Brighton

Dorchester

Hyde Park

Jamaica Plain

Roslindale

Roxbury

West Roxbury

Brookline

Dedham

Needham

Newton

Westwood

The Power to Redefine Aging.

Hebrew SeniorLife | HARVARD MEDICAL SCHOOL AFFILIATE

2016 Community Health Needs Assessment and Implementation Plan

Hebrew Rehabilitation Center
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Boston, MA 02131

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Executive Summary

In 2016, Hebrew Rehabilitation Center (HRC), an affiliate of Harvard Medical School, updated its 2013 Community Health Needs Assessment (CHNA). Founded with the promise to honor our elders, for 110 years we have served seniors' health care needs in several communities within the city of Boston, and more recently, in the towns of Brookline, Dedham, Needham, Newton and Westwood. As a chronic care hospital, HRC offers long-term care, post-acute care, adult day health and outpatient services.

As a hospital that primarily serves a community of senior citizens, we know first-hand the health challenges of older populations. We are especially in tune with baby boomers, who are reaching the age of 65 at a rate of about 10,000 people a day. Health care is transforming, and the baby boom generation will help us redefine the experience of aging.

The senior community continues to be the fastest growing population segment in Massachusetts.
In 2015, persons 65 years and over represented 15.4% of the population in Massachusetts (6,794,422). This is up from 13.8 % in 2010. 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 flu clinics 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 services leader that provides communities and health care for seniors, research into aging and education for geriatric care providers, HRC is a leader in transforming health care for seniors and delivering world-class senior care and wellness.

In 2016, we evaluated the needs of our community and the services we offer as well as those offered by others within and around the communities we serve. Our goal is to continue to move forward to meet the guidelines that the U.S. Department of Health and Human Services outlined for seniors in its *Healthy People 2020 Report* and better address the health needs of seniors in our community.

Our findings show that HRC continues to align with *Healthy People 2020* in the areas of prevention, long-term services and supports for our seniors. However, the CHNA findings show that seniors in our communities also need assistance with the following:

- Transportation
- Alzheimer's Care
- Mental health and depression services
- Linguistic and cultural barriers
- Access to various geriatric specialists
- Falls prevention

In response to these findings, HRC is developing an implementation plan documenting goals, our current services, and our action plan and timeline. This implementation plan will be completed in early 2017.

We thank members of HRC community for their helpful guidance and input in compiling this 2016 CHNA. We look forward to your joining us in 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 in the next step.

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 reflect the best options possible to meet any given individual's goals for care. Our staff provides medical and psychosocial care that encourages involvement from residents and families in the decision-making process. We strive to create the best living environments for residents and patients, promote wellness and establish caring practices that provide a personal, nurturing touch.

Led by Helen Chen, M.D., Chief Medical Officer, members of the Department of Medicine at HRC believe that all older patients should 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 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.

Our Partners

The oft-heard phrase, "It takes a village," extends to the care and wellness of our seniors. At HRC, a Harvard Medical School affiliate and the major chronic care hospital of Hebrew SeniorLife, our physicians, other clinicians and staff advance the standard of health care for seniors through innovation and specialized geriatrics expertise. We are proud of our relationships with a number of preferred provider partnerships 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 formal preferred providers for both the Beth Israel Deaconess Medical Center and the New England Baptist Hospital. 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 with the goal of improving the health of seniors in our local community. 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 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 residents 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.

HRC reviewed community health needs in 2016. The gathering and analysis of key community data available via publically accessible documents as well as the design, fielding and analysis of the community survey were key deliverables during this timeframe. The committee is now designing an implementation plan with goals and a description of the programs.

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 Hebrew SeniorLife Health Care Services, 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.

Ms. Moscato has nearly three decades of health care leadership and most recently served as president and chief executive officer for Care Alternatives, a multi-state provider of community-based health care services. She received her undergraduate degree from Northeastern University and an M.B.A. and M.P.H. from Boston University.

Clinical Advisor

Helen Chen, M.D., Chief Medical Officer, Hebrew SeniorLife

Helen Chen is Chief Medical Officer at Hebrew SeniorLife serving as senior clinical advisor and overseeing the organization's Department of Medicine. Dr. Chen brings over 20 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 to 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.

Prior to joining HRC, Dr. Chen served as Chief Medical Officer at the Center for Elders' Independence in Oakland, Calif, a nationally recognized, multi-site, non-profit Program of All-inclusive Care for the Elderly (PACE) designed for seniors whose health problems make it impossible for them to stay at home without the help of caregivers. A graduate of Brown University Medical School, she completed both her residency in Internal Medicine and fellowship program in Clinical Geriatrics at UCSF. Dr. Chen holds board certifications in geriatric medicine as well as hospice and palliative care.

Jennifer Raymond, Director of The Healthy Living Center of Excellence

Jennifer Raymond is the Director of The Healthy Living Center of Excellence, a partnership between Hebrew SeniorLife and Elder Services of the Merrimack Valley She oversees the community and statewide implementation and strategic planning for a variety of evidence-based community programs, including Chronic Disease Self-Management Programs, A Matter of Balance, Healthy Eating for Successful Living in Older Adults and many others. Raymond provides technical assistance at the local, state, and national level to organizations seeking to improve the health of older adults through improved education, access to resources, and behavior change. As a member of the CHNA committee, Raymond is responsible for community outreach, data gathering and analysis.

As Director of the Healthy Living Center of Excellence, Raymond works to imbed and sustain community programs, with a focus on reaching diverse populations and building a sustainable statewide infrastructure. She is a Master Trainer for the Chronic Disease Self-Management Program, Healthy Eating and Diabetes Self-Management programs, as well as a certified leader in a variety of other healthy aging programs, such as A Matter of Balance, Fit for your Life and the Arthritis Foundation Exercise Program. She serves on the national Evidence-based Leadership Council (EBLC) and as a consultant to the National Council on Aging (NCOA) and the National Association of Area Agencies on Aging (N4A). She received her law degree from the University of Maine School of Law and practiced domestic and elder law before joining Hebrew SeniorLife. Raymond earned an M.B.A. from Saint Joseph College in Maine.

Bill Burgey, Health Care Marketing Communications Manager

Bill joined Hebrew SeniorLife in 2008. As a member of the Hebrew SeniorLife marketing communications team, Burgey is responsible for leading marketing initiatives for Hebrew Rehabilitation Center. He takes great pride in working with staff at all levels of the organization to achieve desired results.

Burgey works on projects to build census and strengthen branding ties between HSL and its health care services. Bill works with the marketing teams at Boston area hospitals to develop strategic communications plans around partnerships and is a member of the HSL Brand Steering Committee.
Bill graduated from Worcester State College and received a MS in Advertising from Boston University. He has more than 20 years of marketing experience in health care.

Day to Day Lead

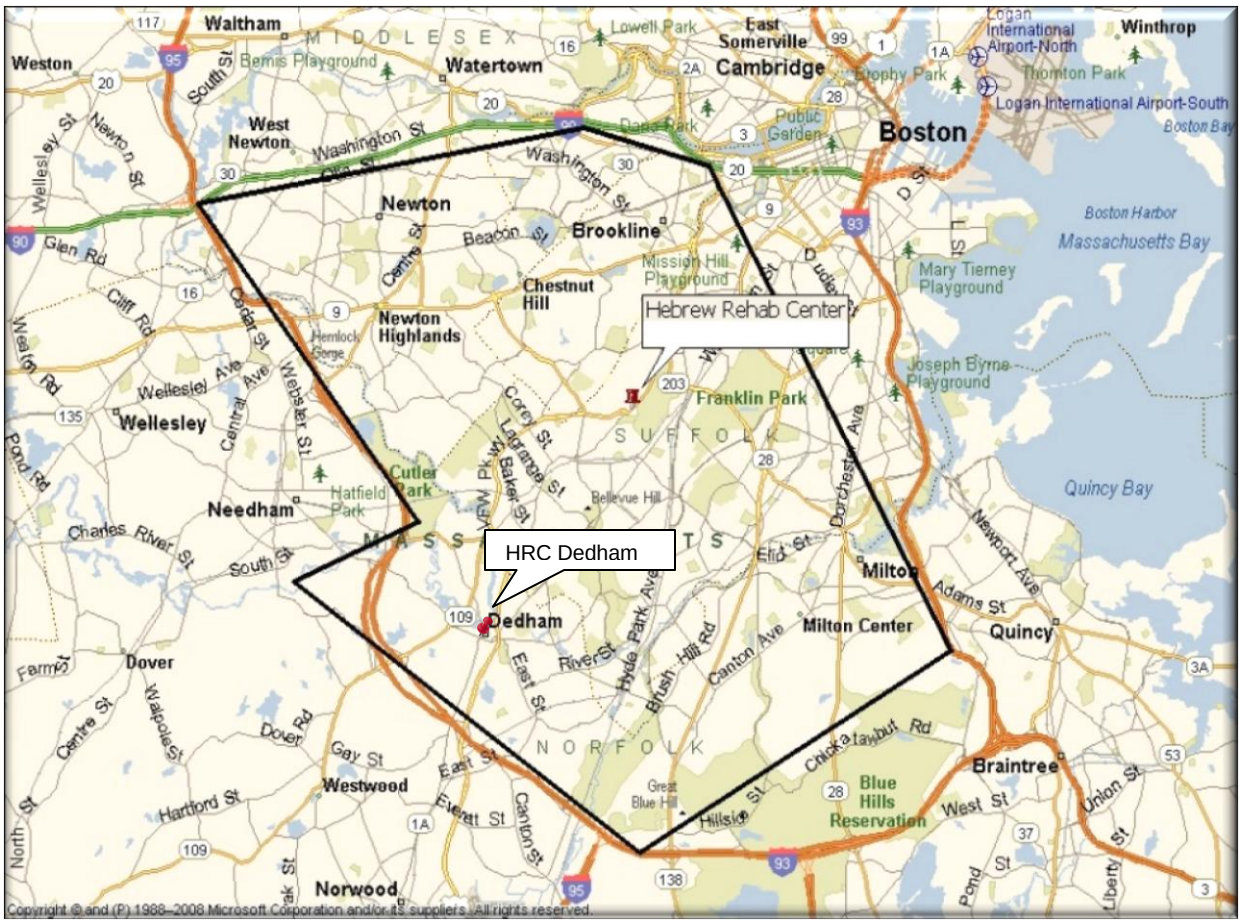
Rachel Whitehouse, Vice President of Marketing, Communications and Planning

