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The Future of Jewish Long-Term Care Facilities

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Introduction

This paper will explore the history, current situation, and proposed future of Jewish long-term care facilities (hereupon LTCF) through the lens of the Jewish chaplains and CEOs of Jewish facilities across the United States. By exploring these professionals' thoughts on the future of their communities, I hope to gain a better understanding of how we as a Jewish community have taken care of the elderly historically, and what needs to happen in the future to continue such care. The questions will be asked: What does the future look like for Jewish LTCF? How will these facilities continue to survive and thrive in an ever-changing health care system?

Terminology

This paper uses terminology that may be unfamiliar or uncomfortable for readers. This section will list the terms used throughout the thesis along with explanations for why I have chosen to use such words.

Types of Care

Long-Term Care Facility: The National Institute of Health defines a LTCF as an organization that provides "a variety of services designed to meet a person's health or personal care needs during a short or long period of time. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own."[1]

I have chosen this term because it encompasses all the different programs and types of care that an organization may provide. Others may use the term Continuing Care Retirement Community (CCRC) interchangeably with LTCF. Historically, these facilities were given names like "Homes for the Aged" as in Cincinnati or "Homes for the Aged and Infirm" as in New York. These terms are outdated, as is referring to these facilities as "institutions." It is common to use the term "nursing home" to describe a LTCF, however, as will be described below, this is also

[1] https://www.nia.nih.gov/health/what-long-term-care

an outdated term.

Below are the explanations of the types of care that LTCF provide.

Skilled Care: Sheldon Tobin defines skilled care as "facilities [that] provide twenty-four hour care supervised by professionals, such as registered nurses, physical therapists, occupational therapists, and so forth."[2]

Skilled care units can be short-term or long-term. Short-term skilled care can also be called "rehab," because, depending on their insurance, stays at these facilities can be anywhere from a few weeks to a few months. People who need these services are often recovering from a surgery or traumatic injury or are transitioning into long-term skilled care and receive intense therapy during their stay. Long-term skilled care is what is commonly thought of when the term "nursing home" is used. "The typical nursing home resident is a person of advanced old age with extensive health problems. The average age of nursing home residents is now nearly eighty-five".[3] Many people who live in long-term skilled care facilities pay with private long-term insurance, or more commonly, Medicare and Medicaid.

Independent Living: These are apartments that are usually made for people over the age of 55. "[T]hey are often designed to be accessible and include transportation services. Many offer recreational and social services, too."[4] Those who choose to live in such a community do so for the socialization more than the health care provided.

Assisted Living: Like independent living communities, people who live in assisted living facilities are often independent but need more help with activities of daily living. "They offer meals, activities, housekeeping, transportation, and some level of security."[5] Like independent living, these facilities are

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[2] Tobin, Sheldon S., et al. *Enabling the Elderly: Religious Institutions within the Community Service System*. State University of New York Press, 1986. 98.
[3] Ibid.
[4] https://www.aarp.org/home-garden/housing/info-08-2009/ginzler_housing_choices.html
[5] Ibid.

generally paid for out-of-pocket.

Transitional Care: These units, often within a facility, "promote the safe and timely passage of patients between levels of health care and across care settings."[6] In other words, this type of care provides care to people and their families as they move from one type of care (e.g. short-term skilled care) to another type of care (e.g. long-term skilled care).

Adult Day Care Center: As their name implies, these centers provide care for seniors while their primary caregivers "go to work, handle personal business, or just relax while knowing their relative is well cared for and safe."[7]

> One type of adult day care center is called respite care. The National Institute of Health defines respite care as a program that "provides short-term relief for primary caregivers. It can be arranged for just an afternoon or for several days or weeks. Care can be provided at home, in a healthcare facility, or at an adult day center."[8] Most insurance plans do not cover day or respite care, meaning these services must be paid for out-of-pocket.

Elder Abuse Shelter: The National Center on Elder Abuse explains "that as many as two million elders are abused in the United States."[9] To protect the older adults who are experiencing such abuse, some LTCF provide shelters for victims of abuse.

Home Health Care: Health care services that are provided in the comfort of one's own home are often connected to a LTCF and are becoming more common. As medicare.gov explains, this type of care "is usually less expensive, more convenient, and just as effect as care you get in a hospital or skilled nursing facility."[10] These organizations will send nurses, aids and therapists to a person's home to provide the care. Insurance and Medicare or Medicaid can be used to pay for such services.

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[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2768550/
[7] https://eldercare.acl.gov/Public/Resources/Factsheets/Adult_Day_Care.aspx
[8] https://www.nia.nih.gov/health/caregiving
[9] https://ncea.acl.gov/
[10] https://www.medicare.gov/what-medicare-covers/whats-home-health-care

Hospice: This type of care is provided to any person "whose doctor believes he or she has 6 months or less to live if the illness runs its natural course."[11] All treatments fighting a disease are stopped and only measures for comfort are applied. Not only is support for the patient provided, but support for the family is built into the program. Many insurance plans cover hospice, as does Medicare.

> Similar to hospice is palliative care. This type of program allows the patient to continue receiving curative care, although the ultimate focus is on their comfort and that of their family. Staff from all areas of healthcare are involved in the care, even if the patient has not been told they will die within the next 6 months. Some insurance or Medicare plans will cover the cost of palliative care.[12]

Types of People Use Services

The terminology used regarding the people who use the services provided by Jewish LTCF has been an intentional choice throughout this project. Historically, people who lived in Jewish homes for the aged were called "inmates." For obvious reasons, this term is no longer used. Instead, people who live in LTCF are referred to as "residents." They are not patients, a term that is more appropriately applied to a hospital or hospice setting. They are also not clients, a term that ignores the intended homely feeling of living in a LTCF.

I have also chosen to use the term "elderly" or "senior" when referring to the people who choose to live in Jewish LTCF. These terms are the most common used when talking about the group of people over the age of 65, and especially over the age of 75. In a poll about most preferred language referenced by NPR expert on aging Ina Jaffe, "Older adults was the winner and it's the term you hear used most frequently. It's considered politically correct, but in a way I don't think it says very much. I mean, older than what? Seniors was tolerable; likewise for elders. Everything else - golden years, silvered tsunami,

[11] https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care#palliative-vs-hospice
[12] Ibid.

geriatrics - all of that, forget about it."[13] While I recognize that older adults may be "the winner," for sake of space and fluency, I have worked with the two terms mentioned above.

Methodology

The following chapters are based on interviews with chaplains and CEOs of Jewish LTCFs across the United States. Each person interviewed was asked questions regarding the mission of their facility, Jewish nature of that facility, its relationship with the larger Jewish community, and their thoughts on the future of their organization.

When I had completed the interviews, I organized the information gathered into categories including "mission," "relations with Jewish community," "relations with non-Jewish facilities," "make-up of the board," "funding," etc. These categories were the X-axis on a chart with the facility names as the Y-axis to allow for easier comparison between the organization and policies of each organization. Further research was conducted on the internet to determine location to each city's Jewish community. To research the history of Jewish homes, I referred almost exclusively to Edna Friedberg's 2007 dissertation entitled *Abandon us not in our old age: The Origins of American Jewish Residential Services for the Elderly.*[14]

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[13] https://www.npr.org/2016/02/06/465819152/times-have-changed-what-should-we-call-old-people

[14] Friedberg, Edna Sarah (Ph.D. 2007, Jewish Theological Seminary of America) *Abandon Us Not in Our Old Age: The Origins of American Jewish Residential Services for the Elderly* Adviser: Jack Wertheimer

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Chapter 1

Short History of Jewish Homes for the Aged

Introduction

The history of Jewish homes for the aged in America is one of continual transformation. The following chapter will explore the development of Jewish institutional care for the elderly, from homes for the aged poor to medical facilities for the aged sick. The early history of American Jewish homes for the aged is chronicled in Edna Friedberg's dissertation entitled *Abandon us not in our old age: The Origins of American Jewish Residential Services for the Elderly*. Friedberg researches American Jewish old age facilities from their earliest in 1870 to 1935, when the Social Security program was established, "which fundamentally changed the context of aging in America."[15] While Friedberg bases her research on six of the earliest American homes for the aged in Cincinnati, Philadelphia, New York, and Washington D.C., this chapter will focus on the conclusions derived by Friedberg from her study of these six homes. There are four main developmental periods of American homes for the aged: Charitable facilities as homes for the aged Jewish poor; professional facilities as homes for the aged Jewish sick; professional facilities for the aged poor of all faiths and incomes; and the current stage, which will be discussed in the conclusion, a shift toward a facility that serves people of all faiths, ages, and incomes. The first two stages will be outlined in this chapter. The third stage is where Jewish homes for the aged are currently residing, although, as will be discussed throughout this thesis, Jewish facilities for the aged are currently going through a transition into a fourth stage.[16]

Charitable Facilities as Homes for the Aged Jewish Poor

The history of Jewish care for the elderly begins in 1870 in New York City with the Home for the Aged

15 Friedberg, i.

16 These four stages have been developed by me based on my own research and that done by Edna Friedberg, as well as from interviews with chaplains and CEOs of Jewish LTCF across the country.

and Infirm Hebrews. This East Coast facility was the first stand-alone building dedicated to taking care of the Jewish elderly.[17] Jewish immigrants who came to America throughout the 19th century were almost exclusively young families, and thus, they did not have a need for such a home. In addition, as was common in the larger American culture, people would work as long as possible, often until they died. The low percentage of Jewish elderly in America and the fact that there was no concept of an 'active retirement' where people lived for many years in good health after their work ended meant that institutional care for the elderly was not needed until the mid-1800s.[18]

In these last years of the 19th century, Jewish homes for the aged were not medical facilities as we know nursing homes to be today. A different need was being served by these institutions – poverty. Homes for the aged in America during this time would actually turn away aged Jews who were suffering from illness. It was socially expected that if a person had children, it would be the children who would be responsible for the care of their aging parents. Those who did not have children were, in addition to those in extreme poverty, the targets of the first facilities for the aged.[19] Often, the homes for the aged had close connections to the local Jewish hospital, and it was the obligation of the hospital to take in the ailing elderly.[20]

The function of these early homes has had a profound effect on the expectations Jews have about nursing homes today. For one, there is often a negative stigma that comes with entering a nursing home. Friedberg attributes this negativity to the early connection between the homes and poverty or childlessness.[21] Entering a home was a last resort, when there was no other option. Friedberg also notes that when there were extra beds, the leaders of the homes would travel to the local poorhouse to bring the Jewish elderly to their facility. The poorhouses in America in the 19th century were open to anyone

17 Ibid., 2. Friebderg notes that the Philadelphia Jewish Hospital had beds set aside for Jewish elderly, but since it was not a stand-alone building, it is not considered the oldest home.
18 Ibid., 21, 45.
19 Ibid., 23, 38
20 Ibid., 24-25.
21 Ibid., 4.

who needed a temporary shelter, including the elderly, children, and alcoholics. The conditions were atrocious, yet as the number of Jewish elderly grew, so too did the poverty rates, and at the same time, the percentage of the Jewish aged in poorhouses.

