2019 Community Health Needs Assessment and Implementation Plan

Hebrew Rehabilitation Center
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Boston, MA 02131

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Executive Summary

Hebrew Rehabilitation Center (HRC), a teaching affiliate of Harvard Medical School, is a licensed chronic care hospital that offers geriatric specialty care that meets the chronic and acute medical needs of older adult patients in a therapeutic and healing environment. Founded with the promise to honor our elders, for more than 116 years we have served seniors’ health care needs in several communities within the city of Boston, and more recently, in the towns of Dedham, Needham, Wellesley, Weston, and Westwood.

We know first-hand the health challenges of older populations. The senior community continues to be the fastest growing population segment in Massachusetts. Approximately one in four households has at least one person 65 years old or older.

At HRC, it is our priority to keep seniors healthy and safe in their homes, until a choice is made that a more advanced level of care may provide a better life. From outpatient memory care assessments to caregiver training sessions, we educate seniors and their families on the necessary steps and care needed to remain independent.

As the flagship health care provider of Hebrew SeniorLife, a Harvard Medical School affiliate and nationally known senior services leader that provides communities and health care for seniors, research into aging, and education for geriatric care providers, HRC is a leader in advancing health care for seniors and delivering high quality, evidence-based senior care and wellness.

This 2019 Community Health Needs Assessment (CHNA) and Implementation Plan provides a comprehensive review of unmet health needs of the HRC community, including negative health impacts of social and environmental conditions. The CHNA Committee analyzed community input, available public health data, and an inventory of existing programs. Additionally, this year, HRC also took part in the first ever Boston CHNA-CHIP Collaborative, a group initiative to develop a Boston-wide CHNA and Community Health Improvement Plan (CHIP). Initiative members include hospitals, health centers, community organizations, the Boston Public Health Commission, and others, all working together for sustainable change in the health of the residents of Boston. Key learnings and research from our participation in the CHNA-CHIP Collaborative factored in prominently in the HRC CHNA and related Implementation Plan.

HRC is focused on the Attorney General’s (AG) efforts to support health care reform, reduce barriers to access, improve quality, and reduce costs in health care for patients of the HRC community.

We considered four focus areas as identified in 2017 by the Executive Office of Health and Human Services (EOHHS) and the Department of Public Health (DPH) including:

- Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes
- Housing Stability/Homelessness
- Mental Illness and Mental Health
- Substance Use Disorders

We agree with the AG that racism and institutional bias impact health outcomes, both through their influence on the social determinants of health and also as an independent factor affecting health.
Our CHNA findings show that seniors in our communities need assistance with the following:

- **Access to Geriatric Specialists and Services:**
  - Access to Various Geriatric Specialists
  - Transportation
- **Behavioral Health**
  - Outpatient Alzheimer’s Care
  - Mental Health and Depression Services
- **Financial Security**
  - Prevention of Elder Abuse and Neglect
  - Financial Assistance Programs
- **Housing Affordability**
  - Supportive Senior Living with Affordable Services
- **Closing Racial and Ethnic Disparities that Exist in Health Care**
  - Addressing Linguistic and Cultural Barriers

In response to these findings, HRC developed the included Implementation Plan which documents goals, current services, and action plans.

We thank members of the HRC community for their helpful guidance and input in compiling this 2019 CHNA. We look forward to your joining us on this journey to redefine the experience of aging and our mission to deliver health care in new ways to meet the needs of today’s seniors and those to come. We invite you to become involved by exploring ways to volunteer at HRC – on your own schedule, days, evenings, and weekends. No matter how much time you have to give, you will make a difference! Through our robust [volunteer program](#), you will receive on-the-job training and supervision, and an opportunity to belong to a wonderful group of caring people.
Chapter 1: Introduction

About Hebrew Rehabilitation Center

At HRC, our approach to care is grounded in the belief that the quality of an individual's life is not defined by functional ability, but by the environment that responds to his or her needs and aspirations. HRC’s services, which include long-term chronic care, medically acute care, post-acute care, and outpatient services, reflect the best options possible to meet any given individual's goals for care. Our staff members provide medical and psychosocial care that encourages involvement from patients and families in the decision-making process. We strive to create the best living environments for patients, promote wellness, and establish caring practices that provide a personal, nurturing touch. We are proud of again earning in 2019 the Five-Star rating from the Centers for Medicare & Medicaid Services (CMS). CMS created the Five-Star Quality Rating System to help consumers compare facilities more easily, with Five-Star organizations considered to have much above average quality than those with Four Stars or less.

Led by Helen Chen, M.D., Chief Medical Officer, the Department of Medicine at HRC is committed to ensuring all older patients receive compassionate, individualized, and dignified care from qualified professionals, and that this goal can best be achieved in an atmosphere that is respectful and collegial, and supports a broad range of activities and in which excellence is paramount.

In addition to physicians, our care team of nurses, therapists, social workers, and chaplains provide in-patient post-acute and long-term chronic care, and to seniors in the community—adult day health care, outpatient specialty care, and geriatric primary care. Our care team also teaches students, professionals, and families who seek geriatric expertise, undertaking research in health care services and clinical geriatrics and serving as advocates for older patients.

The Patient & Family Advisory Council is a group of engaged family members and staff that meets on a regular basis for the purpose of supporting and enhancing the care at HRC. New members are always welcome to join. For more information, including receiving the Patient & Family Advisory Council report, please contact evoneychung@hsli.harvard.edu.

Our Partners

The oft-heard phrase, “It takes a village,” extends to the care and wellness of our seniors. At HRC, our physicians, other clinicians, and staff advance the standard of health care for seniors through innovative and specialized geriatrics expertise. We are proud of our relationships with a number of preferred provider partners that lead to improved health and quality of life for seniors. Together we are creating opportunities to provide the highest standards of clinical care for our mutual patients. Extending beyond our affiliation with Harvard Medical School and into the community, we are preferred providers for the Beth Israel Deaconess Medical Center and the New England Baptist Hospital, now part of Beth Israel Lahey Health established in March 2019. These reciprocal relationships ensure that patients within our care have access to top quality acute- and specialty care facilities any time they are needed.
Why a Community Health Needs Assessment?

HRC conducted this CHNA in alignment with the AG’s efforts to support health care reform, reduce barriers to access, improve quality, and reduce costs in health care for HRC patients.

In order to identify the needs of the region, we compiled and analyzed data about our service area, demographics, social and economic factors, and access to health care. This assessment is aligned with the federal Patient Protection and Affordable Care Act (PPACA) that calls for private, nonprofit hospitals to conduct community health needs assessments once every three years and to develop implementation strategies to meet the community health needs identified through the process.

A CHNA is a disciplined approach to collecting, analyzing, and using data to identify barriers to the health and well-being of patients and communities. HRC is committed to addressing the needs of the seniors in our community and helping them manage and maintain their health at every stage of their lives, and we evaluated community health needs in 2013 and 2016 prior to this 2019 update.

This year and for the first time, the major acute hospitals and health partners within the city of Boston collaborated on a joint, participatory CHNA and CHIP to address the top priority issues and identify opportunities for shared investment in Boston.

The Boston CHNA-CHIP Collaborative has a compelling mission: Achieve sustainable positive change in the health of Boston by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. We are an active participant and member of the Boston CHNA-CHIP Collaborative, and our insights contributed to both the Boston CHNA-CHIP as well as the HRC CHNA, and vice versa.

