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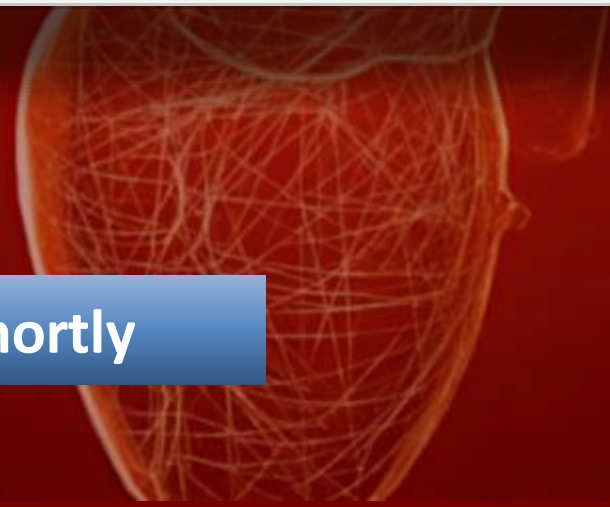
From Screening to Support:
Hospital Strategies for Addressing Health-Related Social Needs in HFpEF/HFmrEF Patients



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In 2025, the American Heart Association, launched a quality improvement initiative to:

- Discover current gaps and identify ideal care models in the HFpEF/HFmrEF patient journey
- Build a network of multidisciplinary team members focused on improving HFpEF/HFmrEF care
- Amplify HFpEF/HFmrEF awareness with healthcare professionals and monitoring adherence to evidence-based therapies for HFpEF/HFmrEF patients in hospitals

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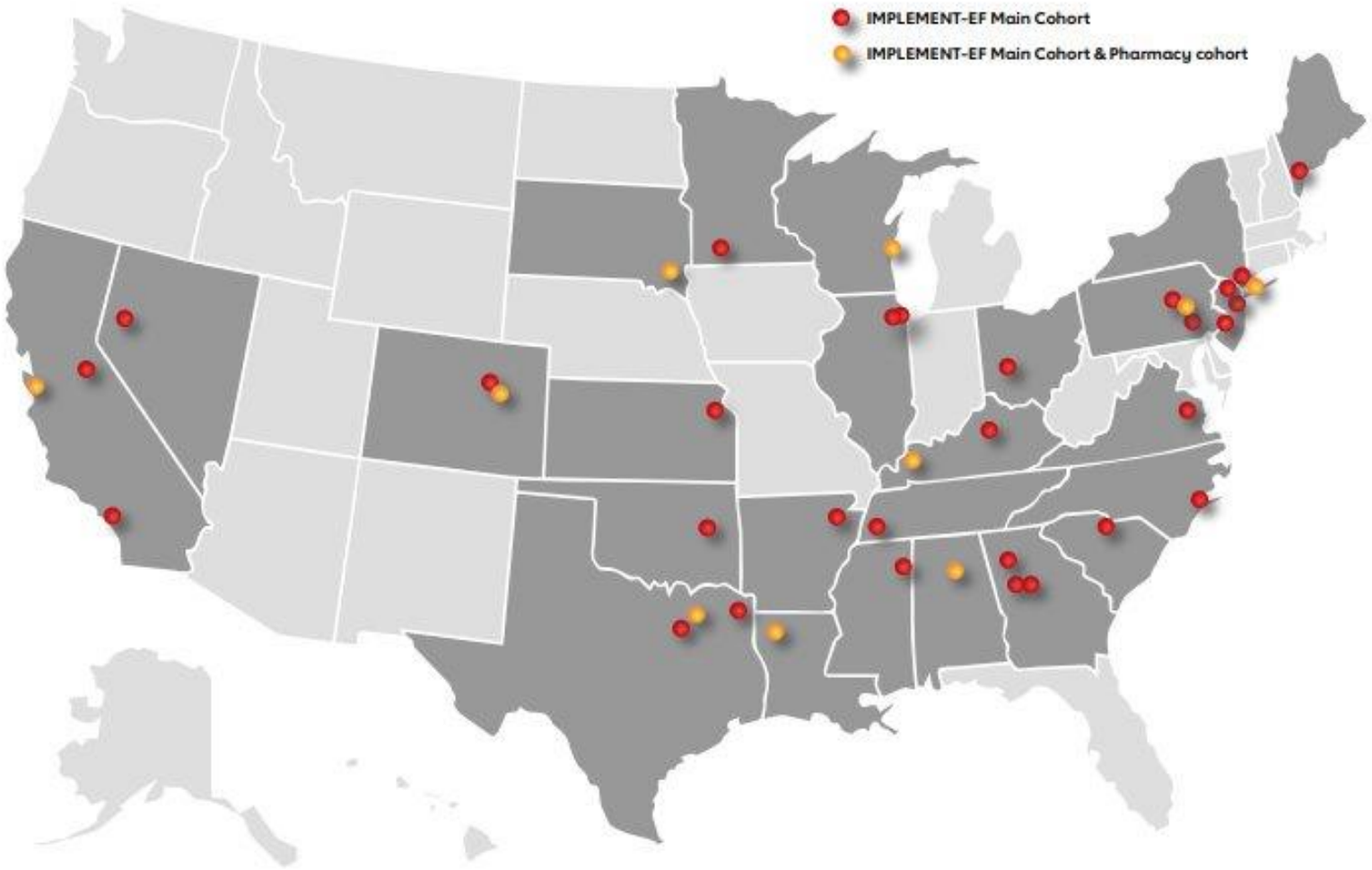

