Success Stories

Building Collaborative Contracts With Health Care:

A Social Connection Partnership Between United Disabilities Services Foundation and WellSpan Ephrata Community Hospital

Introduction

Since 2016, The John A. Hartford Foundation Business Innovation Award[1] has honored community-based organizations (CBOs) that partner and contract with health care entities, such as health systems, health plans and accountable care organizations, to improve health outcomes and quality of life for older adults, people with disabilities and family caregivers, and to replicate these successful partnerships nationwide. Award winners are recognized for bold, transformative initiatives that align health and community care and strengthen their organizations' sustainability. The award is sponsored by The John A. Hartford Foundation and presented by USAging's Aging and Disability Business Institute and Engaged: USAging's Resource Center for Engaging Older Adults.

Operating under the umbrella of the United Disabilities Services Foundation (UDSF), the Advanced Care Management Solutions (ACMS) program supports individuals 18 and older with complex clinical and social needs. UDSF—recipient of The John A. Hartford Foundation 2025 Business Innovation Award—is widely recognized for pioneering contracts with seven health systems and one behavioral health managed care organization in Pennsylvania. These cross-sector partnerships, first piloted at WellSpan Ephrata Community Hospital and rapidly scaled, optimize patient care transitions and strengthen community integration. Ultimately, this model demonstrates the profound value of community-based organizations (CBOs) working in deep partnership with health care entities to bridge the gap between medical care and the upstream drivers of health.

This Success Story highlights how UDSF's Advanced Care Management Solutions (ACMS) operates two programs, the Intensive Case Management (ICM) and CAPABLE. The ACMS ICM program embeds CBO care managers directly within hospital discharge teams to address complex community needs through immediate, early intervention. By leveraging resource flexibility and maintaining a rigorous six-month post-discharge follow-up model, the program dramatically reduces prolonged hospital stays and avoidable returns. The results speak for themselves: ACMS' ICM program achieves a remarkable four percent unplanned hospital readmission rate among the region's most complex patient populations, vastly outperforming the Pennsylvania baseline of 14.7 percent for all discharges and demonstrating that integrated CBO partnerships are essential to true value-based care.

About the Partners

United Disabilities Services Foundation[2] (UDSF) is a nonprofit organization based in Lancaster, Pennsylvania, that provides comprehensive community-based services to empower older adults, individuals with disabilities and their caregivers to live independently and flourish in their communities. With over 60 years of experience, UDSF offers vital care options, promotes social connection and provides a straightforward approach to accessing care to improve overall well-being. UDSF serves more than 15,000 people through 16 programs in 40 counties across Pennsylvania and New Jersey.

WellSpan Ephrata Community Hospital[3] is a nonprofit health care provider serving northern Lancaster County and surrounding communities. It offers preventive and primary care, diagnostic testing, acute treatment and rehabilitation services. The hospital is licensed for 115 acute care patients, 18 behavioral health patients and eight acute rehabilitation patients. It provides a range of inpatient and outpatient services tailored to its community's needs.

About the Contract

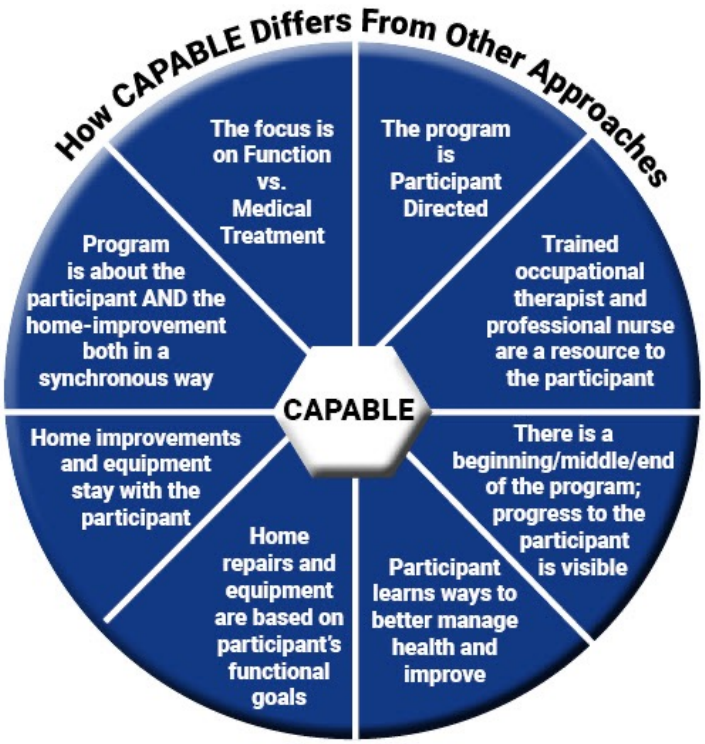
In June 2022, UDSF created the ACMS Intensive Case Management program to partner with health care providers to support patients with complex needs, especially during hospital-to-home transitions. ACMS contracts with seven health systems—WellSpan Ephrata Hospital, St. Luke's University Health Network, University of Pittsburgh Medical Center, Tower Health, Perform Care, Penn State Health, Lancaster General Hospital/Penn Med—on a per-member-per-month (PMPM) basis. ACMS works with health care systems that use Epic,[4] an electronic health record system, to access medical records, better understand patients' needs and share patient progress.

