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Milford Wellness Village – Foundation of Value-Based Care in Rural Delaware:

Adaptive Reuse, Social Determinants of Health, and an Integrated Continuum of Care

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Abstract

This article offers insights into an innovative community-based organization improving the health of individuals residing in Delaware, with a focus on older adults and rural populations. We profile Milford Wellness Village (MWV), an integrated health and social services campus hosting over 30 service providers and offering a suite of interventions that help residents to age in place, address chronic conditions, and reduce overall health care costs. Specifically, MWV's adaptive reuse of community facilities, establishment of an integrated continuum of care, and adoption of value-based payment approaches make it a unique entity worthy of ongoing study. As communities across the country wrestle with how to address public health concerns, improve service delivery, and enhance outcomes for vulnerable populations, innovative models like MWV can serve as a blueprint. Adoption of value-based payment is a growing priority for stakeholders across the health care system who are seeking ways to reform traditional approaches to reimbursement to address cost growth while ensuring access to high-quality care. For many providers and payers, the path forward has been challenging, but examples of successful models offer important lessons for national efforts.

Introduction

Milford Wellness Village (MWV), is an integrated health and social services campus hosting over 30 service providers and offering a suite of interventions that help residents to age in place, address chronic conditions, and reduce overall health care costs. MWV's programs support measurable improvements in population health infrastructure, access to care, workforce capacity, and care for uninsured and vulnerable populations. The organization's success rests with a combination of elements, including the strategic adaptive reuse of a legacy institutional asset: the former 22-acre Bayhealth Milford Memorial Hospital campus. By transforming this space into a co-located, multi-organizational ecosystem, MWV delivers a comprehensive continuum of care under one roof. Additional focus on social supports such as food, housing and other determinants of health contributes to a proactive and patient-centered model that improves health outcomes.

This is value-based payment in action. By orienting around outcomes rather than volume, MWV offers a tested framework for shifting public health from reactive intervention to proactive, community-centered care.

Delaware's Challenges and Need for Community-Based Models

Across Delaware, and particularly in the rural expanses of Kent and Sussex Counties, traditional,

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fragmented health care delivery models fail to meet the multi-layered needs of older adults, a growing population with substantial care needs.[1] As the population ages, geographic dispersion is compounded by resource scarcity. Older adults in those rural counties face systemic vulnerabilities: a lack of localized specialized providers, extensive transportation barriers, social isolation, and fragmented transitions of care that drive avoidable emergency department utilization and early institutionalization in nursing facilities and generate higher costs to state Medicaid programs and the federal government.[2]

Successful efforts to keep people at home or in their communities with appropriate supports, often referred to as "aging in place," require more than isolated clinical interventions, which is one reason they have stalled in many areas across the country. Instead, the challenge is to design a system where individuals can access needed and complex services under an organized structure of care coordination in their community. That approach must prioritize prevention and chronic condition management, put the patient in the center of its programs, and pursue improved outcomes across its programming.

Milford Wellness Village: Evidenced-Based Approach and Community Focus

This imperative was the animating force behind the establishment of MWV. The organization transformed a massive infrastructure vacancy into a centralized, walkable, and collaborative “destination” for health care and related social services. On-site clinical care providers and referral partners offer a range of services, and help to improve primary care, and integrate post-acute institutional care and all-inclusive community aging programs (PACE). To provide administrative and programmatic infrastructure, MWV engaged Education Health and Research International (EHRI), an approach that enabled independent clinicians to function as a coordinated system rather than a collection of co-located practices.

For example, EHRI administers the WeCare community care program, which deploys personal health nurses and care coordinators to serve at-risk seniors across southern Delaware. The organization holds licenses for and administers evidence-based programs including Chronic Disease Self-Management Education (CDSME), Diabetes Self-Management, falls prevention programs, and medication management. EHRI also manages federal grant partnerships with the Administration for Community Living (ACL) and the Health Resources and Services Administration (HRSA) and leads regional workforce development through the Delaware Geriatric Workforce Enhancement Program (GWEP). Where MWV’s clinical tenants manage direct patient care, EHRI manages referral infrastructure, data systems, community outreach, and the program design that ties clinical services to measurable population health outcomes.

