



Hebrew
Rehabilitation Center

Hebrew SeniorLife



HARVARD MEDICAL SCHOOL
AFFILIATE

2022 Community Health Needs Assessment and Implementation Plan

Hebrew Rehabilitation Center
1200 Centre Street
Boston, MA 02131

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Includes Spanish language version of 2022 Implementation Plan



Executive Summary

Hebrew Rehabilitation Center, a teaching affiliate of Harvard Medical School and part of Hebrew SeniorLife, is a licensed long-term 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 almost 120 years we have served seniors' health care needs in several communities within the city of Boston, and in the towns of Brookline, Chestnut Hill, Dedham, Needham, Newton, Wellesley, Weston, and Westwood.

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.

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. Through our array of services to our community outreach efforts, we educate seniors and their families on the necessary steps and care needed to remain independent.

We know first-hand the health challenges of older populations. In Massachusetts 17 percent of the population is 65 years old or older. Life expectancy is 80.4 years, sixth-highest in the United States, almost a full two years higher than the overall life expectancy in the U.S. [Source: https://www.seniorliving.org/massachusetts/](https://www.seniorliving.org/massachusetts/)

This 2022 Community Health Needs Assessment provides a comprehensive review of unmet health needs of the HRC community, including the negative health impacts of social and environmental conditions. The CHNA Committee analyzed community input and available public health data, and conducted an inventory of existing programs. While the COVID-19 pandemic that started in 2020 and continues through today impacted the timing and delivery of certain programs, we did make solid progress against our goals. Key learnings, and research from these efforts, factor prominently in the development of the 2022 CHNA and implementation plan.

We also considered these 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

HRC agrees with the Attorney General's "Building Toward Racial Justice and Equity in Health: A Call to Action," that describes the health care system's failure to equitably serve the Commonwealth's most vulnerable residents. We take seriously the urgency to address health inequities caused by racism and institutional bias and their influence on the social determinants of health and also as an independent factor affecting health. We demonstrate our commitment to make an impact on these disparities through accessibility and specific services detailed in our 2022 CHNA and implementation plan.



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Our CHNA findings show that seniors in our communities need assistance with the following:

- Geriatric Specialists and Services
- Behavioral/Mental Health Health
- In-Home Health
- Social Determinants of Health

In response to these findings, HRC developed the included 2022 Implementation Plan which documents target population, programmatic objectives, activities/strategies, partners, and metrics.

We thank members of the HRC community for their helpful guidance and input in compiling this 2022 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.



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Introduction to Hebrew Rehabilitation Center

Background/Overview

At HRC, our continuum of health care services reflects best practices informed by the latest geriatric research, including studies from our own Hinda and Arthur Marcus Institute for Aging Research. Our approach to care is personalized according to the goals of the seniors we serve and their families with a focus on maximizing independence, quality of life, and dignity by helping each patient optimize their activities of daily living and functional mobility.

HRC's inpatient services, which include long-term chronic care and post-acute rehabilitative care, reflect the best options possible to meet any given individual's goals for care. We strive to create the best living environments for patients, promote wellness, and establish caring practices that provide a personal, nurturing touch. Our staff members deliver medical and psychosocial care that encourages involvement from patients and families in the decision-making process. We are proud of again earning in 2021 the Five-Star rating from the Centers for Medicare & Medicaid Services, created to help consumers compare facilities more easily. HRC proudly received additional numerous quality performances and achievements in 2021 and early 2022:

- HRC-Boston in Roslindale and HRC-NewBridge in Dedham Recuperative Services Units named in 2021-2022 U.S. News Names Best Nursing Homes
- HRC-Boston and HRC-NewBridge named by Institute for Health Improvement as an Age-Friendly Health System
- The Boston Globe/The Commonwealth Institute 2021 Top 100 Women-Led Businesses
- The Boston Globe Top Places to Work 2021 Massachusetts
- 2021 Top 25 Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Medical care is provided by clinicians from our Department of Medicine, which is one of the largest geriatric practices in Massachusetts. Many of our physicians are affiliated with Harvard Medical School, and the practice includes geriatricians, geriatric nurse practitioners, geriatric psychiatrists, and other specialists. In addition, our integrated care team of nurses, therapists, social workers, and chaplains provides inpatient post-acute and long-term chronic care, and to seniors in the community—also adult day health care, outpatient specialty care, and geriatric primary care. Our care team also teaches students, professionals, and families who seek geriatric expertise, conducts research in health care services and clinical geriatrics, and serves 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, 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. These reciprocal relationships ensure that patients within our care have access to top quality acute- and specialty care facilities should they be needed.

Hebrew Rehabilitation Center Geography: Licensure

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

Boston: HRC-Boston, 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) beds. Outpatient services are also provided under this license.

- The 50 Skilled Nursing Facility (SNF or short-term rehab/RSU) beds at HRC-Boston are operated by HRC under a SNF license from the Department of Public Health/Medicare.
- Adult Day Health is operated by HRC with a separate license from MassHealth.
- HRC outpatient services are provided in outpatient clinical settings in Dedham and Roslindale, offering a 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-NewBridge, 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 location.

- The 48 Skilled Nursing Facility (SNF or short-term rehab/RSU) beds at HRC-NewBridge are operated by HRC under a SNF license from the Department of Public Health/Medicare.

The local communities served, as defined by our licensure, are Boston and Dedham.



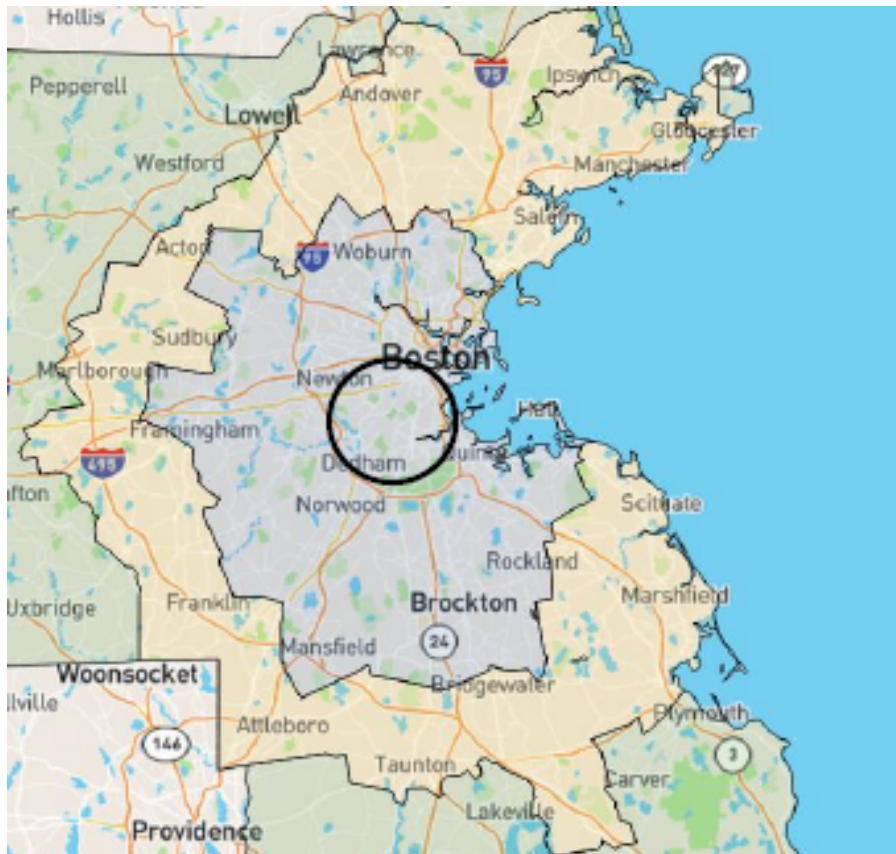
Purpose

Why a Community Health Needs Assessment?

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. We evaluated community health needs in 2013, 2016, and 2019 prior to this 2022 update. This tri-annual, disciplined approach demonstrates HRC's commitment to addressing the needs of the seniors in our community and helping them manage and maintain their health at every stage of their lives.

Service Area

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 on the left illustrates HRC's primary service area.

Based on patient zip code of origin, the HRC core service area is within an approximate five-mile radius from our campuses in Roslindale and Dedham, as the crow flies.



Based on patient zip code of origin, the local communities we serve are particular neighborhoods of Boston and the towns of Brookline, Chestnut Hill, Dedham, Needham, Newton, Wellesley, Weston, and Westwood.

Community	Zip Codes	Community	Zip Codes
Allston	02134, 02134-5015	Needham	02492, 02944
Brighton	02135	Newton	02458, 02459, 02460, 02461
Brookline	02445, 02446	Roslindale	02131
Chestnut Hill	02467	Roxbury	02118, 02119, 02120
Dedham	02026	Wellesley	02481, 02482
Dorchester	02122, 02125	Weston	02493
Jamaica Plain	02130,	Westwood	02090
Hyde Park	02136	West Roxbury	02132

Patient Population Demographics

Age/Gender

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 90 percent of the patients of HRC are older than 65. Those younger include many employees receiving outpatient and therapeutic services.



Age at Admission - 2022

Campus - Service Line	Median Age	Average Age
HRC Boston - LTCC	80	86
HRC - Memory Care	70	83
HRC Boston- SNF	78	80
HRC Dedham - LTCC	76	85
HRC Dedham - SNF	80	80
Adult Day Health Brighton	80	83

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”).

Services Offered

The 2016-2022 Hebrew SeniorLife 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 and under-served seniors. The Strategic Plan comprised five strategic approaches, one of which is directly relevant to our CHNA Implementation plan: **We plan to proactively reach more seniors in the community and engage them earlier.**

In 2017 we embarked on a business planning effort that resulted in HSL’s 2019-2023 Business Plan, developed to establish a comprehensive and consistent organization-wide service line model and financial plan to support our 2016-2022 strategic plan, and that also reaffirmed our commitment to reach more seniors in the community and engage them earlier.



We recognize 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. Since publishing our 2019 CHNA, HRC is increasingly focused on the needs of seniors who live at home in the communities we serve.

From HRC's outpatient wellness cluster in Roslindale, to the outpatient Deanna and Sidney Wolk Center for Memory Health, to pioneering Boston's first shelter for seniors suffering from elder abuse and neglect, HSL is dedicated to providing seniors in the community with a wide array of outpatient and home-based services to live their best lives. We have introduced multiple community-focused health care services, including among others, community-based palliative care, outpatient nutrition services, occupational therapy house calls and physical therapy house calls.

The 2022 CHNA Implementation Plan lays out how HRC continues to invest in areas we believe will help seniors stay healthy and independent by aligning our strategic aim - **to improve the quality of life for a growing number of seniors and their families, focusing on the vulnerable and underserved, through direct care and services, and by generating long-term influence through research, teaching, and advocacy efforts that will benefit generations of seniors, providers, and caregivers.**

New services and new ways to access them 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 and at the same time actively respond to the Attorney General's "Building Toward Racial Justice and Equity in Health: A Call to Action."

The overarching goals of our 2022 Implementation Plan outline our intention to reach some of our community's most at-risk seniors are as follows:

- Geriatric Specialists and Services: Increase availability and accessibility of our geriatric specialists to seniors the community
- Behavioral Health Service: Increase the availability and accessibility of our outpatient Alzheimer's and dementia care as well as mental health and depression services to seniors in the community and their families
- In-Home Care: Increase types of and access to services for older adults who live at home
- Social Determinants of Health: Focus on non-health sector services to increase health and health equity



The 2022 CHNA Implementation Plan is structured around these identified areas of need. For each area of need, we outline our target population, programmatic objectives, future community activities/strategies, metrics, and community partners. The plan references HSL's many outpatient, in-home, and community-based services that 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, that increasingly include collaborations between non-traditional partners, such as private duty services, transportation providers, post-acute care services, and others.

