EMPOWERING HEALTH THROUGH PARTNERSHIP:

Grady's Community Health Improvement Plan

2025

Grady

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ABOUT GRADY HEALTH SYSTEM

Grady Health System (GHS) is one of the largest safety net health systems in the United States. GHS is the only Level 1 trauma center in Atlanta verified by the American College of Surgeons and serves a population of over 1.8 million residents primarily in DeKalb and Fulton counties. GHS has grown significantly to include 16 locations, with its main hospital in Atlanta including four Centers of Excellence. GHS provides a range of critical and intensive care, including the Marcus Stroke and Neuroscience Center and the Walter L. Ingram Burn Center. There are additionally nine outpatient centers, four specialty centers, and a long-term care center. With new clinic sites at Lee + White in West End, additional sites opening soon in Candler and East Atlanta Village, as well as a new emergency department in South Fulton, GHS is making rapid strides toward expansion to better serve the community in their neighborhoods.
Table 1 provides a list of GHS's primary care centers.

Table 1. GHS Primary Care Centers

GHS Primary Care Centers	County
Asa G. Yancey Health Center	Fulton
Brookhaven Health Center	DeKalb
Camp Creek Comprehensive Care Center	Fulton
Candler Outpatient Center	DeKalb
East Point Health Center	Fulton
Cascade Outpatient Center	Fulton
Flat Shoals Outpatient Center	DeKalb
Kirkwood Health Center	DeKalb
North Fulton Health Center	Fulton
Lee + White Outpatient Center	Fulton
Primary Care Center at Grady Memorial Hospital	Fulton

GHS continues to maintain its strong commitment to the healthcare needs of Fulton and DeKalb counties' underserved while also offering a full range of specialized medical services for all segments of the community.

Grady Memorial Hospital is an internationally recognized teaching hospital staffed by faculty from Emory University School of Medicine and Morehouse School of Medicine. The hospital has grown considerably from its original 110-bed facility to a hospital with more than 900 licensed beds. Twenty-five percent of all physicians practicing medicine in Georgia received training at Grady.

Some of Grady's other services include a Diabetes Center, the Georgia Cancer Center of Excellence, and 911 EMS. It is also a designated Regional Perinatal Center, and 100 other subspecialty services.

Moreover, GHS houses Georgia's Poison Center, a 24-hour Rape Crisis Center, a comprehensive 24-hour Sickle Cell Center, the largest nursing home in the state of Georgia, Nurse Advice Lines, and has one of the top three HIV/AIDS outpatient clinics in the country.

GHS addresses the healthcare needs of the community locally, regionally, and statewide through multiple efforts. GHS has a steadfast commitment to the underserved and a mission to "improve the health of the community by providing quality, comprehensive healthcare in a compassionate, culturally competent, ethical, and fiscally responsible manner." While its primary geographic service area consists of Fulton and DeKalb counties, GHS serves thousands of other residents in the Atlanta area and throughout Georgia. In its 2024 Annual Report, Grady had a total of 737,170 patient visits, responding to almost 179,318 911 calls, and providing almost 148,907 Emergency Department visits.[1]

The GHS website Atlanta's Hospital | Atlanta Can't Live Without Grady and Community Benefit Report detail the health system efforts for the 2020-2024 calendar years. The report begins by recognizing the shifts in community needs with the closure of Atlanta Medical Center in 2022, and the increased patient and community needs associated with that closure, amid recovery from the peak of the coronavirus pandemic. It goes on to address the health system's efforts in the following areas:

- Care coordination
- Promoting healthy behaviors and relationships
- Innovating care delivery
- Beyond Health: social and economic impact

Grady's mission has been to provide excellent care to anyone who enters our doors. In 2023, Grady provided more than $701 million in care to our uninsured and low-income neighbors. Medicaid reimbursement and the Indigent Care Trust Fund covered 77% of these costs, while the remaining $164 million was a shortfall Grady absorbed.

ABOUT THE GHS COMMUNITY

Georgia's population continues to grow rapidly, making it one of the fastest-growing states in the nation. As of 2024, Georgia's population is 11.18 million and ranks 8th nationally. These numbers reflect a growth rate that outpaces the U.S. average. The community served by GHS, Fulton and DeKalb counties, is also projected to grow at a rapid pace. Fulton and DeKalb are among the most populous counties in the state, and both have seen steady growth since 2010. Compared to Georgia, these counties are younger, more diverse, and higher-income.

