COMMUNITY HEALTH IMPROVEMENT PLAN

2020-2022 Implementation Strategy

I. About Grady Health System

Grady Health System (GHS) stands as one of the largest safety net health systems in the United States, and is the only Level 1 trauma center verified by the American College of Surgeons in Atlanta, serving a population of almost 1.7 million residents primarily in DeKalb and Fulton counties. GHS provides a range of critical and intensive care, including the Marcus Stroke and Neuroscience Center and a comprehensive Burn Center. GHS also provides primary care services at the main hospital, and six primary care centers and one walk-in center dispersed throughout Fulton and DeKalb counties and the Infectious Disease Program. A list of GHS's primary care centers is provided in Table 1.

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
East Point Health Center	Fulton
North Fulton Health Center	Fulton
Primary Care Center at Grady Memorial Hospital	Fulton
Kirkwood Health Center	DeKalb

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 provides a dedicated 60+ service line for older adults, and 100 other subspecialty services. Moreover, GHS houses Georgia's Poison Center, a 24-hour Rape Crisis Center, 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.

Managing about 700,000 patient visits each year, the majority of GHS's revenue is generated through Medicare and Medicaid reimbursement. Still, millions of dollars in indigent and charity care are provided monthly – expensive care that GHS must shoulder. In 2017, Grady provided more than $400 million in indigent and charity care (including non-reimbursed dollars).

Although vital to GHS's survival, Fulton and DeKalb taxpayer support constitutes a relatively small portion of GHS's operating budget. Charity medical care, including essential supplies and equipment, is provided at all levels of the health system and across all specialty areas.

II. About the GHS Community

The population of Georgia is one of the fastest growing in the nation. The community served by GHS, Fulton and DeKalb counties, is also projected to grow at a rapid pace. According to 2018 population estimates, these counties have remained in the top four most populous in the state (Fulton #1, DeKalb #4) since 2016. DeKalb County's population is expected to increase by 5.6 percent between 2018 and 2023; the population in Fulton County is projected to grow by 6.7 percent during this period. When compared to Georgia, these counties are younger, more diverse, and higher income earning.

The African American population constitutes 54 percent of the population in DeKalb County and 44 percent in Fulton County. Comparatively, African American residents make up less than one-third of the total state population. The Hispanic/Latino population makes up 8.7 percent and 7.4 percent of the population in DeKalb and Fulton Counties, respectively. The White population is less than 50 percent in each county. Since 2016, when the last community health improvement plan was authored, the Hispanic population has decreased slightly. During the same period, the population with limited English speaking skills decreased in both counties; however, it remains higher in DeKalb County when compared to the state (6.2 percent and 3.2 percent, respectively).

The service area's population has remained relatively young, but is projected to grow slightly older by 2023. The median age is 35.5 years in DeKalb and 35.2 years in Fulton. The largest segment of the population in both counties is in the 35-54 age range. The second largest segment is in the 0-14 age range. Residents age 65 years and older make up slightly more than 10 percent of the population in both counties, but this is increasing.

Social and economic drivers are significant determinants of an individual's health. Among these factors are education, language skills, access to insurance, and income. These factors influence an individual's ability to obtain employment, safe housing, nutritious foods, and access healthcare, all of which impact health. Poverty has decreased in the GHS service area since the 2016 Community Health Needs Assessment (CHNA). The percentage of the population living at or below the Federal Poverty Level (FPL) in DeKalb County, which is $25,750[1] for a family of four, decreased from 19.0 percent to 17.6 percent. Similarly, poverty decreased in Fulton County from 17.6 percent to 16.0 percent. While single-parent families experience the highest rates of poverty throughout the service area, Fulton County shows the starkest contrast between single-parent poverty (30.1%) when compared to all other types of families (11.7%).

