rules that have evolved around each separate discipline, effectively creating jealously guarded monopolies on procedures, will break down because of the shortage of allied health professionals and because mechanical, isolated skill roles for highly capable professionals will become too boring. Multidisciplinary skills and training will increase so that professionals will be better prepared to interact with other disciplines. And there will be a proliferation of modestly trained specialists working under the supervision of highly trained generalists.

We will also find more pockets of resident competencies, of heretofore untapped remaining abilities, which will result in more specialized interventions and even

greater differentiation among residents. And we will move beyond such anecdotal, descriptive models as disengagement theory and toward more analytic understandings of aging in our populations.

Finally, buildings will themselves become a form of intervention. With the increasing costs of labor (currently only 8 percent of the life-cycle cost of a building is start-up costs), we will design environments that will be expected to shape and facilitate the delivery of care in the facility.

Jewish Staff

There will be a thinner and thinner layer of Jewish staff to deliver services in the facility. Those now doing so must "age in place" because there will be few younger Jewish professionals to replace them. Organized in-service programs designed to upgrade the skills of these Jewish professionals will be critically needed.

Nursing Homes as Universities

The traditional education system has failed in its mission to train employees for our facilities. Twenty percent of the population does not acquire even basic skills (Workforce 2000, 1987). At a higher level, universities have been unable to train specialists with up-to-date practical tools for caring for older people. As a consequence, our facilities will be forced to develop, build upon, and supplement the skills of our staff.

Industry has already recognized a similar reality. Today, corporations are, in effect, creating an alternative to the nation's system of public and private schools, colleges, and universities. They spend nearly $60 billion a year on education and training, equivalent to the amount spent on education in the nation's four-year colleges (Naisbitt & Aburdene, 1986).

We can expect our staff members to be involved in a process of lifelong learning, with many eventually earning two and three advanced university degrees. Departments will be viewed as laboratories, and nursing homes will become applied research centers.

Work Expectations

The nursing home is an extremely labor-intensive environment. To a large degree, the culture of the home is dictated by the ideas, feelings, and expectations of its workforce. Education has changed people's expectations of work. The parents of the Baby Boomers made a bargain with society: during the week they worked obediently on the job so that on the weekend they could "be themselves" with their families and hobbies. They compartmentalized their lives in order to satisfy both the demands of society and their personal desires. The Baby Boom generation has very different expectations. They see no dichotomy between private and social values and have no intention of denying their real selves on the job. The purpose of the job, they argue, is *not* to meet their material needs, but to satisfy their emotional needs. Employers thus owe their employees not just a living but security and self-fulfillment as well. Employees have the "right" to participate in decisions that affect their lives. They want personal recognition, a chance to be heard, a chance to learn and grow.

These changed expectations of work as a source of emotional satisfaction come into conflict with the promotion squeeze. Because of their sheer numbers, there will not be enough room at the top for all the Baby Boomers, and many will be crowded on the first steps of management, forced to stay there. The frustration will be acute for many people with fast-track expectations. Baby Boomers will have to reconcile themselves to slower climbs toward the top. Greater emphasis will need to be placed on job rotations, lateral transfers, and "psychic benefits."

Management

John Scully, in his book *Odyssey,* suggests "that the basic corporate model, the one

we've followed for more than fifty years, may be outdated" (1987, p. 368). Using Alvin Toffler's *Third Wave* as a reference, he explains that "the source of strength in industrial-age (second wave) companies is stability. . . including their emphasis on title and ranks rather than on making a difference, on structure over flexibility, on putting the institution's needs before the individual's." In contrast, third-wave companies are "the emerging form, not only for high-tech companies, but for all institutions. Simply put, the source of their strength lies in change—in the ability to transform their products and organization in response to changes in the economy, in social habits, in consumer interest" (Scully, 1987, p. 368).