DeKalb and Fulton counties have higher rates of Black (52.8% and 43.4% respectively) and Asian (6.2% and 7.6%) residents than the state and the country.[1] Both counties are "majority minority" counties, meaning that White residents no longer make up the majority of residents. DeKalb became a minority majority county in 1991, and Fulton became a minority majority county sometime after the 2010 census. DeKalb county also has a higher percentage of population with limited English proficiency (8.0%) than Fulton County (4.8%) or the state (5.5%).

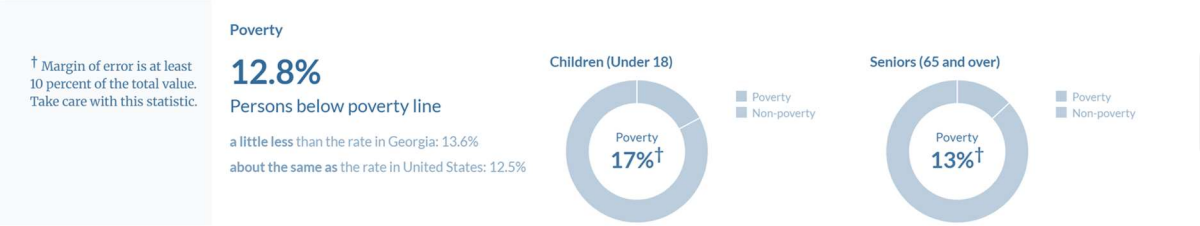
[1] U.S. Census Bureau. 2023 Update: *American Community Survey, Five Year Estimates, 2018-2022*. Updated September 12. 2024. Retrieved February 26, 2025 from https://data.census.gov

The service area's population has remained relatively young, with the median age at 36.3 years in DeKalb and 36.1 years in Fulton. Residents aged 65 years and older make up slightly more than 13 percent of the population in both counties.

Social and economic drivers are significant determinants of an individual's health. Among these factors are education, access to insurance, income, and housing. These factors influence an individual's ability to obtain employment, safe living conditions, nutritious foods, and access healthcare, all which impact health.

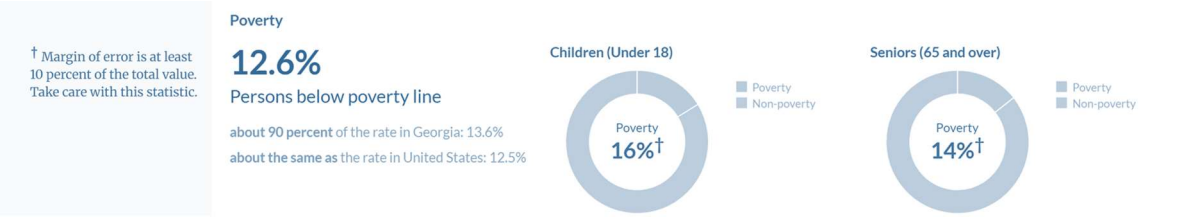
When we examine poverty rates in the service area, we see that DeKalb and Fulton Counties' rates fall below the state rate (13.6%) and are roughly the same as the national rate. However, when we look at census tract data, we see that there are areas within the service area with rates over 3 times the state rate. [2]

Figure 11: DeKalb County Poverty Rate



Source: Census Reporter. (2023). DeKalb County Profile.

Figure 22: Fulton County Poverty Rate



Source: Census Reporter. (2023). Fulton County Profile.

Access to insurance is closely related to poverty and income, as low-income residents are more likely to be uninsured or underinsured. Since 2019, the percentage of uninsured residents decreased throughout the service area, though gaps persist. In 2024, an estimated 14.1 percent of adults 19-64 years of age were uninsured in Fulton County, and 12.3 percent in DeKalb County, compared to 11.4 percent uninsured statewide, however both counties have census tracts with uninsured populations above 20%. According to the most recent estimate, 17.2 percent of Fulton County and 21 percent of DeKalb County are enrolled in Medicaid. Statewide, 19.8 percent of the total population is enrolled in Medicaid. The lack of access to insurance limits access to healthcare services, and particularly access to preventive services.