Access to insurance is closely related to poverty and income, as low-income residents are more likely to be uninsured or underinsured. Since 2016, the percentage of uninsured residents decreased throughout the service area. In 2018, 16.1 percent of adults 18-64 years of age were uninsured in Fulton County, and 14.6 percent in DeKalb County, compared to 14.8 percent uninsured statewide. Some of the highest uninsured rates in the service area occur in Fulton County ZIP codes[2]. According to the most recent estimate, 11.9 percent of Fulton County and 17.2 percent of DeKalb County are enrolled in Medicaid. Statewide, 14.6 percent of the total population is enrolled in Medicaid. The lack of access to insurance limits access to healthcare services, particularly, access to preventive services.

[1] 2019 Federal Poverty Guidelines

[2] [30315 (43.6%), 30310 (38.1%), 30314 (33.3%), 30354 (33.2%), 30311 (39.8%), 30322 (32.2%), and 30337 (30.5%)]

III. Community Health Needs

In 2013 and 2016, Georgia Health Policy Center conducted a similar CHNA and Implementation Strategy for GHS. When comparing to the previous two CHNAs, there are several notable trends in the 2019 findings:

There are notable improvements in:

- Cancer incidence and mortality rates;
- The number of providers generally, though safety-net providers remain low;
- Poverty, though the rate remains slightly higher than 10 years ago;
- Unemployment; and
- Insurance rates, but there is no measurement of underinsurance.

Trends worsened for:

- Cardiovascular conditions;
- Maternal and child health, specifically in Fulton County;
- Obesity, though the rate of growth has slowed;
- Human immunodeficiency virus (HIV) and STIs;
- Substance abuse and overdose;
- Violence and injury; and
- Inequities.

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 2019 to identify needs and resources in its community. Since GHS is part of the Atlanta Regional Collaborative for Health Improvement (ARCHI), data collection, analysis, and community engagement activities were done in partnership with other ARCHI members. The CHNA examined secondary data and took into account 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 review of the data, GHS used a set of criteria, including importance to stakeholders, relative burden, and disparities to identify and prioritize the significant health needs facing the community and documented them in a written CHNA Report.

GHS set goals and selected ARCHI strategies for each of the prioritized health needs. A description of each ARCHI strategy is provided on page 5.

Table 2. GHS Community Health Priorities and ARCHI Strategies

Prioritized Need	3-Year Goal	Care Coordination	Healthy Behaviors	Insurance	Pathways to Advantage
1. **HIV/STD**	Increase the percentage of HIV patients retained in care at GHS	X	X		
2. **Social Determinants of Health**	- Increase the percent of patients screened for SDOH - Increase the number of partnerships to address SDOH				X
3. **Access to Care**	Decrease the percent of uninsured residents in Fulton and DeKalb	X		X	X
4. **Cardiometabolic Syndrome**	Decrease the percent of GHS primary care patients with: - uncontrolled hypertension - uncontrolled diabetes	X	X		X
5. **Violence and Injury**	Increase the number of GHS patients served by a violence prevention program	X			X
6. **Mental Health**	Increase depression remission among GHS primary care patients	X			
7. **Maternal and Child Health**	Improve maternal outcomes for moms delivering at Grady	X	X		X
8. **Cancer**	Increase the number of patients screened for breast, lung, and prostate cancer	X	X		

The commitment to ARCHI's community health collective impact model was the backdrop for the prioritization of health needs and determination of strategies. Additionally, stakeholders agreed that targeting efforts in specific geographic areas and subpopulations in the community will ensure the greatest community benefit is achieved with potential to impact health disparities.

IV. Implementation Strategy Development Process

GHS employed a two-phased approach to prioritize the health needs and determine the strategies to address the needs. In the first phase, the GHS Executive Planning Council reviewed and prioritized health needs from the CHNA. The second phase included confirming needs to be addressed and developing strategies to address them using the ARCHI framework.

Table 3 lists members of the GHS Executive Planning Council, the group that participated in the development of Community Health Improvement Strategy through a series of work sessions.

