



# COMMUNITY BENEFIT REPORT 2016-2019

## 2019 Update

At Grady, our care, expertise, and innovation extend from acute hospital care to wellness and prevention at home. We are committed to providing high quality services for our patients and striving toward better health for our community as a whole. We are continually innovating to improve care for today's patients and for those who will become our patients, for our neighbors managing chronic disease on a daily basis, and for those who are fighting for their lives after catastrophic injury.

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

- **ARCHI Diabetes Collaborative**

In partnership with the Atlanta Regional Collaborative for Health Improvement (ARCHI), several health systems in metro-Atlanta—Grady Health System, St. Joseph's Mercy Care, Wellstar, Piedmont Hospital, and Kaiser Permanente—that each identified diabetes as a pressing issue for their community came together to improve diabetes outcomes at a population health level. The systems formed a collaborative and launched a pilot that included digital education and telephonic coaching.

Digital DSME	Telephonic Coaching
613 patients participated	70 patients enrolled
<ul style="list-style-type: none"><li>• 97% were satisfied with the course</li><li>• 98% said the course material was helpful to diabetes management</li></ul>	<ul style="list-style-type: none"><li>• 67% lowered their A1C</li><li>• 61% lost weight</li><li>• 65% lowered their blood pressure</li></ul>



This pilot highlighted the complex nature of patients with uncontrolled diabetes and showed that person-centered coaching focused on addressing nonclinical needs is effective in improving clinical outcomes. Among the 70 coaching patients, nearly half (49%) had two or more social needs. Coaches were able to connect patients to resources including financial assistance, housing, transportation, SNAP, and mental health services. The partners continue to work together to address diabetes and apply lessons learned to the next phase.

- **Women’s Services Community Health Worker (CHW)**

Community Health Workers (CHWs) are critical members of a patient’s care team, and Grady continues to expand access to CHWs to improve outcomes. In late 2018, in partnership with United Way of Greater Atlanta, Grady added a CHW in Women’s Services to reduce preterm births, low birth weight, infant mortality, maternal mortality, and the use of emergency services for pregnancy care through prenatal care coordination, linkage to other health, community or social services, and education to reinforce healthy behaviors. In the first year, 22 of 26 women completed the intervention and achieved these positive outcomes:

- 63% (14) were breastfeeding one-week post-partum
- 63% (14) were connected to a primary care physician
- 18% (4) had an infant with low or very low birth weight (lower is better)
- 18% (4) had a pre-term delivery (lower is better)

In addition, the CHW completed 35 home visits, coordinated 217 medical appointments, completed 13 community referrals, and helped secure housing, baby supplies, and transportation. Grady continues to optimize this program through expanded referral pathways and partnerships with other Grady services to better serve moms and babies.

- **Westside Health Collaborative CHW Program**

Grady also worked with the Westside Health Collaborative (WHC) to refer patients with uncontrolled diabetes or hypertension to CHWs based at Chris 180, a WHC partner. The program was designed to help residents of Westside neighborhoods, Vine City and English Avenue, improve their health and connect to community resources. Ten percent of Grady’s patients reside in Westside neighborhoods, a community with high poverty rates, low educational attainment, and significant health disparities. Throughout 2019, a Nurse Care Coordinator at Grady’s Asa Yancey Neighborhood Health Center identified and referred 111 eligible patients.

Among the 59 patients who enrolled, 51 attended follow up appointments, 53 achieved blood glucose readings within the prescribed range, and 57 recorded blood pressure readings within the healthy range. Just over half were taking their medication as prescribed and engaging in physical activity. In addition, the CHW was able to connect 21 patients with transportation support, 10 with food assistance, eight with utility assistance, and five with home health coordination.

- **Medication-Assisted Treatment**

In 2019, Grady expanded Medication-Assisted Treatment (MAT) in partnership with Fulton County. MAT is a treatment that combines medications with counseling and behavioral therapies for patients who suffer from an opioid use disorder (OUD) related to prescription opioids. With the support of the County, Grady doubled the capacity of the service to increase access for Fulton County residents. Grady also added inductions, MAT initiation, at the main hospital to better facilitate the transition to outpatient care. Through this partnership, Grady served 139 people in 2019, about one-third of whom came from Grady Hospital following an overdose.

## Healthy Behaviors

---

- **Pre-exposure Prophylaxis (PrEP) Clinic**

Georgia has the highest rate of HIV diagnoses of all states and most HIV diagnoses occur in Atlanta. Pre-exposure Prophylaxis (PrEP) with once daily, oral Truvada® is up to 99% effective at preventing HIV infection in high-risk groups, including men who have sex with men. Despite its safety and effectiveness, PrEP use remains low in Atlanta and the Southern US. In 2018, Grady launched its first pilot PrEP program within the Primary Care Center and neighborhood health centers. After starting 94 individuals on PrEP during the nine-month pilot, Grady expanded the service in 2019. Grady is committed to growing the PrEP program through increased staff capacity and expanded internal and external referral pathways.