One of the reasons that the number of people, including elderly, were inhabiting poorhouses was the economic depression of the post-Civil War era in the late 1870s. As more people needed financial help, the American philanthropic value of taking care of the less fortunate became more prominent around the United States. As Friedberg writes: "The first American Jewish old age home offered a self-conscious projection of their sponsors as socially progressive and compassionate in a new landscape."[22] Jewish communities wanted to be seen as American to their non-Jewish peers, and to do so, they needed to prove that they were just as charitable and philanthropic as their neighbors. The opening of the homes for the aged around the country were a result of this desire to fit in.

The earnestness to be accepted by the larger American community meant that when Jewish homes for the aged were first opened, there was a large amount of money available to take care of the poor elderly, and not as large of a need. Although the percentage of elderly in poorhouses increased, the number did not represent a majority of the Jewish elderly in America. Most Jews over the age of 65 were able to work or be taken care of by their family, as noted above. Thus, there was more money than need. For example, in the city of Cincinnati, there was enough money to sustain two Jewish homes for the aged, one affiliated with the Reform movement and one with Orthodox Jewry. These two homes existed more because of ideology than an actual need.[23] In 1920, Max Englander, author of *History of the Orthodox Jewish Home* wrote that: "The publicity of the building aroused opposition to the establishment of a Home for the Aged, on the ground that a Jewish Home for the Aged already existed with (with) a capacity of accomadating [sic] twice as many inmates [an outdated term to refer to

22 Ibid., 5.
23 Ibid., 21-22.

residents] as have thus far been accomadated. [sic].”[24] When the Orthodox home was opened, the other Jewish Home for the Aged was only half full. It was clear that the Jewish community of Cincinnati did not need another home, except for ideological and religious reasons. As will be discussed in further chapters, the Reform home of Cincinnati did not provide its inmates with kosher food. The Orthodox home was established to address the needs of the observant poor.

The large amount of money available was a result of the desire for Jews to be seen as sharing American values and the increased need for such services. With the funds available to provide room and board for many inmates, Jewish homes for the aged in America grew quickly. By the late 1800s, homes that had at one time housed less than ten residents were now home to hundreds. The new size of the homes helped bring the Jewish homes for the aged in America into the next stage of development.

Professional Facilities as Homes for the Aged Jewish Sick

When Jewish homes were first opened, the main requirement for admission was financial. Jewish elderly who were sick were not admitted and were instead sent to the hospital for care or were expected to be tended to by their family members. Only those who fell under a certain economic threshold were allowed to reside in the homes for the aged, which were first opened in the mid-1800s. Within a few years, especially after the economic depression of the late 1870s, the demand for these homes greatly increased. Other factors also contributed to this increase.

When the homes first founded, the inmates who used their services were poor and not sick. However, as time went on, and inmates continued to live out their lives in the home, they inevitably became older and sicker. The result was that homes, which were dedicated to taking care of the less fortunate elderly, were tasked with providing not only room and board for the inmates, but also medical care. In addition, the Jewish homes for the aged were originally intended for Jewish elderly who had no

24 *History of the Orthodox Jewish Home*, Cincinnati Ohio by M. Englander. AJA 5X-318.

children to take care of them in their old age. Yet some of the inhabitants of the homes did have family who were not willing or not able to take care of them. Friedberg cites one example given by the home in New York:

> There were several instances of elderly couples entering the B'nai Brith home [in New York]; after the death of the husband, the wife received a lifetime pension to which B'nai Brith members were entitled. Exploiting a loophole in the policy, some widows gave the pension money away to relatives, and remained in the home the rest of their lives, expecting the organization to even cover funeral expenses now that they had impoverished themselves.[25]

These situations remained the exception; most of the Jewish aged who used the services provided by the home were in fact childless and poor. However, as people learned how to take advantage of the home, the demand increased.

The increased number of Jewish elderly who wanted the services provided, and the aging and ailing of the long-term residents were factors in the facilities' need to change their mission to that of taking care of the poor *and* the sick. During their early history, leaders of these homes took pride in the care they gave to the indigent living under their roofs. As their charges got older and sicker, the mortality rate grew. In order to keep their homes as places to live and not to die, more time, staff, and money were directed toward healing their residents and extending their comfortable lives. The transition from homes for the poor to homes for the poor and sick was slow, and often the home's board was in denial of such a change. As Friedberg writes: "Despite protests to the contrary, the records of these facilities reveal a slow but unmistakable transition from sheltering homes to 'nursing homes.'"[26]

As the need for the Jewish elderly to receive medical care rose, so too did the cost to maintain the home. The boards of the homes under Friedberg's study desperately wanted to stay true to their mission of taking care of the Jewish indigent elderly. This meant remaining free of any necessary payment, either for admission or for the ongoing care. The mission was to be a literal "home," to be the

25 Friedberg, 76
26 Ibid., 103-104.

family that could take care of the elderly when biological relations could not. Boards did not want to accept any money from their charges, but "the increasingly poor medical state of new residents as the years went by made it impossible not to."[27]

The increased need for funding was paired with the expansion of local charities asking for money. Different charities across a city where these homes were located were competing for the limited amount of funds the members of the Jewish community were willing to donate. Friedberg spends a large portion of her dissertation describing the fundraising tactics of the facilities' leaders to guilt donors into giving their money to the homes instead of to other organizations. One tactic of the facilities was to use Judaism to inspire philanthropy. "Almost without exception, every Jewish residence for the aged invoked Psalms 71:9 to frame its mission and appeal to financial supporters: "Do not cast me off in my old age; when my strength fails, do not forsake me!"[28] This plea epitomized an image of these organizations as caring for an otherwise abandoned elderly in keeping with the Jewish religious and textual tradition."[29] Donors were asked to give money to the homes because it was a Jewish obligation, both religiously and socially, and if they did not give their donations, the Jewish elderly would be abandoned. And in a country that valued charitable giving, how could Jews not be a part of that? Homes also held fundraising events to solicit funds from members of the larger Jewish community, sometimes even on a weekly basis.[30]

The main funders, however, were not only individuals, but often organizations run by women, like benevolent societies or women's auxiliaries. In Cincinnati, the Orthodox Jewish Home for the Aged was established by the Somech Noflim Society, a Jewish chapter of the national Women's Benevolent Society.[31] These women saw a need that was not being met, kosher food for the residents,

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27 Ibid., 88.
28 *Tanakh The Holy Scriptures*. Jewish Pubn Society, 1985.
29 Ibid., 18.
30 Ibid., 233.
31 Englander. Somech Noflim is Hebrew for "Supporting the fallen."

and they gathered together the funds and resources necessary to take care of the Jewish elderly. These women were well known in the Jewish community, usually serving on many different boards around the city, and, perhaps most importantly for the home, they were "among the richest […] in their communities."[32]

As the residential homes slowly morphed into medical facilities, the management style also experienced a change. The homes were no longer places for Jewish elderly to enjoy their last days in a familial environment. Now, beginning in the late 1800s and early 1900s, as residents were getting older and sicker, medical staff needed to be hired, equipment had to be brought in, and a variety of other business decisions were being made to ensure the health and safety of the residents. This transformation brought with it a change in leadership. Executive boards that had once been predominantly female were now almost exclusively male, saturated with men from business backgrounds.[33]

The Introduction of the Federal Social Security Act of 1935

As Jewish and non-Jewish homes around the country became more professional, and the concept of active retirement became more prevalent, the federal government instituted the Social Security Act of 1935. This program was modeled after the 1862 Civil War Pension program, which had been modified in 1906 to include old-age benefits. The benefits provided by the Civil War program, however, were only available to veterans or their widows and orphans.

By 1934, after the Great Depression, "poverty among the elderly grew dramatically. The best estimates are that […] over half of the elderly in America lacked sufficient income to be self-supporting."[34] Due to these frightening statistics, individual states began implementing their own

32 Friedberg, 156-157.
33 Ibid., 199-201.
34 https://www.ssa.gov/history/briefhistory3.html

welfare systems. Unfortunately, these programs were largely ineffective for a myriad of reasons, including the stigma of being poor (a stigma that is also connected with the admission into homes for the aged), lack of follow-through with the local governments, and failure to opt-in by individual counties. The Social Security Administration's website explains that the Industrial Revolution, the urbanization of America, the appearance of the nuclear family, and an increase in life expectancy were all factors in the fragility of financial stability for elders over the age of 65 in America.

Before the formal Social Security program, a social insurance plan was implemented modeled after the European social insurance. “Insurance” was the term used because “that is precisely how the early social insurance theorists conceived of retirement, as producing a loss of income due to cessation of work activity.”[35]

Finally, in 1935, the Social Security Act was passed by President Franklin Roosevelt. The provisions of this bill that are relevant to this research include Title II benefits, where workers would pay into a fund during their working years which would then be distributed back to them when they went into retirement.[36] It would not be until 1940 when the monthly benefits payments began, although lump sums had been paid out to citizens who were old enough to be entitled to the program.[37]

In order for Jewish homes to be eligible to receive payment for the care of elderly from the Social Security program, major changes needed to be made to “their admissions requirements and other practices since the receipt of federal funds mandated non-discriminatory policies.”[38] Directors of Jewish homes for the aged around America were faced with the decision of remaining exclusively Jewish institutions or accepting funds that would address some of their financial instabilities. Every facility interviewed for this thesis and those researched by Friedberg accepted the funds offered by the

35 Ibid.
36 As an interesting sidenote, this is also the program that created Social Security numbers for residents of the United States.
37 Ibid.
38 Friedberg, 8.

federal program. Based on the amount of concern for financial survival and desperate fundraising described in Friedberg's dissertation, the additional funds were likely seen as a lifesaver, even if the exclusive Jewish atmosphere was compromised.

The change in the admissions policies of the facilities, while perhaps altering the demographics of the institution, did not have a profound effect on the definition of what made a Jewish home consider itself Jewish. As will be explored in the next chapter, the definition of being Jewish is not solely dependent upon the residents of the facility, but on a host of factors together creating a Jewish identity.