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2.	AdventHealth Shawnee Mission	Shawnee Mission, KS
3.	Avera McKennan Hospital & University Health Center*	Sioux Falls, SD
4.	Baptist Health Paducah*	Paducah, KY
5.	Baptist Health Lexington	Lexington, KY
6.	Baptist Memorial Hospital - Memphis	Memphis, TN
7.	Bon Secours St. Mary's Hospital	Richmond, VA
8.	Carolina Pines Regional Medical Center	Hartsville, SC
9.	Carteret Health Care	Morehead City, NC
10.	Dayton Veterans Affairs Medical Center	Dayton, OH
11.	Froedtert Hospital*	Milwaukee, WI
12.	Froedtert West Bend Hospital	West Bend, WI
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14.	Hackensack Meridian JFK University Medical Center	Edison, NJ
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16.	Hackensack University Medical Center	Hackensack, NJ
17.	MaineHealth Maine Medical Center Biddeford	Biddeford, ME
18.	Mount Sinai Health System	New York, NY
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20.	NEA Baptist Memorial Hospital	Jonesboro, AR
21.	North Mississippi Medical Center	Tupelo, MS
22.	Northwestern Medicine Palos Hospital	Palos Heights, IL
23.	NYC Health + Hospitals / Elmhurst*	Elmhurst, NY
24.	Ochsner LSU Health Shreveport*	Shreveport, LA
25.	Penn Medicine Lancaster General Health	Lancaster, PA
26.	Penn State Health Milton S. Hershey Medical Center*	Hershey, PA
27.	Renown Regional Medical Center	Reno, NV
28.	Saint Francis Hospital Muskogee	Muskogee, OK
29.	Stanford Health Care*	Stanford, CA
30.	Sutter Medical Center, Sacramento	Sacramento, CA
31.	Texas Health Fort Worth*	Fort Worth, TX
32.	Titus Regional Medical Center	Mount Pleasant, TX
33.	UCHealth - Memorial Hospital Central	Colorado Springs, CO
34.	UCHealth University of Colorado Hospital*	Aurora, CO
35.	UI Health	Chicago, IL
36.	University of Alabama at Birmingham Hospital*	Birmingham, AL
37.	University of California Irvine Medical Center	Orange, CA
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*Participating in the Pharmacy cohort

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Maria Welch, MPH, CHES

Director of Community Health and Social Needs

Geisinger Medical Center – Danville, PA

No Disclosures

From Screening to Support: Hospital Strategies for Addressing Health-Related Social Needs

Maria Welch, Director of Community Health and Social Needs

Geisinger

Geisinger: Integrated health system with $8.2 billion in combined revenues

We care for patients.

- **10** hospital campuses
- **160+** primary and specialty clinics
- **27,500+** employees
- **1,800+** employed physicians

We provide quality, affordable healthcare coverage.

- **More than 550,000** Geisinger Health Plan enrollees
- **More than 71,000 c**ontracted providers in network
- **217** hospitals in network

We shape the future of medicine.

- **500+** MBS/MD students at Geisinger College of Health Sciences
- **100+** students at Geisinger School of Nursing
- **1,400+** active research projects

Community and Social Health Strategy

Vision: To advance health and contribute to the transformation in health outcomes, quality, and innovation by addressing factors impacting total health for patients, members and communities. Maximize impact by looking strategically at each of these data driven areas of focus through the lens of compliance, regulatory, community needs and patient care.

Access to Food and Nutrition

Social Needs Coordination

Workforce Development

Removing Barriers to Care.

Chronic Disease Impact

Behavioral Health

Social Needs Strategy: Comprehensive approach for the Clinical Enterprise and GHP to address social needs that includes **screening and information, interventions, and outcomes**

Screening and Information

Interventions

Outcomes

Our Journey

2019

Launched formal social needs strategy

2020

Implemented Neighborly with a community first approach

2021 & 2022

Implemented a 13-question urgent adult in outpatient workflows

Implemented an 11-question urgent household screening for pediatrics

2023

Added 5 question screening to inpatient workflows

Added questions to new EPIC Healthy Planet builds for Geisinger

2025

Added 5 question adult screening to ED workflows

Social Needs Resource Hub Launch

Expanded to new Community and Social Needs Strategy

2026

Full household screening to inpatient pediatrics

Social Needs Screening

Screening

- Screening tool is standardized across Geisinger (household or adult screening)
  - Custom screening tool designed to identify urgent needs and meet regulatory requirements
- Screen for social needs annually to meet regulatory, contractual and accreditation requirements
  - Rescreen logic available to rescreen at 6 months if at least one positive screening
- Screenings fire in various clinical depts (ex: outpatient, ED, IP)
  - Short and long version

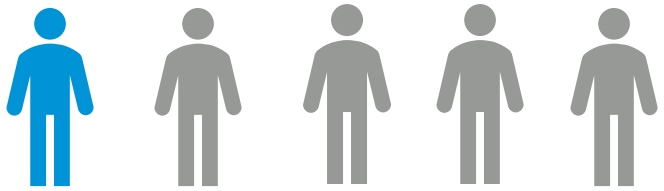
Methods

- EMR workflows (MyChart, waiting room, rooming process)
- Health plan workflows determine screening frequency (at least annual) – telephonic interactions
- Translated into various languages (paper screenings that are entered into EMR)

Intervention

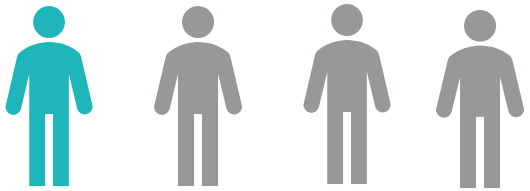
- Neighborly
- Clinical workflows
- Social Needs Resource Hub

Geisinger's Social Needs Snapshot



1 OUT OF 5

Patients screened have at least one social need



1 OUT OF 4

Patients who screened positive want connected to resources

Screenings occur in select outpatient departments and inpatient workflows to assess the patient's health related social needs

As needs are identified, teams complete workflows to address needs using tools like Neighborly and connect patients to local community resources or Geisinger programming