In addition to leveraging the gathering and analysis of key community data publicly available, we took an active role in the fielding of the Boston CHNA community survey. This Boston CHNA data gathering included a review of existing social, economic, and health data from other sources; interviews with organizational and community leaders across sectors, including representatives from housing, transportation, faith community, education, public health, and health care; organizations that work with specific populations; focus groups with community members not typically represented in these processes (e.g., LGBTQ youth, low-wage workers, family members affected by violence, specific immigrant populations, etc.). HRC was primarily involved in the administration of the online and in-person survey instruments, particularly in the communities served by HRC and to audiences age 65 or older. The survey, conducted in English, Spanish, Portuguese, Haitian Creole, Vietnamese, Arabic, and Chinese, was disseminated online and in hard copy, and reached 2,404 residents of the city of Boston.
CHNA Management Structure and Committee

President’s Oversight

Mary Moscato, President, Hebrew Rehabilitation Center and Hebrew SeniorLife Health Care Services
As President, HRC and Hebrew SeniorLife Health Care Services, Mary Moscato draws on her dynamic background in health care operations and management to lead the organization in its commitment to providing the highest quality care available to seniors in Greater Boston. Additionally, she helps develop the organization’s strategic plans in expanding its health care services. With her executive leadership roles, both at HRC and HSL, Moscato is uniquely qualified to bring important oversight and vision to the CHNA process, as well as guidance on how best to implement our next steps moving forward.

Clinical Advisor

Helen Chen, M.D., Chief Medical Officer, Hebrew SeniorLife
Dr. Helen Chen is Chief Medical Officer at HSL serving as senior clinical advisor and overseeing the organization’s Department of Medicine. Dr. Chen brings more than 25 years of experience with evidence-based geriatric clinical care and training to her role along with her longstanding interest in caring for our country’s growing senior population. She oversees clinical care in all HRC long-term care programs, post-acute rehabilitation, and community-based health care services, including home care and adult day health. As clinical advisor in the CHNA process, Dr. Chen brings medical insights to the needs assessment process and helps identify and guide the health care programs best suited to meet the needs of the community.

Governance

Julie Rosen, Chair, Health Care Services Committee of the Board
As Chair, Health Care Services Committee of the Board at HSL, Julie Rosen brings more than 30 years of experience working in health care and not-for-profit organizations and associations to the CHNA governance role. Her expertise is in building effective boards and staff, developing and executing fundraising strategies, building organizations and brands through government, media, and community strategies, and developing business and programmatic solutions. Her extensive knowledge of federal and state public health policy, issues, and players lends further credence to the expertise she brings to HSL and the HRC CHNA. Rosen is Consultant and Leader of the Not-For-Profit Practice at WittKeiffer, a global executive search firm.

Day-to-Day Lead

Rachel Joslin Whitehouse, Chief Communications and Planning Officer
Rachel Joslin Whitehouse is Chief Communications and Planning Officer at HSL. In her planning role, she partners with the operational leadership of HSL’s health care, senior living, teaching, and research departments to develop strategic plans and align them with annual operational goals.

As the day-to-day lead for the CHNA, Whitehouse leverages her planning and strategic communications expertise to guide the gathering of research and data, as well as to serve as the liaison to the rest of the HSL community to report on progress, findings, and observations.
Chapter 2: Defining the Community

Hebrew Rehabilitation Center Geography: Licensure

HRC operates under a chronic care hospital license with 675 beds in the following three locations.

- **Boston:** HRC, located at 1200 Centre Street in Roslindale, a neighborhood of the city of Boston, is licensed for 405 long-term chronic care (LTCC) and 50 long-term acute care (LTAC) or medical acute care unit (MACU) beds. Outpatient services are also provided under this license.
  
  - The 50 Skilled Nursing Facility (SNF or short-term rehab/RSU) beds at HRC in Roslindale are operated by HRC under a SNF license from the Department of Public Health/Medicare.
  - Adult Day Health is operated by HRC but with a separate, non-hospital license from MassHealth; however, the CHNA committee included Adult Day Health in this analysis.
  - HRC outpatient services are provided in outpatient clinical settings in Dedham and Roslindale, offering a comprehensive range of outpatient programs that provide specialized care to seniors in the Greater Boston area. From primary care to rehabilitative services to memory care to wellness programs, our outpatient services help seniors stay healthy and independent, and enjoy the best quality of life possible.

- **Dedham:** HRC at NewBridge on the Charles, 7000 Great Meadow Road, Dedham, has 220 of HRC’s long-term chronic care (LTCC) licensed beds. Outpatient services are also provided at this HRC satellite.
  
  - The 48 Skilled Nursing Facility (SNF or short-term rehab/RSU) beds at HRC in Dedham are operated by HRC for NewBridge under a SNF license from the Department of Public Health/Medicare.

- **Brookline:** Operating as a satellite of the HRC hospital license, the HSL Medical Group provides outpatient geriatric care to the patients of Center Communities of Brookline and the Brookline community at The Sloane Family/Century Bank Primary & Specialty Care Center at 100 Centre Street, Brookline.

The local communities served, as defined by our licensure, are Boston, Dedham, and Brookline.
Zip Code of Origin Analysis

The community served by HRC consists of thriving Boston neighborhoods and bustling suburbs in the Greater Boston area. Based on our analysis of the market and the communities we serve, the black circle in the map below illustrates HRC’s primary service area.

We analyzed patient zip codes of origin for 2017 - 2019 and determined that the following communities and zip codes were the most prominent. We established the HRC core service area as an approximate five-mile radius from our campuses in Roslindale and Dedham, as the crow flies.

<table>
<thead>
<tr>
<th>Community</th>
<th>Zip Codes</th>
<th>Community</th>
<th>Zip Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allston</td>
<td>02134, 02134-5015</td>
<td>Needham</td>
<td>02492, 02444</td>
</tr>
<tr>
<td>Brighton</td>
<td>02135</td>
<td>Newton</td>
<td>02458, 02459, 02460, 02461</td>
</tr>
<tr>
<td>Brookline</td>
<td>02445, 02446</td>
<td>Roslindale</td>
<td>02131</td>
</tr>
<tr>
<td>Chestnut Hill</td>
<td>02467</td>
<td>Roxbury</td>
<td>02118, 02119, 02120</td>
</tr>
<tr>
<td>Dedham</td>
<td>02026</td>
<td>Wellesley</td>
<td>02481, 02482</td>
</tr>
<tr>
<td>Dorchester</td>
<td>02122, 02125</td>
<td>Weston</td>
<td>02493</td>
</tr>
<tr>
<td>Jamaica Plain</td>
<td>02130,</td>
<td>Westwood</td>
<td>02090</td>
</tr>
<tr>
<td>Hyde Park</td>
<td>02136</td>
<td>West Roxbury</td>
<td>02132</td>
</tr>
</tbody>
</table>

Based on patient zip code of origin, the local communities we serve are particular neighborhoods of Boston and the towns of Brookline, Dedham, Needham, Newton, Wellesley, Weston, and Westwood.
Hebrew Rehabilitation Center Patient Population Demographics

In addition to licensure and zip code of origin, the CHNA committee reviewed current hospital and community demographic and environmental data.

Current Hospital Patients

HRC provides services to seniors. Approximately 85 percent of the patients of HRC are older than 65. Those younger include many employees receiving outpatient and therapeutic services.

Age at Admission - 2019

<table>
<thead>
<tr>
<th>Campus - Service Line</th>
<th>Average Age</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRC Boston - LTCC</td>
<td>86.89</td>
<td>89</td>
</tr>
<tr>
<td>HRC Boston - MACU</td>
<td>67.25</td>
<td>71</td>
</tr>
<tr>
<td>HRC - Memory Care</td>
<td>66.67</td>
<td>68</td>
</tr>
<tr>
<td>HRC Boston - SNF</td>
<td>80.18</td>
<td>81</td>
</tr>
<tr>
<td>HRC Dedham - LTCC</td>
<td>87.08</td>
<td>89</td>
</tr>
<tr>
<td>HRC Dedham - SNF</td>
<td>80.36</td>
<td>81</td>
</tr>
<tr>
<td>Adult Day Health Roslindale</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>Adult Day Health Brighton</td>
<td>84</td>
<td>90</td>
</tr>
<tr>
<td>Brookline Medical Practice</td>
<td>84</td>
<td>87</td>
</tr>
</tbody>
</table>

Insurance Profile

Approximately 80 percent of the patients in our long-term chronic care are dual eligible for Medicare and Medicaid coverage. The remainder of our long-term chronic care population is private pay, with Medicare and other insurance providing auxiliary service coverage.

Massachusetts has an “individual health insurance mandate,” which requires most adults to carry health insurance if it is affordable to them and that meets certain coverage standards (referred to as “Minimum Creditable Coverage” (MCC)).