It is apparent that nursing homes' second-wave management arrangements are inadequate for a variety of reasons. The fluidity and rapid response time required to adapt and thrive in today's health care environment demand new patterns of managerial relationships. Hierarchical structures are breaking down because they slow the flow of information at a time when its velocity is increasing exponentially. Also, traditional superior/inferior relationships are increasingly ineffective and unsatisfying to the Baby Boom generation. Those organizations will grow that foster personal growth and satisfaction consistent with their expectations. The manager's role will become one of coach, teacher, and mentor.

Problem-Solving Techniques

Finally, to address the new problems, an organization's problem-solving techniques will have to change. The ripple effects from environmental changes will make it impossible to foresee and plan for all contingencies. Therefore, organizations will move away from ponderous hierarchies and toward models congenial to ongoing adaptation.

Individuals at all levels will be required to develop and maintain relationships with the regulatory octopus on different levels simultaneously. They must be able to isolate issues while continuing to appreciate their interrelatedness. They will simultaneously play the part of partner, adversary, regulated, and lobbyist. The successful employee will have bipolar clusters of skills: a mastery of intricate detailed regulations and the ability to conceptualize; the ability to anticipate and plan for ripple effect changes and to react to crisis; and the strength to maintain idealism while withstanding pressures that can easily lead to cynicism.

SUMMARY AND CONCLUSIONS

The central challenge for Jewish homes is to combine the seemingly disparate issues outlined in this article into an integrated whole. Only those nursing home organizations will survive that can create broad, flexible, conceptual frameworks that can respond effectively to their fragmented environments. Such organizations will be moving, evolving sets of resources that touch a number of communities simultaneously: the more frail resident, both the professional and the undereducated staff, the new family, new financial intermediaries, new governmental players and regulations, new technologies to be tamed and adopted, and the evolving educational world. They will develop new formats that will allow the Jews of past generations and the Baby Boomers to engage meaningfully.

The evolving responsive organization will no longer be the Jewish nursing home, at least in its familiar form. That model is an invention of the last quarter century; it has evolved into a tightly regulated structure in a level-of-care construct that itself is breaking apart. There are a variety of reasons for this breakup. First, there are simply too many different kinds of gerontological needs to fit into the financial cubbyholes developed for former generations of old people. Also, regulatory social engineering has enveloped the home in a web of conflicting, overlapping rules that make it virtually impossible for it to evolve naturally

in response to a changing community. For example, reimbursement systems demand that Jewish homes serve broader catchment populations beyond their traditional Jewish constituency in order to fill beds with clients who will maintain the home's financial integrity. The government's ambivalence about whether to support religious diversity/pluralism or absolute democratic access further restricts the home's ability to express the values of the Jewish community.

Finally, many in the next generation of aged Jews will simply reject the restrictions of today's institutions. They will want increased individualization, not the batch processing that is increasingly mandated. Indeed, despite policy statements to the contrary, the uniformity demanded by higher standards of quality of *care* often works at cross-purposes to, and is squeezing out, quality of *life*. And increasingly, Jews have the resources to find and select alternative settings. Simply stated, for the Jewish community, the stand-alone nursing home is a dinosaur. Even in small Jewish communities, the separate nursing home must create links to larger systems.

This is not to say that the Jewish nursing home is irrelevant and will fade away. To the contrary, the modern nursing home will act as a core of the Jewish system. Even if its percentage of Jewish residents declines, it will continue to be a reservoir of services for the Jewish community for four reasons. *First*, the nursing home is a model of gerontological services in their most concentrated form. Day care, home health, congregate housing, counseling, meal programs—all can be viewed as derivatives of or component aspects of the central core of nursing home services. The logic of building on that core is overwhelming. *Second*, the government, recognizing this fact, has decided to funnel its massive array of resources and available programs through nursing home conduits. Today, Jewish homes are a $1 billion industry, much of that from government funding. By the year 2000, that figure could well be $2 to $3 billion. *Third*, access to a nursing home is known to be critical to the viability of other associated aging service components. Older clients seek the continuity and assurance of a nursing home "system" that has helped their parents, friends, siblings, and spouses. And *fourth*, older Jews generally desire to spend their last years surrounded by members of their community and within the comfort of their own customs and beliefs.