- **Food as Medicine Partnership**

Through the Food as Medicine (FAM) Partnership, a collaboration between Grady, the Atlanta Community Food Bank, and Open Hand Atlanta, Grady established the Fresh Food Cart (FFC) at Grady's Brookhaven Health Center in June 2019 to pilot a scaled approach to fresh food distribution at our neighborhood health centers. In an effort to address both food insecurity and chronic disease, the FFC provides fresh produce to Grady patients and their families twice a month. In 2019, the FFC grew from serving about 100 patients per event to nearly 200. In 2019, there were 1,400 patient visits and we distributed over 41,000 pounds of fresh produce.

Fresh Food Cart	FVRx	CHF Meals
1,402 patient visits 41,888 lbs. of fresh produce distributed	156 patients enrolled \$48,838 in food prescriptions redeemed	38 patients served 9,153 home-delivered meals

FAM Partners also expanded the Fruit and Vegetable Prescription (FVRx) Program in partnership with Wholesome Wave Georgia in 2019 from four to seven cohorts. The Grady Nutrition Team achieved a 90% retention rate in this six-month program. This resulted in 156 patients receiving six cooking classes, six nutrition classes, and nearly \$50,000 of food prescriptions redeemed for fresh

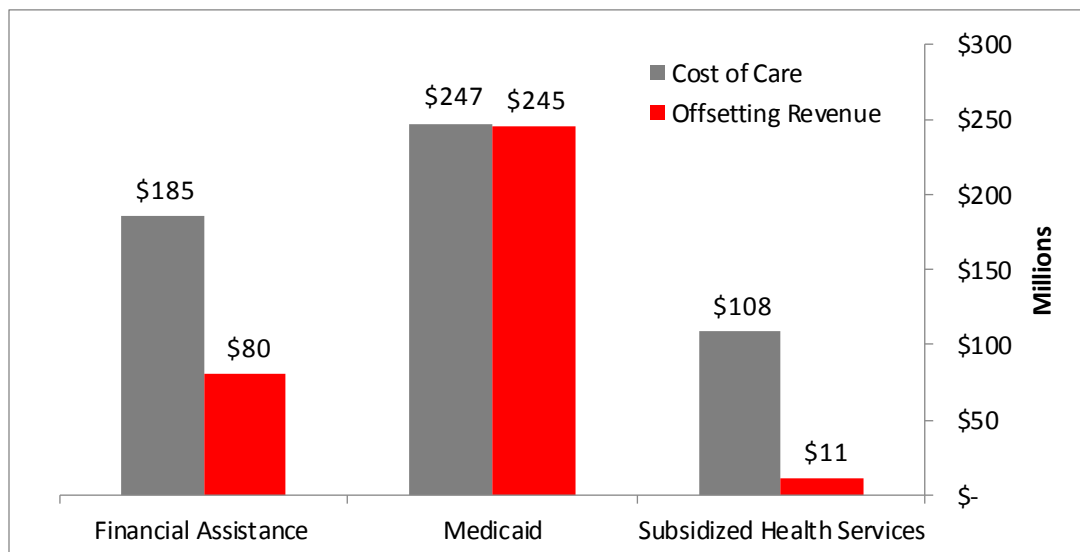
produce at local farmers markets. Most importantly, patient health improved. We observed reductions in weight, waist circumference, blood pressure, and A1C for those with diabetes.

Finally, Open Hand Atlanta worked with Grady's Chronic Heart Failure (CHF) Clinic to provide patients with three months of home-delivered meals and nutrition counseling post-discharge. With support from Kaiser Permanente of Georgia, Open Hand delivered more than 9,000 meals to 38 Grady patients. Seventy-three percent of patients avoided a readmission and many made significant improvements in their diet, a critical component of CHF management. Open Hand measured a 48% decrease in sodium consumption and a 53% increase in fruit and vegetable intake.

## 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 2018, Grady provided more than \$541 million in care to our uninsured and low-income neighbors. Medicaid reimbursement and the Indigent Care Trust Fund covered 62% of these costs, while the remaining \$205 million was a shortfall Grady had to cover.



- Camp Creek Comprehensive Care Center**

In 2019, Grady expanded critical health care services to southwest Atlanta with our newest facility, Camp Creek Comprehensive Care Center. It is a state-of-the-art, one-stop shop for adult and pediatric primary care and specialty care, including women's health services, cardiology, orthopedics, geriatrics, and much more. The Center has quick on-site lab services and advanced imaging including X-ray, CT, and mammography.

