COMMUNITY BENEFIT REPORT 2025

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2025 Update

Enhancing the Health of Our Communities

Grady remains committed to making a lasting impact in critical health areas in the greater Atlanta community.

Our Mission

At Grady, we are dedicated to improving the health of the communities we serve across greater Atlanta. Access to high-quality care remains the foundation of a healthy community, and in 2025, Team Grady reaffirmed its commitment through innovative programs, strong partnerships, and targeted investments.

Achievements in 2025

In 2025, Grady completed the final year of its 2023–2025 Community Health Improvement Plan (CHIP), building on prior efforts to deepen impact across key priority areas. Over the past year, we made measurable progress in expanding access to care, strengthening care coordination, and addressing social and economic drivers of health.

Grady also conducted its 2025 Community Health Needs Assessment (CHNA) in collaboration with regional partners. Through the Atlanta Regional Collaborative for Health Improvement (ARCHI), Grady aligned its strategies with shared priorities, including Care Coordination, Healthy Behaviors, Access to Care, and Family Pathways to Advantage.

This report highlights key accomplishments from 2025 while reflecting on the collective progress achieved over the full three-year CHIP cycle. It showcases the impact of our programs, the partnerships that made this work possible, and the outcomes that continue to shape a healthier future for our community.

Key Performance Indicators

High Quality Care For All

Grady is the largest hospital in Georgia with

953 Licensed Beds

10 Grady Neighborhod Health Centers

804,868+
Patient Visits per Year

9,144 Total Staff

174,360
Emergency Department Visits

3,753 Births

Grady EMS responded to

216,658+ 911 Calls

19,640 Urgent Care Visits

25%
of all Georgia Physicians Received some of their training from Grady

413,490
Specialty Clinic Visits

210,841
Neighborhood Health Center Visits

Priority Solutions

We embody the spirit of collaboration in our community benefit work

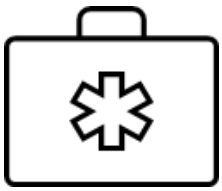
Grady participates in a collaborative Community Health Needs Assessment (CHNA) process with other health systems every three years. We prioritize solutions that align with ARCHI's health improvement strategies: Care Coordination, Healthy Behaviors, Innovating Care Delivery, and Social & Economic Impact.

CARE COORDINATION

Care coordination efforts work to ensure that all providers, both within a health care system and throughout the community, are working together to provide high quality, effective care.

HEALTHY BEHAVIORS

Grady's CHNA identified hypertension, diabetes, injuries, and violence as priorities best addressed through behavior change. Through innovative new programs and services, Grady is equipping patients to better manage chronic diseases.



INNOVATING CARE DELIVERY

Grady continues to improve access to care by narrowing insurance coverage gaps, offering mobile health services, online appointment scheduling, virtual on-demand care, and expanding outpatient clinics.

BEYOND HEALTH: SOCIAL & ECONOMIC IMPACT

Grady is essential to the economic vitality of our city and region. As one of the largest health systems in the region, Grady's extensive purchasing power provides financial benefits to many other businesses, contributing to the region's economic success.

Care Coordination

Turning Care Into Action.

Social Determinants of Health (SDOH) Screening

Grady continues to prioritize identifying social determinants of health (SDOH) to better understand and address patients' needs across the health system. In 2025, efforts focused on expanding screening in inpatient settings while maintaining strong performance in outpatient care.

System-Wide Progress

In 2025, Grady exceeded system-wide screening goals, reaching 89% in outpatient settings and 65% in inpatient settings. This marked a 10% increase from 2024, enhancing Grady's ability to identify patients with social needs across care settings.

Clinics Implementing SDOH Screening	**38**
Patients Screened for SDOH	**121,572**
Employees Trained	**350+**

SCREENING PERFORMANCE VS. 2025 GOAL

Setting	Goal	Actual
Outpatient	85%	**89%** ✅
Inpatient	60%	**65%** ✅

Screening results were used to identify patients with unmet social needs and inform referrals to appropriate community resources.

Care Coordination

Connecting Patients to Resources

TRANSITION TO FINDHELP

In 2025, Grady transitioned from Unite Us to FindHelp, implementing a unified referral platform across hospital and outpatient settings. The system was fully deployed by mid-year and enabled coordinated, closed-loop referrals to community-based services addressing patients' social needs.

357 Staff Users

400 Staff trained to Use FindHelp

3,955 Visits the Grady's FindHelp Site

2,243 Referrals Made (July-Dec 2025)

Expanded platform adoption increased referral activity and improved patient connection to community-based services.

The transition to FindHelp strengthened Grady's system-wide capacity to connect patients to community resources. Referrals were informed by SDOH screening results and connected patients to resources addressing identified needs.

