JAHF Business Innovation Award Winners:

Achieving Success in Social Connection Contracting

January 21, 2026

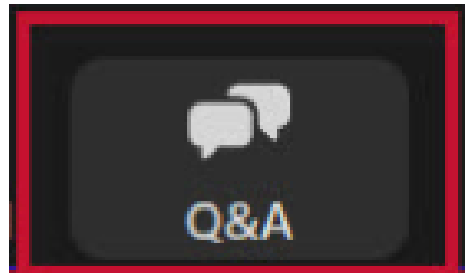
Strengthening Social Connection in Communities

The John A. Hartford Foundation

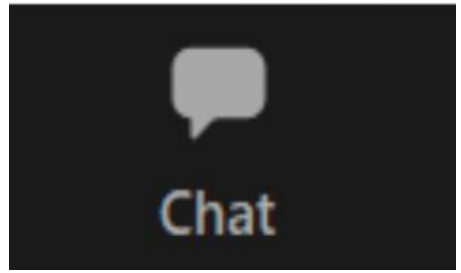
powered by USAging

Welcome

- You can submit questions for the presenters at any time in the **Q & A.** We will answer as many as we can at the **end** of the presentation.



- During the presentation, additional information and resources will be added in the **Chat** but it will be disabled for participants.



- This webinar is being recorded and the recording and slides **will be available** on USAging's Aging and Disability Business Institute and Strengthening Social Connection in Communities webpages:
  - https://aginganddisabilitybusinessinstitute.org/
  - https://www.usaging.org/social-connection-communities

Strengthening Social Connection in Communities

Business Innovation Award

- Honors CBOs partnering with health systems, health plans and accountable care organizations
- Recognizes initiatives that improve outcomes for older adults, people with disabilities and caregivers
- Celebrates models that align health and social care and support sustainability
- Sponsored by JAHF; presented by USAging's Aging and Disability Business Institute and engAGED: The National Resource Center for Engaging Older Adults

Strengthening Social Connection in Communities

The John A. Hartford Foundation
BUSINESS INNOVATION AWARD

The John A. Hartford Foundation

USAging
Leaders in Aging Well at Home

Congratulations and thank you for creating innovative social connection initiatives!

Winner

United Disabilities Services

Runners Up

Senior Connection
Aging Well Together

ESWA
Elder Services Of Worcester Area

Strengthening Social Connection in Communities

Debra Scheidt, MS, BA
Senior Vice President, Clinical Operations
United Disabilities Services

Moses Dixon, PhD
President & CEO
Senior Connection

Ashley Gibbons, MA, BS
Director, Business Development & Quality Improvement
Elder Services of Worcester Area

Nancy Wexler, DBH, MPH
Senior Program Officer
The John A. Hartford Foundation

The John A. Hartford Foundation

JAHF Business Innovation Award Winners:

Achieving Success in Social Connection Contracting

January 21, 2026

Nancy Wexler, DBH, MPH

Senior Program Officer

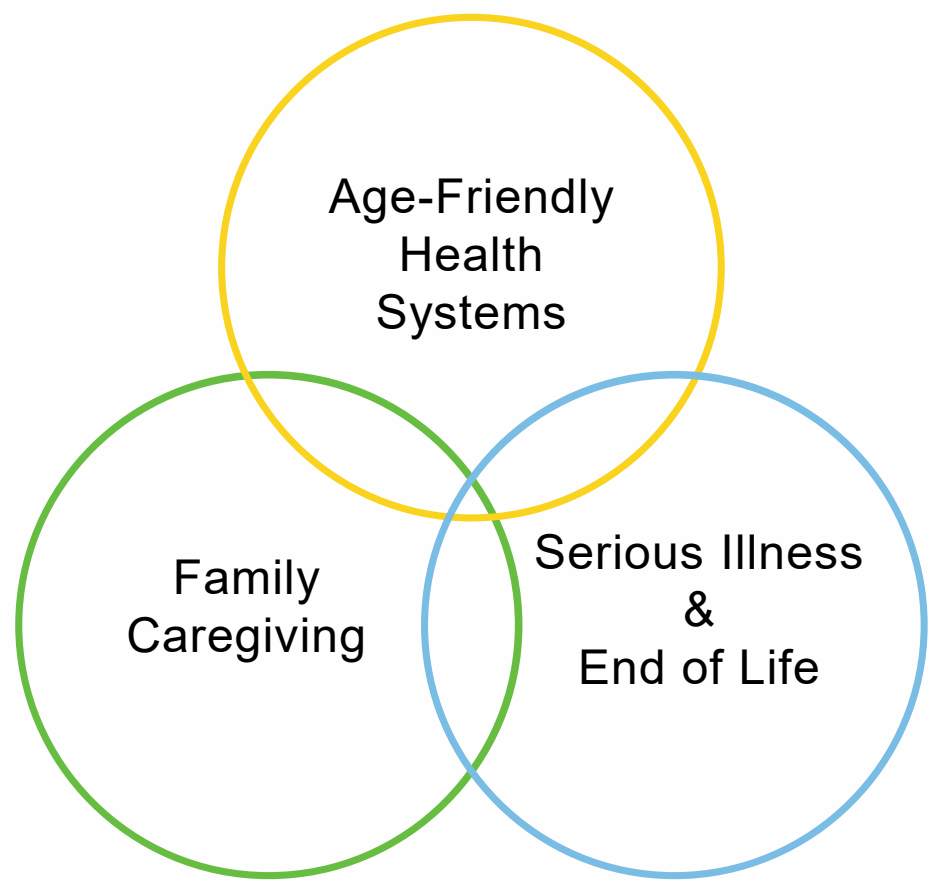
The John A. Hartford Foundation


DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS
1929
The John A. Hartford Foundation
A private philanthropy based in New York City, established by family owners of the A&P grocery chain in 1929.
DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