Conclusion

Jewish long term care facilities have experienced a long history of transformation. Beginning in 1870 with the first home for the aged in New York, Jewish homes were intended to be just that – homes. Housing less than ten inmates, early homes for the aged were surrogate families for Jewish indigent elderly who had no descendants to take care of them. Jewish aged with chronic illnesses were turned away and directed to the local Jewish hospital. As the inmates within the walls of the Jewish homes became older and sicker, the organizations run primarily by women and their benevolent societies offered their charges more medical care and longer term residences. Slowly, men with business backgrounds took over the management of the facilities as the number of elderly Jews in America increased significantly. By the time the federal Social Security Act was introduced in 1935, Jewish homes for the aged were struggling financially to survive while at the same time the cost of caring for the residents was significantly increasing. This program led Jewish facilities into their third developmental stage as professional facilities that serve the aged poor of all faiths and incomes. As will be discussed in further chapters, recent changes to the federal Social Security Act, including Medicare and Medicaid are leading to a transition into the fourth and most recent developmental stage, that of facilities that serves people of all faiths, ages, and incomes.

Chapter 2

What makes a Jewish Long-Term Care Facility Jewish?

Introduction

Every chaplain and CEO of the eight facilities interviewed were asked the following question: What makes a Jewish long-term care facility Jewish? The following list was given by the majority of these leaders: kosher food; the presence of Jewish culture around the building, including artwork and adherence to the Jewish calendar; the presence of Jewish clergy on site, and a mission that commits to taking care of people. The following chapter will explore these attributes as to what defines a long-term care facility as Jewish, and then conclude with a suggested working definition.

Jewish Facility as a Kosher Facility

For its entire history, starting in 1997, Cedar Village has been a kosher facility. The need for kashrut within the facility was part of the bylaws, and therefore could not be changed. Kashrut, then, was bound up with Cedar Village's identity as a Jewish institution. Prior to 1997, before Cedar Village came into existence, the city of Cincinnati had two Jewish LTCF, one that identified as an Orthodox institution and one connected to the Reform Movement. The Reform Home, often called Glen Manor, was not created to be a kosher institution. As Edna Friedberg explains, Glen Manor, which opened its doors in 1883, "was closely aligned with Reform Judaism's radical Pittsburgh Platform of 1885, including a repudiation of the dietary laws."[39] This means that from the moment the first tenant moved in, the facility was not kosher.

In addition, when the argument was made that a second Jewish LTCF needed to be opened in Cincinnati, the reason given was that "'[40] The old men and old women who have made so many

39 Friedberg, Edna Sarah. " 113.

40 *First Annual Report of the Orthodox Jewish Home for the Aged (Beit Moshav Zkenim)*. Cincinnati, OH, 1917. pp. 8-9. AJA Box X-318. Quoted in Friedberg, 113.

sacrifices throughout their lives for the sake of their convictions and religion must not be compelled to eat 'Terefo' [non-kosher food] in their last days.'" The officers of the Orthodox home were not arguing that a non-kosher facility was not Jewish, but that the facility was not Jewish *enough*. Both homes were considered Jewish facilities, even though one followed Jewish dietary laws and the other did not.
In 2018, Cedar Village was sold to a non-Jewish company. After much deliberation among the board of the home, it was decided that the facility would be partially kosher.[41]

Another home, Wexner Heritage Village in Columbus, Ohio, made the decision in the early 2000s to stop buying kosher meat for the long-term care and rehabilitation units due to the high cost of kashrut. The residents currently receive kosher-style meals, "meaning that they serve [...] meat not certified as kosher but [do] not serve dairy (to avoid mixing with meat) or any pork and shellfish products."[42] The reason given for the change in diet was budgetary. As the facility's chaplain, Rabbi Deborah Lefton noted, however, when the home's board was going through the budget to make necessary cuts, kashrut was the very last line-item to be touched. Wexner Heritage Village has previously relied on donors to contribute to the Kashrut Fund, and as these donors stopped funding the program, either because they left town, died, or decided to donate to other causes, the institution itself was tasked with finding the funds to provide kosher meals to its residents.[43] The cost outweighed the benefit of having a strictly kosher building, and the decision was made to make changes, especially since most of the patients on the rehab unit are not Jewish.

This decision created, as Rabbi Lefton notes, a war in the Jewish community of Columbus. In the 1940s and 1950s, the Columbus Jewish community, including the Jewish Federation, the Jewish Foundation (which together are now called Jewish Columbus), Jewish Family Services, the synagogues around the city and Wexner made a verbal agreement to keep all of their buildings kosher. Wexner was

41 See chapter 3, "Issues Facing Jewish LTCF" for more information about the future of Cedar Village's dietary plans.
42 Smith, Andrew F. *Savoring Gotham: a Food Lover's Companion to New York City*. Oxford University Press, 2016. 164.
43 Schapera, Samantha, and Rabbi Deborah Lefton. "Interview with Rabbi Deborah Lefton." 25 Oct. 2018.

the first among these institutions to break this agreement. In addition, the Orthodox community of Columbus boycotted Wexner and would not allow their Jewish elderly to live in the home. The reason given for the boycott was that it is forbidden to eat in a Jewish home that serves non-kosher food, but it is not forbidden to eat in a non-Jewish home that obviously has no obligation to serve kosher food. Note here, that the Orthodox argument is not that Wexner is not a Jewish facility, but that it is not Jewish *enough*.

Jewish Senior Life, the Jewish LTCF in Rochester, New York has also found a solution to balance the need of some Jews to follow Jewish dietary laws and the high cost of such a diet. According to the admissions application to the facility:

> "The Jewish Home of Rochester (JHR) adheres to kosher dietary laws and Passover dietary observance. Therefore, anyone admitted to the Tower 6th floor or Cottage 3 is informed of and agrees to comply with the laws of kashruth. Kosher meals served at the Jewish Home do not mix milk and meat at the same time. Pork, pork products, and shellfish are not served. Additionally, during the eight-day Passover holiday, only specially prepared kosher foods are served."[44]

Jewish Senior Life is currently in the process of creating "nine 'small homes' for long-term care residents."[45] according to former Director of Chaplaincy Rabbi Sandra Katz (now president of *Neshama*: Association of Jewish Chaplains), one of these communal living spaces will be kosher while the others will serve a kosher-style menu.[46] Once again, the home maintains its Jewish identity even though the entire campus will not be certified as kosher.

The Campus of Jewish Senior Living in San Francisco, California, in a similar way, has adopted a two-tier approach to kashrut. Residents, according to chaplain Rabbi Sheldon Marder, can choose between meals supervised by the vaad and the onsite rabbi, or the heritage dining program, which serves a kosher-style menu. The decision to move away from an entirely kosher campus to the two-

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44 https://jewishseniorlife.org/wp-content/uploads/2018/06/JHR-Application-Packet-JUNE_2018.pdf. 7.
45 https://jewishseniorlife.org/buildingforthefuture/
46 Schapera, Samantha, and Rabbi Sandra Katz. "Interview with Rabbi Sandra Katz." 26 Feb. 2018.

tiered system was made about ten years ago.[47]

In addition to the high cost of keeping a kosher facility, there is one other reason given for why Jewish facilities are moving away from a strictly kosher model. There is less of a desire now for kosher food than there was even a generation before. Rabbi Sandra Katz explained that often times, it is the children of the residents who make the final decision on where their aging parents will live.[48] For them, keeping kosher and other Jewish observances is less important than two other factors that will be discussed later – location and reputation. Rabbi Zlochower and Steelman agree. They claim that baby boomers (but certainly not the entire Baby Boomer generation) are generally less inclined to keep kosher due to the negative connection to an old-world shtetl mentality. Fewer residents desire kosher in their facility, a fact that is not unique to Abramson Center for Jewish Living, located in Philadelphia, Pennsylvania.[49]

As explained by Rabbi Lefton of Wexner Heritage Village, when there are so few residents who desire kosher, especially in rehab units where the vast majority of patients are not Jewish, it is difficult for a board to justify spending a large portion of their budget on a kosher facility. Many of the facilities interviewed, including Campus for Jewish Living, Cedar Village, and Menorah Park in Cleveland, Ohio have a minority of residents who require kosher food.[50]

Other homes interviewed for this research, including Menorah Manor in St. Petersburg, Florida, Daughters of Sarah in Albany, New York, and Abramson Center for Jewish Life in North Wales, Pennsylvania all have completely kosher facilities. These facilities are the only kosher LTCF in their area and understand their kashrut to be both an important part of their Jewish identity and a necessity

47 Schapera, Samantha and Rabbi Sheldon Marder. "Interview with Rabbi Sheldon Marder." 24 Oct. 2018.
48 "Interview with Rabbi Sandra Katz."
49 Schapera, Samantha, Rabbi Joshua Zlochower, and Rabbi Erica Steelman. "Interview with Rabbi Joshua Zlochower and Rabbi Erica Steelman." 13 Nov. 2018.
50 An interesting note about the decreasing need for kosher food is in the discussion of the extremely small percentage of Orthodox residents who live in the homes interviewed. While this is a topic for a different thesis and will not be explored at length here, it is interesting to note that most of the Jewish residents are from liberal denominations.

for the elderly Jews they serve and their families.

Kashrut is no doubt an important part of Jewish identity. I will argue, however, that kashrut does not make a Jewish identity, and therefore a Jewish facility does not require kosher food to be Jewish. Kashrut is part of the culture of a Jewish community, which will be explored in the next section of this chapter.

Jewish Facility as a Home for Jewish Culture

When each of the chaplains and CEOs of the various Jewish LTCFs were asked about what makes their facility Jewish, they all mentioned the importance of the presence of Jewish culture. For the sake of this thesis, the presence of Jewish culture includes the artwork on the walls and Jewish events. These Jewish events often involve music from the resident's time period or home country, and activities led by Jewish organizations around the city, such as Jewish day schools or synagogue sisterhoods.

The importance of these cultural events is related to what the leaders of the interviewed homes understand their role to be for the Jewish community. The administrator for Manorah Park in Cleveland, Ohio, Mr. Richard Schwalberg, repeatedly explained that when the board of the facility thinks about their future, they always keep in mind who they are serving (the resident) and their family.[51]

One of the ways that Mr. Schwalberg explained that both the Jewish residents and their families are served is through various partnerships that Menorah Park has with the local Jewish organizations, including synagogues and day schools that run programs based on education and intergenerational activities. He also notes that when a person walks around the building, Jewish culture is a visible part

51 Schapera, Samantha and Richard Schwalberg “Interview with Richard Schwalberg.” 19 April. 2018.

of the decoration of the home.

The chaplain and CEO of Daughters of Sarah in Albany, New York presented the Jewish culture in their home in similar terms with some added points. In addition to visits from local Jewish organizations and Jewish education, they explained that many of the Jewish elderly in Albany had grown up in Albany or lived there long enough to know many of the other residents from their previous lives. This extension of the Jewish community adds to the Jewish culture within the home.[52] The same is true for Abramson Center for Jewish Life in New Wales, a suburb of Philadelphia, Pennsylvania. And not only do the residents know each other from the larger Jewish community, but so do the volunteers who work within the organization and lead programs and fundraising. Their knowledge of both the Jewish community in the city and within the home itself lead to what the chaplains call an organic Jewish culture.[53] Cantor Lanie Katzew at Cedar Village in Cincinnati noted that in the day-long orientation for new staff members, she leads a section on Judaism and Jewish culture. This allows the non-Jews within the building, staff and residents, to understand and appreciate the uniqueness of Judaism and the present culture where they work and live.[54] When the entire staff, including volunteers, understand and appreciate the Jewish culture of an institution, Jewish elderly can feel safe and comfortable in the home.

