# GRADY HEALTH SYSTEM

## Community Health Needs Assessment 2025

Grady

# Table of Contents

Grady

# List of Tables

# List of Figures

# A Reader's Guide

The purpose of a Community Health Needs Assessment (CHNA) is to systematically identify and analyze a community's health status, needs, and priorities to guide the development of targeted health improvement plans. A CHNA serves as a magnifying glass examining the health of a community. A commonly used process in public health, CHNAs include gathering a combination of qualitative and quantitative data to understand the story within the health outcomes in a community. Findings are shared with stakeholders to inform potential actions, from a small local non-profit's strategic planning to state or national level policy creation.[1]

This report outlines the 2025-2028 CHNA for Grady Health System. The report is broken into multiple sections:

- **Executive Summary**, an overarching snapshot of the CHNAs methods and findings.
- **Introduction** to the community, known as the "service area/region," and its associated demographics.
- **Methodology**, which outlines primary and secondary data collection processes.
- **Findings**, which outlines primary and secondary outcomes.
- **Health priorities and recommendations** for possible solutions to the current health concerns within the community, as summarized according to the qualitative, quantitative data and primary feedback from the community members and Grady Population Health Council.
- **References and Appendices**.

# Executive Summary

The 2025-2028 Grady Health System Community Health Needs Assessment (CHNA) used a population health approach to understand the factors impacting the health of communities served by the Grady Health System (GHS), which includes residents from Fulton and DeKalb counties in Georgia. The Georgia Health Policy Center (GHPC) at Georgia State University was the partner coordinating with Grady's Strategy and Population Health team on the CHNA. County and census tract data, extensive input from community leaders and residents, and a community survey informed this assessment. The CHNA and subsequent Community Health Implementation Plan (CHIP) informs health system leadership regarding strategies to address the health priorities in the service region over the next three years in accordance with Internal Revenue Service guidelines and regulations pertaining to not-for-profit hospitals in the United States.

## Why The Grady CHNA Matters

Since its founding in 1892, Grady has remained dedicated to serving those who cannot afford care. Over time, the mission has evolved with expansion of services, scientific advances, and the modernization of health care. Yet the core promise endures: to improve the health and well-being of all community members. Of note in the CHNA process over the last 10 years, Fulton and DeKalb residents have expressed challenges in accessing care and maintaining their families' health. Recently residents have reported significant challenges obtaining and maintaining access to the Social Determinants of Health (SDOH), namely stable income, quality education, safe housing, reliable transportation, healthy and affordable food, and child- and eldercare.[1] Multiple reports have revealed differences in life expectancy between races and geographic areas throughout the Fulton and DeKalb counties due in part to disparate chronic health outcomes including cardiovascular health, diabetes, hypertension, sexual health and substance use disorders.[2] To address these inequities and continue to fulfill its mission, Grady must conduct research via the CHNA to understand the community's true needs and the factors influencing overall well-being.

## Methodology

Per Section 501(r) entitled "Additional Requirements for Charitable Hospitals" of the IRS guidance, the primary focus of the CHNA is to address medical care, financial practices and efforts in providing care to low resourced and medically underserved populations within the primary service areas.[3] While GHS serves residents from counties across and outside the Atlanta metro area, this CHNA focuses on Fulton and DeKalb counties where the majority of patients reside.

[1] County Health Rankings & Roadmaps, 2025 (2023 data)
[2] Mapping Life Expectancy - 33n
[3] Section 501(r) reporting | Internal Revenue Service

Data collection, synthesis and interpretation took place between January and November 2025, under the approval of the Georgia State University Institutional Review Board. The CHNA was conducted using a mixed methods approach which included the synthesis of:

- Secondary data specific to the populations and geographic areas served by GHS comprised of data gathered from publicly available databases, overseen by federal, state and non-profit health and social services agencies. Health indicators reviewed included topics of focus from the previous CHNA, newly emerging health concerns and barriers, as well as other recent county, state and private community health assessments for the service area.
- Primary data including:
    - 11 key informant interviews with community leaders and local subject matter experts on health and social determinants of health;
    - 2 community conversations with residents;
    - 3 focus groups; 2 with residents and 1 with Grady's Patient & Community Advisory Committee;
    - Input and feedback from Grady's Population Health Council (PHC) and topic-specific work group members; and
    - A community survey conducted by Grady and distributed with the support of GHPC and other community stakeholders and partnering agencies.

Stipends were provided to the community members and key informants for their time and knowledge.

# Identifying and Prioritizing Community Health Needs

After compiling and analyzing both quantitative and qualitative data, the findings were cross-referenced to identify the leading health issues and uncover recurring themes within the qualitative insights. The top health concerns supported by the quantitative and qualitative data are:

- Mental health
- Violence and injury
- Access to Care
- Social determinants of health
    - Economic Stability/ Mobility
    - Housing cost
    - Healthy food access
    - Cost of Health Care
- HIV and STIs
- Cancer
- Maternal and child health
- Chronic Conditions
- Substance use

The list of significant health needs was presented to GHS' Population Health Council (PHC) by GPHC representatives. During the meeting, PHC members were provided with an overview of the primary and secondary data results as well as the opportunity to discuss and rank the top health needs listed. PHC members were asked to consider the magnitude, severity, and the impact each health need has on the community when completing the ranking activity. The magnitude of the problem included the number of residents impacted by the problem, while severity focused on the risk of morbidity and mortality associated with the problem.

# Health Priorities

Figure 1 summarizes the triangulation of results for the 2025 Grady CHNA. Considering all inputs (primary data, secondary data, and PHC), the primary health priorities for Grady Health System over the next three years are:

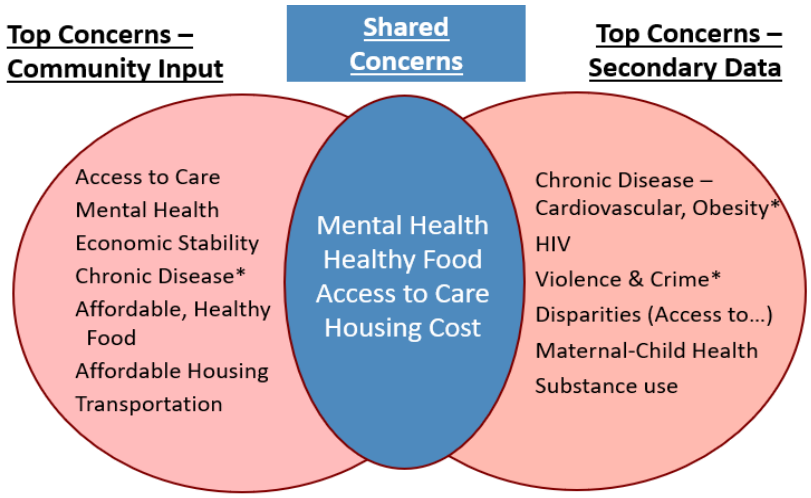
- Access to care
- Social determinants of health (SDOH)
- Mental health
- HIV
- Maternal and child health (MCH)

It is recommended that these primary health priorities be highlighted in the community health improvement plan and the focus of new community benefit investments.

Secondary priority areas were also identified during the CHNA process. These priorities were especially prevalent in the qualitative feedback and recognized by the PHC as being part of existing, ongoing work:

- Chronic conditions (diabetes and hypertension)
- Cancer
- Violence and injury

**FIGURE 1: HEALTH AND SOCIAL CONCERNS ARISING FROM THE 2025-2028 GRADY CHNA**




*Secondary priorities



Grady

Primary data collection participants were asked to share perspectives about (1) overall community health, (2) differences in life expectancy, (3) the support and resources available in their communities, (4) gaps in resources and services available, (5) challenges and barriers to achieving health, and (6) facilitators and resources that support improved community health and well-being. These audiences were also asked to prioritize what GHS should focus on over the next three years to improve community health and wellbeing. The recommendations are summarized in Table 1.

**TABLE 1: COMMUNITY RECOMMENDATIONS**

| ACTION AREAS 2025-2028 | COMMUNITY RECOMMENDED STRATEGIES |
|---|---|
| Access to care | Increase access to primary, maternal and child health, urgent, and dental care. Provide more in-community mobile care and screenings. |
| Clinical partnerships | Form new or expand existing partnerships and referral pathways with public health, FQHCs, and care management organization providers. |
| Health education | Focus on education regarding patient portal use and digital health literacy. Support chronic disease management initiatives, especially diabetes and hypertension. |
| Accessible mental health services | Mental Health via telemedicine and alternative appointment hours. Support people who are experiencing homelessness in receiving evidence-based mental health support. |
| Care navigation support | Increase the number of Community Health Workers in the region and empower them to support all aspects of care coordination. |
| Housing and homelessness | Partner to make affordable housing available in the region and to expand shelter access for those who are experiencing homelessness. |
| Transportation | Transportation to medical appointments is a top need. |
| Economic stability | Lack of income stability and affordable basic needs is a key source of stress in under-resourced families. Referrals to certificate or job training programs would help. |
| Food and nutrition | Access to healthy and affordable food that was culturally relevant was a need. Dietary guidance (Food as Medicine) to enhance chronic disease management was also a preferred strategy. |

# Conclusion

The 2025-2028 Grady CHNA highlights the key health issues and social determinants impacting the health and wellbeing of residents living in the service area. This Grady Community Health Needs Assessment report includes a summary of more than 70 indicators in 10 categories: healthcare access and affordability, mental health, economic stability, sexual health, health behaviors, maternal and child health, neighborhood and built environment, chronic conditions, and social and community context including social determinants of health.

Participants were eager to highlight potential solutions focusing on bringing care to community members and helping residents manage their health over time through partnerships that expand access to resources. Participants also highlighted the need for more education and reliable sources of information to manage their health conditions. In service of its mission and vision, GHS is encouraged to

expand strategic partnerships within Fulton and DeKalb communities by leveraging its history, knowledge, relationships and investments to improve community health across the GHS service area.

# Introduction

Grady Health System (GHS) was founded by Henry W. Grady in 1892. Now ranked as one of the largest hospitals in the country, GHS has grown considerably from its original three-story, 100-bed facility to a hospital with 950+ beds, seeing over 700 patients daily, and has come to be known for its specialty care centers including its trauma center, cancer treatment center, and its heart and vascular center.

Since its founding in 1892, the mission of Grady hospital and health system has focused on providing health care for the surrounding community that is ethical, culturally competent and compassionate. GHS Staff pride themselves on clinical and research achievements, collaboration in medical education and commitment to training the health workforce of tomorrow.[4]

Upon passing the 2010 Affordable Care Act (ACA), it was mandated that all not-for-profit hospitals are required to complete a Community Health Needs Assessment (CHNA) and Community Health Implementation Plan or Strategy every three years in the communities they serve.[5] The frequency of these assessments is to ensure health care systems are appropriately identifying and addressing the needs of their patient populations, particularly those who are most vulnerable.

Georgia Health Policy Center (GHPC) has been contracted to support GHS in completing this comprehensive CHNA report, so that it will meet the necessary Internal Revenue Service (IRS) final regulations of Section 501(r) entitled "Additional Requirements for Charitable Hospitals." In such collaborative efforts, this report marks the fifth cycle of using thoughtful, data driven approaches to assess, prioritize and determine the health needs of GHS's service region.[6]

Per Section 501(r) entitled "Additional Requirements for Charitable Hospitals" IRS guidance, the primary focus of the CHNA is to address medical care, financial practices and efforts in providing care to low resourced and medically underserved populations within the primary service areas,[7] in this case focusing on Fulton and DeKalb counties (located in north Georgia), even though it is known that GHS does receive patients from several other surrounding counties and rural areas of the state.

GHS has grown significantly to include 16 locations, with its main hospital in Atlanta including four Centers of Excellence. 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.