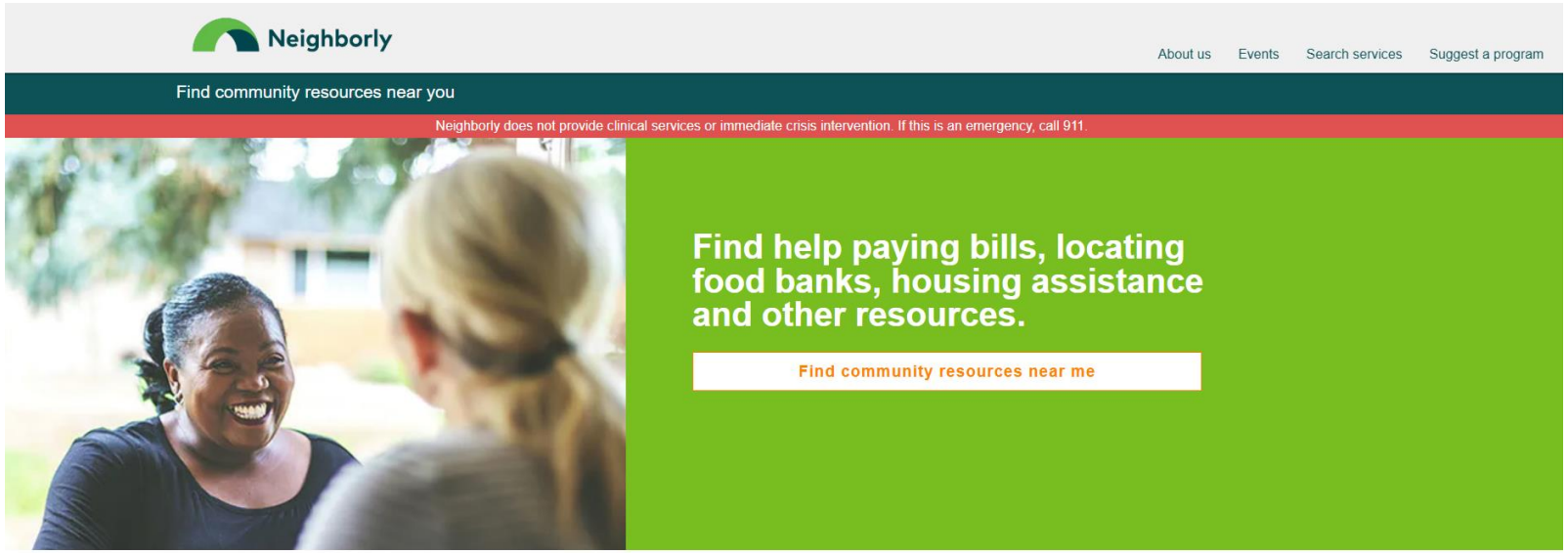
Screening Results

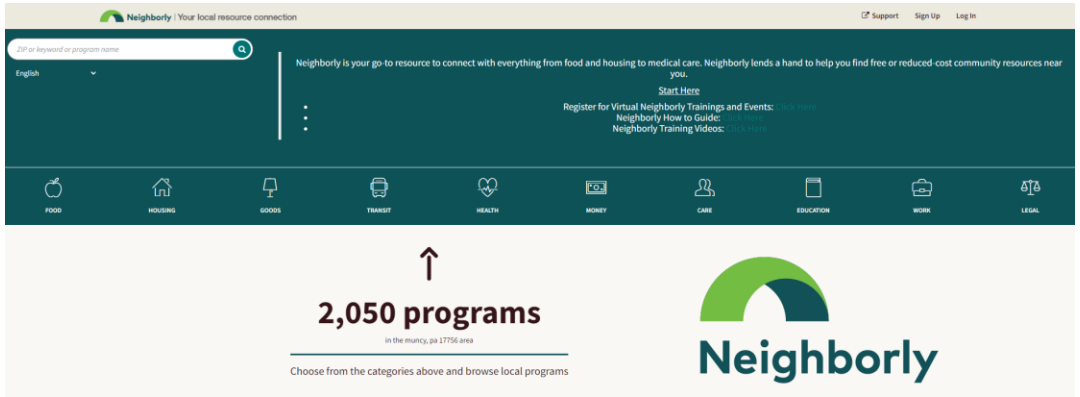
- Screening information varies by department (Emergency Department, Inpatient, Outpatient Healthy Planet)
  - Tools developed to utilize various visualizations in EMR
    - Snapshot reports
      - SDOH wheel and print group
      - Screening history
      - Links to automation BOT
      - Neighborly links
    - Storyboard (views vary)
    - Synopsis reports
    - Questionnaire flowsheets in notes
    - MyChart questionnaires
    - Neighborly (MyChart)
    - AVS/discharge documents (Neighborly)
    - Various websites and marketing materials, clinic TV screens (Neighborly)

Care closer to home

Neighborly

- Launched online resource in March 2020
- Over 11,000+ programs and services listed and growing in Pennsylvania (local, statewide and national resources) and over 600,000 in the United States
  - Program and service categories: food, housing, childcare, transportation, utility assistance, education, health care, legal services, financial assistance resources
- Partners with local community organizations to connect members and patients with services
- Available at www.NeighborlyPA.com and as a dedicated staff site and launchable in EHR

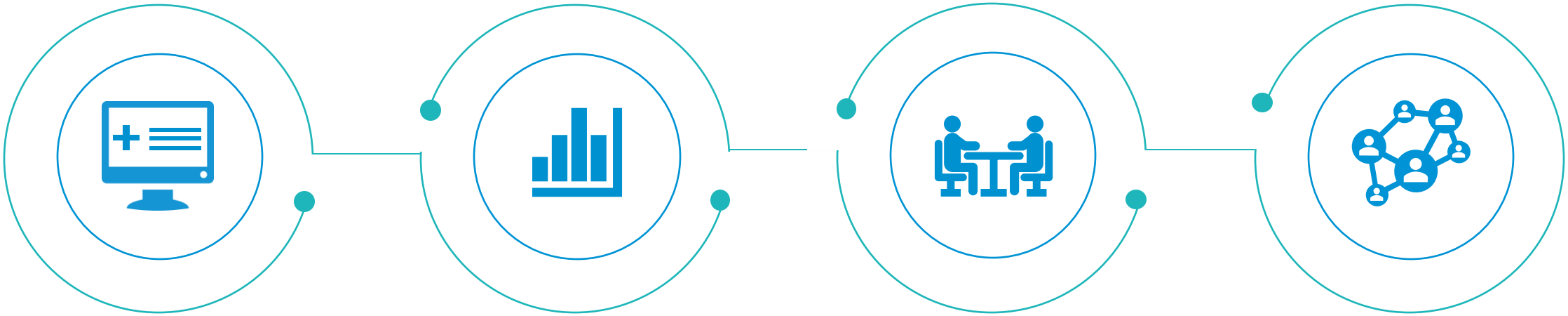




Neighborly

Using our data to develop strategies

Data-driven approach drives all strategy creation to build a network to address social needs in members and patients