Table 3. GHS Executive Planning Council Members

GHS Executive Planning Council Members	
John M. Haupert, FACHE - Chief Executive Officer	Timothy Jefferson, Esq. - Chief Legal Officer
Joselyn Butler Baker - President, Grady Health Foundation	Ben McKeeby - Chief Information Officer
Kelley Carroll, MD - Chief of Ambulatory Services	Richard Rhine - Chief Financial Officer
Lindsay Caulfield - Chief Marketing & Experience Officer	Carlos del Rio, MD - Executive Associate Dean, Emory School of Medicine at Grady
Lina George - Chief Human Resources Officer	Shannon Sale - Chief Strategy Officer
Jacqueline Herd - Chief Nursing Officer	Michelle Wallace - Chief of Clinical Operations
Matthew Hicks - Chief Policy Officer	Yolanda Wimberly, MD - Senior Associate Dean, Clinical Affairs, Morehouse School of Medicine
Robert Jansen, MD, MBA - Chief Medical Officer/ Chief of Staff	

Council 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?*

After ranking the needs, the Council selected ARCHI focus areas as the foundation of the Implementation Strategy. Each of the ARCHI areas are aimed at improving the health of people in Fulton and DeKalb Counties by 2040. A description of each focus area included in this plan follows:

Coordinated Care: Focuses on coordinating patient care, and providing patient and provider coaching to reduce duplicate or unnecessary care and costs. Using integrated information systems, coaching arrangements, protocols for shared decision-making and increased use of generic drugs when appropriate.

Insurance: Promoting policies and practices that result in reductions in the uninsured population.

Encouraging Healthy Behaviors: Promoting healthy behavior can prevent people from developing chronic conditions or help people stop doing behaviors that can lead to chronic physical illness – smoking, poor diet, inadequate exercise, alcohol and drug abuse, unprotected sex, etc. Efforts may be focused at the population level or targeted audiences.

Pathways to Advantage: Instituting policies and programs to improve economic prospects so that financially disadvantaged families — those earning below twice the federal poverty level — may become advantaged.

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 in order to identify strategies to address the selected health needs:

(1) Previous strategies;
(2) ARCHI Playbook;[3]
(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 – patient, organization, and community – defined as follows:

- **Patient** – Target a specific Grady patient population
- **Organization** – Establish or improve system-wide programs, policies or procedures
- **Community** – Collaborate with partners in community settings

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. New initiatives are marked with an asterisk in the tables below. 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 Planning Council, goals, strategies, target population, and expected outcomes for each prioritized health need were drafted. The needs that GHS has chosen not to track and measure are noted, and rationale is provided in the section following the Implementation Strategy.

V. Implementation Strategy

The Implementation Strategy tables in this section detail the three-year plan to address the prioritized health needs in Fulton and DeKalb counties.

HEALTH EQUITY Foundation for All Implementation Strategies

Nearly all of the community health needs identified in the CHNA disproportionately affect certain portions of the population. For example, the rates of chronic disease and homicide deaths are higher in the African American community; people in low-income households are more likely to be uninsured; and the HIV epidemic disproportionately affects African American and LGBTQ communities. As we work to address the health needs of our community, it is Grady's underlying priority to promote health equity. The majority of Grady's patient population is African-American and low income. In 2018, 76 percent of patients were African American, 9 percent were Hispanic/Latino, 41 percent were uninsured, and 22 percent were enrolled in Medicaid. Strategies that target Grady's patients will have a significant impact on low-income and minority populations. Moreover,

[3] http://www.archicollaborative.org/archi_playbook.pdf
[4] https://www.thecommunityguide.org/

GHS will work to implement community-focused strategies in neighborhoods that represent Grady's patient population, since that is where health inequities persist.

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 ARCHI 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.