JAHF Mission & Priorities

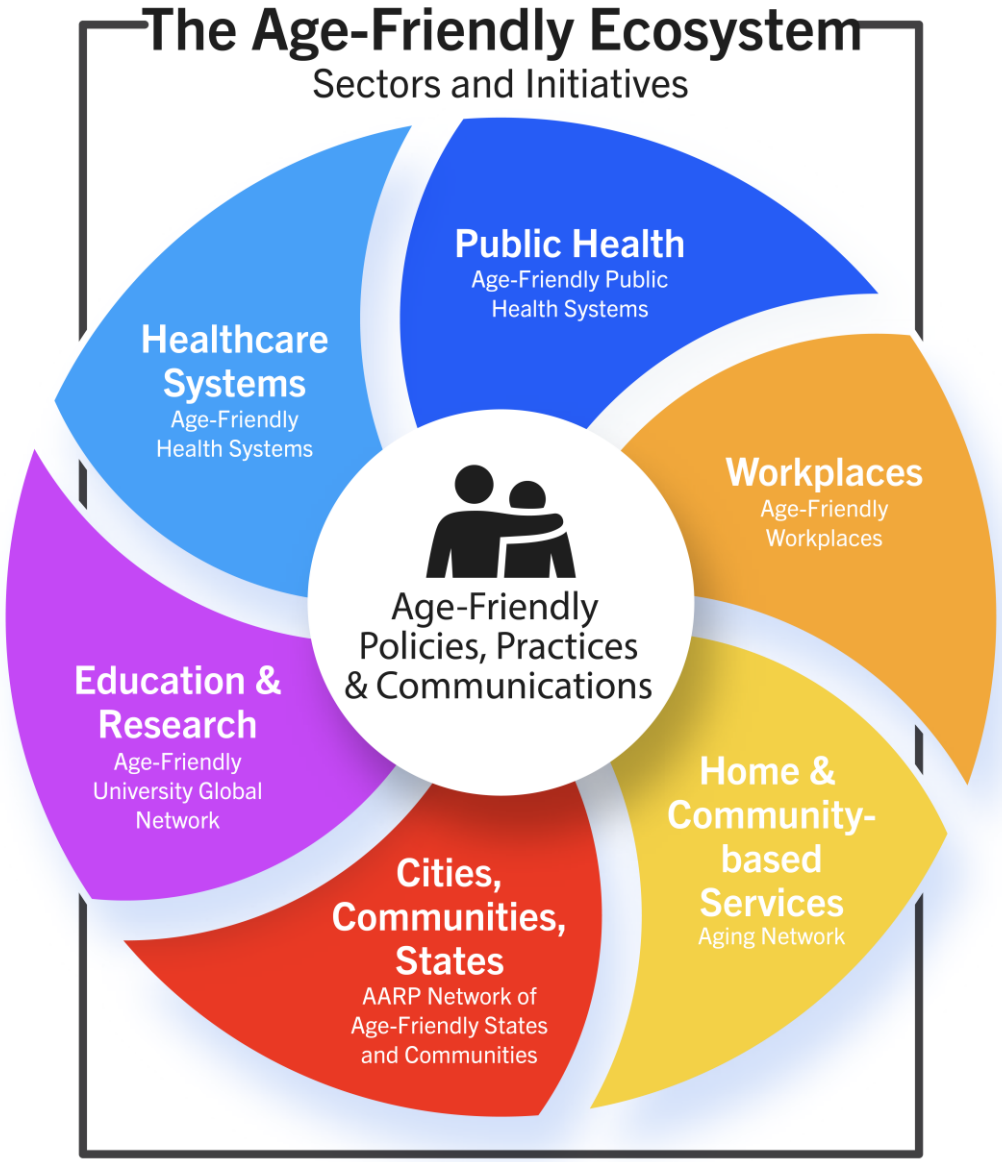
DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

PRIORITY AREAS



We All Need an Age-Friendly Society

- Longevity is greatest success story of last century
- As we age, we can make vital contributions and power up communities – with support
- A just society requires us to make all sectors **age-friendly**



We Need Healthcare Systems to be Age-Friendly

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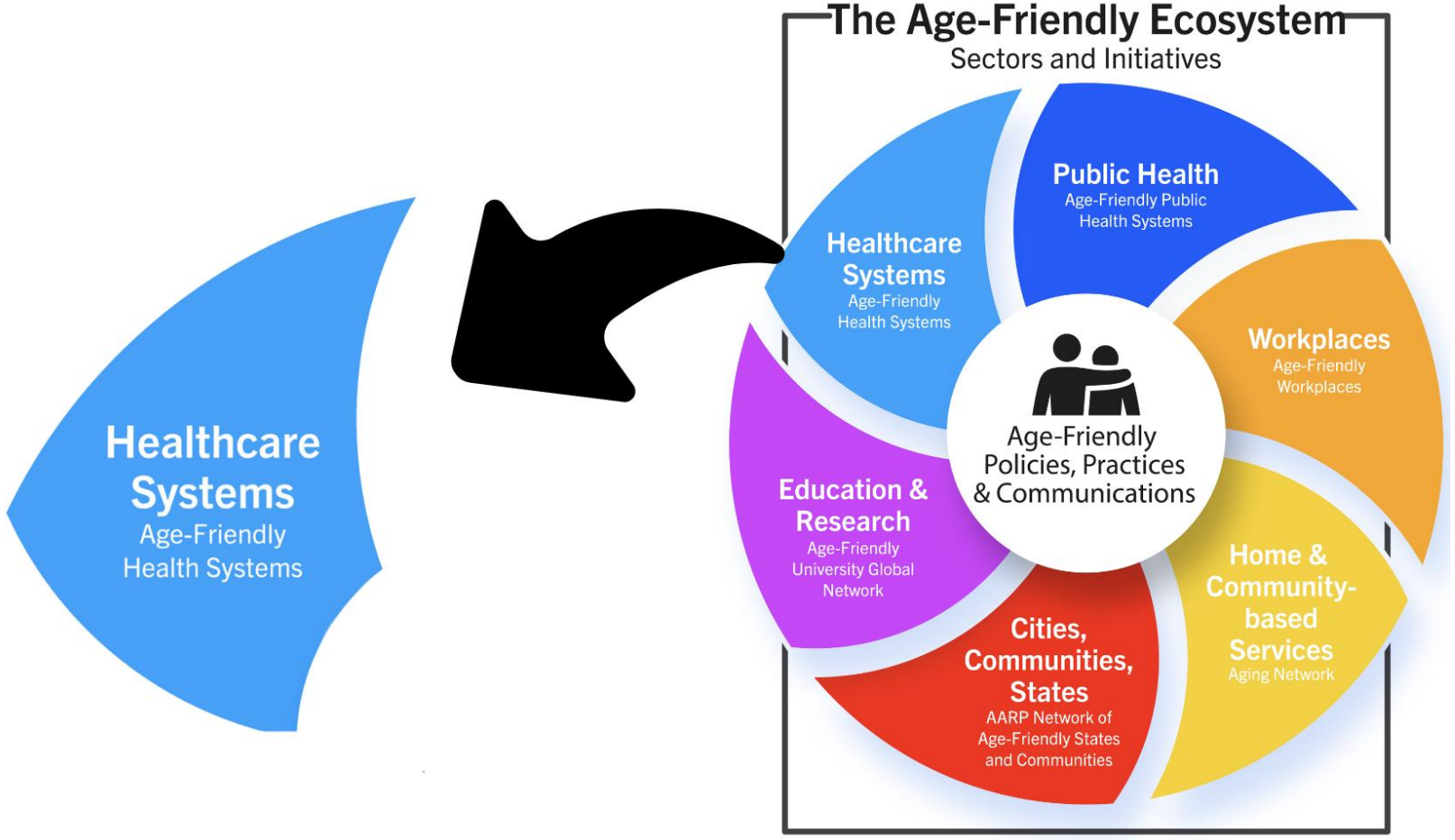
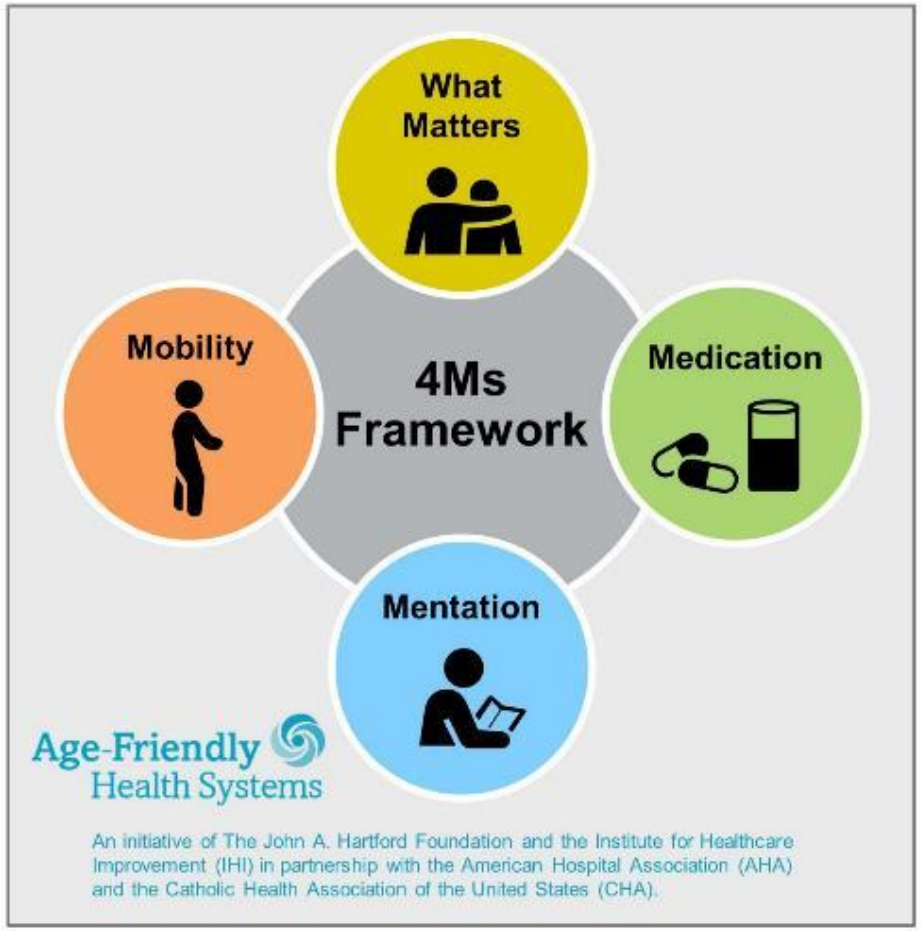