The state is among the nation’s lowest in rates of the uninsured. The United States 2010 Census indicates that 86.8 percent of the state’s total population has health insurance.

In summary, our primary community is comprised of seniors and low-income seniors, 65+, in certain neighborhoods of Boston and the towns of Brookline, Dedham, Needham, Newton, Wellesley, Weston, and Westwood.
Population Trends

Approximately 86,367 individuals age 65 or older reside within our service area as of 2018; across Massachusetts, those 65 or older account for 1,016,679, approximately 15% of all residents. Each community’s seniors over age 65 represent a low of 9.5% (Allston/Brighton) to a high of 19.9% (Westwood) of the overall community population.

Additionally, as you can see from the chart above, there is a significant percentage of adults age 50+, with the biggest groups falling between 50 and 65 years old, indicating a potential growing need for senior housing and services, including adult day health and home care. A look at the chart below indicates that Massachusetts is already hiring for this need, particularly in home health care.

In Massachusetts, since 2013, home health care workers increased by 65.3 workers per 1,000 adults aged 75 and older.

Our senior populations are projected to grow, and will need an increasing amount of services.
Household Income
Seniors over 65 years old in Boston had a median household income of under $30,000 from 2011-2015.

![Median Household Income by Age and Year](image)


Particularly insightful is the data from the Boston CHNA-CHIP that highlights the financial worries of Boston residents. Paying medical bills and purchasing medicine are real concerns for residents in Boston.

![Household Income Distribution](image)


Note: Neighborhoods are defined by Boston CHNA Health Coordinators. Boston CHNA excludes Belltown, North End, and Revere Blvd. South End includes South End and Charlestown.
Ethnicity/Race

Based on the United States 2010 Census, which is the most recently available federal Census, the CHNA committee also examined the ethnicity/race background of our local communities. Understanding our market, community by community, can help HRC develop specific programs and services that map to individuals, not only by age or general location, but also possibly by cultural norms or sensitivities that may affect healthy outcomes. The chart below illustrates a community by community view.

<table>
<thead>
<tr>
<th>Community</th>
<th>Total Population</th>
<th>% White</th>
<th>% African American</th>
<th>% Asian</th>
<th>% Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allston*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Brighton</td>
<td>42,780</td>
<td>74.4</td>
<td>5.0</td>
<td>13.4</td>
<td>8.9</td>
</tr>
<tr>
<td>Brookline</td>
<td>58,732</td>
<td>76.7</td>
<td>3.4</td>
<td>15.6</td>
<td>5.0</td>
</tr>
<tr>
<td>Chestnut Hill**</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dorchester</td>
<td>25,978</td>
<td>7.6</td>
<td>70.5</td>
<td>.8</td>
<td>27.4</td>
</tr>
<tr>
<td>Dedham</td>
<td>24,729</td>
<td>88.4</td>
<td>5.4</td>
<td>2.6</td>
<td>5.5</td>
</tr>
<tr>
<td>Jamaica Plain</td>
<td>35,401</td>
<td>66.0</td>
<td>14.2</td>
<td>5.2</td>
<td>22.6</td>
</tr>
<tr>
<td>Hyde Park***</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Needham</td>
<td>28,886</td>
<td>90.8</td>
<td>1.0</td>
<td>6.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Newton</td>
<td>85,146</td>
<td>82.3</td>
<td>2.5</td>
<td>11.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Roslindale</td>
<td>29,826</td>
<td>57.4</td>
<td>23.6</td>
<td>2.7</td>
<td>25.9</td>
</tr>
<tr>
<td>Roxbury</td>
<td>25,346</td>
<td>14.8</td>
<td>59.2</td>
<td>1.4</td>
<td>29.4</td>
</tr>
<tr>
<td>Wellesley</td>
<td>27,982</td>
<td>82.2</td>
<td>3.2</td>
<td>11.2</td>
<td>5.0</td>
</tr>
<tr>
<td>Westwood</td>
<td>14,618</td>
<td>99.0</td>
<td>.09</td>
<td>5.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Weston****</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>West Roxbury</td>
<td>25,861</td>
<td>83.7</td>
<td>5.5</td>
<td>6.3</td>
<td>6.8</td>
</tr>
<tr>
<td>Boston</td>
<td>617,594</td>
<td>53.9</td>
<td>24.4</td>
<td>8.9</td>
<td>17.5</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>6,547,629</td>
<td>80.4</td>
<td>6.6</td>
<td>5.3</td>
<td>9.6</td>
</tr>
</tbody>
</table>

*Not broken out/Included in Boston numbers
**Not broken out/Included in the Brookline, West Roxbury and Newton numbers
***Not broken out/Included in the Boston numbers
****Not broken out/Included in Needham, Waltham, Newton numbers
The chart below shows the county by county breakdown by race.

<table>
<thead>
<tr>
<th>Race</th>
<th>Suffolk County</th>
<th>Norfolk County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>722,023</td>
<td>670,850</td>
</tr>
<tr>
<td>White</td>
<td>61.5%</td>
<td>78.1%</td>
</tr>
<tr>
<td>African American</td>
<td>24.7%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>9.3%</td>
<td>11.8%</td>
</tr>
<tr>
<td>AIAN</td>
<td>.7%</td>
<td>.2%</td>
</tr>
<tr>
<td>NHPI</td>
<td>.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>3.6%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

The chart below highlights a county by county breakdown by ethnicity, Hispanic/Latino or Not Hispanic/Latino.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Suffolk County</th>
<th>Norfolk County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>23.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>44.9%</td>
<td>74.4%</td>
</tr>
</tbody>
</table>
Chapter 3: Defining the Community Health Needs

Publicly Available Data
Patients come to HRC from Boston, Brookline, Chestnut Hill, Dedham, Needham, Newton, Needham, Wellesley, Weston, and Westwood. In recent years, these cities and towns have all been included in multiple publically available public health assessments. As part of the HRC CHNA, the committee reviewed a variety of data sets to identify health needs relevant to our community and target population.

The data sources are:
- 2019 Boston CHNA - CHIP
- 2018 Massachusetts Healthy Aging Community Profile
- The Massachusetts DPH West Suburban Community Network Area (CHNA 18) that consists of Brookline, Dedham, Dover, Needham, Newton, Waltham, Wellesley, and Weston.

Select highlights of our CHNA based on publically available data are included below.

<table>
<thead>
<tr>
<th>Need</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boston Area</strong></td>
<td></td>
</tr>
<tr>
<td>The diabetes hospitalization rate for ROSLINDALE was 14.4, lower than the overall Boston rate of 21.1 per 10,000</td>
<td>Health of Boston, Boston Public Health Commission Report, page 395</td>
</tr>
<tr>
<td>The diabetes hospitalization rate for ROXBURY was 32.4, significantly higher than Boston</td>
<td>Health of Boston, Boston Public Health Commission Report, page 395</td>
</tr>
<tr>
<td>ROXBURY has the highest rate of heart disease hospitalization in Boston</td>
<td>Health of Boston, Boston Public Health Commission Report, page 403</td>
</tr>
<tr>
<td>23.3-28.6% of adults in ROSLINDALE and ROXBURY are obese</td>
<td>Health of Boston, Boston Public Health Commission Report, page 418</td>
</tr>
<tr>
<td>Approximately 96.7 out of every 10,000 people in HYDE PARK are hospitalized for heart disease</td>
<td>Health of Boston, Boston Public Health Commission Report, page 403</td>
</tr>
<tr>
<td>ALLSTON/BRIGHTON has a lower percentage of obese adults (13.6) than the overall Boston rate</td>
<td>Health of Boston, Boston Public Health Commission Report, pages 416</td>
</tr>
<tr>
<td><strong>Dedham</strong></td>
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<tr>
<td>DEDHAM has a higher rate of diabetes, than the state overall</td>
<td>CHNA 18 Needs Assessment (Dedham Supplement)</td>
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<tr>
<td>DEDHAM has a higher percentage of people 65+ and a higher percentage of residents over 80 years than state average</td>
<td>CHNA 18 Needs Assessment (Dedham Supplement)</td>
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<tr>
<td><strong>Brookline</strong></td>
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<tr>
<td>BROOKLINE has lower rates of mortality, diabetes, smoking, hypertension and adult and child obesity than the state average</td>
<td>CHNA 18 Needs Assessment (Brookline Supplement)</td>
</tr>
<tr>
<td>BROOKLINE has a lower percentage of young people under 19 and those 65+ than towns in CHNA 18 and state average</td>
<td>CHNA 18 Needs Assessment (Brookline Supplement)</td>
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<tr>
<td><strong>Needham</strong></td>
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<tr>
<td>NEEDHAM has among the highest percentages of the &quot;old (over 80) of all Massachusetts communities.</td>
<td>CHNA 18 Needs Assessment (Needham Supplement)</td>
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</table>
NEEDHAM has lower rates of mortality, diabetes, smoking, hypertension and adult and child obesity than the State.

