
JAHF Business Innovation Award Winners

Health Care-CBO Partnerships: Improving Health Outcomes & Social Connection

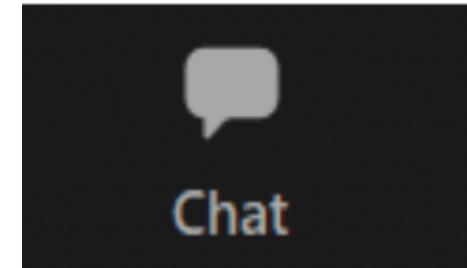
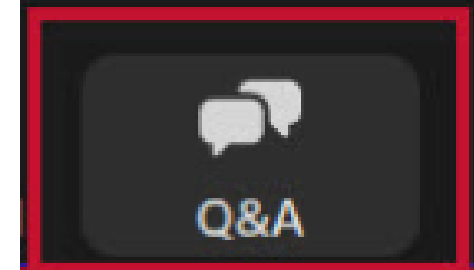
October 15, 2026



The
John A. Hartford
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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**. Please introduce yourself and leave any comments in the chat.
- This webinar is being recorded. The recording and slides **will be sent to each person who registered and also 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>



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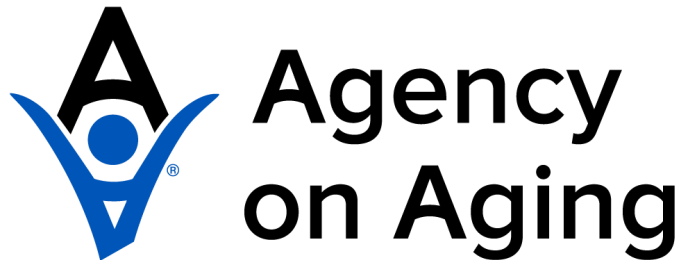
Business Innovation Award

- 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: USAging's National Resource Center for Engaging Older Adults



Congratulations and thank you for creating innovative social connection initiatives!

Winner



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Runners Up



FAIRFAX COUNTY DEPARTMENT OF
FAMILY SERVICES
ADULT AND AGING
AREA AGENCY ON AGING





Melissa Lang, DrPH, MPH, MPA, MA
President & CEO
Agency on Aging
of South Central CT



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



Jeffrey Klein, MBA, FACHE
President & CEO
Nevada Senior Services



Lauren Elcesser, LCSW
Director, Community Health
Inova Health



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FAMILY SERVICES
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Tara Turner, MS
Director
Fairfax Area Agency on Aging





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JAHF Business Innovation Award Winners:
Health Care-CBO Partnerships: Improving
Health Outcomes & Social Connection

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



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DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS



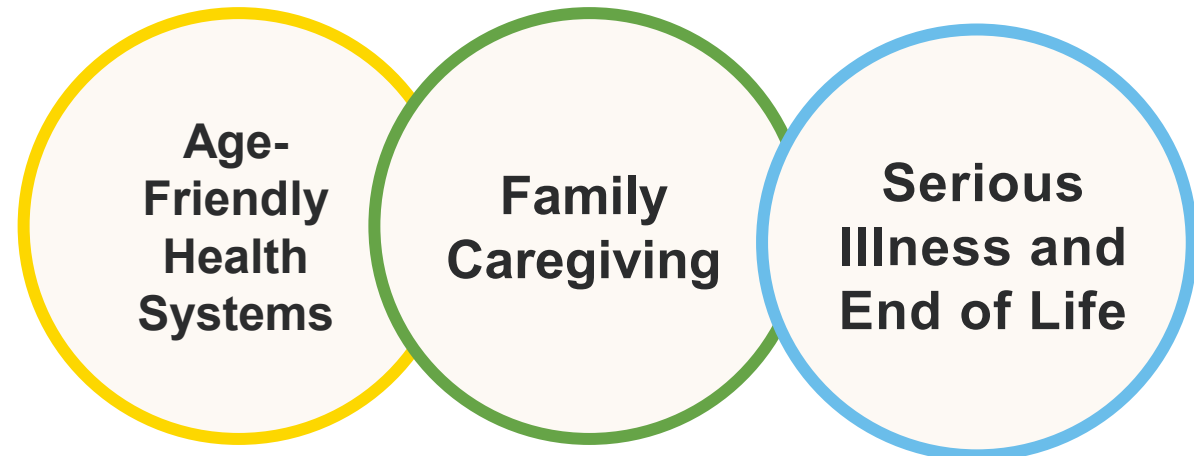
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Our Mission