COMMUNITY HEALTH NEEDS

In 2019 and 2022, Georgia Health Policy Center conducted a similar CHNA and Implementation Strategy for GHS. When compared to the previous two CHNAs, there are several notable trends in the 2025 findings.

Notable improvements were made in:

- Cancer incidence and mortality rates
- The number of healthcare providers generally, though safety-net providers remain low
- Poverty
- Unemployment
- Insurance rates, but there is no measure of the rate of underinsurance
- Obstructive heart disease
- Respiratory health
- Infant mortality rate

Trends worsened for:

- Obesity and diabetes morbidity and mortality
- Hypertensive heart disease and stroke
- Human Immunodeficiency Virus (HIV)
- Mental health and behavioral disorders
- Suicide mortality, specifically in DeKalb County
- Substance use and overdose
- Assault (Homicide) morbidity and mortality

The CHNA and the Implementation Strategy development process (described next) were conducted in compliance with the Patient Protection and Affordable Care Act (ACA) federal requirements. These requirements, Section 501(r) of the Internal Revenue Code, require nonprofit hospitals to (a) conduct a community health needs assessment at least once every three years and describe the process and findings and (b) describe in a written community health improvement plan, or Implementation Strategy, the plan to address each identified health need and provide a rationale for the health needs that will not be addressed by the hospital.

GHS conducted the most recent CHNA in 2025 to identify needs and resources in its community. The CHNA examined secondary data and considered input from public health experts, as well as community leaders and representatives of high-need populations in Fulton and DeKalb counties this included minority groups, low-income individuals, medically underserved populations, and those with chronic conditions. Upon reviewing the data, GHS used a set of criteria, including importance to stakeholders, relative burden, current GHS capacity, and disparities to identify and prioritize the significant health needs facing the community and documented them in a written CHNA Report.

Based on the primary and secondary analysis completed for the CHNA report, GHS decided on five primary priorities (Figure 1) for new work, investments, and population health team support:

Figure 1. Community Health Improvement Priorities

PRIORITY #1

ACCESS TO CARE

- Expand access and hours of primary care clinics
- Promote health insurance enrollment
- Build deeper community engagement/ partnerships

PRIORITY #2

SOCIAL DETERMINANTS OF HEALTH

- SDOH screening and resource connection
- Contribute to city-wide Strategy to End Homelessness
- Increase utilization and support of Small emerging and community-based enterprises (SECBE)
- Prepare young people for healthcare careers; skill-building for economic mobility

PRIORITY #3

MENTAL HEALTH

- Increase awareness and access to Grady Mental Health services
- Partner to expand access to adolescent and family mental health supports
- Enhance services and supports for substance use, justice involved and homelessness
- Launch anti-stigma & community education campaign

PRIORITY #4

HIV

- Integrate status neutral care in the fabric of primary care at Grady
- Lead in good science to End the Epidemic with treatment innovation, prevention, and supportive services
- Rapid person-centered linkage to care for every positive HIV test
- Broaden community partnerships

PRIORITY #5

MATERNAL AND CHILD HEALTH

- Expand and optimize community access to prenatal care
- Enhance clinical programming for high-risk OB
- Provide culturally competent care with holistic support services (doulas, lactation support, pp depression support)
- Increase awareness and improve access to Grady services

In addition to the primary priorities, GHS also identified three secondary priorities in areas that continue to be important to Grady and the community:

- Chronic Conditions
- Cancer
- Violence & Injury

Robust services and innovative programs already exist for these priority areas; implementation strategies will focus on improving, growing, and sustaining these programs.

IMPLEMENTATION STRATEGY DEVELOPMENT PROCESS

GHS employed a two-phased approach to prioritize health needs and determine the strategies to address the needs. In the first phase, the GHS Population Health Council (PHC) reviewed and prioritized health needs from the CHNA. The second phase included confirming needs to be addressed and developing strategies to address them using evidence-based strategies and feedback from the PHC work groups and input from primary priority work groups.