Newton

NEWTON’s top health concerns are: Mental Health, Affordable Housing, Transportation Barriers, and Financial Strain

NEWTON has a greater percentage of both older people and young people than do other towns in CHNA 18 and the state; it also has a higher percentage of the “old” (over 80) than other Massachusetts communities as a whole

Additionally, we looked at Boston CHNA-CHIP, particularly in regard to the top issues in the community, including health concerns and other areas of need. The chart below captures the findings, with elder/aging health issues essentially on par with employment/job opportunities, diabetes, and poverty.

Overall Morbidity and Mortality

According to the Boston CHNA-CHIP, the leading causes of death include cancer (all types combined) and heart disease; Black and White residents experience higher rates of death due to cancer and heart disease compared to Latinos and Asians. Accidents are the third leading cause of death among all racial/ethnic groups - except for Asians, where the third leading cause of death was cerebrovascular disease (e.g., stroke).
Obesity, Nutrition, and Physical Activity

The research conducted through the Boston CHNA - CHIP cites more than half of Boston adults (57%) reported being overweight or obese; Black and Latino adults (68% for both groups) were more likely to be overweight or obese than White adults (51%). The prevalence of obesity and overweight also follows a socioeconomic gradient; residents who are renters, have lower levels of education, and lower income were more likely to be obese or overweight compared to their counterparts.

As shown below, at the neighborhood level, the percent of adults in Hyde Park, Dorchester, West Roxbury, and Roslindale who were obese or overweight was significantly higher than the prevalence of obesity for the rest of Boston.

Health Care Access and Utilization

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. Boston CHNA community survey respondents indicated that having a regular source of care is one of the top factors that makes it easier for them to get the health care services they need (63%).
Obtaining Community Input

Approach

The primary vehicle for gathering community input was the Boston CHNA-CHIP Collaborative survey that we helped implement, both online and in person. The survey was fielded to patients who utilize the services of HRC Roslindale, those who leverage our Home Care services, and those who participate in Great Days for Seniors in Roslindale and Brighton. We also leveraged several community partnerships to complete the survey, e.g., former members of the Multicultural Coalition on Aging, which represented Boston and its immediate suburbs, 2Life Communities, which ran a lunch program/party to encourage seniors to participate, local churches, senior centers, and the like. We also fielded the survey to more than 700 employees who are residents of Boston. The surveys were in the field for one month.

Sample questions are highlighted below. The full survey can be found in Appendix A.

<table>
<thead>
<tr>
<th>Sample Questions</th>
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<tbody>
<tr>
<td>When you are sick or need advice about your health, to which of the following places do you usually go? (public health clinic or community health center, doctor’s office, hospital outpatient department, hospital emergency room, urgent care provider, some other kind of place, no usual place, prefer not to answer/don’t know)</td>
</tr>
<tr>
<td>Was there a time in the past 12 months when you need to see a doctor but could not because of the cost? (yes, no, prefer not to answer/don’t know)</td>
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</table>

The HRC team took the following approach to examining the survey content:

- Reviewed the survey instrument in detail as well as a representative sample of responses that were gathered via implementing the survey in person
- Requested multilingual versions to ensure our patients were able to read it and respond to it in their native languages
- Examined the executive summary of the Boston CHNA-CHIP, which detailed many priorities
- Also reviewed the streamlined priorities and rationale that Boston CHNA-CHIP members further developed and refined in the Boston CHNA-CHIP.
Community Resources

The CHNA committee also examined existing medical facilities in our community. According to *U.S. News and World Report*, there are 70 hospitals in Metro Boston alone (including Boston, Brookline, Cambridge and Chelsea). Of these, many are among the top ranking/high performing facilities in the country. From teaching hospitals to community health centers, Boston is a world-renowned medical destination. The map below shows HRC facilities as well as acute-care hospitals within a 10-mile radius. A significant number of additional hospitals, major care practices, and community health facilities add to the depth of medical services available in our local communities.

With so many world-class health facilities in the Greater Boston area, patients from all over the world come to Boston for treatment, and physicians from around the world come to train and practice cutting-edge techniques. Seniors in our local communities need go no further than their Boston doorstep to leverage the world’s greatest medical minds and facilities.

### Acute Care Hospitals (10-mile radius)

1. Brigham and Women’s Hospital – Faulkner
2. New England Baptist Hospital
3. Brigham and Women’s Hospital
4. Dana-Farber Cancer Institute
5. Tufts Medical Center
6. Beth Israel Deaconness Medical Center
7. Carney Hospital
8. St. Elizabeth’s Medical Center
9. Boston Medical Center
10. Beth Israel Deaconness Medical Hospital – Milton
Defining HRC Priorities

In determining priorities, the CHNA committee considered the degree of community need for additional resources, our ability to meet that need through our experience, expertise, and programming, and the capability of other medical and hospital organizations to meet that same need.

At the same time, we focused on the Attorney General’s (AG) efforts to support health care reform, reduce barriers to access, improve quality, and reduce cost in health care for patients of the HRC community; we also reviewed the four focus areas identified in 2017 by the EOHHS and DPH including:

- Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes
- Housing Stability/Homelessness
- Mental Illness and Mental Health
- Substance Use Disorders

The priority themes and conclusions from the Boston CHNA – CHIP were also examined:

- With a current population of nearly 670,000 residents, Boston has experienced—and is expected to continue to experience—population growth across every neighborhood in the city, though growth rates across neighborhoods vary.
- Boston is a richly diverse city in terms of racial, ethnic, and linguistic population groups, though data show this diversity is not equally distributed across neighborhoods. Although unemployment rates are low and there is economic opportunity for many residents across the city, there are substantial differences in financial security across neighborhoods and racial and ethnic groups.
- Housing affordability and its implications emerged as a key theme that arose across secondary data, the community survey, focus groups, and interviews.
- The impact of chronic diseases and their risk factors—especially diabetes, obesity, and pediatric asthma—emerged as a priority concern among residents.
- Behavioral health, specifically mental health and drug addiction among young people are growing concerns among community residents; opioids, prescription medication, and marijuana use were reported as most concerning.
- Violence-based trauma was identified as a major factor of negative community health outcomes, and there is a need for more trauma-informed approaches to care, particularly for children and communities of color.
- Reducing environmental risk factors that impact poor community health outcomes will be central to improving population health—particularly related to climate change, exposure to hazardous substances in the air and home, and the built environment.
- Boston is a resource-rich city; however, resources are not equitably distributed across neighborhoods and population groups, namely communities of color.
Boston has many health care and social service assets that can be leveraged, but access to those services is a challenge for some residents.

The CHNA committee determined that its priority should to reach some of our community’s most at-risk seniors, including those experiencing abuse and neglect and/or suffering from dementia and behavioral health issues and to provide access to the geriatric-specific care and services available in Boston, whether at HRC or our sister health care organizations, specifically in the following areas:

- **Access to Geriatric Specialists**: Increase availability and accessibility of our geriatric specialists and the ways seniors in the community can access them.

- **Behavioral Health**: Increase the availability and accessibility of outpatient Alzheimer’s care as well as mental health and depression services for seniors who live in the community and their families.