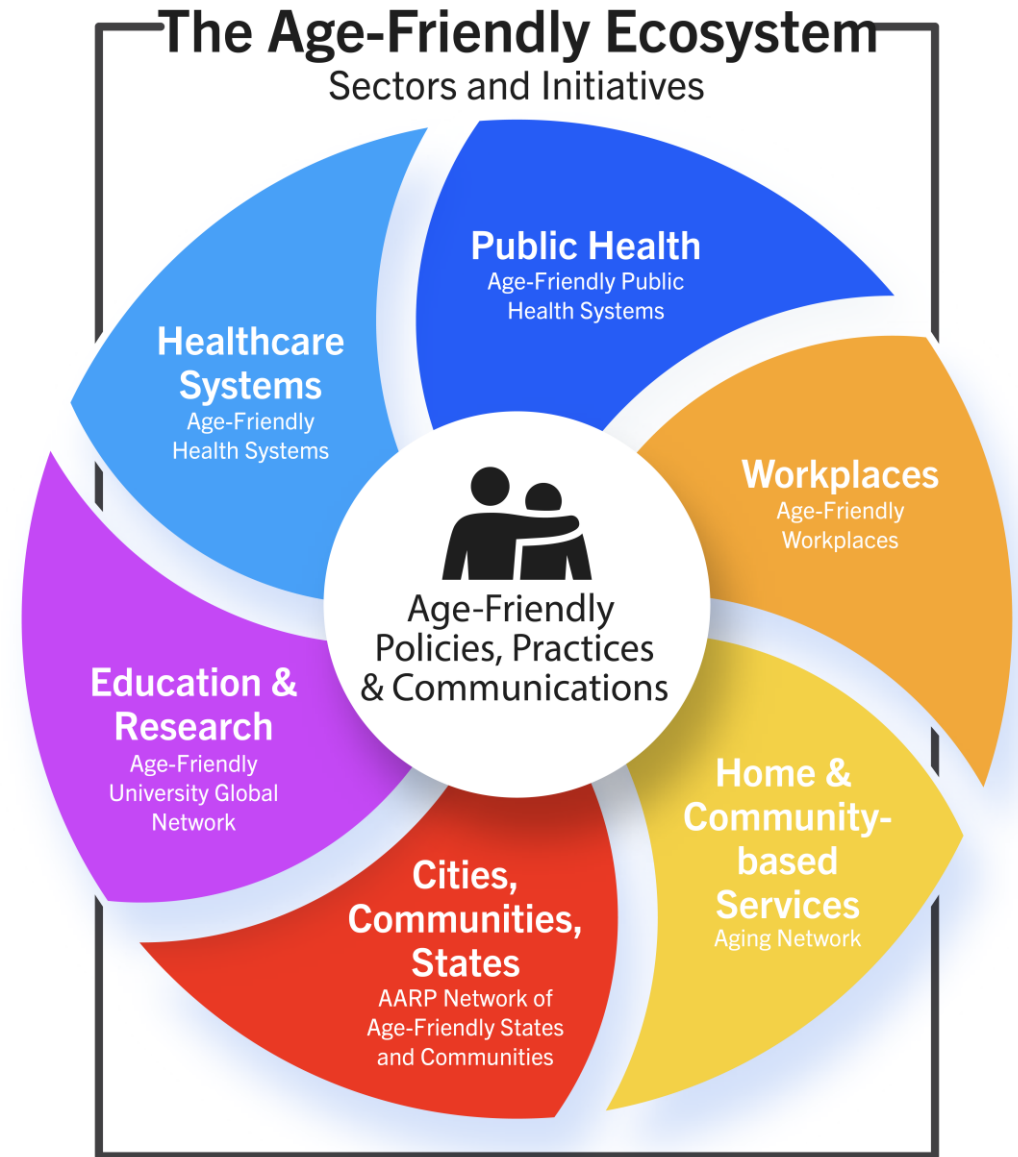
Dedicated to improving the care of older adults.

Priority Areas



We All Need an Age-Friendly Society

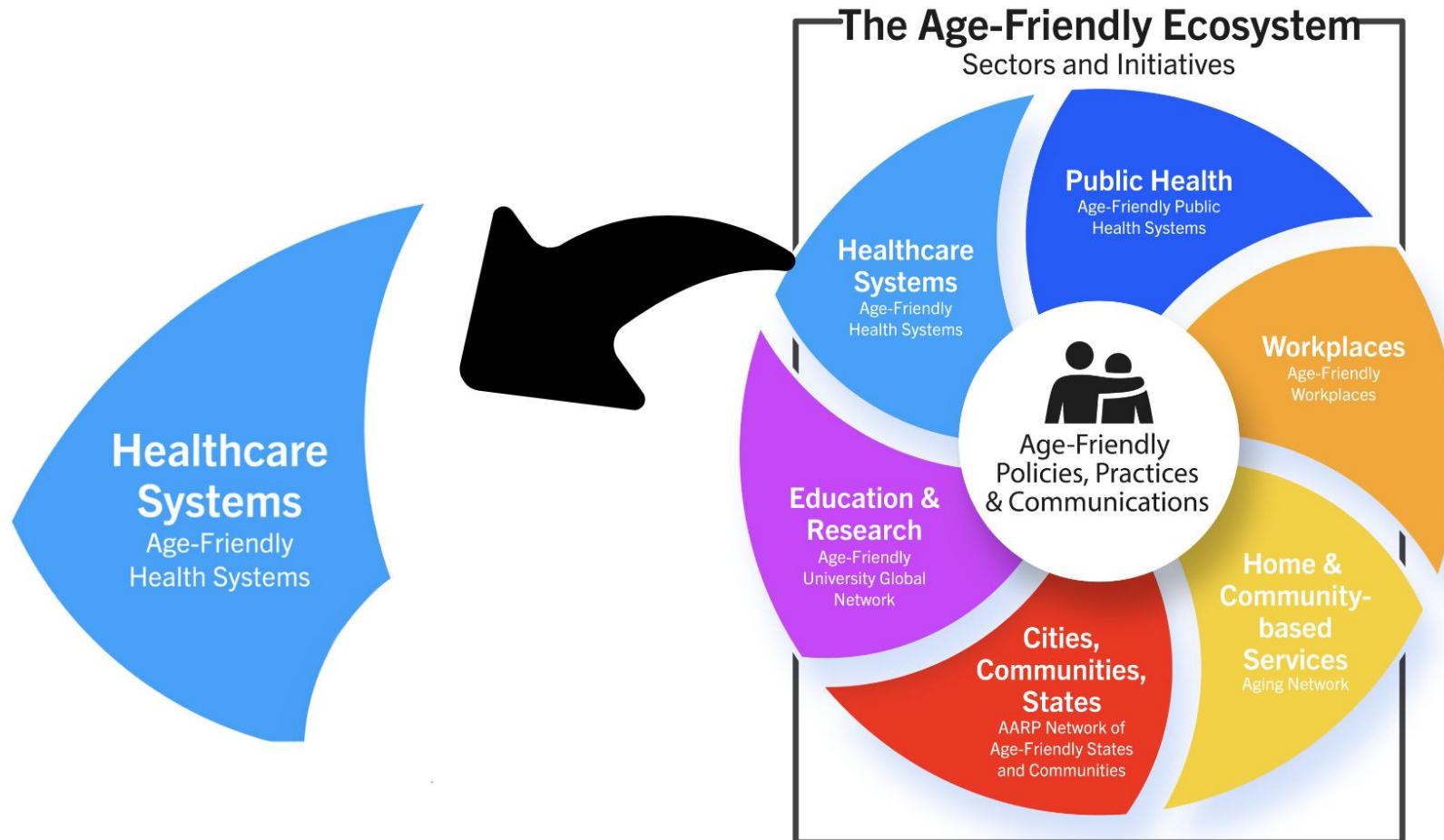
- Longevity is greatest success story of last century
- As we age, we can make vital contributions and power up communities – with support
- A just society requires us to make all sectors **age-friendly**