CARE COORDINATION Implementation Strategy

According to the U.S. Agency for Healthcare Research and Quality, care coordination involves the deliberate marshalling of personnel and resources needed to facilitate the appropriate delivery of healthcare and other required patient care activities.[5] The New England Journal of Medicine concludes that successful coordination requires four elements: (1) easy access to a range of healthcare services and providers; (2) good communication and effective care plan transitions between providers; (3) a focus on the total healthcare needs of the patient; and (4) clear and simple information that patients can understand.[6] When implemented successfully, the coordination of care across providers can improve disease outcomes while containing overall healthcare costs.[7]

Health Need	HIV/STD, Access to Care, Cardiometabolic Syndrome, Violence and Injury, Behavioral Health, Maternal and Child Health, and Cancer
3-Year Goal	Promote patient health through effective and efficient care coordination among persons served by GHS with the following conditions: HIV/STD, cardiometabolic syndrome, victims of intentional and unintentional injury, pregnancy, cancer, or those with barriers to accessing care
Target Population	Underserved populations in Fulton and DeKalb Counties (low-income, racial/ethnic minorities, uninsured)

Strategies		
Patients	**Organizational**	**Community**
Maintain collaboration with partners and leverage internal resources to improve care management and ensure appropriate follow-up for high-risk patients through the use of patient navigators, increased monitoring, telehealth, preventive screenings, and Community Health Workers[8] (CHWs). • Chronic Care Clinic • Transitions of Care Clinic • Mobile Integrated Health • Cancer Center Nurse Navigators • PrEP clinic and expanded access* • Centering Pregnancy Program	Optimize resource utilization to improve chronic disease and behavioral health services for the patient population served by GHS, and continue growing partnerships to increase available services in the community. • Telehealth services • Patient-centered care initiatives • HIV Rapid Entry Program • CHW workforce development at GHS • Integrated behavioral health in Primary Care • Extended hours*	Continue to collaborate with stakeholders and partners to support the development of infrastructure and policies to streamline and expand care coordination, through the use of CHWs and other resources. • Statewide CHW Advisory Board • Community-based CHWs • Improve specialty referral management • Strengthening alignment with substance abuse providers • Expand partnerships and coordination with public health agencies to strengthen

[5] US Agency for Healthcare Research and Quality. Care Coordination, Quality Improvement. website. https://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html. October 2014. Accessed October 28, 2019.
[6] New England Journal of Medicine. What is care coordination? website. https://catalyst.nejm.org/what-is-care-coordination/. January 1, 2018. Accessed October 28, 2019.
[7] McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun. (Technical Reviews, No. 9.7.) 2, Background: Ongoing Efforts in Care Coordination and Gaps in the Evidence.
[8] Georgia Department of Public Health. A Community Health Worker (CHW) is a frontline health worker who is a trusted member of and/or has a demonstrated working knowledge of the community and individuals served.

• Chronic Heart Failure (CHF) value-based care initiative • Trauma Recovery Center and wraparound services for victims*		patient care engagement and mother/baby efforts • Access to HIV care outside of IDP • Alignment with End the Epidemic Initiative in Atlanta*

Outcomes

- Improved compliance with and adherence to medication and other disease management protocols among primary care providers
- Increased provider capacity and access across primary care centers
- Increased support for high-risk patients post-discharge
- Improved self-management among patients
- Reduction in complications due to conditions of focus
- Increase in appropriate screenings and primary care visits for high-risk and low-income populations
- Increased number of community health workers and patient navigators serving community
- Decreased emergency room visits among high-risk patients and emergency department high utilizers
- More clarity and consensus around the training, use, and reimbursement of CHWs
- Increased partnerships and collaborations aimed at providing behavioral health services

* New community health program to be initiated over the next three years

Anticipated Impact

Several strategies at the patient, organizational, and community-level have been outlined. In implementing these care coordination strategies, the following evidence-based programmatic outcomes can be anticipated:

- 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.[9,10]
- Improved access to primary care, quality of discharge, patient satisfaction with care, and hospital readmission rates for patients with chronic diseases.[11,12]
- Improved trauma care and comprehensive wraparound services structured around patients' experiences and holistic needs.[13]

[9] Buchbinder SP. Maximizing the Benefits of HIV Preexposure Prophylaxis. Top Antivir Med. 2018;25(4):138–142.