- **Financial Security**: Prevent the exploitation of seniors for financial gain and increase awareness of and access to Financial Assistance Programs for community dwelling seniors.

- **Housing Affordability**: Create a replicable model of senior supportive housing with affordable services.

- **Closing Racial and Ethnic Disparities that Exist in Health Care**: Increase the availability of linguistic services to community dwelling seniors. Increase the training of HSL staff in best practices to address cultural barriers.

Details on each of these priorities are described in the following implementation plan.
Chapter 4: Implementation Plan

Since publishing its 2016 CHNA, HRC is increasingly focused on the needs of seniors who live at home in the communities we serve.

The 2016-2022 HSL Strategic Plan set the direction for HSL to do an even better job of fulfilling our strategic aim, which is to improve the quality of life for a growing number of seniors and their families, with a focus on the most vulnerable, under-served, and medically complex seniors. The Strategic Plan comprised five strategic approaches, one of which is directly relevant to our CHNA Implementation plan: **We will reach more seniors in the community and engage them earlier.**

A commitment to “**Reach more seniors in the community and engage them earlier**” recognizes that seniors have evolving expectations and expect more, and different, services. They want to age in place, prevent and manage chronic disease, and maintain their active lifestyle as long as their health permits. Because they are living longer, their medical needs will be complex, and many will require long-term supports and services. As such, seniors who live in their own homes require services that span education and prevention, direct care, and other forms of assistance.

For those seniors who choose to live in congregate housing, HSL is dedicated to providing **supportive living opportunities, regardless of income level.** The burden of high housing costs forces millions of low-income seniors to sacrifice spending on basic necessities, damaging their health and well-being. Disconnects between housing programs and the health care system put many aging seniors at risk of poor quality of life and premature institutionalization. This is why HSL is committed to developing a **repackable model of Affordable Housing with Supportive Services.**

From creating an outpatient wellness cluster in Roslindale, to opening an outpatient Center for Memory Health, to pioneering the City’s first shelter for seniors suffering from elder abuse and neglect, since 2016 HRC has invested in areas we believe will help seniors in our community stay healthy and independent, and have brought dozens of new services to them.

This 2019 CHNA Implementation Plan marries the direction of the HSL Strategic Plan with the immediate health needs of seniors in our community and identified in the Boston CHNA-CHIP:

- **Access to Geriatric Specialists and Services:**
  - Access to Various Geriatric Specialists
  - Transportation
- **Behavioral Health**
  - Outpatient Alzheimer’s Care
  - Mental Health and Depression Services
- **Financial Security**
  - Prevention of Elder Abuse and Neglect
  - Financial Assistance Programs
- **Housing Affordability**
  - Supportive Senior Living with Affordable Services
- **Closing Racial and Ethnic Disparities that Exist in Health Care**
  - Addressing Linguistic and Cultural Barriers
New services and new ways to access them will not only will help meet the guidelines established by the Attorney General; more importantly, they will help the most vulnerable seniors in the communities we serve to live their best lives in the best place to achieve what matters most to them.

The overarching goals of our 2019 Implementation Plan outline our intention to reach some of our community’s most at-risk seniors, including those experiencing abuse and neglect and/or suffering from dementia and behavioral health issues and are as follows:

- **Access to Geriatric Specialists:** Increase availability and accessibility of our geriatric specialists and the ways seniors in the community can access them.

- **Behavioral Health:** Increase the availability and accessibility of outpatient Alzheimer’s care as well as mental health and depression services for seniors who live in the community and their families.

- **Financial Security:** Prevent the exploitation of seniors for financial gain and increase awareness of and access to Financial Assistance Programs for community dwelling seniors.

- **Housing Affordability:** Create a replicable model of senior supportive housing with affordable services.

- **Closing Racial and Ethnic Disparities that Exist in Health Care:** Increase the availability of linguistic services to community dwelling seniors. Increase the training of HSL staff in best practices to address cultural barriers.

The following pages outline our 2019 CHNA implementation plan, structured around the four identified areas of need, and the AG’s priority of Closing Racial and Ethnic Disparities that Exist in Health Care. For each area of need, we outline our goals, current services, recent progress, and our action plan. We will use the next three years to establish benchmarks on the number of seniors served across our service areas, and then use the benchmarks to develop measurement metrics for HRC’s 2022 CHNA.
The plan references HSL’s many Outpatient, In-Home and Community based services. These services touch more than 600 seniors daily. In structuring and growing these services, we focused on increasing preventive care services that offer seniors assistance with daily tasks. These preventive services increasingly include collaborations between non-traditional partners, such as private duty services, transportation providers, maintenance workers, post-acute care services, and others.

For reference, following is a brief overview of the services we provide to community-dwelling seniors.

**Outpatient Care and Services**

**Hebrew SeniorLife Medical Group:** Provides primary and specialty medical care to Boston-area patients at its practice located at Center Communities of Brookline. Here, geriatric care experts focus on the unique needs of each individual they serve. Certified by the DPH and operating as a satellite of HRC, the Medical Group offers routine exams, psychiatric care, podiatry, memory support consultation, chronic disease and diabetes self-management, and addresses issues such as chronic pain from arthritis, congestive heart failure, cognitive impairments, and palliative care.

**Specialty Outpatient Care Services:** Based at HRC-Roslindale, and focused on two medical specialties: Osteoporosis and Wound-Healing. The Osteoporosis Clinic does screening to help detect osteoporosis before a fracture occurs, predict chances of a future fracture, and determine rate of bone loss or monitor treatment. The Wound-Healing Clinic treats and promotes the healing of chronic or slow-healing wounds.

**Adult Day Health Programs:** "Great Days for Seniors" at two locations in Boston: HRC- Roslindale and at 2Life Communities, formerly known as Jewish Community Housing for the Elderly (JCHE) in Brighton. Licensed by the Massachusetts DPH, this is an active, social daytime community for seniors living at home supported by an interdisciplinary team of nursing, social work, and therapeutic recreation professionals. Staff are trained in the Alzheimer’s Association Habilitation program and provide person-centered care for people with memory loss, and also offer services and support to participants with mental health issues that help reduce depression.

**Outpatient Therapy Services:** Based at HRC-Roslindale, Outpatient Therapy services specialize in the treatment of older adults. An experienced team of physical therapists, occupational therapists, speech and language therapists, and audiologists utilize the most up-to-date information and treatment techniques to maximize function and independence. Programs include a partnership with the Jewish Community Center of Greater Boston which provides free hearing aids.

**Outpatient "Get Up & Go" Senior Exercise:** HRC offers Get Up and Go, a supervised, medically based program for seniors over age 60 who wish to exercise at our Boston campus. It includes: a complete fitness exam by exercise professionals, progressive strength training, and balance and flexibility.

**HSL Rehabilitation Services:** HSL’s exercise therapists offer training and education on the “Fit For Your Life” training program to internal and external rehab and fitness specialists so that they can incorporate this evidence-based knowledge into their practices.
HSL Off-Road Clinical Driver Evaluation Program: HSL’s safe driving program is designed specifically to assess the driving needs of older adults based on current research, as well as recommendations from the American Occupational Therapy Association, National Highway Traffic Safety Administration, AAA, AARP, and current state regulations.

In-Home Care in Greater Boston

Medicare-certified Home Care: Services to assist seniors with recovery following surgery, illness, or hospital stay or to manage chronic illness. Services include nursing, palliative care programs, physical therapy, occupational therapy, speech and language therapy, and social work. Depression screening is included in all new patient evaluations. Additionally, HRC physical or occupational therapists perform Home Safety Evaluations for seniors to ensure their environments are comfortable, secure, and safe.

Therapy House Calls: An innovative program offered by HSL Home Care brings outpatient and rehabilitation therapy to seniors at home, a particular advantage for seniors with limited mobility and limited transportation.

Fitness House Calls: One-on-one personal training for seniors in their homes is offered by exercise physiologists or personal trainers with experience working with seniors as a private pay service.