These supports reduced immediate barriers to care and helped ensure patients could access medical appointments and essential services.

findhelp

Care Coordination

Connecting Patients to Resources

To help support resource connection, we partnered with community organizations or utilized grant funding to expand resource access.

COMMUNITY PARTNERSHIP IMPACT (ARCHI)

In 2025, Grady continued its work with the Atlanta Regional Collaborative for Health Improvement (ARCHI) on two Community Resource Hub Pilot projects. Grady expanded programs focused on chronic disease management and healthy aging by connecting patients to nutrition, education, and support services.

- 50 SENIORS ENROLLED IN HEALTHY AGING PROGRAM
- 50 PATIENTS ENROLLED IN HYPERTENSION HUB PROGRAM

archi

DIRECT PATIENT SUPPORT

Grady also provided direct assistance to address immediate social needs identified through screening. Patients screening positive for food insecurity received grocery vouchers, with approximately **300 vouchers distributed in 2025.**

Additionally, grant funding supported **141 MARTA transportation vouchers** for patients experiencing transportation insecurity, helping ensure access to medical appointments and services.

Healthy Behaviors

Preventing Violence and Injury Across the Community

Grady's trauma and injury prevention programs address violence and injury through a continuum of care, including hospital-based intervention, community education, and long-term recovery support. In 2025, Grady delivered multiple injury prevention initiatives serving youth, adults, and families impacted by violence and trauma.

CENTERS, TRAININGS AND PROGRAMS OFFERED IN 2025

- Interrupting Violence in Youth & Young Adults (IVYY)
- Trauma Recovery Center (TRC)
- Community Injury Prevention & Education
- Stop the Bleed Training

Community Reach

3,368 Community Contacts

54 Injury Prevention Events

700 Individuals Trained in Stop the Bleed

120 Education Events

3,000 Community and Staff Trained

These efforts expanded community awareness and prevention skills to reduce injury and violence across metro Atlanta.

Supporting Recovery After Injury

Grady's Trauma Recovery Center (TRC) provides ongoing support to patients experiencing intentional injury, including care coordination, behavioral health services, and community resource connections.

- 2,638 ENCOUNTERS DELIVERED
- 291 PATIENTS SERVED
- EXPANDED TO INCLUDE CLAYTON COUNTY RESIDENTS
- 2.4% REINJURY RATE

TRC services help stabilize patients after injury and reduce the likelihood of repeat violence.

Across programs, Grady maintained low reinjury rates, with **3.4% in IVYY** and **2.4% in TRC**, demonstrating the effectiveness of coordinated intervention and recovery services.

Healthy Behaviors

Advancing Health. Empowering Communities.

Interrupting Violence in Youth and Young Adults (IVYY) Program

The IVYY Project is a hospital-based violence intervention initiative committed to disrupting cycles of community violence through trauma-informed care, advocacy, and long-term support. Housed within Grady Memorial Hospital, the program engages patients at the bedside following violent injury and provides ongoing support during recovery and reintegration.

IVYY PROJECT
INTERRUPTING VIOLENCE IN YOUTH AND YOUNG ADULTS

THE IVYY PROGRAM HAS THREE PILLARS:

- Bedside Response
- IVYY Clinic
- Circle of Safety

2025 Enrollment Summary

573 Bedside Consults

336 Patient Enrollments

58.6% Patient enrollment

2025 Patient Profile

86% Male Participants

96% Black/African American

22 y/o Median Patient Age

IVYY Program's reinjury rate remains well below the national average, at 3.4%, reflecting success in reducing repeat violent injury.

IVYY's data reflects the disproportionate burden of violence experienced by young Black men in Atlanta and reinforces the program's vital role in reaching individuals during a vulnerable and formative period of life. Additionally, it continues to highlight the importance of culturally responsive, community-centered interventions that not only address physical injury but support long-term healing and community reinvestment.

In 2025, IVYY continued strong partnerships with government agencies, research institutions, and community coalitions.

The Fulton-DeKalb Hospital Authority — Owner of Grady Health System
DeKalb County GEORGIA
Georgia State University
EMORY UNIVERSITY
HAVI
BUILDING A SUSTAINABLE FUTURE
BJA
EVERYTOWN FOR GUN SAFETY
KAISER PERMANENTE
CITIES UNITED
Grady