[4] About Us | Grady Health Atlanta Hospital
[5] Requirements for 501(c)(3) hospitals under the Affordable Care Act – Section 501(r) | Internal Revenue Service
[6] Requirements for 501(c)(3) hospitals under the Affordable Care Act – Section 501(r) | Internal Revenue Service
[7] Requirements for 501(c)(3) hospitals under the Affordable Care Act – Section 501(r) | Internal Revenue Service

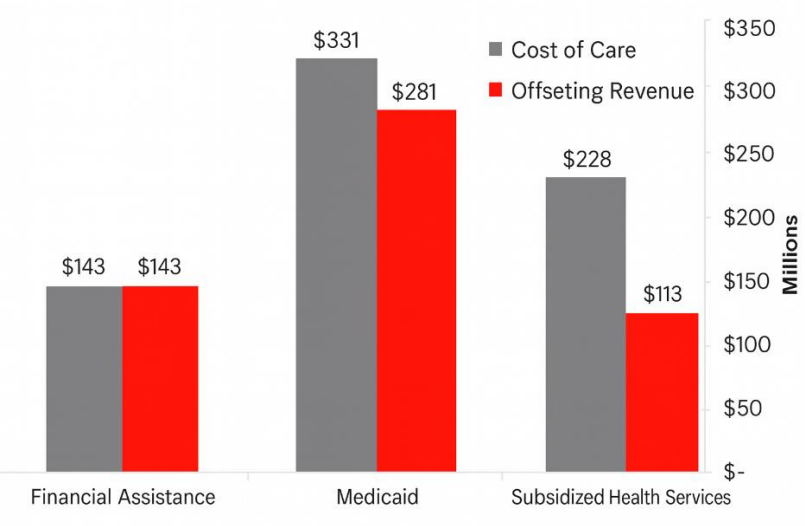
GHS Services include an ambulance EMS fleet equipped with medical helicopter, a designated Regional Perinatal Center, Cancer Center, Trauma Center, Outpatient Behavioral Health Center, Radiation-Oncology Center, and one of the top HIV/AIDS outpatient clinics in the country.

The GHS website Atlanta's Hospital | Atlanta Can't Live Without Grady and Community Benefit Report detail the health system efforts for the 2022-2025 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 (Figure 2)."

**FIGURE 2: COMPARISON OF 2023 COST OF CARE AND OFFSETTING REVENUE**




# Methodology

The CHNA was conducted using a mixed methods approach which included the synthesis of:

- Primary data collection was conducted using the following methods:

    - Key informant interviews (KII) with community leaders and local subject matter experts on health and social determinants of health. The KII guide is found in Appendix A.
    - Focus groups with residents. The focus group guide is found in Appendix B.
    - Community conversations with residents. The community conversation guide is found in Appendix C.
    - Input and feedback from Grady's PHC and topic-specific work group members.
    - Community survey conducted by Grady and distributed with the support of GHPC and other community stakeholders and partnering agencies. The community survey is found in Appendix D.
- Secondary data specific to the populations and geographic areas served by GHS comprised of data gathered from publicly available databases, overseen by federal, state and non-profit health and social services agencies

Health indicators reviewed included topics of focus from the previous CHNA, newly emerging health concerns and barriers, as well as other recent county, state and private community health assessments for the service area.

# Secondary Data Collection

Secondary data collection aimed to understand the incidence and prevalence of chronic diseases, maternal and child health statistics, causes of premature death and Years of Potential Life Lost (YPLL) as well as the impacts of mental and behavioral health (including substance use) conditions on hospitalizations and mortality.

The GHPC team collected quantitative data which included secondary data from census tract, zip code and county levels and included comparison to state and national level outcomes. Secondary data was largely obtained from the Georgia OASIS dashboard (maintained by the Georgia Department of Public Health), the Centers for Disease Control and Prevention, American Community Survey (US Census Bureau), County Health Rankings and Roadmaps, and Neighborhood Nexus. The data was supplemented by other public data sets where available and when necessary. This data was presented periodically to the Grady PHC, executive leadership staff, and the Grady Patient and Community Advisory Committee for review and feedback. Data collection, synthesis and interpretation took place throughout 2025, under the approval of the Georgia State University Institutional Review Board.

# Primary Data Collection

Primary data collection took place between August and October 2025. The GHPC team conducted interviews, community conversations, and focus groups that took approximately 60-75 minutes each. Key Informant Interviews and Focus Groups were conducted virtually, recorded, and transcribed (by AI) for analysis.

## Key Informant Interviews

Key informants represented organizations working in public health, healthcare, refugee services, faith-based health ministries, care management and housing/homelessness (Table 2).

**TABLE 2: SECTORS REPRESENTED BY KEY INFORMANTS**

| SECTOR | NUMBER OF INTERVIEWEES | REGION | POPULATION(S) SERVED | RACE |
|---|---|---|---|---|
| Housing/ Homeless Response | 1 | Fulton County | Housing insecure/ homeless, more recently, increased senior | Any/All |
| Faith Based Health Ministry | 1 | Fulton Cunty | South Atlanta, low income | Black and Latino primarily |
| HIV/Sexual Health/ LGBTQ+, Social Support Services- Mental Health, Substance Use, Housing Assistance | 1 | Greater Metro Atlanta | LGBTQ+, low income, Women | Any/All |
| Care Management Organization (Non-profit) | 1 | Statewide | Low Income | Any |
| Mental/ Behavioral Health | 2 | DeKalb County | Low-income, Uninsured | Any |
| Women's Health/ Maternal Child Health/ Refugee Services | 1 | Statewide | Women and children, families, Refugee | Various |
| Community Health, Pan Asian focused | 2 | Southeast Region | Immigrant/Refugee, Women & Children | Asian Primarily |
| Women's Health/ Sexual Health | 1 | Greater Atlanta/ Clarkston | Women & Children, Low-income, Uninsured | People of Color primarily |
| Public Health | 1 | DeKalb | All | All |

Interviews used a semi-structured interview guide developed by GHPC with input from Grady. The interview guide included questions about:

- Current health needs
- Drivers contributing to health needs
- Groups disproportionately affected by barriers to care and poor health outcomes
- Lasting impacts of Covid-19
- Prioritizing health needs
- Strategies for addressing health priorities
- Community resources, assets or partnerships that can support GHS in addressing health needs
- Access to Care (including the strategies and techniques GHS is currently using to address accessibility)

Interviews were conducted virtually using Zoom and Microsoft Teams and recorded. Transcripts were analyzed in Microsoft Excel using a codebook (Appendix E). The information gathered during interviews informed the development of the community conversation and focus group discussion guides.

## Focus Groups & Community Conversations

The goal of the Focus Group Discussions (FGD) and Community Conversations was to:

- Identify public health concerns and community strengths,
- Determine health priorities, and,
- Identify practical strategies for addressing those priorities in ways that have local meaning.

### Focus Groups

Three FGDs were completed with:

1. Members of the Grady Patient Community Advisory Council (PCAC) (n=7).
2. Residents from DeKalb County (n=14) living in the following zip codes: 30002, 30016, 30021, 30032, 30038, 30058, 30318, 30307, 30345, 30322, 30310, and 30340.
3. Residents from Fulton County (n=14) living in zip codes: 30005, 30038, 30076, 30213, 30268, 30303, 30305, 30308, 30309, 30313, 30331, 30342, and 30331.

GHPC recruited FGD participants from Fulton and DeKalb counties by disseminating e-flyers through community partner organizations including Grady, GHPC, county public health departments and their many partner organizations. GHPC created a screening questionnaire and recruitment grids that contained 10 selection criteria for each focus group. Individuals were asked to provide information about their age, race/ethnicity, gender, county of residence and zip code. Collectively, FGD participants represented 24 zip codes.

Focus groups were held virtually using Zoom and lasted approximately 1 to 1.5 hours. Each focus group was moderated by two GHPC facilitators who took notes and monitored the chat. Participants from the DeKalb and Fulton County FGDs received a $50 Amazon gift card for their time.

Race/ethnicity of residents was self-reported with some individuals checking more than one category:

- American Indian or Alaska Native 11%
- Asian 7%
- Black or African American 43%
- White 18%
- Other race 4%
- Hispanic or Latino 18%

Two virtual focus groups were conducted in English with a total of 28 adults in:

## Community Conversations

The goal of the Community Conversations was to identify public health concerns, community strengths, and determine health priorities and potential solutions to address those priorities in ways that have local meaning and utility. GHPC recruited participants from targeted geographies- Fulton and DeKalb counties through disseminating e-flyers through community partner organizations including public health, social service, healthcare, non-profit, education, faith, and organizations serving specific populations (e.g., refugees, LGBTQ+, Hispanic, Pan Asian, etc.). GHPC created a screening questionnaire and recruitment grids that contained 10 selection criteria for each focus group. Individuals were asked to provide information about their age, race/ethnicity, gender, county of residence, and zip code. Two in person community conversations were conducted in English in:

1. DeKalb County on September 24, 2025, with 26 participants.
2. Fulton County on October 11, 2025, with 10 participants.

The community conversations lasted approximately one and one-half hours. Attending community members received a stipend of $20 and a meal. The first community conversation group was moderated by two GHPC facilitators who also took notes and monitored the chat. The second group included three facilitators who rotated through leading the discussion and taking notes. The meeting notes were analyzed by the GHPC research team members, who identified themes and sub-themes for summarization.

### Analysis

As with the key informant interviews, transcripts and notes from the FGDs and community conversations were analyzed in Microsoft Excel using a codebook.

## Community Survey

A cross-sectional community survey was developed collaboratively with input from Grady Health System, the Population Health Patient Advisory Council, and the Georgia Health Policy Center. The survey included 28 questions pertaining to:

- Community health needs and concerns,
- Community assets and resources, and
- Recommendations for improving the health of residents.

GHPC's Communications and Marketing team worked with members of the GHS team to prepare a dissemination toolkit to accompany the survey. English and Spanish versions of the survey and dissemination toolkit were distributed to GHPC's and GHS' partners.

To be eligible, respondents had to live or work in Fulton or DeKalb Counties, be able to read and respond in either English or Spanish, and have access to the internet, or be interviewed at a clinic location. The survey was self-administered online or in-person at various clinics and community sites in Fulton and DeKalb Counties. County, age range, race/ethnicity, and education were the main analysis

variables. Survey data were managed and analyzed using Qualtrics XM.

## Survey Respondent Demographics

Survey respondents represented a diverse cross-section of Fulton and DeKalb counties.

Key demographic characteristics include county of residence, age distribution, race/ethnicity, language spoken at home, gender identity, insurance status, education level, and employment status.

### County of residence

Almost 190 Fulton County residents responded to the survey (n=189) or 60% of responses. Thirty-six percent (36%) of responses were from DeKalb County (n=112).

### Age distribution

Participants ranged from 18 to over 75 years of age. The age distribution of survey respondents shows that older adults make up the largest share of participants (Table 3). Nearly half of respondents are aged 55 or older, with 22% in the 65–74 age group and 21.7% in the 55–64 group. Middle-aged adults (45–54 and 35–44) account for about one-third of responses combined, while younger adults (25–34 and 18–24) represent a smaller proportion at roughly 18%. Only 4.7% of respondents are 75 or older, and less than 1% declined to answer. This pattern suggests that the survey reached a significant number of older adults, which may influence priorities related to chronic disease management, access to care, and aging-related services.

**TABLE 3: AGE DISTRIBUTION OF SURVEY PARTICIPANTS**

| AGE GROUP | QUANTITY | PERCENT |
|---|---|---|
| 75 or older | 13 | 4.7% |
| 65-74 | 61 | 22.0% |
| 55-64 | 60 | 21.7% |
| 45-54 | 46 | 16.6% |
| 35-44 | 45 | 16.2% |
| 25-34 | 39 | 14.1% |
| 18-24 | 11 | 4.0% |
| Decline to answer | 2 | 0.7% |

### Race/ethnicity

A majority identified as Black or African American (203 respondents), followed by White (47 respondents) (Table 4). Hispanic identity was reported by 52 respondents, while 36 identified as Latino in the race category. Smaller groups included Asian (10), American Indian or Alaskan Native (8), and Native Hawaiian or Other Pacific Islander (1). Ten respondents selected multiple ethnicities or another option not listed, and 11 preferred not to answer. This distribution highlights the diversity within Fulton

and DeKalb counties and underscores the importance of culturally responsive strategies in addressing health needs.