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

Outpatient Care and Services

Primary Care: Provides specialized on-site geriatric primary care to seniors, and operates practices at NewBridge on the Charles and Orchard Cove. Practitioners in the Hebrew SeniorLife Medical Group take a holistic approach to wellness, ensuring patients' physical, social, and spiritual needs are considered in care plans. Certified by the DPH and operating as a satellite of HRC, the Medical Group offers routine exams, urgent care, psychiatric care, podiatry, memory support consultation, chronic disease and diabetes self-management; addresses issues such as chronic pain from arthritis, congestive heart failure, cognitive impairments, and palliative care; and offers integrative therapies such as acupuncture and massage.

Adult Day Health Program: Provides active, social daytime community for seniors living at home supported by an interdisciplinary team of nursing, social work, and therapeutic recreation professionals in a safe, structured environment. Licensed by the DPH, the program is located at 2Life Communities in Brighton and serves Russian- and Chinese-speaking seniors with Alzheimer's disease, other dementias, and frailty due to health problems. Staff are trained in the Alzheimer's Association Habilitation program.

Outpatient Therapy Services: Offers adult physical therapy, occupational therapy, speech-language pathology, and lymphedema management. Using state-of-the-art mobility and treatment equipment including manual therapy, joint mobilization, and therapeutic modalities to maximize function and independence, services utilize the most up-to-date information and treatment techniques to maximize function and independence.

Specialty Outpatient Care Services: Offers a variety of services including memory evaluations, osteoporosis screenings, medical nutrition therapy, and audiology at HRC-Boston.

Outpatient "Get Up & Go" Senior Exercise: Offers a comprehensive fitness evaluation by experienced exercise physiologists to develop a personalized exercise program that focuses on progressive strength, balance, and endurance or cardiovascular training. This supervised, medically based program is located at HRC-Boston.



HSL Off-Road Clinical Driver Evaluation Program: 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, American Automobile Association (AAA), AARP, and current state regulations.

Car Fit Program: Offers seniors education on how to achieve the best fit in their personal vehicles using everyday household objects to measure and make adjustments to keep our roads safer for all. This national program was created in 2006 in collaboration with AAA, AARP and the American Occupational Therapy Association.

In-Home Care in Greater Boston

Medicare-certified Home Care: Offers a comprehensive range of services to assist seniors with their recovery following surgery, illness, a hospital stay, or to manage chronic illness. Medicare-certified home care services include nursing, palliative care programs, physical therapy, occupational therapy, speech and language therapy, and social work.

Home Health: Sends registered nurses and home health aides with a physician's referral to provide skilled care at home for the following conditions and situations: acute illness care for falls and conditions such as diabetes, chronic heart failure, COPD, and cancer; post-surgical care following orthopedic, spinal, heart, and other surgeries; wound care; IV therapy; physical, occupational, and speech therapies; and palliative care. Depression screening is included in all new patient evaluations. Additionally, HRC physical or occupational therapists can perform home safety evaluations for seniors to ensure their environments are comfortable, secure, and safe.

Private Care: Provides non-medical support for activities of daily living that help seniors age at home safely.

Personal Assistance Services: Working under contracts with state-funded Aging Senior Access Points (ASAPs) and available to income-qualified seniors, helps seniors maintain independence in their own homes through support with housekeeping tasks and personal care. HRC partners with the following ASAPs to serve seniors in the Greater Boston area: Boston Senior Home Care, Central Boston Elder Services, and Ethos.

Therapy House Calls: Brings outpatient therapy to seniors at home, a particular advantage for seniors with limited mobility and limited transportation. Offerings include geriatric physical therapy, occupational therapy, and speech-language pathology.

HSL Hospice Care: A multidisciplinary team, comprised of medical professionals, including physicians and nurses, in-home aides, social workers, chaplains, volunteers, families, and friends cares for terminally ill patients and their families. They 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. Services include complimentary therapy services through the generous contributions of donors.



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Community Partnerships, Education, and Awareness

As leaders in the field of senior services, HRC works hand in hand with many organizations in Greater Boston to provide critical services to seniors in our community. From our Harvard Medical School affiliation, to our preferred provider partnerships with acute care hospitals, to leadership positions with professional organizations, to support of community advocacy and senior service initiatives, we are working to promote healthy aging in Greater Boston and beyond.

HRC works with dozens of community organizations to build on and round out their newsletters, speaking engagements, and education fairs. We sponsor many community events in order to help build awareness, and facilitate support groups and education for seniors and their caregivers in the community.

HSL is proud to be a partner organization of ReiMAgine Aging, Governor Charlie Baker's Age-Friendly Massachusetts Action Plan.



Impact of COVID-19

The COVID-19 pandemic devastated tens of thousands of people in senior care communities—particularly nursing homes—and changed the landscape of senior care in Massachusetts, nationally, and globally. HSL quickly pivoted to respond to the pandemic and led the way in determining how to provide the best possible care for seniors in this new world.

Since the coronavirus first appeared, HSL staff and volunteers worked diligently to provide our patients and residents with the care and safety they deserve, including closing our campuses to visitors, providing food and other basic supplies for seniors when they needed to self-shelter, and opening what we believe was the first COVID-19 isolation unit in a U.S. long-term chronic care hospital. We now incorporate COVID-19 as a factor in our everyday care—continuing to develop and implement best practices in infection control to mitigate future spread and working to address the emotional needs of patients, residents, and employees.

HSL led the way in vaccination in its senior care and living settings, introducing its COVID-19 vaccination program in December 2020 and being one of the earliest senior care organizations to require that all employees be fully vaccinated—and subsequently boosted—against COVID-19 as a condition of employment. The program included vaccine clinics for all patients, residents, and employees. HSL also quickly implemented systematic testing and contact tracing among all patient- and resident-facing staff.

Driven by our mission to care for the most vulnerable, HSL stepped forward during the COVID-19 pandemic to lead in creating best practices for nursing homes across the country. Massachusetts Governor Charlie Baker and Secretary of Health and Human Services Mary Lou Sudders called on HSL in April 2020 to lead a task force that set infection control guidelines for all 350+ nursing homes in the state and helped them develop the capabilities to meet those objectives. This model was adopted nationally, with HSL and the Massachusetts Senior Care Organization again leading the Commonwealth's effort.

Throughout the pandemic, we shared our key learnings freely with senior care organizations across the country. Our expertise is available via an [online resource library](#) that includes materials, tools, protocols, and sample documents.

In addition, HSL's Marcus Institute for Aging Research is partnering with institutions all over the world to study COVID-19. For example, Marcus Institute faculty are studying the mental health impacts of social isolation on seniors. The research is aimed at developing tools and services to support the mental health needs of caregivers for seniors with memory concerns and utilizing a digital-visual interface to promote social connectedness for seniors.

HSL has re-engineered our facilities and processes to prevent the spread of the virus at our six campuses, positioning us for a post-COVID-19 future. We have enhanced our lab capabilities to support widespread testing of our patients, residents, and staff, which will inform our research and policy efforts by examining the spread of COVID-19 in long-term chronic care communities.



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During the COVID-19 crisis we put telehealth efforts in place across many of HSL's outpatient services, including our Center for Memory Health, many of which are reimbursable by MassHealth and other third-party payers. We expanded video visits into non-reimbursable areas such as home-based palliative care and hospice. We leveraged technology to help our patients and residents to interact with their loved ones and benefit from virtual cultural, life enhancement, spiritual, fitness, and social activities. We have seen what a vital role technology can play in our care and continue to invest in new ways of fostering community connections when mobility is limited—either by public health concerns or disability.

Many seniors in our care—even those who did not contract COVID-19—experienced physical and/or cognitive decline and struggled with mental health as a result of isolation during the crisis. Moreover, HSL staff faced emotional hardships in the wake of COVID-19, including depression, anxiety, and PTSD. Our in-house psychiatry and chaplaincy departments continue to address these challenges through regular check-ins and conversations and, when necessary, referrals for longer-term treatment plans. In response to feedback from the staff on “what matters most to you,” we provided several supports to help reduce stress that included front-line staff appreciation pay, hotel accommodations, food and meal deliveries, and transportation.

HSL was no exception among hospitals across the entire country when the pandemic required a complete shift of attention and resources to protect the seniors we serve. We suspended many outpatient services, which included outpatient therapy, therapy house calls, specialty outpatient care, adult day health, and in-person visits to the HSL Medical Group Practices. This, combined with the nursing shortage crisis, affected the delivery of the 2019 implementation plan. Yet we report proudly that progress was made, albeit limited, and we are eager to approach the 2022 implementation plan in an environment that is less constrained by COVID-19.



Summary of Approach and Methods

Community Engagement Process

The Boston CHNA-CHIP Collaborative

In our last CHNA, we actively participated in the Boston CHNA-CHIP Collaborative and incorporated its 2019 senior-oriented implications and findings into our plans. This year we did the same.

Collaborative Community Survey

We augmented those Boston CHNA-CHIP Collaborative findings through a collaborative community survey in partnership with Brigham and Women's Faulkner Hospital and Massachusetts General Hospital. This survey was distributed online and in person, and invitations to members of our local communities were distributed via social media, email, and word of mouth. We also participated in Beth Israel Deaconess Needham listening sessions to glean additional input.

The community survey was fielded to patients who utilize the services of HRC and Home Care services, those who participate in Adult Day Health in Brighton, and more than 700 employees who are residents of Boston. We also asked several community partners that serve the Boston area to distribute the survey to potential participants. The survey was in the field for approximately nine weeks, and the full survey can be found in Appendix A.

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

- Made the survey in five languages (Spanish, Portuguese, Haitian Creole, Chinese (traditional and simplified) to ensure those we serve could access and respond to it in their native languages
- Compared our findings against the streamlined priorities and rationale that Boston CHNA-CHIP members developed in the Boston 2019 CHNA/2020 CHIP Reports.

494 respondents were in the final sample, 82% of whom either live, or live AND work in the community.

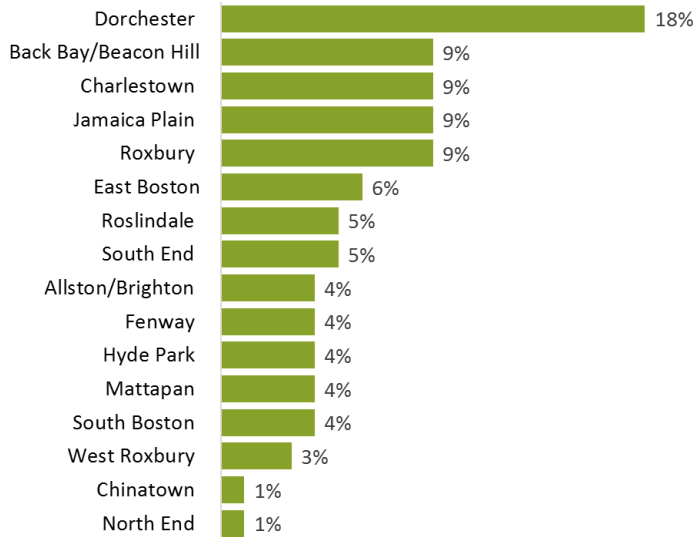
Respondents represented the following demographics:

Gender Identity
Woman (76%)
Man (21%)
Gender queer or gender non-conforming (2%)
Transgender (0.6%)
Prefer to self-describe (0.6%)

Age Categories	N=444
Under 18	23 (5%)
18-24	39 (9%)
25-29	78 (18%)
30-39	112 (25%)
40-49	74 (17%)
50-59	63 (14%)
60-69	42 (9%)
70-79	11 (2%)
80-89	2 (<1%)



Neighborhood of Respondents



American Indian or Alaska Native	11 (2%)
Asian	22 (4%)
Black or African American	158 (32%)
Hispanic/Latino	110 (22%)
Native Hawaiian or Other Pacific Islander	1 (<1%)
White	213 (43%)
Other	16 (3%)

Other: American Indian, Scottish, Ashkenazi Jew, British/Black, Cape Verdean, Caribbean, First people, First people/mix, Haitian, Irish American, Middle Eastern, Mixed Race, Multicultural, Multiracial, Native American

Based on these exercises and the desire to be narrowly focused on what we could deliver in our new implementation plan, we streamlined priorities that we felt would be impactful, leveraged the strengths we bring to senior health care and the community, and reduced potential project redundancy across HRC departments.