We Need Healthcare Systems to be Age-Friendly



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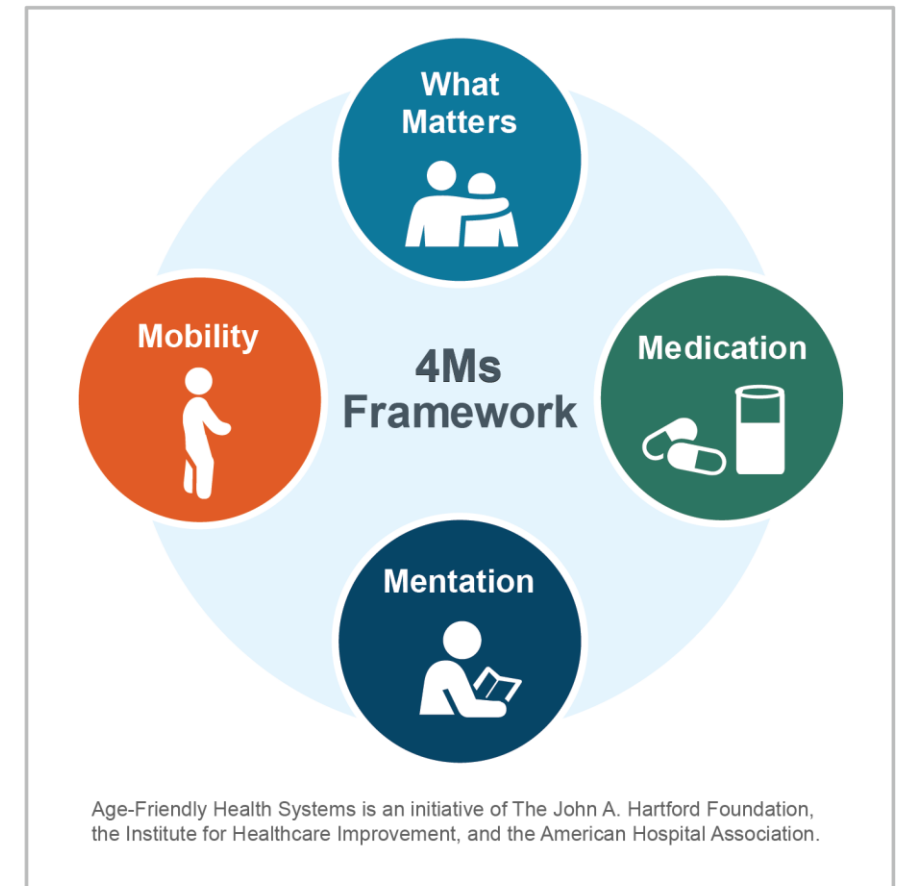
Age-Friendly Health Systems

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.



For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly



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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!



aginganddisabilitybusinessinstitute.org



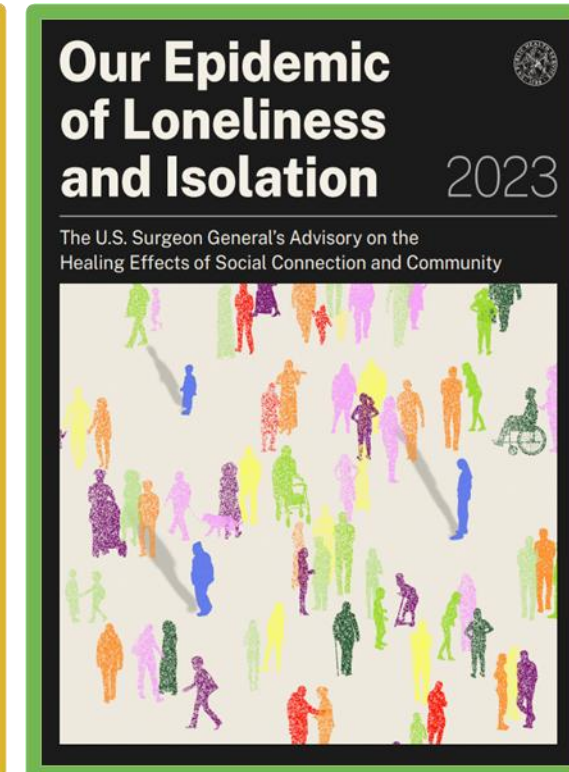
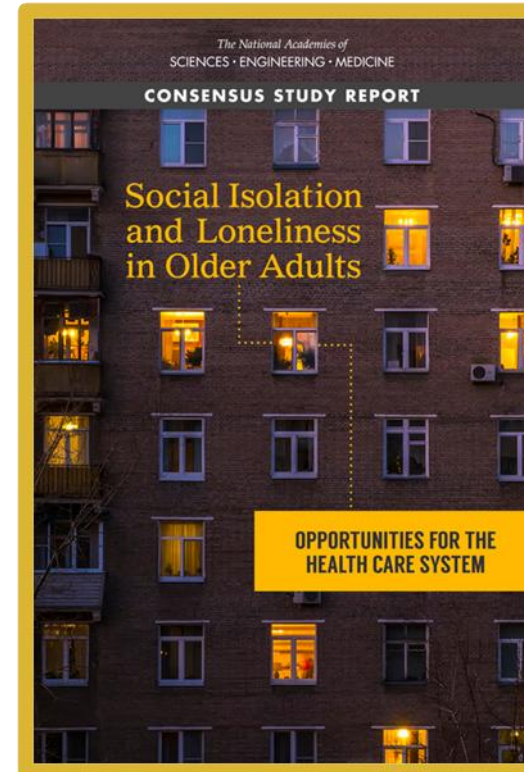
Shaping a Social Isolation Strategy for Older Adults