**TABLE 4: DISTRIBUTION OF RACE AND ETHNICITY AMONG SURVEY PARTICIPANTS**

| RACE/ ETHNICITY | QUANTITY | % OF TOTAL |
|---|---|---|
| Black or African American | 203 | 53.7% |
| White | 47 | 12.4% |
| Prefer not to answer | 11 | 2.9% |
| Asian | 10 | 2.6% |
| Latino | 36 | 9.5% |
| Multiple ethnicity/another option not listed (please specify) | 10 | 2.6% |
| American Indian or Alaskan Native | 8 | 2.1% |
| Native Hawaiian or Other Pacific Islander | 1 | 0.3% |
| Respondents who identified as Hispanic | 52 | 13.8% |

## Language Spoken at Home

Among the 316 survey respondents, the majority reported English as their primary language (274 respondents, 86.7%). Spanish was the second most common language, reported by 36 respondents (11.4%). A small proportion indicated another language, with five respondents (1.6%) specifying a different language and one respondent (0.3%) reporting an "other" language. No respondents left this question blank. This distribution highlights that while English is predominant, a notable segment of the population speaks Spanish, and there is minimal representation of other languages.

## Gender Identity

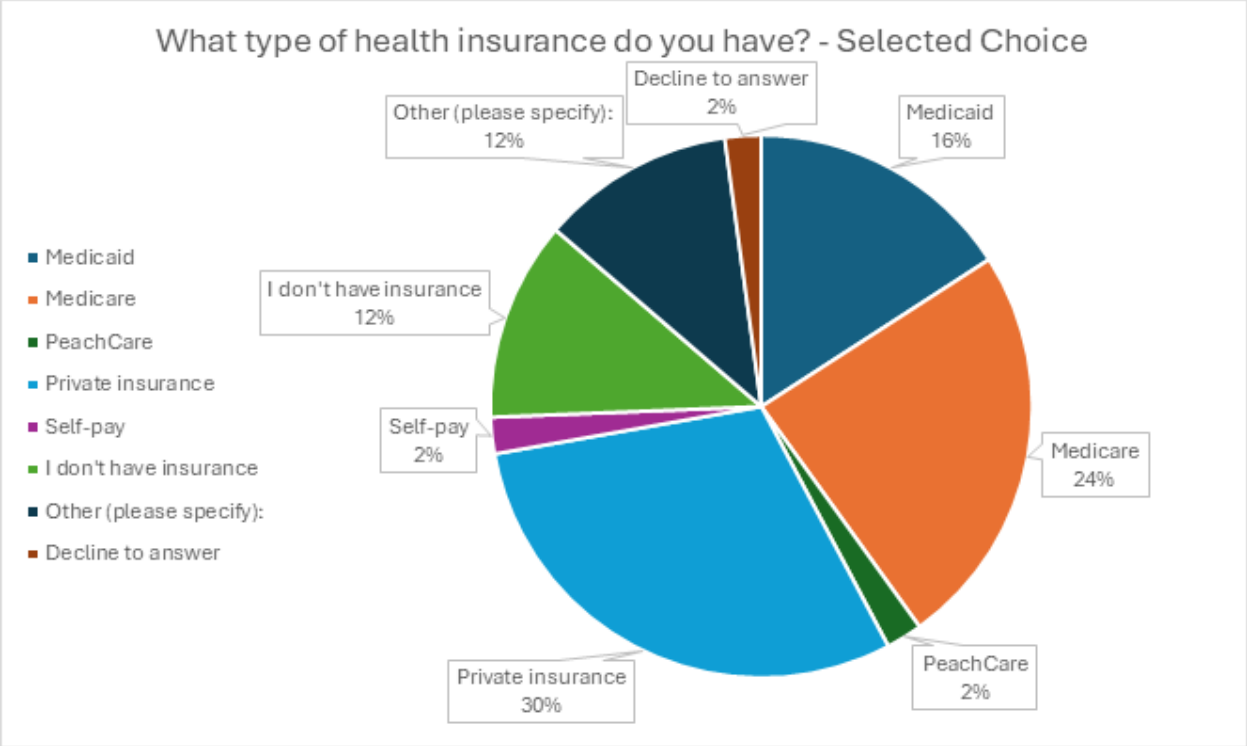
The gender identity of survey respondents indicates that women make up the majority of participants, accounting for 70% (194 respondents). Men represent 27.8% (77 respondents), while transgender and non-binary or gender nonconforming individuals each account for 1.1% (3 respondents each). A small proportion declined to answer (0.7%), and no respondents selected another option not listed. This distribution suggests that women's perspectives are strongly represented in the survey, which may influence priorities related to maternal health, caregiving, and access to services.

## Insurance Status

Insurance coverage among respondents shows a mix of public and private plans, with private insurance being the most common (30%). Medicare accounts for 24.2%, reflecting a significant older adult population, while Medicaid covers 15.9%, indicating a substantial low-income segment. PeachCare and self-pay options are minimal at 2.2% each. Notably, 11.9% of respondents reported having no insurance, and another 11.6% selected "Other," suggesting gaps in coverage and potential reliance on alternative

or limited plans. These figures highlight affordability and access challenges, reinforcing the need for CHIP strategies that expand coverage and reduce cost barriers.

**FIGURE 3: INSURANCE COVERAGE AMONG SURVEY PARTICIPANTS**




## Education level

Among the 316 respondents, the most common level of education was a high school diploma or GED, reported by 85 individuals (26.9%). Some college or university experience without a degree was noted by 56 respondents (17.7%), while 12 respondents (3.8%) held an associate degree. Bachelor's degrees were reported by 48 respondents (15.2%), and 42 respondents (13.3%) had completed a master's degree. Twenty-one respondents (6.6%) reported earning a doctoral degree (PhD, MD, JD, DDS, etc.). Vocational or trade school degrees were reported by 17 respondents (5.4%). Nineteen respondents (6.0%) had less than a high school education, and 3 respondents (0.9%) selected "Other." These findings suggest a diverse range of educational backgrounds, with a significant proportion having completed high school or pursued higher education.

## Employment status

Among respondents, the most frequently reported category was “I’m not working right now,” selected by 88 individuals (29.9%). Sixty-six respondents (22.4%) reported working in health or helping people, while 60 respondents (20.4%) indicated they work in a different kind of job. Food service or restaurant work was reported by 17 respondents (5.8%), and 23 respondents (7.8%) stated they work for themselves. Sixteen respondents (5.4%) reported taking care of children or teaching in a school, and 11 respondents (3.7%) work for the government. Smaller groups included manufacturing or trades (4 respondents, 1.4%) and other self-employment categories (8 respondents, 2.7%). These findings suggest a diverse range of employment types, with a significant proportion currently unemployed and a notable representation in health-related roles.

These data was presented periodically to the Grady team staff and the Grady PHC for review and feedback.

# Primary Data Findings

Top of mind for KII, FGD and community conversation participants were:

- Economic stability, with many reporting poor job stability and low wages as challenges in the current economic climate.
- Access to health care, specifically affordability and ability to see providers when needed.
- Chronic disease management, especially health education and support for diabetes, heart disease, hypertension and obesity management.
- Mental health, barriers to which included stigma and insurance coverage.
- Housing stability and affordability.
- Food security, including the affordability and availability of quality fresh foods at the neighborhood level.

**Grady CHNA Survey Question:** *What makes a community healthy?*

1. Affordable housing is the most cited factor (75%), followed by safe neighborhoods and good schools.

2. Healthcare access and affordability (quality health care and insurance) is nearly as important to survey respondents as housing and safety.

3. Environmental factors (clean air and water) and affordable food are strong priorities.

4. Social services and job opportunities also rank high, showing economic stability and support systems matter.

There was strong clustering among housing, safety, schools, and healthcare, indicating these are seen as interconnected needs.

- Reliable and affordable transportation, including the need for expanded public transportation.

Participants were asked to share their communities' strengths and assets. Answers included diversity, knowing their neighbors and checking in on each other, access to libraries, and the availability of health clinics and mobile units that provide dental care and assistance with medications. A few participants shared that they appreciate their school system and living in intergenerational neighborhoods.

**Survey responses** affirmed the importance of accessible and affordable healthcare, housing, and food. Respondents also named safety, environmental factors and economic stability as important to community health. The top places that help a community stay healthy, according to the survey responses, are faith-based institutions (churches, 56%), followed closely by clinics/hospitals (50%) and community centers (43%).

# Access to Care

When asked what makes it difficult to be healthy or maintain health in their neighborhoods, participants shared a variety of answers (Table 5).

**TABLE 5: BARRIERS TO HEALTHCARE ACCESS REPORTED BY KII, FGD AND COMMUNITY CONVERSATION PARTICIPANTS**

| BARRIERS TO ACCESS |
|---|
| Affordability (for those with and without insurance) |
| Lack of insurance (including the uninsured and under-insured) |
| Lack of health facilities (including urgent care facilities & mobile units) |
| Provider shortages |
| Insufficient Maternal and Child Health (MCH) and reproductive healthcare |
| Language & cultural competence |
| Lack of trust/fear of the health system |

**Survey results noted that mental** health care and dental care are the hardest to access (both cited by ~44% of respondents) followed by specialty doctors (40%) and primary care (38%). Urgent care (30%) and hospitals (21%) are less frequent but still notable among survey respondents.

Access to healthcare continues to be the most pressing concern among community-serving organizations and community residents. The following section includes access-related themes that emerged during data analysis and are presented in order of importance. Participants placed greatest emphasis on the need for more community health workers and patient navigators, followed by the need for referral networks, and the use of technology for telemedicine and communications. Lower ranked themes included addressing system barriers, the long-term impacts of COVID-10 and geographic health disparities.

## Community Health Workers (CHWs)

CHWs are essential in helping families navigate care, especially persons whose first language is not English. Several key informants noted that CHWs are central to care navigation, especially for immigrant and refugee populations. CHWs can assist with scheduling appointments, completing paperwork, assisting with medications, providing transportation, and helping residents navigate the health system (e.g., Medicaid, Medicare, SNAP). *Expanding the network of CHWs providing community-based care was a top recommendation among key informants.*

> *"CHWs are the glue or oil in the healthcare system, facilitating access and continuity of care."*
> -Representative from Social Service Organization

## Provider Networks

According to participants, community members need to be able to access primary and specialty care in a timely manner; and they need reliable transportation to get to their appointments. However, a lack of available health facilities makes it difficult to direct patients to appropriate care, especially when patients lack access to reliable transportation. Participants felt that the community would benefit from having more independent and local clinics, specifically for residents who are un- or under-insured.

Participants also voiced strong concern about the lack of free or low-cost dental services in the service area and considered access to dental care a priority. GHS may want to consider including more dental providers in their provider networks.

To address these needs, participants recommended that Grady and their partners establish more robust referral networks between managed care organizations (MCO), public health agencies, community service organizations, Federally Qualified Health Clinics (FQHC), other neighborhood clinics and larger health systems (e.g., Grady or Emory). However, some healthcare providers shared that the problem is not a lack of services, but a lack of utilization. According to some participants, there are many existing resources and services that facilitate access to continuity of care; but community members are not utilizing them. As one participant shared:

> *"We have a 24-7 nurse line – [clients] don't call that much. There is a list of providers with appointments to get in the same week, but they don't use it. How do we ensure clients know about and access the services and tools available?"*
> -Representative from Healthcare Provider Agency

Thus, in addition to establishing new/strengthening existing networks, providers need to ensure community members are aware of and can easily access existing services.

## Technology

Telehealth and telemedicine (including video calls, phone calls, and secure messaging) can make accessing healthcare more convenient and less expensive. It is regarded by many as a way to increase access to specialists and reduce barriers to access (time, transportation, provider shortages, childcare, etc.). It can be especially helpful for people with limited mobility, those who are immuno-compromised, or individuals who need quick follow-up visits. Barriers to telehealth use include concerns about confidentiality, language barriers, and limited internet access and digital literacy (specifically among older adults).

Older adults are more likely to have chronic conditions that require regular health appointments and careful monitoring. With virtual visits and remote monitoring, seniors could manage their health more consistently and receive quicker attention when issues arise. However, some older adults have limited digital literacy. Some telecare technologies like digital medication reminder systems, sensors that detect falls and easy to use communication tools that connect older adults with family members and healthcare providers can be installed and operated remotely, reducing the digital burden on the patients.