Quantitative Data Collection

Publicly Available Data

To identify the needs of seniors in the community, we gathered and analyzed key publicly available community data, and we compiled and analyzed data about our service area including demographics, social and economic factors, and access to health care. 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. All data sources have been noted within the document.

Limitations

Every data source has its own set of limitations. The many data sources used in the development of this report applied different ways of measuring similar variables. Some data are not available by specific population groups or at a more granular geographic level due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups. There may be a time lag for data sources from the time of data collection to data availability, therefore the data sets may not fully reflect recent trends in health statistics. However, the data was still valuable and allowed for identification of health needs relative to the Commonwealth and specific communities.



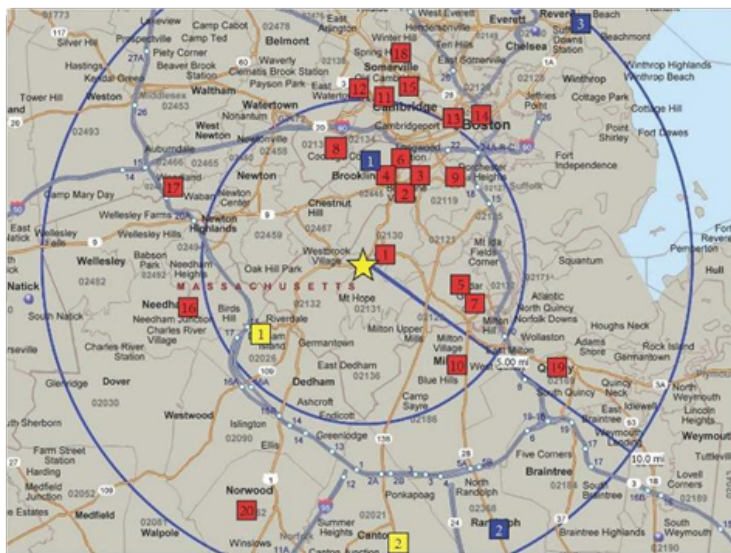
Community Resources

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.

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 Lahey Health
7	Carney Hospital
8	St. Elizabeth’s Medical Center
9	Boston Medical Center
10	Beth Israel Deaconess Hospital - Milton

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 learn the newest techniques. Seniors in our local communities need go no further than their Boston doorstep to leverage the world’s greatest medical minds and facilities.



- Hebrew Rehabilitation Center
- NewBridge on the Charles
- Orchard Cove
- Center Communities of Brookline
- Simon C. Fireman Community
- Jack Satter House



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Approval

For HRC's 2022 CHNA, Mary Moscato, President, Hebrew Rehabilitation Center and Hebrew SeniorLife Health Care Services, provided oversight and Rachel Joslin Whitehouse, Chief Communications and Planning Officer, served as the day-to-day lead. Consistent communication and strategic consultations between these senior leaders and members of their teams provided the foundation for its development. HSL's board-level Health Care Services Committee, chaired by Julie Rosen, reviewed and granted approval in June 2022. HRC's key management and a list of members of the committee may be found in Appendices B and C.



Key Findings

State 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 to the left, 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.

[Source: World Population Review](#)

A look at the chart to the right shows employment projections that demonstrate the increasing demand for the services of home health and personal care aides through 2030.

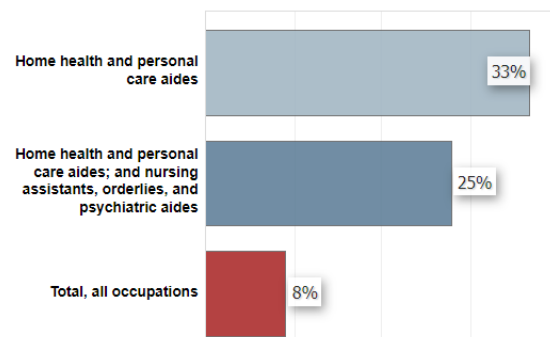
[Source: American Health Rankings Senior Report 2021](#)

In Massachusetts, the number of home health care workers in 2021 was 311 workers per 1,000 adults ages 65+ with a disability compared to 157 in 2018. [Source: U.S. Bureau of Labor Statistics](#)

Our senior populations are projected to grow, and will need an increasing amount of services.

Home Health and Personal Care Aides

Percent change in employment, projected 2020-30



Note: All Occupations includes all occupations in the U.S. Economy.
Source: U.S. Bureau of Labor Statistics, Employment Projections program

Community Survey Trends

When asked to “Select the top 3 areas that hospitals should focus on to make your community healthier,” respondents to the community survey indicated several areas of importance. The red items denote particular areas that HRC plans to address in its 2022 implementation plan.

Affordable childcare	106 (21%)
Affordable and reliable internet	41 (8%)
Mental health services	274 (55%)
COVID-19 pandemic (testing, vaccinations, information, supplies, etc.)	132 (27%)
Food insecurity	102 (21%)
Substance misuse and the opioid crisis	133 (27%)
Transportation	68 (14%)
Career training for quality jobs	65 (13%)
Education supports and activities for youth	94 (19%)
Housing stability and homeownership	183 (37%)
Improved care for medical conditions, such as heart disease, cancer, diabetes, etc.	138 (28%)
Neighborhood safety and violence	91 (18%)
Small business support	26 (5%)
Other	16 (3%)

Language

Our survey examined the languages in our local communities by asking “What is the primary language(s) spoken in your home?” By understanding our market, HRC can develop specific programs and services that map to individuals, not only by age or general location, but also by the availability of language services to community dwelling seniors that may affect health outcomes.

Our diverse employee and patient population underscores the need to tailor services to non-English speaking seniors, as well as HRC’s Haitian-Creole and Russian-speaking employees.

We will continue to offer targeted services to these populations, such as our free interpreter services to all non-English speaking seniors who are receiving services through HRC outpatient care, Home Care, Adult Day Health, and our LTCH Bilingual Services Program.

English	412 (85%)
Spanish	53 (11%)
Other Languages	37 (8%)

Other Languages include	
Af-Maay	1
Albanian	1
Arabic	2
Cantonese	1
Cape Verdean Creole	3
Chinese	1
Creole	3
French	4
French Creole	1
Greek	1
Haitian Creole	9
Mandarin	1
Russian	2
Swahili	1
Tigrinya	1
Vietnamese	5



Food Access

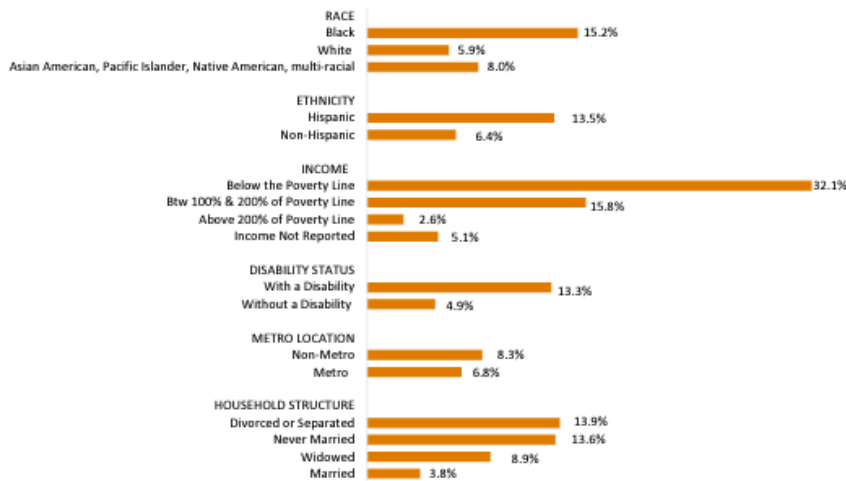
Access to food	108 (22%)
Access to medication	70 (14%)
Broadband/Internet or computer	47 (10%)
Educational opportunities	78 (16%)
Fitness and physical wellbeing	227 (46%)
Housing	85 (17%)
Paying for utilities, rent, other supplies	176 (36%)
Safety	63 (13%)
Social isolation/mental and emotional wellbeing	266 (54%)
Spiritual wellbeing	121 (25%)
Transportation	71 (14%)
Unemployment	70 (14%)
Other	20 (4%)

Responses to the community survey question “What are the main challenges you are experiencing due to COVID-19?” revealed that hunger/food insecurity was ranked number one. This is supported by key informant interviews and low-income focus group participants across neighborhoods who discussed the challenge of not having enough money to afford the food they and their families needed, especially in light of recent inflation.

Feeding America’s *The State of Senior Hunger in America 2019* shows that “food insecure seniors consumed lower quantities of key nutrients..than food secure seniors. In addition, for a wide array of health outcomes, food insecure seniors were worse-off than food secure seniors. Food insecure seniors were more likely to have depression (262%), asthma (78%), diabetes (74%), and congestive heart failure (71%).” *Source: Feeding America 2019 Executive Summary*

Food insecurity rates among seniors vary by demographic and socioeconomic status

Food Insecurity Rates by Select Characteristics among Seniors Age 60 and Above in 2019 (%)



Not surprisingly, seniors who are people of color, live below the poverty line, or have disabilities are disproportionately impacted by food insecurity. Forcing seniors with limited incomes to choose between food, housing, medical or other bills requires trade offs that can lead to or worsen food insecurity.



Access to Care and Transportation

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. In particular, transportation barriers can lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences may lead to poorer management of chronic illness and thus poorer health outcomes. As indicated above in community survey trends, 14% of respondents chose transportation among the “top 3 areas that hospitals should focus on to make your community healthier.” Furthermore, when specifically asked “What barriers, if any, prevent you from getting needed health care?” 15% of respondents answered transportation.

Fear or distrust of the health care system	88 (18%)
Not enough time	114 (23%)
Insurance issues	95 (19%)
Transportation	73 (15%)
No providers or staff speak my language	29 (6%)
Can't get an appointment	131 (27%)
Cost	92 (19%)
Concern about COVID exposure	112 (23%)
No barrier	121 (24%)
Other	20 (4%)

Respondents also responded favorably that they would benefit from and utilize a mobile health unit as demonstrated by their answers to: “What types of health care services or resources would you seek for yourself or family on a mobile health van in your community?”