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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

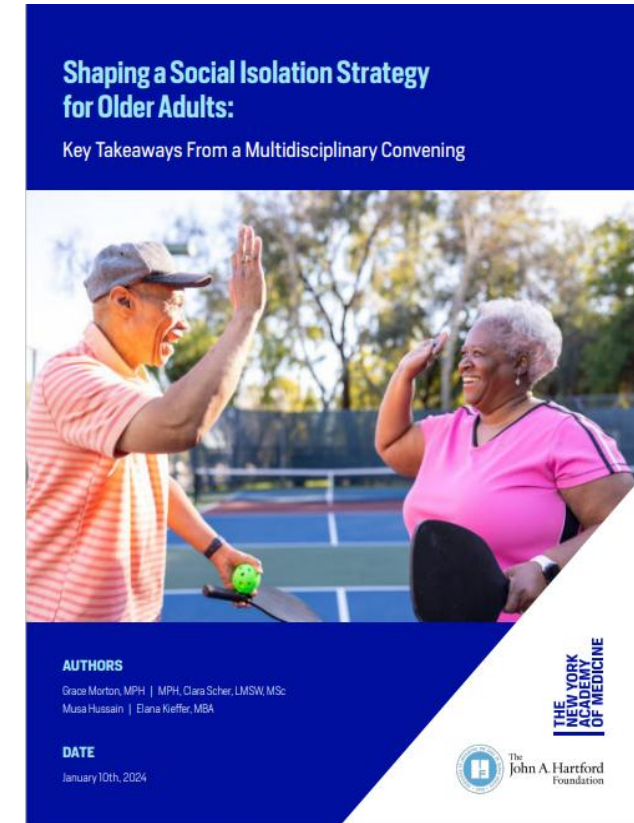
Convening report released April 2024, with opportunities for implementation

8 Recommendations, including:

- Promoting partnerships between community-based organizations and health care



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



Fostering Social Connections



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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



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- 
- # Strengthening Social Connection in Communities
- powered by **USAging**





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Thank You!

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FAIRFAX COUNTY DEPARTMENT OF
FAMILY SERVICES

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ElderLink

A nonprofit partnership program between the
Fairfax Area Agency on Aging and Inova



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About ElderLink

- **A partnership built to fill a community gap**
 - Established in September 1990
 - Created through shared interest between the Fairfax Area Agency on Aging (AAA) and Inova Health System
 - Addressed an unmet need for people whose circumstances fell between public assistance and private-pay services
- **Timeline**
 - 1990: ElderLink founded
 - Early partnership predates most cross-sector models
 - 35+ years of continuous operation
 - An early and forward-looking model

Core Partnership Principles

- **Fairfax AAA brings**

- Community knowledge and aging services expertise and funding
- Public-sector coordination

- **Inova brings**

- Health system partnership and funding
- Alignment with prevention and community health goals

- **Together**

- Support people before needs escalate into crisis
- Reduce social isolation
- Support caregivers
- Promote independence and safety
- Shared mission, complementary strengths

Who ElderLink Serves

- **Target Populations**

- Older adults
- Adults with disabilities
- Family and friend caregivers

- **Services that strengthen Community Health**

- Case management
- Personal care services
- Caregiver training and counseling
- Support groups
- Evidence-based workshops
 - Falls prevention
 - Chronic disease self-management
- Money management
- Home safety assessments
- Volunteer respite

Evidence of Reach and Impact

- **People served in the last five years: 3,481**
- **2025: 804 served**
 - 55% Older Adults/Adults with disabilities
 - 45% Caregivers
- **2024: 502 served**
 - 60% Older adults/adults with disabilities
 - 40% caregivers
- **2023: 495 served**
 - 89% Older adults/adults with disabilities
 - 11% Caregivers
- **2022: 1,076 served**
 - 91% Older adults/adults with disabilities
 - 9% Caregivers
- **2021: 604 served**
 - 85% Older adults/adults with disabilities
 - 15% Caregivers

Innovation in Action

- **A partnership that evolves with community needs**
 - ElderLink has served as a platform for pilot programs and service innovation
 - Evidence-based workshops foster both education and social connection
- **How the partnership makes a difference**
 - Improves quality of life, independence, and safety
 - Helps older adults and adults with disabilities remain in the community longer
 - Supports caregivers with training, counseling, respite, and peer connection
 - Addresses social isolation through group-based and educational programming
 - Contributes to reduced falls, avoidable ER visits, hospital admissions, and health disparities
 - Makes services accessible through free or sliding-scale offerings

Award-winning partnership

- **2024:** Launched **Exploring the Dimensions of Aging**
 - Immersive learning for caregivers and supporters of older adults
 - Topics: Alzheimer's Disease, End of Life Conversations, Social Isolation, Elder Safety & Well-Being (PTSD, Burnout, De-Escalation), Parkinson's Disease & Lewy Body Dementia
- **2024:** Volunteer Respite received **Best Practice Recognition** from **Virginia DARS**
- **2025:** Received the **USAging Aging Innovations & Achievement Award** for **Exploring the Dimensions of Aging**
- **2026:** ElderLink's partnership model received the **JAHF Business Innovations Award**

Sustainability and Strategic Value

- **Why ElderLink has endured for 35+ years**

- Formal partnership with active contractual support

Blended funding model including:

- Older Americans Act funding
- Grants pursued by the AAA
- Local AAA funding
- Inova funding
 - Demonstrated value for both organizations over time
 - Shared investment allows both organizations to extend impact further than either could alone

Replicability

- **Key ingredients other communities can adapt:**
 - Start with a clearly defined community gap
 - Align around shared goals between healthcare and aging/community services
 - Build a formal partnership structure with clear accountability
 - Blend funding sources to improve resilience
 - Offer a mix of direct services, prevention, and caregiver support
 - Measure reach, participant mix, and practical outcomes
 - Keep evolving based on local needs

Takeaways

- **What ElderLink demonstrates:**
 - Long-term healthcare–community partnerships can be sustainable
 - Prevention and caregiver support are essential parts of community health
 - Cross-sector collaboration can reduce gaps that neither partner can solve alone
 - ElderLink offers a strong example of a replicable, mission-aligned partnership model

ElderLink shows how a health system and an Area Agency on Aging can work together over decades to improve lives, strengthen community support, and build a model worth adapting elsewhere.

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Nevada Senior Services

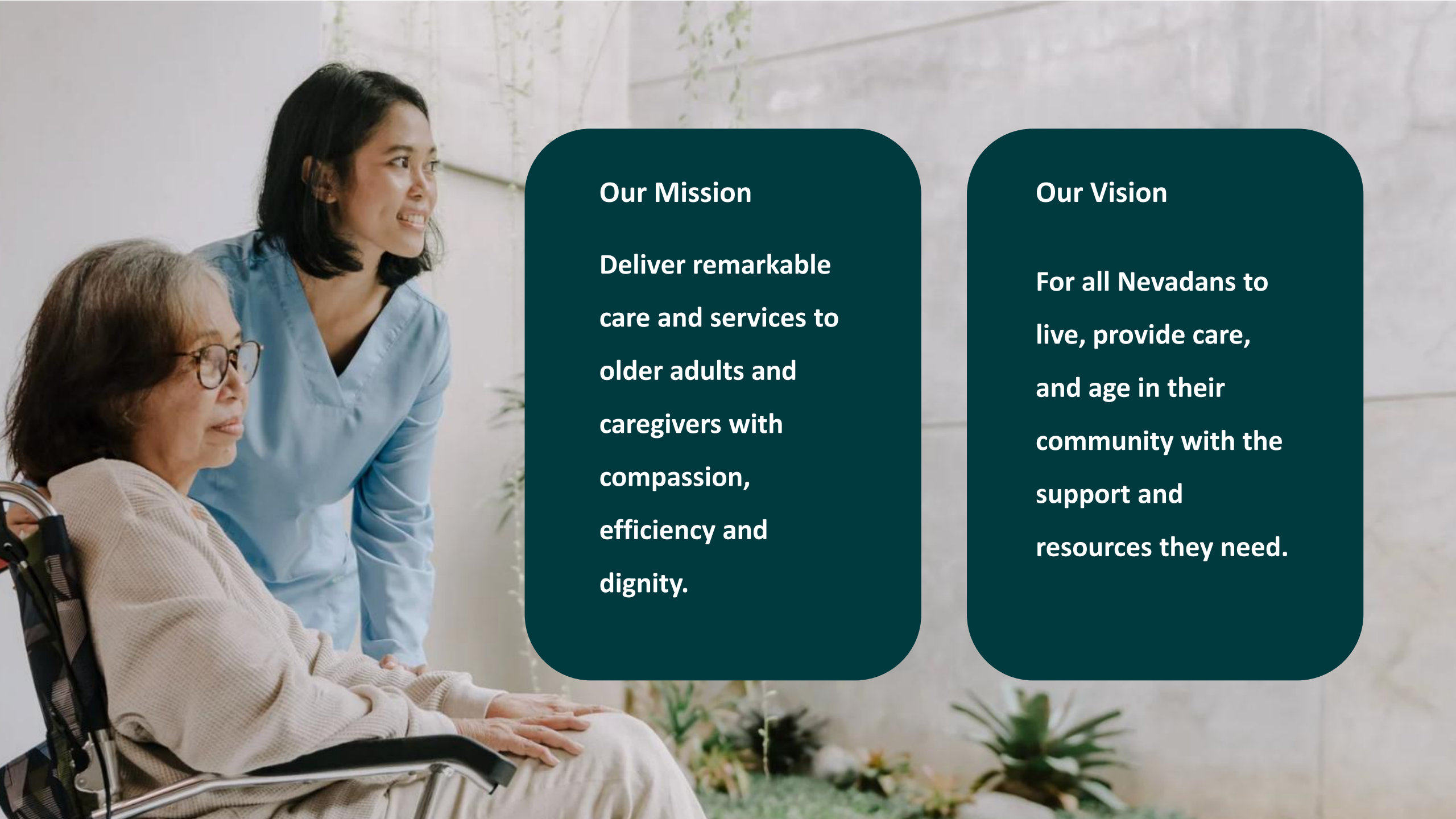
Delivering remarkable care with compassion.





About Nevada Senior Services

For more than two decades, Nevada Senior Services has been a trusted leader in aging and caregiving support across Southern Nevada. Through innovative, evidence-based programs and strong community partnerships, we deliver integrated care solutions that help older adults live at home and remain connected to their communities, while supporting quality of life and strengthening support for caregivers.



Our Mission

Deliver remarkable care and services to older adults and caregivers with compassion, efficiency and dignity.

Our Vision

For all Nevadans to live, provide care, and age in their community with the support and resources they need.

Our Services

Our holistic, person-centered philosophy means we provide more than one type of care.

We provide options.

With services that span health, home, and family support, we help our clients and their families find exactly what they need... all in one place.