Age-Friendly Health Systems

The aim: Build a movement so ***all care*** with older adults is **equitable age-friendly care**:

- Guided by an essential set of evidence-based practices (**4Ms**)
- Causes no harms
- Is consistent with **What Matters** to the older adult and their family



Fulmer, T., Mate, K. S., & Berman, A. (2018). The age-friendly health system imperative. *Journal of the American Geriatrics Society*, *66*(1), 22-24.

Countering Ageism

The John A. Hartford Foundation

- Longevity: one of our greatest success stories
- Yet, **ageism** gets in the way of realizing benefits:
  - Is unjust, has **negative impact on health**

National Center to Reframe Aging
LED BY THE GERONTOLOGICAL SOCIETY OF AMERICA
ReframingAging.org

Ageism exists in several forms

- Stereotypes: *How we think*
- Prejudices: *How we feel*
- Discrimination *How we act*

Ageism exists on multiple levels

- Interpersonal
- Compassionate
- Systemic/ Institutional
- Self-directed

Building Momentum in Practice

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National Center to Reframe Aging
LED BY THE GERONTOLOGICAL SOCIETY OF AMERICA
ReframingAging.org

Before *After*

Age Strong Shuttle Redesign in Boston, MA

Eliminate Ageism

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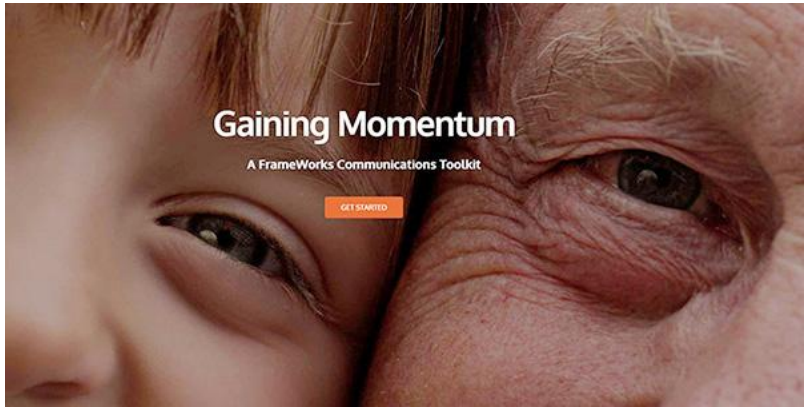
- Ageism has a negative impact on health
- We all need to redefine aging, e.g.
  - "We" are ALL aging (not "they" and "them")
  - Aging is the accumulation of experience and knowledge
  - Aging is a natural progression through life, not something to be fixed
- Tell a different story
- Resources available at the National Center to Reframe Aging!



Reframing Aging

A Social Change Endeavor designed to improve the public's understanding of aging

reframingaging.org

Strengthening Aging Services

JAHF Support of Business Institute

Grants to USAging since 2016 to build business capacity of AAAs and other CBOs:

- Resource library and evidence bank
- Organizational assessment tools
- Spreading success stories
- The John A. Hartford Foundation Business Innovation Award!