PHC members used the following criteria to rank health needs that were identified in the CHNA:

- **Comparison to national benchmarks** – *How far is the need from national averages?*
- **Magnitude/scale of the problem** – *How many people are impacted?*
- **Severity of the problem** – *How serious are the consequences if not addressed?*
- **GHS assets** – *Does Grady have relevant expertise and unique assets to address the need?*

Given the commitment to evidence-based approaches, achievable results, and the opportunity to leverage GHS assets and build on the work of partner organizations, Grady considered the following information and databases to identify strategies to address the selected health needs:

- Previous strategies including achieved outcomes
- The Atlanta Regional Collaborative for Health Improvement (ARCHI) Playbook[3]
- The Guide to Community Preventive Services[4]

The Council discussed strategies for implementation over the next three years. This information is detailed in the Implementation Strategy tables that follow. Within each table, the strategies are organized by type of intervention, the description each intervention, and metrics to monitor the implementation of the strategy.

The strategies outlined in the tables include both ongoing programs and services, as well as new initiatives planned for the next three years. Many of the ongoing programs and services were established only during the previous three-year period. Efforts in the upcoming three-year period will focus on growing, optimizing, and ensuring sustainability of these programs. Including these programs in the Implementation Strategy allows Grady to continue prioritizing these critical activities and will ensure that they have the greatest community health impact. Finally, the evidence supporting the identified implementation strategies is listed in the Anticipated Impact section below each table.

Based on the health needs prioritization and feedback from the PHC, goals, strategies, target population, and expected outcomes for each prioritized health need were drafted. The primary and

secondary needs that GHS has chosen to track and measure are noted, and rationale is provided in the section following the Implementation Strategy.

IMPLEMENTATION STRATEGY

The CHIP will be implemented over the next three years, from January 2026 to December 2028. It will be jointly implemented through collaboration between GHS, partners, and community organizations in the service region. The Implementation Strategy tables in this section detail the three-year plan to address the prioritized health needs in Fulton and DeKalb counties.

According to The Community Guide from the Community Preventive Services Task Force (CPSTF), health exists when individuals have equal opportunities to be healthy. Nearly all the community health needs identified in the CHNA disproportionately affect certain portions of the population. Examples include the rates of chronic disease and homicide deaths are higher in the African American community;[5] people in low-income households and of Hispanic ethnicity are more likely to be uninsured;[6] the HIV epidemic disproportionately affects African American and LGBTQ communities;[6] and, COVID-19 disproportionately impacted persons of color and those living in healthcare professional shortage areas.[7]

As investments are made to address the health needs of our community, it is Grady's underlying priority to promote health equity. While residents in Grady's service area generally have higher income, employment, insurance, housing, and education rates when compared to the state, a closer look at the data by zip/race/ethnicity reveals that both DeKalb and Fulton Counties have geographic pockets where the burden of inequitable SDOH matches or exceeds those found at the state level. Single female head of household families and African American, Multiracial, and Hispanic residents experience the highest rates of poverty throughout the service area, and while 11.4% of residents are uninsured overall, 13.6% of African American residents and 30.3% of Hispanic residents lack insurance in the service area.

The patients served by Grady in 2024 were 79.1 percent African American, 11.3 percent non-English speaking, 31 percent uninsured, and 16 percent Medicaid-enrolled. Strategies that target Grady's patients will have a significant impact on low-income and minority populations. Moreover, GHS will work to implement community-focused strategies in neighborhoods that represent Grady's patient population, since that is where health inequities persist. As such, health equity strategies spearheaded by Dr. Yolanda Wimberly in the Health Outcomes Office at GHS are reflected in this implementation plan and are integral to reducing health inequities in Grady's community.

In addition to the health-specific strategies previously outlined, GHS is committed to equity as an anchor institution in Atlanta. GHS is a founding member of ARCHI, a coalition of more than 100 public, private, and nonprofit organizations working to improve the region's health. As an active partner, Grady is committed to the ARCHI philosophy of upstream, cross-sector work, with an emphasis on health equity. GHS also has an award-winning Supplier Diversity Program and is a pioneering leader in this work in Atlanta and the healthcare industry. This work is increasing the economic status of women and minority business owners, and their employees in Atlanta and nationwide. Another organizational priority for GHS is participating in regional workforce development programs. GHS will continue to work with partners to increase healthcare training opportunities for low-income individuals and entry-level healthcare staff to build the healthcare workforce, provide opportunities for minority and low-income populations, and ensure the highest quality of care for GHS patients.