Blood pressure checks	212 (43%)
Cancer screenings	161 (33%)
Food assistance, including SNAP enrollment	188 (38%)
Housing resources and support	189 (38%)
Mental health services	219 (44%)
Substance use counseling	111 (22%)
Supplies, such as face masks and hand sanitizer	259 (52%)
Other	16 (3%)
I would not seek any health care services or resources on a mobile health van	73 (15%)

Brain Health/Dementia

Among mental health concerns, stress, anxiety, and depression were the most frequently cited challenges among Boston residents. Community suggestions to address mental health issues include investing in more mental health supports. While HRC’s Department of Medicine offers psychiatric and psychological services for seniors, one of our most unique areas of focus is sustaining brain health and offering resources and support to individuals experiencing memory loss - which may also include those with diagnoses of Alzheimer’s disease and other dementias - and their families and caregivers. Pre-pandemic, dementia was the nation’s leading health crisis; the subsequent isolation of older adults has only made it worse. We will be dealing with the lingering effects of the pandemic for many years to come. Consider these statistics from the Alzheimer’s Association. [Source: Alzheimer’s Association MA State overview](#)

- 130,000 people aged 65 and older are living with Alzheimer’s in Massachusetts.
- 9.3% of people aged 45 and older have subjective cognitive decline.
- 284,000 family caregivers bear the burden of the disease in Massachusetts.
- 411 million hours of unpaid care provided by Alzheimer’s caregivers.
- \$8.7 billion is the value of the unpaid care.
- \$1.7 billion is the cost of Alzheimer’s to the state Medicaid program



Hebrew
Rehabilitation Center

Hebrew SeniorLife



HARVARD MEDICAL SCHOOL
AFFILIATE

Furthermore, in the Alzheimer's Association's "Special Report: More Than Normal Aging: Understanding Mild Cognitive Impairment," the following facts are noted about caregivers.

Source: [Alzheimer's Association](#)

- The prevalence of depression is higher among dementia caregivers (30% to 40%) than other caregivers, such as those who provide help to individuals with schizophrenia (20%) or stroke (19%).
- The prevalence of anxiety among dementia caregivers is 44%, which is higher than among caregivers of people with stroke (31%).

These numbers show that a public health approach is necessary to lessen the burden and enhance the quality of life for those living with cognitive impairment and their families.



Community Health Priorities Implementation Plan

2019 Summary

The 2019 HRC CHNA priorities were: 1) 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; 2) 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.

Metrics and status on each of these priorities are described in the 2019 Community Health Needs Assessment Implementation Plan Results (Appendix D).

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.



The CHNA committee determined that its priority should be to reach some of our community's most at-risk seniors and to provide access to the geriatric-specific care and services they need, 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 and dementia care for seniors who live in the community and their families.
- In Home Health: Expand availability to health and wellness interventions by offering more entry points to meet a senior care expert.
- Social Determinants of Health: Improve health and reduce longstanding disparities in health and health care by reducing the impact of the following social determinants: food insecurity, transportation challenges, language barriers, and domestic abuse.

Metrics and status on each of these priorities are described in the 2022 Community Health Needs Assessment Implementation Plan (Appendix E).



Appendices

[Appendix A: 2022 Community Health Survey](#)



Mass General Brigham

Community Health Survey

Brigham and Women's Faulkner Hospital and Massachusetts General Hospital, hospitals in the Mass General Brigham system (MGB), are conducting a community health assessment to explore what matters most to people in Boston. The purpose of this survey is to hear directly from community members like you. The results of this survey will be analyzed and shared back with the community and will help us to take action to positively change the factors that influence people's health.

Please read this important information before you begin the survey.

- This survey will take approximately 5-10 minutes to complete.
- If you do not feel comfortable answering a question, you may skip it.
- Taking this survey will not affect any services that you receive.
- This survey is anonymous.
- You will have the option at the end of the survey to enter a drawing for 1 of 5 \$100 gift cards, in appreciation of your participation. The contact information you provide to be entered into the drawing will not be attached to your survey responses in any way.
- If you have any questions about this survey, please contact Kelly Washburn at kwashburn@mgh.harvard.edu



Your Community

- 1. Please enter the zip code of the community in which you spend the most time?**

- 2. Please select the response(s) that best describes your relationship to the community:**
 - * I live in this community
 - * I work in this community

- 3. Select the top 3 areas that hospitals should focus on to make your community healthier.**
 - * Affordable childcare
 - * Affordable and reliable internet
 - * Mental health services
 - * COVID-19 pandemic (testing, vaccinations, information, supplies, etc.)
 - * Food insecurity
 - * Substance misuse and the opioid crisis
 - * Transportation
 - * Career training for quality jobs
 - * Education supports and activities for youth
 - * Housing stability and homeownership
 - * Improved care for medical conditions, such as heart disease, cancer, diabetes, etc.
 - * Neighborhood safety and violence
 - * Small business support
 - * Other, please specify: _____

- 4. Of the above top 3 areas you selected above, which is most important to you?**

- 5. Please share any specific ideas or suggestions you have on how hospitals can address your top priority.**



6. What are the main challenges you are experiencing due to COVID-19? Please select all that apply.

- * Access to food
- * Access to medication
- * Broadband/Internet or computer
- * Educational opportunities
- * Fitness and physical wellbeing
- * Housing
- * Paying for utilities, rent, other supplies
- * Safety
- * Social isolation/mental and emotional wellbeing
- * Spiritual wellbeing
- * Transportation
- * Unemployment
- * Other, please specify: _____

Your Health Care

7. Where do you primarily receive your routine health care? Please choose one.

- * A doctor's office
- * A public health clinic or community health center
- * Urgent care provider
- * A hospital emergency room
- * No usual place
- * Other, please specify: _____

8. What barriers, if any, prevent you from getting needed health care? Please select all that apply.

- * Fear or distrust of the health care system
- * Not enough time
- * Insurance issues
- * No providers or staff speak my language
- * Can't get an appointment
- * Cost
- * Concern about COVID exposure
- * Transportation
- * Other, please specify: _____
- * No barrier



9. What types of health care services or resources would you seek for yourself or family on a mobile health van in your community? Please select all that apply.

- * Blood pressure checks
- * Cancer screenings
- * Food assistance, including SNAP enrollment
- * Housing resources and support
- * Mental health services
- * Substance use counseling
- * Supplies, such as face masks and hand sanitizer
- * Other, please specify: _____
- * I would not seek any health care services or resources on a mobile health van

About You

The following questions help us to better understand how people of diverse identities and life experiences may have similar or different experiences of the community.

You may skip or leave blank any questions that you prefer not to answer.

10. How old are you? _____ (years)

11. What is your gender identity?

- * Gender queer or gender non-conforming
- * Man
- * Transgender
- * Woman
- * Prefer to self-describe: _____

12. Which of these groups best represents your race/ethnicity? Please select all that apply.

- * American Indian or Alaska Native
- * Asian
- * Black or African American
- * Hispanic/Latino
- * Native Hawaiian or Other Pacific Islander
- * White
- * Other, please specify _____

13. What is the primary language(s) spoken in your home?

14. Are you currently: (Please select one)



- * Employed/self-employed full time
- * Employed part time or seasonal work
- * A stay at home parent or caregiver
- * A student (full or part time)
- * Currently out of work
- * Unable to work for health reasons
- * Retired
- * Other, specify: _____

Gift Card Drawing Information

If you would like to enter a drawing to win 1 of 5 \$100 gift cards, please complete the form below to tell us the best way to contact you (you can provide email and/or phone number). **This information will not be used to identify your responses to the survey.** The drawing will take place in February. Please return your completed survey and form to the place where you picked it up. **Thank you for your participation.**

Gift Card Drawing Form

First Name: _____

Email Address or Phone number: _____



Appendix B: CHNA Management Structure

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 oversight and vision to the CHNA process, as well as guidance on how best to implement the Implementation Plan.

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 long standing 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 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.

Appendix C: Health Care Services Committee

Julie Rosen, Chair

Valerie Fleishman, Vice Chair

Phyllis Baron

Rev. Dr. Gloria Harris Cater

Ruth Ellen Fitch

Steven Flier, M.D.

Jonathan Freedman

Marjorie Glou

Peter Gordon

Beth Greenspan

Paul Hardiman

Jon Kingsdale

Harold Kotler

Lynda Rowe

Jeff Swartz

Lynne Wolf

[Appendix D: 2019 Community Health Needs Assessment Implementation Plan Results](#)

[Appendix E: 2022 Community Health Needs Assessment Implementation Plan \(English language version\)](#)

[Appendix F: 2022 Community Health Needs Assessment Implementation Plan \(Spanish language version\)](#)

APPENDIX D
Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results
Access to Geriatric Specialists

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

Area	Target Population	Programmatic Objectives	Community Activities / Strategies	Metrics and Status since 2019	Community Partners
Progressive Community-Based Ambulatory Care Center	Community dwelling Seniors	Establish an ambulatory care cluster, where community dwelling seniors can easily and safely access a range of preventative care, geriatric medical specialties, mental health services, and associated care coordination and financial services	Offer increased accessibility to ambulatory wellness services such as geriatric specialty clinics, Wolk Center for Memory Health, rehabilitation therapies, dental, vision, and more; addition of an ambulatory care procedure room	<p>Metrics:</p> <ul style="list-style-type: none"> • Reorganize services based on current patient needs • Augment existing personnel with new hires to add depth to the program <p>Status:</p> <ul style="list-style-type: none"> • Expanded fitness, nutrition, memory care services • Collaboration with Marcus Institute • Reorganized and hired new personnel to address new Wolk Center offerings • Refreshed ambulatory care area (e.g., Wolk Center, PT/OT area) • Identified new services to offer at the Wolk, such as TMS • Began offering Wolk Center services to residents at NewBridge and Orchard Cove • Greater access to ambulatory services for new Wolk Centers • Promoted services via Wolk newsletter, outreach to the community (virtual counseling sessions, podcasts and webinars, media and social media placements, blogs, partner newsletters, etc.) 	Temple Emanuel, Age Strong Commission, Elder Care Alliance
Community Based Palliative Care	Frail elders with advancing illness who live in their homes in the community	Ensure patient has a holistic support network and comprehensive expertise through team approach	<ul style="list-style-type: none"> • Provide 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 • Offer social worker support to answer questions and provide guidance about community resources • Provide chaplain care for spiritual support and complementary therapy services of music and massage 	<p>Metrics:</p> <ul style="list-style-type: none"> • Hire a senior lead to develop and implement program • Identify communities to be supported through HCBS • Extend reach through public education and telehealth <p>Status:</p> <ul style="list-style-type: none"> • Hired a nurse practitioner to lead the program • Extended reach to all communities/towns served by HCBS, all active patients of HSL Home Health, and all HSL housing residents (excluding Jack Satter House) whose PCP is an HSL physician and served approximately 75 individuals • Developed new marketing and communications vehicles and built website content: https://www.hebrewseniorlife.org/services/health-care/home-senior-care-services • Presented at national level to Center for Advanced Palliative Care Services on: COVID-19 Advance Care Planning with Telehealth for Long-Term Care Residents • Adopted telehealth outreach to continue to reach seniors & their caregivers during the pandemic 	Case Management Society of New England Frail Elders Conference, Aging Life Care Association NE
New Wellness Nurse Consultant Program	Adult Day Health participants at Brighton campus	Create a safety net for detecting early disease exacerbation and functional decline	<ul style="list-style-type: none"> • Offer nurse expertise and teaching on medications, health and wellness topics, self-care, and disease management • Offer Wellness Nurse Consultant program in Russian and Chinese 	<p>Metrics:</p> <ul style="list-style-type: none"> • Launch program by 2022 • Engage 2Life audience in Brighton • Russian and Chinese populations served <p>Status:</p> <ul style="list-style-type: none"> • Launched program in 2021 • Currently serving five sites for 2Life Senior Living and recently embarked with The Villages of Brookline • Currently offering Russian bilingual services, and serving Chinese population through specialized English services 	2Life