When asked why their city needs a Jewish facility, every facility interviewed gave a version of the following answer: Aging Jews need a place where they do not have to explain themselves, where they feel comfortable being who they are with no fear of proselytizing and cared for by people who understand them and their culture.

While I agree that this must be a mission for all Jewish homes, I also argue that culture alone is

52 Schapera, Samantha, Rabbi Beverly Magidson, and Mark Koblenz. “Interview with Rabbi Beverly Magidson and Mark Koblenz.” 19 April 2018.
53 “Interview with Rabbi Joshua Zlochower and Rabbi Erica Steelman.”
54 Schapera, Samantha, Cantor Alane Katzew. “Interview with Cantor Lanie Katzew.” 2 Nov. 2018.

not enough to define a Jewish LTCF as Jewish. In many of the cities where the interviewed facilities are located, there are other institutions to which Jews flock. This is due to both location and reputation, as will be explored further in chapter 3. If the Jewish home is not located in the Jewish community, aging Jews, and as discussed by Rabbi Sandra Katz, their children, will be more likely to choose a home that is closer to where they live, even if the facility is not Jewish. A person who works all day is more likely to want to drive five minutes to a non-Jewish facility to see their parent than thirty minutes to a Jewish one. This is especially true if the reputation of the non-Jewish facility is equal to or better than the Jewish home, unless, of course, a family values Judaism far above location and reputation. In San Francisco, a Presbyterian home caters to many Jewish elderly, especially in independent and assisted living, since it will not be until 2019 when the Campus for Jewish Living will have its own independent and assisted living facilities.[55] (See chapter 4 on future plans for more information about these facilities, and the introduction for an explanation of the terms independent and assisted living). In Albany, where the Jewish community is so spread out that the Jewish home only serves one portion of the city, aging Jews may live in non-Jewish facilities that are around their area. To address the spread-out nature of the Jewish community, Daughters of Sarah receives the services of the community chaplain, who visiting three separate communities throughout the week. New Wales and Columbus also have incredibly diffuse Jewish populations.[56] In fact, in Columbus, there is a Lutheran home that has such a large Jewish community that they recently hired a full-time rabbi to serve in their institution.[57] Cincinnati is unique in this sense in that the Jewish home was built outside of the Jewish community, and there are a few non-Jewish facilities that serve a large Jewish population.[58] These non-Jewish facilities are currently being served by students at Hebrew Union College-Jewish Institute of

55 "Interview with Rabbi Sheldon Marder"
56 "Interview with Rabbi Joshua Zlochower and Rabbi Erica Steelman."
57 "Interview with Rabbi Deborah Lefton."
58 "Interview with Cantor Alane Katzew."

Religion[59]. They lead short services on Friday nights and visit with the Jewish elderly in those homes.

Non-Jewish facilities are certainly capable of creating an atmosphere of Jewish culture, especially if there is such a large population within them. The familiarity among the residents, the sensitivity training given to non-Jewish staff members, and the presence of Jewish clergy can all lead to a Jewish culture within a non-Jewish facility. The presence of Jewish clergy in Jewish homes will be discussed in the following section.

Jewish Home as Employer of Jewish Clergy

Every LTCF interviewed for this project had at least one Jewish clergy member on staff. Wexner Heritage Village in Columbus has one full-time rabbi and a part-time minister; Menorah Park in Cleveland employs four rabbis; Cedar Village in Cincinnati has one full-time cantor and one part-time rabbi; Ambramson Center for Jewish Living in New Wales employs 2 full-time rabbis; and Campus for Jewish Life in San Francisco has one full-time rabbi.[60] The exception to these full-time rabbis is at Daughters of Sarah in Albany. The Director of Chaplaincy for northeastern New York, Rabbi Beverly Magidson, is employed by the Jewish Federation of Northeastern New York and is contracted to visit Daughters of Sarah two full days a week. The other three days of the week, she visits Jewish residents living in other non-Jewish LTCFs around the district.[61] The "Jewish Federation Chaplain Services" information page explains what this position entails:

> We are an arm of the organized Jewish community that reaches out to Jewish residents of nursing homes and assisted living facilities in the greater Capital District, and surrounding counties. […] We have the support of the local congregational rabbis, community leaders, and Jewish Family Services of the Capital District, and work in cooperation with them.[62]

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59 This note is only in reference to the students studying at the historic Cincinnati campus.
60 Based on interviews with chaplains and CEOs of these facilities.
61 "Interview with Rabbi Beverly Magidson and Mark Koblenz"
62 https://www.jewishfedny.org/wp-content/uploads/2013/02/Chaplaincy-Services-brochure-101.pdf

The absence of a full-time rabbi employed by the facility itself is not an uncommon phenomenon in the history of LTCF. Edna Friedberg, whose dissertation focused on the history of six nursing homes in America prior to the 1930s writes that "of the six case studies under consideration, only the Philadelphia home [the nursing home working out of the Jewish Hospital Association of Philadelphia] employed a staff rabbi." And when he died in 1932, there is no evidence that another rabbi was hired.[63]

The reasons given for why the remaining five homes did not hire clergy included "a higher level of Jewish literacy on the part of the residents, enabling them to lead their own prayer services."[64] For the Orthodox home of Cincinnati (which would merge with the Reform home in 1997 to create Cedar Village), the residents seemed able to take care of their own religious needs. In New York City, The Home for Aged and Infirm Hebrews was visited by local rabbis who were affiliated with congregations of different denominations and communities. These visits allowed the home to "not hire a paid staff rabbi for another half century, relying instead (as did almost all homes of the era) on donated rabbinical services for both prayer and pastoral needs."[65]

The presence or absence of a Jewish clergy member serving as a chaplain in the Jewish home, therefore, cannot be an accurate indicator of whether a LTCF can be defined as Jewish. Historically, not all homes have employed rabbis, and some non-Jewish facilities have hired Jewish clergy without becoming Jewish institutions.

A Jewish Home with a Mission that Reflects Jewish Values

Taking care of the elderly is an ingrained Jewish value. From Torah to Midrash, Jews are told to take care of and honor the aging Jews in our society.[66] One of the most commonly referred to biblical

63 Friedberg, 134.
64 Ibid, 135.
65 Ibid. 137.
66 For examples, see Leviticus 19:32, Proverbs 16:31, and Midrash Leviticus Rabbah 35:3

passage is Psalm 71:9: "Do not cast me off in old age; when my strength fails, do not forsake me!"[67] In her history, Friedberg writes that "Almost without exception, every Jewish residence for the aged invoked Psalm 71:9 to frame its mission and appeal to financial supporters. This plea epitomized an image of these organizations as caring for an otherwise abandoned elderly in keeping with the Jewish religious and textual traditions."[68] Not only was the psalm a reflection of the values espoused by the facilities themselves, but also reflected the sensibilities of the larger Jewish community and the hope that the call would be a call to action, or at least financial giving.

A mission statement is defined in a text distributed by the University of Michigan: "A **mission statement** communicates the organization's reason for being, and how it aims to serve its key stakeholders. Customers, employees, and investors are the stakeholders most emphasized […] Sometimes mission statements also include a summation of the firm's values."[69] In other words, a mission statements informs both the organization itself and those who invest in the organization an idea of the values that are held. This is true for Jewish homes for the aged beginning in the late 19th century, and Jewish LTCF today.

The mission statement of every JLTCF interviewed (with the exception of two facilities) does in fact fit the definition provided by the University of Michigan. Each home's mission begins the intent to provide the aging population, which is not only a Jewish population, with safety, dignity, independence, excellence, compassion, connection to their community, and a partnership between the residents and their families. The statement often ends with a phrase akin to: "based on Jewish values and traditions." With the addition of this phrase, the reader of the mission understands that the values of the administration and staff will be molded by Judaism, whether or not they themselves are of the

67 *Tanakh The Holy Scriptures*. Jewish Pubn Society, 1985.
68 Friedberg, 18. Note that this is also the psalm Friedberg uses in the title of her dissertation.
69 https://open.lib.umn.edu/principlesmanagement/chapter/4-3-the-roles-of-mission-vision-and-values/. Bolding is theirs

Jewish faith.

Two exceptions are Menorah Park in Cleveland and Cedar Village in Cincinnati. When Mr. Schwalberg was interviewed in April of 2018, the mission statement of Menorah Park did not include any statement about Judaism. The reason for the absence of a statement of Jewish values was the ingrained assumption that Menorah Park was a Jewish place that lived out such values. Mr. Schwalberg did mention, however, that the mission statement was being revised. Upon viewing the Menorah Park website in November of 2018, the mission has been emended to include a clause that they are "guided by Jewish values."[70]

Cedar Village, on the other hand, used to have Jewish values in its mission statement. In the 2016 Employee Reference Guide, the vision (which I would suggest is mislabeled and should be their mission) is "Cedar Village provides residents of the Greater Cincinnati community with the highest quality of healthcare, senior residential and community services, in keeping with Jewish values."[71] When the facility was sold in 2018, their mission statement changed "To provide a community of services and support to adults and their families through all stages of aging guided by the values of compassion, caring, and respect."[72]

I provide these two missions in full to illustrate that they are not very different from each other. Other than the inclusion of "Jewish values," the two statements communicate the same message – this organization will take care of the elderly and their families and do so in a way that is warm and dignified. In fact, in 2017, then Cedar Village CEO Dan Fagin was interviewed by the CEO of the Jewish Federation of Cincinnati, Shep Englander. Englender asked what would happen to the mission of Cedar Village if, hypothetically, the business was sold (although we know now that this became the

70 https://www.menorahpark.org/about
71 Cedar Village 2016 Employee Reference Guide
72 https://cedarvillage.org/about/mission/

reality). Fagin's reply was:

> Our mission would remain largely unchanged. We will still be here to provide services for seniors, to support their families, their children as they age, and we will remain committed to the values that we hold dear today. So I don't think anything will change dramatically for our mission, it may just be that we pursue the delivery of that mission in a different way.[73]

Dan Fagin was not wrong. The mission did in fact "remain largely unchanged" but the avenue through which the goals are achieved is different, meaning not necessarily through Jewish values. "Providing services and support" and being "guided by the values of compassion, caring, and respect" are sentiments found in every other Jewish LTCF's mission statement. All Cedar Village's current mission is missing is the explicit phrase "guided by Jewish values."