Access To Care Implementation Strategy

Priority	Access to Care	
3-Year Goal	Increase access to preventive and specialty services by strengthening partnerships and community trust	
Plan		
Strategy	**Description**	**Metric**
Expand Grady **primary care access**	• Continued expansion of new neighborhood clinics; heat mapping for community location planning • Partner with CBOs to establish satellite and mobile clinics, pop-up health screenings, and other alternative forms of healthcare access • Provide care navigation services for individuals with complex medical needs	# of primary care patient visits
Promote **health insurance enrollment**	• Educate patients and the community about health insurance options, covered benefits, and the value of enrolling in available plans, partnering with organizations and using tailored outreach • Maintain Grady's status as a Certified Designated Organization (CDO) under Georgia Access • Utilize financial assistant navigators to assist patients with applying for all forms of financial assistance	# of insurance enrollments
Increase specialty care access **(e.g., dental, urgent care)** via partnerships	• Increase specialty care access (e.g., dental and mental health) via partnerships, resource alignment, and referral pathways; Increase usage of FindHelp and improve other health resource connections • Develop seamless care pathways from primary care to specialty care and improve time to next appointment for key specialty areas	Third Next Available (TNA) for specialty care
Amplify awareness of Grady's multicultural staff, language interpretation services, and resources	• Expand community outreach programs to increase awareness of Gradys services, improve website navigation for key service areas; launch targeted marketing campaigns to promote services • Strengthen partnerships with agencies that support vulnerable populations with unique barriers to care to promote specialized services available at Grady (e.g. ASL interpreter) • Support culturally diverse hiring practices; grow the number of certified medical interpreters among providers to address language and cultural barriers; adopt advanced technology solutions for interpreter services	# of community health screenings and # of community events # of Grady staff trained as medical interpreters

According to the Agency for Healthcare Research and Quality, access to care means having the timely use of personal health services to achieve the best health outcomes. This consists of four components: 1) healthcare coverage 2) having a usual source for receiving health services 3) having timely access to care when a need is recognized, and 4) access to a capable, qualified, and culturally competent workforce of providers.[8] Among GHS' 2026-2028 primary priorities, access to care is a critical concern and action area.

Access to Care Anticipated Impact

In implementing access to care strategies, the following evidence-based programmatic outcomes can be anticipated:

- Improved access to primary care, quality of discharge, patient satisfaction with care, and hospital readmission rates for patients with chronic diseases.[9]
- Increased community support, engagement, and social capital through strategic partnerships with community stakeholders, organizations, and institutions, leading to better health outcomes and utilization of care services.[10,11,12]
- By leveraging partnerships and maximizing internal resources to increase coverage and access to care, the following outcomes are anticipated:[2]
    - Reduction in the likelihood of premature death
    - Reduction in hospital death rates
    - Reduction in adverse medical event due to patient negligence
    - Increase in pharmacy usage and medication compliance
    - Reduction in uncontrolled blood glucose levels (diabetes)
    - Improved access to appropriate preventive care and screening services
    - Improved cancer diagnosis and treatment

[2] Effects of Health Insurance on Health. Institute of Medicine (US) Committee on the Consequences of Uninsurance, Washington (DC): National Academies Press (US); 2002.

Social Determinants of Health Implementation Strategy

Priority	SDOH	
3-Year Goal	Improve social support through continued universal SDOH screenings and targeted programming related to economic mobility, housing, transportation.	
Plan		
Strategy	**Description**	**Metric**
SDOH screening and resource connection	• Continue universal screening for SDOH; continue training to ensure patient-centered, culturally-competent screening and sustainability of the process • Utilize MSWs, Navigators, and CHWs along with a technology platform to connect patients to internal and community-based resources; strengthen the network of community-based resources in collaboration with partner agencies • Develop innovative plan to address the myriad transportation insecurities for Grady patients focusing first on patients needing procedural or diagnostic care • Continue to expand food access programs	# resource connections
Contribute to **city-wide Strategy to End Homelessness** via Project HEAL	• Establish referral process for individuals needing medically supported care following discharge to access Project HEAL beds • Provide mobile primary care at two housing developments that are part of the Rise Atlanta campaign	# served in Project HEAL
Increase utilization and support of Small emerging and community-based enterprises (SECBE)	• Increase utilization of Small emerging and community-based enterprises (SECBE) to support Grady operations • Mentor, develop and advocate for SECBEs to grow and build capacity • Provide financial literacy workshops on a range of topics (access to capital, personal finances, credit education) facilitated by Grady staff and/or partners	# of SECBEs in Grady Supply Chain Increase in % and dollar of SECBE
Prepare young people for healthcare careers; **skill-building for economic mobility**	• Prepare young adults (ages 18–28) for meaningful healthcare careers through structured workforce development, skills-building, and job readiness programs that support economic stability and strengthen Grady's workforce pipeline	% of 18–28-year-olds who obtain employment at Grady

