Success Stories

Building Collaborative Contracts With Health Care:

A Social Connection Partnership Between Elder Services of Worcester, Inc., and Blue Cross Blue Shield of Massachusetts

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 their bold, transformative initiatives that align health and community care and increase their organization's 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.

Elder Services of Worcester, Inc., a runner-up for The John A. Hartford Foundation 2025 Business Innovation Award, was recognized for its collaboration with Blue Cross Blue Shield of Massachusetts and its Transition in Care (TiC) program. This program aims to reduce emergency department (ED) visits by improving efficiency and lowering costs through coaching, assessments and referrals, guiding patients to suitable alternative health care settings and strengthening social connection. This Success Story highlights how an interdisciplinary team of RN case managers and Transitions Coaches, trained in a care transitions model, successfully implemented the TiC program and achieved positive health and community care outcomes.

About the Partners

Elder Services of Worcester Area, Inc.[2] (ESWA), functions as a nonprofit Aging Services Access Point[3] (ASAP) serving approximately 17,000 people annually in central Massachusetts. In Massachusetts, ASAPs are contracted local agencies that directly manage and coordinate care for consumers. ASAPs serve as "entry points" for personalized direct services and coordinate care within communities statewide. Private nonprofit agencies, such as ASAPs, are contracted by the Massachusetts Executive Office of Aging and Independence. ESWA's goal is to provide eligible consumers with services that improve their quality of life, supporting their independence with dignity and respect.

Consumers participating in ESWA's TiC program consistently report increased confidence, emotional support and a stronger sense of connection following hospital discharge. A TiC consumer had the following to say:

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

Blue Cross Blue Shield of Massachusetts[4] (BCBSMA) is an Independent Licensee of the Blue Cross and Blue Shield Association. BCBSMA, a not-for-profit health plan based in Massachusetts, is the first health plan in Massachusetts to reward clinicians for addressing inequities in the quality of care across racial and ethnic groups. Additionally, more than 80 percent of Massachusetts doctors and hospitals participate in the Alternative Quality Contract (AQC) program, which rewards clinicians and hospitals for delivering high-quality, high-value patient care. AQC has proven to slow the rate of medical spending and improve care.[5]

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About the Contract

After leaving the hospital, poor coordination among health care providers and inadequate patient preparation can lead to preventable medication errors and worsening health conditions. These problems often result in higher readmission rates and increased health care costs. The national 30-day readmission rate is 14.67 percent,[6] while among Medicare beneficiaries, it is 17 percent.[7, 8] Readmission rates are higher for certain conditions, such as heart failure (22.4 percent) and diabetes with complications (22.2 percent).[9] Massachusetts hospitals have the highest average readmission rate in the country.[10]

ESWA and BCBSMA formed a partnership in 2016, beginning with a pilot of the Medicare Community-Based Care Transitions Program. Today, ESWA has an active contract with BCBSMA to help reduce avoidable ED visits and foster social connection by offering its TiC program to BCBSMA Medicare Advantage members. Key contributors to high medical costs include a lack of social support, limited access to timely care, insufficient education, unnecessary ED visits and preventable hospital readmissions. ESWA's TiC program addresses these issues by focusing on post-hospital discharge, aiming to reduce readmissions and training staff and ASAP subcontractors in the care transitions model.

The TiC program is a 30-day short-term support service for BCBSMA Medicare Advantage members following an ED visit. It helps members transition safely back home and prevents repeat hospital or ED visits. The program includes one in-home visit about a week after discharge and three weekly follow-up phone calls. During these calls, a TiC Coach helps members understand discharge instructions, prepare questions for their primary care provider, schedule follow-up care, recognize warning signs that require urgent attention, organize medications and health information and connect to appropriate community resources.

ESWA's TiC program involves subcontracting with 19 partner ASAPs and creating a new role within these organizations: the Transition Coach. These coaches are trained in the care transitions model and evaluate social factors driving ED use, such as isolation, while also assessing the social and medical circumstances contributing to ED visits. Additionally, coaches screen for isolation and loneliness; connecting clients with companion visits, congregate meals and other social groups; as well as providing education and coaching on using technology to stay connected with family, friends and health care providers.

One tool used in the TiC program screening to identify upstream drivers of health impacting a client was the Blue Cross Members 2025 Social Determinants of Health Screening. This tool was designed to assess patient challenges and needs in achieving their optimal health. It focused on the following areas:

- Mood and Interest
  - Over the past two weeks, how often have you felt down, depressed or hopeless?
  - Over the past two 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, have you worried that your food would run out before you received money to buy more?
- Transportation Barriers
  - In the past 12 months, has a lack of transportation prevented you from attending medical appointments, meeting work obligations or obtaining things needed for daily living?