My argument, then, is that having the phrase "Jewish values" in a mission statement is not enough to define a facility as Jewish or not, since Jewish values can be expressed with or without the word "Jewish." It was Dan Fagin who points out that it is not what the mission statement is, but how it is carried out that defines a Jewish home. And the people who decide how the mission will be carried out is the Board of Trustees. The members who make up that board, their Jewish values, and how they allow those values to be played out in the facility is, as I argue, what makes a Jewish home Jewish.

A Jewish Home has a Jewish Board of Trustees/Directors

Rabbi Sandra Katz, the president of *Neshama*: Association of Jewish Chaplains was hesitant to provide one definition to the question of what makes a Jewish LTCF Jewish. If we define it, she explained, that will become the minimum standard, and people will settle. Definitions can be dangerous. But if we need a definition, it needs to be flexible, adaptable, and in a framework that works with change.[74]

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73 https://blog.jewishcincinnati.org/se1-cedar-village-cant-stand-still-qa-ceo-dan-fagin/
74 "Interview with Rabbi Sandra Katz."

Every community is different and has different Jewish needs. Some communities need a completely kosher facility, and for others, kosher-style is the most appropriate for them, at least for that moment in time. Some communities need to work hard to create a culture that provides Jewish safety for the residents, and for others, the focus is on quality of care, or being in a advantageous location. Some communities hire one or more full-time Jewish clergy member, and some are able to rely on the larger community to provide for the religious and pastoral needs of the residents. And for some, the mission statement focuses on Judaism, and for others, the focus is on caring for the residents first. What brings each of these LTCF under the definition of "Jewish" is that these are all values of a Jewish board. It is the board that decides how their values are played out based on the needs of their specific community.

It is the board's job to look at big picture issues of the facility and make decisions based on their Jewish values. Their mission statement reminds them of that responsibility, but it is their decisions that make a facility Jewish. One requirement for a board, then, is that a majority of the members are Jewish. In many of the institutions interviewed, a majority of the board members are Jewish and are also involved in a myriad of Jewish organizations around their city. This is especially true in smaller cities, like Albany, where a few members of the Jewish community are on multiple boards. This allows them to see how the Jewish home interacts with the Jewish community as a whole.

As both Rabbi Deborah Lefton in Columbus and Mr. Richard Schwalberg in Cleveland note, however, an entirely Jewish board may not be logistically possible. There must be a variety of expertise on the board so that the Jewish values can be played out in the most effective way possible. In Columbus, some non-Jewish members of the board are experts in the medical field and real estate. It is the role of the Jewish members of the board to disseminate their contributions in a Jewish way.

One example of how the board makes decisions according to its Jewish values is in the budget. As explained in the section on kashrut, Rabbi Deborah Lefton in Columbus noted that when budget cuts had to be made, it was the board that decided to save kashrut for as long as possible. It was only at

the last minute, when the choice was between suffering a severe financial crisis or keeping kosher kitchens that the board made the decision to alter the home's dietary restrictions. And even then, it was the board who decided to keep kosher kitchens in the independent and assisted living areas while moving to kosher-style in skilled care units. The board valued kashrut and saw the needs of their community and thus made the tough decision that kept a necessary balance between survival and Judaism.[75]

Another example comes from the Campus for Jewish Living in San Francisco. This home, as will be discussed further in chapter 4 recently made renovations to their campus. When the architect was building the plans for the new building, he worked with rabbi Sheldon Marder so that the synagogue was in the center of the building. This synagogue also had the ability to be used as a social hall so that Jewish activities and classes could be held in this Jewish space. It was the board who saw and understood the Jewish needs of the community, a community of Jewish elderly who could not walk the entirety of the campus to attend worship services. And it was the board who valued having a social space dedicated to Judaism. Their Jewish values encouraged Rabbi Marder to work with the architect to create the best Jewish space for the residents on the Campus for Jewish Living.[76]

The last example to be discussed is Cedar Village. In June of 2018, the Jewish LTCF was sold and the current ownership requires some explanation. The facility sold to a for-profit organization called CarDon.[77] CarDon then contracted the ownership to a non-profit organization called Indiana Senior Housing Health Care Properties, or ISH.[78] Of the four members of the board, only one is Jewish, and he serves as the Jewish liaison, with the responsibility of advising the leadership of ISH of what it means for Cedar Village to serve Jewish residents. If this were the only board operating in Cedar

75 "Interview with Rabbi Deborah Lefton."
76 "Interview with Rabbi Sheldon Marder."
77 https://cedarvillage.org/about/cardon-associates/
The name CarDon is derived from the combination of the names of the two founders, Carroll and Donna.
78 https://cedarvillage.org/about/ish-senior-housing-services/

Village, I would argue that the Cincinnati LTCF can no longer be considered a Jewish facility. However, there is a second board that operates in the building. The previous owners of Cedar Village, Jewish Home of Cincinnati, Inc., continues to exist as a foundation of funds from the sale of the building. This money pays for the Jewish life in Cedar Village, including the salary of the chaplains. In other words, as Cantor Lanie Katzew explained, the board "orchestrate[s] the relationship between the Jewish mission and CarDon."[79] As I argue, if a Jewish board and the manifestation of its Jewish values make a LTCF Jewish, then Cedar Village, would qualify as a Jewish facility. There is a board made up a members who value Judaism and whose Jewish mission is expressed throughout the building.

Conclusion

In this chapter, I have explored four proposed definitions of a Jewish LTCF. These four expressions of Judaism – kosher kitchens, Jewish culture, Jewish clergy, and a mission of care – are all expected definitions of a Jewish home. However, the presence of these expressions in and of themselves are not what makes a Jewish home Jewish. These four, as well as many other aspects of Jewish homes that have not been discussed here, are manifestations of the values of the Jewish board members. Without their commitment to both the Jewish identity of the facility as well as its survival, the homes interviewed, along with the almost ninety other homes, would not be able to call themselves Jewish.

In the next chapter, I will explore the future of the homes studied based on interviews with their chaplains and CEOS. The future plans for these organizations are a direct result of the long hours and hard work of the homes' board of trustees or directors and the support they receive from the staff members and donors. I will also explore the current state of funding for LTCF from the United States.

79 "Interview with Cantor Alane Katzew."

Chapter 3

Issues Facing Jewish LTCF

Introduction

When looking to the future of their organization, chaplains and CEOs of Jewish LTCF across the country face issues that make the current mode of existing unsustainable. In this chapter, the issues of revenue will be discussed along with concerns about a rising trend of aging-in-place and the issues of reputation and location.

Issues of Revenue

The Jewish LTCF interviewed are all concerned about how they will financially be able to survive and thrive into the future. The main sources for outside funding come from Medicare, Medicaid, or MediCal in California. A brief synopsis of how these programs work and how the changes to reimbursement that every chaplain and CEO mentioned affect the facilities will follow. Also discussed will be the financial support that comes from that city's Jewish community. This chapter will end with an exploration into other avenues that Jewish LTCF take to fund themselves.

Funding from the Jewish Community

It is appropriate to expect the Jewish community to donate a large portion of the money available to them to the support of the poor and elderly. Jews are commanded throughout the Bible to take care of the poor, the widowed, and the orphaned.[80] However, when it comes to allocating funds for the stability of Jewish nursing homes and LTCF, very little money from Jewish Federations and Foundations of cities across the United States are directed to these facilities.

According to Edna Friedberg's dissertation on the history of Jewish nursing homes:

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80 For Biblical passages, see Exodus 22:22; Deuteronomy 10:18, 14:28-29, 24:19-21, 27:19; Isaiah 1:17; Jeremiah 22:3; Zecheriah 7:10

> Starting in the 1890s, a growing number of American Jewish communities established federated philanthropic groups. Each federation was an umbrella organization of local Jewish charitable bodies intended to centralize fundraising and reduce the number of duplicate or competing agencies.[81]

The homes that joined their local federation with the hope of financial stability and consolidation of fundraising were faced with an unexpected problem. Many were not allowed to do their own fundraising in order to avoid the possibility of donors giving twice to the same organization. The unintended outcome came when federations did not give enough money for the nursing homes to survive, and the homes were stuck in an agreement with the federations to not solicit more funding. Often times, as Friedberg illustrates in the case of The Philadelphia Jewish Federation, homes were given special permission to do their own non-federation fundraising when asking their current supporters to give more money ceased to be a viable option.[82]

Since the early 1900s, Jewish federations have gone through a great deal of change, and yet their basic goals remain in place today. According to a 2015 article published by the Jewish Telegraphic Agency, Jewish federations are still "centralized charities run by local Jewish communities around the United States. In each community, the federation raises money from local sources and then funds a variety of local, national and international needs – everything from elder housing for local Jews to Jewish identity programming in Russia to reinforcing bomb shelters in Israel."[83] In other words, Jewish federations do the fundraising and then allocate the raised money to a myriad of organizations in their communities and abroad.

Although "Many federations have been able to maintain or increase their fundraising," despite the actual number of donors decreasing, the chaplains and CEOs interviewed all stated that a very small portion of their budget comes from their Jewish Federation.[84] Mr. Schwalberg from Menorah Park in

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81 Friedberg, 234.
82 Ibid., 238-9
83 https://www.jta.org/2015/10/29/united-states/ahead-of-the-g-a-what-do-jewish-federations-actually-do
84 Ibid.

Cleveland did note that perhaps, the percentage of funding given may seem large from the perspective of the Federations. Upon examination of five federation annual reports, it seems that this is not actually the case.

It is common for federations to separate their local giving from their international giving. The total following percentages are derived from allocations directed toward local organizations only, unless otherwise noted. Out of the $16.6 million allocated by the Jewish Federation of Cleveland during the 2017-2018 fiscal year, a total of $428,235 was directed to Menorah Park.[85] This amounts to about 2% of the federation's yearly budget. Such a low percentage allocated to the Jewish LTCF of a city from the federation is not unique to the city of Cleveland. Jewish Columbus was created out of a merger of the Jewish Federation and Jewish Foundation of Columbus. $1.8 million is allocated to twelve local organizations, of which Wexner Heritage Village receives the fourth largest amount at $278,775, a whopping 15% of the budget.[86] Fifteen percent is also the largest allocation of funds given to any Jewish LTCF studied by far. Only Jewish Senior Life comes close to allocations received by Wexner. This New York facility is allocated 7% of the Jewish Federation of Greater Rochester's funds, a total of $73,404.[87] It should be noted that the $1 million of allocation from which the 7% is derived does not include grants, and the Jewish Senior Life Foundation also receives an annual grant of $79,211from the Jewish Federation of Greater Rochester. In Albany, the Jewish Federation of Northeastern New York's annual report does not present their allocations by individual organization, but by category of giving. There are 46 organizations, of which Daughters of Sarah is included, that receive 23% of the federation's $915,000.[88] Also noted in a financial audit is that the Jewish Federation of Northeastern New York leases land owned by Daughters of Sarah for $25,000 a year.[89]

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85 http://www.jewishcleveland.org/news/blog/federation_allocates_33M/
86 https://jewishcolumbus.org/community-investments-2/
87 https://cdn.fedweb.org/fed-6/2/jfgr%2520ar%252014-15%25208.pdf?v=1540414292
An additional $79,211 is given as a grant to Jewish Senior Life Foundation.
88 https://www.jewishfedny.org/wp-content/uploads/2013/02/2017-Annual-Report_web.pdf. Pg. 3.
89 https://www.jewishfedny.org/wp-content/uploads/2018/05/2017-Financial-audit.pdf. Pg. 14

The final annual report explored is from the Jewish Federation of Cincinnati.[90] In 2018, the Cincinnati federation was able to allocate the largest amount of funds out of all five federations researched - $2.8 million. And yet, Cedar Village received the lowest allocation, a total of $26,750. At first glance, this may seem disheartening, but upon further inspection of the annual report, a different picture is painted of Cincinnati. The Jewish Federation of Cincinnati allocates a total of $682,900, almost 24% of their annual budget, to various senior services around the city. These services are comprised of programs, mainly through the Cincinnati Jewish Community Center, that serve home-bound elderly.