APPENDIX D

Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results Access to Geriatric Specialists

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

HRC In-Home Telehealth Videoconferencing	Home Health patients at high risk for rehospitalization	Enable early indication of disease exacerbation and improved disease management	<ul style="list-style-type: none"> • Leverage telehealth unit as a teaching tool and outreach platform in the community • Shift from audio-based option to videoconferencing by 2020 	<p>Metrics:</p> <ul style="list-style-type: none"> • # seniors reached using telehealth • Shift from audio-based option to videoconferencing <p>Status:</p> <ul style="list-style-type: none"> • Reached 30-45 seniors using service-revealed diagnoses • Hired New Clinical Informatics staff member to lead program development • Investigating alternative technology to optimize senior wellness in partnership with Marcus Institute • Shifted from audio to videoconferencing using (employed iPad apps, including FaceTime) 	
Extending Therapy House Calls Service Area and Programming	CCB Medical Center Patients	Optimize seniors' independence	<ul style="list-style-type: none"> • Extend clinician-led educational sessions called <i>Optimizing Independence</i> to other senior housing communities • Integrate a standardized fall prevention educational component into treatments for all patients with balance disorders, prior falls, and gait difficulty 	<p>Metrics:</p> <ul style="list-style-type: none"> • Educational session offered quarterly • Standardized educational component for falls fully integrated into all PT treatment plans <p>Status:</p> <ul style="list-style-type: none"> • Unable to offer educational sessions and standardize educational component due to COVID-19 • Provided Therapy House Calls at non-HSL assisted living communities in Newton, Framingham, and Milton • Conducted one HRC Outpatient Therapy "<i>Balance/Optimizing Independence Fairs</i>" in 2019 and several Zoom sessions for CCB resident • Launched Fitness House Calls with 1:1 personal training and fitness instruction from exercise physiology therapists • Collaborated with Marcus Institute on home-based rehab interventions to improve functional recovery after trans-aortic valve replacement - research completed 	
STEP-HI Hip Fracture Recovery Clinical Trial	Women age 65 and older	Test strategies that may improve recovery after a hip fracture	Conduct research study to see if combining testosterone with exercise can lead to even greater improvements in physical abilities after a hip fracture	<p>Metrics:</p> <ul style="list-style-type: none"> • Recruit participants to the study <p>Status:</p> <ul style="list-style-type: none"> • In process of recruiting 125 participants nationally; HSL has recruited 28 to date • Clinical trial outreach shared with professional hospital networks throughout Greater Boston 	Beth Israel, Brigham and Women, Faulkner, St. Elizabeth, Boston Medical Center, Tufts Medical Center
Continuing Care at Home	Seniors at home	Meaningfully impact elders who prefer to age in home but can benefit from the types of HSL services typically offered at senior living communities	Design and launch a coordinated care model serving older adults living in their individual homes	Put on hold due to COVID-19	N/A

APPENDIX D

**Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results
Access to Geriatric Specialists**

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

Community Education/Awareness	Local Boston seniors, caregivers, and community partners	Raise awareness of care options by providing education about HRC services	Participate in local community events	<p>Metrics:</p> <ul style="list-style-type: none"> • # community events <p>Status:</p> <ul style="list-style-type: none"> • 2019 - 29 community events; 8 recorded webinars • 2021 - 64 community events 	Needham Senior Center, Norwood Senior Center, Brookline Senior Center, Mass Council on Aging, JP@Home
Community Health Support	Local Boston seniors, caregivers, and community partners	Equip and empower participants to share personal experiences and feelings, coping strategies, or firsthand information	Facilitate support groups and education, offer blood pressure and flu clinics	<p>Metrics:</p> <ul style="list-style-type: none"> • Host support groups throughout the community • Provide education and support through webinars and health fairs <p>Status:</p> <ul style="list-style-type: none"> • 2019 offered 16 Support Groups, 4 Health Fairs; 2020 offered 15 support groups • Hosted various webinars for family members who are caregivers/supports for seniors • Hosted HRC Roslindale Health Fair 	Temple Emanuel, Working Daughters Online Community, Wellesley Senior Center, Newton Senior Center
Transportation	Employees, seniors	Eliminate barriers to employment and care related to transportation	<ul style="list-style-type: none"> • Ease commute for employees who rely on public transportation; research and publicize materials related to transportation offerings • Co-locate services to locations where older adults already live or congregate 	<p>Metrics:</p> <ul style="list-style-type: none"> • Provide transportation options to HRC campuses and ensure that information is available to employees/public • Provide in-home/HRC on-site opportunities for seniors to access services <p>Status:</p> <ul style="list-style-type: none"> • Offered HSL Shuttle service throughout day w/stops at Roslindale and NewBridge campuses and MBTA Forest Hills Station • Maintained current transportation offerings on HSL website and new patient materials • In partnership with HSL in-patient team, initiated planning and obtained financial support for a transportation system that enables seniors to overcome transportation barriers and access the Wolk Center for Memory Health 	Commission on Elder Affairs, City of Boston, SCOs (ETHOS, Senior Whole Health, and Commonwealth Care Alliance)
Meals on Wheels	Seniors in Boston age 60+ who are either temporarily or permanently homebound	Provide food security to help keep seniors in their home	Provide nutritious, kosher meals	<p>Metrics:</p> <ul style="list-style-type: none"> • Provide meals to Boston seniors <p>Status:</p> <ul style="list-style-type: none"> • Provided 500 meals provided to Boston Seniors • Sponsored HESSCO Holiday Meals 	Ethos and Springwell

APPENDIX D

Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results

Access to Geriatric Specialists

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

CarFit Program	Seniors who still drive	Increase road safety for all	Offer educational program for seniors to check how well their personal vehicles "fit" them	Metrics: <ul style="list-style-type: none">• # seniors participating• # events held Status: <ul style="list-style-type: none">• 203 seniors participating• 16 events across all sites since inception• Placed media stories, blogs to promote program	AAA, AARP, and AOTA
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APPENDIX D

Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results

Behavioral Health

Overall 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.

Area	Target Population	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Connect existing services across HSL’s continuum of care and in the community	Persons with a memory concern or cognitive disorder and their family members	Improve care coordination to help relieve the burden of care giving	Provide care, education, and counseling	<p>Metrics:</p> <ul style="list-style-type: none"> Variety of methods implemented to improve care coordination <p>Status:</p> <ul style="list-style-type: none"> Determined workflow of nurse practitioners a) to collaborate with primary care physicians and b) for the interdisciplinary team at Wolk Center Collaboration between Wolk Center social workers and community geriatric care managers through ongoing communication Collaboration between Wolk Center and senior living care teams through regular, ongoing meetings 	
Research	Older adults with dementia, mild cognitive impairment, or delirium	Discover new ways to improve cognitive function and quality of life for older adults experiencing cognitive impairments through brain stimulation, drug trials, physical exercise, and health care service interventions.	<ul style="list-style-type: none"> Conduct clinical trials; Improve the ability of health care systems to care for people with cognitive impairments. Actively train next generation of researchers 	<p>Metrics:</p> <ul style="list-style-type: none"> # of clinical trials conducted # of post-doc scientists trained <p>Status:</p> <ul style="list-style-type: none"> Conduct 6 clinical trials of drugs, brain stimulation, education, health care services, physical activity, and environmental temperature to improve cognition and quality of life in older adults with cognitive impairments. <p>Metrics:</p> <ul style="list-style-type: none"> Training 5 postdoctoral scientists to conduct research and clinical trials focused on improving cognitive impairments in older adults. See our website for more information: https://www.marcusinstituteforaging.org/ 	Senior Housing facilities operated by Hebrew SeniorLife, and - ADD R3 sites.
Home Care	Older adults in Greater Boston’s communities	Reduce severity of depressive symptoms and improve overall health	Expand HSL’s “Making Real Progress in Emotional Health” (MARPEH) program to HSL Home Care	<p>Metrics:</p> <ul style="list-style-type: none"> % patients receiving depression assessment <p>Status:</p> <ul style="list-style-type: none"> 100% home care patients receive depression assessment on admittance 	
In-Community Support	CCB seniors	Reduce severity of depressive symptoms and improve overall health	Explore ways to extend the reach of mental health and depression services	<p>Metrics:</p> <ul style="list-style-type: none"> # new approaches to reach more people <p>Status:</p> <ul style="list-style-type: none"> Full time social worker who provides psychotherapy Doubled number of psychiatry hours from 4 to 8 hours/week 	Brookline Mental Health Center (BMHC)

APPENDIX D

**Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results
Housing Affordability**

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

Area	Target Population	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Right Care, Right Place, Right Time: Effectively Integrating Senior Care and Housing (R3 Initiative)	Seniors in HSL's affordable housing with supportive services	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	Conduct full evaluation to measure the impact of the model on health care spending and quality of life	Metrics: <ul style="list-style-type: none"> • Full evaluation complete Status: <ul style="list-style-type: none"> • Dramatic reductions in emergency department trips (19%) and revisits (24%) • Lower inpatient hospitalization rates (16%), days (25%), and payments (22%) • Increased engagement in self-care and satisfaction with the program, as reported by residents 	

APPENDIX D

Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results

Financial Security

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

Area	Target Population	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Financial Assistance	Community dwelling seniors	Increase access to care through education and assistance to financial programs	Work to ensure that seniors in the communities we serve are aware of this program	Metrics: • # of placements on HSL communications channels Status 2 blog posts offering tips for avoiding scams: https://www.hebrewseniorlife.org/blog/tips-avoid-coronavirus-scams-targeting-seniors https://www.hebrewseniorlife.org/blog/7-ways-help-prevent-seniors-falling-victim-scams	
Protecting Seniors	Seniors who are victims of elder abuse and neglect	Combat the incidence of elder abuse in Massachusetts	<ul style="list-style-type: none"> • 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 • Collaborate with community partners as well as educate the public through programming and communication vehicles such as HSL newsletters, our blog, and social channels 	Metrics: • # of seniors sheltered • # of educational offerings Status: • 1 senior sheltered • 1 educational offering • Promote World Elder Abuse Awareness Day post on social	Cambridge-Somerville Elder Services; Jewish Family & Children's Services; Greater Boston Legal Services

APPENDIX D

**Hebrew Rehabilitation Center 2019 Community Health Needs Assessment Implementation Plan Results
Closing Racial and Ethnic Disparities that Exist in Health Care**

Overall goal: Increase the availability of linguistic services to community dwelling seniors. Increase the training of HSL staff in best practices to address cultural barriers.