[10] 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).

[11] Kangovi S, Mitra N, Grande D, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. JAMA Intern Med. 2014;174(4):535–543.

[12] Lee T, Ko I, Lee I, Kim E, Shin M, Roh S, Yoon D, Choi S, Chang H. Effects of nurse navigators on health outcomes of cancer patients. Cancer Nurs. 2011 Sep-Oct;34(5):376-84.

[13] Berwick D, Downey A, Cornett E, editors. A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury. Washington, DC: National Academies Press; 2016 Sep 12. 6, Delivering Patient-Centered Trauma Care.

- Increased community support, engagement, and social capital through strategic partnerships with community stakeholders, organizations, and institutions.[14,15]
- Enhanced value-based clinical care and disease management through the implementation of telemedicine.[16]
- Improved cost-effective care and health outcomes for patients with mental illness through the collaboration and co-location of primary care and behavioral health clinicians.[17,18]
- Improved birth and maternal health outcomes through the expansion of group prenatal care services.[19,20]

When taken together, these strategies would:

- Increase provider capacity and access at primary care and neighborhood health centers;
- Increase partnerships and collaborations aimed at providing behavioral health services;
- Increase support and services for survivors of trauma and their families;
- Increase the number of CHWs and patient navigators serving the community;
- Improve care engagement and self-management among patients; and
- Decrease pre-term and low-birthweight births, and maternal mortality rates among patients.

[14] Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington, DC: National Academies Press; 2017 Jan 11. 7, Partners in Promoting Health Equity in Communities.

[15] University of Kansas. Chapter 1. Our Model for Community Change and Improvement. Section 7. Working Together for Healthier Communities: A Framework for Collaboration Among Community Partnerships, Support Organizations, and Funders. website. https://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement/framework-for-collaboration/main. Accessed October 28, 2019.

[16] Tuckson RV, Edmunds M, Hodgkins ML. Telehealth. N Engl J Med. 2017 Oct 19;377(16):1585-1592.

[17] National Institute of Mental Health. Integrated Care. website. https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml. February 2017. Accessed October 28, 2019.

[18] Gerrity M, Zoller E, Pinson N, Pettinari C, King V. Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. https://www.milbank.org/wp-content/uploads/2016/04/Integrating-Primary-Care-Report.pdf. Published December 2014. Accessed October 28, 2019.

[19] 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

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

INSURANCE Implementation Strategy

Since the inception of the ACA in 2010, there has been a gradual decline in overall uninsured rates. However, throughout the US, there was a 1.9 million increase in uninsured people in 2018, when compared to 2017.[21,22] Uninsured rates disproportionately affect young adults (19–25 years old), non-citizens, people living in Southern states or states that haven't expanded Medicaid, Hispanics and African-Americans, and residents that fall below the 100% FPL.[23] Uninsured adults are less likely to seek preventive services for chronic diseases, and they may resort to delaying care due to unaffordability of coverage and overall out-of-pocket medical expenses.[24] Evidence shows coverage expansion can greatly improve health; it has been shown to vastly reduce medical expenses, improve access to primary care and preventive services, and increase chronic disease treatment and diagnosis rates.[25]

Health Need	Access to Care
3-Year Goal	Increased insurance coverage among all Georgians and persons served by GHS
Target Population	Uninsured population across Georgia, including Fulton and DeKalb Counties

Strategies

Patients	Organizational	Community
Support efforts to increase insurance coverage of uninsured populations among GHS patients. • Onsite Medicaid application assistance through Food As Medicine Partnership	Continue to leverage organizational policies and practices to increase access to insurance and necessary healthcare among uninsured residents. • Medicaid and PeachCare enrollment • Financial Assistance Program	Continue to convene and collaborate with stakeholders to support policies that increase access to health insurance for all Georgians. • Healthy Georgia Solution (1115 Medicaid Waiver)*