The Jewish Federation of Cincinnati's tendency to allocate more money to Jews aging-in-place than to Cedar Village shows the trend that is typical among cities across the United States. Elderly Americans are more often choosing to age-in-place for as long as possible instead of moving into LTCF. One important factor that leads to this decision is the ramifications from the process of applying for Medicare and Medicaid, or MediCal in California. The reimbursement program is ever changing and also instills concern among the chaplains and CEOs interviewed.

Funding from Medicare and Medicaid

Every chaplain and CEO interviewed discussed the concerns their facility is facing as a result of the changes to how LTCF are reimbursed from these government programs. In nursing homes (i.e. the area of LTCF which provide skilled care on a long term or permament basis), there are two types of care provided – skilled care and custodial care.[91] Skilled care is any medically necessary care that a trained professional must provide because a resident is unable to provide that care for themselves, such as

90 https://jewishcincinnati.org/impact-local-allocations
Note that in 2019, while many senior services provided through the JCC are still funded, Cedar Village no longer receives funding from the Jewish Federation of Cincinnati.

91 Note that this conversation is about skilled long-term care, or care in a nursing home. Medicare and some of Medicaid cannot generally not be applied to independent or assisted living facilities.

changing a wound dressing or putting in an IV. “Custodial care” on the other hand, “means help with daily living activities, such as eating, getting in and out of bed, washing and bathing, going to the toilet and moving around.”[92] Medicare, a federal government funded program for seniors over the age of 65, only pays for skilled care. This means that the resident and their families must find an alternative source of payment for the home. Alternative sources include private long-term insurance used as a supplement to Medicare, or Medicaid, the federal and state funded program that helps people with low income. Without these supplements, a resident would have to pay for custodial care out of their own pocket. The amount that Medicare and Medicaid pay to the homes is called reimbursement.[93]

The restrictions of reimbursement set by Medicare lead to two phenomena that make long-term skilled nursing a poor source of revenue for LTCF. The first issue that arises is the amount of hurdles a family must overcome in order to qualify for both Medicare and Medicaid. A person becomes eligible for the Medicaid program only after they have run out of private insurance and when they no longer have enough savings to pay out of pocket for their room and care in the facility. Each state has different requirements for how many remaining assets a person must have before becoming eligible.[94] Medicare, however, allows for easier eligibility. The United States Department of Health and Human Services explains that anyone is “eligible for premium-free Part A [insurance that covers hospitals, hospice, and LTC] if you are age 65 or older and you and your spouse worked and paid Medicare taxes for at least 10 years.”[95] The requirements set by Medicare and Medicaid make it more likely that a new resident will have Medicare when they first arrive at a LTCF. If, however, a person is uneligible or unwilling to apply for Medicaid, and they cannot afford to pay the custodial costs of the facility out of pocket or with their insurance, the argument for aging-in-place becomes stronger and more attractive.

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92 https://www.aarp.org/health/medicare-insurance/info-03-2009/ask_ms__medicare_8.html

93 Note that the information provided here about Medicare and Medicaid represents only a small portion of very complicated programs. More information can be found on the aarp website, medicare.gov and medicaid.gov.

94 https://www.aarp.org/health/medicare-insurance/info-09-2010/ask_ms_medicare_question_89.html

95 https://www.hhs.gov/answers/medicare-and-medicaid/who-is-elibible-for-medicare/index.html

The second concern that comes along with residents who are covered by Medicare and Medicaid is that facilities may have to swallow some of the costs that are not covered by the programs or that the residents do not pay. For example, Medicaid will assess a person's financial eligibility by examining their financial history of up to five years. “If they find one [a financial record] that falls outside the rules your Medicaid coverage for nursing home care would be delayed by a certain length of time.”[96] This means that although a facility may receive payment for their services through Medicare, they will lose out on the bulk of the payment when Medicaid is delayed. If this is the case, a facility will eventually need to make the difficult decision to ask a resident to leave, a decision that goes against the Jewish command “to not cast the aging off in their old age.”[97][98] The choice really is about ensuring the survival of the facility in order to serve the elderly for many years to come, or serving poor elderly now who cannot pay and thus remaining unsure about the future of the home.

The two issues surrounding Medicare and Medicaid reimbursement for individuals and facilities explains why all of the chaplains and CEOs interviewed expressed concerns for the future financial stability of their institution. Finding a balance between surviving as a business and fulfilling the Jewish expectation of taking care of the elderly in the community is a source of great stress and fear for facilities across the country.

Due to the complexities of Medicare and Medicaid for both families and facilities, LTCF would prefer residents who pay with private insurance or out of pocket. As noted in footnote 11, Medicare and Medicaid generally do not pay for independent or assisted living. When a person moves into such a

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96 https://www.aarp.org/health/medicare-insurance/info-09-2010/ask_ms_medicare_question_89.html
The example given by the author is a house gifted to family or friends for $250,000. If the cost to live in the facility is $5,000 per month, the coverage provided by Medicaid is delayed for 50 months (250,000/5,000). A facility then expects a resident to find a way to pay the difference until Medicaid coverage begins. This rule applies for any asset that is transferred to another person within the five years before the application is made.

97 Based on Psalm 91:7

98 A 2018 court case in Illinois (none of the LTCF interviewed for this thesis are located in Illinois) brought to light the problems that Medicaid delays cause LTCF. Illinois ruled in April that seniors would be able to sue the state for being over-zealous in their coverage delays and hurting both the elderly and the facilities that are meant to take care of them.
https://blog.levinperconti.com/illinois-seniors-can-sue-state-over-medicaid-delays/
http://chronicleillinois.com/state-news/medicaid-payment-delays-hurt-nursing-homes-patients/

community, they are expected to pay for the services the facility provides with private insurance or out of their savings. It is for this reason, as will be discussed further in chapter 4, that facilities like the San Fracisco Center for Jewish Living has decided to open independent and assisted living.

Other Avenues for Revenue

The leaders interviewed for this study noted that reimbursements from government programs were the main source of income for their facilities. However, these programs along with the funds provided by the Jewish community federations are not enough to ensure the survival of the LTCF. Not only are the amounts not sufficient, they are unstable sources of income. This was experienced first-hand by the Campus for Jewish Living. Rabbi Marder remembered when California withdrew from the Medicaid program. Many organizations around the state were in danger of closing due to lack of funds. After these varied organizations came together and lobbied the state government, the bill ab97 was passed, creating a program called MediCal. While MediCal stabilized the income of institutions around California like the Center for Jewish Living, the traumatic process left the facility scarred and taught them a great lesson – it is impossible to rely on one source of revenue.[99] Not only is this lesson true for LTCFs in California, organizations across the United States cannot rely on one source of revenue.

Other sources include endowment funds or private foundations, and these funds are provided by donors targeted through fundraising campaigns. Lastly, many facilities are expanding the types of care they provide to the community, both Jewish and non-Jewish. Diversification of services means there are more avenues for revenue and a lesser reliance on one large source of income. The necessity for diversification will be discussed more extensively in chapter 4, along with the strategic plans that Jewish facilities across the United States are working on in order to survive as successful Jewish LTCFs.

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99 "Interview with Rabbi Sheldon Marder."

Issues of Location and Reputation

Throughout the interviews conducted with chaplains and CEOs of Jewish LTCF, two factors were repeatedly noted as concerns for residents and their families when choosing a facility. The first is location. Children of elderly would prefer their parents to live in facilities that are close to where they live, even if the home is not Jewish. After a long day of work, it is more convenient for a person to drive five minutes to a non-Jewish facility than thirty minutes to a Jewish home.

The second factor is reputation. If a non-Jewish facility has a better reputation than a Jewish facility, a family will be more likely to choose the non-Jewish location because they trust that their parent will receive better care. In order to attract Jewish elderly from their community, a Jewish facility must ensure they provide great care for the residents and their families and thus, word of mouth gives them a positive reputation and be cognizant of their physical location when compared to the larger Jewish community.

Location

The San Francisco Jewish community is spread throughout the Bay Area. In a study released by the Jewish Community Federation of San Francisco published in 2018 on Jewish San Francisco's dispersion and affiliation, it was found that only 17% of Jews live in San Francisco proper while the majority live in the East Bay and in the Peninsula or South Bay (35% and 34% respectively). The other consolidated Jewish communities have access to closer homes, such as Jewish Senior Living Group in Palo Alto (located in the Peninsula and close to the South Bay).

Not only is the Campus for Jewish Living across the bay from the larger Jewish communities, San Francisco also has a much younger Jewish population when compared to other American Jewish communities. Only 2% of Jews in the Greater San Francisco area are over the age of 80, while 24% are

between the ages of 18-29.[100] This data reveals that the Campus for Jewish Living was intended to serve a population that is now too young to use the services, and too far for them to be useful. For this San Francisco Jewish home, it is most beneficial for them to facilitate services which appeal a wider range of ages as well as add assisted living facilities for younger residents.