## System Barriers

Participants identified many system-related barriers (Table 6) including:

- **Healthcare System:** Recent cuts to federal funding for social service programs, along with proposed reductions to Medicare, Medicaid, and Affordable Care Act are likely to leave more people uninsured and in need of care.
- **Food System:** There is a lack of affordable healthy food, making it harder to prevent and manage chronic conditions. Recent cuts to the Supplemental Nutrition Assistance Program (SNAP) will further decrease access to healthy foods and increase food insecurity.
- **Economic System:** Economic instability worsens health outcomes especially in low-income communities, where fluctuating jobs and wages make it difficult for families to afford basic healthcare and other essentials as costs rise. Additionally, many jobs do not offer health insurance or offer high-deductible health insurance that people cannot afford.
- **Education System:** Education challenges—such as overcrowded classrooms, limited school resources, and a lack of affordable after-school programs or comprehensive health education—also contribute to poorer long-term health.
- **City Infrastructure and the Built Environment:** In many neighborhoods, the built environment limits opportunities for physical activity, particularly in low-income neighborhoods. These neighborhoods may have few parks, unsafe or disconnected walking paths, and poor access to essential destinations.
- **Transportation System:** Inadequate public transportation and deteriorating roads make it harder for individuals to reach healthcare services, jobs, and other critical resources, deepening existing health disparities.

**TABLE 6: BARRIERS BY SYSTEM**

| SYSTEM | BARRIERS |
|---|---|
| Healthcare | Cuts to social service programs, Medicare, Medicaid and the ACA |
| | Healthcare workers are leaving Georgia |
| Food | Lack of affordable healthy food |
| | Difficult to prevent and manage chronic conditions |
| | Recent cuts to the Supplemental Nutrition Assistance Program (SNAP) |
| Economics (including employment and cost of living) | Lack of jobs and low wages |
| | Rising cost of living |
| | Employers not offering health insurance or offering unaffordable insurance |
| | High cost of childcare |
| | Lack of affordable skill building/job training programs |
| Education | Overcrowded classrooms |
| | Limited school resources |
| | Lack of affordable after-school programs |
| | Lack of comprehensive health education |
| Infrastructure | Few parks |
| | Unsafe walking paths |
| | Poor access to essential destinations |
| Transportation | Limited public transportation |
| | Deteriorating roadways |

Survey respondents were asked about barriers to health, specifically, "What makes it hard for you or others in your community to stay healthy?" The responses were clustered on four key themes:

1. Cost and insurance dominated as barriers: nearly 70% cite high cost of care, and 50% cite lack of insurance.
2. Transportation issues (30%) and distance to care (19%) highlight access challenges.
3. Discrimination or lack of trust (26%) and language/cultural barriers (10%) indicate equity and communication gaps.
4. Limited appointment times and difficulty understanding health information (~19%) suggest systemic and literacy issues.

## COVID-19 Impact

According to participants, the pandemic led to decreased clinic visits, reducing opportunities for preventive care, and the ability to appropriately monitor chronic conditions. The pandemic also highlighted the need for more primary care facilities. Grady's expansion of clinics was seen by participants as a good strategy for addressing the need for more health facilities.

As community leaders shared, severe illness and death related to COVID-19 have decreased. However, CDC is monitoring wastewater out of abundance of caution.[8]

### Geographic Inequalities

According to participants, access to affordable healthcare varies significantly depending on where in DeKalb and Fulton Counties one lives. Some areas, particularly those away from major thoroughfares and densely populated areas, are considered medical deserts.

## Chronic Conditions

Chronic conditions were identified by key informants and community members as a key concern during this CHNA cycle. Diabetes and hypertension were the chronic conditions identified most often as requiring improved education and self-management.

### Inequalities in Health Outcomes

Participants regularly mentioned their concerns about the high rates of childhood and adult obesity, particularly among those facing poverty and nutrition insecurity. Having limited access to healthy foods makes it harder for households to maintain consistent, healthy eating habits. Interviews and focus groups identified low-income middle-aged adults and senior adults as the groups most affected by chronic illnesses.

Racial and ethnic disparities were also discussed. Older African American adults were noted as having higher rates of cardiovascular disease and hypertension, conditions often linked to long-standing inequities in healthcare access, environmental stressors, and social determinants of health. Additionally, key informants highlighted that Hispanic women and refugee women from the Middle East and Africa are experiencing disproportionately high rates of obesity and diabetes, pointing to the combined effects of cultural, economic, and systemic barriers on chronic disease and maternal and child health risk.

Access and affordability challenges continue to make chronic disease management difficult across communities. Participants shared that many patients struggle to obtain the medications they need—especially those taking insulin to manage diabetes. Lack of insurance and ongoing financial strain often prevent individuals from seeking consistent care or following recommended treatment plans.

### Preventive Care Concerns

Community members noted a significant lack of preventive screenings among low-income adults, including cancer screenings and diabetes testing. Reasons include transportation barriers, limited awareness, and challenges navigating the healthcare and health insurance systems. They also reported that health systems and clinics are offering fewer free screening events in the community. The disruptions caused by COVID-19 further contributed to delays in routine care, leading to later diagnoses and worsening chronic conditions. Throughout the interviews, discussions and conversations community

[8] COVID-19 National Wastewater Data. CDC.

health workers were consistently identified as a vital resource, helping residents manage chronic illnesses, access services, and stay informed about screening and care options.

## Community-Specific Challenges

Individuals with chronic conditions have specific health needs; and different groups within the chronic disease community have different health risks and needs. Participants from the key informant interviews, FGDs and community conversations, highlighted these challenges specifically:

- Some patients work multiple jobs and/or lack time, childcare, transport, and funds making it hard to attend health education or treatment sessions.
- Language and cultural barriers hinder effective chronic disease management and education.
- Navigating the health system, following up on referrals and attending follow-up visits can be challenging for those with multiple chronic conditions. Expanding the number of CHWs and health navigators that can guide patients through chronic disease appointments and support disease self-management was strongly recommended.

## Healthy Living

Contributors to development of chronic conditions include genetics, smoking, stress, an unhealthy diet and physical inactivity, among others. Participants indicated that there are barriers to healthy living. In particular, they focused on knowledge of and access to healthy food. Interviewees discussed many factors that influence whether individuals consume healthy food, including:

- Not knowing where to purchase or how to prepare healthy food,
- High cost of healthier food,
- Time constraints that limit grocery shopping and meal preparation,
- Lack of transportation, and
- Prevalence of unhealthy food options and fast food.

> *"The onus of change is put on the individual. You tell people from impoverished neighborhoods to eat better and exercise, but they don't have a quality grocery store or access to healthy affordable food options in their neighborhood or have safe places to be active."*
> -Service Organization Leader

Interview participants considered the following groups vulnerable to poor nutrition:

- People with lower socio-economic status,
- Aging adults,

- People experiencing homelessness, and
- Those with pre-existing conditions.

Community leaders were concerned about the lack of access to affordable, healthy food and food insecurity. Leaders noted how difficult it is currently to make ends meet; the cost of food and other necessities have increased while wages and/or fixed-income benefits have not. When healthy food is unaffordable, individuals consume foods with more sugar, fat, and cholesterol. While purchasing ultra processed foods may be cost-effective in the short term, it may lead to high medical costs in the long-term.

Interview participants discussed how people want to be healthier but need access to more information about chronic disease, affordable food, and recreation opportunities. Community leaders identified the following nutrition-related needs:

- The Hispanic / Latino population is at risk for developing diabetes and lacks access to culturally relevant programs in Spanish.
- There is a lack of knowledge about the risk factors for cardiovascular disease and death, especially poor eating and lack of exercise.
- There is a lack of knowledge about the impact of excessive technology, like social media, on health.
- Supplemental Nutrition Assistance Program-eligible individuals and families would benefit from increased exposure to “new” fruits and vegetables and education on how to affordably cook and store healthy foods.

Interview participants discussed how resources “infused into the community” could reduce healthy lifestyle barriers. They shared residents value exercise programs offered through city and county public services, paved trail systems, walkable areas, parks, and gyms with affordable membership options, like the YMCA. Residents found farmers’ markets in the area particularly beneficial as they offer live food demonstrations, a greater variety of healthy options than grocery stores, and coupons for fresh foods.

Regarding developing knowledge of health and health services, survey respondents were asked to identify where they and others in their community learn about health and available resources. Greater than half of respondents (54.4%) cited friends and family as the most common source, followed closely by health institutions. Social media is a significant source (36%) and about one-fourth said church or faith groups are a source of information.

# Mental Health and Substance Use

## Mental Health

Since the COVID-19 pandemic, mental health, including increased anxiety, depression and suicidal ideation, has become a top concern among residents. Families experiencing instability were considered most at risk. Participants feel that 1) stressors associated with the social determinants of health

(employment, housing, food access, environment), 2) increased social isolation and 3) reduced access to preventive care are making mental health worse.

Participants identified older adults and adolescents as being more at risk for poor mental health outcomes. Social isolation was considered a problem among older adults. Adolescents, especially girls, were thought to be experiencing more anxiety, depression, and suicidal ideation. Finally, participants also shared concerns about the lack of services and support for substance use.

***Mental health is a growing concern; 38% of survey respondents rated their overall mental health as fair or poor***

## Substance Use

Substance use is a chronic disease, characterized by the continued use of chemical substances, in spite of negative physiological, cognitive, and/or behavioral symptoms.[9] Participants emphasized the association between mental health challenges and substance use, noting that individuals with mental illness are disproportionately affected by substance use concerns. In the CHNA survey, participants did not explicitly state substance use. Instead, many respondents tied substance use to mental health and community stressors.

Secondary data, presented further in this report, note that hospitalizations and overdose deaths associated with substance use have increased over the past 10 years across the service area.

> *"We're seeing more symptomology for adolescents - more trauma, more substance use, including vaping, marijuana, opioid use, and more suicide ideation."*
> -Community Service Board Clinician Leader

## Barriers to Care for Mental Health & Substance Use

According to participants, barriers to mental and substance use care (Table 7) include provider shortages, limited appointment times, lack of transportation and stigma. Barriers preventing immigrant and refugee populations from accessing care are language barriers and lack of cultural competency/humility among health providers**. Within the survey 42% of respondents stated that accessing mental health care is one of the hardest services to access in their areas. One respondent stated that:**

*"I would like there to be a place for emotional therapy groups where I can go and share with more people from time to time."*

[9] American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

Additionally, many insurance plans do not adequately cover mental health care costs, if they cover it at all.

> *"There is not much movement in reducing stigma. Severity of symptoms seem to be getting worse. Death by suicide is increasing."*
> - Mental Health Organization Representative

Survey respondents stated in their open-ended responses that *"More mental health care and affordable healthy food."* And *"Mental health issues on the rise."*

**TABLE 7: BARRIERS TO MENTAL HEALTH CARE**

| BARRIERS TO MENTAL HEALTH CARE |
|---|
| Shortage of services/providers |
| No/limited insurance coverage for mental health services |
| Stigma |
| Challenges related to substance use/abuse |
| Challenges related to housing instability/homelessness |

> *"We need more friendly treatment programs, more harm reduction, and more treatment programs without waiting lists."*
> -Public Health Leader

## Facilitators to Care for Mental Health & Substance Use

While Georgia lacks the providers and infrastructure to adequately meet the current community need for mental and substance use services, health systems and community partners are coming together to provide solutions to reduce service gaps and remove barriers to care. Interview participants celebrated the positive progress the state has made in passing mental health parity legislation and improvements in Medicaid reimbursement rates.

> *"We are trying to figure out the balance between [virtual and in person service provision], virtual because it's easy, and in person because of the engagement."*
> - Mental Health Organization Representative

Telehealth services, licensure compacts, and community collaboration are being used to address provider shortages and better meet community mental health needs. There is an increased focus on

strengthening community-level interventions focused on reducing preventable emergency room visits and hospital stays and increasing awareness around available resources.

> *"If we can address mental health, it can often positively impact the other challenges – work, housing, etc."*
> - Nonprofit Organization Representative

# Recommendations

The qualitative findings, particularly the KII results, note that funding instability threatens the sustainability of health services and programs. It is recommended that Grady develop new and strengthen existing partnerships with federally qualified health centers, nonprofit and social service organizations, and schools to reach vulnerable populations. Community members asked that GHS send providers to medical deserts, either through mobile clinics or partnerships with public health or other healthcare organizations.