USAging Leaders in Aging Well at Home

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

aginganddisabilitybusinessinstitute.org

Shaping a Social Isolation Strategy for Older Adults

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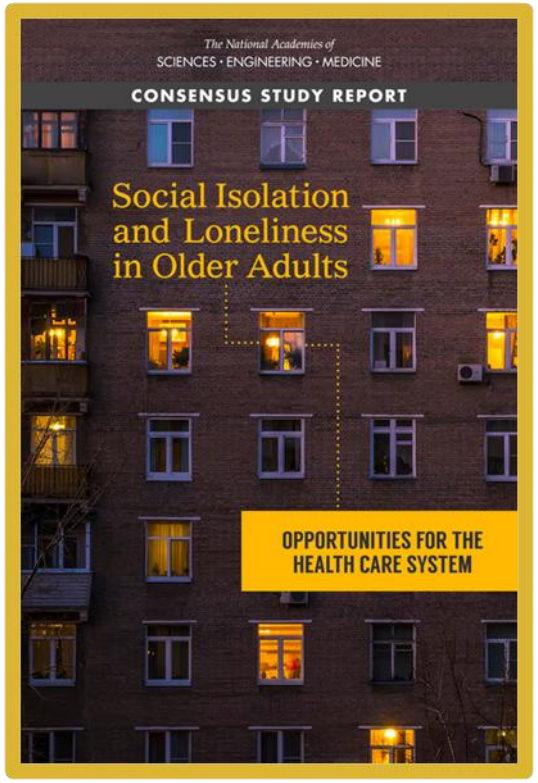
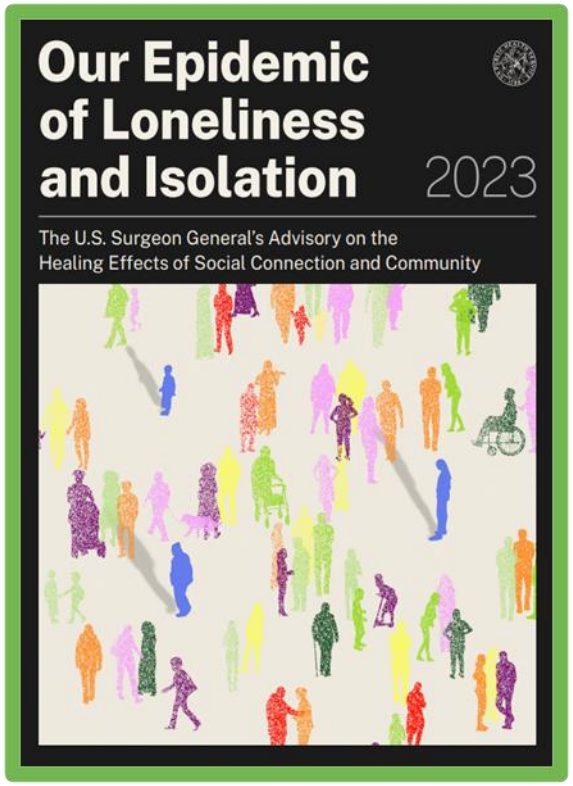
2024 Convening:

- Discussed **collaborative action** that can improve care of older adults by addressing social isolation and loneliness
- Reviewed **existing evidence** to determine what actions JAHF could take



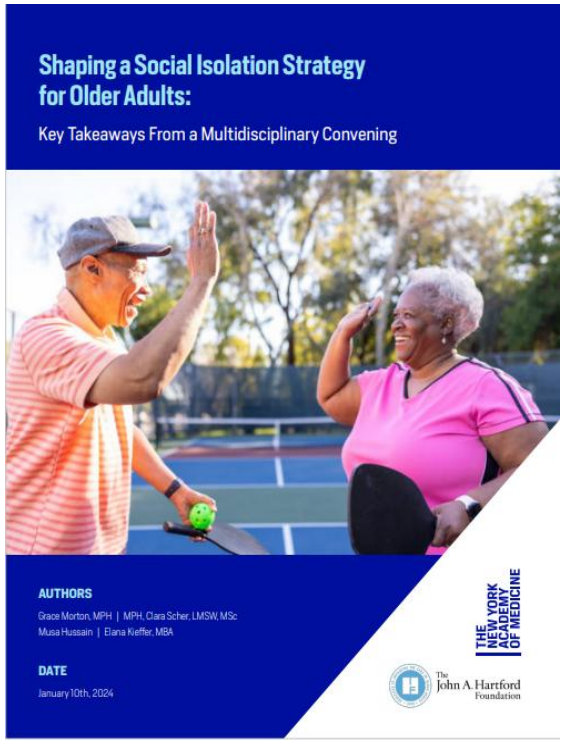


Shaping Social Isolation Strategy for Older Adults

Convening report released April 2024, with opportunities for implementation

8 Recommendations, including:

- Promoting partnerships between community-based organizations and health care



https://www.nyam.org/publications/publication/shaping-social-isolation-strategy-older-adults/

Fostering Social Connections

The John A. Hartford Foundation

New Grant to USAging (2025)

Goal: Improve health by replicating evidence-based social connection programs for older adults

Why it Matters: Social isolation increases mortality risk – comparable to smoking and obesity

Age-Friendly Alignment: Supports "What Matters" by addressing social connections

Support Includes:

- Seed grant pilot program
- Technical assistance to grantees
- Capacity building for Aging Network and community organizations

The John A. Hartford Foundation

Thank You!

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Care Express: Reimagining Rural Health Access

A Collaborative Initiative by Senior Connection, Inc. & UnitedHealthcare Community Plan of Massachusetts

The Mission:

Addressing health disparities in rural Central Massachusetts through "Social Medicine.

The Partnership:

Senior Connection's deep community trust paired with UnitedHealthcare's scale and health resources.

The Recognition:

Runner-up for the 2025 John A. Hartford Foundation Business Innovation Award.