Outcomes

- Reduction in the number of the Fulton and DeKalb residents without health insurance
- Increased access to healthcare for low-income residents
- Expanded partnerships in support of increasing health insurance access
- Statewide reduction in the number of uninsured individuals

* New community health program to be initiated over the next three years

[21] U.S. Census Bureau American Community Surveys. 1-Year Estimates, 2008–2018,

[22] U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement, https://www.census.gov/content/dam/Census/newsroom/press-kits/2019/iphi/presentation-iphi-overview.pdf

[23] U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement

[24] C. Pryor, D. Gurewich, "Getting Care But Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices," The Access Project, 2004. J.Z. Ayanian, "Unmet health needs of uninsured adults in the United States," *JAMA* 2000. 284(16): pp. 2061–9.

[25] B.D. Sommers, A.A. Gawande, K. Baicker, "Health Insurance Coverage and Health – What the Recent Evidence Tells Us," *N Engl J Med*, 2017 377(6): pp. 586–593.

Anticipated Impact

By leveraging partnerships and maximizing internal resources to increase coverage and access to care, the following outcomes are anticipated:[26]

- 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

Fidelity in all proposed strategies will continue to support efforts to increase insurance eligibility assessment and enrollment for uninsured patents. This will allow for expanded healthcare access for the target populations.

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

HEALTHY BEHAVIORS Implementation Strategy

Evidence-based health education and promotion initiatives stand as the cornerstone of population health. A population's health and wellness are not simply determined by the presence, or absence, of a well-functioning health care system. Health, and subsequently quality of life, is the result of many dynamic and complex systems and factors at multiple levels: individual, interpersonal, organizational/institutional, community, environmental, and policy. According to Healthy People 2020, "educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings."[27] Health education programs are essential as they are designed to reach individuals outside of traditional clinical settings using existing social structures and resources. When evidence-based educational programs are implemented effectively, they can help reduce health disparities, improve outcomes among marginalized communities, and promote health equity.[28]

Health Need	HIV/STD, Cardiometabolic Syndrome, Maternal and Child Health, and Cancer
3-Year Goal	Increase patient and community engagement in healthy behaviors
Target Population	Residents of Fulton and DeKalb Counties (low-income, racial/ethnic minorities, uninsured)

Strategies		
Patients	**Organizational**	**Community**
Promote healthy behaviors (e.g., smoking cessation, physical activity, healthy eating, healthy sexual practices, etc.) among patients in clinical settings by increasing patient engagement in care plans and providing information, referrals, and follow up. • ARCHI Diabetes Collaborative • Food as Medicine Prescription Program* • Hypertension Peer Educator Program* • Linkage to physical activity opportunities*	Leverage organizational policies and practices to promote and support healthy behaviors among patients and community members. • Talk With Me Baby • Cancer screenings • Chronic Disease Self-Management Program (CDSMP) • Diabetes Prevention Program • Health literacy training for employees*	Continue to collaborate with stakeholders and community partners to support the development of programs and policies that promote healthy behaviors in DeKalb and Fulton Counties. • Deploy and equip staff or volunteers to provide community-based education, screening and connection to care (HIV/STD, diabetes, hypertension, cancer) • Expand partnerships with public health agencies, faith-based organization, schools and other community-based organizations • Walk the Line wellness program • Address stigma associated with HIV and sexual health*

[27] US Department of Health & Human Services. Educational and Community-Based Programs. Website. https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs. Accessed October 28, 2019.
[28] Hahn RA, Truman BI. Education Improves Public Health and Promotes Health Equity. Int J Health Serv. 2015;45(4):657–678.