Adult Day
ReCreation

BY NEVADA SENIOR SERVICES



In Home Services

BY NEVADA SENIOR SERVICES



Hospital 2 Home

BY NEVADA SENIOR SERVICES



RAMP
Home Modifications

BY NEVADA SENIOR SERVICES



Hospital 2 Home

BY NEVADA SENIOR SERVICES

Nevada Senior Services partnered with Clark County to deliver the Hospital 2 Home program and provide dementia-capable care transitions for older adults and individuals with complex conditions discharged from the University Medical Center and several partner hospitals in the Las Vegas area.



Hospital 2 Home

BY NEVADA SENIOR SERVICES

Hospital 2 Home helps older adults and individuals with chronic illness, memory loss, or disabilities transition safely from hospital or rehab back to their homes.

We work directly with caregivers and community partners to ensure continuity of care, reduced stress, and improved health outcomes.

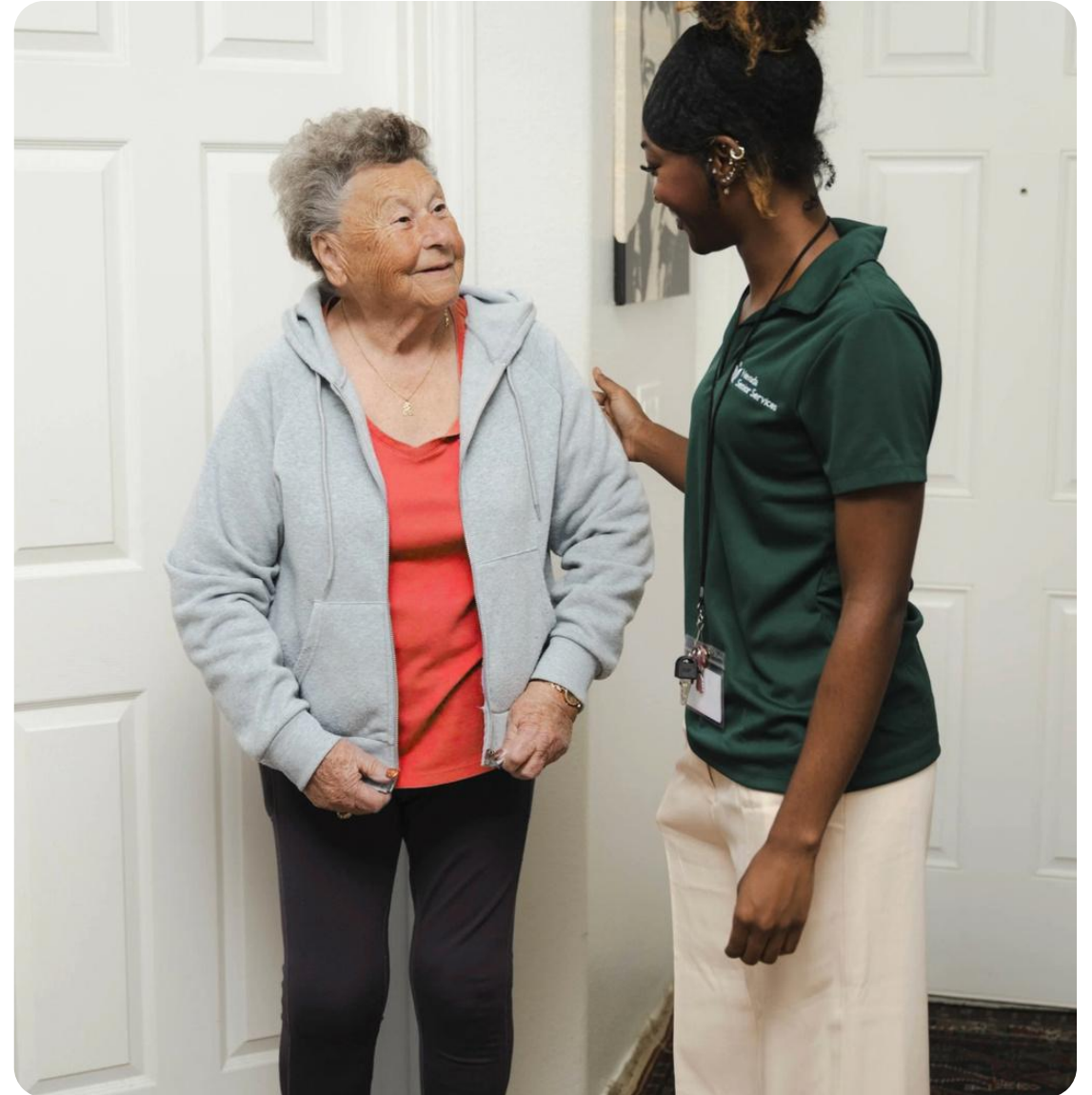
Hospital 2 Home provides:

✓ Care Coordination

✓ Respite Coaching

✓ Crisis Intervention

✓ Resource Navigation





togetherfor**better**

Clark County Contract

- 5 Years Plus 6 Month Supplemental
- Priority University Medical Center
- Clark County Social Services Referrals
- Other Designated Health Care Systems

Case Rate

Current average monthly caseload= **180-200**

Medicare Readmission Rate

Overall Clark County

34%

Hospital 2 Home

1%



Nevada
Senior Services

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Your Advocate for Independence®



Integrating Social Care into an Age-Friendly Primary Care Model for Older Adults

Melissa Lang, DrPH, MPH, MPA, MA



Agency on Aging

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Background

Agency on Aging of South Central Connecticut partnered with the COACH 4M Team at Yale School of Medicine and Fair Haven Community Health Care (Federally Qualified Health Center) to integrate social care into an Age-Friendly primary care model for older adults. The program is supported by five-year HRSA GWEP pursued by the Yale School of Medicine in collaboration with AOA. The program addresses HRSNs and social isolation among vulnerable older adults with complex medical and social needs. The population served is predominantly low-income and under-resourced, with many individuals experiencing limited health literacy. Reducing loneliness and strengthening social connectedness are central goals of the program, recognizing the significant impact isolation has on health.