Rachel Joslin Whitehouse is vice president of marketing, communications and planning at Hebrew SeniorLife. In her planning role, she partners with the operational leadership of Hebrew SeniorLife's health care, senior living 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 serves as the liaison to the rest of the Hebrew SeniorLife community to report on progress, findings and observations. Prior to joining Hebrew SeniorLife, Whitehouse was vice president for communications and public relations at Joslin Diabetes Center. She was an executive vice president at Brodeur Worldwide, an international communications consulting firm. She received her bachelor's degree from Northeastern University.

Chapter 2: Defining the Community

The local community served by HRC consists of thriving Boston neighborhoods and bustling suburbs in the Greater Boston area. The map below illustrates the local communities served.



However, to better define the population best served by the mission of HRC, the CHNA committee further analyzed HRC's licensure and patient zip codes of origin.

Hebrew Rehabilitation Center Geography: Licensure and Zip Code of Origin

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 chronic care/long-term care (LTC) 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.

- **Dedham:** HRC at NewBridge on the Charles, 7000 Great Meadow Road, Dedham, has 220 of HRC's chronic care/long-term care (LTC) 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 residents 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 CHNA committee further defined the community based on a patient zip code of origin analysis. Typically a facility can expect to draw 70 percent or more of residents from their local community. As can be expected in a dense urban area, there is significant overlap in the geographic origin of residents and patients for several of our health care services.

Zip Code Analysis
Admissions from 1/1/15-12/31/15
Top Towns Per Service

	Totals	Boston	Allston/Brighton	Brookline	Canton	Chestnut Hill	Dedham	Dorchester	Hyde Park	Jamaica Plain	Mattapan	Newton	Randolph	Roslindale	Roxbury	Needham/Needham Heights	West Roxbury	Westwood
MACU Boston	273	19	4	13	1	3	15	8	16	10	3	8	2	11	5	14	24	7
RSU Boston	852	45	49	118	4	14	24	37	39	62	21	62	26	65	7	14	7	2
LTC Boston	**165**	16	16	20	1	1	1	2	3	6	0	19	11	5	2	3	1	2
RSU Dedham	1083	23	8	42	51	35	178	7	26	19	6	80	10	15	1	51	53	32
LTC Dedham (by town rank)	**75**	1	2	10	1	1	26	1	0	2	0	7	0	3	3	3	0	2

Indicates top 4 by patient volume

Hebrew SeniorLife Medical Group – Brookline
Hebrew SeniorLife Medical Group Practice draws primarily from the community of Brookline.

Based on patient zip code of origin, the local communities we serve are particular neighborhoods of Boston and the towns of Brookline, Newton, Dedham, Needham 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 and its satellite medical clinics are on Medicare and are older than 65. Those younger include many employees receiving outpatient and therapeutic services.

Age at Admission - 2015

Campus - Service Line	Average Age	Median Age
HRC-LTC	88.1	89.5
HRC-MACU (2010)	75.8	79.5
HRC-RSU	81.5	79.5
Adult Day Health	85	81
HRC NewBridge-LTC	89.5	89.5
HRC NewBridge-RSU	80.4	79.5
Brookline Medical Practice	85	87

Insurance Profile

Approximately 80 percent of the patients in our long-term care are dual eligible for Medicare and Medicaid coverage. The remainder of our long-term 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)).

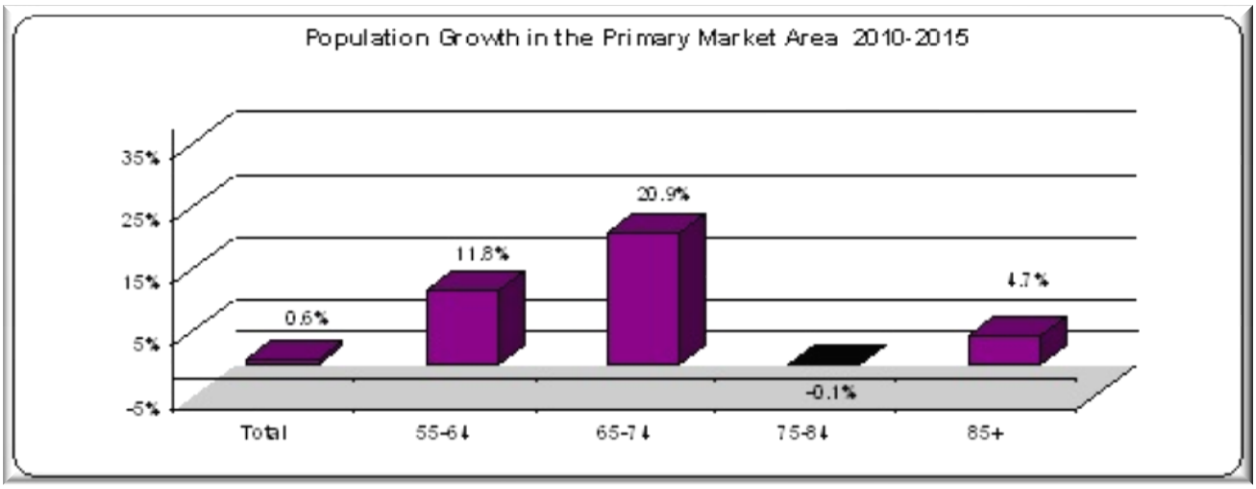
The state is among the nation’s lowest in rates of uninsured. The United States 2010 Census indicates that 86.8 percent of the total population has health insurance; this is below the *Healthy People 2020* goal of 100 percent.

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

Population Trends

Approximately 56,283 individuals age 65 or older reside within the local area as of 2012, representing 12.4 percent of the total population within the area, which is similar to the 13.9 percent within Massachusetts. The senior population is projected to increase by 11.2 percent over the period of 2010 to 2015, in contrast to a projected increase of 0.6 percent for the total population.

Relatively substantial increases in each of the older adult age cohorts are projected through 2015, except for the 75 – 84 age group. The increases in the other older adult age groups indicate a potential growing need for senior housing and services.



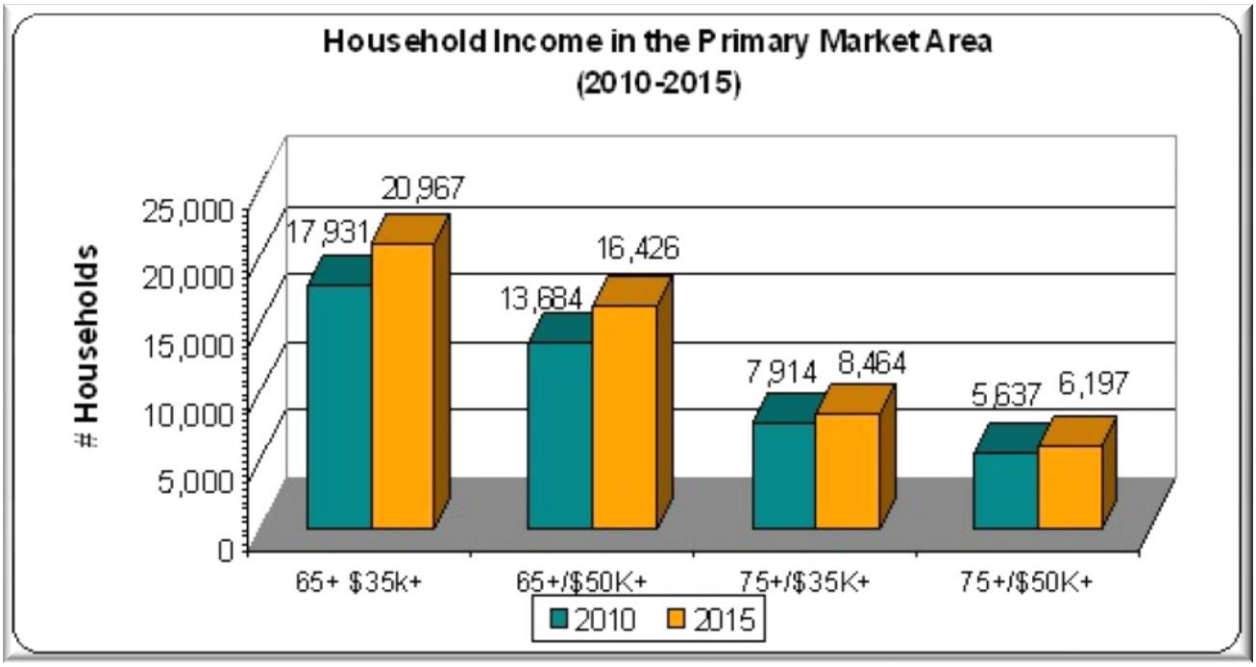
The slight decrease in the 75-84 age group (0.1%) is typical, as the lower birth rates during the Depression have caused this age cohort throughout many markets in the United States to remain flat or decline through 2015.