United Healthcare

Senior Connection

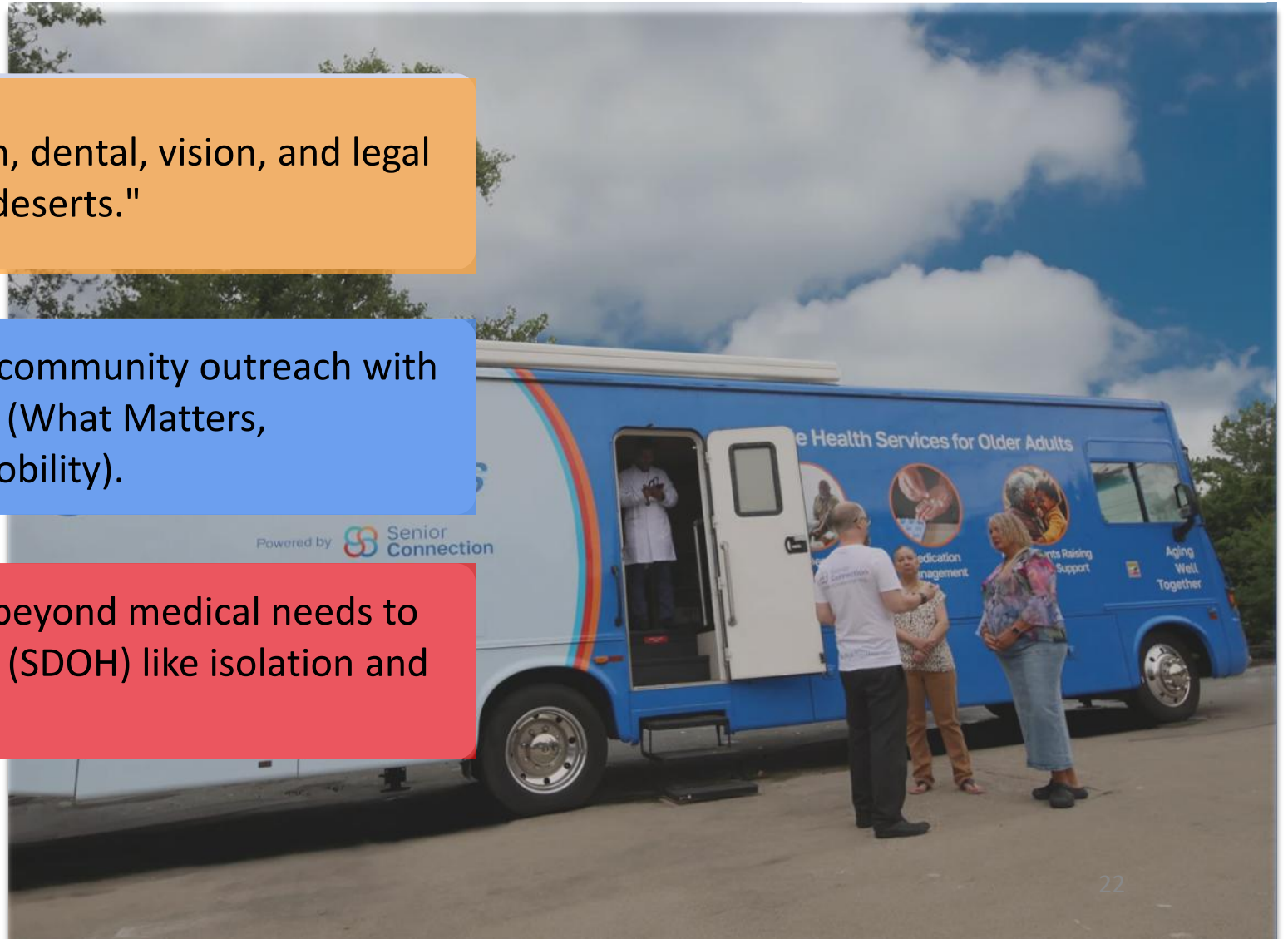
Breaking Barriers via the Mobile Unit

Senior Connection

Direct Delivery: Bringing health, dental, vision, and legal services directly to rural "care deserts."

The 4Ms Framework: Aligning community outreach with the Hartford Foundation's **4Ms** (What Matters, Medication, Mentation, and Mobility).

Comprehensive Care: Moving beyond medical needs to address social drivers of health (SDOH) like isolation and legal crisis intervention.



Proven Impact: By the Numbers

Senior Connection

Bridging the Gap:

- Since 2024, the Care Express program has served over 260 older adults across more than a dozen rural towns.
- Over 200 completed assessments for cognition, mobility, and chronic disease.

Health Outcomes:

- Early identification of health issues through mobile screenings resulted in a 45% reduction in ER visits.
- 92% are now connected to a primary care provider.

Social Connectivity:

- Services delivered in English, Spanish, Vietnamese, and Haitian Creole by culturally matched CHWs.
- 87% reported greater health confidence and reduced isolation through consistent community touchpoints.

"This partnership meets people where they are by showing up in their communities with care, dignity, and trust."

A Blueprint for National Replication

Sustainable Funding: Using the UnitedHealthcare partnership as a model for how CBOs can contract with payers.

Future Growth: Expanding the fleet and service range to reach more "invisible" seniors.

The Call to Action: Reaffirming the commitment to equitable, age-friendly care for all older adults in Massachusetts.

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ESWA
Elder Services Of Worcester Area

BLUE CROSS BLUE SHIELD TRANSITIONS IN CARE PROGRAM

John A. Hartford Business Innovation Award

Ashley Gibbons, MA
Director of Business Development and Quality Improvement

Date: January 21, 2026

TRANSITIONS IN CARE PROGRAM

ESWA
Elder Services Of Worcester Area

1

Elder Services of Worcester Area's (ESWA) Transitions in Care (TiC) Program delivers in-home Coaching, reduces avoidable Emergency Department use, and strengthens social connection.

2

Blue Cross Blue Shield MA contracts with ESWA for this program.

3

ESWA subcontracts with 19 local Aging Services Access Points (ASAP) to provide statewide coverage.

4

Eligible members are Medicare Advantage beneficiaries who present to the ED and are generally 65+.

TRANSITIONS IN CARE INTERVENTION

ESWA
Elder Services Of Worcester Area

Connecting with the member in person or via phone after the ED encounter.

Coach focuses on patient empowerment through motivational interviewing while reviewing:

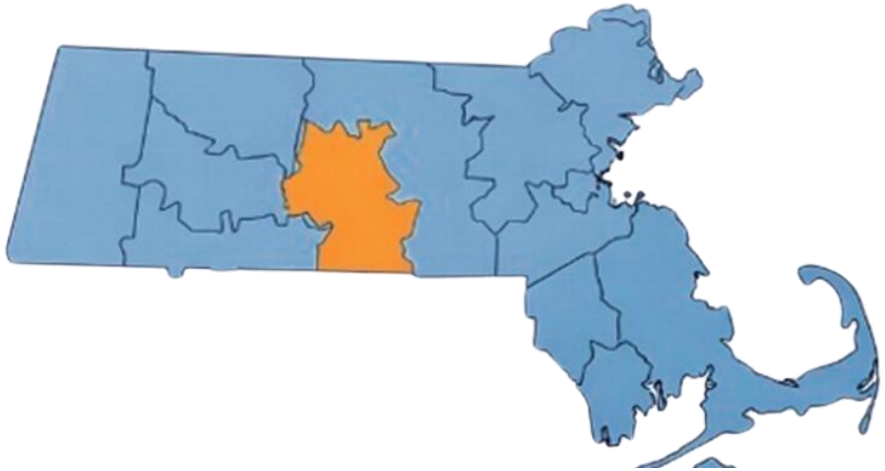
- Member goals
- Provider follow up
- Concerning symptoms to be aware of
- Medication review
- Writing down questions for your provider
- Assisting members on how to navigate the medical system
- Identifying unmet needs and connecting them to resources and supports