Area	Target Population	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update	Community Partners
Bilingual Services	<ul style="list-style-type: none"> • Russian speaking seniors at HRC • Offer educational and career advancement opportunities to employees committed to serving this population 	Offer culturally appropriate care and services tailored to their individual needs	Expand program by providing additional services and events each year, such as concerts and speakers, with a variety of programs available for all cognitive levels	<p>Metrics:</p> <ul style="list-style-type: none"> • Offer weekly programming to patients through life enhancement and expressive therapies • Leverage technology to keep patients engaged <p>Status:</p> <ul style="list-style-type: none"> • Installed technology that allowed for patients to engage in live-streamed events at least twice a week during pandemic • Music and memory program continues throughout the pandemic in patient rooms and introduction of 4 listening stations on each unit 	
Community Events	Russian-speaking and other non-English speaking seniors	Actively address the special needs for this population	<ul style="list-style-type: none"> • Explore ways to extend linguistic and cultural services • Strengthen relationship with professional providers in the community • Cultivate and grow the donor base by attending community events 	<p>Metrics:</p> <ul style="list-style-type: none"> • Offer interpreter services <p>Status:</p> <ul style="list-style-type: none"> • Increased number of per-diem interpreters, written and oral, to meet increased demand; 2 full time interpreters on staff and increased utilization of Spanish speaking interpreter • Added annual LMS module and trained clinical team on appropriate documentation for patients who use interpreter services • Conducted process improvement that resulted in 1) conducting surveymonkey for users of services with higher response rate, 2) enhanced existing dashboard, and 3) streamlined cross-departmental coordination of interpreter requests/utilization across three campuses 	
Know our Seniors	<ul style="list-style-type: none"> • HRC LTCC patients • Holocaust survivors • Brandeis students 	Connect more deeply through oral histories	<ul style="list-style-type: none"> • Offer Brandeis University oral history project • Research and explore Hukulah fund, a German government-funded program 	<p>Metrics:</p> <ul style="list-style-type: none"> • # of years oral history project offered • Hukulah fund research complete <p>Status:</p> <ul style="list-style-type: none"> • Offered in-person oral history project 2019, 2020; shifted to letter-writing correspondence model in 2021 due to COVID and culminated in a poster display • Hukulah fund research suspended due to COVID 	Brandeis University

APPENDIX E

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Access to Geriatric Specialists

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

Area	Target Population	Programmatic Objectives	Future Community Activities / Strategies	Future Metrics	Community Partners
Outpatient Therapy	Seniors at home who need rehab services	Offer HRC Rehab virtual visits for patients who are better served to receive therapy at home	<ul style="list-style-type: none"> • Pilot virtual reality system to deliver therapeutic interventions • Offer remote therapeutic monitoring applicability and usability • Incorporate therapy assessments for fall risks as part of assisted living application • Determine best practices for falls prevention in assisted living settings and apply to other facilities • Collaborate with Marcus Institute on Pilot and Feasibility Study for Multi-Component Prehabilitation Program for High-Risk Older Adults Undergoing Major Elective Surgery 	<ul style="list-style-type: none"> • VR pilot complete • # users on remote therapeutic monitoring • Assisted Living application therapy assessments in place • Production of best practices document and # other facilities utilizing practices • Feasibility pilot complete 	XR Health
STEP-HI Hip Fracture Recovery Clinical Trial	Women age 65 and older	Through collaboration between Marcus Institute and rehab, test strategies that may improve recovery after a hip fracture, specifically whether combining testosterone with exercise can lead to even greater improvements in physical abilities	<ul style="list-style-type: none"> • Continue to recruit participants • Conduct ongoing study of intervention • Continued outreach to professional hospital networks throughout Greater Boston • Publish and promote results 	<ul style="list-style-type: none"> • # participants recruited to the study to date • # of publications that promote results 	Beth Israel, Brigham and Women, Faulkner, St. Elizabeth, Boston Medical Center, Tufts Medical Center
CarFit Program	Seniors in surrounding communities	Increase road safety for all	Offer educational program for seniors to check how well their personal vehicles “fit” them	<ul style="list-style-type: none"> • # seniors participating 	
Therapy House Calls	Seniors living at home	Optimize seniors' independence through Service Area and Programming	<ul style="list-style-type: none"> • Extend educational sessions led by clinicians called Optimizing Independence to other senior housing communities • Gait Speed Testing to assess impact of pandemic on function • Increase # of seniors impacted by our service delivery 	<ul style="list-style-type: none"> • # of educational sessions offered • # participants of Gait Speed Testing • % increase of seniors impacted by service delivery 	

APPENDIX E

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Access to Geriatric Specialists

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

Outpatient Nutrition Services	Seniors in surrounding communities and HSL employees	Raise awareness and provide nutrition education for elders in the community	<ul style="list-style-type: none"> • Increase awareness of nutritional services at HSL by working with R3 and marketing teams to provide presentation on topics such as diabetes management, hypertension, healthful eating, and how to eat nutritionally when financially insecure at Needham, Brookline, and Jamaica Plain Senior Centers • Offer 1:1 counseling w/Medical Nutrition Therapy (MNT) for seniors in the community, HSL seniors from all sites, and HSL employees • Initiate group education for seniors or employees as alternative way to conduct nutritional counseling on topics such as: diabetes, cardiac, and weight management • Offer nutritional counseling sessions for Harvard-Pilgrim insured employees via Preventative Health MNT and coordinate with Livewell to earn participation points 	<ul style="list-style-type: none"> • # employee clients • # of community clients • # of nutritional groups • # presentations in the community • # hours spent on research • Listing of MNT client referral sources 	Senior Centers, Ethos, JP at Home
Dietetic Internship	Seniors in surrounding communities and HSL employees	Raise awareness and provide nutrition education for elders in the community	<ul style="list-style-type: none"> • Conduct clinical dietary intern rotations to provide geriatric clinical nutrition, dietary counseling, and support 	<ul style="list-style-type: none"> • # seniors served 	Senior Centers, Ethos, JP at Home, Brigham & Women's Faulkner Hospital, Pam Health, Functional Nutrition, Community Servings, and others
Community Education/Awareness	Local Boston seniors, caregivers, and community partners	Raise awareness of care options by providing education about HRC services	<ul style="list-style-type: none"> • Offer public caregiver support group • Sponsor memory cafe to the public • Sponsor community events and forums 	<ul style="list-style-type: none"> • # public caregiver support group • # memory cafes to the public • # community events and forums 	Temple Emanuel and other community organizations
Get up And Go	Seniors in surrounding communities	Provide individualized and supervised fitness and strengthening programs for seniors in the area at a reduced cost	Expand program to more seniors through more outreach	<ul style="list-style-type: none"> • Scores on SPPB, Gait Speed to measure pandemic's impact on function • % increase participant volume 	JP @ Home, Ethos, OP Therapy Services Referrals

APPENDIX E

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Access to Geriatric Specialists

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

Outpatient Therapy Specialty Certifications	Geriatric specialists at HRC	Increase number of specialty certifications to meet diverse needs in the aging senior population	<ul style="list-style-type: none"> • Increase awareness of opportunities for community access to specialty certifications in collaboration with the marketing department 	<ul style="list-style-type: none"> • # new certifications for the following specialties: Lymphedema, Hand Therapy, Certified Geriatric Specialist, Orthopedic Certified, LSVT, Functional Medicine Certified, Driver Safely, Vestibular, Wound Care, Pilates, Tai Chi, Pelvic Floor, Vital Stim • Patient satisfaction measures • # specialty treatment plans 	Health providers in the area
Progressive Community-Based Ambulatory Care Center	Seniors in surrounding communities	Offer increased accessibility to HRC's ambulatory care cluster, where community dwelling seniors can easily and safely access a range of preventative care services	<ul style="list-style-type: none"> • Offer increased accessibility to ambulatory wellness services through increased marketing and use of HRC Transportation program 	<ul style="list-style-type: none"> • Patient satisfaction measures • % increase patient volume for following services: Wolk Center for Memory Health, Physical Therapy, Occupational Therapy, Speech Language Pathology, Audiology, OP Nutrition Services, Bone Scan, OP Modified Barium Swallows, Shoe and Brace Clinics 	
Memory Health	People living with cognitive symptoms or disorders at any stage - and their families and caregivers	Provide comprehensive outpatient care related to brain health, cognitive and behavioral problems, and memory loss, whether due to Alzheimer's disease, other dementias, or other neurological or psychiatric conditions	<ul style="list-style-type: none"> • Program expansion to HSL housing sites clinics and other senior living sites • Reach more seniors through mobile van concept • Assessment & Diagnosis including neurology, psychiatry, neuropsychology, and geriatric specialists • Clinical Treatment including the opportunity to participate in leading edge research • Initiate brain health programming and to reach seniors in their residence as part of their wellness plan 	<ul style="list-style-type: none"> • # new HSL housing sites clinics and other senior living sites reached • # seniors reached through mobile van concept • # seniors reached at-home for brain health programming • # diagnostic procedures performed • % increase of new patient volume and clinic visit targets • # functional assessments conducted 	

APPENDIX E

**Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan
Behavioral Health**

Overall goal: Increase the availability and accessibility of outpatient Alzheimer’s and dementia care for seniors who live in the community and their families.

Area	Target Population	Programmatic Objectives	Future Community Activities / Strategies	Future Metrics and Status Update	Community Partners
Wolk Center for Memory Health	Families and patients at any stage of brain health/memory loss	Help individuals maintain the highest possible level of brain function as they age—and provide the family and caregiver support that is critical to achieving the best long-term outcomes	<ul style="list-style-type: none"> Resources and Support for Living with Dementia including support groups, personalized resource planning, and individual and family counseling Expand family caregiver program services Expand customized support group offerings (examples: spouses, newly diagnosed individuals/families) Expand use of TMS treatment programming beyond singular diagnosis of depression Use of telehealth interface with patients/caregivers 	<ul style="list-style-type: none"> # caregivers connected with resources/support # of new services/resources offered to family caregivers and # of caregivers served # new, customized support group offerings Use of TMS treatment programming beyond singular diagnosis of depression % increase of telehealth use with patients/caregivers # seniors reached at-home for brain health programming # of cross team referrals and external referrals # Blog posts 	
Psychiatry Division	Patients and families affected by dementia	Improve identification of / coordination of services for patients and families affected by dementia	<ul style="list-style-type: none"> Initiate scheduled monthly meetings between Wolk and Psychiatry to review identified clients and coordinate services 	<ul style="list-style-type: none"> # clients referred to Wolk by Psychiatry # clients referred to Psychiatry by Wolk 	
Psychiatry Division	Patients whose mobility challenges limit access to behavioral health care	Increased access to behavioral health services through use of telehealth for clients whose mobility challenges would otherwise limit access	<ul style="list-style-type: none"> Enable all behavioral health clinicians to implement telehealth Provide clients technical support necessary to enable them to use telehealth services 	<ul style="list-style-type: none"> % clinicians telehealth enabled # of patients receiving behavioral health services via telehealth 	

APPENDIX E

**Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan
In Home Health**

Overall goal: Expand availability to health and wellness interventions by offering more entry points to meet a senior care expert.

Area	Target Population	Programmatic Objectives	Future Community Activities / Strategies	Future Metrics	Community Partners
In-Home Telehealth Videoconferencing	Home Health patients at high risk for rehospitalization	Enable early indication of disease exacerbation and improved disease management	<ul style="list-style-type: none"> • Explore technology use options, including fall detection, for seniors residing in community • Institute methodology to capture SDOH data as part of senior care planning 	<ul style="list-style-type: none"> • Technology use option exploration complete and, based on findings, viable options being pursued/implemented • Methodology established and implemented/ SDOH data capture in progress 	
Community Based Palliative Care	Frail elders with advancing illness who live in their homes in the community	Ensure patient has a holistic support network and comprehensive expertise through team approach	<ul style="list-style-type: none"> • Apply for Medicare Part B billing status which will allow for reach to seniors beyond those currently being served by HSL home health • Reinvigorate community based educational programming in post pandemic era 	<ul style="list-style-type: none"> • Application submission for Medicare Part B billing status • Assuming approval received, reach extended beyond HSL home health clients to 7 patients in year 1, 12 patients in year 2 • # community-based education efforts (presentations, webinars, blogs, social media) • # presentations to Case Management Society of New England Frail Elders Conference, Aging Life Care Association NE 	
New Wellness Nurse Consultant Program	Residents in HSL senior living communities and seniors using HSL private pay services	Create a safety net for detecting early disease exacerbation and functional decline	<ul style="list-style-type: none"> • Expand reach to HSL senior living and HSL private pay services 	<ul style="list-style-type: none"> • # new senior living sites served • # new people served HSL private pay services 	2Life Communities

APPENDIX E

**Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan
Social Determinants of Health**

Overall goal: Improve health and reduce longstanding disparities in health and health care by reducing the impact of the following social determinants: food insecurity, transportation challenges, language barriers, and domestic abuse.