Social Determinants of Health (SDOH) are the economic, educational, political, and environmental circumstances in which people are born, grow up, live, work, and age. The Healthy People 2030 initiative defines the SDOH categories as:[13]

- Economic stability- reduce household food insecurity and hunger, increase employment in working-age people, reduce the proportion of adolescents and young adults who are not in school or working, reduce the proportion of families that spend more than 30% of income on housing.
- Education access and quality- increase the proportion of high school students who graduate in four years, increase interprofessional prevention education in health professions training programs

- Healthcare access and quality- increase the proportion of people with a usual primary care provider; increase the proportion of adults whose healthcare provider checked their understanding and/or involved them in decisions.
- Neighborhood and built environment- reduce the rate of minors and young adults committing violent crimes.
- Social and community context- increase the health literacy of the population.

SDOH Anticipated Impact

Research suggests that the implementation of these evidence-based strategies can yield the following outcomes:

- Training providers in culturally competent SDOH screening and care will increase provider cultural competence and patient satisfaction, especially for minority populations.[14,15]
- Through increased SDOH screenings, more patients with social needs will be identified for referrals to resources.[16,17,]
- Integrated referral systems increase successful resource connection, resulting in improved access to food, transportation, and housing support.[18,19, 20]
- Improved access to primary care for people who are homeless and other marginalized communities.[21,22]
- Engaging young adults on workforce readiness will prepare them with skills to improve their economic outlook.
- Mentorship, capacity building, and procurement partnerships improve the financial sustainability of small business, strengthening long-term community infrastructure.

Mental Health Implementation Strategy

Priority	Mental Health	
3-Year Goal	Increase the use of mental health and supportive services	
Plan		
Strategy	**Description**	**Metric**
Increase awareness and access to Grady mental health services	• Launch internal and external awareness campaigns about mental health services and clinic locations to increase awareness among internal and external stakeholders • Develop smart sets in Epic for the clinician referrals and navigation	# of patients served by Grady BH
Partner to expand access to **adolescent and family mental health supports**	• Strengthen adolescent/family mental health programs through partnerships (CHOA, DPH, Morehouse School of Medicine)	New services added
Enhance services and supports for **substance use, justice involved and homelessness**	• Expand housing and wraparound supports through partnerships with Project HEAL and other CBOs to reduce ER visits linked to housing instability • Explore additional substance use interventions in Primary Care and continue specialty focused programs like LINCS Up and Life Care Specialists • Provide support to justice involved through court/jail diversion activities	# patients connected to and sustained in housing
Launch **anti-stigma & community education** campaign	• Increase staff-led community education and outreach events • Support Grady staff with Mental Health First Aid training to ensure all patients receive unbiased care • Formalize a Patient/Family Advisory Council for behavioral health to inform anti-stigma campaign and outreach efforts	# of community education/ outreach events

According to the World Health Organization, mental health is a state of well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community.[23] Mental health is not only the absence of mental disorders, but exists on a continuum which is experienced differently across all individuals. Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment of function, or risk of self-harm.