Personal Assistance: Non-medical services and companion support, such as personal grooming, homemaking, and meal preparation. Available to low-income seniors under contracts with state-funded Aging Senior Access Points (ASAPs).

HSL Hospice Care: A multidisciplinary team, comprised of medical professionals, including physicians and nurses, in-home aides, social workers, chaplains, volunteers, families, and friends works with patients and families to maintain the dignity, comfort, and spiritual wellbeing of seniors and to empower them and their families to make well-informed decisions as they move through the end-of-life experience. The majority of HSL’s hospice clients have dementia. Service include complimentary therapy services through the generous contributions of donors.

Community Education: HRC continues to build new community relationships and is working with dozens of community organizations to build on and round out their newsletters, speaking engagements, and education fairs to educate seniors and their caregivers. Topics include:

- Understanding Emotional and Psychological Changes in Older Adults
- Financial Considerations in Retirement
- Not Thriving at Home
- Cognitive Issues as We Age

Spiritual Care: Spiritual Care at HRC is dedicated to helping enrich the spiritual lives of all patients and their families, and support people during good and bad times. This might mean working together to make each day have meaning, drawing spiritual strength from identifying and expressing deeply held values, helping affirm one’s legacy in the face of terminal illness, facing fears and sadness about aging and loss, or simply enjoying companionship. Staffed by experienced interfaith chaplains and rabbis, our team offers specialty skills that include: Russian language, American Sign Language, Hebrew language, music, spiritual care with persons with dementia, and palliative care and hospice chaplaincy. In addition, two spiritual care therapy dogs provide canine companionship and love alongside HRC chaplains.
Need-Specific Implementation Plan

**Need: Access to Geriatric Specialists**

**Goal:** Increase availability and accessibility of our geriatric specialists and the ways seniors in the community can access them.

**Recent Advancements:**

As a long-term chronic care hospital, HRC is a trusted, high quality provider of inpatient hospital-level care for medically compromised, frail and vulnerable seniors. In 2016, our Strategic Plan identified the importance of reaching more seniors in the community and engaging them earlier.

The HRC leadership team set the direction to revitalize the HRC Roslindale campus, which sits in the heart of Boston, to enable community access to and use of HRC’s specialized geriatrics services. HRC’s vision was to establish an ambulatory care cluster, where community dwelling seniors could easily and safely access a range of preventative care, geriatric medical specialties, mental health services, and associated care coordination and financial services.

HRC’s main floor, the B1 Level, has undergone significant renovation to achieve this goal, and that renovation will continue over the coming years.

Today, community dwelling seniors can come to HRC B1 and be sure of both valet parking and reserved, easy access parking spaces. There are expanded sitting areas. The gym and outpatient rehab are more easily accessible. The outpatient CMH is open and sits in the heart of B1. Care coordination is available to help seniors access Financial Services, Home Care, and Language services.

In addition, Spiritual Care launched a Community Chaplaincy Initiative (CCI) designed specifically to combat isolation among frail Jewish seniors living in Greater Boston. The CCI is working to expand the number of non-Jewish eldercare facilities and acute-care settings where HSL provides spiritual care and connect isolated Jewish elders with other HSL services and supports.

HRC is also involved in clinical trials. As an example, HSL is studying the effects of exercise and behavioral interventions in transaortic valve replacement (TAVR), with research being conducted with participants within a 20-mile radius of Boston. The research has two goals: 1) Determine the effect of a home-based exercise program with or without cognitive behavioral intervention combined vs. attention control education on physical function and disability during the eight week period after TAVR 2) Determine the effect of cognitive behavioral intervention on adherence and the change in physical function and disability among participants in the home-based exercise program.

**Action Plan:**

**Progressive Community-Based Ambulatory Care Center at HRC-Roslindale:** HRC plans to continue renovation of the HRC-Roslindale B1 Level and offer increased accessibility to ambulatory wellness services such as geriatric specialty clinics, the CMH, rehabilitation therapies, dental, vision, and more.
We recently renovated the café for family caregivers to have coffee or a bite to eat while they wait and have extended our free valet and reserved parking as well. Future plans call for adding an ambulatory care procedure room.

**Community Based Palliative Care:** The HSL Home Care team successfully piloted and launched an innovative Community Based Palliative Care program, which provides services and consultation from a Geriatric Nurse Expert and a Geriatrician for very frail elders with advancing illness who live in their homes in the community. The program also offers social worker support to answer questions and provide guidance about community resources. In addition, chaplain care for spiritual support and complimentary therapy services of music and massage is available thanks to a three-year grant from the Rubenstein Foundation. This team approach assures that the patient has a holistic support network and comprehensive expertise.

**New Wellness Nurse Consultant Program:** This program will be offered at the Brighton campus of 2Life and offer nurse expertise and teaching on medications, health and wellness topics, self-care, and disease management. The Wellness Nurse Consultant program will be offered in Russian and Chinese to meet the needs of resident demographics. This program will offer value as a safety net for detecting early disease exacerbation and functional decline.

**HRC In-Home Telehealth Videoconferencing:** This service is offered through our Home Health program for those patients at high risk for re-hospitalization. The telehealth unit provides early indication of disease exacerbation and is used as a teaching tool for disease management. Currently audio-based, the program will be via videoconferencing by 2020.

**Extending Therapy House Calls Service Area and Programming:** This team launched a series of educational sessions led by clinicians called *Optimizing Independence*, covering specific areas related to healthy aging and maintaining independence including changes in mobility, continence improvement, energy conservation, joint protection, and memory changes. Initially for patients at HSL’s Center Communities of Brookline, plans are in place to extend it to other senior housing communities. Other programming to come will include integrating a standardized educational component for fall prevention into all treatments for patients with balance disorders, prior falls, and gait difficulty.

**STEP-HI Hip Fracture Recovery Clinical Trial:** More than 265,000 older adults fracture a hip each year in the U.S., and the majority never return to their pre-fracture level of daily functioning and mobility. Researchers at the HSL Hinda and Arthur Marcus Institute for Aging Research are testing strategies that may improve recovery after a hip fracture. According to Douglas Kiel, M.D. M.P.H., the Principal Investigator of the HSL site for the STEP-HI study, after a hip fracture, physical therapy is generally completed within a few weeks, leaving many patients with significant limitations in mobility and inability to perform daily activities. Continuing physical therapy and exercise for six months-especially weight lifting exercise-improves mobility and function after the fracture. In this study, which is enrolling women age 65 and older, researchers will test whether combining testosterone with exercise can lead to even greater improvements in physical abilities after a hip fracture.

**Continuing Care @Home:** HSL plans to create and launch a Continuing Care @Home program that would benefit seniors and their families by leveraging our expertise in coordinating and navigating care services and resources, as well as connecting seniors to services and events at our campuses.
Community Education/Awareness: HRC sponsors many community events to build awareness and provide seniors and their caregivers with education about the services we offer. Examples include:
  - The Roslindale Day Parade
  - Canton Fall Classic and Canton Health Fair
  - Brookline Day
  - Boston Jewish Film Festival (Dedham & Foxboro)
  - Needham Goes Purple
  - Roslindale Farmer’s Market
  - Needham Street Fair
  - Brookline Silver Party for the LGBTQ Senior Community
  - Needham Jog Your Memory 5K and Seniors Walk
  - The Boston and South Shore (Foxboro) Alzheimer’s walks
  - JP @ Home Anniversary Event
  - BID Lahey Needham & Milton Galas
  - Ethos Age Well Café

Community Health Support: HSL sponsors and/or facilitates support groups and education for seniors and their caregivers in the community.

- Support Groups:
  - Sponsors and facilitates Alzheimer’s Support Group for caregivers in the community at NewBridge on the Charles
  - Sponsors Memory Cafes at Temple Emanuel in Newton; Wellesley Senior Center and Newton Senior Center
  - Sponsors Parkinson’s Support Group at the Wellesley Senior Center
  - CMH Sponsors and facilitates Adult Child Support Group for caregivers in the community at Temple Emanuel in Newton.
  - Sponsors and facilitates stroke support groups for families of patients in the HRC RSU
  - HRC Roslindale Health Fair for seniors and their caregivers in the community.