Value-Based Payment in Action at MWV and Opportunities for Rural Health Transformation

In general, value-based payment programs include reimbursement to providers that include financial incentives to produce quality outcomes and cost efficiency, rather than paying solely for volume of services. Often those programs include coverage of services such as care navigation, chronic disease management, or provision of social services related to improvements in health and wellness.[3] Rural populations have high rates of chronic disease, leading them to benefit from

different kinds of interventions that help them with management and education of beneficiaries. Additionally, those populations tend to be older than average, with needs unique to low-income seniors.[4,5] Access to important social supports is also a challenge, with medical transportation a common issue.

Payment to entities who provide those services can yield savings in health care costs in other parts of the health care system, such as Medicaid (which helps state and federal budgets) and Medicare (which reduces spending by the federal government), and support broader public health goals for populations.[6] Programs generally design such payment to include a per member per month (PMPM) fee for entities offering services and then include performance-based rewards for outcomes in the areas of cost and quality.[7]

Entities participating in those value-based payment programs do not need to be typical providers of medical services; they could include organizations helping to manage a bundle of services and interventions that have an impact on health costs and quality. In some cases, they may also provide medical services or work in alignment with medical organizations such as primary care providers who are at risk for the costs of care they provide. Integrated campus models, such as those that co-locate primary care, behavioral health, senior care, and social services, are particularly well-suited to this kind of intervention. They can expand evidence-based services to existing and new populations, monitor outcomes, and scale efforts that reduce health care costs over the long term, including reducing Medicare and Medicaid spending through lower utilization of inpatient and emergency services.

Integrated care campuses that host multiple service providers at a shared site have capabilities in coordinating health and social services for rural populations and represent a promising application of value-based care. MWV's WeCare community care program offers perhaps the most direct evidence of value-based impact in action. A three-year independent evaluation by the University of Delaware found that WeCare enrollees demonstrated improvements in quality of life and maintained or reduced scores on activities of daily living, outcomes that signal reduced risk of costly institutionalization. A companion study conducted in partnership with the Delaware Division of Medicaid and Medical Assistance and the Delaware Health Information Network (DHIN) documented measurable cost savings in health service utilization among WeCare enrollees compared to a matched control group of non-enrolled older adults.[8]

These findings position MWV not merely as a provider of services, but as a demonstrable driver of downstream savings in Medicaid and Medicare spending, the very outcome-linked model that value-based payment frameworks are designed to reward. In part, success is due to the “hub” design, which much like the MWV, allows for the inclusion of various health professionals and local resources as needed to enhance patient care across medical episodes. Effective models of this nature include a focus on social determinants of health, support for activities of daily living and delivery of personal nursing care, chronic disease, falls prevention, nutrition programs, housing support and transitions to primary care and specialty care. A robust data management system also enhances overall capabilities to serve patients and deliver on outcomes. This type of model may also be positioned to serve as a replicable template for rural health transformation, where access constraints make integrated, hub-based service delivery particularly valuable.

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Adaptive Reuse – Infrastructure as a Social Determinant of Health

When a community hospital relocates or closes, the resulting structural vacancy frequently triggers a cascade of negative outcomes due to reduced social and community-based supports—leaving local populations without nearby emergency infrastructure and hollowing out economic stability.[9] The redevelopment of the former Milford Memorial Hospital campus presents an alternative paradigm. Rather than demolition or conversion into non-civic commercial space, the 256,000-square-foot medical facility underwent an intentional adaptive reuse strategy.

This structural rehabilitation achieved two major policy goals: it bypassed the multi-year timelines and high capital costs of ground-up development, and it preserved a trusted, central geographic location deeply familiar to southern Delaware's senior population.

This approach was important for seniors navigating chronic disease, which requires a fluid, uninterrupted network of support. By relying on traditional town planning principles to design a user-friendly, interconnected floor plan, MWV brings over 30 mission-aligned service partners into immediate physical and clinical alignment.