ACMS ICM addresses complex health-related social needs (HRSNs) that contribute to prolonged hospital stays. Unlike traditional approaches, ACMS Intensive Case managers are part of hospital discharge teams and work closely with discharge planners to develop and implement person-centered care plans. This early, integrated strategy has proven successful. ACMS Intensive Case managers not only identify needs but also secure community resources, including housing, food, transportation and long-term services and supports. Intensive Case managers craft personalized plans, using "resource agility" to access resources through the CAPABLE home modifications program and community collaborations to support successful transitions. The six-month post-discharge follow-up, called "sustained connection," is vital for ongoing patient engagement, ensuring continuity of care, connecting patients with recovery resources, and preventing isolation and rehospitalizations.

ACMS serves more than 9,000 patients and offers the following programs:

- Home & Community-Based Services (State Waiver Programs)
- CAPABLE
- Intensive Case Management

Another key initiative offered by UDSF through its ACMS program is the evidence-based CAPABLE[5] program, developed more than 15 years ago by the Johns Hopkins School of Nursing. This person-centered, home-based program improves function and reduces health care costs. CAPABLE is delivered by occupational therapists, registered nurses, home modification experts, IT design and implementation specialists and care managers. It is designed to help individuals aged 60 and above enhance their mobility, function and overall capacity to remain in their homes. CAPABLE partners with local health care systems and Area Agencies on Aging. UDSF's ACMS program has offered CAPABLE locally for more than two years. UDSF funds CAPABLE for older adults in its community and seeks additional grants to help subsidize some of the program's costs.



UDSF ACMS CAPABLE,[6] Johns Hopkins School of Nursing.[7]

Rosemary

“I’ve felt the best I have in years, all because of the UDS CAPABLE team.”

The CAPABLE program delivers person-centered interventions, secures essential community resources and provides support. CAPABLE’s holistic approach integrates direct services, home modifications and evidence-informed strategies to ensure successful transitions and sustained community integration for vulnerable populations. By focusing on non-medical barriers to recovery and in-home support, CAPABLE helps improve outcomes, reduce hospitalizations and emergency room visits and enhance quality of life for older adults.

Impact and Outcomes

The ACMS ICM and CAPABLE programs use evidence-based and evidence-informed social connection interventions that integrate research, expertise and client preferences through social prescribing, skills-based interventions and home modifications to foster connections. Both programs demonstrate accomplishments including improved clients’ physical and mental health and quality of life, reduced risk of functional decline and lower health care costs due to reduced hospital utilization. The impressive results (comparing a year prior to program participation) include:

- 57 percent of participants demonstrated improvement in their PHQ9[8] scores (a reliable, valid screening tool for depression and anxiety), which was linked to increased independence and community engagement.
- 86 percent of participants showed a reduction in hospitalizations.
- 2.8 percent 30-day hospital readmission rate for program participants.
- 54 percent reduction in hospital length of stay for program participants.
- Participants showed an improved ability to complete activities of daily living[9] by 85 percent, instrumental activities of daily living[10] by 63 percent and functional mobility tasks by 63 percent.
- 39 percent reduction in fall risk (demonstrated by the Timed Up and Go Assessment[11]) and a 92 percent reduction in actual falls.
- 69 percent reduction in housing insecurity; 100-percent had safe and secure housing at the end of the program.

Lessons Learned

UDSF’s ACMS team gained important insights during the design, implementation and contracting phases. Although the program initially partnered with a single hospital system, it quickly expanded to cover all seven hospitals within two months. This experience taught the team to establish system-wide contracts from the outset to save time and prevent redundancy.