- Community Clinics:
  - Blood pressure clinics in Brookline at CCB, Brookline Council on Aging, and Waterstone
  - Flu Clinics at CCB and NewBridge

Transportation: Transportation for community dwelling seniors is a persistent and growing need. HRC takes a wide view of transportation, and approaches the solution in three ways:

- Employee Transportation: HRC employs more than 700 Boston residents, many of whom rely on public transportation to get to HRC-Roslindale. The HSL shuttle runs throughout the day, with stops on the Roslindale, Bridge Street, and NewBridge campuses, and regular pick-ups/drop-offs at the MBTA’s Forest Hills station with trains and buses to downtown Boston, local neighborhoods, and more.

- Senior Transportation: HRC continually works to ensure the seniors we serve are aware of the transportation services we offer independently and with other organizations. Services include the Senior Shuttle, a free door-to-door transportation service for Boston patients age 60 and older, provided by the Commission on Elder Affairs, City of Boston.
We create materials outlining available transportation offerings for posting on our website and delivering to new patients. Many of the programs are available now and will continue to be provided in partnerships with Senior Care Options programs (SCOs) that address the needs of dually eligible older adults. Among the partnership SCOs are ETHOS, Senior Whole Health, and Commonwealth Care Alliance, both of which have ability to provide transportation to health and wellness programs. A good resource for seniors and caregivers alike is [https://www.auntbertha.com/](https://www.auntbertha.com/), which provides easy access to information on free or low-cost transportation, job training and other services organized by zip code.

- **Eliminating the Transportation Barrier by Co-Locating Services:** HRC will continue to work with partners to offer programs at community locations where older adults already live or congregate, eliminating the transportation barrier. These locations include assisted living communities, independent living, public housing, and at local senior centers.

  For example, HRC’s innovative Therapy House Calls are being provided at non-HSL assisted living communities in Newton, Framingham, and Milton. In addition, HRC Outpatient Therapy conducts “Balance Fairs” at HSL’s low-income senior supported communities on a yearly basis.

  Also, HRC launched Fitness House Calls. Under this program seniors are seen in their homes with 1:1 personal training and fitness instruction from exercise physiology therapists. The program provides strength training and will directly lower an individual’s fall risk. The program on HSL’s NewBridge campus in Dedham is well-established, with a similar program also running on HSL’s Orchard Cove campus.

**Meals on Wheels:** HRC has teamed with the Meals on Wheels program to prepare the only kosher meals delivered in the city of Boston.

**CarFit Program:** HRC offers an educational program that provides seniors the opportunity to check how well their personal vehicles “fit” them, which can increase not only their safety but also the safety of others.
Need: Behavioral Health

Goal: Increase the availability and accessibility of outpatient Alzheimer’s care, as well as mental health and depression services for seniors who live in the community and their families.

Recent Advancements in Alzheimer’s Care, Mental Health and Depression Services

HSL has always cared for seniors affected by Mental Health and Depression, and especially Alzheimer’s and other dementias. We offer memory care services at access points across our continuum, including in adult day health care, home health care, and memory support assisted living. Close to a third of the patients in our senior living communities are coping with varying degrees of dementia either as patients or caregivers.

At HRC-Roslindale and HRC-Dedham, close to 98 percent of our patients in long-term chronic care suffer from some form of dementia, and we provide compassionate end-of-life care to these medically compromised seniors.

In 2016, our Strategic Plan identified the importance of building on this strong history and committed HSL to increasing its focus on diagnosis, management, and education around dementia and depression, providing increased support for patients, family members, and caregivers.

To achieve this, HSL and HRC decided to establish an outpatient Center for Memory Health (CMH), and to locate it on the HRC-Roslindale campus, in the ambulatory cluster on the B1 level. The CMH would offer a holistic approach to memory care, delivering personalized, evidence-based care that maximizes the functional capacity of older adults at all stages of memory loss and provides essential services to their families.

It serves many people, including families, caregivers and people living with cognitive symptoms at all stages, including those with no memory symptoms; early, undiagnosed symptoms; moderate to severe symptoms; or advanced symptoms at end of life.

The CMH was officially opened in April 2019 and offers the following outpatient programs, either individually or in combination, to provide customized support:

- **Consultation**—Anyone who has a memory concern or caregiving concern can come in for a one-hour consultation. Designed to determine a path forward for each person, consultations vary in content or style depending on who is being seen and what the particular issue might be.
- **Assessment**—When there is an observable change in cognition and/or functioning, or a person has already “screened positive” on a standard cognitive assessment tool, the CMH can facilitate a clinical diagnosis through advanced diagnostic testing as needed.
- **Care Management**—We work to develop and monitor a person-centered care plan tailored to the individual’s and caregiver’s concerns and needs. Round-the-clock access to assistance and advice.
- **Family Care**—Caregivers face a variety of challenges when a loved one develops Alzheimer’s disease or related dementia. All family members and caregivers are eligible for our family care program which focuses on their well-being. This includes several counseling options, personalized supports, and referrals to help individuals and family members make informed decisions and cope with the stress of their loved one’s condition.
Action Plan:

Connect existing services across HSL’s continuum of care and in the community: Our goal is to provide care, education, and counseling for persons with a memory concern or cognitive disorder and their family members. We know that care coordination is an issue of great concern for the families of those affected by Alzheimer’s and dementia. By better integrating our current services, including our CMH, senior living communities, expressive therapies, home and community services, palliative care and hospice, we can improve care and help relieve the burden of care giving.

Research: Researchers in the Marcus Institute for Aging Research work with experts around the world to discover new ways to ease the effects of dementia. Patients have the opportunity to participate in clinical trials if they choose. In addition, our staff is actively involved in training the next generation of clinicians and service providers.

Home Care: In 2015 HSL received a three-year $525,000 grant from Blue Cross Blue Shield of Massachusetts Foundation. The grant is supporting the expansion of HSL’s “Making Real Progress in Emotional Health” (MARPEH) program.

The goal of MARPEH is to connect behavioral health treatment with primary care and other health services to reduce severity of depressive symptoms in seniors and improve their overall health. MARPEH is currently reaching more than 1,000 patients at HSL’s senior living communities for low-income seniors.

Shown to improve treatment of depression in HSL’s affordable senior living communities, we’re now applying the MARPEH concept to HSL Home Care, aimed at improving lines of communication between home care providers and PCPs, and also to provide home care staff, who already have experience with disease management, with tools that allow them to better recognize early signs and symptoms of depression.

The goal is to bring the same quality psychiatric care that we’ve been able to offer to HSL patients with the MARPEH program to many older adults in Greater Boston’s communities.

In-Community Support: HSL will continue to explore ways to extend the reach of its mental health and depression services to seniors in the community. CCB recognizes the need in the community for more ongoing counseling services and the challenges that many CCB residents have, either due to their insurance or transportation difficulty, in finding an appropriate therapist. CCB has partnered with Brookline Mental Health Center (BMHC) to better meet this need. A BMHC therapist is now on-site at CCB for 10 hours a week and can meet with residents either in an office or in their apartment. This therapist works collaboratively with the CCB resident services team to best support these residents.

Resources:

HSL offers several free resource guides that can be downloaded free from our website and are available at community events:

- Understanding and Living with Dementia: A Resource for Families
- Advanced Dementia: A Guide for Families
Need: Financial Security

Goal: Prevent the exploitation of seniors for financial gain and increase awareness of and access to Financial Assistance Programs for community dwelling seniors.

Recent Progress:

Each year, millions of older Americans are abused, neglected, and exploited. In Massachusetts, elder abuse reports have increased by 37 percent since 2011, with more than 1,000 additional cases reported in each of the past five years. In 2016 alone, the Massachusetts Executive Office of Elder Affairs recorded nearly 25,000 cases.

As part of our mission, HSL is dedicated to combating the incidence of elder abuse in Massachusetts. In doing so, we have dedicated resources to the creation of a center for the prevention of elder abuse and neglect.