Healthy Behaviors

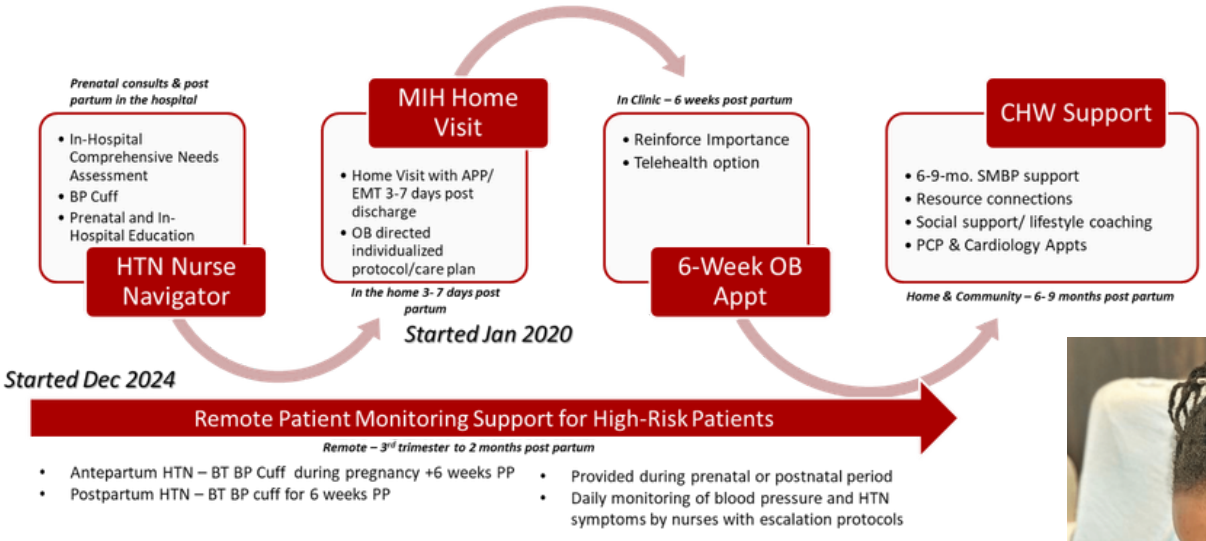
Addressing Maternal Health and Postpartum Care

In 2025, Grady's women's services continued to address maternal mortality and improve care for high-risk pregnancies. Grady is addressing maternal health outcomes by targeting hypertensive disorders, a leading cause of complications during pregnancy and postpartum care.

According to the National Perinatal Information Center (NPIC), in 2025, **51% of deliveries at Grady had hypertension, and 79% of postpartum readmissions were a result of a hypertension diagnosis.** These data underscore the significant impact of hypertensive conditions on maternal health and the need for coordinated, system-level interventions.

To address these challenges, Grady implemented a comprehensive obstetric hypertension program designed to support patients across the full continuum of care. This model integrates inpatient care, care coordination, home-based services, and community support to ensure continuity of care from delivery through postpartum recovery.

Comprehensive Obstetrical Hypertension Care



These initiatives have resulted in 1,318 hypertensive nurse navigator encounters and 1,513 OB hypertensive Mobile Integrated Health (MIH) referrals in 2025. Grady Women's Health Center will continue a systematic approach to providing comprehensive and equitable care for all patients.

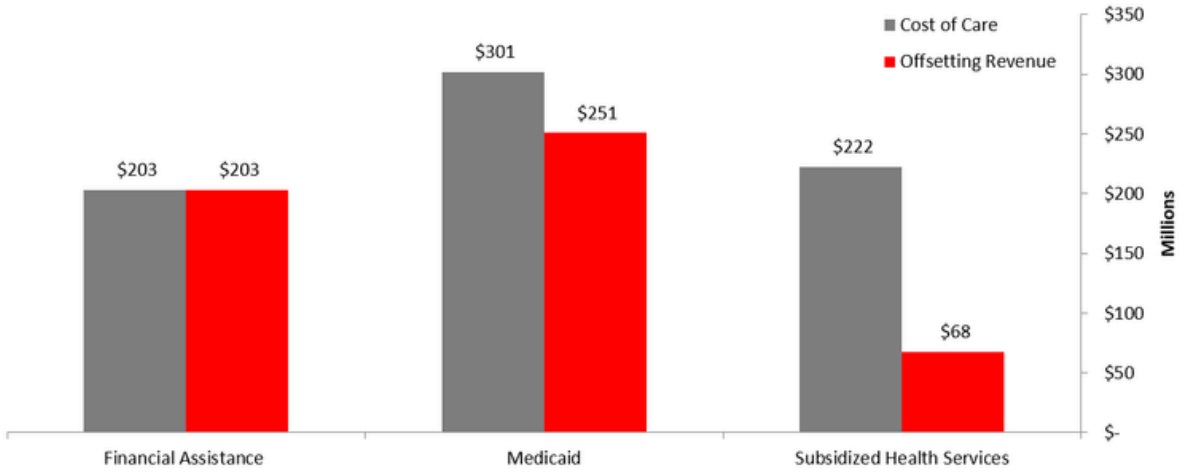
BABY-FRIENDLY DESIGNATED FACILITY
Grady

Innovating Care Delivery

Caring Beyond the Clinic Walls

Financial Assistance & Uncompensated Care

Since our founding, Grady's mission has been to provide excellent care to anyone who enters our doors. In 2024[1], Grady provided more than **$726 million** in care to our uninsured and low-income neighbors. Medicaid reimbursement and the Indigent Care Trust Fund covered **72% of these costs**, while the remaining **$205 million** was a shortfall that Grady had to cover.