ESWA offers the TiC program to BCBSMA Medicare Advantage members who visit the ED and are mostly age 65 or older. The Transition Coach emphasizes patient empowerment through motivational interviewing (MI). MI is a goal-oriented, guiding communication style that focuses on collaboration, empathy and respect for client autonomy.[11] It is person centered and increases an individual's motivation and commitment to change. MI is widely utilized in health care, counseling, addiction treatment and behavioral interventions. It is highly effective for promoting lifestyle changes, supporting mental health and substance use recovery, improving adherence to treatment plans, resolving ambivalence and increasing internal motivation.[12]

The TiC program focuses on:

- Improving understanding of post-ED care.
- Supporting follow-up with primary care.
- Helping members manage their medications and symptoms.
- Preventing avoidable hospital or ED readmissions.
- Helping consumers navigate the health care system.
- Identifying unmet needs and connecting consumers to resources and support.

Impact and Outcomes

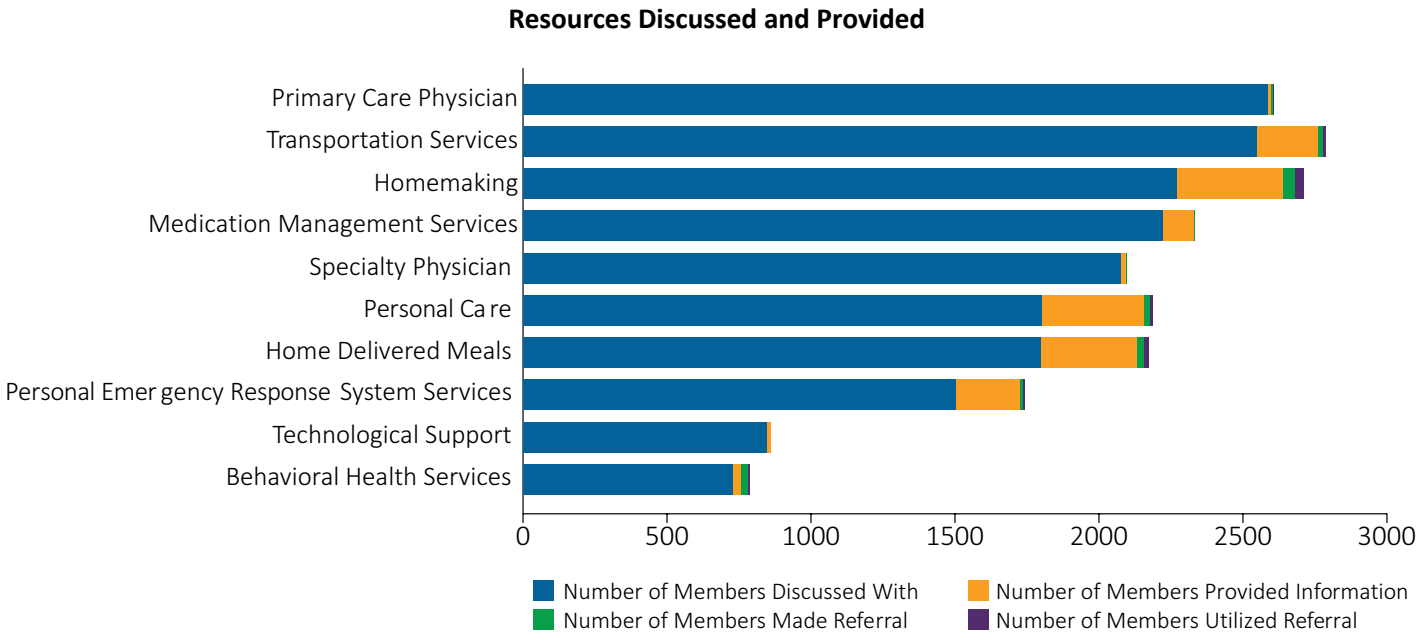
TiC's Transition Coaches program addresses social isolation, loneliness and post-ED discharge needs. Transition Coaches connect clients with Senior Companion visits, local meal sites, social groups and educational activities. They also teach clients to use technology to stay in touch with family, friends and health care providers. Additionally, coaches help clients attend medical appointments by offering transportation or guiding them through telehealth options. The program enhances social connection by engaging older adults who may lack support and by allowing them to meet with their Transition Coach up to four times per month.

ESWA's TiC program has enrolled more than 5,200 people, with participant numbers increasing every year. From 2023 to 2025, the TiC program expanded its reach from one county to 13 counties, enrolling participants from all but one county in Massachusetts. ESWA's TiC program has achieved several notable outcomes. Among its positive outcomes are:

- Ninety-four percent satisfaction rate with TiC.
- Ninety-five percent said it's helpful to have support during the ED post-discharge.
- More than 250 people were educated about the availability of the Senior Companion program.
- Nearly 500 reported using technology to contact family and friends as a result of technology education and coaching through TiC.
- One hundred percent of respondents who reported depression or loss of interest were referred to appropriate support resources.