Mental Health Anticipated Impact

Research suggests that the implementation of these evidence-based mental health strategies can yield the following outcomes:

- Improved outcomes for individuals with addictive disorders through utilization of new technologies such as neuromodulation intervention (ECT).[24]
- Decreased use of Emergency Department visits from individuals experiencing homelessness and mental illness. **Error! Bookmark not defined.**, 25
- Housing supports will decrease the number of individuals experiencing homelessness in the community and improve health outcomes for those individuals.[26]
- Improved social outcomes for patients through integration of mental health care with social intervention services.[27]
- Increased reach of services for marginalized communities will improve health outcomes.[22]

Maternal and Child Health Implementation Strategy

Priority	Maternal and Child Health	
3-Year Goal	Improve prenatal and postpartum outcomes, focusing on high-risk OB patients and equity	
Plan		
Strategy	**Description**	**Metric**
Expand and Optimize Community Access to Prenatal Care	• Increase new patient Obstetrics ambulatory access (increase staffing, expand OB service to NHCs, explore mobile community-based options) • Promote virtual visit once a positive pregnancy test to increase access and initiate prenatal care earlier • Re-activate centering groups and expand into neighborhood sites and mobile/community locations (schools, churches). Co-market with partners to drive early engagement.	% of births with prenatal care started in 1st Trimester

Enhance Clinical Programming for High-Risk OB	• Expand access to multi-disciplinary care for high-risk obstetric patients
	  • Expand Cardio-OB Services, Implement Cardio-OB Screening Tool
	  • Enhance access to pre-/ post-natal medical care (diabetes, etc.)
	  • Develop Psych-OB service
		• % completion of CV assessment
		• # patients in high-risk OB

Provide Culturally Competent Care with Holistic Support Services	• Expand provision of doula and patient navigator services, linking patients to culturally competent and compassionate care (for both high-risk and low-risk groups). • Enhance lactation and breastfeeding support, integrating community-based efforts and collaboration with programs like Rose. • Enhance post-partum depression identification and support	% of births exclusive breast milk Post-partum Depression Screening
Community Engagement and Awareness Campaigns	• Design and launch a campaign that educates about the importance of early and ongoing prenatal care, targeting both patients and referring providers in the community. • Improve Grady's web resources and online scheduling to facilitate access to care and information. • Build equity dashboards for prenatal visits, breastfeeding, and postpartum depression screening; integrate Epic workflows for risk screening and referrals.	% of births with prenatal care started in 1st Trimester

Improving maternal and infant health outcomes require early and consistent prenatal care, coordinated support for high-risk pregnancies, and culturally responsive services that address both clinical and social needs. Expanding access to prenatal care, enhancing multidisciplinary care models, strengthening lactation and postpartum support, and improving community outreach can significantly reduce preventable complications and inequities.

Maternal & Child Health Anticipated Impact

- Earlier initiation and increased consistency of prenatal care leads to improved birth outcomes, reduced preterm births, and decreased morbidity and mortality rates.[3,4]
- Improved outcomes for high-risk pregnancies through coordinated multidisciplinary care, enhanced monitoring, and early intervention for conditions such as hypertension, diabetes and cardiovascular complications.[5,6]
- Higher breastfeeding initiation and continuation rates as a result of culturally competent lactation support, doula integration, and improved postpartum education.[7]

[3] Albarqi, M. N. (2025). *The impact of prenatal care on the prevention of neonatal outcomes: A systematic review and meta-analysis of global health interventions*. Healthcare (Basel), *13*(9), 1076. doi.orgCrockett AH, Heberlein EC, Smith JC, Ozluk P, Covington-Kolb S, Willis C. Effects of a Multi-site Expansion of Group Prenatal Care on Birth Outcomes. Maternal & Child Health Journal. 2019;23(10):1424-1433

[4] Ickovics JR, Kershaw TS, Westdahl C, et al. Group Prenatal Care and Preterm Birth Weight. Obstetrics & Gynecology. 2003;102(5 part 1):1051-1057.

[5]Crockett AH, Heberlein EC, Smith JC, Ozluk P, Covington-Kolb S, Willis C. Effects of a Multi-site Expansion of Group Prenatal Care on Birth Outcomes. Maternal & Child Health Journal. 2019;23(10):1424-1433

[6] Ickovics JR, Kershaw TS, Westdahl C, et al. Group Prenatal Care and Preterm Birth Weight. Obstetrics & Gynecology. 2003;102(5 part 1):1051-1057.