The center offers short-term care and shelter within existing HSL communities to seniors who are suffering from abuse or neglect, along with access to legal, financial, mental health and other needed support services. In addition, the center is collaborating with community partners to educate the public and build awareness of this growing problem, and to offer training and screening tools for health care and other service professionals who interact frequently with seniors and serve as a resource to identify signs of elder abuse.

Financial exploitation is just one form of elder abuse, and it is on the rise. Seniors are common targets as they have had more time to accumulate wealth, which is often invested in their homes and retirement savings. Some scams target older adults because of perceived or real frailty. Today’s seniors also grew up in a more trusting time. When older adults are scammed, they’re often too embarrassed to report the crime. Our Center for the Prevention of Elder Abuse and Neglect is committed to raising awareness of the scams that target seniors.

Current Programs:

The HRC Financial Assistance Program offers medically necessary services at discounted cost to qualified patients. Whether patients are uninsured or underinsured, they can apply for financial assistance from HRC. Our Fiscal staff will assist individuals in applying for eligible government health insurance programs and completing the financial assistance application. Upon approval patients at or below 300% of the Federal Poverty Level (FPL) may receive a 40% discount on billed charges.

Patients who qualify cannot be charged more than the amount generally billed (AGB), currently 63% of billed charges.

Patients found to be eligible for assistance through Massachusetts Medicaid (known as MassHealth) or other program are not pursued through collection efforts, but rather are assisted free-of-charge with the MassHealth application and eligibility process through to completion, including any necessary appeals.
HRC has provided financial assistance to selected adult day care participants since August 1999, covering the costs of transportation (in prior years) and some daily programs. The financial assistance has been essential to those participants who cannot afford to pay privately, but who have periods of ineligibility for MassHealth or other financial subsidies (given that the services are not covered by Medicare or private health insurance plans).

In addition, HRC offers sliding fee scales in Outpatient Services. Home Care has created “short shift private pay” for those patients who cannot afford full shifts. These are offered in a congregate housing setting.

**Action Plan:**

**Financial Assistance:** HSL will continue offering its [HRC Financial Assistance Program](#) programs and work to ensure that seniors in the communities we serve are aware of this program on our campuses.

**Protecting Seniors:** Our [Center for the Prevention of Elder Abuse and Neglect](#) will continue to offer short-term care and shelter within existing HSL communities to seniors who are suffering from abuse or neglect, along with access to legal, financial, mental health and other needed support services. It will continue to collaborate with community partners as well as educate the public through programming and communication vehicles such as HSL newsletters, our [blog](#), and social channels.

**Need: Housing Affordability**

**Goal:** Create a replicable model of senior supportive housing with affordable services.

**Recent Progress:**

Housing is increasingly recognized as a social determinant of health. Boston health care and housing markets are unprepared to meet seniors’ needs for affordability, accessibility, and supportive services, and the disconnects between them put seniors at risk of premature institutionalization. Consider this:

- According to the Harvard Joint Center on Housing Studies, 65 million older households require different types of housing to meet their needs and preferences. Affordable, accessible housing located in age-friendly communities and linked to health supports is particularly in short supply.

- According to Housing and Urban Development (HUD), just one percent of the existing housing stock includes all of the following features: single-floor living, doorways and hallways that can accommodate a wheelchair, zero-step entrances, lever-style door and faucet handles, and electrical controls that be reached from a wheelchair.

- Not all seniors can afford to modify the homes they own; and for seniors who rent, such modifications may violate the terms of their rental agreement.

- Current HUD congregate affordable housing facilities have waitlists that will take years to surmount.
• And when congregate affordable housing is available, the shortage of support services often makes it woefully ineffective.

• By 2040, up to a third of people over 65 will have moderate to severe functional limitations and will need long-term support and services (LTSS) in their homes, communities, or institutions.

We do see positive steps forward to counter these trends. The city of Boston’s Spring 2019 announcement of a $26 million investment in affordable housing is a step in the right direction to provide lower and middle income patients and seniors with a place to call home. The funding will preserve 290 affordable units that will be restricted to households with low, moderate, and middle incomes of all ages.

In addition to this major investment in Boston, low-income housing tax credit programs spur investment designed to meet this growing need and supply gap. According to Mass.Gov, tax credits can be applied for buying or rehabbing existing buildings or the building of new ones. Leveraging tax credits guarantees a property will be affordable for at least 30 years. Over the last two years, HSL has leveraged tax credits to refurbish and remodel buildings on our campuses to ensure our seniors are enjoying their best life possible with optimal facilities, amenities, and services.

We also see encouraging new models of affordable housing with supportive services. For example, our “R3 Initiative” — more formally known as “Right Care, Right Place, Right Time: Effectively Integrating Senior Care and Housing” — aims to measure the positive impact of integrating health care and affordable senior housing in the Greater Boston area.

Embedded wellness teams and community organizations partner to support senior independence, prevent or reduce hospital and long-term care transfers, and maintain quality of life. Our CCB Campus, for example, includes a HMS-affiliated medical practice, fitness center, transportation, social workers, and more. The goal is to clearly demonstrate a best-practice model that redefines and integrates senior affordable housing and health care for the overall benefit of seniors, with an eye toward creating a sustainable, replicable national model that improves quality of care and reduces costs.

**Housing Affordability Action Plan:**

Our R3 Initiative aims to effectively integrate health care and affordable senior housing, and create a sustainable model that can be replicated nationally. The demonstration is also measuring increased utilization of wellness programs, linkages to mental health services, and life satisfaction.

A full evaluation is being conducted to measure the impact of the model on health care spending and quality of life. In addition to continuing the program in 2020, we anticipate reporting on the initial results of the R3 program.
**Need: Linguistic and Cultural Barriers**

**Goal:** Increase the availability of linguistic services to community dwelling seniors. Increase the training of HLS staff in best practices to address cultural barriers.

**Current Services:**

HRC recognizes that barriers to health care can include both linguistic and cultural barriers. Therefore, we make it our commitment to offer programs and services to meet the needs of our diverse communities and work to increase the visibility of these programs and remove barriers.

Our organization has a history of responding to the unique needs of a minority community that had suffered from anti-Semitism and often the traumas of war and immigration. This history informs our current commitment to serving communities in need, and intentionally welcoming people of all races, faiths, ethnic backgrounds, gender expression, and sexual orientations.

**Interpreter Services:** HRC provides free interpreter services to all non English speaking seniors who are receiving outpatient care at HRC and Home Care.

**Support for Russian-Speaking and Other Non-English-Speaking Seniors**

- **Long-term care:** At HRC-Roslindale, we provide a community where long-term care patients receive culturally appropriate care and services tailored to their individual needs. HRC employs more than 80 bilingual staff members and offers educational and career advancement opportunities, allowing us to attract employees who are committed to serving our Russian-speaking seniors.

- **Adult Day Health Program in Brighton for Russian and Chinese Speaking Seniors:** As part of its commitment to care for seniors in their native language, HRC opened the first bilingual Russian-English adult day health program in Massachusetts in 1999. This program is located on-site at the 2Life complex on Wallingford Road in Brighton.

- **Home Care:** Home Health and Personal Assistance Care professionals provide care to Russian-speaking seniors in their homes.

**Action Plan:**

- **Program Expansion:** In 2020, HSL will be celebrating 20 years of having a Russian-speaking community. We continue to provide additional services and events each year, such as concerts and speakers featuring outside guests, with a variety of programs available for all cognitive levels.

- **Community Events:** HSL will continue to take an active role in addressing the special needs for Russian-speaking and other non-English speaking seniors. Going forward, HSL will continue to explore ways to extend its linguistic and cultural services and continue to strengthen the relationship with professional providers in the community as well as cultivate and grow the donor base by attending community events.
• **Know Our Seniors:** We continue to get to know our seniors and their histories. One way we do this is through an oral history project with Brandeis University, where students come to HSL to interview seniors and tell their stories. These stories are shared in many ways, including a book that is produced in two languages.

• **Explore the Hukulah Fund:** HSL will research and explore this fund, which is a German government-funded program for holocaust survivors in the community.

**APPENDICES**

Appendices

Appendix A: Community Survey

[PDF]

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