There is also a projected increase (11.8%) in the population age 55 to 64 (the leading edge of the Baby Boom generation), which is relatively modest compared to other market areas.

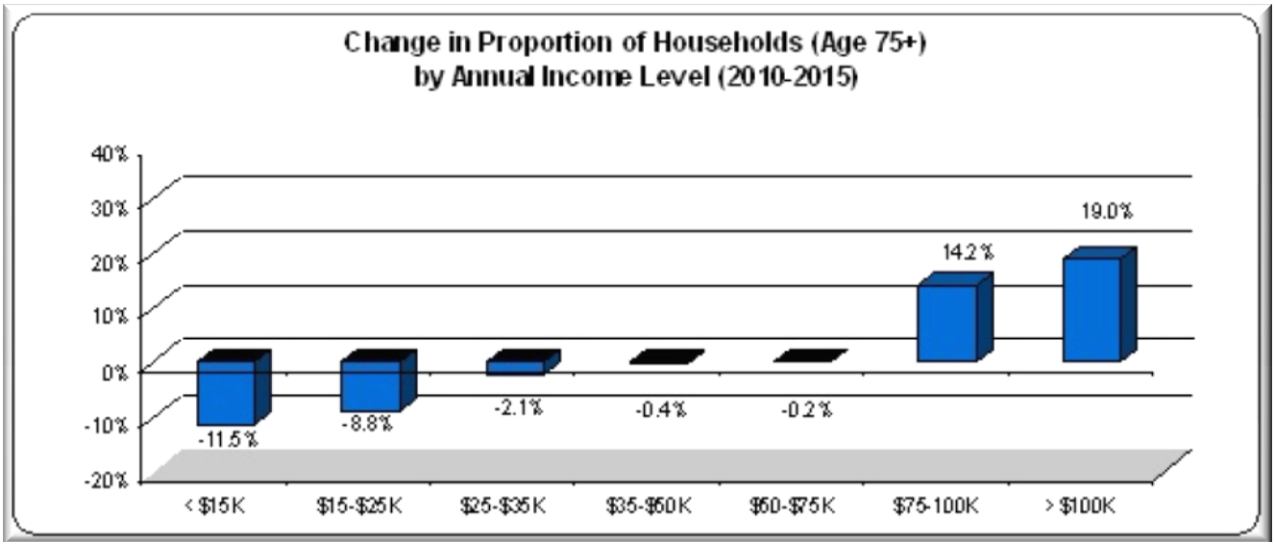
Our senior communities are on a growth path, suggesting an increasing need for services.

Household Income

As shown in the graph below, the number of seniors residing in the local community area (age 65+ and 75+, with incomes of $35,000+ and $50,000+) is anticipated to increase 6.9 percent to 20 percent in the period of 2010 - 2015.



The graph below illustrates the projected percentage increase in the number of householders age 75 or older, by income level. As can be seen from the graph, increases in household income are only occurring at the highest income levels, starting at $75,000 and higher. Low income remains a challenge for most of our seniors.



Ethnicity/Race

Based on the United States 2010 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.

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

The chart below shows the county by county breakdown by race.

Race	Suffolk County	Norfolk County
White	404,269	551,847
African American	156,292	38,148
Asian	59,429	57,803
AIAN	2,984	1,091
NHPI	292	129
Some Other Race	70,315	8,926
Two or More Races	28,442	12,906

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

Ethnicity	Suffolk County	Norfolk County
Hispanic or Latino	143,455	22,004
Not Hispanic or Latino	578,568	648,846

Chapter 3: Defining the Community Health Needs

Healthy People 2020

The U.S. Department of Health & Human Services (DHHS) has defined goals through *Healthy People 2020*, a set of science-based, 10-year national objectives for improving the health of all Americans. *Healthy People 2020* outlines a comprehensive, nationwide health promotion and disease prevention agenda.

The Healthy People 2020 objectives for older adults are designed to promote healthy outcomes for this population. Many factors affect the health, function and quality of life of older adults. Specifically, the objectives take into account the following determinants and issues, as outlined by the DHHS in its documentation:

- Individual Behavioral Determinants of Health in Older Adults
    - Behaviors such as participation in physical activity, self-management of chronic diseases, or use of preventive health services can improve health outcomes.
- Social Environment Determinants of Health in Older Adults
    - Housing and transportation services affect the ability of older adults to access care. People from minority populations tend to be in poorer health and use health services less often than people from non-minority populations.
- Health Services-Related Determinants of Health in Older Adults
    - The quality of the health and social services available to older adults and their caregivers affects their ability to manage chronic conditions and long-term care needs effectively.
- Emerging Issues in the Health of Older Adults
    - Emerging issues for improving the health of older adults include:
        - Person-centered care planning that includes caregivers
        - Quality measures of care and monitoring of health conditions
        - Fair pay and compensation standards for formal and informal caregivers
        - Minimum levels of geriatric training for health professionals
        - Enhanced data on certain subpopulations of older adults, including aging LGBT populations

The CHNA committee re-reviewed the *Healthy People 2020 "Objectives for Older Adults"* and determined the following as an appropriate fit for HRC. These objectives are in the categories of Prevention and Long-Term Services and Supports. The CHNA committee will work to align its January 2017 implementation plan with these objectives:

- Prevention
  Of particular note are:
  - Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate or vigorous leisure-time physical activities.
  - Increase the proportion of older adults who receive Diabetes Self-Management Benefits.
  - Increase the proportion of older adults who are up-to-date on a core set of clinical preventative services.
  - Increase the proportion of the health care workforce with geriatric certification.

- Long-Term Services and Supports
  Of particular note are:
  - Reduce the rate of pressure ulcer-related hospitalizations among older adults
  - Reduce the rate of emergency department (ED) visits due to falls among older adults.

The most pertinent objectives of Healthy People 2020 for HRC are Prevention and Long-Term Services and Supports.

Publically Available Data

As previously stated, HRC offers its services in Boston, Brookline, Dedham, Newton, Needham and Westwood. In recent years, these cities and towns have all been included in multiple publically available public health assessments. As part of the CHNA, the committee reviewed those public health assessments to identify health needs relevant to our community and target population.

The data sources are:

- Boston Public Health Commission "Health of Boston 2011"

- Mass. Department of Public Health: Mass. CHIP Massachusetts Community Health Information Profile

    - Behavioral Risk Factor Surveillance System (BRFSS) Special Reports: Chronic Illness for Boston
    - Diabetes Report for Brookline
    - Older Adults Report for Brookline
    - Health Status Indicators Report for Dedham

- The Massachusetts Department of Public Health has designated 27 areas within the state as "Community Health Network Areas" or "CHNAs." One such area is the West Suburban CHNA (CHNA 18) that consists of **Brookline**, **Dedham**, Dover, **Needham**, **Newton**, Waltham, Wellesley, Weston and **Westwood**. In 2011, that CHNA completed an extremely thorough community health needs assessment.

    - West Suburban Community Health Network (CHNA) 18 Community Needs Assessment
    - West Suburban Community Health Network (CHNA) 18 Community Needs Assessment – Dedham Supplement
    - West Suburban Community Health Network (CHNA) 18 Community Needs Assessment – Brookline Supplement

Highlights of our community health needs assessment based on publically available data are included below.

	Need	Source
Boston Area	The diabetes hospitalization rate for ROSLINDALE was more than twice the rate for Boston overall	Health of Boston, Boston Public Health Commission Report, page 365
	The diabetes hospitalization rate for ROXBURY was more than twice the rate for Boston overall	Health of Boston, Boston Public Health Commission Report, page 365
	ROXBURY has the highest rate of heart disease hospitalization in Boston	Health of Boston, Boston Public Health Commission Report, page 372
	ROXBURY has the lowest median income in Boston and the highest percentage of people below the poverty level	Health of Boston, Boston Public Health Commission Report, pages 354-355
	Only 49-60% of adults in ROSLINDALE, WEST ROXBURY, JAMAICA PLAIN, DORCHESTER and ROXBURY report engaging in regular physical activity	Health of Boston, Boston Public Health Commission Report, page 362
	25-30% of adults in ROSLINDALE and ROXBURY are obese	Health of Boston, Boston Public Health Commission Report, page 366
	DORCHESTER has a rate of approximately 1.65 per 1000 people hospitalized for diabetes	Health of Boston, Boston Public Health Commission Report, page 365
	Approximately 19 out of every 1000 people in HYDE PARK are hospitalized for heart disease	Health of Boston, Boston Public Health Commission Report, page 372
	BRIGHTON has a lower percentage of obese adults and a higher percentage of adults engaged in physical activity than the rest of Boston	Health of Boston, Boston Public Health Commission Report, pages 363, 366
	59% of individuals over age 65 in BOSTON suffer from high blood pressure (higher than state average)	BSRF Boston (MassCHIP)
	Over half (55%) adults over age 65 in BOSTON suffer from arthritis (consistent with state average)	BSRF Boston (MassCHIP)
Dedham	DEDHAM has a higher rate of diabetes than the rest of the state	CHNA 18 Needs Assessment (Dedham Supplement)
	The rate of falls among seniors in CHNA 18 (DEDHAM, BROOKLINE, NEEDHAM, NEWTON and WESTWOOD) is higher than that of the state	CHNA 18 Needs Assessment (Dedham), page 40, MassCHIP

