

# ***JAHF Business Innovation Award 2025 Winners:***

## **Achieving Success in Social Connection Contracting**

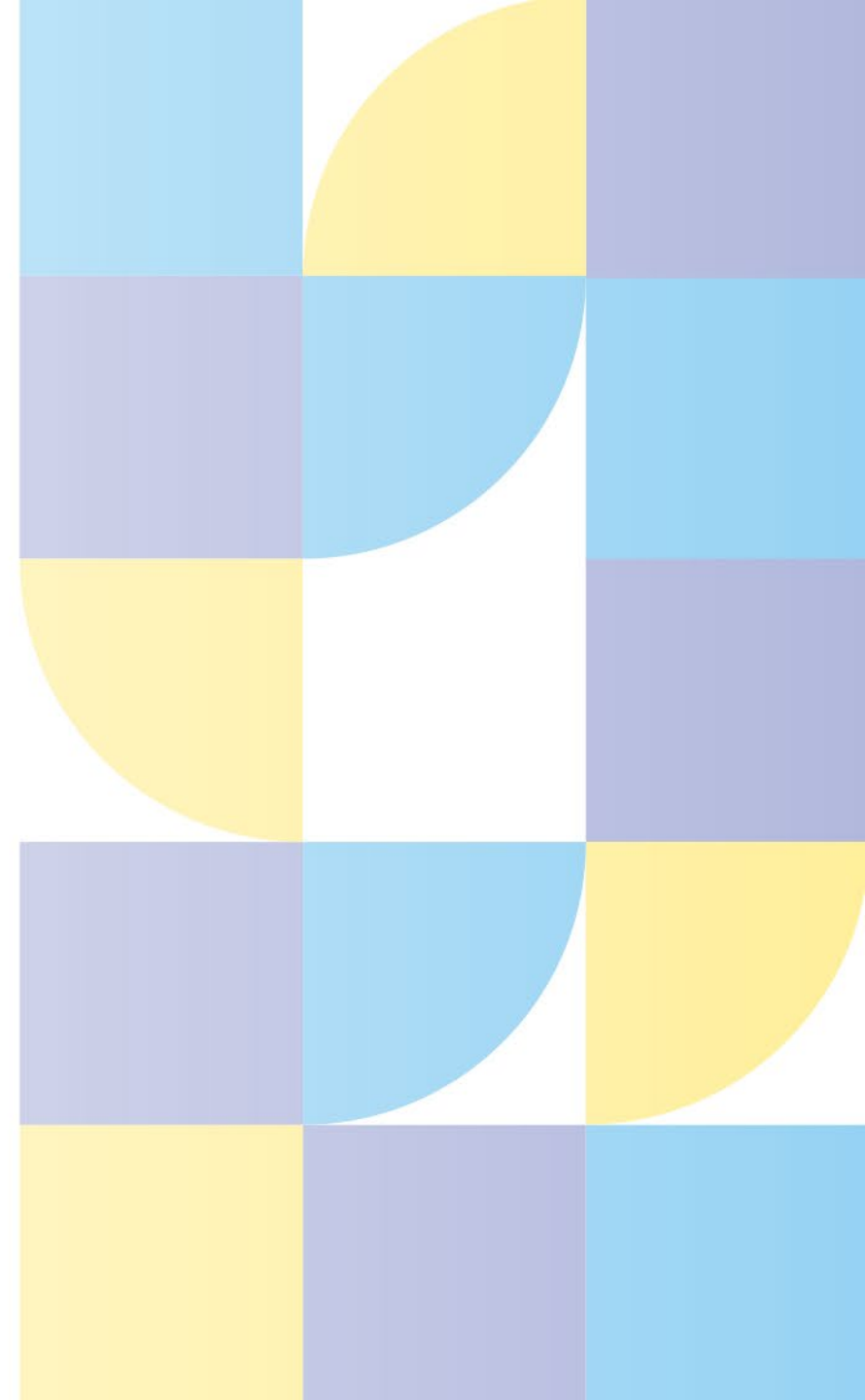
*July 18, 2026*



powered by **USAging**



The  
**John A. Hartford**  
Foundation



# Welcome



**Dr. Kathie C. Garbe**  
**Senior Program Manager**  
**USAging**

# 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 community care and support sustainability
- Sponsored by JAHF; presented by USAging's Aging and Disability Business Institute and engaged: USAging's Resource Center for Engaging Older Adults



# Congratulations and thank you for creating innovative social connection initiatives!

## Winner



United Disabilities Services



## Runners Up





**Shauna Buchmoyer, MSOTR/L  
CAPABLE Program Manager  
United Disabilities Services**



**Kimberly Martinez, BS, CHW  
Director, Family Caregiver Support  
Programs and Outreach  
Senior Connection**



**Senior  
Connection**  
Aging Well Together



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



**ESWA**

Elder Services Of Worcester Area



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



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*ASA On Aging 2026*  
JAHF Business Innovation Award Winners:  
Achieving Success in Social  
Connection Contracting

July 18, 2026

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





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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



# Our Mission

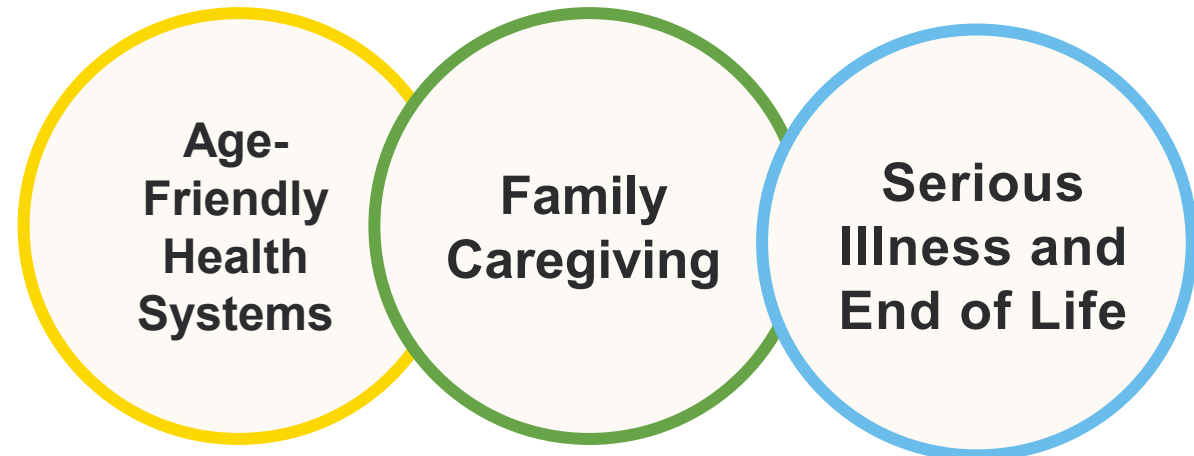


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Dedicated to improving the care  
of older adults.

