



COMMUNITY BENEFIT REPORT 2016-2019

2018 Update

At Grady, our care, expertise, and innovation go beyond hospital beds and clinic rooms. We are committed to providing high quality services for our patients, as well as enhancing the health of our community. We are continually innovating to improve care for today's patients and for those who will become our patients, for our neighbors managing hypertension day-to-day and those who are fighting for their lives after catastrophic injury, and for patients with financial and social support, and for those without.

Our Community Benefit work is driven by our commitment to the collective impact model of the Atlanta Regional Collaborative for Health Improvement (ARCHI). Since ARCHI's inception, Grady has participated in the collaborative Community Health Needs Assessment (CHNA) process with other health systems. Subsequently, our work aligns with ARCHI's health improvement strategies: Care Coordination, Healthy Behaviors, Access to Care, and Family Pathways.

Care Coordination

- **Integrated Behavioral Health Services**

Grady's Behavioral Health Integrated Care program places licensed therapists and health coaches in our hospital and neighborhood-based primary care centers, and several specialty clinics, to offer real time services during primary care visits. Behavioral health clinicians assess and treat depression, anxiety, trauma, bipolar disorder, and substance abuse, and a team of psychiatrists provide expert guidance to primary care physicians on medication use, management of side effects, and other treatment practices.

The program is designed to reduce symptoms of depression and anxiety, improve chronic disease management, and reduce ED use, impacting both mental and physical health. Since the launch of the program in April 2018, the Behavioral Health team has conducted over 2,500 visits with primary care patients. This collaboration reduces the stigma of seeking help for mental health conditions and is part of our holistic approach to patient health.

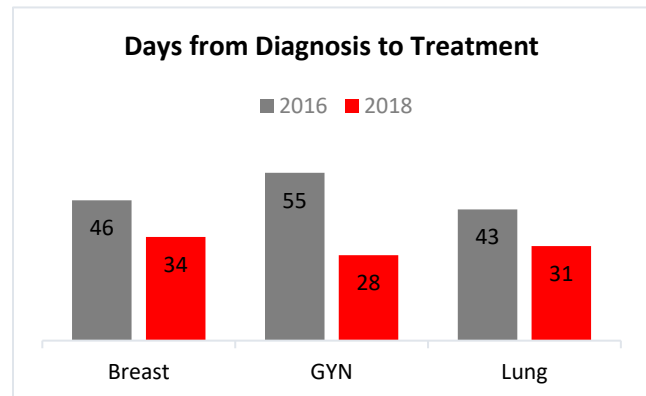
- **Patient-Centered Cancer Care**

The Georgia Cancer Center for Excellence at Grady was one of six sites across the nation selected to participate in the Alliance to Advance Patient-Centered Cancer Care. The Merck Foundation



committed \$15 million over five years to increase timely access to patient-centered cancer care for underserved communities. Through this initiative, Grady has prioritized care coordination through expanded nurse navigation, began a rigorous patient-centered designation process with Planetree to enhance patient-provider communication and patient engagement, and expanded community partnerships to strengthen psychosocial and supportive care for patients. Several notable achievements include:

- Significant reductions in average time from diagnosis to treatment for priority cancer sites
- More than 200 patients have received nutrition counseling from a Registered Dietitian during treatment
- The Cancer Center's Exercise Coach has developed programming to enhance staff wellness and is assessing patient needs and interests for patient programming



Through this process, the Grady Cancer Center is transforming cancer care, and will continue developing sustainable services over the remaining three years of the initiative.

- **Specialty Clinics for High Risk Patients**

To improve care coordination for high risk patients and reduce unnecessary emergency department utilization, Grady launched the Chronic Care Clinic in 2017. The goal of the program is to engage patients in their care to identify and remove barriers and foster self-management. The multi-disciplinary care team establishes patient-specific care goals, and patients received monthly clinic visits with home visits and telephone follow-ups in between. Patients enrolled in the program have reduced emergency department use and inpatient admissions.