When independent providers operate within a shared physical environment, structural communication barriers dissolve, producing the kind of coordinated, outcome-driven care that value-based payment frameworks are designed to incentivize. A physical therapist, a primary care provider, an adult day care director, and a home-care coordinator can easily communicate without the traditional bureaucratic friction of disparate health systems. State health leaders and rural health advocates have increasingly spotlighted the Milford Wellness Village as a premier, real-world case study for the execution of Delaware's Rural Health Transformation Plan.[10] While state policy outlines macro-level goals—reducing reliance on overburdened hospital emergency rooms, scaling the rural medical workforce, and mitigating care fragmentation and bridging rural gaps—MWV offers an operational proof-of-concept.

Integration of Continuum of Care – Architecture

MWV organizes services across four sequential tiers: community screening and prevention; primary and preventive clinical care; specialty and advanced clinical coordination; and long-term care coordination and social support. This structure reflects the actual trajectory of a rural senior navigating the health system, from first contact through ongoing management of complex chronic conditions. Technology infrastructure supports continuity across these tiers through a phased integration strategy anchored by the DHIN. Building on prior DHIN collaboration in nutrition services, MWV is developing shared patient identifiers, EMR integration across provider partners, and closed-loop referral tracking, the data architecture that makes coordination visible, measurable, and improvable over time.

Furthermore, the campus structurally addresses the aging continuum in three ways:

Primary Prevention, Allied Health, and Chronic Care. The continuum is supported by localized primary care medical homes, including Village Primary Care and La Red Health Center, which emphasize multi-generational care, behavioral health integration, and proactive chronic disease screening. Specialized providers like Aquacare Physical Therapy and Easterseals Delaware enhance service provision, the latter providing vital community outreach, case management, and respite care resources for families navigating the complexities of cognitive or

physical decline.

All-Inclusive Community Care and Aging in Place. For seniors with preferences to remain at home but requiring institutional-level support, the campus integrates PACE Your LIFE (Program of All-Inclusive Care for the Elderly). This program customizes medical, nutritional, rehabilitative, and social care delivered by an interdisciplinary team on-site, removing the administrative and physical burden from family caregivers.

High-Acuity Post-Acute and Institutional Care. At the physical core of the village sits the Polaris Healthcare & Rehabilitation Center, a state-of-the-art 100-bed skilled nursing facility. Polaris acts as a crucial transitional bridge, managing complex post-acute discharges from regional hospitals (such as Bayhealth's clinical network). Featuring dedicated Activities of Daily Living (ADL) simulation labs equipped with mock home environments, the facility focuses heavily on functional rehabilitation to safely transition seniors back to independent living.

Workforce Development

A critical element of the MWV model is its proactive approach to workforce shortages and the need for targeted solutions to improve care in rural Delaware in particular. By integrating dedicated education and training infrastructure directly into the village, the campus links healthcare reform with economic development.

MWV focuses on building a workforce that is trained to address the needs of an aging demographic and is working on programs that will help train and enhance the care system and talent pipeline. Working with partners at Delaware State University (DSU), Milford Wellness Village and EHRI have made strides in clinical model development and advanced care pathways. MWV programming has support from the federal government; HRSA awarded a $5 million grant to DSU and its lead partner EHRI. This funding expands evidence-based CDSME targeting older adults with complex chronic conditions throughout the region, providing public health researchers with measurable data on health literacy and emergency care reduction.

Conclusion

Meeting the compounding public health challenges of rural aging does not inherently require the creation of new, siloed systems. Instead, the solution lies in the strategic, community-focused reorganization of existing assets around a value-based framework, one that ties coordination, prevention, and chronic disease management to measurable reductions in cost and utilization. The WeCare program's documented cost savings in Medicaid and Medicare utilization demonstrate that this orientation produces real results. By transforming a vacant institutional footprint into an integrated, collaborative health village, Delaware has established a highly reproducible blueprint for geriatric care systems. This model proves that when clinical precision, social support, and structural innovation intersect, and when payment structures reward outcomes rather than volume, aging in place evolves from a policy ideal into a tangible, sustainable community reality. In a state where the senior population is expanding faster than the health system can absorb it, that combination of better outcomes for vulnerable populations and measurable savings across the broader care continuum supports the broader goals of value-based payment.

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