Public Benefits Enrollment

In 2025, Grady completed Medicaid enrollment for an estimated **5,491 patients (4,238 for medical/surgical services and 1,253 for OB/newborn services).** While this reflects a slight decrease compared to 2024, Grady continued to support thousands of patients in securing insurance coverage, improving access to care, and helping reduce the burden of uncompensated services.

Grady continued to refer patients to the Atlanta Community Food Bank and Open Hand for assistance with SNAP enrollment.

These efforts play a critical role in expanding healthcare access, improving continuity of care, and strengthening financial stability for patients and the health system.

ATLANTA COMMUNITY FOODBANK

Open Hand

archi
Atlanta Regional Collaborative for Health Improvement

[1] COMMUNITY BENEFIT EXPENSES ARE REPORTED ON TAX FORMS SUBMITTED AT THE END OF THE FOLLOWING FISCAL YEAR. THUS, 2024 EXPENSES WERE FINALIZED AT THE END OF 2025 AND ARE INCLUDED IN THE 2025 COMMUNITY BENEFIT REPORT.

Innovating Care Delivery

Caring Beyond the Clinic Walls.

Virtual on Demand Visits

Grady's Virtual On Demand (VOD) Clinic expands access to care by providing same-day, video-based visits for patients with common, low-acuity health conditions. Through this model, patients can receive timely care for conditions such as minor infections, hypertension management, and medication refills without needing to travel to a clinical site, helping reduce barriers related to transportation, mobility, and time constraints.

The VOD Clinic also supports care coordination across the health system by allowing clinics to direct lower-acuity patients to virtual care, enabling in-person providers to focus on higher-complexity cases. Visits are conducted through the MyChart platform and are designed to complement primary care services by ensuring appropriate triage, follow-up, and referral when in-person care is needed.

2025 Highlights

6,289 Patient Served

500+ Clinic Visits per Month

2025 Highlights

10 Staff Members

93% Press Ganey Patient Satisfaction Score

Through its virtual care model, the VOD Clinic enhances access to timely services, strengthens continuity of care, and helps reduce strain on in-person clinical settings, contributing to a more flexible and patient-centered system of care delivery.

Expansion of Outpatient Clinics

In 2025, Grady continued to expand access to care through the development of new clinic sites and community-based services designed to meet the needs of the underserved and growing populations. These efforts focused on increasing access to primary care, addressing geographic gaps in service availability, and improving health outcomes in areas with limited healthcare infrastructure.

Innovating Care Delivery

Caring Beyond the Clinic Walls.

During the year, Grady opened t**wo new Neighborhood Health Centers** (NHCs), bringing the system **total to 10 NHCs**. These new sites increase access to primary care services across the DeKalb area and support Grady's ability to serve patients in communities that are close to their homes.

These sites provide critical access points for patients who may otherwise face barriers to care, including transportation challenges and limited availability of nearby providers.

Facility Name	Patients Encounters
Candler	124
Flat Shoals	575

Opened Dec 2025

EXPANDING ACCESS IN UNDERSERVED COMMUNITIES

Grady continued to advance plans for a freestanding emergency department in South Fulton, an area identified as a healthcare desert due to limited access to hospital-based and emergency services. Following the closure of nearby hospitals, many residents in this region face extended travel times for urgent and emergent care. The development of a freestanding emergency department is intended to improve timely access to emergency services, reduce strain on Grady's main campus, and address longstanding disparities in healthcare access.

Opening Soon

Grady also expanded specialty services through the establishment of the **Grady Wound and Hyperbaric Center in the Correll Pavilion**, addressing a critical gap in care for patients requiring advanced wound treatment and limb preservation services. This clinic provides access to specialized care that was previously limited for many patients within Grady's service area.

Innovating Care Delivery

Caring Beyond the Clinic Walls.

Mobile and Community-Based Care Delivery

Grady continues to expand access to care beyond traditional clinical settings through mobile health services, home-based care, and remote patient monitoring programs. These models are designed to improve access for patients experiencing barriers to care, including transportation limitations, geographic gaps in service availability, and unmet clinical needs in underserved communities.

Mobile Screening Services

In 2025, Grady advanced its strategy to expand access to primary care through the development of a Mobile Primary Care Unit. This unit is designed to deliver comprehensive primary care services directly within underserved communities, including chronic disease management, preventive screenings, vaccinations, laboratory services, and health education.

The Mobile Primary Care Unit is being deployed in partnership with community organizations to reach populations with limited access to primary care. This model focuses on engaging patients who are not actively connected to care, including individuals without an established primary care provider and those who frequently rely on emergency services for non-urgent conditions.