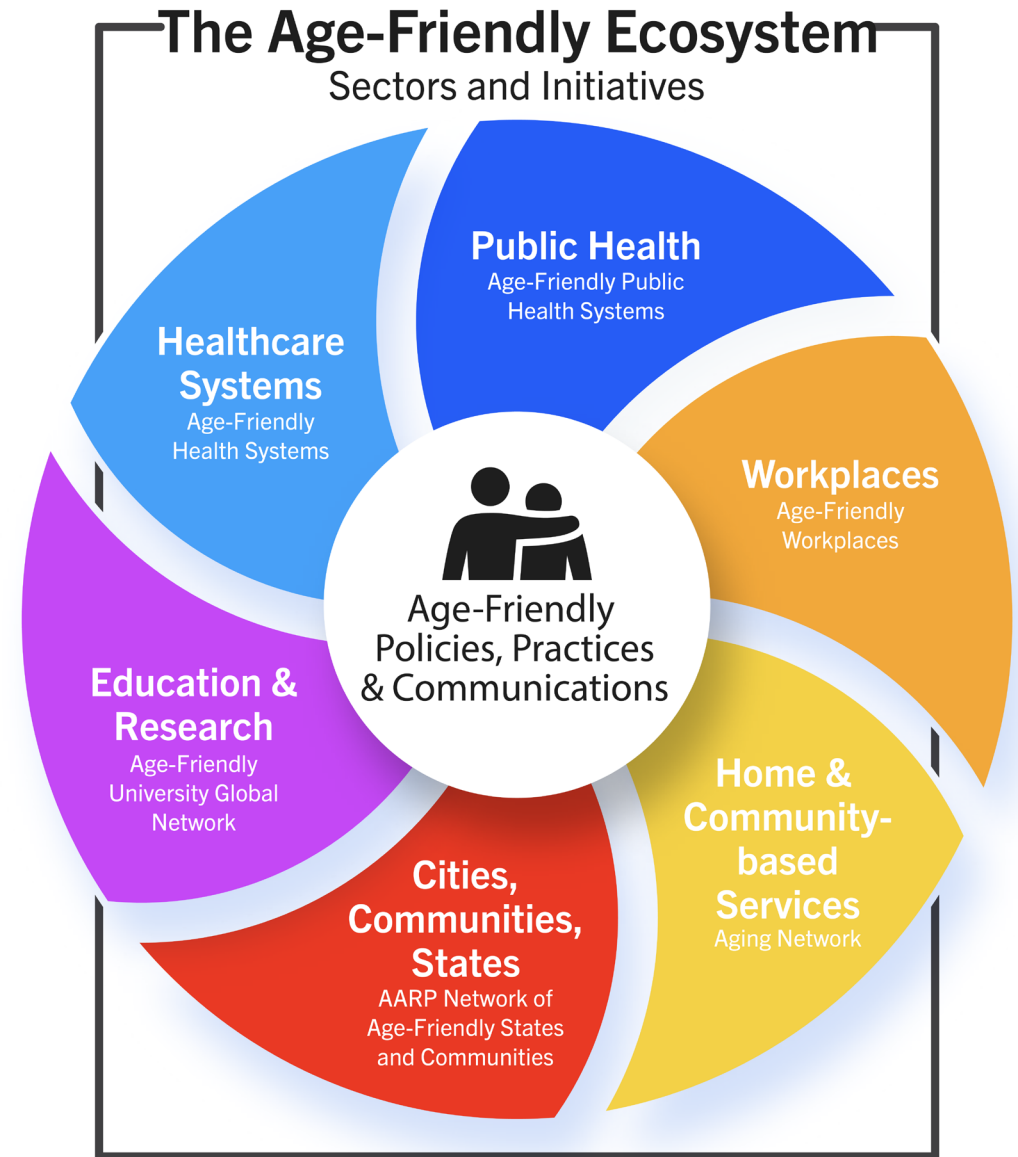
## Priority Areas





# We All Need an Age-Friendly Society

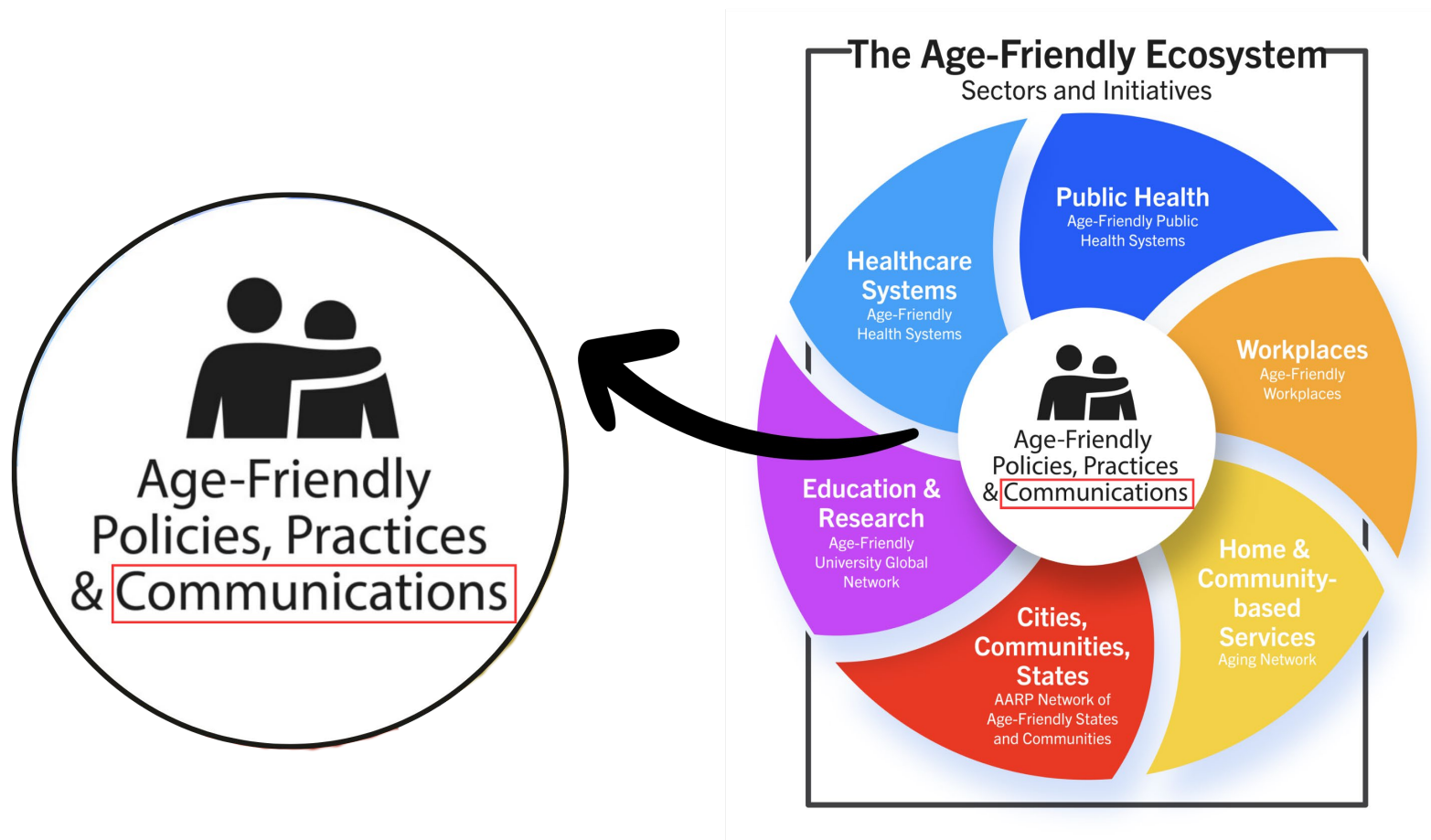
- Longevity is greatest success story of last century
- As we age, we can make vital contributions and power up communities – with support
- A just society requires us to make all sectors **age-friendly**