In 2018, Grady launched another new clinic, the Transitions of Care (TOC) Clinic, for newly discharged patients with a high risk of readmissions. Eligible patients are identified while they are still in the hospital, and the TOC Navigators visit the patient to ensure they have the appropriate follow up care arranged. The multi-disciplinary team assists the patient with a range of medical and social needs from scheduling an appointment in the TOC clinic, transportation to that appointment, medication management, and successful transition to ongoing primary care and disease management support.

Healthy Behaviors

- **Walk the Line**

Grady continues to partner with the Atlanta Beltline to increase access to safe parks, trails, and health education. In 2017, Grady received a Health Grant to support a wellness program for community members. Grady's comprehensive program, Walk the Line, launched that September in collaboration with the opening of the BeltLine's Westside Trail. Walk the Line is a 10 week, healthy lifestyle class targeting African American adults.

Walk the Line has connected more than 100 residents to this new community resource through weekly walks on the trail. Participants also received weekly health education, healthy meals and health coaching. Walk the Line has helped residents achieve positive health changes including:

- 75% reported an increase in frequency of Westside Trail use
- 38% reported increases in weekly physical activity levels
- 65% of participants with elevated BMI, blood pressure, or blood glucose were able to reduce at least one measure by the end of WTL





"I really loved the different experts that came to inform about topics that help us."

"My greatest success was my healthy diet change. I eat more vegetables now!"

"Walk the Line helped me begin the process of retirement in a healthy way."

- **HIV Rapid Entry Program**

HIV treatment is critical to an individual's health, but also to community health. Early, effective treatment prevents the spread of HIV to others. With Ryan White Part A funding provided by Fulton County, Grady launched a Rapid Entry program in 2018. This high-touch, multidisciplinary team enrolls patients quickly, schedules a provider visit, and initiates treatment, ART, all within 72 hours. Peer Counselors and Patient Navigators also provide timely linkage to mental/behavioral health and case management to address housing support, employment, food security, and other barriers to retention, ART adherence, and viral suppression.

The Rapid Entry pilot served 91 clients, and yielded a reduction of time to first medical appointment from 17 days to 5 days and time to viral suppression from 63 days to 45 days. Grady enrolled more than 360 patients through Rapid Entry in 2018 and aims to enroll more than 500 in years two and three of the grant.

- **Talk With Me Baby**

Through a grant from James M. Cox Foundation, Grady launched the Talk With Me Baby (TWMB) pilot program designed to improve language development in the first years of life. Grady is leveraging its many touch points with expectant and new parents to promote healthy brain development. Nurses are trained to educate caregivers on the importance of talking with a baby every day, and parents are taught about important milestones to monitor a child's language development.

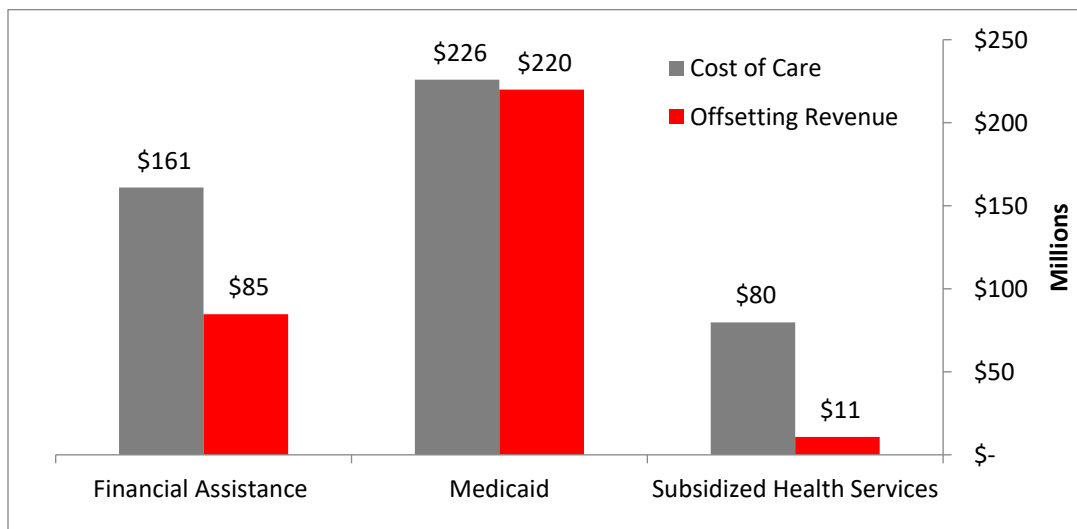
- Over 2,100 Grady staff members have received TWMB training
- 1,700+ mothers and other family members have participated in TWMB education