Area	Target Population	Programmatic Objectives	Future Community Activities / Strategies	Future Metrics	Community Partners
Hunger/Nutrition	Seniors in the greater Boston area	To provide high quality, nutritionally sound, cost effective meals through Meals on Wheels (MOW)	Increase number of seniors who receive Meals on Wheels	<ul style="list-style-type: none"> • Provide 1800 meals per day, five days a week 	Ethos, Springwell, Mystic Valley
Transportation	Seniors in Greater Boston	Offer free transportation service to limited-income, community-dwelling seniors, including those who are frail or critically-ill	<ul style="list-style-type: none"> • Offer free transportation to seniors who are living in other HSL communities or receiving care in their homes that enables them access to Wolk Center for Memory Health and other outpatient services at HRC • Increase community outreach as part of the transportation program to ensure we are reaching seniors who would most benefit from this service • Seek funding to enable expansion of vehicle utilization as “mobile clinics” 		
Protecting Seniors	Seniors who are at risk for abuse, neglect or financial exploitation	Combat the incidence of elder abuse in Massachusetts	<ul style="list-style-type: none"> • Offer shelter and victim support services to seniors who are suffering from abuse, neglect or financial exploitation • Collaborate with community partners to provide education and build awareness • Establish and facilitate multi-agency elder abuse prevention coalitions (known as multidisciplinary teams) 	<ul style="list-style-type: none"> • # of referrals for shelter or supportive services • # of seniors sheltered (incl relocation to permanent housing at HSL sites) • # of educational offerings • # of agencies participating in HSL-led multidisciplinary teams 	Greater Boston Legal Services, Jewish Family & Children’s Services, various ASAPs, various Councils on Aging, various Senior Centers
Language and cultural sensitivity	Russian speaking seniors in the greater Boston area	Actively provide professional, accurate, and culturally sensitive translation and interpreter services to ensure health equity and patient-centered care	<ul style="list-style-type: none"> • Publication of biannual newsletter for Russian Speaking community at large • Support HRC outpatient service lines with translation of written materials and interpreter services 	<ul style="list-style-type: none"> • # of newsletters published • # of interpreters available to outpatient services • # languages offered for interpreter services • # of translated written materials for various HRC outpatient services 	

APPENDIX F

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Plan de implementación para especialistas en geriatría

Objetivo general: Aumentar la disponibilidad y accesibilidad de nuestros especialistas en geriatría y las maneras en que los ancianos de la comunidad pueden acceder a ellos.

Área	Población destinataria	Objetivos programáticos	Actividades/estrategias comunitarias en el futuro	Métricas futuras	Socios de la comunidad
Terapia ambulatoria	Ancianos en casa que necesitan servicios de rehabilitación	Ofrecer visitas virtuales de rehabilitación de Hebrew Rehabilitation Center (HRC) a los pacientes que están mejor atendidos para que reciban terapia en su casa	<ul style="list-style-type: none"> • Utilizar un sistema piloto de realidad virtual para realizar intervenciones terapéuticas • Ofrecer aplicabilidad y facilidad de uso de monitoreo terapéutico remoto • Incorporar evaluaciones terapéuticas para riesgos de caídas como parte de la aplicación en viviendas asistidas • Determinar cuáles son las mejores prácticas para la prevención de caídas en entornos de vivienda asistida y aplicarlas en otros centros • Colaborar con Marcus Institute en el Estudio piloto y de viabilidad del Programa de Prehabilitación Multicomponente (Multi-Component Prehabilitation Program) para adultos mayores de alto riesgo que se someten a una cirugía mayor programada 	<ul style="list-style-type: none"> • Piloto de realidad virtual (Virtual Reality, VR) completo • Cantidad de usuarios en monitoreo terapéutico remoto • Implementación de evaluaciones terapéuticas en la aplicación en viviendas asistidas • Producción del documento sobre mejores prácticas y cantidad de otros centros que utilizan las prácticas • Piloto de viabilidad completo 	XR Health
Ensayo clínico STEP-HI sobre recuperación de fractura de cadera	Mujeres de 65 años o más	A través de la colaboración entre Marcus Institute y la rehabilitación, evaluar estrategias que puedan mejorar la recuperación después de una fractura de cadera, específicamente, si la combinación de testosterona con ejercicio puede producir mejoras incluso mayores en las capacidades físicas	<ul style="list-style-type: none"> • Continuar seleccionando participantes • Llevar a cabo estudio de intervención continuo • Continuar la divulgación en las redes de hospitales profesionales de todo el Gran Boston • Publicar y promover resultados 	<ul style="list-style-type: none"> • Cantidad de participantes reclutados para el estudio hasta la fecha • Cantidad de publicaciones que promueven resultados 	Beth Israel, Brigham and Women, Faulkner, St. Elizabeth, Boston Medical Center, Tufts Medical Center
Programa CarFit	Ancianos de comunidades de alrededores	Aumentar la seguridad vial para todos	Ofrecer programas educativos para ancianos, a fin de comprobar cuán bien se "adaptan" sus vehículos personales	<ul style="list-style-type: none"> • Cantidad de ancianos que participan 	

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Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Plan de implementación para especialistas en geriatría

Objetivo general: Aumentar la disponibilidad y accesibilidad de nuestros especialistas en geriatría y las maneras en que los ancianos de la comunidad pueden acceder a ellos.

<p>Visitas terapéuticas a domicilio</p>	<p>Ancianos que viven en casa</p>	<p>Optimizar la independencia de los ancianos a través del área de servicios y la programación</p>	<ul style="list-style-type: none"> • Ampliar las sesiones educativas dirigidas por profesionales clínicos llamadas "Optimización de la independencia" (Optimizing Independence) para incluir a otras comunidades de viviendas para ancianos • Hacer pruebas de velocidad de marcha para evaluar el impacto de la pandemia en la capacidad funcional • Aumentar la cantidad de ancianos impactados por la prestación de servicios 	<ul style="list-style-type: none"> • Cantidad de sesiones educativas ofrecidas • Cantidad de participantes de las pruebas de velocidad de marcha • Aumento del % de ancianos impactados por la prestación de servicios 	
<p>Servicios nutricionales ambulatorios</p>	<p>Ancianos de comunidades de alrededores y empleados de Hebrew SeniorLife (HSL)</p>	<p>Generar conciencia sobre nutrición y educar en nutrición a los ancianos de la comunidad</p>	<ul style="list-style-type: none"> • Aumentar la conciencia sobre los servicios nutricionales de HSL mediante el trabajo con equipos de comercialización y de la iniciativa "Atención correcta, lugar correcto, momento correcto" (Right Care, Right Place, Right Time; R3) para presentar temas, como control de la diabetes, hipertensión, alimentación saludable y cómo comer de manera nutritiva cuando se está poco seguro financieramente en centros de ancianos de Needham, Brookline y Jamaica Plain • Ofrecer asesoramiento individualizado con terapia médica nutricional (Medical Nutrition Therapy, MNT) a ancianos de la comunidad, ancianos de HSL de todos los centros y empleados de HSL • Iniciar sesiones educativas grupales para ancianos o empleados como una manera alternativa de dar asesoramiento nutricional en temas, como por ejemplo: diabetes, enfermedades cardíacas y control de peso • Ofrecer sesiones de asesoramiento nutricional a empleados con seguro de Harvard-Pilgrim a través de MNT de salud preventiva y coordinar con Livewell para ganar puntos por participación 	<ul style="list-style-type: none"> • Cantidad de clientes empleados • Cantidad de clientes de la comunidad • Cantidad de grupos de nutrición • Cantidad de presentaciones en la comunidad • Cantidad de horas dedicadas a investigación • Listado de fuentes de derivación de clientes de MNT 	<p>Centros de ancianos, Ethos, JP at Home</p>
<p>Pasantía en dietas</p>	<p>Ancianos de comunidades de alrededores y empleados de Hebrew SeniorLife (HSL)</p>	<p>Generar conciencia sobre nutrición y educar en nutrición a los ancianos de la comunidad</p>	<ul style="list-style-type: none"> • Dirigir rotaciones internas de nutrición clínica para dar atención en nutrición clínica geriátrica, y asesoramiento y apoyo en nutrición 	<ul style="list-style-type: none"> • Cantidad de ancianos que se atienden 	<p>Centros de ancianos, Ethos, JP at Home, Brigham & Women's, Faulkner Hospital, Pam Health, Functional Nutrition, Community Servings y otros</p>

APPENDIX F

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Plan de implementación para especialistas en geriatría

Objetivo general: Aumentar la disponibilidad y accesibilidad de nuestros especialistas en geriatría y las maneras en que los ancianos de la comunidad pueden acceder a ellos.

Educación/conciencia comunitarias	Ancianos, cuidadores y socios de la comunidad del área de Boston	Generar conciencia sobre las opciones de atención mediante sesiones educativas acerca de los servicios de HRC	<ul style="list-style-type: none"> • Ofrecer grupo de apoyo público a cuidadores • Patrocinar Café de los Recuerdos (Memory Café) al público • Patrocinar eventos y foros comunitarios 	<ul style="list-style-type: none"> • Cantidad de grupos de apoyo públicos a cuidadores • Cantidad de Memory Cafés al público • Cantidad de eventos y foros comunitarios 	Temple Emanuel y otras organizaciones comunitarias
Prueba Levántese y ande (Get up And Go)	Ancianos de comunidades de alrededores	Proporcionar programas de estado físico y fortalecimiento individualizados y supervisados para ancianos del área a un costo reducido	Expandir el programa a más ancianos a través de una mayor difusión	<ul style="list-style-type: none"> • Puntajes en la prueba Bateria de desempeño físico corto (Short Physical Performance Battery, SPPB), velocidad de marcha para medir el impacto de la pandemia en la capacidad funcional • Aumento del % del volumen de participantes 	JP at Home, Ethos, derivaciones de servicios terapéuticos ambulatorios (Outpatient, OP)
Certificaciones de especialidad en terapia ambulatoria	Especialistas en geriatría de HRC	Aumentar la cantidad de certificaciones de especialidad para satisfacer las distintas necesidades de la población de ancianos	<ul style="list-style-type: none"> • Aumentar la conciencia sobre las oportunidades de acceso comunitario a las certificaciones de especialidad con la colaboración del departamento de comercialización 	<ul style="list-style-type: none"> • Cantidad de nuevas certificaciones para las siguientes especialidades: linfedema, terapia de manos, especialista con certificación en geriatría, certificación en ortopedia, tratamiento de voz Lee Silverman (Lee Silverman Voice Treatment, LSVT), certificación en medicina funcional, conducción segura (Driver Safely), sistema vestibular, cuidado de heridas, pilates, tai chi, suelo pélvico, sistema VitalStim® • Medidas de satisfacción del paciente • Cantidad de planes de tratamiento de especialidades 	Proveedores de atención médica en el área

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Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Plan de implementación para especialistas en geriatría

Objetivo general: Aumentar la disponibilidad y accesibilidad de nuestros especialistas en geriatría y las maneras en que los ancianos de la comunidad pueden acceder a ellos.