The collaboration embeds an Agency on Aging Service Navigator within the team at Fair Haven, allowing medical and social needs to be addressed simultaneously. Unlike traditional referral models, the Service Navigator is fully integrated into care planning, electronic medical records, and interdisciplinary meetings, ensuring that social needs and “What Matters” to the patient guide healthcare delivery.

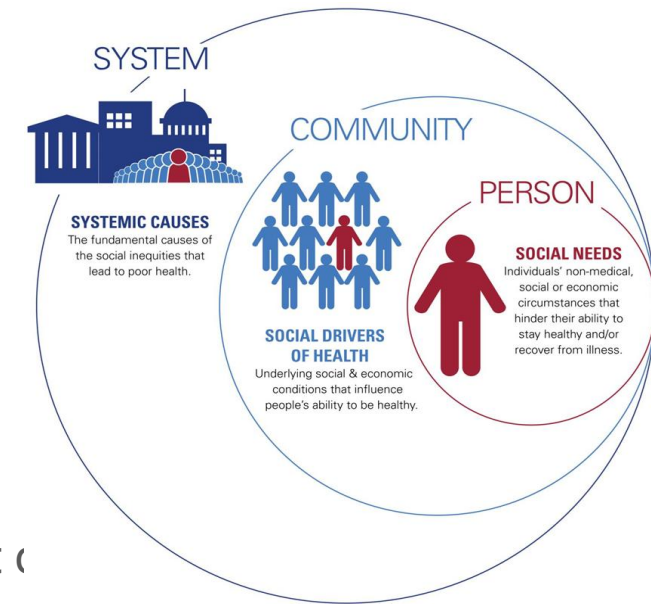
The program expanded to include a deprescribing initiative focused on addressing polypharmacy among older adults, with Service Navigators addressing HRSNs that may contribute to or be affected by medication burden.



Formal Integration

Building the Team:

- Traditional referral models can be very challenging.
- Interdisciplinary approach, helping us reach people earlier to disrupt factors that lead to poor health outcomes and lower quality of life.
- As experts in Aging Services, AOA serves as an integrated extension into the community, specializing in community-based health and social support for older adults.
- Service Navigators are fully integrated into the healthcare team, participation in care team meetings, and full access to the Epic electronic medical record. This integration allows Navigators to document encounters in real time, ensuring providers can immediately access information related to patients' social needs and follow-up plans. The model strengthens coordinated, person-centered care by incorporating the Age-Friendly Health Systems 4Ms framework into care planning and ongoing support.



Improving Health and Well-Being

Assessment

Assess for HRSNs

Eligibility Review eligibility for all programs and services

Enrollment Assist with application and enrollment process to ensure service connection



In-Home Support

Personal Care Aide, Companion, Nursing, rides to medical appointments

Food

Grocery delivery, SNAP application assistance, Home delivered meals

Financial Resources

Rental Rebate, Energy Assistance

Housing Resources

Eviction prevention, Connection to legal support, Housing application assistance



Agency on Aging Service Navigation Process



Service Navigation

Identify Health-Related Social Needs (HRSNs), recommend services, help with application and enrollment process across all programs.

Screening Tools:

- Accountable Health Communities - HRSNs
- Steptoe Social Isolation Index- identifies prevalence, risk factors, and health impacts of social isolation
- Zung Self Rating Anxiety Scale
- PHQ-9 - self reported screening tool for depression

Eligibility: All patients can be eligible for Service Navigation, eligibility for programs is determined by guidelines, can vary based on age, financial requirements, functional status. We have bilingual eligibility specialist (English and Spanish) and use language line for audio and print support.

Enrollment: Service Navigators provide assistance completing all applications (e.g., Medicaid, Medicare Savings Program, SNAP, housing applications, rental rebate, energy assistance) and monitor during pending period to enroll successfully. Virtually all services are at no cost to the patient/client.



4Ms Framework



- The partnership incorporates 4Ms of Age-Friendly Care. “What Matters” drives individualized care planning; “Mentation” is addressed through depression and social isolation screening and counseling referrals; “Mobility” is supported through transportation coordination and connection to community-based services; and “Medication” is reinforced through collaboration with the healthcare team to support follow-up care and deprescribing. This evidence-informed model improves quality of life for vulnerable older adults.
- Through this approach, Navigators help ensure that patients’ goals, preferences, social supports, and emotional well-being guide clinical decision-making and follow-up care. The Service Navigator develops trusting relationships with patients, connects them to community supports, and helps strengthen social networks to reduce loneliness and isolation. By integrating social services directly into the healthcare team and care planning process, the partnership ensures that “What Matters” to the patient drives care delivery while improving quality of life, healthcare engagement, and access to supports for vulnerable older adults.
- Validated screening tools for social isolation, depression, nutrition risk, and HRSNs guide interventions. As trusting relationships develop, older adults become more connected to formal and informal support, reducing loneliness and increasing engagement.



Outcomes



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Since the partnership began, approximately 475 older adults with complex medical and social needs have been served, including low-income and culturally diverse populations residing in the New Haven area. Patients were screened using validated tools assessing social isolation, depression, nutrition risk, transportation barriers, and other health-related social needs. The partnership has demonstrated measurable improvements in social connection and quality of life outcomes.

Using the Steptoe Social Isolation Scale, Zung Self Rating Anxiety Scale and PHQ-9, 125 older adults were identified as experiencing loneliness, anxiety and/or depression and were connected to in home mental health services. The Service Navigator also connected these participants to home-delivered meals, in-home supports, benefits programs, caregiver assistance, utility assistance, and community-based wellness programs.

Additional accomplishments include improved appointment adherence, increased engagement in preventive health activities, enhanced coordination between medical and social service providers, and stronger integration of HRSNs into patient-centered care planning. Overall, integrating social care into Age-Friendly healthcare strengthens attention to “What Matters” and improves outcomes related to social isolation, engagement, and overall wellbeing for older adults.