Community members specifically called for more accessible and affordable primary care, mental health care, and dental care and recommended these specific strategies:

- Affordable and flexible primary care centers with alternative hours and diverse healthcare providers would improve access and support trust building among certain populations.
- Expanded access to care using more mobile units and co-location of services in places families already go for services and support.
- More crisis centers and therapeutic care sites that offer affordable mental health treatment options with flexible hours.
- Affordable dental care is needed; Community members, especially seniors recommended using mobile units to provide dental care.
- Culturally tailored healthcare that respects cultural beliefs and integrates diverse languages are important for some vulnerable populations.
- Fear and mistrust of health systems, especially among undocumented individuals, further complicates access to care. There was great emphasis on the importance of community health workers (CHWs) and care navigators to bridge gaps in healthcare and mental health access and education.

> *"Systems working together would be ideal. There [are] efforts to not work in silos, but improvement is needed and would help address access and outcomes if the systems would work together."*
> - Social Service Organization Representative

Economic and job instability exacerbates health outcomes, especially in low-income communities. This instability which may impact basic needs, combined with low health literacy, stigma, and multiple chronic conditions, makes it challenging for Fulton and DeKalb residents to manage their chronic conditions.

Transportation is often cited as a key reason for missing medical appointments. Grady could enhance use of telehealth services by investing in digital literacy education. Promoting use of technology to individuals with a high level of readiness or acceptance of telemedicine for health and/or mental health services may reduce missed appointments and free up appointments for in-person care.

Financial limitations and social isolation among older adults contribute to unmanaged chronic conditions. Peer-led education sessions or peer-facilitated discussion groups hosted in-person at senior centers or virtually among those older adults with diabetes or high blood pressure could improve disease self-management, peer connections, and be provided free of charge.

# Secondary Data Findings

The GHPC team collected, synthesized and interpreted data from multiple national, state, and county level public secondary data sources in 2025 to understand the health outcomes in GHS' service area, and how they compare to state and national health outcomes. Secondary data collection included the prevalence of chronic diseases, maternal and child health statistics, causes of premature death and Years of Potential Life Lost (YPLL) as well as the impacts of mental and behavioral health (including substance use) conditions on hospitalizations and mortality.

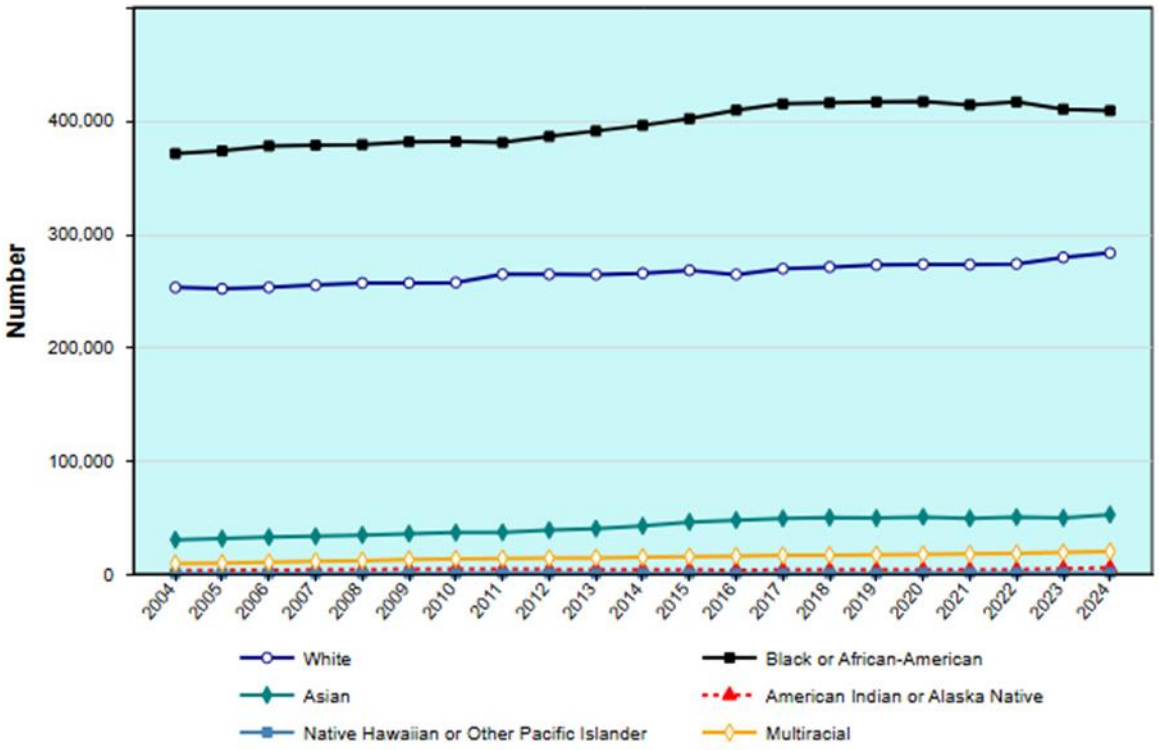
## Community Context & Landscape

### Service Area Demographics and Population Characteristics

In the past 5 years, the population in Georgia has grown by an estimated 4 million residents. With this growth, most of which has centered around the greater Atlanta metropolitan area and surrounding counties, there have been noticeable shifts in population demographics. The new arrivals to the region have included more Hispanic, Black, Asian and Multi-racial residents, and with them, they have brought new cultural and linguistic diversity (Figures 4-5).[10]

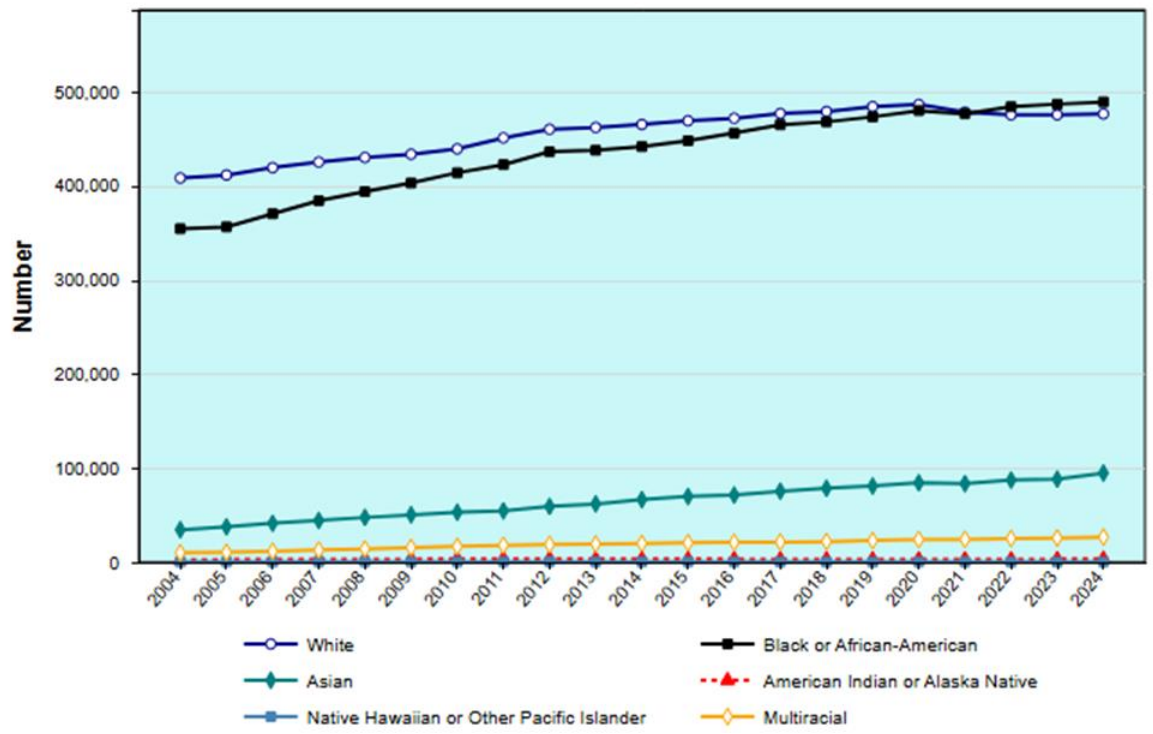
**FIGURE 4: RACIAL DEMOGRAPHICS OF DEKALB COUNTY 2004-2024**

[10] Georgia Rural Health Innovation Center. (2025). Georgia Rural Health Indicators Report. Mercer University. Retrieved from https://www.georgiaruralhealth.org/ 2025




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

**FIGURE 5: RACIAL DEMOGRAPHICS OF DEKALB COUNTY 2004-2024**



**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

The estimated population of the service area is 1,860,661 with 770,307 residents in DeKalb County and 1,090,354 residents in Fulton County (GA Oasis, 2025 update) (Table 8). Among the 1.8 million, approximately 20% are under 18 years old and approximately 13.5% are 65 years and over. When compared to Georgia, service area residents are more diverse, and earn a higher household income than the rest of the state. DeKalb and Fulton Counties also have a younger population compared to other state and national averages, with lower median ages (36.3 and 36.1 years respectively).[11]

**TABLE 8: SELECT DEMOGRAPHICS BY LOCATION**

| DEMOGRAPHIC AREAS | GEORGIA | FULTON | DEKALB |
|---|---|---|---|
| Population | 11,180,878 | 1,090,354 | 770,307 |
| % Below 18 Years of Age | 23.0% | 20.6% | 22.4% |
| % 65 and Older | 15.4% | 13.1% | 14.3% |
| % Female | 51.3% | 51.4% | 52.6% |
| % American Indian or Alaska Native | 0.6% | 0.3% | 0.6% |
| % Asian | 4.9% | 8.2% | 6.5% |
| % Non-Hispanic Black | 32.1% | 44.0% | 52.3% |
| % Non-Hispanic White | 49.6% | 37.5% | 28.7% |
| % Hispanic | 11.1% | 8.2% | 10.4% |
| % Disability: Functional Limitations | 29% | 23% | 27% |
| % Not Proficient in English | 3% | 2% | 4% |
| Children in Single-Parent Households | 30% | 36% | 34% |

**Source:** Georgia Department of Public Health OASIS and U.S. Census Bureau ACS estimates (2025). 2025 Update.

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 (Figure 6).[12] 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%).

[11] 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

[12] 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

**FIGURE 6: POPULATION BY RACE AND ETHNICITY (2018-2024)**

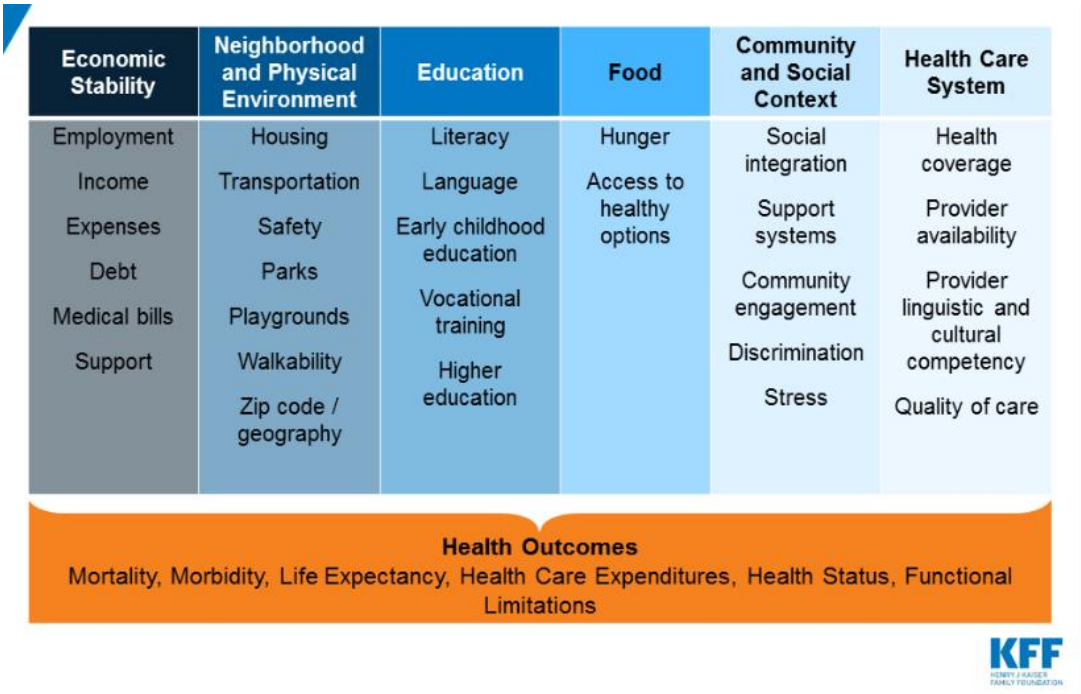

*Pie charts only reflect demographic groups that make up at least 1% of the population.
Source: US Census Bureau, American Community Survey

## Social Risk Factors

Research indicates that genetics and behavior are insufficient predictors of health outcomes. There are non-medical factors that must be regarded as well. Healthy People 2030 defines these non-medical factors as Social Determinants of Health (SDOH), "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Figure 7).[13] In this section, we explore 6 SDHOs in Grady's service area: economic stability, neighborhood and physical environment, education, food, community and social context, and health care system.