Cedar Village in Cincinnati, Ohio is not located in close proximity to the city's condensed Jewish community. The facility is located in the Cincinnati suburb of Mason, Ohio. From the largest section of the Jewish community, Cedar Village is located about twenty minutes north. According to city-data.com, which uses information from the 2010 US Religion Census, in Hamilton County, where the largest Cincinnati Jewish community is located, there are 10,829 Jews.[101] In Warren County, however, where Cedar Village is located, there are only 68 Jews listed.[102] From what we know about the importance of location, Jews are more likely to choose a home for their parents that is closer to where they live than to choose a faith-based facility. With this in mind, it becomes clear that Cincinnati Jewish elderly are more likely to live in non-Jewish homes with sizable Jewish communities in locations closer to their own homes or the homes of their children.[103]

Likewise in Columbus, Ohio, location is a key factor in the planning of Wexner's future. Currently, Wexner's facility is located on a campus that also houses the Jewish Community Center and Jewish Columbus (a joint organization of the Jewish Federation and Foundation). However, as Rabbi Lefton pointed out, the Columbus Jewish community is dispersing.[104] Wexner is located in the Bexley area, where 21% of all Jews in Columbus live. Of this 21%, 21% of that are over the age of 65. The next largest Jewish community is in the Downtown/University area, but only 7% of these Jews are over

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100 https://www.jweekly.com/2018/02/13/first-ever-survey-entire-bay-area-paints-portrait-jewish-life/

101 http://www.city-data.com/county/religion/Hamilton-County-OH.html
The data is collected from the Reform, Conservative, and Orthodox communities.

102 http://www.city-data.com/county/religion/Warren-County-OH.html
The only denomination listed in this census is the Reconstructionist Movement. Jews in both Hamilton and Warren Counties make up less than 1% of the population.

103 Note that the Jewish Federation and Foundation of Cincinnati are planning a Cincinnati Jewish Community Study to take place in early 2019.

104 Ibid.

the age 65.[105] 28% of Jews living in the East area of Columbus are in this demographic, the largest percentage out of all four areas studied.[106] One of the plans for Wexner's future is to open up another campus. The new campus, understandably, will be located in New Albany, a city within the East area.

The community in Albany is spread throughout Northeastern New York, so spread out, in fact, that there are two Jewish Community Centers for the area which span four separate Jewish communities. Daughters of Sarah is the only Jewish LTCF in Northeastern New York and is located in Albany County. From the information collected in the "2010 Capital Region Jewish Community Survey" funded by the Jewish Federation of Northeastern New York, 60% of Jews in Northeastern New York live in Albany County.[107] While the survey did not break down age demographics by geography, researchers found that 39% of Northeastern New York residents were over the age of 65 in 2010, and the median age was 60.[108] This shows that while Albany county has the largest Jewish community, the majority of the population does not yet need the services that Daughters of Sarah provides. In addition, the Jewish community is certainly not limited to Albany County, and aging Jews in other areas are more likely to live in non-Jewish facilities that are closer to their homes and families. This is why Rabbi Magidson and her colleagues are community rabbis and thus do not only work for Daughters of Sarah.[109] The need for Jewish pastoral care for the elderly expands far and beyond the one Jewish facility.

Reaching out to the Jewish elderly who are aging-in-place may not be as difficult for Menorah Park as it is for a city like Albany. Even though the Cleveland Jewish community is much larger than

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105 Due to the presence of Ohio State University, 52% of Jews living in Downtown/University are between the ages of 18-44. It makes sense that there would be a small percentage of Jews over the age of 65 in this location.

106 https://www.jewishdatabank.org/content/upload/bjdb/2013_Portrait_of_Jewish_Columbus_April_21_Slide_set_updated.pdf. Pg 23.
The fourth area studied is called "Perimeter North."

107 https://www.jewishfedny.org/wp-content/uploads/2013/02/2010-Capital-Region-Jewish-Community-Survey-Final-Report.pdf. Pg. 186. Note that the survey conducted was by phone and online. The results regarding "county of residence" were from a subsample of the phone interviews. Only 178 respondents were included in these results even though 306 interviews were done over the phone and another 180 were completed online.

108 Ibid. 184.

109 https://www.jewishfedny.org/wp-content/uploads/2013/02/Chaplaincy-Services-brochure-101.pdf

Northeastern New York, Cleveland's Jews are much less spread out, as illustrated in the "2011 Greater Cleveland Jewish Population Study."[110] Menorah Park's main campus is located in the East Side Suburbs. In 2011, there were about 5,300 Jewish people living in this area of Cleveland. However, Menorah Park is located on the border of Beachwood and the Northern Heights, which each have a Jewish population of over 10,000.[111] Even though none of these areas are where the densely packed Jewish community is located, in The Heights, Menorah Park is situated only five miles from this consolidated Jewish area. The closeness of Menorah Park to the large Cleveland Jewish community helps the facility attract elderly Jews throughout the city.

Reputation

One primary factor to be considered in terms of reputation is the non-profit status of all of the Jewish LTCF studied. Being non-profit means that "no part of the organization's income is distributed to its members, directors, or officers."[112] Any money the facilities receive from the residents goes directly toward their care and none of the money pays for staffing. In an article published by The Center for Medicare Advocacy, studies comparing the reputation of for-profit facilities was compared with the reputation of non-profit facilities are compiled.

> A review and meta-analysis of 82 studies comparing quality of care in for-profit and not-for-profit nursing facilities reported that nearly all the studies found higher quality, higher staffing, and fewer pressure sores in non-for-profit facilities.[113][114]

Simply by being non-profit organizations, the Jewish LTCF studied have better reputations than their for-profit counterparts.

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110 https://www.jewishdatabank.org/content/upload/bjdb/2011_Cleve-Federation-Community_Slide_Presentation.pdf. Pg. 14.
111 Ibid, 16
112 https://www.law.cornell.edu/wex/non-profit_organizations
113 http://www.medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care/
114 "Bedsores — also called pressure ulcers and decubitus ulcers — are injuries to skin and underlying tissue resulting from prolonged pressure on the skin."
https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893

Vincent Mor of Brown University published an article entitled "Improving the Quality of Long-Term Care with Better Information." In his article, Mor explores how LTCF are rated, as well as the benefits and challenges to these rating systems. Official quality reports are based on "individual data [that] come from clinical assessments of patients that are recorded and then computerized," and are collected by the Centers for Medicare and Medicaid Services.[115] In other words, these "quality" reports are actually quantitative. These records are also varied by state and closely connected to reports that Medicaid receives and then uses to help determine a person's eligibility for coverage.[116] These reports are not anecdotal and do not comment on personal experiences or quality of life, forcing potential residents and their families to rely on reputation to make their decision about which nursing home is best for their family. In addition, as Mor notes, not only is word of mouth an important factor in creating a reputation, LTCF also need to be on hospital's preferred provider lists. Mor notes that the creators of these lists called "discharge planners might be the most important audience" for the quality reports. Relying on word of mouth and hospitals to get new long-term residents means LTCF must work to create an environment where elderly Jews want to age and at the same time create and maintain strong relationships with hospitals.

Conclusion

Issues of funding have played a critical role in the decisions that boards of Jewish LTCF must make for the survival of their institutions. Changes to the social security program, specifically Medicare, Medicaid, and MediCal have made it more difficult for residents and their families to receive aid for

115 Mor, Vincent. "Improving the Quality of Long-Term Care with Better Information." The Milbank Quarterly, vol. 83, no. 3, 2005, 337, 336.

116 Ibid., 342. To illustrate this point, Mor gives the example of discharge rates. Discharges are seen as a positive, and homes are given a review on how many discharges they have each year. If the Medicaid program in one state is more willing to pay for a resident's transfer to a hospital when they are sick, the home's rating in regards to discharges may be high, even though in reality they are sending more people to the hospital. Medicaid in another state, however, may not pay for transportation, and homes in that state may have a lower rating in regards to discharge even if they have fewer sicker residents or are able to provide their own residents with the care they need.

care. These changes have also meant facilities receive fewer reimbursements from these programs. Additionally, as religion becomes less of a motivating factor for people as they choose the most appropriate facility, location and reputation have grown in importance. Facilities with high ratings that are located closer to the Jewish community are more likely to be utilized by Jewish elderly and their families. All of these factors together, along with the greater tendency for people to choose to age-in-place has meant that Jewish LTCF must find new and innovative ways to create revenue and survive. As these facilities transition into their new stage, they are moving away from the post-1935 model of serving the elderly and sick of all faiths and into serving people of all faiths and all ages.

Chapter 4

The Future of Jewish LTCF

Introduction

As discussed in chapter 3, financial insecurity due to changes in the health care system and new decisions made in regards to aging-in-place, Jewish LTCF across the nations have had to make difficult decisions about how to survive in the future. One major decision made by the boards of the facilities interviewed has been to reduce the number of beds available in long-term skilled nursing, or the nursing home section of the facility. There is a general decreased need for these beds, and the residents who come in are older and sicker. An older and sicker resident often comes with Medicare and Medicaid, programs which, as discussed in chapter 3, are not profitable for LTCF.

In addition to a lowered availability of healthcare beds, many facilities are also choosing to diversify the services offered. While each community is shaped differently and has different needs, the necessity of diversification is present among every facility interviewed, except, as will be discussed, Cedar Village in Cincinnati. The most common solution has been to expand assisted and independent living. These types of care are primarily utilized by residents who can pay out-of-pocket from which facilities are able to make a profit. Satellite locations closer to the Jewish community have also been opened. These locations offer specialized care, such as brain health, therapy, and home health. Once again, patients who utilize these services use their private insurance and allow the facility to have a better sense of financial security for their future.

In the chapter below, I will outline the strategic plans of the facilities interviewed. Some facilities are already implementing the plans their boards have spent years developing while others are in the midst of their strategic planning. There are chaplains and CEOs interviewed who have discussed their thoughts about the future, but their boards have not yet come to a decision about what the future

will look like.

Diversification is Key

Eight Jewish LTCF were interviewed for this project, and all were asked what the future of their organization looks like. Every chaplain and CEO responded that their homes are in the midst of strategic planning or are carrying out those plans throughout 2018 and 2019. Two of the largest factors that play into what the strategic plans look like is location and reputation.[117]

For Rabbi Sandra Katz, the current president of *Neshama*: Association of Jewish Chaplains and former Director of Chaplaincy at Jewish Senior Life, the concern about the future is religious. She sees the necessity of creating a Jewish home that the Rochester Jewish community is proud to pass down to the next generation. This includes innovations in worship, for example, and adding a PowerPoint presentation for the residents who cannot hold a book in their hands or read the small, or even large printed, prayer books.[118]

Other leaders answered the question about their institution's future with the survival of their home in mind. The Campus for Jewish Living in San Francisco is in the midst of a major construction project. According to their website, this construction is expected to cost $140 million. The goal of this reconstruction, however, is not to increase the number of beds on the campus. In fact, the number of beds in the skilled nursing section is decreasing from 430 to 260 long term skilled care and 100 rehab beds. What is increasing, however, are the number of services provided by the campus. The current facility has rooms for rehab care and skilled nursing. Until now, the Campus for Jewish Living has not had any assisted living or memory care units and Jewish residents have had to choose other, non-Jewish

117 See Chapter 3 for more information on the impact location and reputation have on those who choose LTCF.
118 “Interview with Rabbi Sandra Katz.”

institutions for this type of care. Now, patients and residents from San Francisco and the surrounding areas will be able to come to the Campus for Jewish Living for these services.[119] Rabbi Sheldon Marder explained that even though the new facility is still under construction, outreach efforts have shown that there is a great interest in the types of care that will be offered. But there is much more to this California home's plan.