Mobile Integrated Health (MIH)

Grady Health System launched the innovative Mobile Integrated Health program in 2013 to reduce hospital admissions and improve the quality of patient care. MIH provides a comprehensive range of services, including home visits, remote patient monitoring, annual wellness visits, 911 mobile crisis response, and mobile screening services.

Program data demonstrate measurable clinical improvements, including significant reductions in blood pressure and improvement rates exceeding 80% among postpartum patients, reflecting strong engagement and effectiveness of the monitoring model.

Innovating Care Delivery

Caring Beyond the Clinic Walls

Addressing Access to Mental Health Services at Grady

In 2025, the Grady Behavioral Health Department team achieved significant milestones in community-focused care. In January, they opened the Center for Diversion. This effort was made jointly with the City of Atlanta, Fulton County, Georgia Justice Project, Policing Alternatives and Diversion, and Crossroads Community Ministry. Integrated Behavioral Health also expanded, with the opening of 2 new neighborhood health centers. Additionally, a licensed therapist was added to the OB clinic at Grady to support delivering mothers and postpartum women. The coordinated care model improves patient outcomes, increases patient engagement, and addresses social determinants of health.

Housing Support

Additionally, the Housing Support Team provided:

- 326 patients received housing support
- 300 maintained permanent housing
- 37 transitioned from homelessness to housing
- 47 newly enrolled
- 6 individuals into emergency housing

They also participated in a forum hosted by Emory Healthcare, Project HEAL, and Partners for HOME. This forum brought together leaders and practitioners from local homeless shelters and hospital systems to collaboratively address the barriers to stable housing after discharge. A dedicated case manager has been hired to focus on individuals with complex needs, including behavioral health and medical.

Behavioral Health has formed a partnership with Accessible Suite Clairmont LLC, a housing provider that offers handicap-accessible rentals. They have also teamed up with a local organization, Making a Way, which provides emergency shelter, transitional housing, and permanent supportive housing.

In collaboration with Fulton County and the Department of Behavioral Health and Developmental Disabilities (DBHDD), the Behavioral Health Crisis Center in South Fulton celebrated its one-year anniversary on October 31, 2025. Over the past year, the center has reached full capacity, operated an emergency receiving system 24/7, and provided 24 crisis stabilization beds. Additionally, there are 16 temporary observation spaces and a living room dedicated for peer support.

Innovating Care Delivery

Caring Beyond the Clinic Walls

Cancer Center

In 2025, the Grady Cancer Center made remarkable progress in advancing equitable cancer care through innovative programs, strategic partnerships, and a deep commitment to community engagement. By prioritizing access, educational enrichment, and culturally responsive support, the Center led the state in breast and cervical cancer screenings, expanded its genetics and colorectal cancer initiatives, and hosted impactful community outreach events to reach historically underserved populations. In 2025, the Georgia Cancer Center for Excellence continued to treat cancer fearlessly, while embracing the holistic approach to cancer care – one that addresses the medical, social, and mental needs of patients and their families through every stage of the cancer journey.

Cancer Center 2025 Success:

Breast & Cervical Cancer Program (BCCP)	• State partnership expanding cancer screening access • 17550 mammogram screenings, 14.70% increase from 2024
Genetics Program Growth	• Grady Genetics Clinic completed 1303 genetic evaluations between September 2024 and December 2025 • 5% of patients who underwent genetic evaluations were found to have a cancer-related gene
ACS Gentech SDOH Grant	• Patients received 2, 1.5 hour sessions with a cancer dietician • 55 patients enrolled in the program, and enrolled in a 1-year long food stipend through the Neighbor Program
BC NiCE program	• Breast and Cervical Navigation in Communities for Equity, collaboration with Morehouse School of Medicine and Black Women's Health Imperitive • Understanding barriers to treatment in Black in Latina women in Georgia • 55 interested participants
Community Partnerships	• Linking patients to free local support services • Collaborated with over ten trusted organizations - local nonprofits and advocacy groups
CTC-GEP	• Clinical Trials and Genomic Education Program, funded by the National Institue of Health • Discussion of Black and minority population involvement in research and addressing ethical concerns

Innovating Care Delivery

Caring Beyond the Clinic Walls

Cancer Center

In 2025, the Cancer Center tapped into diverse funding sources for various types of cancer. This collaboration with various national and community-based grants enabled resources to continue flowing to patients. The following highlights a few key grant sources:

- American Cancer Society
- Black Women's Health Imperative
- McKesson
- Lois and Lucy Lampkin Foundation
- Komen
- YWCA

In addition to quality clinical care, the Cancer Center provided holistic mental health services for their patients. The following are two key programs designed to address and improve mental health among cancer patients:

- **Life Care Specialist Program**
  - Opioid education, prevention, and mental wellness strategies to support patients in managing pain safely and effectively.
- **Behavioral Health Therapy**
  - Compassionate, patient-centered care to individuals navigating the emotional and psychological impact of cancer

Circle of Strength Support Group

Cancer and Spirituality Group

Social & Economic Impact

INVESTING IN HEALTH. INVESTING IN HOPE.