# The Role of Communications in Age-Friendly Health Systems



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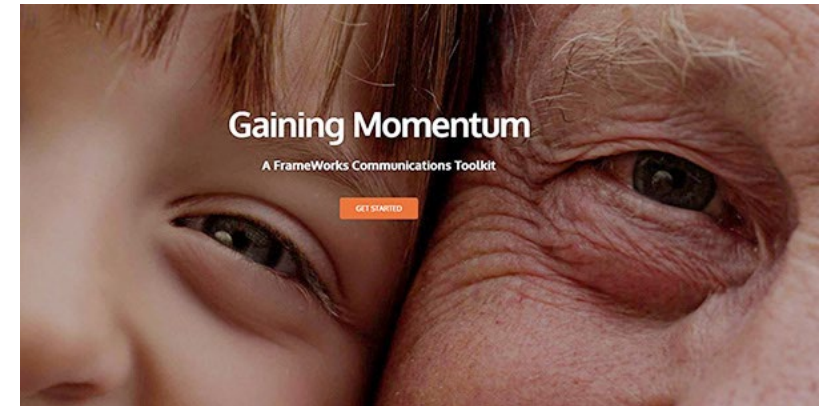


# Eliminate Ageism by Reframing Aging



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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!



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

[reframingaging.org](https://reframingaging.org)





# Building Momentum in Practice



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*Before*



*After*

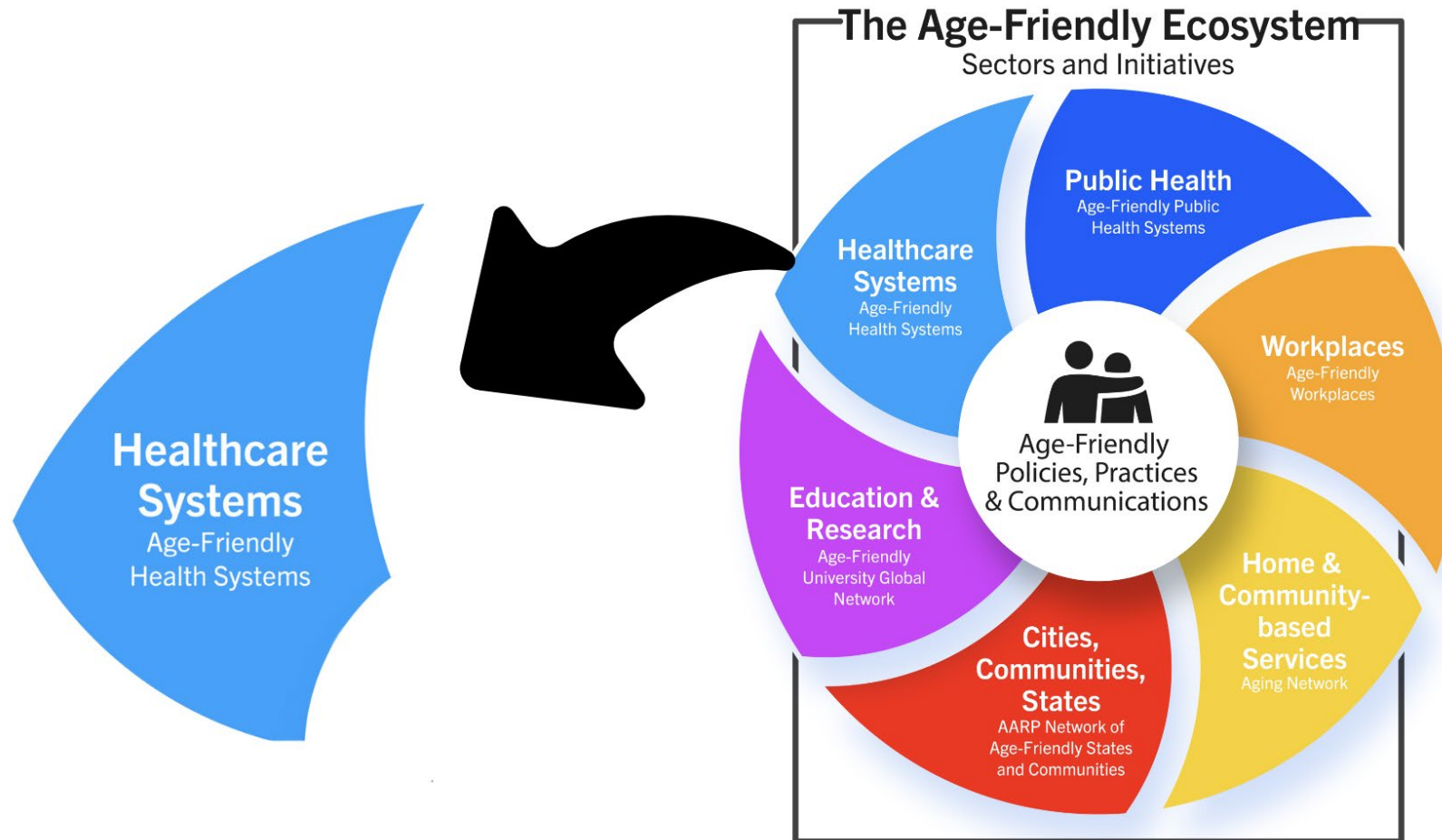
## Age Strong Shuttle Redesign in Boston, MA