	16% of DEDHAM residents are over the age of 65 (higher than the state average)	Health Status Indicators Report (Dedham), MassCHIP
	DEDHAM has a higher rate of cancer-related deaths than the state average	Health Status Indicators Report (Dedham), MassCHIP
	DEDHAM has a higher rate of cardiovascular-related deaths than the state average	Health Status Indicators Report (Dedham), MassCHIP
Brookline	BROOKLINE has a higher rate of residents over age 85 than the state average	CHNA 18 Needs Assessment, page 10, MassCHIP
	BROOKLINE has lower rates of mortality, smoking, hypertension and adult and child obesity, teen births and motor vehicle-related ER visits than the state average	CHNA 18 Needs Assessment, MassCHIP
	BROOKLINE has a higher rate of HIV/AIDS than other CHNA communities but it is still lower than the state average	CHNA 18 Needs Assessment, Mass CHIP
	BROOKLINE has a higher rate of diabetes-related emergency room (ER) visits than the state average	MassCHIP Diabetes Report for Brookline
	BROOKLINE has a higher percentage of adults over age 75 with one or more disabilities than the state average	MassCHIP Older Adults Report for Brookline
Needham	NEEDHAM has a higher percentage of adults over age 65 and a higher percentage of adults over age 80 than the state average	CHNA 18 Needs Assessment, page 11, MassCHIP
	The rate of hypertension in NEEDHAM is better than the state average	CHNA 18 Needs Assessment, page 34, MassCHIP
	NEEDHAM has lower rates of mortality, diabetes, smoking, hypertension and adult and child obesity, teen births and motor vehicle-related ER visits than the state, and lower rates of HIV/AIDS than the state and the other CHNA 18 communities	CHNA 18 Needs Assessment, MassCHIP
	NEEDHAM has a greater percentage of both older people and young people than do other towns in CHNA 18 and the state; it also has among the highest percentages of the “old (over 80) of all state communities	CHNA 18 Needs Assessment, MassCHIP

Newton	NEWTON has a higher percentage of adults over age 65 and a higher percentage of adults over age 80 than the state average	CHNA 18 Needs Assessment, page 11, MassCHIP
	The rate of hypertension in NEWTON is better than the state average	CHNA 18 Needs Assessment, page 34, MassCHIP
	NEWTON has lower rates of mortality, diabetes, smoking, hypertension and adult and child obesity, teen births and motor vehicle-related ER visits than the state, and a similar rate of HIV/AIDS as the state and the other CHNA 18 communities	CHNA 18 Needs Assessment, MassCHIP
	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	CHNA 18 Needs Assessment, MassCHIP
Westwood	WESTWOOD has a higher percentage of adults over age 65 and a higher percentage of adults over age 80 than the state average	CHNA 18 Needs Assessment, page 11, MassCHIP
	The rate of hypertension in WESTWOOD is not significantly different than the state average	CHNA 18 Needs Assessment, page 34, MassCHIP

Several of our local communities have chronic disease and co-morbidity rates higher than the Boston and state averages.

Obtaining Community Input

Approach

The primary vehicle for gathering community input was a Survey Monkey. The survey was fielded to members of the Multicultural Coalition on Aging, which represents Boston and its immediate suburbs, and to members of the Healthy Living Centers of Excellence, Boston Collaborative. Hebrew SeniorLife is a founding member of both these groups. Members of these groups serve or represent members of the medically underserved, low income or minority populations in the community.

The survey, designed to gather external, first-hand input on the needs of seniors in the community, was administered in 2016 to more than 150 contacts.

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

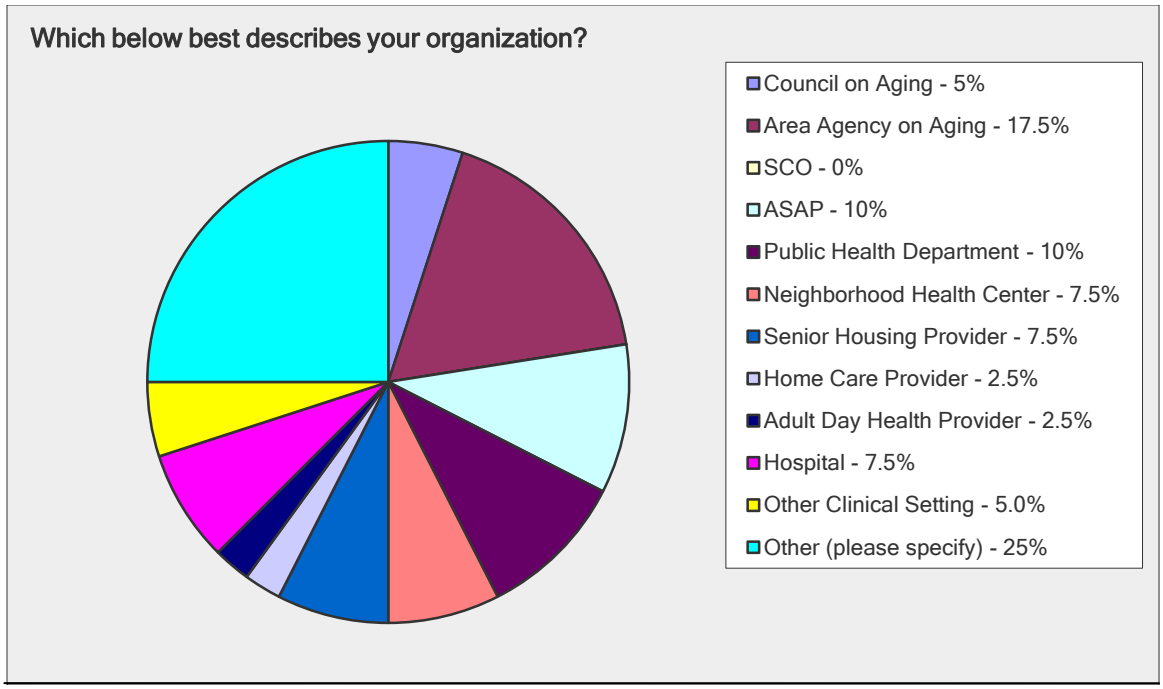
Sample Questions
What do you think are the top three health problems for seniors in our community?
What do you think are the top three medical care access problems for seniors in our community? (i.e., access to a doctor, nurse or other health care provider)
What do you think are the top three healthy living access problems for seniors in our community?

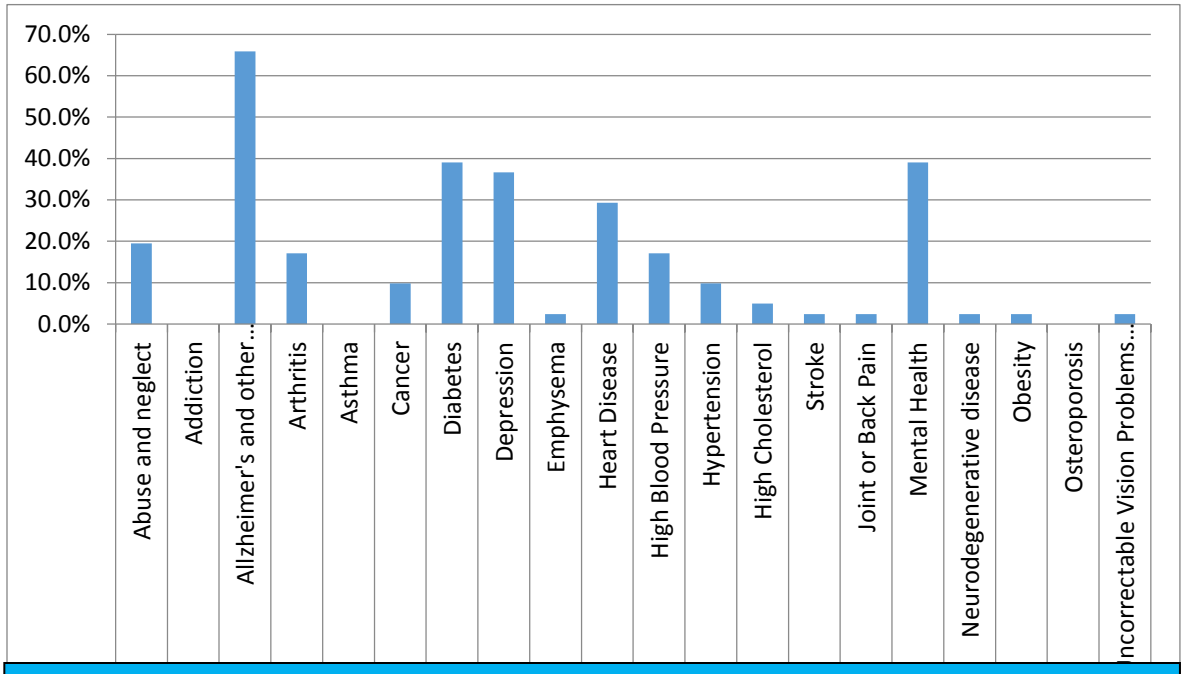
Results

The survey yielded 41 responses. The following were the top three categories of respondents:

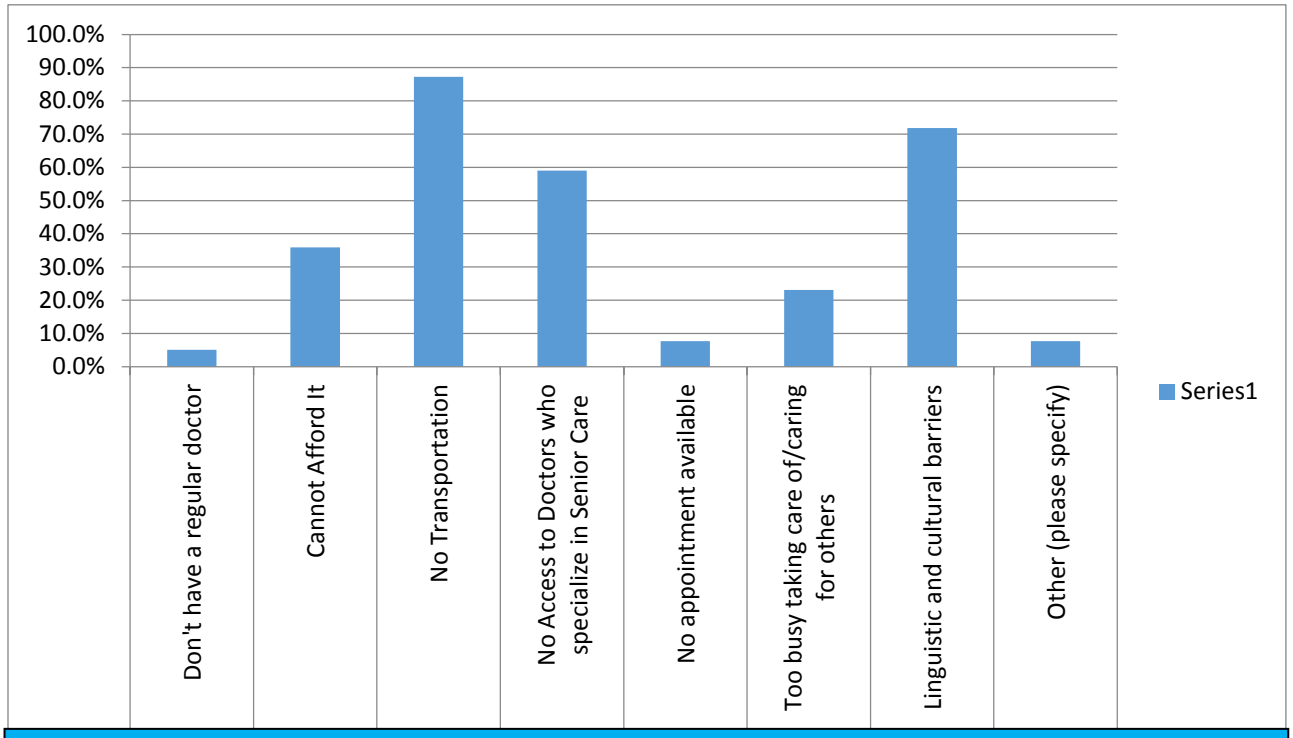
- Area Agencies on Aging
- Aging Services Access Points
- Public Health Department

Following are responses. Please see the full survey in Appendix A.

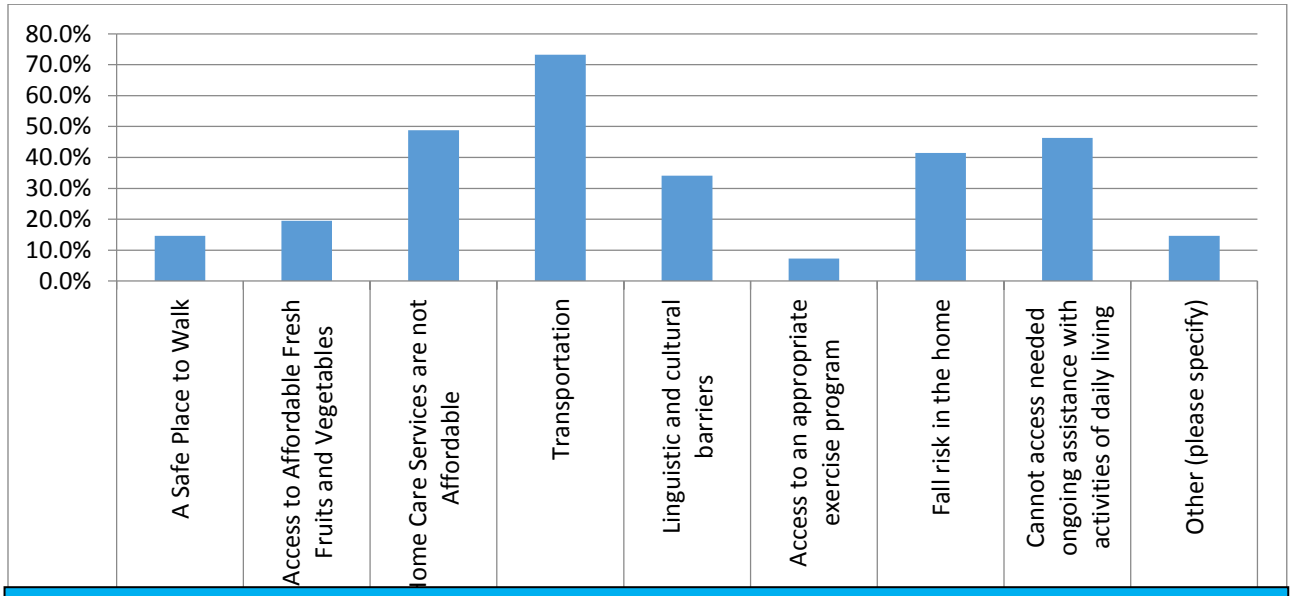




What do you think are the top three health problems for seniors in our community? Please pick the top three:



What do you think are the top three medical care access problems for seniors in our community? (i.e., access to a doctor, nurse or other health care provider) Please pick the top three:



What do you think are the top three healthy living access problems for seniors in our community? Please pick the top three:

From there, the CHNA team took a three-pronged approach to examining the survey content:

- **Community Physical Health Issues/Problems**

    - What do you think are the top three health problems for seniors in our community?
    - What is the most pressing health care related need for seniors in our community?

- **Community Medical Services Access Issues/Problems**

    - What do you think are the top three medical care access problems for seniors in our community?
    - What is the most pressing health care related need for seniors in our community? (Included here as many respondents also suggested medical service access issues)

- **Community Healthy Living Access Issues/Problems**

    - What do you think are the top three healthy living access problems for seniors in our community?
    - What can HSL do to better meet the health needs of the seniors in our community?

Following the review of the survey results and the categories, the CHNA committee set out to prioritize the community need. The CHNA committee's metric for prioritization was: the prevalence of the issue in our survey and in the publically available data, mapped against the *Healthy People 2020* objectives we identified earlier as most relevant to HRC and our local communities.

Priority Community Health Needs

The CHNA committee prioritized the following as the overall community needs, based on all three categories (Physical Health, Medical Services Access, and Healthy Living Access):

- Transportation
- Alzheimer's Care
- Mental health and depression services
- Linguistic and cultural barriers
- Access to various geriatric specialists
- Falls prevention