Food as Medicine

At Grady, patients who have been identified as having uncontrollable diabetes or are hypertensive can take part in our Food as Medicine program. In this program, patients can receive fresh produce, nutritional guidance, and cooking classes.

In 2025, the Food as Medicine program at Grady made significant strides in addressing food insecurity and improving patient health outcomes. A notable highlight was the expansion of the Atlanta Community Food Bank Partnership through the launch of the Neighbor Program in February 2024. This program serves as a continuation of support for graduates from our Food as Medicine (FAM) initiative, ensuring that individuals who have completed FAM can continue receiving fresh produce and assistance in tackling food insecurity. The Neighbor Program specifically targets food-insecure patients who do not suffer from uncontrolled diabetes or hypertension, tailoring our approach to meet diverse community needs.

Food as Medicine 2025 Success:

6,374
total patient visits

19%
increase in teaching kitchen attendance

199,934 lbs.
of fresh produce distributed

2%
decrease in A1c levels

197
cooking classes held

129
Teaching Kitchen Volunteers

208
Fresh Food Cart Volunteers

42%
increase in patient referrals

86%
fresh produce distributed

20%
increase in enrollment

Social & Economic Impact

INVESTING IN HEALTH. INVESTING IN HOPE.

Supplier Investment and Economic Impact

Grady's commitment to community health extends beyond clinical care through its investment in local and small businesses. Strategic sourcing and procurement practices are used to strengthen the economic health of the communities Grady serves and support inclusive economic growth.

In 2025, Grady directed more than **$208.1 million** in spending to a broad range of suppliers, representing **27.44%** of total procurement. This includes **$97.5 million** in spending with certified minority- and women-owned businesses and **$110.6 million** across additional small and locally based business categories, reflecting the scale and reach of Grady's supplier network.

Grady partners with vendors across multiple industries, including healthcare, construction, professional services, and technology, ensuring that businesses of varying sizes and backgrounds have opportunities to participate in the health system's operations.

These investments support local economic development, create opportunities for small and underrepresented businesses, and contribute to broader community stability by strengthening the local business ecosystem.

$208.1 Million **Total Spend**
$97.5 Million MBE & WBE **Total Spent**
$110.6 Million **Additional Suppilers** **Total Spend**
27% **Diverse Supplier Utilization**

Social & Economic Impact

INVESTING IN HEALTH. INVESTING IN HOPE.

Health Outcomes

Grady Hospital's Office of Health Outcomes (OHO) is dedicated to investigating and reducing health disparities at Grady Hospital and in the communities Grady serves. The OHO developed a strategic plan to establish a set course of action to reduce the health equity gap among those we serve. This strategic plan is for 2022-2027 and has four priority pillars.

Office of Health Outcomes Accomplishments in 2025

CARE QUALITY

Improve Clinical Outcomes

- Health Equity Dashboard
- Increased cancer screening rates across breast, cervical, colorectal, lung, and prostate measures from 2023 to 2025
- Health Equity Access Coordinators (HEAC)

COMMUNITY ENGAGEMENT

Expand Community Outreach Programs

- Health and Career Experience and Exposure Programs
- Community Programming
- Introduced 8 different screening services at community events to increase early detection

CROSS CULTURAL EMPATHY

Improving Patient Understanding and Engagement

- Launched a health literacy initiative, screening **1,000+ patients** in the Emergency Department and **400+** individuals in the community
- Workforce Development
- Staff Education & Training

SOCIAL JUSTICE/ADVOCACY

Addressing Social Drivers of Health

- Expanded community-based care delivery through partnerships with over **100 organizations**
- Advanced workforce development through the Teen Experience and Leadership Program, **serving 686 students in 2025**