The future of the Jewish nursing home may be more easily understood against the backdrop of our history over the past 80 to 100 years. Today we are in our third generation of "homes." The first homes built in the early part of this century were literally houses to feed, clothe, and shelter poor immigrants. The second generation, in the mid-1960s to mid-1980s, was the era of the modern nursing home, during which Jewish communities used government funds to build professionalized services. And in the third generation of homes, administrators must develop community systems.

Jewish communities must be in the gerontology business, not merely in geriatrics; involved in continuity, not merely illness and death. We must diversify into gerontological goods and services, whatever the locus. We must find ways of providing physical, financial, and social networks of aging services. And we must also re-establish our intimate relationship with Jewish communities, acting as vehicles for the integration and transmission of Jewish values and identity.

The following two recommendations are essential to understanding and accomplishing these tasks. *First*, we must move to stay in touch with our communities. Services must move from the core to the periphery—not only from nursing home to housing, but also from the city center to the suburbs. As cities grow in concentric circles, with young and upwardly mobile families moving out from the center, those young families will wish to locate their parents near them. They will

want upper-middle-class campuses. And despite the current methodologies and uncertainties of certificates-of-need, structures will be built to meet their needs, either by us or by others. The intermittent anti-institutional myopia and the single-minded rush to so-called alternatives to institutionalizations will abate. The numbers of persons over 85, labor shortages, and the still unrecognized costs and supervision problems with home services will result in additional nursing home construction. We must be prepared to avail ourselves of the opportunities to follow our communities. If we do not, we will lose them.

Second, we must evolve to meet the changing expectations of our communities. By the year 2000, the immigrant generation will have passed. The *American*-born "good times" generation reaching old age in the 1990s will demand an ambiance and level of services consistent with their pre-institutionalized middle-class lifestyles. And they will expect the Jewish community to maintain the continuity of that quality, even after support resources are depleted by sheer longevity and despite increasingly restrictive eligibility rules for government funding. The facility demanded by them will be radically different from the original poor house model. We have progressed from caring for "them" to caring for "us." And those heightened expectations will be absolute in future generations. The Baby Boom's early affluence has created what Daniel Yankelovich (1979) calls "the psychology of entitlement." What other generations have called privilege, the Baby Boomers call rights.

How do we address these challenges? Now that we are being weaned from governmental programs (or perhaps it is more accurate to say that they are becoming unreliable, inappropriate partners) we must look to our own resources. And the stakes in how we use them are nothing less than these—our own future selves; the last 5 to 10 years of our lives; who will control and guide our frail independent years; and who will create and protect our most private moments.

To whom do we entrust this future? To *the proprietary nursing home industry*, which is more interested in subsidiary ventures than in providing care? To a *government* that may be forced into rethinking one of humanity's oldest social contracts: the idea that the working generations will support the old and infirm? To *private insurance companies* that have as their primary goal portfolio growth for shareholders and who are constrained neither by discrimination laws nor even a theoretical accountability to the populace?

Or to tradition that has thrived for close to 6000 years: a tradition of caring for and suffering with one another. For ultimately we are a people. We cannot sell or assign our obligations to one another. We must accept the responsibility for caring for our own, for ourselves.

As Jewish communal leaders, it is our obligation to mobilize, to coalesce, to ignite, to help develop vehicles, and to provide the technical background for our communities' self-expression. We must invest in new physical plants and new systems that reflect the reality of modern America and the profile of a new generation of Jews, using a combination of new and old techniques. We must blend our business and financial acumen with our social conscience. We must overcome our own differences to attack the ravages of old age, of isolation, and fragmentation, both individually and as communities. We must come together and build our future, for aging is the American Jewish community's future.

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