- 78% of mothers who received full TWMB training indicate an understanding of the lasting effects language nutrition
- 80% of mothers trained have committed to speaking 15 minutes per waking hour with their baby

Access to Care

- **Financial Assistance and Uncompensated Care**

Since our founding, Grady's mission has been to provide excellent care to anyone who enters our doors. In 2017, Grady provided more than \$466 million in care to our uninsured and low-income neighbors. Medicaid reimbursement and the Indigent Care Trust Fund covered 68% of these costs, while the remaining \$151 million was a shortfall Grady had to cover.



- **Public Benefits Enrollment**

Grady has engaged a number of resources to assist patients in gaining access to Medicaid and other public benefits. Through partnerships with the Atlanta Community Food Bank and Wholesome Wave Georgia, we are able to serve more patients and offer both Medicaid and SNAP application assistance.

2017	Grady Assistance		Partner Assistance	
	Medicaid applications	7,495	Medicaid applications	63
2018	Grady Assistance		Partner Assistance	
	Medicaid applications	11,602	Medicaid applications	257
2017	Grady Assistance		Partner Assistance	
	SNAP applications	502	SNAP applications	814

Academic Research and Training

- **Motor Vehicle Injury Research**

In 2017, the Injury Prevention Research Center at Emory University, along with Grady Memorial Hospital and collaborators at the University of Michigan, were awarded a five-year, \$4 million grant to study metro-Atlanta motor vehicle crashes that result in injuries treated at Grady. The goal of this project, funded by the National Highway Traffic Safety Administration (NHTSA), is to improve vehicle safety and support injury prevention. The Emory/Grady center is one of seven designated Crash Injury Research and Engineering Network (CIREN) centers in the US.

- **Cardiff Injury Prevention Project**

Through a CDC Foundation grant funded by the Robert Wood Johnson Foundation, Grady Memorial Hospital and DeKalb County Police Department are partnering to prevent violence and make communities safer. The partnership uses the Cardiff Model established in Europe to collect anonymous information on the location and timing of violent events reported at the hospital. Along with existing law enforcement records, they create local maps of where violence occurs, and identify hot spots throughout the county. This information and predictive analysis has been used to develop public health strategies and environmental approaches to address violence in South DeKalb.

Beyond Health: Social and Economic Impacts

- **Rides to Wellness**

Grady partnered with the Atlanta Regional Commission (ARC) and MARTA to address a significant barrier to accessing health care: transportation. Through the Rides to Wellness pilot program, funded by the Federal Transportation Administration, about 200 Grady patients who were missing appointments received six months of free rides on public transportation. Eligible patients also received travel training and assistance with enrolling in MARTA's Paratransit or Reduced Fare programs. As the pilot phase of the program concludes, Grady and the partners are exploring ways of sustaining this critical resource.