Centro progresivo de atención ambulatoria de la comunidad	Ancianos de comunidades de alrededores	Ofrecer una mayor accesibilidad al conjunto de atención ambulatoria de HRC, donde los ancianos que viven en comunidad puedan acceder de manera fácil y segura a diversos servicios de atención preventiva	<ul style="list-style-type: none"> • Ofrecer una mayor accesibilidad a los servicios de bienestar ambulatorios a través de mayor comercialización y uso del programa de transporte de HRC 	<ul style="list-style-type: none"> • Medidas de satisfacción del paciente • Aumento del % del volumen de pacientes para los siguientes servicios: Wolk Center for Memory Health (Centro Wolk para la salud de la memoria), fisioterapia, terapia ocupacional, fonoaudiología, audiología, servicios nutricionales ambulatorios, gammagrafía ósea, tránsito esofágico modificado para pacientes ambulatorios y clínicas ortopédicas 	
Salud de la memoria	Personas que tienen síntomas o trastornos cognitivos en cualquier etapa, y sus familias y cuidadores	Proporcionar atención ambulatoria integral relacionada con la salud del cerebro, los problemas cognitivos y conductuales y la pérdida de la memoria, ya sea a causa de la enfermedad de Alzheimer, otras demencias u otras afecciones neurológicas o psiquiátricas	<ul style="list-style-type: none"> • Programar la expansión de las clínicas de los centros de viviendas de HSL y otros centros de viviendas para ancianos • Llegar a más ancianos a través del concepto de furgoneta móvil • Hacer evaluaciones y diagnósticos, por ejemplo, de especialistas en neurología, psiquiatría, neuropsicología y geriatría • Dar tratamiento clínico, que incluye la oportunidad de participar en investigaciones de vanguardia • Iniciar programas de salud del cerebro y llegar a la casa de los ancianos como parte de su plan de bienestar 	<ul style="list-style-type: none"> • Cantidad de nuevas clínicas de los centros de viviendas de HSL y otros centros de viviendas de ancianos a los que se llega • Cantidad de ancianos a los que se llega a través del concepto de furgoneta móvil • Cantidad de ancianos a los que se llega a su casa en los programas de salud del cerebro • Cantidad de procedimientos de diagnóstico realizados • Aumento del % del volumen de nuevos pacientes y objetivos de visitas a las clínicas • Cantidad de evaluaciones funcionales realizadas 	

APPENDIX F

**Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan
Plan de implementación para salud conductual**

Objetivo general: Aumentar la disponibilidad y accesibilidad de la atención ambulatoria de la enfermedad de Alzheimer y la demencia para ancianos que viven en la comunidad y sus familias.

Área	Población destinataria	Objetivos programáticos	Actividades/estrategias comunitarias en el futuro	Métricas futuras y actualización de estado	Socios de la comunidad
Wolk Center for Memory Health	Familias y pacientes en cualquier etapa de salud del cerebro/pérdida de la memoria	Ayudar a las personas a mantener el máximo nivel posible de función cerebral a medida que envejecen, y dar el apoyo a la familia y a los cuidadores que es fundamental para lograr los mejores resultados a largo plazo	<ul style="list-style-type: none"> Recursos y apoyo para vivir con demencia, incluidos grupos de apoyo, planificación de recursos personalizados, y asesoramiento individual y familiar Ampliación de los servicios de programas de cuidadores de la familia Ampliación de las ofertas de grupos de apoyo personalizado (ejemplos: cónyuges, personas recién diagnosticadas/familias) Ampliación del uso de programas de tratamiento de estimulación magnética transcraneal (Transcranial Magnetic Stimulation, TMS) además del diagnóstico particular de depresión Uso de la interfaz de telemedicina con pacientes/cuidadores 	<ul style="list-style-type: none"> Cantidad de cuidadores conectados con recursos/apoyo Cantidad de nuevos servicios/recursos ofrecidos a cuidadores de la familia y cantidad de cuidadores atendidos Cantidad de nuevas ofertas de grupos de apoyo personalizado Uso de programas de tratamiento de TMS además del diagnóstico particular de depresión Aumento del % de uso de la interfaz de telemedicina con pacientes/cuidadores Cantidad de ancianos a los que se llega a su casa en los programas de salud del cerebro <ul style="list-style-type: none"> Cantidad de derivaciones entre equipos y derivaciones externas Cantidad de publicaciones en blogs 	
División de Psiquiatría	Pacientes y familias afectados por la demencia	Mejorar la identificación/coordinación de servicios para pacientes y familias afectados por la demencia	<ul style="list-style-type: none"> Iniciar reuniones mensuales programadas entre el centro Wolk y la División de Psiquiatría para revisar los clientes identificados y coordinar los servicios 	<ul style="list-style-type: none"> Cantidad de clientes derivados al centro Wolk por la División de Psiquiatría Cantidad de clientes derivados a la División de Psiquiatría por el centro Wolk 	
División de Psiquiatría	Pacientes cuyas dificultades de movilidad limitan su acceso a la atención de salud conductual	Dar mayor acceso a los servicios de salud conductual a través del uso de telemedicina a los clientes cuyas dificultades de movilidad limitarían de otro modo su acceso	<ul style="list-style-type: none"> Permitir a todos los profesionales clínicos de salud conductual implementar la telemedicina Darles a los clientes el soporte técnico necesario que les permita usar los servicios de telemedicina 	<ul style="list-style-type: none"> % de profesionales clínicos con telemedicina habilitada Cantidad de pacientes que reciben servicios de salud conductual a través de telemedicina 	

APPENDIX F

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Plan de implementación para salud en casa

Objetivo general: Ampliar la disponibilidad de las intervenciones de salud y bienestar mediante ofertas de más puntos de entrada para reunirse con un experto en atención de ancianos.

Área	Población destinataria	Objetivos programáticos	Actividades/estrategias comunitarias en el futuro	Métricas futuras	Socios de la comunidad
Videokonferencias de telemedicina en casa	Pacientes de salud en casa de alto riesgo para una nueva hospitalización	Permitir indicaciones tempranas de la exacerbación de la enfermedad y mejora del control de la enfermedad	<ul style="list-style-type: none"> • Explorar opciones uso de tecnología, incluida la detección de caídas para ancianos que viven en la comunidad • Establecer una metodología para capturar datos de los determinantes sociales de la salud (Social Determinants of Health, SDOH) como parte de la planificación de la atención de ancianos 	<ul style="list-style-type: none"> • Exploración de opciones del uso de tecnología completa y, en función de hallazgos, opciones viables que se persiguen/implementan • Metodología establecida e implementada/captura de datos de SDOH en curso 	
Cuidados paliativos en la comunidad	Ancianos debilitados con enfermedad avanzada que viven en casa en la comunidad	Garantizar que el paciente tenga una red de apoyo holístico y conocimientos especializados integrales a través de un enfoque de equipo	<ul style="list-style-type: none"> • Solicitar el estado de facturación de la Parte B de Medicare que permitirá llegar a ancianos además de los que actualmente son atendidos por salud en casa de HSL • Revitalizar los programas educativos comunitarios en la era de la pospandemia 	<ul style="list-style-type: none"> • Presentación de solicitud del estado de facturación de la Parte B de Medicare • Suponiendo que se reciba la aprobación, se ampliará el alcance además de los clientes de salud en casa de HSL a 7 pacientes en el año 1, 12 pacientes en el año 2 • Cantidad de iniciativas educativas comunitarias (presentaciones, seminarios web, blogs, redes sociales) • Cantidad de presentaciones ante la Sociedad de Administración de Casos (Case Management Society) de la Conferencia de Ancianos Debilitados de New England (New England Frail Elders Conference), asociación Aging Life Care™ de New England (NE) 	
Nuevo programa de enfermeras asesoras en bienestar	Residentes en comunidades de viviendas para ancianos de HSL y ancianos que usan los servicios de pago privado de HSL	Crear una red de seguridad para detectar exacerbación temprana de la enfermedad y deterioro funcional	<ul style="list-style-type: none"> • Ampliar el alcance para llegar a las viviendas para ancianos de HSL y servicios de pago privado de HSL 	<ul style="list-style-type: none"> • Cantidad de nuevos centros de viviendas para ancianos que reciben servicios • Cantidad de nuevas personas que reciben servicios de pago privado de HSL 	2Life Communities

APPENDIX F

Hebrew Rehabilitation Center 2022 Community Health Needs Assessment Implementation Plan

Plan de implementación para los determinantes sociales de salud

Objetivo general: Mejorar la salud y reducir las desigualdades que existen desde hace tiempo en cuanto a salud y atención médica mediante la reducción del impacto de los siguientes determinantes sociales: inseguridad alimentaria, problemas de transporte, barreras lingüísticas y maltrato doméstico.

Área	Población destinataria	Objetivos programáticos	Actividades/estrategias comunitarias en el futuro	Métricas futuras	Socios de la comunidad
Hambre/Nutrición	Ancianos del área del Gran Boston	Proporcionar comidas de alta calidad, muy nutritivas y rentables a través de Meals on Wheels (MOW)	Aumentar la cantidad de ancianos que reciben Meals on Wheels	<ul style="list-style-type: none"> • Proporcionar 1800 comidas por día, cinco días a la semana 	Ethos, Springwell, Mystic Valley
Transporte	Ancianos del Gran Boston	Ofrecer servicio de transporte gratuito a ancianos con ingresos limitados, que viven en la comunidad, incluidos aquellos que están debilitados o son enfermos graves	<ul style="list-style-type: none"> • Ofrecer transporte gratuito a ancianos que viven en otras comunidades de HSL o reciben atención en otros hogares que les permite el acceso a servicios de Volk Center for Memory Health y otros servicios ambulatorios de HRC • Aumentar la difusión comunitaria como parte del programa de transporte para garantizar que se llegue a los ancianos que obtendrían más beneficios de este servicio • Buscar financiación para ampliar la utilización de vehículos como "clínicas móviles" 		
Protección de ancianos	Ancianos que están en riesgo de maltrato, abandono o explotación financiera	Combatir la incidencia de maltrato a ancianos de Massachusetts	<ul style="list-style-type: none"> • Ofrecer refugios y servicios de apoyo a ancianos que son víctimas de maltrato, abandono o explotación financiera • Colaborar con socios de la comunidad para ofrecer sesiones educativas y generar conciencia • Establecer y facilitar coaliciones de prevención de maltrato de ancianos de varias agencias (conocidas como "equipos multidisciplinarios") 	<ul style="list-style-type: none"> • Cantidad de derivaciones para refugios o servicios de apoyo • Cantidad de ancianos en refugios (incluida la reubicación en viviendas permanentes en centros de HSL) • Cantidad de ofertas educativas • Cantidad de agencias que participan en equipos multidisciplinarios dirigidos por HSL 	Greater Boston Legal Services, Jewish Family & Children's Services, varios puntos de acceso para ancianos (Aging Senior Access Points, ASAP), varios Consejos sobre Envejecimiento (Councils on Aging), varios centros para ancianos
Idioma y sensibilidad cultural	Ancianos que hablan ruso en el área del Gran Boston	Prestar activamente servicios de traducción e interpretación profesionales, precisos y con sensibilidad cultural para garantizar equidad en salud y atención centrada en el paciente	<ul style="list-style-type: none"> • Publicación de boletín informativo semestral para la comunidad de habla rusa en general • Líneas de apoyo de servicios ambulatorios de HRC con la traducción de material por escrito y servicios de interpretación 	<ul style="list-style-type: none"> • Cantidad de boletines informativos publicados • Cantidad de intérpretes disponibles para servicios ambulatorios • Cantidad de idiomas ofrecidos para servicios de interpretación • Cantidad de material traducido por escrito para diversos servicios ambulatorios de HRC 	