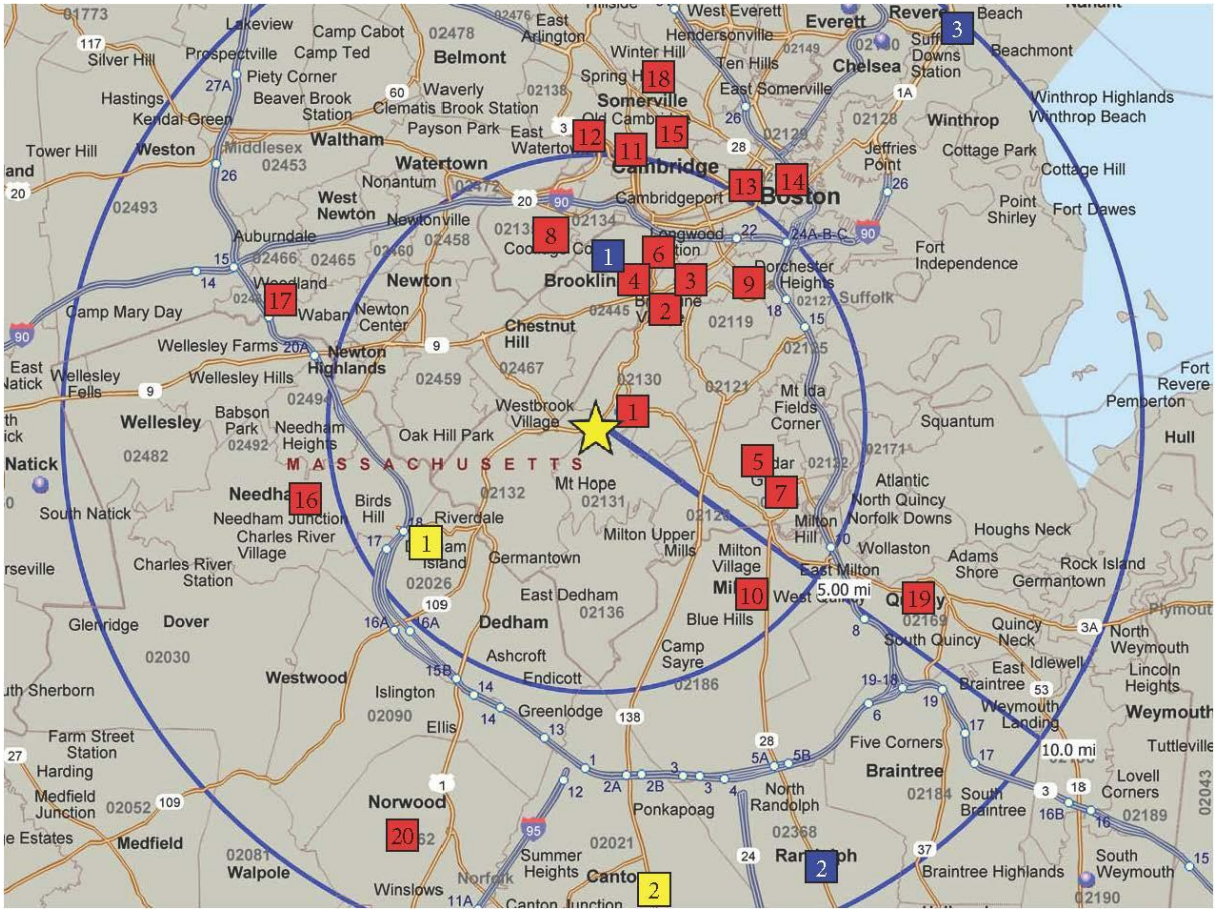
Priority Community Needs	Our Rationale/Impact on Seniors
Transportation to medical appointments	• About 8.4 million senior citizens in the U.S. depend on others for their transportation. • Loss of social independence, reduced mobility and isolation that come as a result of restricted or terminated driving privileges can result in a lack of access to essential services. • Often, a non-driving individual feels that he or she must always plan around others' schedules, and that trips are increasingly made out of necessity rather than for social reasons. • Lack of transportation is not only physically but also emotionally challenging.
Alzheimer's Care	• Alzheimer's disease, the most common form of dementia ("cancer of the next decade"), affects **5.2M** Americans (11% of those > 65), a number expected to triple by 2050 • Alzheimer's is the only cause of death (of the top 10 in the U.S.) that **cannot be prevented, cured, or slowed**
Mental health and depression services	• Nearly six million U.S. seniors are affected by clinical depression. • An estimated 10 percent of elderly Americans, and 20 percent of those living in nursing homes, suffer from depression. • Only 10 percent of those suffering from depression receive treatment. • The good news is that medication and therapy are effective in reducing the recurrence of depression in the elderly.

Linguistic and cultural barriers	• Low health literacy, cultural barriers, and limited English proficiency have been coined the "triple threat" to effective health communication by The Joint Commission • Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse patients. • The percentage of Americans who are racial and ethnic minorities and who speak a primary language other than English continues grow rapidly.
Access to various geriatric specialists	• There is currently one geriatrician for every 5000 seniors, far short of the 14,000 projected as currently needed. (American Geriatrics Society Task Force on the Future of Geriatric Medicine March, 2005.) • Disparities in access to health care affect individuals and society. • Lack of availability, high cost and lack of insurance coverage can lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been avoided.
Falls prevention	• Falls are the leading cause of death from injury for seniors. • Risk increases with aging and even fear of falling reduces quality of life. • One in three seniors fall each year, and 25 percent of those who fall suffer moderate to severe injury, such as hip fractures. • Only 25 percent of seniors with hip fractures make a full recovery. Forty percent require nursing home care and nearly 25 percent die within 12 months. • The good news is that falls in seniors are largely preventable.

Transportation, Alzheimer's care, mental health and depression services, linguistic and cultural barriers, access to specialists, falls prevention are our priority community health needs

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 Hebrew Rehabilitation Center facilities as well as acute care hospitals within a 10-mile radius.



Legends follow on the next page.

Acute Care Hospitals (10-mile radius)	
1	Brigham and Women's Hospital – Faulkner
2	New England Baptist Hospital
3	Brigam 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 Deaconess Medical Hospital – Milton
11	Mount Auburn Hospital
12	Massachucetts Eye and Ear Infirmary
13	Massachusetts General Hospital
14	The Cambridge Hospital
15	Beth Israel Deaconess Hospital – Needham
16	Newton-Wellesley Hospital
17	Somerville Hospital
18	Quincy Medical Center
19	Norwood Hospital

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. A more comprehensive list is included in Appendix B.

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.

In determining priorities in light of the local medical community, 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 organizations to meet that same need. The CHNA committee determined that its priority should be to work closely with patients to provide access to that great care, whether at Hebrew Rehabilitation Center or our sister health care organizations.

According to the U.S. Health Resources and Services Administration, "the growth and aging of the population will contribute to a 22 percent increase in the demand of physician services between 2005 and 2020. Growth in demand will be highest among specialties that predominantly serve the elderly (e.g., cardiology, internal medicine and most surgical specialties." Additionally, Massachusetts has more physicians, nurses, pharmacist, dentists and dental hygienists per 100,000 people than the United States as a whole. With this in mind, we anticipate a long, interconnected relationship with Greater Boston hospitals in the care and treatment of our community's seniors.

HRC will continue to team with its fellow medical facilities in Greater Boston to deliver the best care needed for seniors.

Chapter 4: Implementation Plan

Since publishing its 2013 CHNA, HSL has increasingly focused on the needs of seniors who live at home in the communities we serve. We know these seniors have new expectations and demand more and different services. They want to age in place, engage in lifelong learning, and maintain their active lifestyle as long as their health permits. Yet because they are living longer, their medical needs will be complex. Many will require long-term supports and services, further straining existing systems.

Since 2013, to meet the health needs of these seniors, HSL has significantly expanded the range and reach of its services for community dwelling seniors. From pioneering new services such as Therapy House Calls, to personal assistance services for very low-income seniors, we've invested in areas we believe will help seniors stay healthy and independent, and have brought dozens of new services to them.

In 2014, we launched our first strategic planning initiative in more than 10 years – a process in which we received invaluable input from our local community, our employees, and volunteers from across the organization, as well as national experts.

Our resulting 2016-2022 HSL Strategic Plan focuses on how we can do an even better job of fulfilling our mission to serve and care for seniors. Our plan comprises 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.**

Our strategic plan recognizes that seniors who live in their own homes require services that span direct care, prevention and education, and other forms of assistance. The plan looks to future services, such as 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 them to HSL through services and events at our campuses.

This 2016 CHNA Implementation Plan marries the overarching direction of the HSL Strategic Plan with the immediate health needs of seniors in our community:

- Transportation
- Alzheimer's Care
- Mental Health and Depression Services
- Linguistic and Cultural Barriers
- Access to Various Geriatric Specialists
- Falls Prevention

Prevention, access to care, and long-term services and supports in these areas not only will help meet the guidelines set forth in *Healthy People 2020*; more importantly, they will help the most vulnerable seniors in the communities of Roslindale, Brighton, West Roxbury, Jamaica Plain, Hyde Park, Dorchester, Roxbury, Brookline, Canton, Dedham, Needham, Newton, Randolph and Westwood live their lives with purpose, vigor and their best health possible.

The overarching goals of our 2016 Implementation Plan are as follows:

- **Transportation**: To educate seniors about the transportation methods available to them to access health care services that help them maintain a healthy lifestyle and remain independent.

- **Alzheimer's Care:** Increase the availability and accessibility of Alzheimer's care offerings for community dwelling seniors and their families.

- **Mental Health and Depression Services:** Increase the number of mental health and depression services HSL offers to seniors who live in the community in their own home.

- **Linguistic and Cultural Barriers:** Increase the availability of linguistic services to community dwelling seniors. Increase the training of HLS staff in best practices to address cultural barriers.

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

- **Falls Prevention:** Increase access to HSL's falls prevention offerings to community dwelling seniors.

The following pages outline our 2016 CHNA implementation plan, structured around the six identified areas of need. For each area of need, we outline our goal, our current services, and our action plan.

The plan references HSL's many Home and Community based services. For reference, following is a brief overview of the services we currently provide to community dwelling seniors.

Outpatient Care and Services

Hebrew SeniorLife Medical Group: Specialized geriatric primary care clinic at Center Communities of Brookline, 100 Centre Street, Brookline. Services provided by geriatricians or nurse practitioners include wellness assessments and same-day urgent care appointments with on-site laboratory services.

Adult Day Health Programs: "Great Days for Seniors" programs at two locations in Boston: HRC-Roslindale and Jewish Community Housing for the Elderly (JCHE) in Brighton. An active, social daytime community for seniors living at home supported by an interdisciplinary team of nursing, social work, and therapeutic recreation professionals to meet participants' needs.

Outpatient Therapy Services: Based at HRC, an experienced team of physical therapists, occupational therapists, speech therapists, audiologists, and exercise physiologists utilize the most up-to-date treatment techniques to maximize function and independence.

Specialty Care Services: Based at HRC-Roslindale, services include a Memory Disorders Clinic, osteoporosis screening and wound care.