# We Need Healthcare Systems to be Age-Friendly



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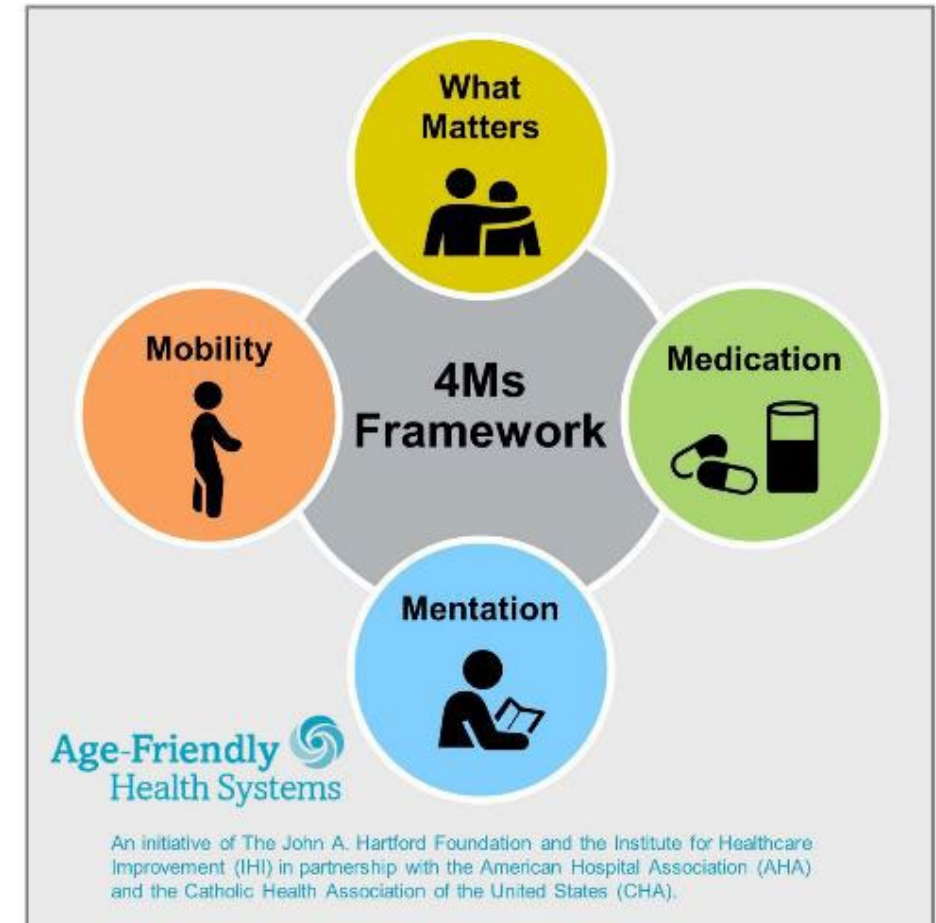


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# Age-Friendly Health Systems

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.





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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](https://aginganddisabilitybusinessinstitute.org)



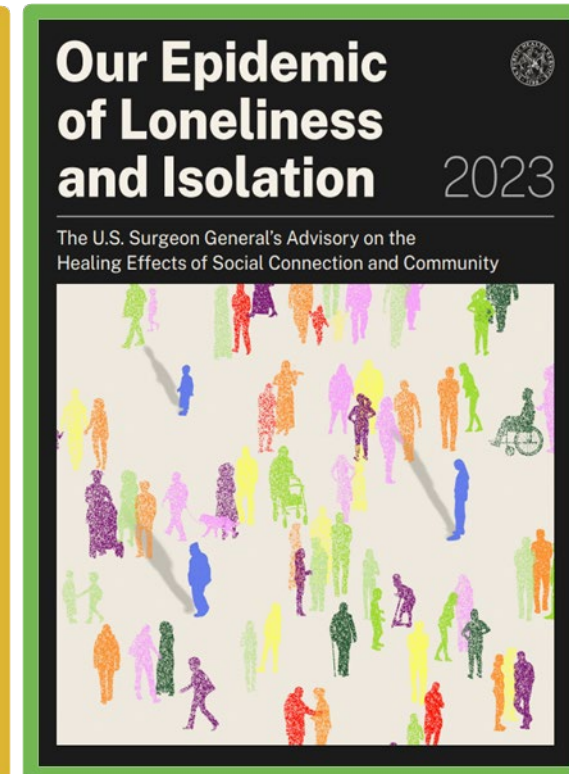
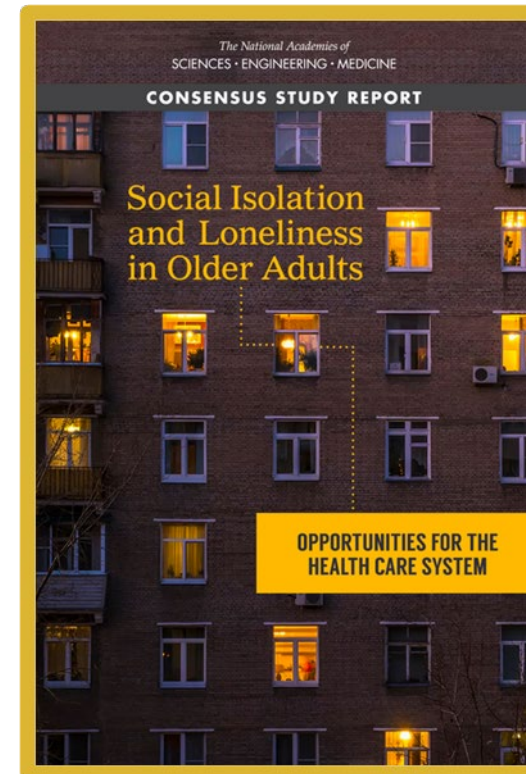
# Shaping a Social Isolation Strategy for Older Adults



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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



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**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



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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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# Thank You!

[Nancy.Wexler@johnahartford.org](mailto:Nancy.Wexler@johnahartford.org)

[WWW.JOHNAHARTFORD.ORG](http://WWW.JOHNAHARTFORD.ORG)



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**2025 RUNNER UP**



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**USAging**  
Leaders in Aging Well at Home