**FIGURE 7: SOCIAL DETERMINANTS OF HEALTH**

[13] Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity | KFF




## Economic Stability

### *Income*

While median household incomes in DeKalb and Fulton counties exceed state and national incomes (Table 9), reviewing county level median incomes can be misleading. Atlanta consistently ranks among cities with the highest income inequality in the United States. According to a report by GoBanking, the city's bottom 20% earn significantly less ($11,221) than the top 20% ($324,230), with a Gini Index[1] (0.5677) reflecting this disparity. According to the American Community Survey, income inequality is greater in DeKalb than in Fulton. From 2019–2024, DeKalb County had more households in the 'less than $50,000' income range and fewer in the '$200,000 or more' range.

**TABLE 9: SERVICE AREA INCOME DISTRIBUTION (2018-2024)**

| | DeKalb | Fulton | GA | US |
|---|---|---|---|---|
| Median Household Income | $78,900 | $95,371 | $74,632 | $77,719 |
| Less than $25,000 | 13.80% | 14.20% | 15.90% | 15.20% |
| $25,000- $49,999 | 18.50% | 13.80% | 18.60% | 17.50% |
| $50,000- $99,999 | 27.10% | 24.00% | 29.20% | 28.40% |
| $100,000- $199,999 | 25.30% | 28.00% | 24.90% | 26.30% |
| $200,000 or more | 15.30% | 20.00% | 11.40% | 12.60% |
| Unemployment Rate (2024) | 3.60% | 3.80% | 3.50% | 3.90% |

**Source:** US Census Bureau. (2024). 2024 American Community Survey.

### *Poverty Rate*

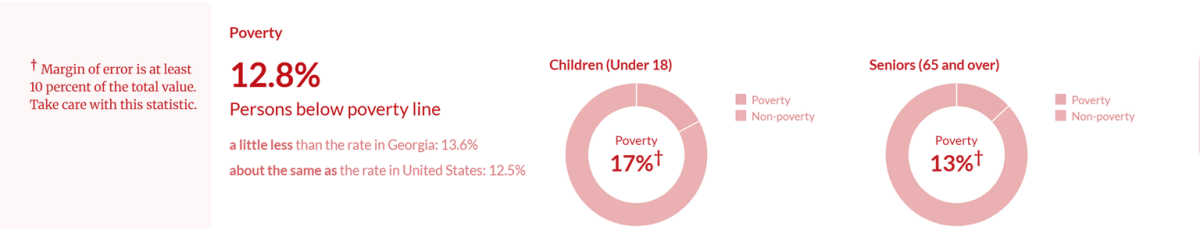
When we examine poverty rates in the service area, we see that DeKalb and Fulton Counties' rates fall below the state rate (13.6%) and are roughly the same as the national rate (12.5) (Table 10 and Figures 8-9). However, when we look at census tract (Figure 10) data, we see that there are areas within the service area with rates over 3 times the state rate.

**TABLE 10: INCOME AND POVERTY MEASURES BY LOCATION (2023)**

| SMALL AREA INCOME AND POVERTY MEASURE | US | GEORGIA | DEKALB | FULTON |
|---|---|---|---|---|
| Total # Persons in Poverty, All Ages | 40,763,043 | 1,477,354 | 100,015 | 136,021 |
| Percent Persons in Poverty, All Ages | 12.5% | 13.7% | 13.3% | 13.0% |
| Total # Children Under Age 18 in Poverty | 11,445,264 | 469,680 | 30,598 | 37,304 |
| Percent Children Under Age 18 in Poverty | 16% | 18.8% | 18.2% | 17% |

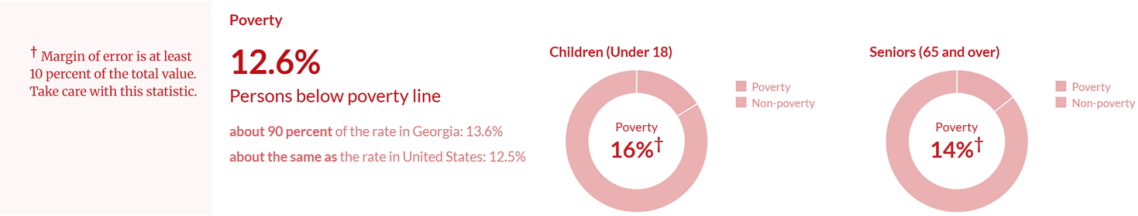
**Source:** U.S. Census Bureau. (2023). Small Area Income and Poverty Estimates (SAIPE) Program.

**FIGURE 88: DEKALB COUNTY POVERTY RATE**



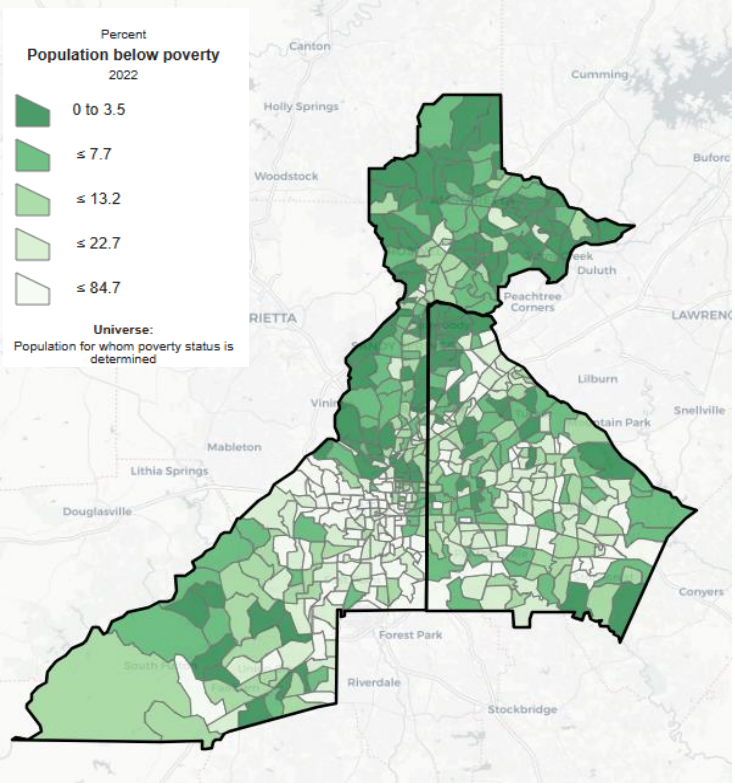

**Source:** Census Reporter. (2023). DeKalb County Profile.

**FIGURE 99: FULTON COUNTY POVERTY RATE**




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

**FIGURE 10: PERCENT OF POPULATION BELOW THE POVERTY LINE BY CENSUS TRACT (2018-2022)**




**Source:** U.S. Census Bureau. (2024). American Community Surveys from 2018-2022 and 2019-2023.

## Neighborhood and Physical Environment

The built environment of the service area is automobile-centric, with low percentages of public transit use, limited sidewalks and bike lanes, and accessibility for alternative modes of transportation. A higher percent of residents in the service area are likely to commute to work and commute long distances than the US average.[14] Additionally, participants in community conversations and focus groups reported a lack of access to safe places (such as parks) for physical activity outdoors, and concerns about community safety and community-based violence. About two-thirds of residents in DeKalb County have access to local parks, and about 63% of Fulton County residents reported access to a local park or area for outdoor activity. [15]These concerns contribute to approximately one in five adults not getting the recommended amount of physical activity each week.[16]

### Housing

Built environment concerns also extend to housing quality, safety, and affordability. Housing affordability, stability, quality, and safety all affect health outcomes. In recent years, Georgia has seen

[14] University of Wisconsin Population Health Institute. (n.d.). *Georgia: 2023*. County Health Rankings & Roadmaps. Retrieved February 15, 2024
[15] University of Wisconsin Population Health Institute. (n.d.). *Georgia: 2023*. County Health Rankings & Roadmaps. Retrieved February 15, 2024
[16] University of Wisconsin Population Health Institute. (n.d.). *Georgia: 2023*. County Health Rankings & Roadmaps. Retrieved 2025

lots of development of new housing units, though many of them are not "affordable units", there is also less effort on maintaining older units through preservation and maintenance efforts according to nonprofit leaders in housing-focused organizations.

Unaffordable housing is uniquely challenging for families with children. A local nonprofit leader noted that many children are moved into hotels as families are unable to afford apartments, which can result in the need to change schools.

Cost burdened households are those paying more than 30% of their monthly income on housing costs, including rent, mortgage, and utilities. Nearly 30% of households in Georgia with children are considered cost burdened. High housing costs may make it difficult for individuals and families to afford other necessities. Evidence shows that high housing costs increase housing instability and negatively impact individuals' ability to seek medical and mental health care.[17] DeKalb County specifically has some of the highest rates of severe housing cost burden in Georgia (Table 11).[18]

**TABLE 11: SELECT HOUSING INDICATORS BY LOCATION (2018-2022)**

| | DEKALB | FULTON | GEORGIA | U.S. |
|---|---|---|---|---|
| Units Affordable at Area Medium Income (AMI) | 57.8% | 64.5% | 60.2% | 59.5% |
| Units Affordable at 125% AMI | 71.5% | 70.1% | 72.3% | 69.6% |
| Median Gross Rent | $1,464 | $1,529 | $1,221 | $1,268 |
| Households paying more than 30% of income for monthly mortgage | 25.9% | 24.4% | 25.0% | 27.3% |
| Households paying more than 30% of income for monthly rent[19] | 55.2% | 48.9% | 50.4% | 49.9% |
| Households with One or More Severe Problems (2017-2021)[20] | 13.7% | 12.5% | 12.8% | 13.1% |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

While Care.org ranked Georgia one of the worst states for older adults to live in, the state ranks fourth in housing for older adults.[21] More than 60% of housing units in Georgia have zero-step entrances and 225 units of subsidized housing per 10,000 people. Atlanta ranks even higher at number 2 nationwide for older adult housing. However, many older adults live on a fixed income that does not 1) allow them to make renovations to meet their changing physical needs or 2) keep up with rising housing costs. One

17 Stahre, M., VanEenwyk, J., Siegel, P., & Njai, R. (2015, July 9). Housing Insecurity and the Association With Health Outcomes and Unhealthy Behaviors, Washington State, 2011. *Preventing Chronic Disease*, *12*(140511). https://doi.org/10.5888/pcd12.140511