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 therapy, depression screening and social work.

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

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).

Home Safety Evaluation: HSL physical or occupational therapists perform home safety evaluations for seniors to ensure their environments are comfortable, secure and safe.

HSL Hospice Care: Multidisciplinary team 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.

Community Education: The Healthy Living Center of Excellence

HSL's Department of Medicine is committed to promoting healthy aging initiatives in our community and across the Commonwealth. For many years, HSL has led education programs across Massachusetts to encourage and educate health care consumers – mainly older adults – to better manage their chronic conditions and become active participants in their own care.

HSL is a founding member of The Massachusetts Healthy Living Center of Excellence (HLCE), which aims to help older adults remain independent and in the community as long as possible through the use of proven evidence-based programs that promote behavior change and encourage older adults to become active partners in managing their own health.

Combining expertise in both the aging services and medical networks, the HLCE is led by HSL and Elder Services of the Merrimack Valley and offers a centralized infrastructure and regional coalition that is making evidence-based disease management and wellness programs more easily replicated and sustainable across the Commonwealth.

Over the past five years, the HLCE has trained more than 200 leaders at 60 community organizations in evidence-based healthy aging initiatives. These interventions take a comprehensive approach to keeping seniors vibrant and healthy by addressing a full spectrum of health-related concerns.

The HLCE offers both participant education and train the trainer program. Sample programs include:

- Healthy Eating for Successful Living in Older Adults
- A Matter of Balance
- Chronic Disease Self-Management Program
- Diabetes Self-Management Program
- Fit For Your Life
- The Arthritis Foundation Exercise Program

Need-Specific Implementation Plans

Need: Transportation

Goal: To educate seniors about the transportation methods available to them to access health care services that help them maintain a healthy lifestyle and remain independent.

Current Services: We recognize that transportation for community dwelling seniors is a growing need and one that is not fully met. To help address this need, HRC is focused on delivering increased services in locations where seniors live, including housing sites sponsored by HSL and by other providers. For example, HSL's Home Care services are now available in more of the communities identified in this CHNA. In another example, HRC's innovative Therapy House Calls are being provided at a non-HSL assisted living community in Newton.

Action Plan: HRC will continue to explore opportunities to partner with other organizations in the community, including ETHOS, that provide transportation services for community dwelling seniors.

HRC will also work to ensure the seniors we serve are aware of the transportation services we offer independently and with other organizations. For example, we will work to raise awareness among our patients about the Senior Shuttle, a free door-to-door transportation service for Boston residents age 60 and older, provided by the Commission on Elder Affairs, City of Boston. We will create materials outlining available transportation offerings for posting on our web site and delivering to new patients.

HRC will continue to work with partners to offer HLCE 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 to. 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 Senior Whole Health and Commonwealth Care Alliance, both of which have ability to provide transportation to health and wellness programs.

Need: Alzheimer's Care

Goal: Increase the availability and accessibility of Alzheimer's care offerings for community dwelling seniors and their families

Current Services:

HSL offers a variety of services for seniors with Alzheimer's and other forms of dementia who live in their own homes. HSL works to raise awareness of its services at a number of community and professional events, including the annual Alzheimer's Association's Greater Boston "Walk to End Alzheimer's," and its annual conference for professionals, "Map through the Maze." HRC staff are regular presenters at the conference.

These services include:

Café Connect: In an effort to provide support to community dwelling seniors, the NewBridge on the Charles team recently launched Café Connect. Café Connect is an interactive program for adults with memory impairment and their loved ones. Each month, a guest artist or facilitator leads the interactive program. NewBridge also partners with Temple Emanuel in Newton to bring Café Connect to adults in nearby communities. With philanthropic support, HSL envisions expanding this program.

Adult Day Health: Staff at both locations completed the Alzheimer's Association Habilitation Training Certification program and provide person-centered care for people with memory loss. Services focus on enhancing the lives of participants and promoting independence.

Hospice: HSL's Hospice reports that the #1 diagnosis for its clients is dementia. Care is provided by specialized multi-disciplinary teams, comprised of medical professionals, including physicians and nurses, in-home aides, social workers, chaplains, volunteers, families and friends.

HLCE Caregiver Training: The Savvy Caregiver Program is a six-week training program for caregivers who care for someone with Alzheimer's or related dementias.

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

- Understanding and Living with Dementia: A Resource for Families
  www.hebrewseniorlife.org/ebook

- Advanced Dementia: A Guide for Families
  https://www.instituteforagingresearch.org/resources/assets/advanced-dementia-guide-families

- How to Talk to Families About Advanced Dementia: A guide for Health Care Professionals
  https://www.instituteforagingresearch.org/resources/assets/how-talk-families-about-advanced-dementia-guide-health-care-professionals

Action Plan: HSL currently provides excellent care for patients and residents with dementia. We have many in-house experts across various disciplines and now seek to knit together and build upon this foundation to create a "one-stop shop" for patients and families trying to cope with Alzheimer's and dementia.

This vision of an Alzheimer's Center of Excellence fits into our strategic plan for the future of Hebrew SeniorLife, which outlines the ways we will extend our impact on the lives of growing numbers of seniors. We will provide best-in-class care and communities, reach more seniors in the community and engage them earlier, and advance the field through research and teaching.

The Center for Excellence will provide best-in-class prevention, care, support and research in aging brain health and Alzheimer's disease. The Center will provide a unified set of preventive, diagnostic, care and complementary services; conduct clinical research; leverage HSL's capabilities while building new ones; increase family empowerment; and become a model of care for Alzheimer's disease and dementia.

The Center's staff will diagnose and treat the cause of memory loss and its complications, provide necessary services so individuals can remain independent as long as possible, provide critically needed support for caregivers and family, and conduct research to continuously advance knowledge in the field.

Specific initiatives of concern to the communities served by HRC include the following:

Connect existing services across HSL's continuum of care. 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 outpatient Memory Clinic, senior living communities, expressive therapies, home and community services, palliative care and hospice, we can improve care and help relieve the burden of caregiving.

Evaluate the needs of the community and expand our offerings as necessary. We will add services in the areas of diagnosis, prevention, training and education, such as early assessments with families and patients, a community hotline, caregiver supports and more.

Need: Mental Health and Depression Services

Goal: Increase the availability and accessibility of mental health and depression services for community dwelling seniors.

Current Services:

Since the completion of the HRC 2013 CHNA, HSL has significantly increased its services to help both its employees and community-dwelling seniors address issues with mental health and depression. These include:

Supporting Our Employees: At HSL, the stigma associated with mental health issues is never a barrier to our holistic approach to care for our patients and residents. In 2016, HSL joined "CEO's Against Stigma," a campaign of The National Alliance on Mental Illness of Massachusetts and pledged to work toward a stigma-free work environment. By partnering with NAMI, HSL now offers training programs and resources for staff to support them with their individual needs. Through this initiative we are extending the same level of respect and dignity we offer to our patients to our dedicated employees who may live with a mental illness.

Adult Day Health: Great Days for Seniors offers services it its participants that help reduce depression and provides support for individuals with mental health issues.

Home Care: Depression screening is included in all new patient evaluations.

HLCE Education: The HLCE offers two educational programs focused on combating depression among community dwelling seniors:

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults. This program addresses depression in older adults often occurring with chronic illness and other losses later in life. Healthy IDEAS ensures older adults get the help they need to manage symptoms of depression and live full lives by screening for symptoms of depression and assessing their severity; educating older adults and caregivers about depression; linking older adults to primary care and mental health providers; and empowering older adults to manage their depression through a behavioral activation approach that encourages involvement in meaningful activities.

The PEARLS Program is designed to reduce depressive symptoms and improve quality of life in older adults. During six to eight in-home sessions that take place in the client's home and focus on brief behavioral techniques, PEARLS Program counselors empower individuals to take action and to make lasting changes so that they can lead more active and rewarding lives. The PEARLS program: Focuses on teaching each client the skills necessary to move to action and make lasting life changes; Is delivered in the client's home; Is designed to be delivered in the community, primarily through existing service-provision programs; Takes a team-based approach, involving PEARLS counselors, supervising psychiatrists and medical providers; Aims to improve quality of life as well as reduce depressive symptoms and Is well-suited for individuals with chronic illness.

Action Plan:

Going forward, HSL will continue to explore innovative ways to extend the reach of its mental health and depression services to seniors in the community. Planned program expansion includes:

Home Care: In 2015 Hebrew SeniorLife 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 the severity of depressive symptoms in seniors and improve their overall health. MARPEH was launched by HSL in 2013 and is led by Dr. Eran Metzger, HSL Director of Psychiatry. It is currently reaching more than 1,000 residents at all three of HSL's senior living communities for low-income seniors.

Shown to improve treatment of depression in HSL's affordable senior living communities, the expansion is bringing MARPEH to patients in the community who are enrolled in HSL Home Care and helps those patients improve their quality of life.

The MARPEH program provides:

- Education to primary care providers to help them better recognize depression in older patients and apply state-of-the-art treatment
- Training to non-clinical staff to help them recognize signs and symptoms of depression in the elderly
- A depression care manager (DCM). A patient who is identified as having depression is referred to the DCM, who provides treatment, including psycho-therapy, and sees the patient on a regular basis reporting back to the patient's PCP. The DCM also meets weekly with a psychiatrist to discuss cases.

We're 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 add depression to the conditions they can treat.