ESWA
Elder Services Of Worcester Area

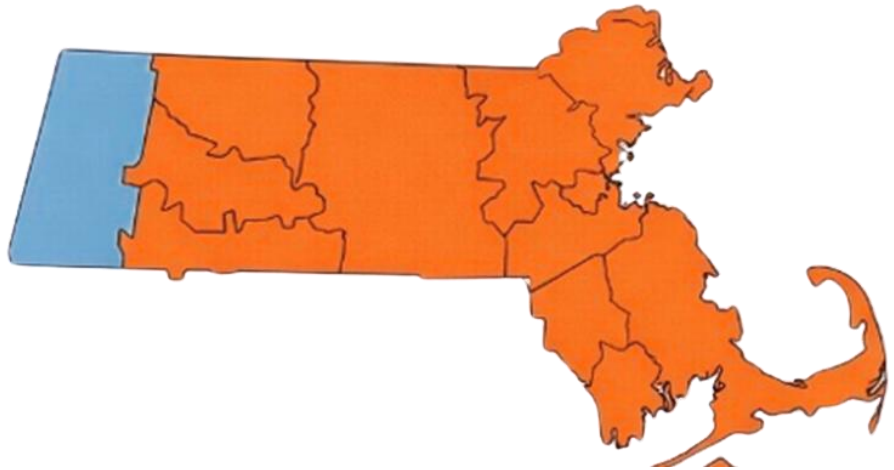
IMPLEMENTATION OF PARTNERSHIPS AND GROWTH

COVERAGE MAP BEFORE AND AFTER

Massachusetts in 2023



Massachusetts in 2025



*Blue is uncovered. Orange is covered

ESWA
Elder Services Of Worcester Area

ESWA
Elder Services Of Worcester Area

STRATEGIES FOR SUCCESSFUL GROWTH AND IMPLEMENTATION

Implement structured workflows; standardize forms and written procedures; consistent training; referral pipelines.

ESWA provides centralized coordination, daily referral distribution, quality monitoring, subcontract alignment.

Sub-contracting: Provide clear scope of work, data-sharing standards, and outcome-driven payment structures.

CBOs can replicate TiC model by prioritizing social connection, strong contracts, measurable outcomes, and community integration.

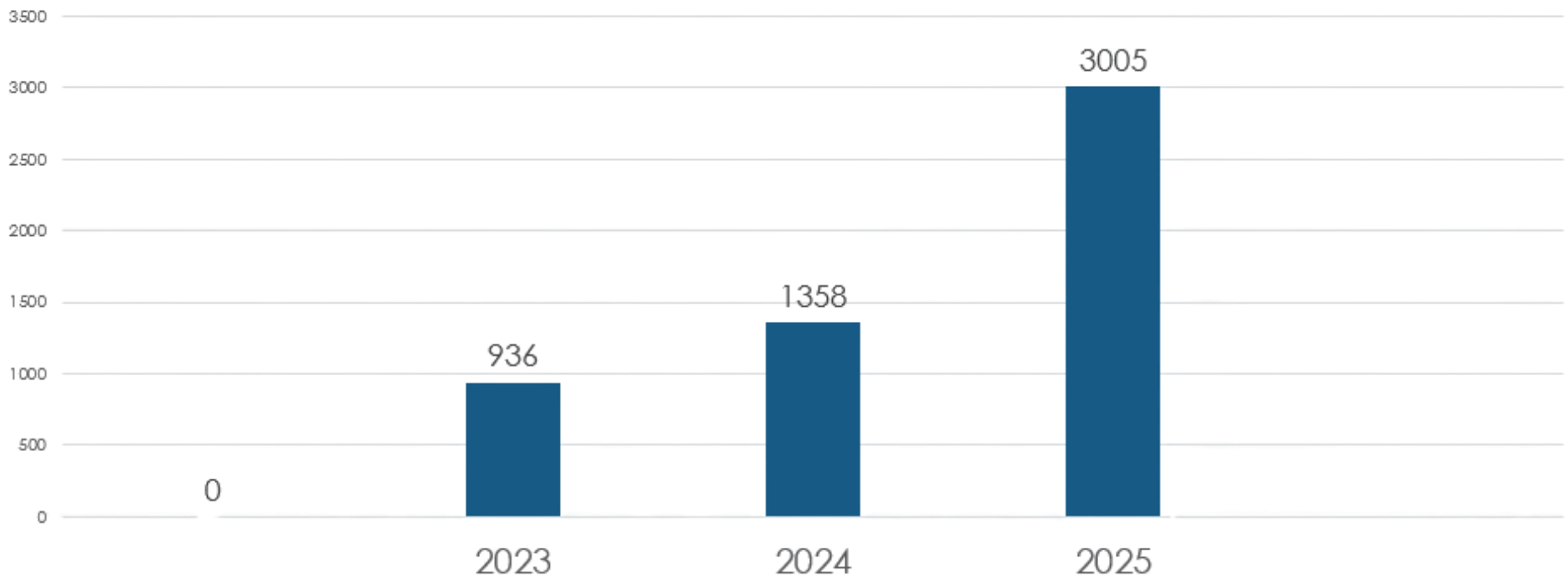
STRENGTH OF HEALTH CARE PARTNER WITH CBO

Weekly rounds with Blue Cross Blue Shield

Referrals to Blue Cross programming in 2025

- Nurse case management = 66
- Behavioral health = 23
- Dietician = 17
- Member services = 55
- Multiple = 14

TRANSITIONS IN CARE ENROLLMENT TOTALS 2023 - 2025



Consumers served (# of interventions)

ESWA
Elder Services Of Worcester Area

ESWA
Elder Services Of Worcester Area

SUCCESSFUL INTERVENTION OUTCOMES

SOCIAL DETERMINANTS OF HEALTH SCREENING – BLUE CROSS MEMBERS 2025

Mood & Interest (Past 2 Weeks)

- Over the past 2 weeks, How often have you felt down, depressed, or hopeless?
- Over the past 2 weeks, how often did you lose interest in the things you enjoy?

Housing

- What is your housing situation today?

Food Security

- Within the past 12 months, you worried that your food would run out before you got money to buy more?

Transportation Barriers (Past 12 Months)

- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

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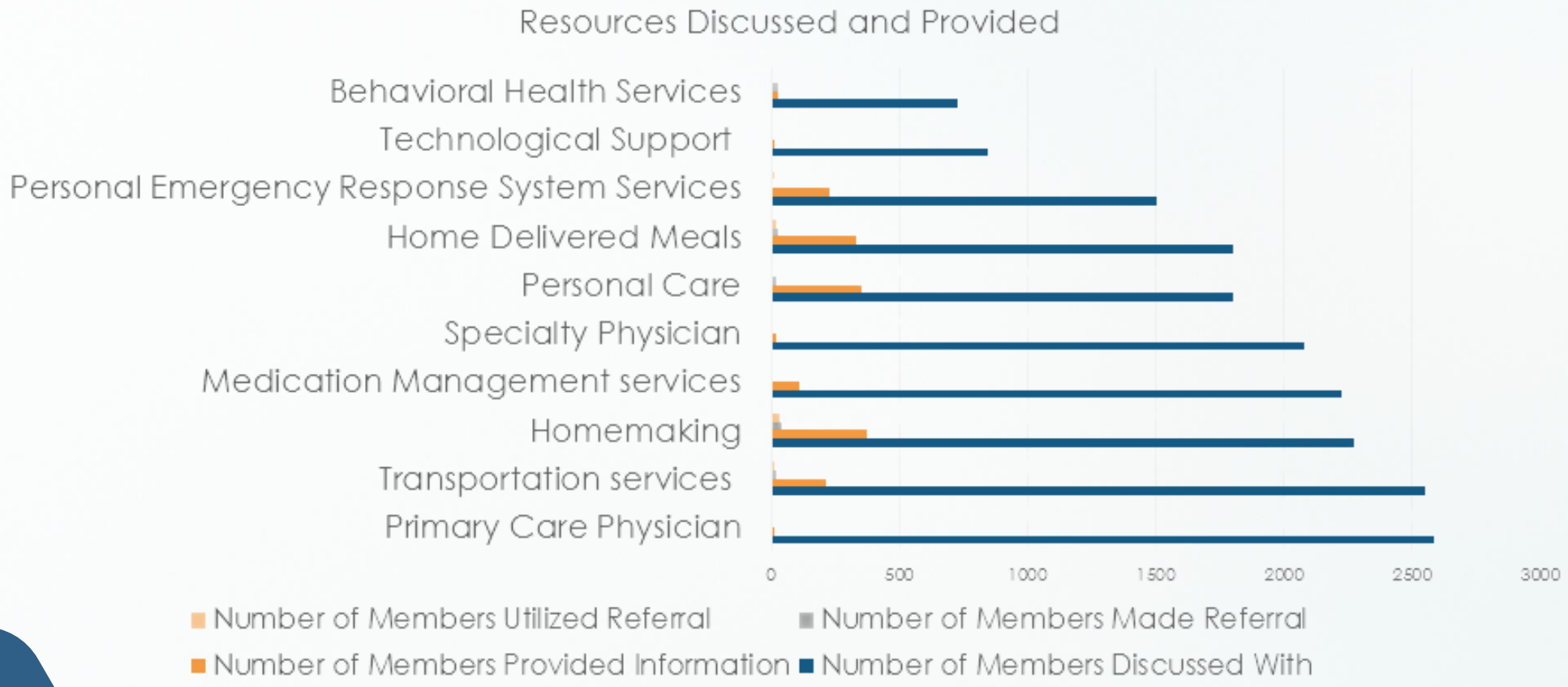
Elder Services Of Worcester Area

SOCIAL CONNECTION STRATEGIES - 2025



ESWA
Elder Services Of Worcester Area

ESWA
Elder Services Of Worcester Area

Member Voices

"Coaching has been wonderful. I feel like I know I can do this now."

"It's very helpful to talk freely with someone without being judged."

Our 2025 TiC survey showed 94% overall satisfaction

95% of consumers said it's helpful to have support within the community post discharge

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uds

United Disabilities Services

Strengthening Social Connection in Communities

Advanced Care Management Solutions

Agenda

History of Program
Program Basics
Learnings & Metrics
Program Expansion
Financial Impact

Person Centered Care

History of The Program

- United Disabilities Services Foundation is a non-profit mission driven organization. Established over 60 years ago.

Our Mission Statement: Enhancing lives through innovative solutions and partnerships that enable and empower those we serve

- Serves 15,000 people in Pennsylvania within 12+ programs.
- This program is housed in Clinical Operations under SVP of Clinical Operations
- Advanced Care Management Solutions Serves 9,000 with its various programs
  - Home & Community Based Services (State Waiver Programs)
  - Advanced Care Management Solutions
    - CAPABLE
    - Short Term Recuperative Housing
    - Community Based Organization (CBO) – Physician Fee Schedule Code

How ACMS Became a Thing…

We asked ourselves how can we do Person Centered Care better in a fragmented health care environment? How can we be a part of the solution?

June 22nd , 2022, we launched ACMS to help solve for a specific at-risk population .

Since we are a Community Based Organization (CBO), we felt that we could help fill in the gaps for many of the Health-Related Social Needs.

Our HCBS participants provided a great model of what UDS can accomplish.

We engaged local hospital systems and proposed our plan to help them with long length of stay patients that no longer met medical necessity but could not be discharge due to social issues. UDS solves for social issues.

Program Basics – The Team

- Medical Director – that shares our vision
- ACMS Program Manager
- ACMS Intensive/Complex Care Managers
- Consultants to ACMS from other areas within Clinical Operations and at UDS overall.
  - Occupational Therapists
  - Registered Nurses
  - Home Modification and Construction Specialists
  - Finance Guidance
  - IT design and implementation specialists
  - Grant/Fund Development
  - Sales and Marketing

Program Basics Process

- Contracted with hospitals for a Per Member Per Month Rate (PMPM)
- Started with one hospital and within 2 month they expanded the contract to all 8 of their other hospitals within their system. After that we learned to contract system wide with the other hospital systems from the beginning.
- We are in the hospital systems under community care for EPIC
- Inpatient CMs send referrals via our website to our Intake Team – **Resource Center.**
  - The sender gets an immediate acknowledgement referral was received.
  - ACMS CM calls within 24 hours to begin discussion.
- **Flash Meetings**: Our Team meets virtually at least once a week with each hospital that has an active inpatient in our program. Larger hospitals we meet twice a week.

Program Basics Process Continued

- **Patient Engagement** : Our ACMS CM meets patient in the hospital. This is the start of the relationship, and we find it reduces anxiety. We follow patients 6 months post discharge to address transition of care and health related social needs for those going back home and 3 months for those going into a Nursing Home permanently (housing, socialization, healthcare, food insecurity, transportation, etc.)