As discussed in the previous chapter on how homes are funded, the state of California withdrew from the Medicaid program. As Medicaid was one of the largest sources of income for the Campus for Jewish Living, there resulted a terrible financial crisis. Soon, California created its own program called MediCal. This move away from the health care program and then back into a new iteration left California LTCF, including Campus for Jewish Living concerned about the fragility of that particular source of financial support. In both Rabbi Sheldon Marder's terms, and that of the current CEO Daniel Ruth, there is a need to diversify funds.[120] As Mr. Ruth explains:

> When I started with the Jewish Home 15 years ago, we were one of the largest Medicaid skilled nursing providers in North America – 90 percent of our funding came from Medicaid/Medi-Cal. By having all of our eggs in one basket, it was very difficult to withstand funding or policy changes. We had to diversify. Now we'll have six or seven different services and product lines, which reduces our reliance on Medicaid-funded programs.[121]

With the addition of assisted living and memory care units, more residents will be paying for their care with Medicare or private insurance.

The Campus for Jewish Living is also expanding its horizons to the larger San Francisco community. On the campus, there will be a square, called Byer Square. The goal, explains Rabbi Sheldon Marder, is to create a social and virtual community center.[122] On this square will be a health clinic, caregiver support, educational programs, as well as "online and in-home services." Diversifying means providing more services to more people and relying on varied sources of income through these

119 https://sfcjl.org/about-bold-vision.htm
120 "Interview with Rabbi Sheldon Marder."
121 https://sfcjl.org/about-bold-vision.htm
122 "Interview with Rabbi Sheldon Marder."

programs. These varied services do not only serve the Jewish community, but also the larger non-Jewish San Francisco population. Mr. Ruth comments:

> We're genetically encoded with the Jewish communtiy [and] We're not isolationists; we're curious about taking on world issues. Our mission statement is to enrich the lives of older adults – it doesn't say Jewish older adults. We're part of a broader world. By contributing programs, services, research, and funding to broader world solutions, we believe that ultimately benefits the Jewish community and beyond.[123]

Back in the Midwest, Cantor Lanie Katzew is also watching as Cedar Village in Cincinnati puts its strategic planning into action. As discussed in chapter 2, after years of financial insecurity, the board of Cedar Village made the difficult decision to sell the building and the business to a non-Jewish company. Through months of negotiations, the boards of CarDon and The Jewish Home of Cincinnati are hard at work creating a stable and Jewish home for their Jewish and non-Jewish residents.

Along with the change in ownership, Cedar Village has also made some alterations to the types of care provided. The home health services are under the auspices of the Jewish Home of Cincinnati in collaboration with the Village Home, a skilled hospice program. This sector of the home has increased while the overall census of the rehab units has dropped. Cantor Lanie Katzew attributes this to the difficulty in handling the changes to healthcare policies, as discussed in chapter 3.

Unlike the homes in San Francisco and Cincinnati, Wexner Heritage Village in Columbus has not yet begun to implement their strategic plan. When I interviewed Rabbi Deborah Lefton on October 25, 2018, the board was in the process of creating a plan for the future. Within a 90 day time frame of our interview, Wexner's board was expected to have a plan to stabilize the facility, secure their medical reputation, and create stronger partnerships with the Jewish community, including reinstating a completely kosher facility. This would be a short-term plan, and out of this plan would come a longer-term five year community plan. This leg of the strategic planning would include creating goals for fundraising, renovations for their building which is need of repairs, and creating a facility that

123 https://sfcjl.org/about-bold-vision.htm

meets the needs of the current Jewish population. Rabbi Lefton explained that in previous years, the Columbus LTCF used to be a social hub, a place where Jews throughout the community would gather and spend time together. A few factors have led to the cessation of this culture, including the need to remove the facility's kosher certification and the spreading out of the larger Jewish community. The hope is to reestablish this Jewish climate for the community, perhaps even holding concerts and opening up a kosher restaurant.[124]

The need to expand services into the cities where the Jews are now living is also being experienced by Rabbis Joshua Zlochower and Erica Steelman. The Abramson Center for Jewish Life is in the process of a complete rebranding; they are working on a new website and at the time of our interview, there was a new mission statement that had not yet been released to the public. The future will no longer be completely focused on the 370-bed skilled LTCF. It should be noted here, however, that the campus itself, which contains the nursing home, assisted living, dialysis, rehab, and hospice units, will remain largely the same. They will remain a kosher facility with two chaplains who provide pastoral care, Jewish programming and worship services. The campus will also retain the Judaism in its name – Abramson Center for Jewish Life. The changes come with the addition of service lines. Service lines are branch locations that serve the needs of the community in areas other than the main campus. The three services provided will be home health care, primary care offices, transitional care, and the Healthy Brain and Memory Center. While these service lines will not have the word “Jewish” in their names – they will be under the name of Abramson Senior Care – they are still associated with the Jewish facility. Rabbis Zlochower and Steelman noted that the reason for these new service lines is two-fold. First, the reputation of the Abramson Center for Jewish Life was so good that people wanted more services to be offered by them. Secondly, the facility wanted to serve the Jewish community which, as was discussed in the previous chapter, is not where the main campus is currently located.[125]

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124 “Interview with Rabbi Deborah Lefton.”
125 “Interview with Rabbi Joshua Zlochower and Rabbi Erica Steelman.”

The main campus of the Abramson Center for Jewish Living is located in the far northern part of Philadelphia, about an hour from the city's downtown. The Jewish community, however, has moved south and west of the facility. According to the "2009 Jewish Population Study of Greater Philadelphia," Montgomery and Philadelphia Counties have the largest Jewish populations in Greater Philadelphia.[126] While both the main campus and the main service line are located in Montgomery County, the service line – which holds the primary care offices, and The Healthy Brain and Memory Center – is almost an hour south of the main campus and twice as close to downtown Philadelphia where the younger and wealthier Jews are living."[127] This will ensure that these Jews will be able to utilize the services provided by the Abramson Center.

For The Campus of Jewish Living, Wexner Heritage Village, and the Ambramson Center for Jewish Living, diversification is the best way to survive; diversification in both their funding as explained in chapter 3 and in partnerships with Jewish and medical facilities. The board of Cedar Village decided that selling was the only way for the Cincinnati facility to protect its Jewish residents and its place in the Jewish community. For them, selling was a way to diversify leadership – one board for building and operating management, and one for Jewish identity.[128]

Diversification in partnerships with other institutions in the area is also an important goal for Daughters of Sarah in Albany and Menorah Park in Cleveland. Partnerships with medical facilities means being put on preferred provider lists. When a patient is in a hospital and cannot return home, either temporarily or permanently, the hospital will give the patient and their family a list of short-term and long-term skilled nursing facilities in the area. That list is made up of facilities that have a good working relationship with the hospital. It is obviously much better for a LTCF to be on a list than off, and creating and maintaining those relationships is imperative for LTCF to attract new patients. These

126 https://www.jewishdatabank.org/content/upload/bjdb/556/C-PA-Philadelphia-2009-Summary_Report_Slides.pdf. pg. 9.
127 "Interview with Rabbi Joshua Zlochower and Rabbi Erica Steelman."
128 See Chapter 2 for more information about the sale and leadership of Cedar Village.

relationships are made even more important given the fact that when patients first transition into nursing homes, they usually have private insurance or they pay out-of-pocket before they apply for Medicare or Medicaid.[129]

In Albany, these relationships are disappearing as hospitals begin to centralize care. Centralizing care means a hospital provides a rehab unit, nursing home, primary care, home health, transportation, and some hospitals are even forming their own insurance companies. With these changes, the opportunity to be on a preferred provider list shrinks for LTCF in the area. The unit that is not available in these hospitals is assisted living. Thus, when thinking about the future, Daughters of Sarah may need to expand assisted living and rehab in order to survive far into the future.[130]

Mr. Richard Schwalberg at Menorah Park also noted the importance of creating partnerships with local hospitals. And as mentioned in other interviews, diversification is also the key to survival. In the interview conducted in April of 2018, Mr. Schwalberg noted the already diverse services the campus provides, including independent living, two separate assisted living buildings, a nursing home, home health, outpatient services, a senior center, an adult day care, pharmacy, ambulance services, and aquatic therapy which serves a couple hundred people a week. Even with the diverse services offered, Menorah Park is continually thinking about how to how to offset the money lost from government reimbursement programs. The board of Menorah Park is thinking about "tele-medicine," or a "nursing home without wall."[131] As Mr. Schwalberg explained the future of nursing homes will be fewer beds with sicker and older residents and there will have to be a larger focus on Jews who are aging-in-place.[132] Menorah Park has, in fact, already started the process of diversifying its location, and has done so by opening brain health and aquatic therapy centers.

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129 See Chapter 3 for more information about the difference in private insurance and Medicare/Medicaid for LTCF.
130 "Interview with Rabbi Beverly Magidson and Mr. Mark Koblenz."
131 "Interview with Mr. Richard Schwalberg."
132 Ibid.

Conclusion

Every facility interviewed has a different solution to the larger problem of financial insecurity caused by the issues discussed in the previous chapter. There is not yet a precedent set for the best practice regarding LTCF in general and Jewish in particular. While each facility has had to learn how to diversify, what that diversification of services looks like is different for every community. As the healthcare system continues to change along with reimbursement policies for Medicare, Medicaid and MediCal, Jewish LTCF will need to continue adapting to find the best way to both meet the needs of the elderly in their cities and to find enough sources of revenue to survive the unknowns of the future.

This adaptation is a result of the movement into the fourth stage of the historical development of Jewish LTCF. The first stage began with the opening of the first Jewish home for the aged in New York City in 1870. These homes were meant to serve the Jewish elderly who were experiencing poverty because they either could not work, or they had no children to take care of them. As the people living in these homes grew older and sicker, the boards of these organizations, often women's benevolent societies or auxiliaries, were compelled to hire trained medical staff to help people remain healthy and alive. With the implementation of the 1935 Social Security Act, Jewish LTCF were suddenly forced to accept people of all religions in order to receive government funding. The boards transitioned into groups of men with business backgrounds, and the facilities became more professionalized. These are the homes that have continued into the most recent decade. However, changes to the healthcare system and religious affiliation have caused the elderly and their families to choose alternative sources of care for their later years. To compensate for the decrease in revenue, Jewish LTCF must think about ways to serve the Jewish community at the same time as providing themselves financial stability. The way to do this is through diversification. By diversifying the services provided as well as the people to whom the services are directed, Jewish LTCF can continue their

mission of caring for the Jewish elderly in the best way while also remaining financially secure into the future. The mission remains the same, but the avenues through which that mission is achieved continually changes as time progresses into the future.

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