18 America's Health Rankings. (2023). Homeownership racial disparity by state.

19 US Census Bureau, American Community Survey. 2018-2022

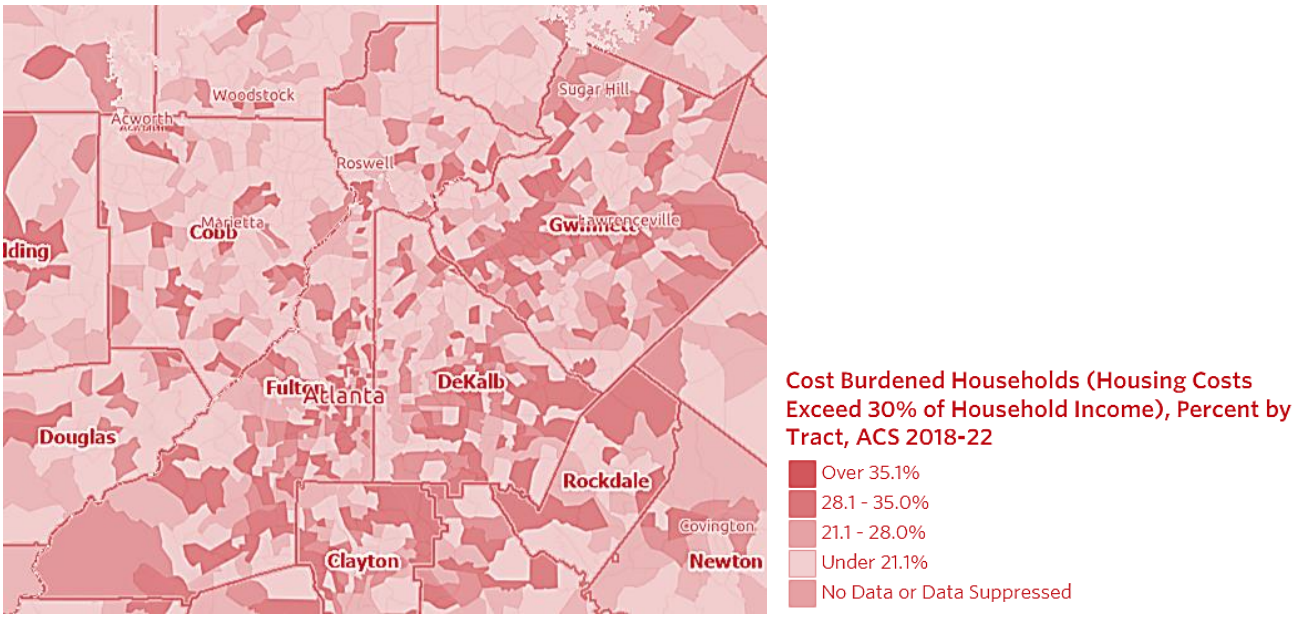
20 US Department of Housing and Urban Development, Consolidated Planning Data 2017-2021

21 Caring.com (2019, October 7). *Caring.com Announces Top 10 Best and Worst Places for Seniors to Live in the United States*, 2019. Retrieved 2025

in four (25.7%) metro Atlanta homeowners aged 65+ pay more than 30% of their household income on housing.[22]

While county-level housing outcomes don't vary considerably from state and national outcomes, census tract data tells a more nuanced story, allowing us to see where burden is greatest across Fulton and DeKalb Counties (Figure 11).

**FIGURE 11:PERCENT OF COST BURDENED HOUSEHOLDS BY CENSUS TRACT (2018-2022)**[23]




**Source:** U.S. Census Bureau. (2024). American Community Surveys 2018-2022.

Homelessness rates are rising across the state due to increases in housing costs and stagnant wages. According to the Centers for Disease Control and Prevention, individuals experiencing homelessness are at an increased risk of infectious diseases, mental illness, alcohol and substance use disorders, diabetes, and heart and lung disease.[24] When we look at state-level data, we find that:

- 12,294 Georgians experienced homelessness on any given night in 2023, an increase of nearly 21% since 2017,
- 1,728 or 14% of Georgia's homeless population are chronically homeless,
- 15% of individuals who are homeless in GA are 55+ years of age,
- 6% of Georgia's homeless are veterans, and
- 29% of people experiencing homelessness are doing so as a family.[25]

[22] American Community Survey 5-Year Estimates, B25093. 2018-2022

[23] U.S. Census Bureau, American Community Survey, 2018-2022 and 2019-2023

[24] Centers for Disease Control and Prevention. (2024, October 15). About Homelessness and Health | Homelessness and Health | CDC. Office of Readiness and Response. Retrieved 2025

[25] National Alliance to End Homelessness. (2024). More investments are needed to end homelessness in Georgia. Endhomelessness.org

Fulton County has the largest homeless population in the state. In 2024, over 3,200 people were counted as homeless in Fulton County alone, representing more than a quarter of Georgia's total homeless population.[26] This high concentration is due in part to the city's larger population and the availability of services, which attract individuals in need from across the region. DeKalb County follows with approximately 1,200 people experiencing homelessness (according to point in time counts).

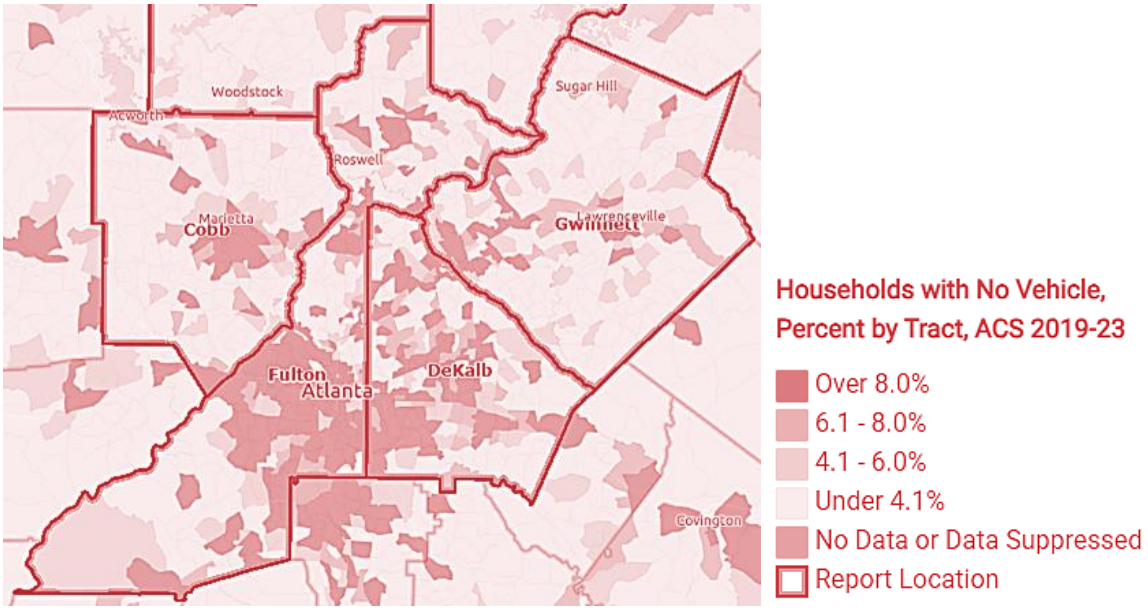
Data from the Georgia Department of Education estimates that 12,000 public school students living in the Atlanta metro area were unhoused in 2024. They estimated that 1.2% (1,258) of the 101,292 students in Dekalb Country and 1.9% (1,822) of the 94,995 students in Fulton County experienced homelessness in 2024.[27]

Local community organization partners are working to address homelessness through prevention efforts, case management services and temporary housing solutions such as hotel vouchers. Some of these efforts are in hopes of aligning with federal government efforts to rapidly rehouse people, in efforts to keep them from becoming unhoused repeatedly.

## Transportation

The service area had more households with no motor vehicle (7.7% in DeKalb county and 10.7% in Fulton) when compared to the state (6%). Over 8% of households in many census tracts do not have a motor vehicle (Figure 12).

**FIGURE 12F: PERCENT OF HOUSEHOLDS WITH NO VEHICLE BY CENSUS TRACT (2019-2023)27F[28]**




[26] Georgia Department of Community Affairs. (2024). Point in Time Homeless Count.
[27] Keenan, Sean. (2024, September 1). Nearly 12,000 metro Atlanta public school students are unhoused - Atlanta Civic Circle. Atlanta Civic Circle: Housing Affordability
[28] U.S. Census Bureau, American Community Survey 2019-2023

**Source:** U.S. Census Bureau. (2024). American Community Surveys 2019-2023.

Motor vehicle crashes remain a leading contributor to years of potential life lost (YPLL) in the service region, with significant racial disparities. According to the most recent Georgia Department of Public Health OASIS data (2020–2024), Black residents experience substantially higher YPLL rates from motor vehicle crashes compared to White, Asian, and Hispanic residents. For example, statewide YPLL rates per 100,000 population are approximately 653 for Black residents, compared to 162 for White residents and 163 for Asian residents, while Hispanic residents experience intermediate rates near 397.

County-level patterns mirror these disparities: DeKalb County's overall YPLL rate from motor vehicle crashes exceeds 540, while Fulton County's rate is 390, both higher than many other Georgia counties. These differences underscore the disproportionate burden of fatal crashes among Black residents and highlight the need for targeted traffic safety and injury prevention strategies (see Table 12).

**TABLE 12: YPLL DUE TO MOTOR VEHICLE CRASHES BY RACE, ETHNICITY AND LOCATION (2020-2024)**

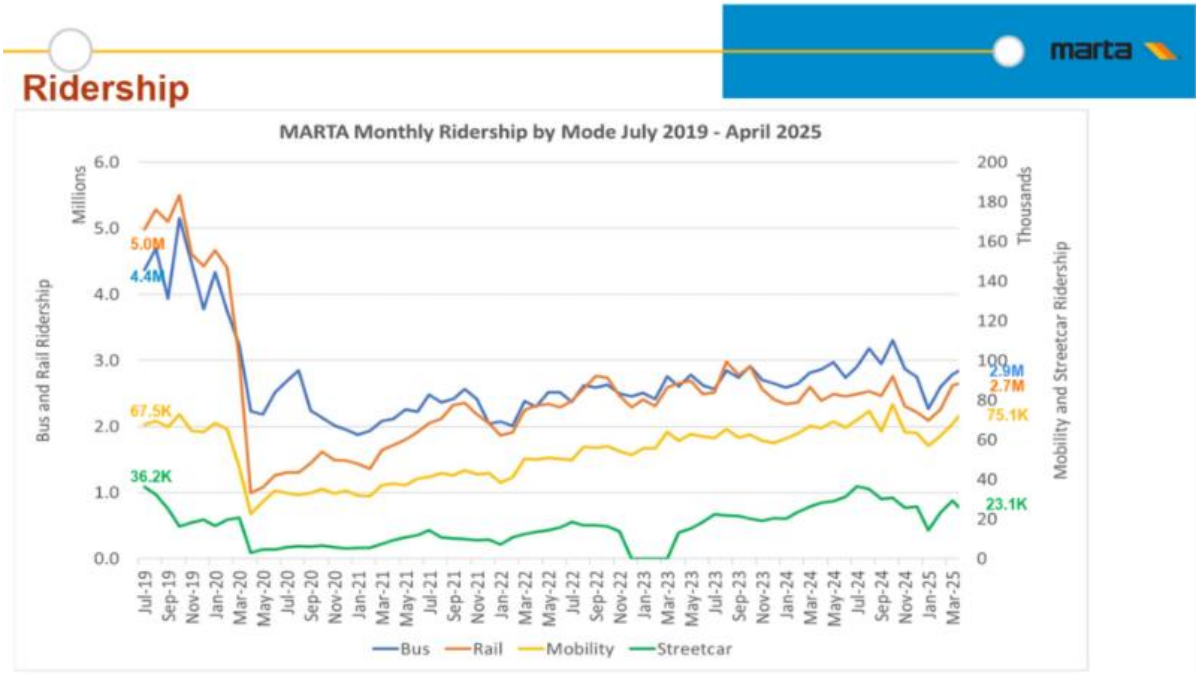
| | WHITE | BLACK | ASIAN | HISPANIC | DEKALB | FULTON | GA |
|---|---|---|---|---|---|---|---|
| Motor Vehicle Crashes | 161.8 | 653.4 | 163.0 | 396.6 | 542.8 | 390.1 | 538.2 |
| Rates are age-adjusted per 100,000 population | | | | | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

The Atlanta area's public transit system, the Metro-Atalanta Regional Transit Authority (MARTA), faces challenges as well including: delays, safety concerns, and insufficient number of routes and long wait times between regularly scheduled pick-ups. According to MARTA's data tracking, ridership has decreased since 2019 (Figure 13); and according to the Federal Transit Administration, MARTA ridership continued to fall between 2024 and 2025.[29] However, MARTA officials suspect data from the last year is inaccurate, making it difficult to pinpoint MARTA's current ridership.[30]

**FIGURE 13: MARTA RIDERSHIP (2019-2025**

[29] Federal Transit Administration. (2025, March). Complete Monthly Ridership.
[30] DiRienzo, R. (2025, March 5). Fewer Atlantans are taking the train, but MARTA says numbers are off. *Fox 5 Atlanta.*




**Source:** MARTA. (2024). City of Atlanta 2025 Q2 Update.

Atlanta voters approved a plan to expand public transit service in 2016. However, as of 2023, progress was delayed and the scope of the proposed projects had narrowed. According to sources, these challenges are due in part to "pandemic-related construction delays, higher material and labor costs, lower ridership and smaller budgets."[31] As of February 2025, it looked as if MARTA's challenges may be exacerbated by proposed federal funding cuts.[32]

## Community Safety

Assault is the #1 cause of YPLL in Fulton and DeKalb counties. Interview participants working in the Atlanta area identified violence as one of their biggest concerns—particularly its impact on children and adolescents.