**Senior  
Connection**  
Aging Well Together



**Strengthening  
Social Connection  
in Communities**

# 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.





# Breaking Barriers via the Mobile Unit



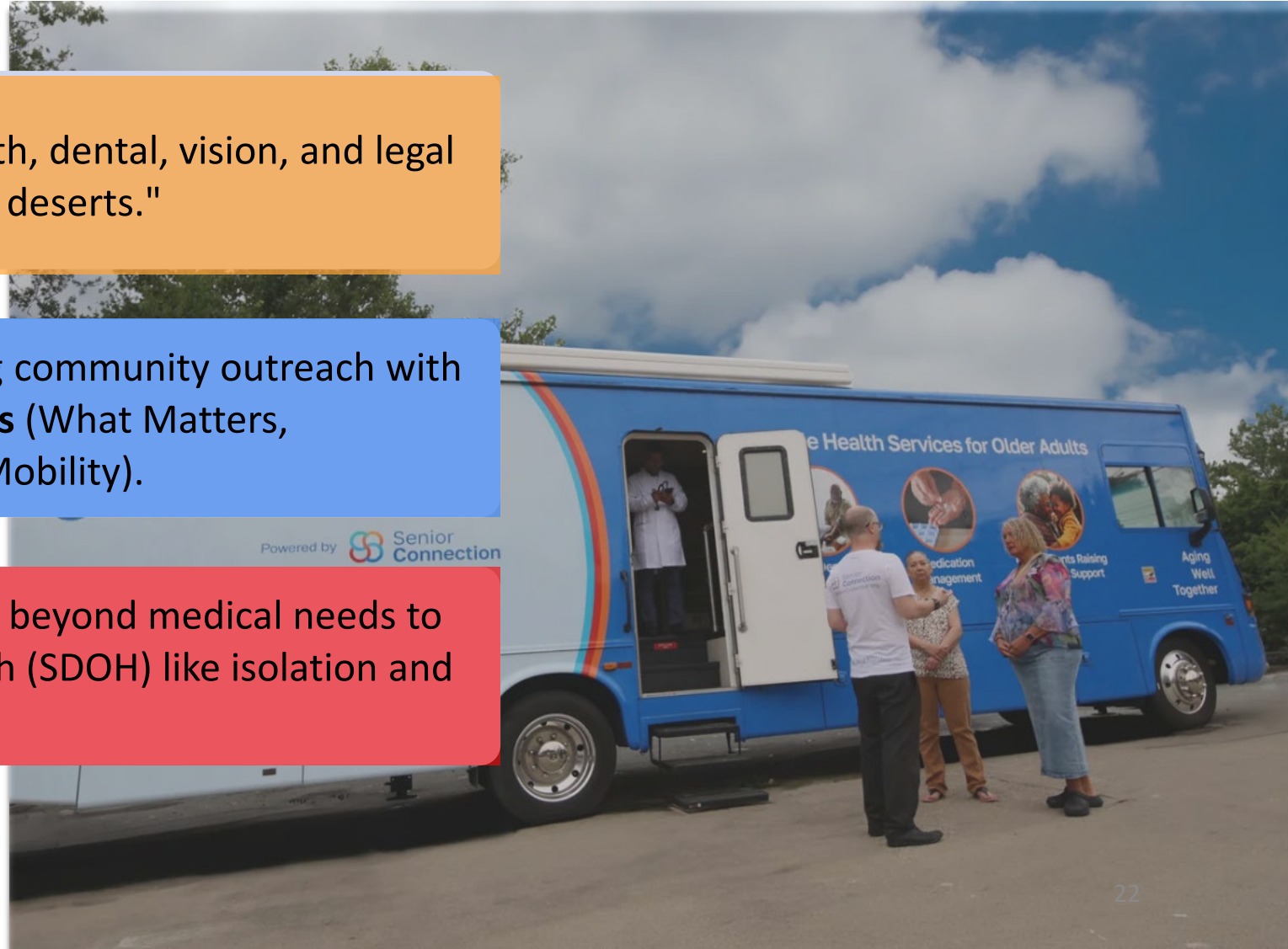
**Direct Delivery:** Bringing health, dental, vision, and legal services directly to rural "care deserts."



**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



## 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.

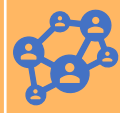
*“This partnership meets people where they are by showing up in their communities with care, dignity, and trust.”*

# A Blueprint for National Replication



## Sustainable

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



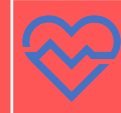
## Future

**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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# BLUE CROSS BLUE SHIELD TRANSITIONS IN CARE PROGRAM

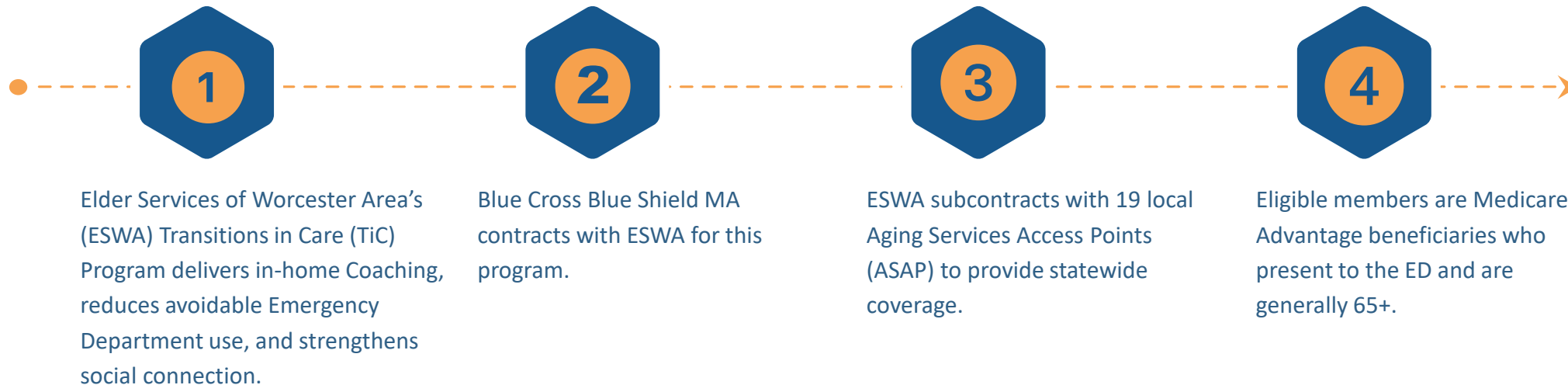
John A. Hartford Business Innovation Award

**Ashley Gibbons, MA**  
*Director of Business Development and Quality  
Improvement*

**Date:** January 21, 2026



# TRANSITIONS IN CARE PROGRAM



# TRANSITIONS IN CARE INTERVENTION



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

**Coach focuses on patient empowerment through motivational interviewing while reviewing:**

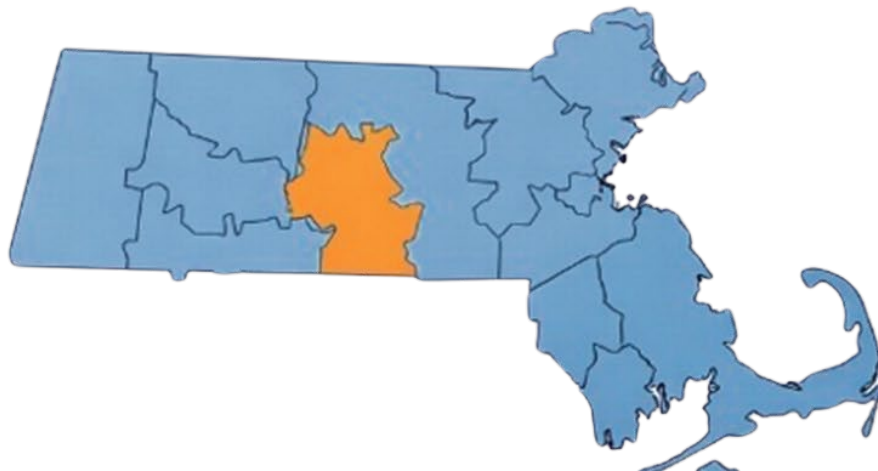
- Member goals
- Provider follow up
- Concerning symptoms to be aware of
- Medication review
- Writing down questions for your provider
- Assisting members on how to navigate the medical system
- Identifying unmet needs and connecting them to resources and supports

