

Geisinger

2026 HAP Achievement Award Community Champions Award—Large Division

Empowering Healthier Communities

The Goal

Unmet social needs—including food, housing, transportation, employment, utilities, financial strain, and emotional wellness—were creating barriers to care and worsening health disparities. While screening had identified more than 428,000 individuals with at least one need, the referral process depended on time-constrained clinical teams and resulted in a closed-loop referral rate of less than 5 percent. A centralized, scalable model was needed to connect patients and members to resources more reliably.

The Intervention

To close the gap between identifying social needs and resolving them, the Social Needs Resource Hub was created as a centralized navigation and coordination model. Using a payor-agnostic, telephonic approach, the hub connects patients and members with trained Community Health Workers and Behavioral Health Care Connectors who provide personalized outreach, warm handoffs, follow-up support, and culturally responsive navigation.



The model brings together routine social needs screening, electronic medical record documentation, a statewide directory of more than 11,000 social programs, and trusted



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community partnerships across food, housing, transportation, workforce, utilities, and emotional wellness. It also strengthened transportation support through a streamlined portal and integrated behavioral health navigation, allowing appointments to be scheduled during the initial outreach when possible.

Results

In its first four months, the Social Needs Resource Hub supported 1,245 patients and members, exceeding its early target. Successful resource connections rose sharply from a baseline of less than 5 percent to 83 percent, showing that more people were getting connected to needed support. The hub also improved access to transportation and emotional wellness resources, while lower screening opt-out rates showed stronger engagement with patients and members.