[7]Alvarado, G., Schultz, D., Malika, N., & Reed, N. (2024). United States doula programs and their outcomes: A scoping review to inform state-level policies. *Women's Health Issues*, *34*(4), 350–360. https://doi.org/10.1016/j.whi.2024.03.001

HIV Implementation Strategy

Priority	HIV	
3-Year Goal	Increase HIV testing and linkage to care by integrating status-neutral HIV services into primary and preventive care, while expanding prevention, treatment innovation and retention programs.	
Plan		
Strategy	**Description**	**Measure**
Integrate Status Neutral Care in the fabric of primary and preventative care at Grady	• Embed HIV testing and prevention into all Neighborhood Health Centers (NHCs) and primary care workflows. • Includes universal testing access, frequent provider/staff education, and rapid linkage to care for every positive HIV test.	% of eligible patients tested for HIV
Lead in Good Science to End the Epidemic by reducing the viral load and lower the number of new infections	• Advanced HIV treatment and prevention (long acting) • Sustain and expand retention in care programs that offer supportive services • Broaden partnerships with community agencies serving persons living with HIV (e.g. justice system, homeless service system)	Retention in Care %
Rapid, Person-Centered Linkage to Care for every Positive HIV Test	• Develop supportive services for prevention patients, leverage technology for education and self-order HIV testing, and strengthen PrEP persistence programs. • Robust staffing with individuals with lived experience where testing occurs – Explore lived experience compensation • Improve data collection of HIV care plans for all Grady patients • System to monitor linkages to care (dashboard, technology enabled education) • Care coordination	% of positive tests linked to care within 30 days
Broaden Community Partnerships	• External education efforts, including community meeting series and digital educational materials. • Community educational meeting series • Develop digital educational materials with a self-order link for HIV testing	PrEP persistence rate

Effective HIV prevention and care strategies require expanding routine testing, strengthening linkage to care, improving adherence support, and reducing barriers driven by SDOH drivers. Implementing the above approaches has been shown to improve early diagnosis, increase viral suppression, and reduce new infections.

HIV Strategy Anticipated Impact

Research suggests that the implementation of these evidence-based mental health strategies can yield the following outcomes:

- Increased access to PrEP for patients at high-risk for HIV infection and improved access or linkage to HIV care and viral suppression for people living with HIV/AIDS through rapid-entry programs.[8,9]
- Higher retention in care and treatment adherence through integrated supportive services, peer navigation, and expanded long-acting HIV treatment options.[2,10]
- Improved medication adherence and viral suppression[11]

[8] Buchbinder SP. Maximizing the Benefits of HIV Preexposure Prophylaxis. Top Antivir Med. 2018;25(4):138–142.
[9] Colasanti J, Sumitani J, Mehta CC, et al. Implementation of a Rapid Entry Program Decreases Time to Viral Suppression Among Vulnerable Persons Living With HIV in the Southern United States. Open Forum Infectious Diseases. 2018;5(6).
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OTHER HEALTH PRIORITIES

Through the prioritization process, GHS identified the health needs that will be considered secondary in the health systems' implementation efforts. The secondary health priorities include:

- Chronic Conditions (Hypertension + Diabetes)
- Cancer
- Violence and Injury

These areas continue to be priorities for Grady and the communities they serve, and robust services and innovative programs are already being implemented. CHIP strategies will include improving, growing and funding existing work. Additionally, strategies implemented under the primary priorities of Access to Care and SDOH will likely improve outcomes across these areas.

	Chronic Conditions (Hypertension + Diabetes)	Cancer	Violence and Injury
Goals	• Improve blood pressure and A1c control for Grady primary care patients	• Increase Cancer Screening Rates for Grady primary care patients • Decrease Time to Treatment	• Increase the number of Grady patients served by violence intervention programs
Strategies	• BP QI initiatives • Food as Medicine Food Pharmacy, Fresh Food Carts • Med Adherence Pharmacy	• Cancer screening (breast, lung, etc.) • Mobile Mammography* • Genetic risk assessment program	• Expand hospital-based violence prevention initiatives (IVYY Program) • Continue community leadership and engagement • Expand the Trauma Recovery Center • Support growth of Cardiff program and network
	Leverage Access to Care Strategies: Expand primary care access, strengthen community relationships to drive health education		
	Leverage SDOH Strategies: Screen for SDOH and connect to resources via partner network; transportation, food and housing partnerships		

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