# **IMPLEMENTATION OF PARTNERSHIPS AND GROWTH**

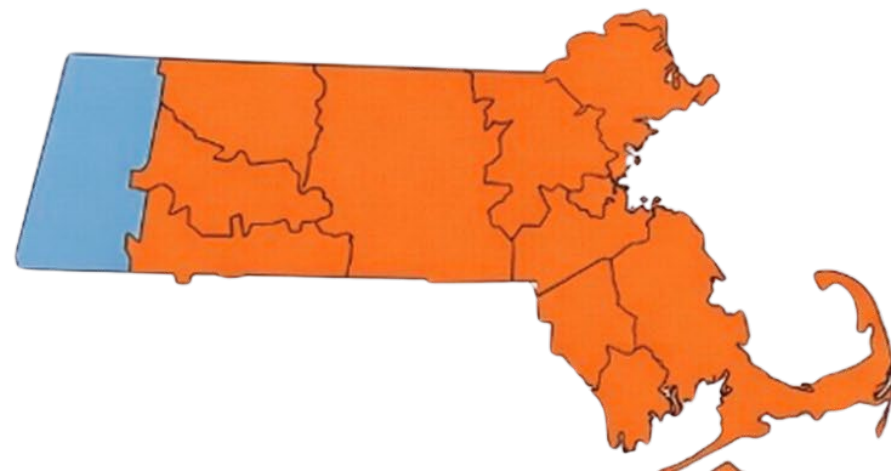


# COVERAGE MAP BEFORE AND AFTER

Massachusetts in 2023



Massachusetts in 2025



\*Blue is uncovered. Orange is covered

# 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.

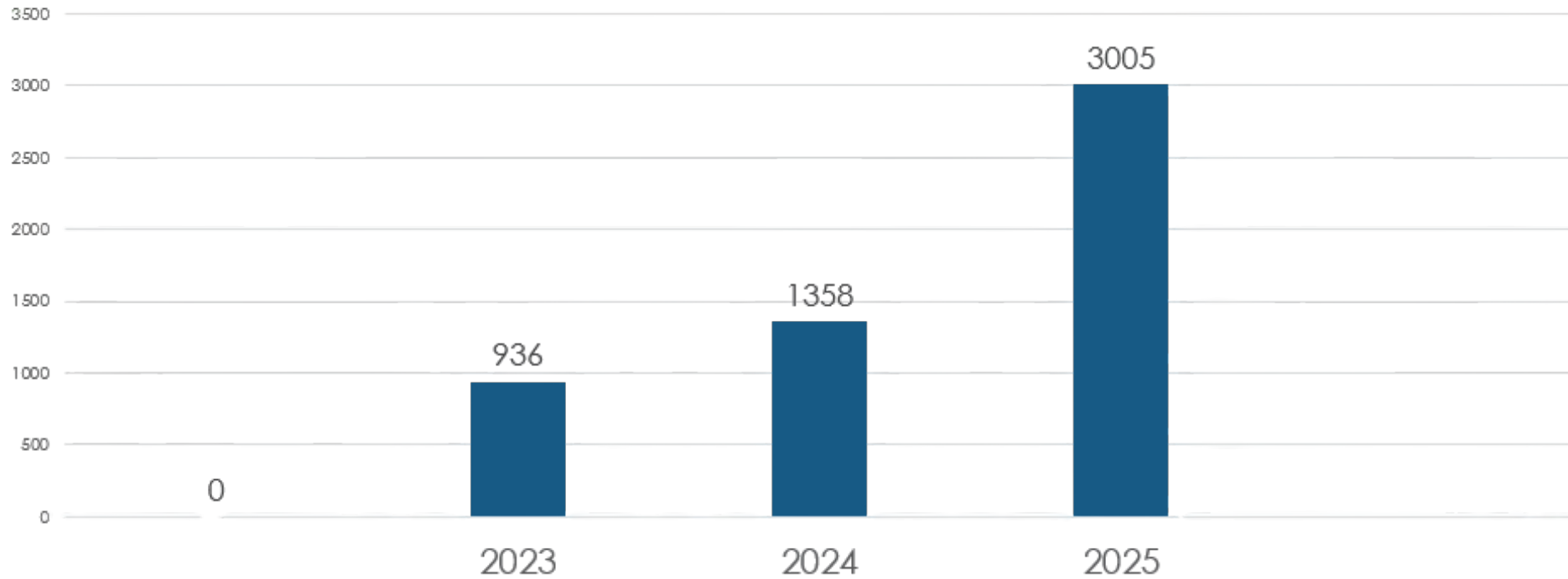
# STRENGTH OF HEALTH CARE PARTNER WITH CBO

**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)



# **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

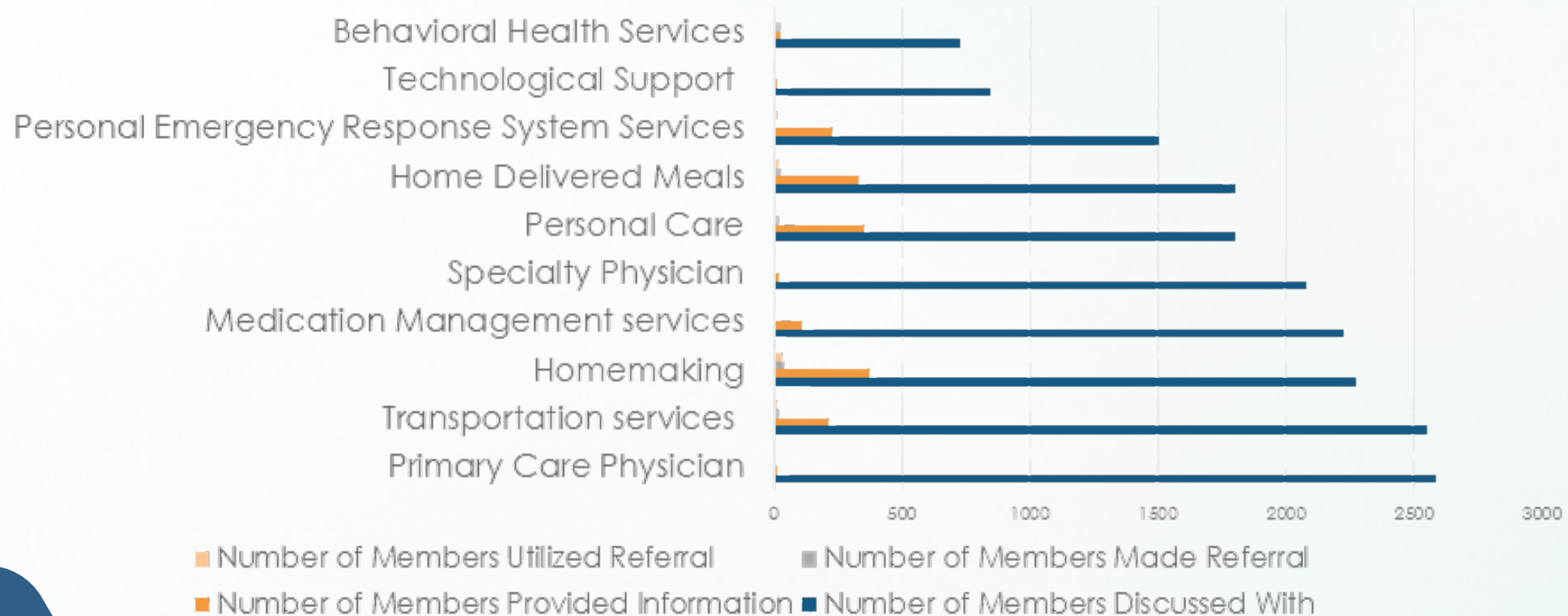
- Within the past 12 months, you worried that your food would run out before you got money to buy more?