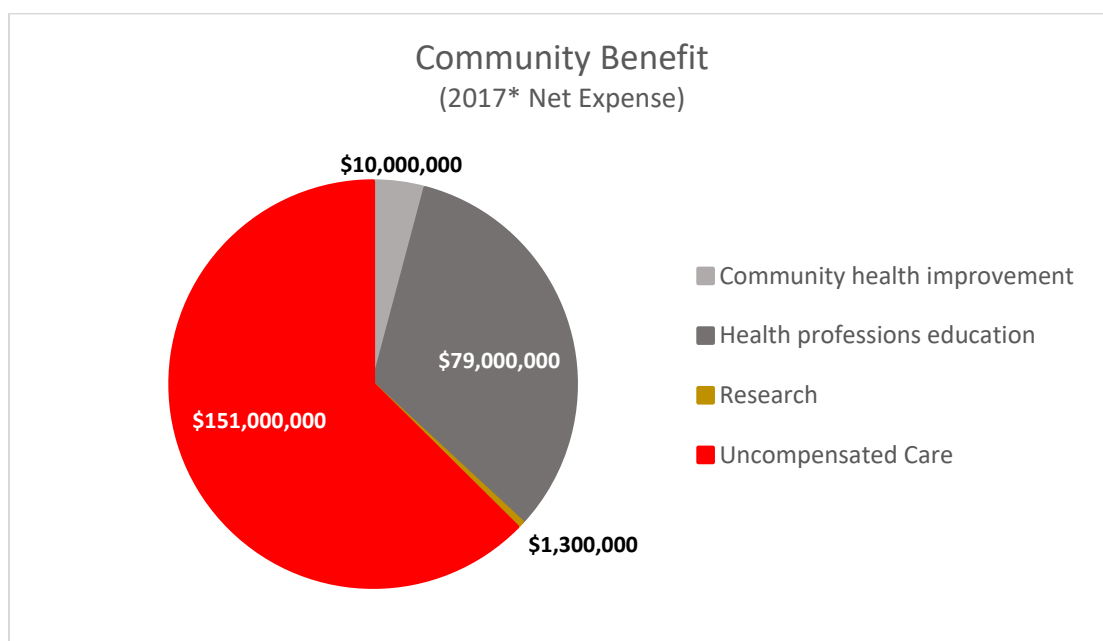
- **Food as Medicine Partnership**

In 2017, Grady expanded its commitment to addressing food insecurity by establishing the Food as Medicine Partnership with the Atlanta Community Food Bank, Open Hand Atlanta, and Wholesome Wave Georgia. The partnership was established to bring innovative food and nutrition solutions to Grady patients, staff and community, and create strategies to better connect patients with existing resources like SNAP and local food pantries. In 2017, Grady leaders approved the Partnership's proposal to establish an onsite food pharmacy, teaching kitchen, and healthy market.

In 2018, all partners began fundraising for the future Food as Medicine services. In addition, partners grew the FVRx program to more than 100 patients and successfully transitioned it into the Medical Nutrition Therapy department to support sustainability. Finally, the Food Bank expanded onsite SNAP screening and enrollment to three Grady clinics.

Community Benefit by the Numbers

In 2017, Grady provided more than \$597 million in Community Benefit services. Grady's net Community Benefit, which totaled more than \$241 million, accounted for 22% of total health system expenses.



Community Health Improvement

Community Health Improvement includes the cost of services to improve access to care or enhance the public's health. Grady's Community Health Needs Assessment informs new activities in this category.

Uncompensated Care

Uncompensated Care is the cost of care provided to patients that remains unreimbursed, which includes financial assistance, Medicaid shortfalls, and other subsidized services. Grady's bad debt, which totaled nearly \$65 million in 2017, is not included.

Health Professions Education

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

Research includes the costs of medical research conducted by Grady and indirect costs of research conducted by partner institutions at Grady.

**Community Benefit expenses are reported on tax forms submitted at the end of the following fiscal year. Thus, 2017 expenses were finalized at the end of 2018 and are included in the 2018 Community Benefit Report. 2018 expenses will be included in the 2019 report.*