Aggregate Data

Identify Patterns*

Develop Partnerships & connect through Neighborly

Social Needs Resource Hub

*Food is Health, Housing, Transportation, Workforce, Maternal Resources

Strategic Approach to Identify Organizations

Top needs identified in each zone

Data sources focus areas: Social Needs screening data, Neighborly, Social Needs Resource Hub and Community Health Needs Assessment (CHNA) clinical and GHP data

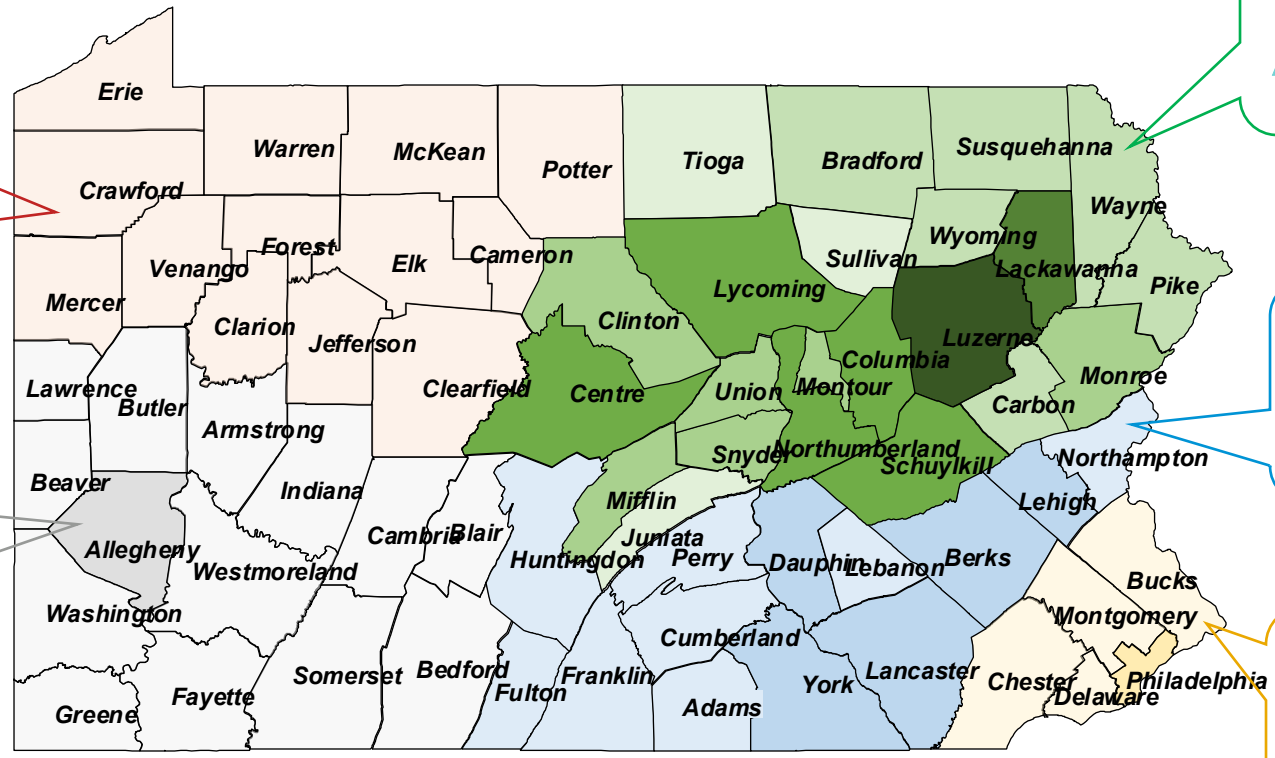
Northwest Zone Top Needs

Northeast* Zone Top Needs

Lehigh Cap Zone Top Needs

Southwest Zone Top Needs

Southeast Zone Top Needs



Identified Needs

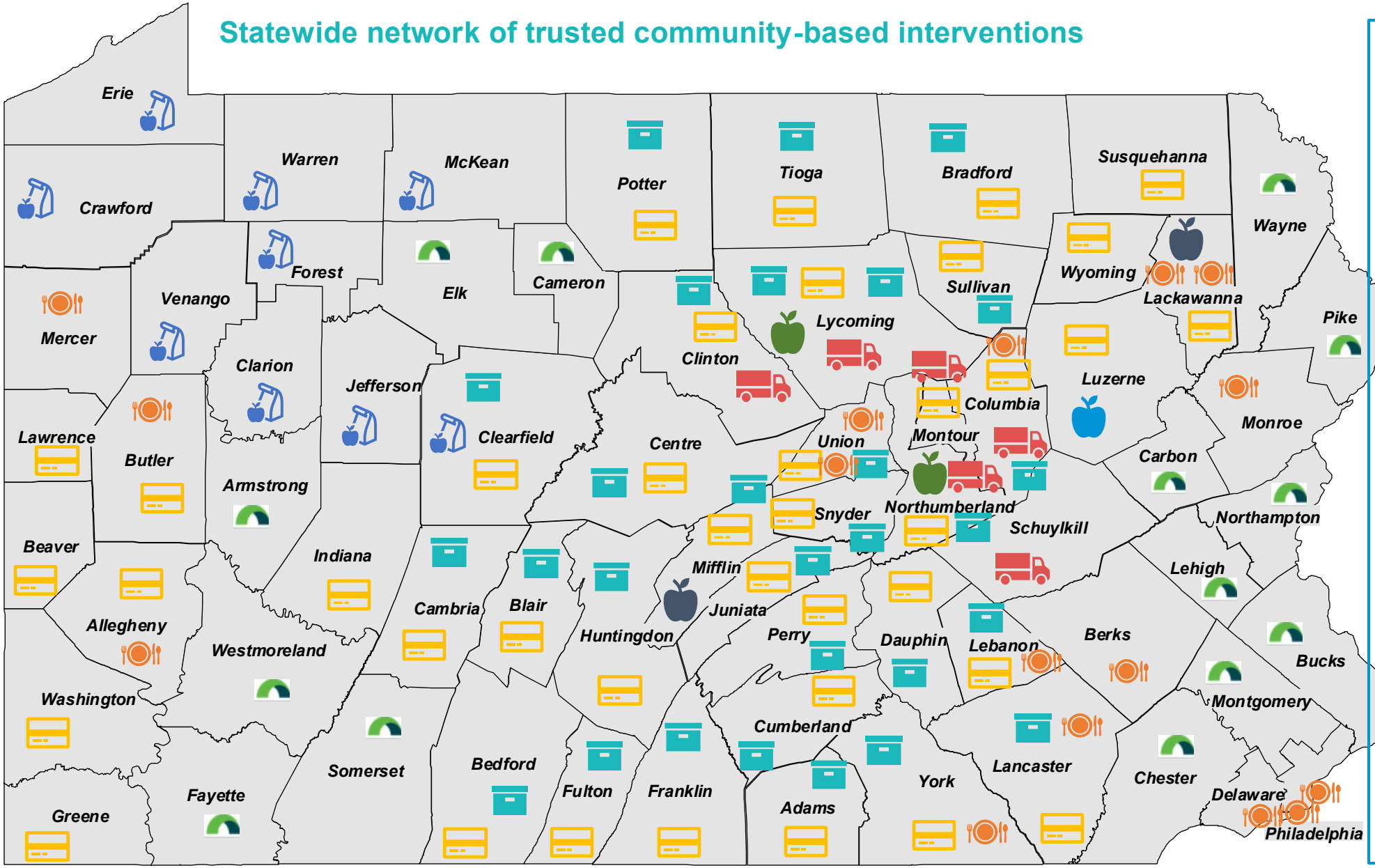
- Food
- Housing
- Utilities
- Transport
- Workforce
- Maternity
- Hygiene
- Health

State-wide:

- Neighborly
- Workforce & GEDWorks

Example: Food is Health Partnerships 2026

Statewide network of trusted community-based interventions



Food is Health Map Key

- Fresh Food Farmacy
- Fresh Food Farmacy Satellite