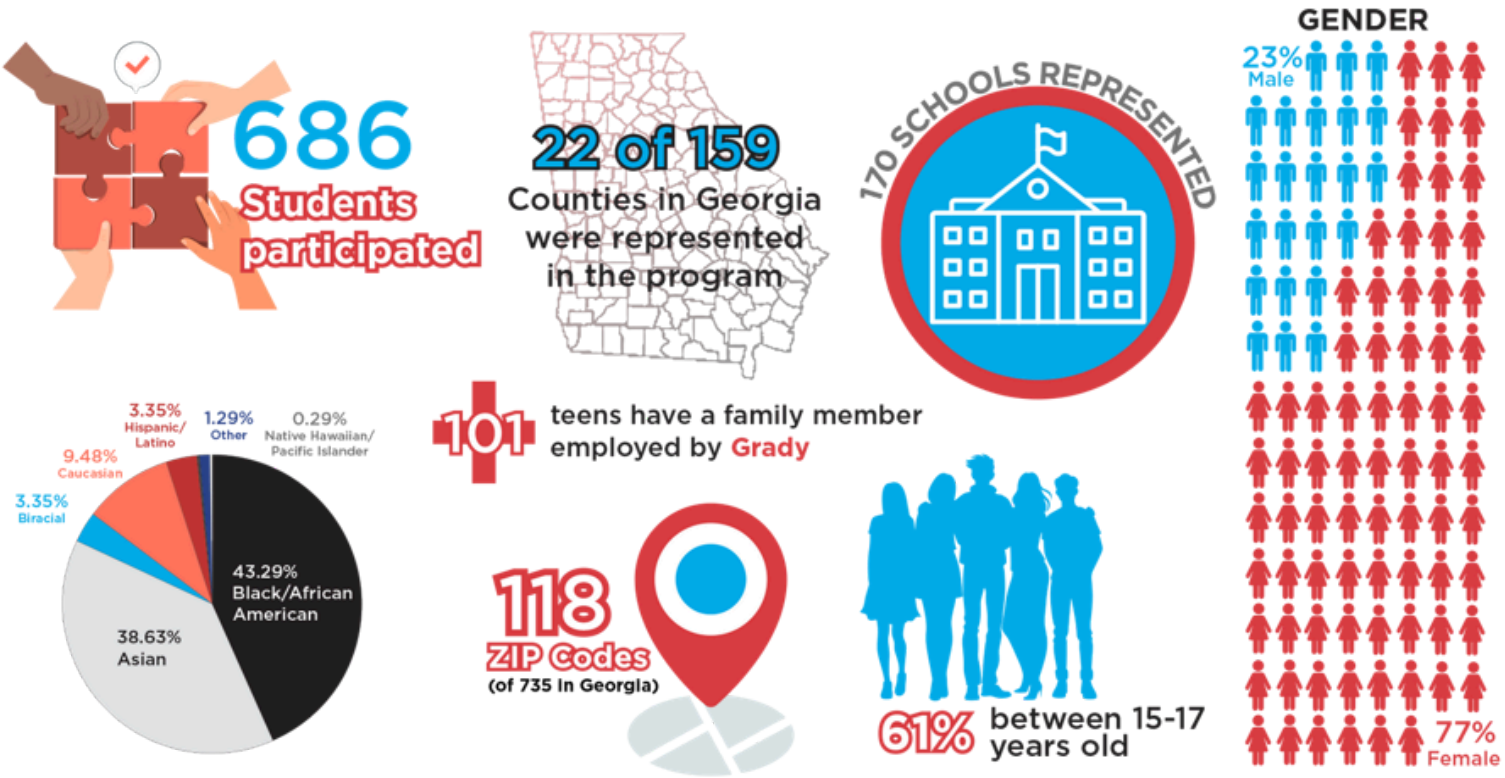
Health outcomes remain a foundational priority for Grady Health System, and the Office of Health Outcomes continues to drive meaningful change and deliver notable accomplishments across each pillar of priority.

Social & Economic Impact

INVESTING IN HEALTH. INVESTING IN HOPE.

Teenage Experience and Leadership Program (TELP)

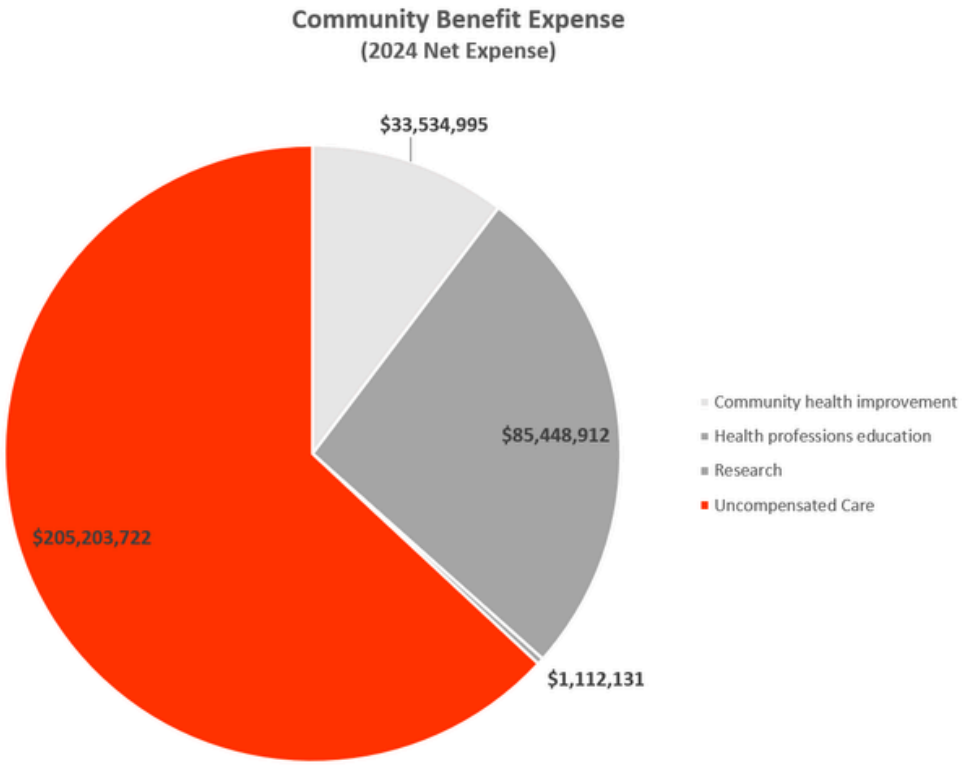
In 2025, the Office of Health Outcomes continued its successful Teen Experience and Leadership Program (TELP). TELP engages high school teens who are interested in learning about and gaining experience in the healthcare field. TELP is a seven-week program in which teens can shadow clinical and non-clinical units at Grady Hospital. In this, the participants gain exposure to and experience with the activities and skills involved in a health care worker's daily schedule.