## ● 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?

# SOCIAL CONNECTION STRATEGIES - 2025

Resources Discussed and Provided



# 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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**United Disabilities Services**





# Advanced Care Management Solutions

# Agenda

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



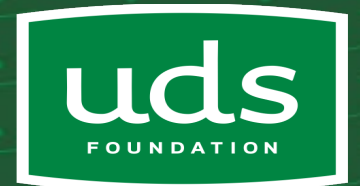
Person Centered Care

# 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
    - Intensive Case Management
    - CAPABLE



# How ACMS Intensive Management 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 Intensive Case Management 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 Intensive Care Management 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

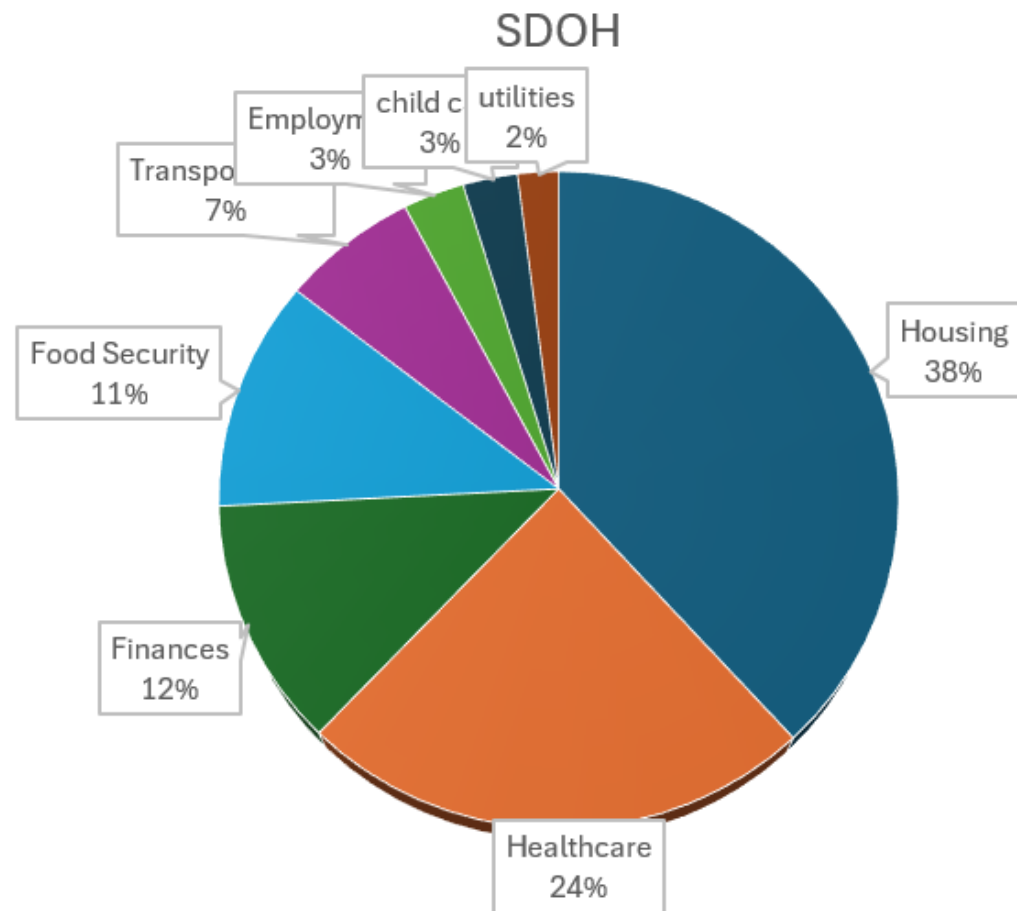
- Contracted with hospitals for a Per Member Per Month Rate (PMPM)
- Started with one hospital and within 2 month they expanded the contract to all 8 of their other hospitals within their system. After that we learned to contract system wide with the other hospital systems from the beginning.
- We are 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 Intensive Case Manager 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 ICM 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.)
- Post discharge we send a 30-day update to the referring team.
- At the ACMS ICM 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

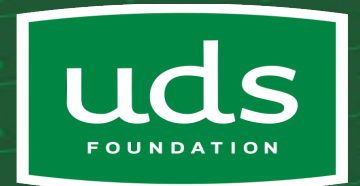
## Learning and making connections

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. We asked ourselves now that they are home how do we help them live and thrive in their environment? Our solution was CAPABLE

- CAPABLE: Community Aging in Place Advancing Better Living for Elders
  - CAPABLE combines the expertise of an Occupational Therapist, Registered Nurse and Handyworker to help the person live successfully at home after discharge

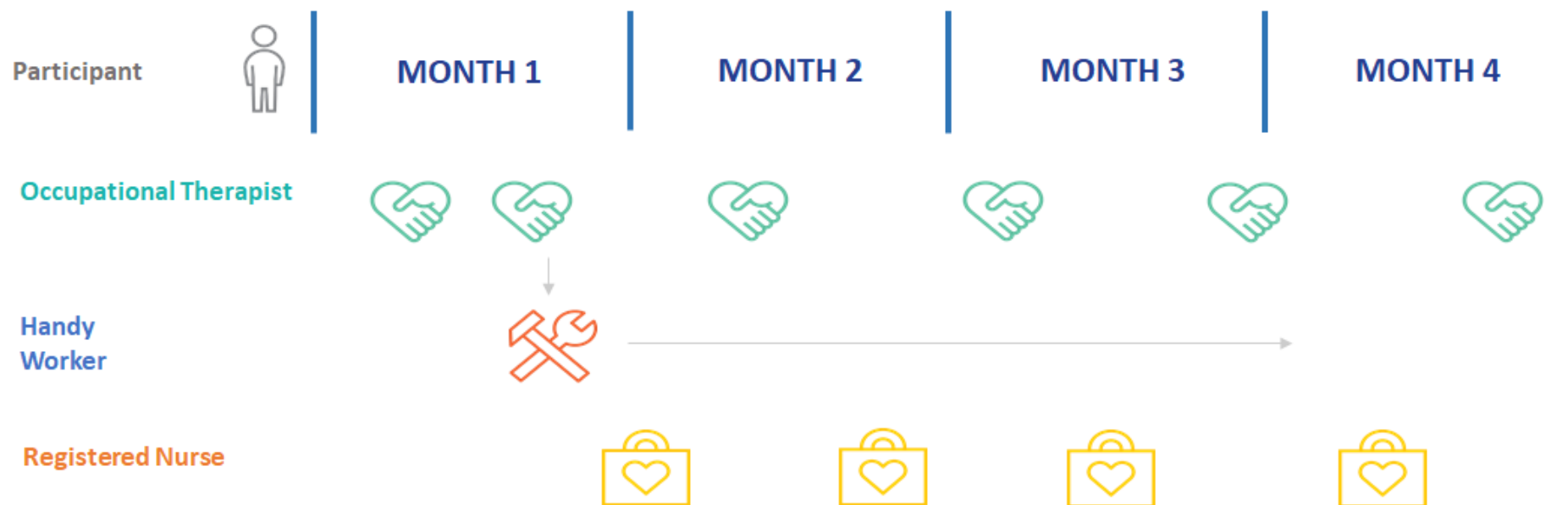




# Program Expansion: CAPABLE

## CAPABLE Program

*An in-home program targeting older adults with functional limitations to achieve functional goals*



# Program Expansion: CAPABLE Outcomes

78% improvement in  
ADL status

66% improvement in  
IADL status

60% improvement in  
mobility status

83% reduction in falls

73% of participants  
showed improvement in  
depression symptoms  
(demonstrated by PHQ9)

41% reduction in fall risk  
(as demonstrated by  
TUG score)

86% reduction in  
hospitalization

# 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.

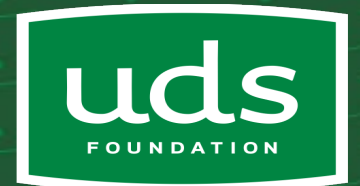
With a medically necessary patient the hospital generally receives \$2,800 per day plus there is a cost of approximately \$600 in care costs (lights, staff, food, medications, etc.) The hospital loses this on social admissions, and it negatively impacts throughput.