- Statewide Neighborly Food Resources– CBO Partnerships
- Neighborly PA NAVIGATE
- Fresh Food Farmacy Community
- Mobile Food Pantry – CBO Partnerships
- SNAP Enrollment Assistance
- Produce Express Distributions- CBO Partnerships
- Home Delivered Food Box Program- CBO Partnerships
- Trusted Network Community Partner

Social Needs Resource Hub

Empowering Health Through Social Resource Connections

Access to Care

- Launched in August 2025, is a team interacting telephonically, to connect members and patients to essential social services; rollout through 2026
- The team will call out within 72 hours to connect

Integration of Supports

- Support both the Clinical Enterprise and GHP

Empowerment of Individuals

- Enables individuals to confidently navigate and manage their social needs for better well-being

Innovation in Service Delivery

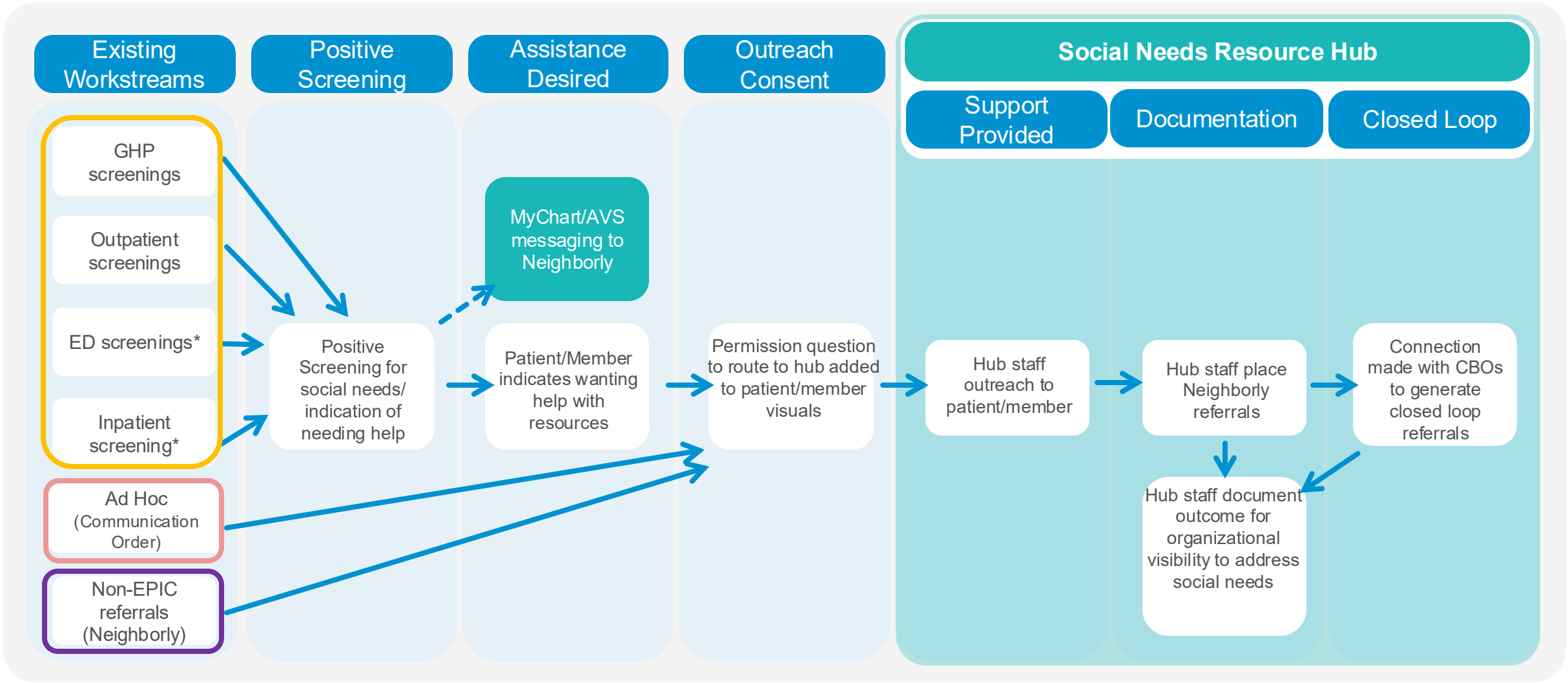
- Leverages existing technology such as Neighborly, EPIC Healthy Planet and community partnerships