Community Benefit by the Numbers

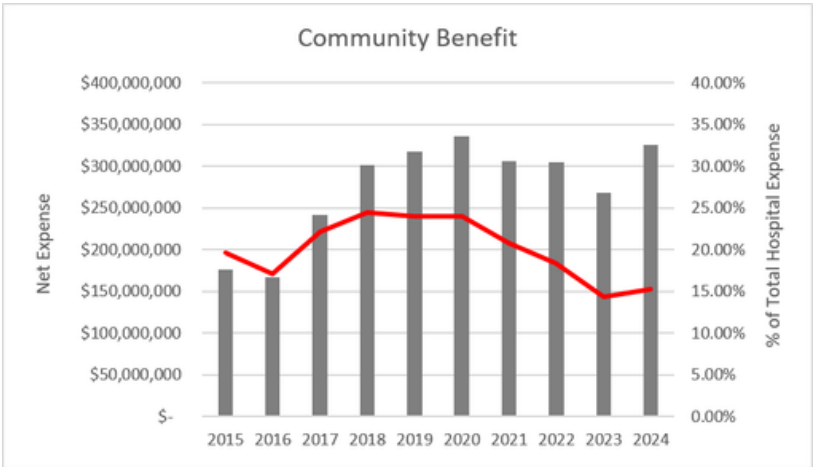
Making Every Investment Count

In 2024, Grady provided more than $890 million in Community Benefit services. Grady's net Community Benefit, which totaled more than $325 million, accounted for 15% of total health system expenses.



Key Indicator

Community Health Improvement	Includes the cost of services to improve access to care or enhance the public's health. Grady's CHNA informs new activities in this category.
Health Professions Education	Includes the unreimbursed cost of operating a teaching institution. Grady is a training site for two medical schools and various other health professions programs.
Research	Includes the costs of medical research conducted by Grady and the indirect costs of research conducted by partner institutions at Grady.
Uncompensated Care	The cost of care provided to patients that remains unreimbursed, including financial assistance, Medicaid shortfalls, and other subsidized services. Grady's bad debt is not included.



Conclusion

Improving Lives Today for a Better Tomorrow.

The 2025 Community Benefit Report reflects Grady Health System's continued commitment to improving access to care, advancing health outcomes, and strengthening the communities it serves. Through strategic investments, innovative care models, and strong partnerships, Grady continues to address critical health needs and reduce disparities across the region.

Expanding Access to Care

- Opened new outpatient clinics in underserved areas of Fulton and DeKalb counties
- Increased access through virtual care, mobile health, and home-based services
- Completed Medicaid enrollment for over 5,400 patients

Advancing Health Outcomes

- Expanded preventive screening efforts across multiple conditions, including cancer and chronic disease
- Conducted health literacy screenings for 1,400+ individuals to improve patient understanding and care engagement
- Strengthened maternal health outcomes through coordinated care and remote monitoring programs

Strengthening Community Partnerships

- Invested $208.1 million in local and small business suppliers, representing 27.44% of procurement spend
- Expanded partnerships with over 100 community organizations to increase outreach and service delivery
- Engaged 686 students through workforce development and education programs

Responding to Emerging Needs

- Expanded behavioral health services, including diversion and crisis stabilization programs
- Delivered integrated mobile, home-based, and remote care to high-risk populations
- Advanced development of new access points, including the South Fulton Emergency Department

Grady Health System remains steadfast in its mission to serve with compassion, innovation, and equity. As we look toward 2026 and beyond, we reaffirm our commitment to improving lives and building a healthier, more just future for all.