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

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.

HSL's Commitment to the LGBT Senior Community: To serve LGBT older adults, HSL developed best practices, guiding principles, and policies to insure inclusiveness and safety. HSL was guided by training from the LGBT Aging Project, an integral part of the Fenway Institute at Fenway Health, a non-profit organization dedicated to ensuring that lesbian, gay, bisexual and transgender older adults have equal access to the life-prolonging benefits, protections, services and institutions.

Along with education, staff members throughout HSL are working to create an informed, welcoming and inclusive community. HSL is committed to supporting the work of The LGBT Aging Project and sponsors a number of community events for seniors.

Support for Russian-Speaking Seniors

Long-term care: At HRC-Roslindale, we provide a community where long-term care residents 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: Since 1994, our Great Days for Seniors adult day health program in Brighton has been committed to caring for Russian-speaking seniors in their native language. In 2015, the team also began to serve Chinese-speaking seniors.

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

Action Plan:

Going forward, HSL will continue to explore ways to extend its linguistic and cultural services. Planned program expansion includes HSL's Home Care which will serve Chinese-language speaking seniors.

Need: Access to Various Geriatric Specialists

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

Current Services:

HSL Medical Group: Provides primary and specialty medical care to Boston area residents 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 Department of Public Health 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 address issues such as chronic pain from arthritis, congestive heart failure, cognitive impairments, and palliative care.

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.

Action Plan:

HSL will continue to explore ways to extend the reach of its geriatric primary care services to more seniors living in the community. These include opportunities for seniors living in the community to engage with our geriatricians and learn how to select them as their primary care physicians.

HSL also has plans to extend the expertise of its clinical team to community dwelling seniors as follows:

Home Care: The HSL Home Care team is currently piloting an innovative Community Based Palliative Care program which provides services and consultation from a Geriatric Nurse Practitioner and a Geriatrician. Following the pilot, the program is slated to be in place by March 2017 for very frail elders with advancing illness who live in their homes in the community.

Therapy House Calls: This team will soon launch 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 residents at HSL's Center Communities of Brookline, plans are in place to extend it to other senior housing communities.

HSL's Right Care, Right Place, Right Time Initiative: This grant funded, recently launched initiative will provide enhanced, person-centered wellness services to vulnerable seniors in affordable housing, starting with HSL senior living communities in Brookline and Randolph. This program will bring more holistic services to seniors and HSL plans to hire a wellness nurse to oversee this initiative.

Need: Falls Prevention

Goal: Increase access to HSL's falls prevention offerings to community dwelling seniors.

Current Services:

Home Care: HSL Home Care offers a Home Safety Evaluation. Experts are trained to recognize environmental hazards that can impact patient's health and independence. They focus on providing care and support that help seniors recover after an illness, adjust to a new environment, and reach goals for wellness and independence.

Outpatient Services: HRC offers *Get Up and Go*, a supervised, medically based program for seniors over the age of 60. It includes: complete fitness exam by expert senior exercise professionals, progressive strength training and balance and flexibility.

HLCE Education: Matter of Balance. This program acknowledges the risk of falling but emphasizes practical coping strategies to reduce this fear. These strategies include promoting a view of falls and fear of falling as controllable, setting realistic goals for increasing activity, changing the environment to reduce fall risk factors, and promoting exercise to increase strength and balance. The workshop is conducted over eight sessions, meeting weekly or twice weekly for two hours per session. Meetings are led by trained leaders. The program's goal is to reduce fear of falling, stop the fear of falling cycle, increase activity levels and confidence among older adults.

Action Plan:

Going forward HSL will explore ways to serve more seniors in its communities and bring Falls Prevention programs and services to them.

Fitness House Calls: HRC recently 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.

Therapy House Calls: This team will soon launch a series of educational sessions led by clinicians called *Optimizing Independence*, covering specific areas related to healthy aging and maintaining independence including falls prevention and outdoor safety.

Tai Chi Training: One specific intervention, Tai Chi training, is under study by the HSL Institute for Aging Research. This project aims to improve the health and reduce the health care costs of seniors living in low-income housing facilities by conducting trial of Tai Chi exercises vs. health education and social calls in 16 housing facilities in cities surrounding Boston. Previous studies have shown multiple benefits of Tai Chi exercises in seniors with a variety of diseases and disabilities. The current study aims are to determine the effects of Tai Chi exercises conducted at least twice weekly over a 1 year period on 1) functional performance measured by the Short Physical Performance Battery and 2) health care utilization and costs determined from Medicare claims data in poor, multiethnic, elderly residents of low income housing facilities. Secondary outcomes will include person-centered measures such as physical function, cognition, psychological well-being, falls, self-efficacy, and satisfaction.

Appendix A: Community Survey

Hebrew SeniorLife Community Health Needs Assessment
This survey was administered to community health leaders in our target neighborhoods. These individuals or organizations serve or represent members of the medically underserved, low income or minority populations in the community.

Hebrew SeniorLife provides a full continuum of health care services for seniors who live in the Boston area. With our community based health services, including geriatric specialty medical clinics, adult day health, rehab therapy house calls, Medicare-certified home health care and personal assistance through Boston ASAPs, we are helping seniors live their best life in their own homes. For those seniors who suffer a more serious incident, we offer rehabilitation services designed to return them to health and get them back home. For seniors who can no longer care for themselves, we enable them to live their best life in a long term care community.

To ensure that we continue to exceed the needs of our community, HSL is conducting a community health needs assessment. This assessment will help us to:

- Identify current and future senior health care needs in our communities
- Improve and strengthen our programs and services
- Increase community awareness of local and regional senior health problems

Your feedback in is invaluable in helping us shape our future plans. By taking this brief survey, you will be sharing what you think are the most important and pressing senior care needs of our community and help HSL develop programs and strategies to meet them. Thank you for your participation.

Which below best describes your organization?
Council on Aging, Area Agency on Aging, SCO, ASAP, Public Health Department, Neighborhood Health Center, Senior Housing Provider, Home Care Provider, Adult Day Health Provider, Hospital, Other Clinic Setting, Other.

What do you think are the top three <u>health problems</u> for seniors in our community? Please pick the top three: Abuse and Neglect, Addiction, Alzheimer's and other dementias, Arthritis, Asthma, Cancer, Diabetes, Depression, Emphysema, Heart Disease, High Blood Pressure, Hypertension, High Cholesterol, Stroke, Joint or Back Pain, Mental Health, Obesity, Osteoporosis, Uncorrectable Vision Problems or Blindness

What do you think are the top three medical care <u>access problems</u> for seniors in our community? (i.e., access to a doctor, nurse or other health care provider) Don't have a regular Doctor, Cannot Afford It, No Transportation, No Access to Doctors who specialize in Senior Care , No Appointment Available, Too busy taking care of/caring for others, Linguistic and cultural barriers, Other

What do you think are the top three <u>healthy living access problems</u> for seniors in our community?
A Safe Place to Walk, Access to Affordable Fresh Fruits and Vegetables, Home Care Services are not Affordable, Transportation, Linguistic and cultural barriers, Access to an appropriate exercise program, fall risk in the home, cannot access needed ongoing assistance with activities of daily living, Other

What is the most pressing health care related need for seniors in our community?
What can Hebrew SeniorLife do to better meet the health needs of the seniors in our community?

Appendix B: External Community Resources

Hospitals	Community Health Centers	Health Associations
Arbour Hospital	Cambridge Family Health	AIDS Action Committee
Boston Medical Center	Dimock Community Health Center	American Cancer Society
Boston University Medical School	East Boston Neighborhood Health Ctr	American Heart Assoc
Beth Israel Deaconess Medical Ctr	East Cambridge Health Center	American Red Cross
Brigham and Women's	East Somerville Health Center	Arthritis Foundation
Cambridge Health Alliance	Federated Dorchester Neighborhood	Greater Boston Aid to
Chelsea Soldiers' Home	Houses, Inc.	the Blind
Children's Hospital	Fenway Community Health Center	Boston Area Rape Crisis
Dana-Farber Cancer Institute	Harvard Street Neighborhood Health	Center
Faulkner Hospital	Center	The Boston Center for
Franciscan Children's Hospital	Joseph M. Smith Community Health Ctr	Independent Living
Jewish Memorial Hospital	Logan International Health Center	Diabetes Society of
Lemuel Shattuck Hospital	Martha Eliot Health Center	Greater Boston
Massachusetts Eye & Ear Infirmary	Mattapan Community Health Center	National Multiple
Mass General Hospital	MGH-Bunker Hill Health Center	Sclerosis Society
Massachusetts Mental Health Ctr	MGH-Chelsea Health Center	United Cerebral Palsy
MIT Medical	Mystic Health Center	
Mount Auburn Hospital	North Cambridge Health Center	
New England Baptist Hospital	North End Community Health Center	
Tufts-New England Medical Center	Riverside Health Center	
Shriners Hospital-Children	Roxbury Comprehensive CHC	
Spaulding Hospital Cambridge	Senior Health Center	
St. Elizabeth's Medical Center	Sidney Borum Jr. Health Center	
St. John of God Hospital	60+ Health Clinic	
Steward Health Care System	South Cove Community Health Center	
U.S. Veterans Hospital	South End Community Health Center	
U.S. Veterans Outpatient Clinic	The Teen Connection	
Kindred Healthcare, Inc.	Teen Health Center	
	Windsor Health Center	