CAPABLE Impact on Healthcare Costs (n=1000) (source: Szanton et al 2017 JAGS)

- \$867,000 cost savings secondary to 39% reduction in total healthcare costs

- Approximately 60% reduction in inpatient costs

- Approximately 62% reduction in long-term care costs



# 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.



2270 Erin Ct.,  
Lancaster, PA 17601



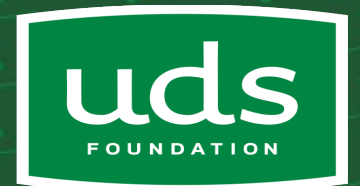
717-947-7446



888-837-4235

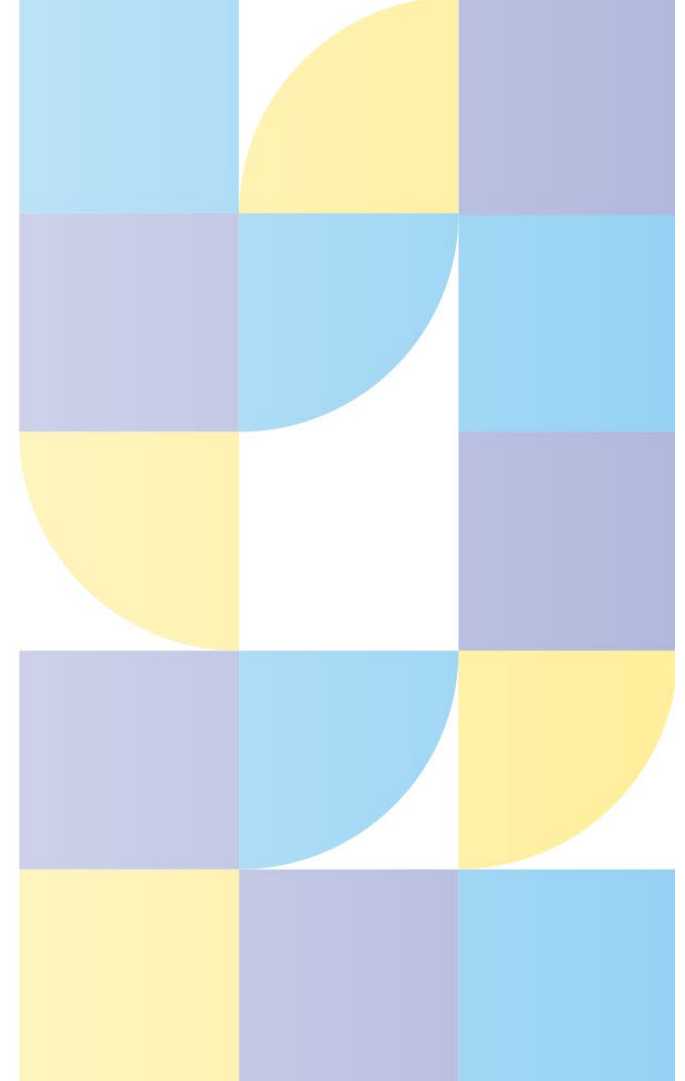


resourcecenter@udservice  
s.org



# Panel Discussion

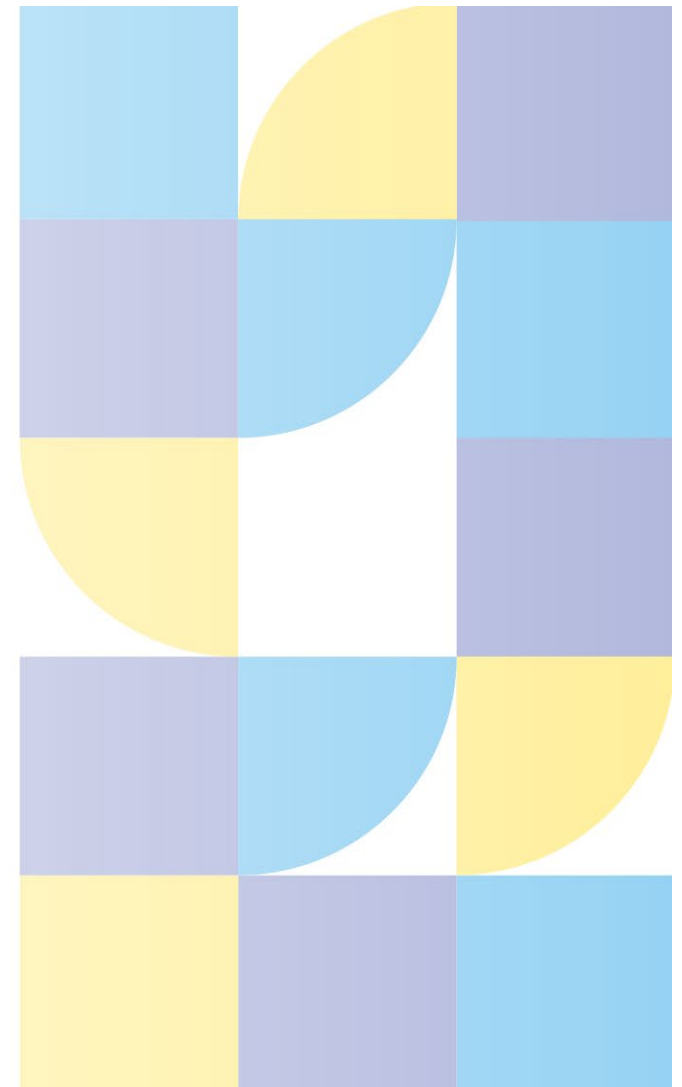
**Moderated by Nancy Wexler  
Program Officer  
The John A. Hartford  
Foundation**





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# Audience Questions



# Connect with Us

- Visit our website to learn more about the Business Institute:  
<https://aginganddisabilitybusinessinstitute.org/>
- Learn more about engaged: USAging's 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](mailto:BusinessInstitute@usaging.org) or [info@engagingolderadults.org](mailto:info@engagingolderadults.org)
- Stay connected, sign up for our newsletters:  
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**engaged**  
USAging's Resource Center  
for Engaging Older Adults