ESWA's TiC program prioritizes social connection, tracks and measures outcomes, and maintains strong partnerships and contracts. The chart below outlines the resources discussed and provided as part of the TiC program.

Social Connection Strategies (2025)



The TiC program, through personalized health coaching, has improved medication management and follow-up care, helping patients adhere to their treatment plans and preventing complications and readmissions. It has also strengthened collaborations between health care providers and social services, improving coordination and access to community resources. Transition Coaches connect BCBSMA Medicare Advantage members with ASAPs and other services that address health and social needs, including housing, food access and companionship opportunities, further improving patient outcomes and reducing social isolation. The program is sustainable because income from the health care contract covers all expenses.

Lessons Learned

To support successful growth and implementation, ESWA provides structured workflows, standardizes as many forms and procedures as possible, offers consistent training and establishes clear referral channels. ESWA hosts two monthly meetings (huddles) where peers can share insights, discuss successful strategies for replication, brainstorm solutions to barriers, exchange updates, ask questions and build team relationships.

ESWA's in-house infrastructure enables centralized coordination; daily referral management; quality control; and other administrative functions, including billing, data entry and clerical tasks. A portion of the per-transition intervention rate is allocated to hiring staff to handle these administrative responsibilities.

ESWA has established partnerships with 19 subcontractors and offers a tailored approach that clarifies the complexities of the subcontractor's agency and staff. They introduce the TiC model and actively support subcontractors from the initial concept through implementation. ESWA also ensures clear communication with subcontractors regarding prime contract terms, including scope of work, data-sharing standards, background check requirements and deadlines for meeting benchmarks.

Transparency is key, as ESWA shares monthly target goals with subcontractors to promote compliance, enable effective interventions and secure necessary funding. During onboarding, ESWA works toward full target achievement by providing progress updates and addressing questions and feedback, helping subcontractors consistently meet their goals. All information is openly shared with the TiC Coach, supervisor, manager and agency leadership.

ESWA has gained many key insights from using transitional coaching, especially the value of building positive relationships. Over the past nine years, ESWA and BCBSMA have maintained a strong partnership, fostering true team integration. Additionally, the importance of administrative simplicity has become clear. ESWA has one coordinator who reviews daily referrals to ASAPs and pre-fills the necessary referral documentation for Transition Coaches. This allows the coaches to spend more time engaging with consumers.

Another key factor is that local control is both a strength and a challenge. ESWA decided to subcontract the Transition Coach role to individual ASAPs to better leverage local resources. However, managing local differences while maintaining program integrity can be difficult. Lastly, ESWA faced staffing challenges similar to those of other Aging Network organizations, such as coaches leaving and the ongoing need to train new coaches within the TiC program model.

The Future

After ESWA's contract with BCBSMA expanded from two ASAPs in 2016–2024 to six in 2024, and then to 20 in 2025, ESWA plans to focus on strengthening operations in 2026 to sustain performance at this larger scale. The TiC program aims to broaden its impact dataset and begin using performance reports to ensure consistency and integrity across all subcontractors. Looking ahead, ESWA hopes to increase its reach by serving more BCBSMA members after their ED visits and by expanding to other payers. Additionally, ESWA plans to extend its TiC program to include transitions between inpatient and nursing home care.

The TiC program will maintain its effectiveness by highlighting its proven cost savings and quality outcomes to health care plans. Other CBOs can replicate the TiC program model by focusing on social connection, establishing strong contracts, collecting data that shows measurable results and a clear impact on participants, and creating opportunities for community integration.

Endnotes

1. The John A. Hartford Business Innovation Award. The John A. Hartford Foundation Business Innovation Award—Aging and Disability Business Institute
2. Elder Services of Worcester Area. eswa.org/
3. Aging Service Access Points. www.mass.gov/info-details/aging-services-network
4. Blue Cross Blue Shield of Massachusetts. www.bluecrossma.org/aboutus/
5. BCBS: Alternative Quality Contract. Extending the Scope of Value-Based Payments. www.bluecrossma.org/aboutus/annual-report-2019/power-of-partnerships/expanding-the-scope-of-value-based-payment
6. Reducing Hospital Readmission Rates. bhmpc.com/2024/11/reducing-hospital-readmission-rates/
7. ibid
8. Medicare Readmission Rates. hcup-us.ahrq.gov/reports/statbriefs/sb304-readmissions-2016-2020.jsp#:~:text=Rates%20of%2030-day%20all-cause%20readmissions%20by%20expected%20primary,in%202016-2019%20and%202020
9. Ibid.
10. Average Hospital Readmission Rates by State. www.definitivehc.com/resources/healthcare-insights/average-hospital-readmission-state
11. What is Motivational Interviewing? www.cdc.gov/overdose-prevention/hcp/training-modules/motivational/page1089570.html
12. 12+ Motivational Interviewing Questions & Techniques. positivepsychology.com/motivational-interviewing/

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.

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.

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.

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 Elder Services of Worcester Area website.