Outcomes
• Improved blood glucose, blood pressure, and cholesterol levels among patients • Reduction in smoking rates among patients • Reduction in body mass indexes (BMIs) of patients • Increased awareness of healthy behaviors among patients • Increased opportunities for residents to engage in healthy behaviors • Increased awareness of risk and preventive behaviors related to cardiometabolic syndrome, cancer, and HIV/AIDS

* New community health program to be initiated over the next three years

Anticipated Impact

Several strategies at the patient, organizational, and community level have been outlined. Research suggests that the implementation of these evidence-based strategies can yield the following outcomes:

- Improvements related to physical activity and healthy eating, cognitive symptom management, communication with physicians, self-reported general health, health distress, quality of life, and social/role activities limitations, days in the hospital, and number of outpatient visits and hospitalizations for those living with HIV/AIDS and diabetes[29,30]
- Increased and improved patient knowledge, attitudes, beliefs, and perceptions regarding hypertension, HIV/AIDS, and diabetes and improved social health/connectedness and engagement[31]
- Improved access to primary care, quality of discharge, and hospital readmission rates for those living with HIV/AIDS and diabetes[32]
- Improved food security, increased fruit and vegetable consumption, decreased barriers to accessing to healthy foods and healthy eating, and associated reductions in BMI and A1C levels for patients with chronic diseases (i.e. hypertension, diabetes)[33,34,35]

[29] Self-Management Resource Center. Chronic Disease Self-Management (CDSMP). website. https://www.selfmanagementresource.com/programs/small-group/chronic-disease-self-management. Accessed October 28, 2019.
[30] Beck J, Greenwood DA, Blanton L, et al. 2017 National Standards for Diabetes Self-Management Education and Support. Diabetes Care. 2017;40(10):1409-1419.
[31] Ramchand R, Xenakis L, Grimm G, Apaydin E, Raaen L, Ahluwalia SC. A systematic review of peer-supported interventions for health promotion and disease prevention. Preventive Medicine. August 2017:156-170.
[32] Kangovi S, Mitra N, Grande D, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. JAMA Intern Med. 2014;174(4):535–543.
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- Increased community support, engagement, and social capital through strategic partnerships with community stakeholders, organizations, and institutions[36,37]
- Increased cancer screening and adherence to diagnostic follow-up care, and increased access to and utilization of cancer care[38,39]
- Increased number of children from birth to three years old who receive adequate language-rich, adult-child interactions[40,41]

Broadly, the implementation of health literacy interventions increase people's capacity to obtain and understand basic health information and health systems necessary to make appropriate health-related decisions. On an individual level, improved health literacy will improve health by increasing health-related knowledge and healthy behavioral skills, promoting self-management practices, and improving adherence to appropriate treatment.[42] Accordingly, hospital systems are likely to expect the following outcomes:[43]

- Lower hospitalization rates
- Reduction in the utilization of the emergency room and inpatient services for routine care
- Improved access to primary care providers
- Improved usage of pharmacy services

Together, these strategies have the potential to decrease Body Mass Index and A1C (average blood glucose) levels; promote healthy eating and physical activity; reduce food insecurity; increase patient knowledge, attitudes, beliefs, and perceptions regarding chronic disease management; increase cancer screening and adherence to follow-up care; increase the number of children from birth to three years of age who receive adequate language and nutrition; and strengthen community partnerships aimed at improving the health of communities served by GHS.

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FAMILY PATHWAYS TO ADVANTAGE Implementation Strategy

According to the County Health Rankings Population Health Model, clinical care influences population health outcomes far less than social and economic factors (SES) (20% and 40%, respectively).[44] Income level, educational attainment, and occupational status collectively define a person's SES. Evidence shows that families from communities that lack basic resources (i.e., healthy housing, medical and educational amenities, or equity) experience poor health outcomes. These disparities exacerbate unhealthy behaviors; influence adverse experiences; and impact access to, use of, and quality of healthcare.[45] African American and Hispanic residents are disproportionately represented in lower SES populations served by GHS, thus increasing their risk of various diseases and reduced life expectancy.[46] In recent years, providers have begun to implement systematic processes to identify and address SDOH for individuals and families to improve health outcomes and provide holistic treatment.