Social Needs Addressed by the Hub

- Food
- Housing
- Transportation
- Medication
- Social Isolation*
- Safety
- Childcare
- Clothing
- Utilities
- Employment
- Emotional Wellness
- Internet**

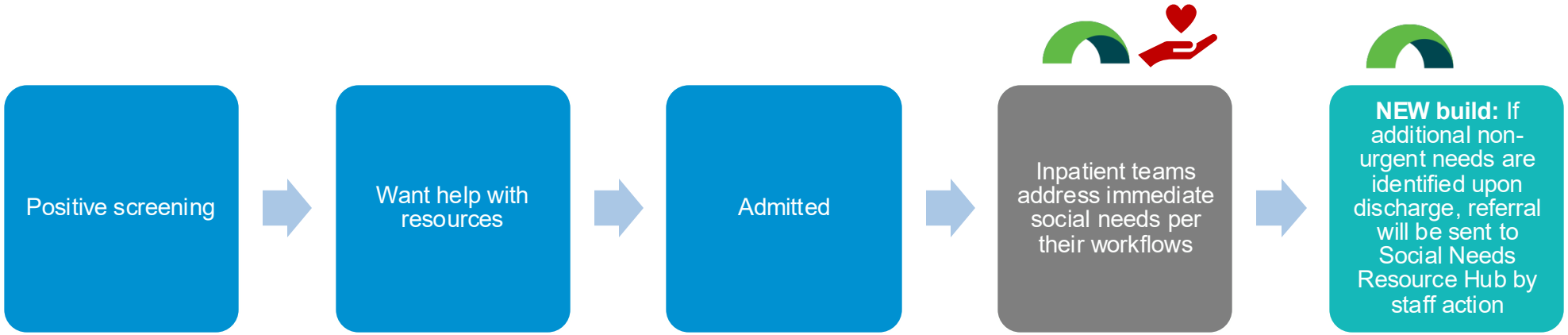
**adult only*
***household only*

Social Needs Resource Hub



*under development

Post discharge workflows



Key

CM intervention

Neighborly

Lessons Learned

- Identify a champion(s)
- Build data sets early
- Infrastructure is an evolution
- Develop a strong foundation of community-based organizations and programming
- Connection and referrals to community-based organizations is as important as screenings

Thank you

Geisinger

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No Disclosures

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CHF Nurse Navigator

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No Disclosures

Health Equity- Creating a Strong Foundation for Stratifying Data to Improve Health Outcomes

Naomi Benson and Vickie Robertson

NEA Baptist Memorial Hospital

Naomi Benson, RN, CEN

Professional Role:

Quality Performance Improvement Coordinator, Sepsis SME, VTE SME, Readmission Review

Nursing Experience:

20 years in Nursing: 4 years in Quality, 15 years ED RN, 4 Years Medical Surgical Nurse

Vickie Robertson, Heart Failure Navigator

Professional Role

Heart Failure Navigator at NEA Baptist since 2019.
Assist patients with disease understanding and home management.
Help patients secure grants for medication co-pays.

Nursing Experience

32 years of nursing experience.
22 years in Emergency Room Nursing.
Psychiatric Mental Health Nursing (inpatient and outpatient).

Accomplishments

Helped establish Arkansas's first LPN-to-RN program at NACC-Batesville.
Supported 10 graduating classes as Administrative Assistant.
Presenter at the 2018 ANA State Convention on Five-Level Triage.

Fun Facts

Former restaurant owner specializing in home cooking and specialty burgers, such as the Dorito Ranch Burger & Sunrise Burger, and weekend fried catfish.

Disclosures

None of the presenters today have relevant financial relationships(s) to disclose with companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products.

Learning Objectives

- Define health equity and describe how SDOH influence patient outcomes.
- Apply data stratification to identify potential disparities in quality and safety outcomes.
- Use risk assessment and PDSA methodology to prioritize and act on identified needs.
- Evaluate action-plan progress and communicate outcomes to key stakeholders.
- Discuss ways CHF Navigator can assist with addressing Social Drivers of Health/Health Related Social Needs

Introduction to Health Equity-

Moving from awareness to action through data, prioritization, and accountability.

NEA BAPTIST

Introduction to Health Equity

The What

According to the CDC, health equity is defined as the attainment of the highest level of health for all people.

In order to provide equitable care to all people, obstacles to healthcare that drive patients' outcomes. Non-medical factors, known as Social Drivers of Health (SDOH), have been shown to have an impact on patient outcomes.

Hospitals and healthcare facilities can help close the gap by stratifying social drivers of health and taking actions to improve health equity.

The Why

Alignment with Joint Commission- National Performance Goal 4- “The Hospital prioritizes excellent health outcomes for all.

Hospitals and healthcare facilities develop trust with patients and families, providing an opportunity to learn social drivers of health.