The CAPABLE Program Provides

The team learned to integrate early in the patient process, emphasizing the importance of embedding CBO case managers within hospital teams. This direct integration streamlines patient identification and ensures holistic care transitions, improving throughput and outcomes. They recognized resource agility as a key lesson, as complex HRSNs require flexible, person-centered solutions that draw on diverse community resources, charitable partnerships and home modifications. The team also prioritized data sharing through standardized, secure protocols and assigned dedicated liaisons. Understanding payer models was essential to achieving financial self-sufficiency, with a clear return on investment (ROI) such as reduced readmissions and shorter lengths of stay, which delivered health care cost savings for partners. A quality manager was appointed to support excellence and showcase the value of these ACMS programs. The team learned to scale the program by implementing robust internal training and recruiting specialized staff. Lastly, they found that maintaining long-term social connections with patients, especially through post-discharge follow-up, is critical to fostering social bonds, supporting patient stability and reducing rehospitalizations.

The Future

This partnership's sustainability is built on demonstrating value to health care systems through outcomes such as reduced readmissions and shorter lengths of stay, which translate into cost savings. UDSF ACMS programs will expand successful contracts to additional health systems, health plans and managed care organizations, leveraging proven impact. The future envisions the ACMS program as a leading, stable model for integrated health and social care, continuously expanding its reach and adapting, bolstered by additional programs that address identified community needs.

The long-term sustainability of ACMS's partnerships depends on demonstrating value to health care systems through outcomes such as fewer readmissions and shorter stays, which translate into cost savings. The ACMS program will grow by extending successful contracts to additional health systems, insurers and managed care organizations, drawing on their proven results. Looking ahead, UDSF's ACMS program aims to become a leading, stable model for integrated health and social care, continuously expanding its scope and evolving, supported by additional programs that meet community needs.

Endnotes

1. The John A. Hartford Business Innovation Award. https://aginganddisabilitybusinessinstitute.org/partnerships-in-action/the-john-a-hartford-foundation-business-innovation-award/
2. United Disabilities Service Foundation. udservices.org/
3. WellSpan Ephrata Community Hospital. wellspan.org/
4. Epic Software. epic.com/
5. The CAPABLE program. capablenationalcenter.org/Home
6. UDS ACMS CAPABLE program. https://udservices.org/capable/
7. Johns Hopkins School of Nursing CAPABLE program. giving.jhu.edu/story/capable-program/
8. Patient Health Questionnaire (PHQ-9). psycnet.apa.org/
9. What are Activities of Daily Living (ADLs) & Instrumental Activities of Daily Living (IADLs)? Better Health While Aging, betterhealthwhileaging.net/what-are-adls-and-iadls/
10. Activities of Daily Living. Cleveland Clinic, my.clevelandclinic.org/health/articles/activities-of-daily-living-adls
11. Timed Up and Go, Centers for Disease Control and Prevention. www.cdc.gov/steadi/media/pdfs/steadi-assessment-tug-508.pdf

USAging

Leaders in Aging Well at Home

About USAging

USAging is the national association representing and supporting the network of Area Agencies on Aging and advocating for the Title VI Native American Aging Programs. Our members help older adults, people with disabilities and family caregivers throughout the United States live with optimal health, well-being, independence and dignity in their homes and communities. For more information, visit the USAging website and follow @theUSAging on Facebook, X and Instagram.

Aging and Disability BUSINESS INSTITUTE

Connecting Communities and Health Care

About the Aging and Disability Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to build and strengthen partnerships and contracting between Area Agencies on Aging, aging and disability community-based organizations (CBOs), community care hubs (CCHs) and their networks, and health care entities. Led by USAging, the Business Institute helps these organizations adapt to a changing health care environment and strengthen their organizational capacity to capitalize on emerging opportunities for sustainable funding. The Business Institute is home to the Center of Excellence to Align Health and Social Care, which funds and supports CCHs and the networks they lead. Learn more at the Aging and Disability Business Institute website.

engaged

USAging's Resource Center for Engaging Older Adults

About Engaged: USAging's Resource Center for Engaging Older Adults

Engaged: USAging's Resource Center for Engaging Older Adults is a national initiative designed to enhance social engagement among older adults, individuals with disabilities and caregivers by expanding and strengthening the Aging Network's capacity to offer social engagement opportunities. Managed by USAging and funded by the U.S. Administration on Aging, the Engaged Resource Center identifies and shares information about emerging trends and best practices, and develops resources and replication tools to support social engagement initiatives within the Aging Network. For more information, visit the Engaged Resource Center website.

The John A. Hartford Foundation

About The John A. Hartford Foundation

The development of this case study was supported by The John A. Hartford Foundation, based in New York City, is a private, nonpartisan, national philanthropy dedicated to improving the care of older adults. The leader in the field of aging and health, the Foundation has three priority areas: creating age-friendly health systems, supporting family caregivers, and improving serious illness and end-of-life care. For more information, visit the John A. Hartford Foundation website.

For more information about this project, visit the United Disabilities Services Foundation website.