Health Need	Social Determinants of Health (SDOH) (including Housing, Access to Food, and Transportation), Access to Care, Cardiometabolic Syndrome, Violence and Injury, and Maternal and Child Health
3-Year Goal	Increase the percent of patients screened for SDOH and referred to services
Target Population	Residents of Fulton and DeKalb Counties (low-income, racial/ethnic minorities, uninsured)

Strategies		
Patients	**Organizational**	**Community**
Promote programs that mitigate the influence of negative SDOH on the health outcomes of GHS patients, with a focus on patients who have limited access to care, have cardiometabolic syndrome, are victims of violence, or are pregnant. • Pilot transportation programs • Onsite SNAP application assistance through FAM Partnership • Housing placement coordination • Violence Reduction Program	Leverage organizational policies and practices to promote and support programs that mitigate the influence of negative SDOH on health outcomes of patients and community members. • SDOH screening and referrals • Jesse Hill Market through FAM Partnership* • Patient and Family Advisory Councils • CHW workforce development • MARTA Reduced Fare enrollment* • Domestic Violence Program*	Continue to collaborate with stakeholders and community partners to support the development of programs and policies that mitigate the influence of negative SDOH on health outcomes in DeKalb and Fulton Counties. • ARCHI Health and Housing work group* • Prestwick Healthy Housing partnership* • Cardiff Injury Prevention Program • Statewide CHW Advisory Board • Housing for persons living with HIV

[44]CHRs and Roadmaps Population Health Model

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Outcomes
• Increased access to social services and programs that address SDOH • Increased access to fresh fruits and vegetables among GHS patients, families, visitors and the community • Increased number of GHS patients that are referred to stable housing • Decreased number of victims of violent crimes

* New community health program to be initiated over the next three years

Anticipated Impact

By addressing social determinants of health on a patient, organization, and community level, evidence suggests that these strategies are likely to:

- Reduce pervasive barriers to healthcare, increase identification of individuals and families in need of resources, and improve outcomes for families earning a low income[47]
- Increase completed appointments, improve medication adherence, and reduce health inequities due to transportation barriers[48]
- Improve body weight and BMI; increase access to fresh fruits and vegetables; improve diet quality; reduce the likelihood of obesity, type two diabetes, and cardiovascular disease; reduce birth defect risks, cognitive disturbances, and anemia in children[49]
- Decrease exposure to violence; reduce behavioral problems, depression, anxiety and PTSD; reduce suicidal ideation and attempts; reduce the number of hospital admissions for conditions related to sexual risk-taking and risky driving practices (DUI); decrease substance abuse; reduce the likelihood of physical health issues such as injuries; improve access to violence-related data from local partnerships; reduce intentional homicide and suicide rates, and decrease the rate of repeat victims of violent injury[50]
- Improve quality, efficiency, and patients' and families' experiences; increase safety measures; and improve performance of CMS quality and safety metrics[51]

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REMAINING HEALTH NEEDS

Through the prioritization process, GHS identified the health needs in the table below as priorities that will not be a primary focus of GHS's implementation efforts. Due to limited resources, GHS will only focus and report on the priorities outlined in the 2020–2022 Implementation Strategy. However, while respiratory conditiona and substance abuse are not included in the strategies outlined, GHS does have programs in place and initiatives underway that are addressing these community health needs.

Remaining Health Needs
Respiratory Conditions
Substance Abuse

Respiratory Conditions. GHS will continue to treat patients with respiratory conditions, and will be standardizing clinical pathways for patients with COPD through evidence-based order sets. During the next three years, GHS may also influence outcomes for residents with respiratory conditions through efforts related to healthy housing. For these reasons, GHS will not be developing a strategy specifically focused on this health need.

Substance Abuse. GHS has valuable partners in the community with the expertise to address substance use among Fulton and DeKalb residents. GHS believes it is crucial to support community partners that are addressing health needs in local communities to continue to be successful in their work with residents. For this reason, GHS is not the appropriate organization to provide substance use services. GHS will continue to support community-based partners working to address substance use and addiction in Fulton and DeKalb communities, and ensure a streamlined process for referral and care coordination for Grady patients.