- **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 Supplemental Nutrition Assistance Program (SNAP) application assistance.

2019	Grady Assistance	Partner Assistance	
	3,962 Medicaid enrollment	369 Medicaid applications	681 SNAP applications

The Atlanta Community Food Bank estimates that 86% of SNAP applications are approved and that each approved application enables 624 meals.

SNAP Impact			
884 Patients screened	681 SNAP applications	586 Estimated approvals	424,944 meals enabled

## Academic Research and Training

---

- **Program to Interrupt Violence through Outreach and Treatment (PIVOT)**

In June 2019, Grady’s hospital-based violence intervention program, known as PIVOT, celebrated its one-year anniversary of serving victims of firearm related injury. In the course of one year, the PIVOT team identified over 700 patients with firearm related injuries, worked with 25 community partners, and held 12 taskforce meetings. Community partners and resources provided to PIVOT participants included the domains of housing, education, job training, and substance use. The PIVOT team also explored partnerships to expand service to DeKalb County.

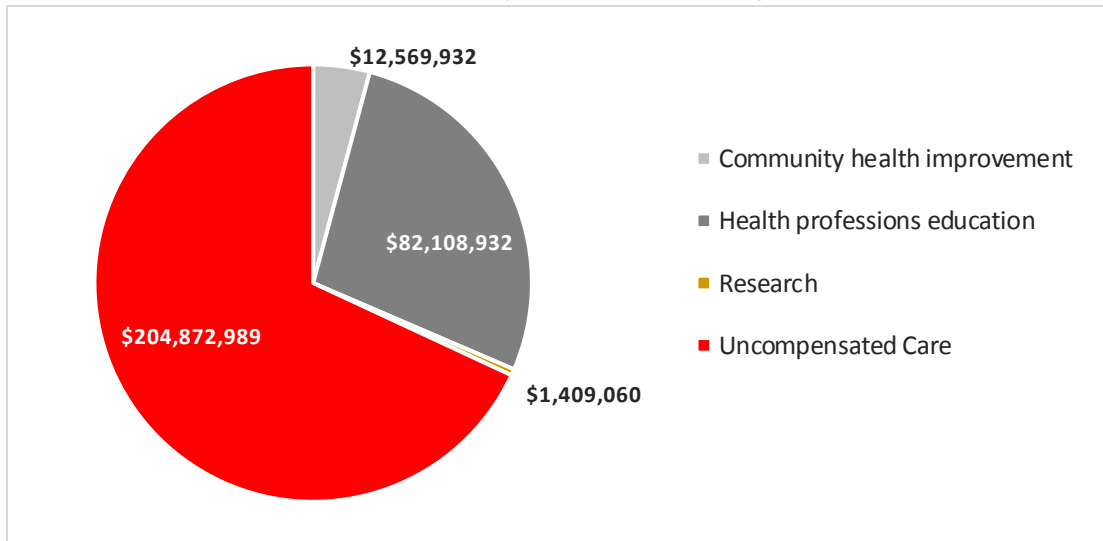
- **Cardiff Injury Prevention Project Expansion**

Additionally in 2019, Grady’s Injury Prevention Team was awarded federal funds to facilitate the statewide expansion of the Cardiff Model for Violence Prevention. The Cardiff model allows stakeholders to create local maps of where violence occurs by combining anonymous information about the location and timing of violent events reported at the hospital with existing law enforcement records. This information and predictive analysis are then used to develop public health strategies and environmental approaches to address violence. One project, funded by the Centers for Disease Control and Prevention through Grady partner the Injury Prevention Research Center at Emory, facilitates the expansion through the Georgia Trauma System and its centers across the state. This two-year project was awarded \$127,000. The second project, funded by the Bureau of Justice Assistance, focuses on expanding the Cardiff Model with metro Atlanta law enforcement agencies, and is funded for one year in the amount of \$80,000.

## Community Benefit by the Numbers

In 2018, Grady provided more than \$677 million in Community Benefit services. Grady's net Community Benefit, which totaled more than \$300 million, accounted for 24% of total health system expenses.

2018 Community Benefit (Net Expense)<sup>1</sup>



**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 indirect costs of research conducted by partner institutions at Grady.

**Uncompensated Care** is 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.

Grady's commitment to the health and well-being of our community is clear. Year over year, Grady's Community Benefit has grown in both total dollars invested and as a percentage of the hospital's total annual expenses.

<sup>1</sup>Community Benefit expenses are reported on tax forms submitted at the end of the following fiscal year. Thus, 2018 expenses were finalized at the end of 2019 and are included in the 2019 Community Benefit Report.

### Community Benefit 2016-2018