Develop ***patient centered care treatment*** based off medical, social, and economic needs

Align with Community Health Needs Assessment goals

Joint Commission
National Performance Goal 4: The hospital prioritizes excellent health outcomes for all.

- Designate an individual to lead activities
- Assess Health Related Social Needs (HRSNs) and provide information about community resources and support services
    - Examples:
        - Access to transportation
        - Ability to afford medications
        - Education and literacy
        - Food insecurity
        - Housing insecurity
- Stratify quality and safety data using the sociodemographic characteristics
    - Age
    - Gender
    - Preferred language
    - Race and ethnicity
    - Veterans
    - Rural communities
    - Physical, mental and cognitive disabilities

- Develop an action plan for at least one of the health care disparities identified
- Inform key stakeholders at least annually.

Creating a Health Equity Plan

- Designate accountable leadership and define committee oversight.
- Standardize screening workflow and escalation pathways.
- Complete a risk assessment to identify high-priority needs.
- Develop an annual action plan with goals, owners, and timelines.
- Evaluate progress and adjust interventions through continuous improvement.

Screening

- Develop a standardized workflow for screening
  - Who is going to screen? How is this information shared?

Social Determinants
Unable to afford food
Housing Instability
Inadequate Housing Utilities
Sheltered homelessness
Unsheltered homelessness
Social Isolation Concern
Transportation needs
Money taken/used without patient's permission
Insurance inadequate
Insurance none
Unable to afford medications

Example of NEA Baptist Memorial Hospital's screening tool:
- Completed by Case Management for inpatient admissions:

Risk Assessment

Step 1: Define the risk

Facility -Health Equity - Risk Assessment FY 2026															
Social Determinant of Health	Probability (4-0)					Risk to Patient's Health (4-1)				Current Systems/Preparedness (0-4)					Total
	Expect It	Likely	Maybe	Rare	Never	Severe- Can cause death	High- can cause hospitalization	Moderate- Can cause Outpatient Visits	Minimal- Does not impact hospitalizations	None	Poor	Fair	Good	Solid	multiply
Unable to afford food			2					2					1		4
Housing Instability			2				3				3				18
Inadequate Housing Utilities				1				2			3				6
Sheltered homelessness			2					2				2			8
Unsheltered homelessness			2				3				3				18
Social Isolation Concern				1					1			2			2
Transportation needs			2				3					2			12
Money taken/used without patient's permission				1				2					1		2
Insurance inadequate		3						2				2			12
Insurance none		3					3					2			18
Unable to afford medications		3				4						2			24

High	20-25
Mod	11-19
Low	0-10

In the above example, social drivers of health are assessed based on probability, risk and current systems. Based on the information provided, inability to afford medications would be the highest risk- indicating that this should be the next focus.

Action Plan

Step 2: Create the action plan, with key stakeholders' input

PERFORMANCE IMPROVEMENT REPORT ANALYSIS AND PLAN FOR IMPROVEMENT For Performance Measure: Health Care Equity 2026							
Date	**Topic**	**Summary of Problem/s Identified or Opportunity for Improvement**	**Goal**	**Plan/Study**	**Individual(s) Responsible for Action/s**	**Action (dates)**	**Follow-up evaluation of implemented plan**

At NEA Baptist Memorial Hospital, we utilized Plan, Do, Study, Act. A stoplight approach was utilized to determine progress. Actions, barriers, successes, etc. are discussed within the monthly Health Equity Committee. In addition, Health Equity is embedded into various quality and safety meetings throughout the organization.

Evaluation

Step 3: Evaluation of Previous Year (sometimes done prior to risk assessment)

NEA Baptist Memorial Health System

Health Equity Annual Evaluation- FY2025

Primary Driver	Goals	Evaluation methods	Goal Met	Questions to Ask / Comments

At NEA Baptist Memorial Hospital, we utilized a simple template to evaluate action plans from the previous year.

The evaluation helps identify areas that may need additional focus in the coming year. It is important to evaluate actions to determine their effectiveness, measure progress towards goals, and support continuous improvement efforts.

Getting Started: Practical Implementation Tips

- Start with one priority population, measure, or high-risk need.
- Make screening and referral steps clear for frontline staff.
- Build a resource list that is current, local, and easy to access.
- Use dashboards or committee reports to monitor trends over time.
- Celebrate progress and share patient-centered outcomes.

Health Related Social Needs in HFpEF/HFmrEF-

How the Heart Failure Navigator Identifies and Addresses Social Drivers of Health

NEA BAPTIST

Identifying Social Drivers of Health

- Transportation barriers.
- Medication Affordability.
- Health literacy challenges.
- Food Insecurities.
- Social Isolation
- Caregiver Support Needs

Benefit: Early identification enables timely intervention, improved care coordination, and reduced readmissions

HF Navigator Interventions to Address Health Equity Barriers

Care Coordination & Resource Connection

- Collaborates with CM, SW, providers, and Population Health teams
- Refers patients for APCM and outpatient care coordination
- Supports PCP and cardiology follow-up

Medication Access Support

- Assists with insurance navigation and affordability concerns
- Connects patients with available program and resources
- Recommendation to CM/SW for refers to Home Health, Population Health, and Outpatient Pharmacy

Benefit: Improves access to care and reduces financial barriers.

Patient Education, Empowerment and Community Resource Referrals

Provides individualized verbal and written HF education

- Uses teach-back and patient-centered communication
- Focuses on symptom recognition, daily weights, medication adherence, and sodium reduction
- Connects patients to food assistance, caregiver resources, and community services
- Collaborates with CM/SW and local food bank partners

Benefit: Empowers self-management while addressing social needs that impact outcomes.

Impact on Health Equity

- Improved access to care
- Improved medication adherence
- Increased patient engagement
- Reduced care gaps
- Reduced risk of readmission
- Improved quality of life

Benefit: Helps ensure patients have the resources, support, and education needed to achieve optimal outcomes.