Key Lessons



Fully integrating community-based organizations into healthcare teams produces stronger outcomes than traditional referral relationships alone, allows us to reach more people sooner. Embedding the Service Navigator onsite and providing access to the electronic medical record improved communication, coordination, and understanding of patients' social and medical needs.

Early investment in HIPAA compliance, data-sharing agreements, and staff training was essential to successful implementation. One challenge was securing full medical record access for the Service Navigator; this was addressed through collaboration, credentialing, and ongoing relationship-building with healthcare leadership.

The partnership strengthened AOASCC's sustainability by expanding its role as an integrated healthcare partner within Age-Friendly primary care. Through GWEP funding and increased collaboration with healthcare systems, the model has positioned AOA for future expansion into additional healthcare settings.



Thank you!

Contact: mlang@aoascc.org



Agency on Aging

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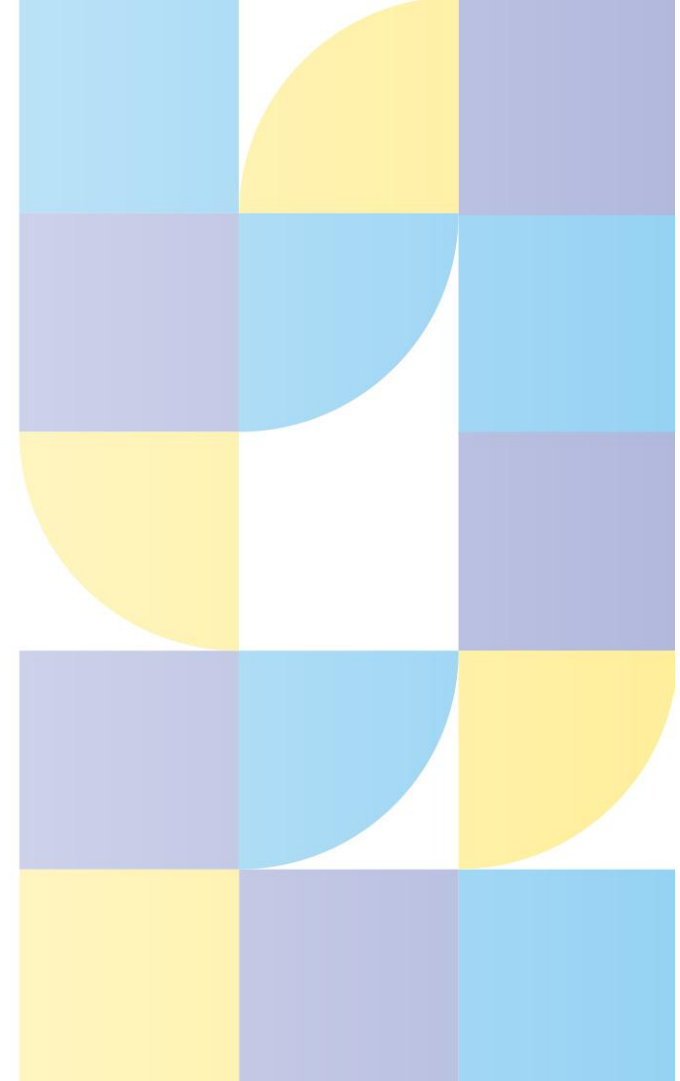
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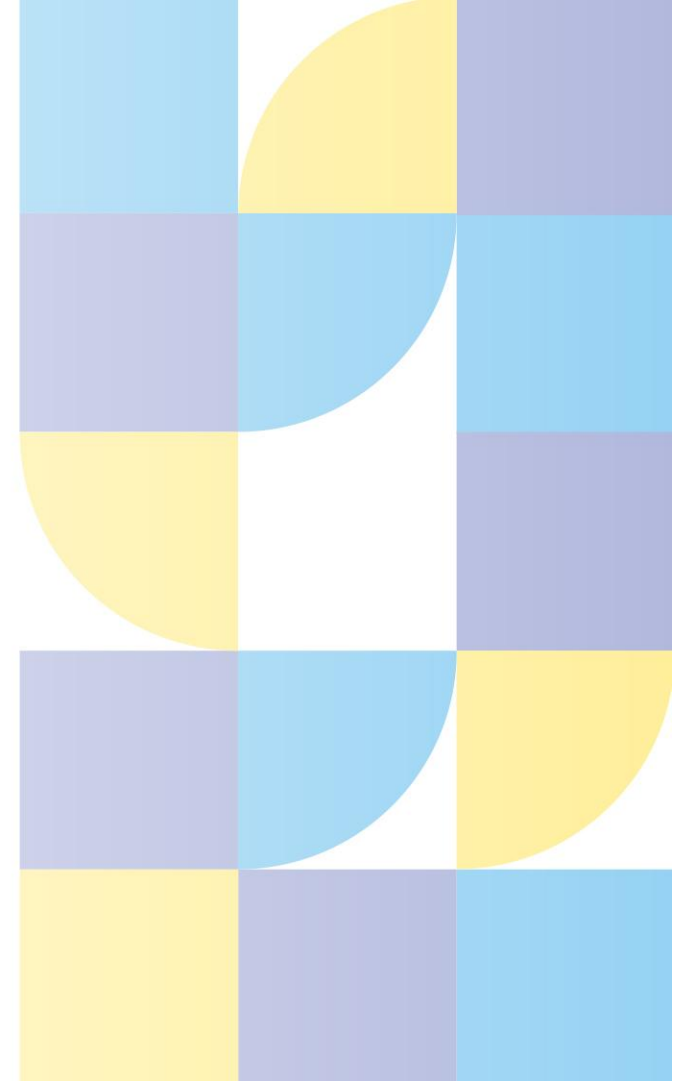
Panel Discussion

**Moderated by Nancy Wexler
Senior Program Officer**

**The John A. Hartford
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Audience Questions



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