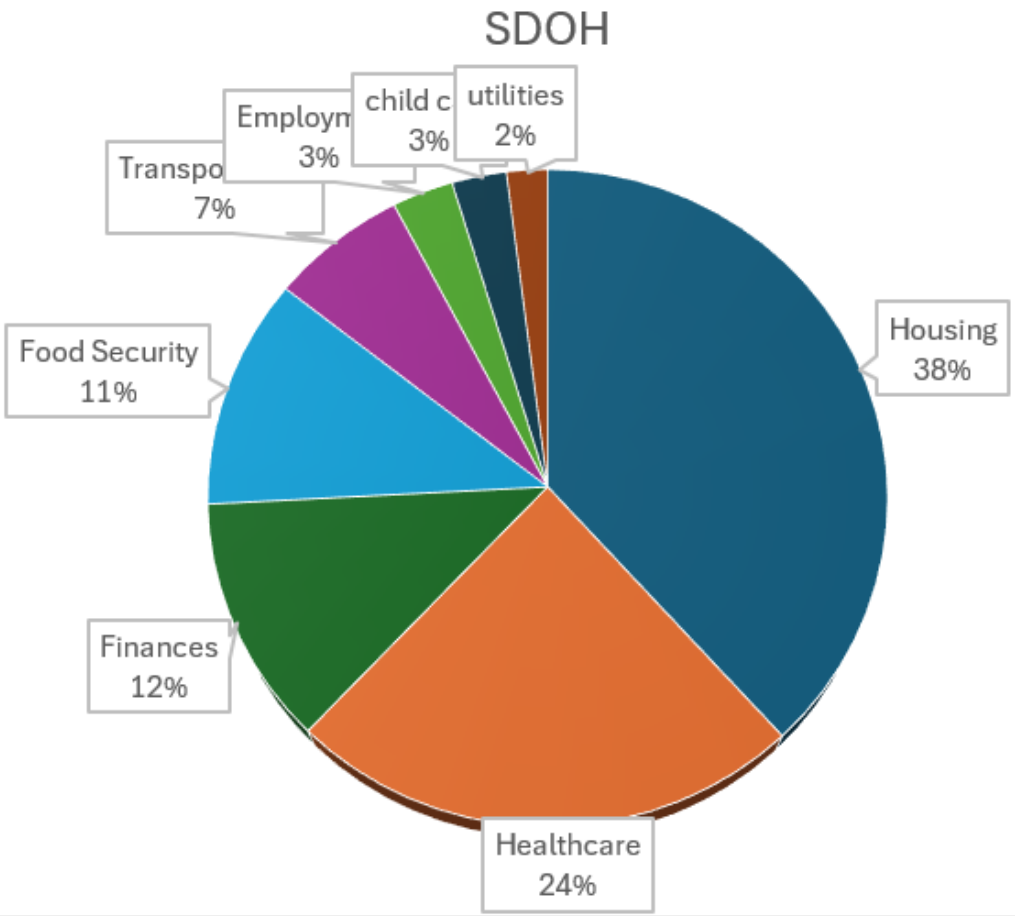
- Let me share Joe's impact story to emphasize engagement

- Post discharge we send a 30-day update to the referring team.

- At the ACMS discharge we send a complete discharge summary to the referring team

- We collect Impact stories to share with our stakeholders monthly

Learnings & Metrics Beginning to Date



PROGRAM OUTCOMES
FY 2024/25

2.8% 30-day Readmission Rate

54% Reduction in Length of Stay

54% of ACMS Patients Have SPMI/Dementia

31% of Patients Were Housing Insecure;
→ 100% of these individuals had safe and secure housing at close of ACMs involvement

Program Expansion

Learning and making connections

We had to have a team members become SME (subject matter experts) some examples…

- 811 Housing Authority Connections
- Undocumented people with precarious immigration status
- Behavioral Health and Intellectual Disabilities

- Housing was our largest need followed by healthcare and that helped lead into expanded programs such as
  - **CAPABLE** for those over 60 wanting to stay in there home but need accommodations
  - **Short-Term Accessible Housing Initiative –** still in development.
  - **Community Based Organization usage of Physician Fee Schedule** – still in development

Financial Impact

We used Strategic Development dollars to hire staff for the start up of ACMS.

ACMS had a positive NI within a few months.

We now contract with 7 hospital systems in Pennsylvania and are in discussion with two others.

We are in discussions with the Health Plans to become a separate ACMS payor for their members that are stratified as high risk.

With a medically necessary patient the hospital generally receives $2,800 per day plus there is a cost of approximately $600 in care costs (lights, staff, food, medications, etc.) The hospital loses this on social admissions, and it negatively impacts throughput.

Contact information for UDS

Whether You Have a Question or Want to Say “Hello,” We’re Here

UDSF welcomes your comments, questions, and requests. Use the contact form below to get in touch with us, and we’ll get back to you as soon as possible. If you need immediate assistance, feel free to call us at (888) 837-4235.

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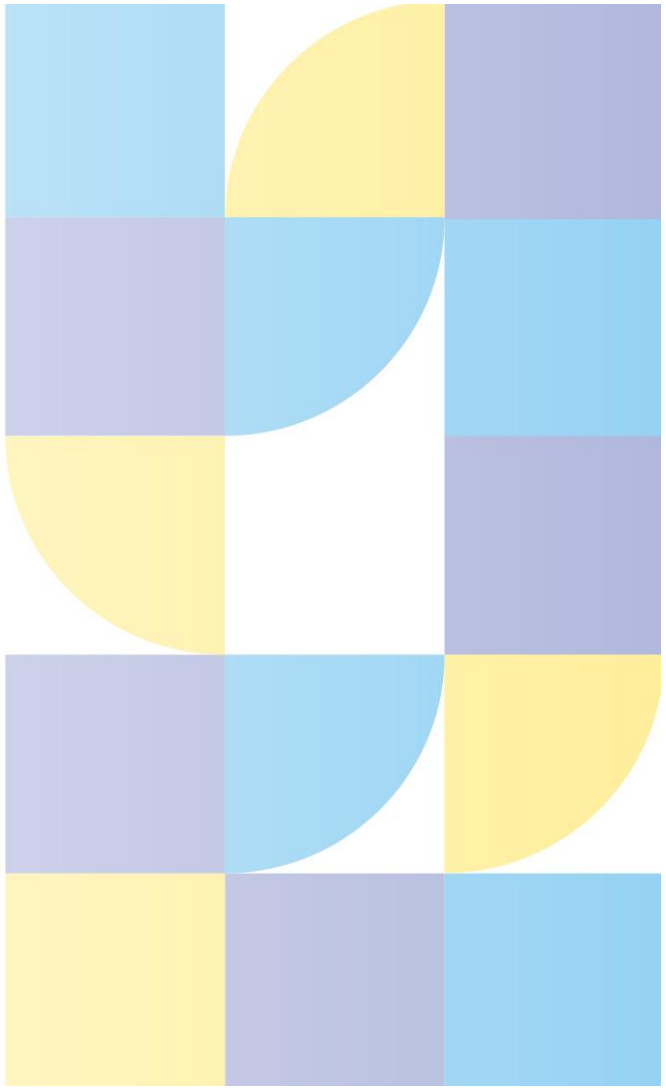
Panel Discussion

Moderated by Nancy Wexler
Senior Program Officer

The John A. Hartford Foundation



Audience Questions

Connect with Us

- Visit our website to learn more about the Business Institute: https://aginganddisabilitybusinessinstitute.org/
- Learn more about engAGED: The National Resource Center for Engaging Older Adults: https://www.engagingolderadults.org/
- Learn about our Center of Excellence to Align Health and Social Care: https://coe.aginganddisabilitybusinessinstitute.org/
- Still have questions? Email us: BusinessInstitute@usaging.org or info@engagingolderadults.org
- Stay connected, sign up for our newsletters: https://www.aginganddisabilitybusinessinstitute.org/subscribe-to-our-mailing-list/

  https://www.engagingolderadults.org/newsletter-archive

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