References

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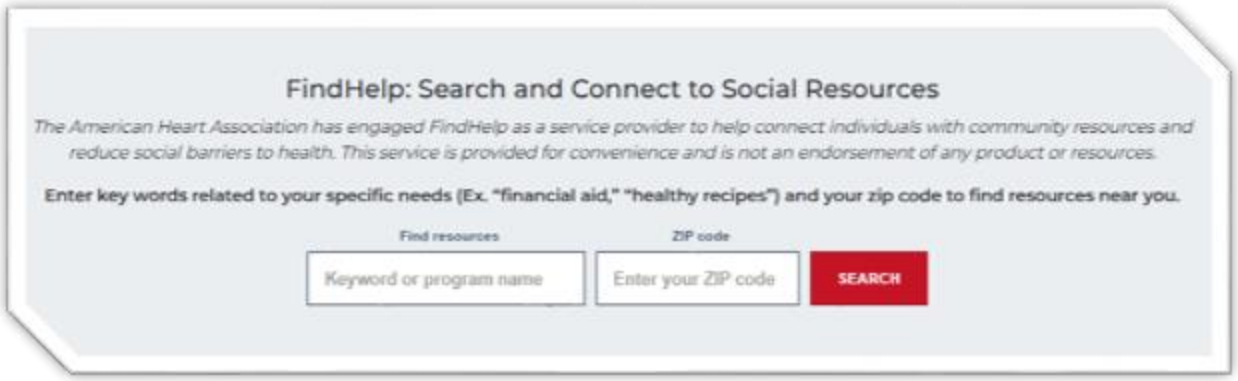
Questions?

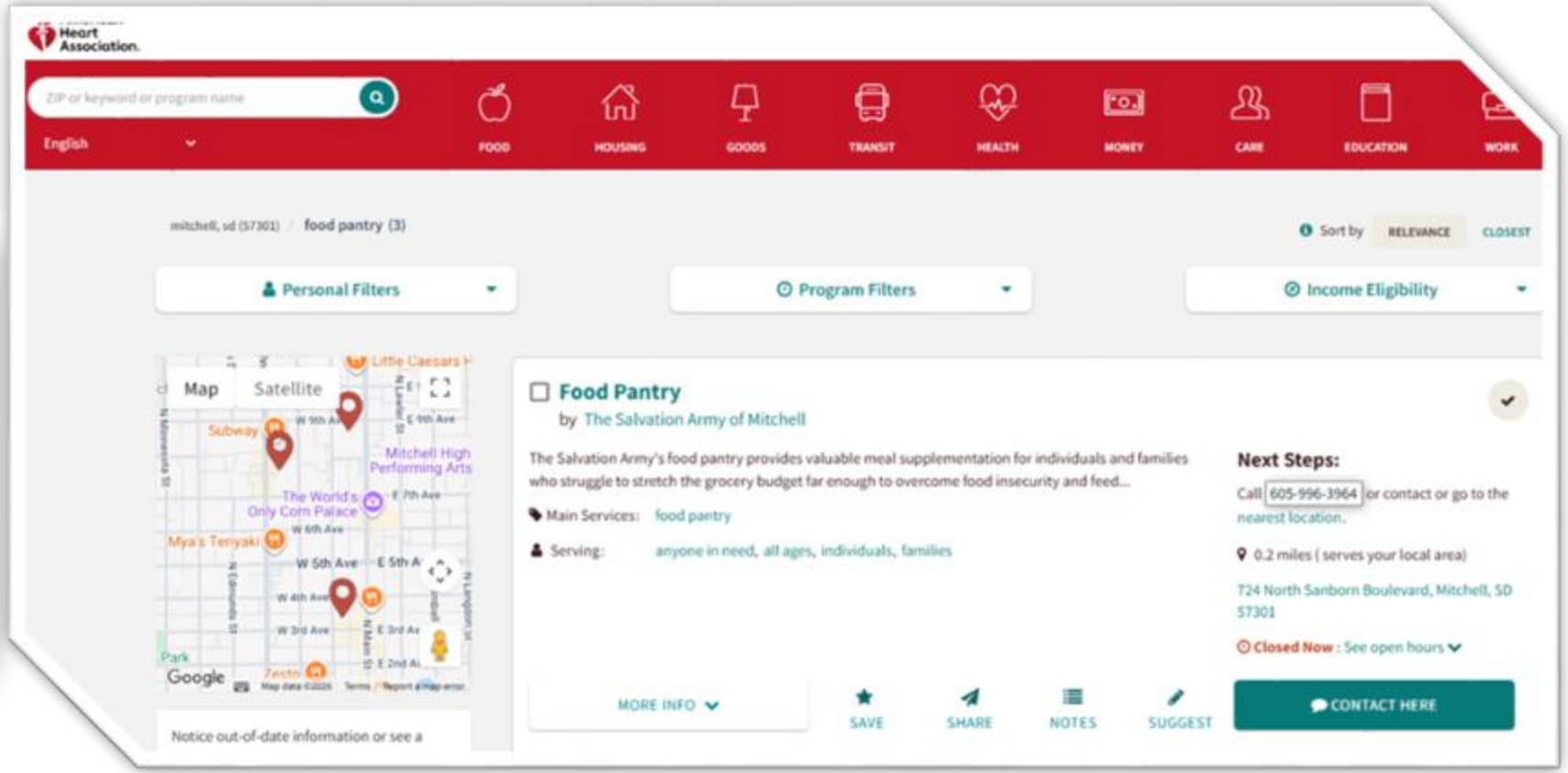
American Heart Association.

AHA FindHelp is a free online resource provided by the American Heart Association that helps people locate community services and support programs in their area. The platform, powered by FindHelp, connects users to resources that address social and health-related needs by searching with a ZIP code and keywords.

Your Health Roadmap

Use FindHelp today to search for financial, legal, transportation and other aid. A free resource to guide your path to a healthier, happier you!





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2nd Annual Healthcare Professional Connection Forum

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HFSA 2026

Oct 9-Oct 12, 2026
Phoenix, AZ

AHA Scientific Sessions 2026

Nov. 7-9, 2026
Chicago, IL

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Thank You.

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