According to CrimeGrade,[33] DeKalb County ranks in the 42nd percentile for safety, meaning it is less safe than 58% of counties. The violent crime rate in DeKalb County is 4.052 per 1,000 residents in the typical year. Residents' chance of being a victim of violent crime in DeKalb County varies by area – ranging from 1 in 146 in the southern part of the county to 1 in 431 in the west.

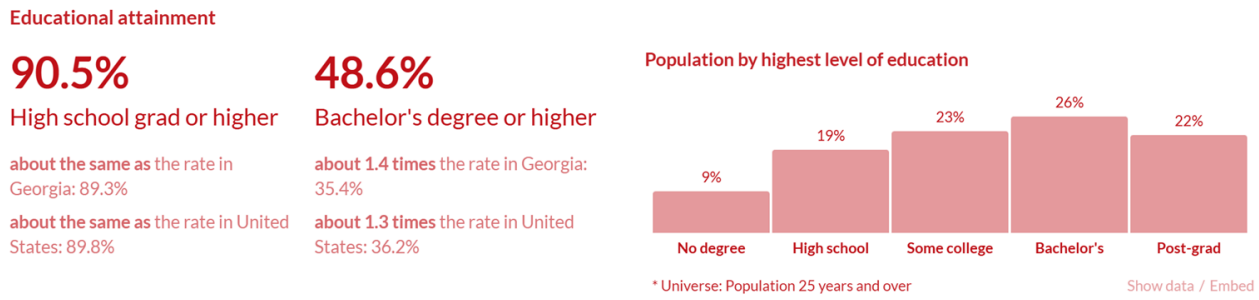
[31] Brey, J. (2023, March 14). Atlanta's Incredible Shrinking Transit Plan. *Governing*.
[32] Raymond, J. (2025, February 19). MARTA faces $89 million in budget 'challenges' under possible federal funding cuts, agency CEO says. *11Alive News*.
[33] CrimeGrade uses a complex process of statistical computation and machine learning to identify the safest and most dangerous areas in a geographic location. Data sources include dataset from Federal Bureau of Investigation (FBI), Local law enforcement agencies, State criminal justice departments, and Best Neighborhood's proprietary data collection.

Fulton County ranks in the 33rd percentile for safety, meaning it is less safe than 67% of counties. The violent crime rate in Fulton County is 4.575 per 1,000 residents in a typical year. Residents' chance of being a victim of violent crime in Fulton County varies by area – ranging from 1 in 96 in the southern part of the county to 1 in 362 in the northwest.

## Education

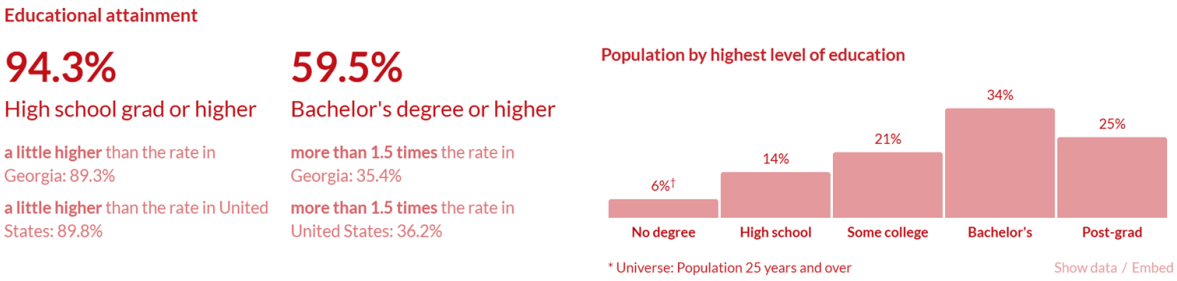
Compared to Georgia (35.4%) and the country (36.2), DeKalb (48.6%) and Fulton (59.9%) counties have a higher percentage of adults 25 or older with Bachelor's degrees or higher (Figures 14-15). However, when we look at the census tract data (Figure 16), we do see that there are parts of the service area where over 21% of adults 25 or older do not have a high school diploma. [34]

**FIGURE 14: DEKALB COUNTY EDUCATION OUTCOMES**




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

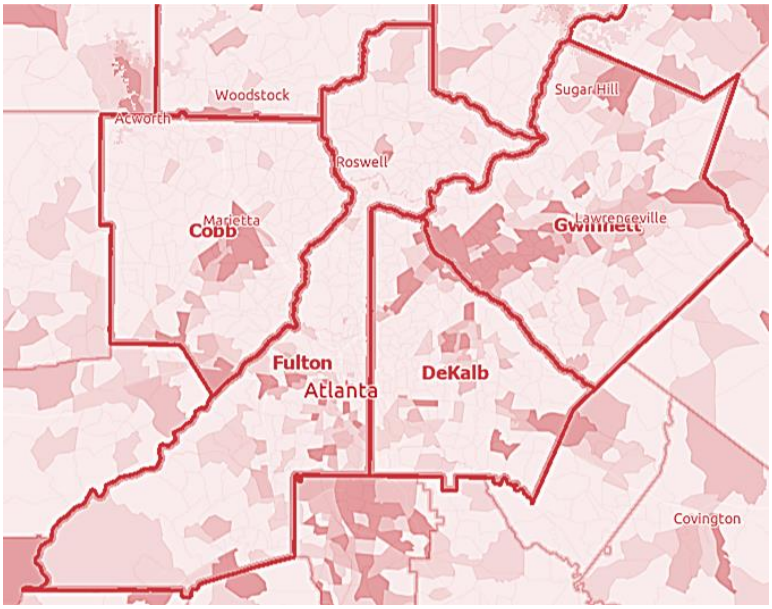
**FIGURE 15: FULTON COUNTY EDUCATION OUTCOMES**




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

**FIGURE 16: POPULATION WITH NO HIGH SCHOOL DIPLOMA (AGED 25 AND OLDER) BY CENSUS TRACT AND COUNTY (2018-2022)**

[34] U.S. Census Bureau (2023). *American Community Survey 1-year estimates.* Retrieved from *Census Reporter Profile page for DeKalb County, GA* <http://censusreporter.org/profiles/05000US13089-dekalb-county-ga/>




**Source:** U.S. Census Bureau. (2023). American Community Survey, 2018-2022.

Educational attainment is often linked to chronic disease, sexual health, and health behavior management outcomes.

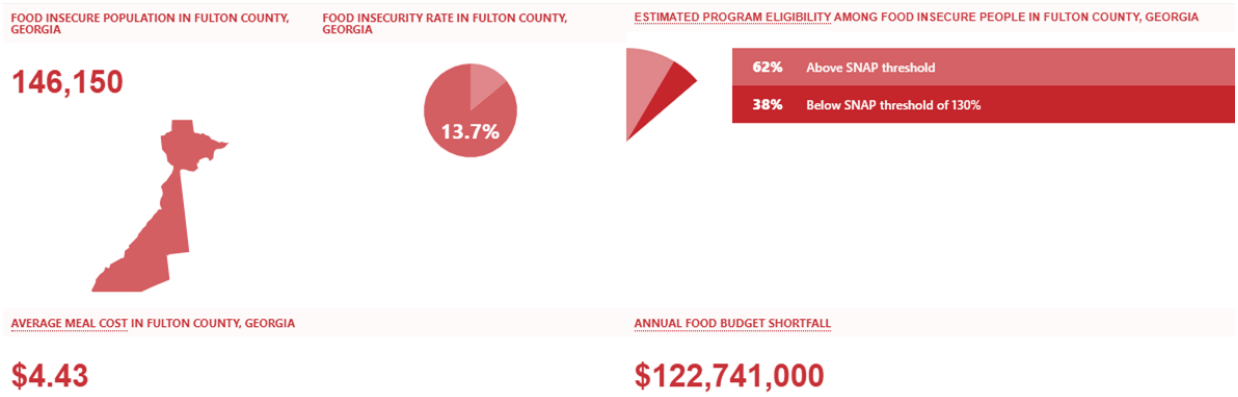
## Food & Nutrition

Nutrition and food access have a significant impact on health. Lack of access to healthy, affordable, and culturally preferred food on a consistent basis can exacerbate chronic conditions (diabetes, heart disease, obesity) and mental health and stress among adults.[35] Food insecurity can negatively impact children's social, emotional, academic, and physical health especially when it is experienced consistently.[36]

To ensure good nutrition, residents must be able to access healthy foods. An estimated 13.1% of Georgians are food insecure and 18.4% of Georgia's children live in food insecure homes.[37] This equates to about 1.4 million Georgians who lack access to sufficient food to maintain health and prevent disease.[38] Georgians living in under-resourced, low-income urban communities, experience higher rates of food and nutrition insecurity. In 2023, 21.3% of children in DeKalb County and 18.8% of children in Fulton County were food insecure (Figures 17-18).[39]

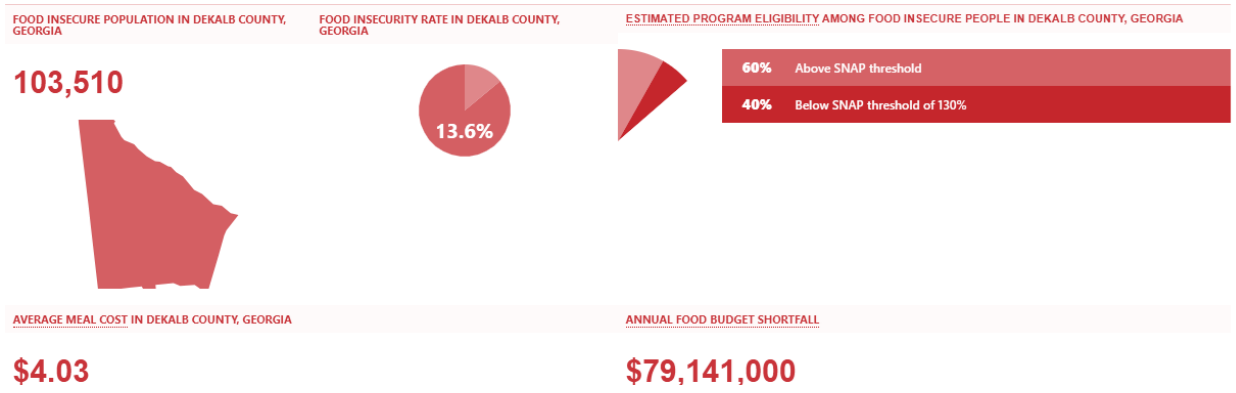
[35] Centers for Disease Control and Prevention. (2025, January 23). Nutrition: Health Food Environments. National Center for Chronic Disease Prevention and Health Promotion.
[36] Nemours Children's Health. (2024). Impact of Nutrition and Food Insecurity on Child Health.
[37] Food security is defined as "having access to enough food for an active, healthy life." Nutrition security is defined as "consistent access, availability, and affordability of foods and beverages that promote well-being, prevent disease, and, if needed, treat disease." Mozaffarian D, Fleischhacker S, Andrés JR. (2021). Prioritizing Nutrition Security in the US. *JAMA*.
[38] Map the Meal Gap. (2022). What Hunger Looks Like in Georgia. Feeding America. Georgia | Feeding America
[39] Dewey, A., Hilvers, J., Dawes, S., Harris, V., Hake, M., and Engelhard, E. (2025). Map the Meal Gap: A Report of Local Food Insecurity and Food Costs in the United States in 2023. Feeding America National Organization. https://www.feedingamerica.org/research/map-the-meal-gap

**FIGURE 17: FOOD INSECURITY IN FULTON COUNTY**




**Source:** Feeding America. (2025). Map the Meal Gap.

**FIGURE 18: FOOD INSECURITY IN DEKALB COUNTY**

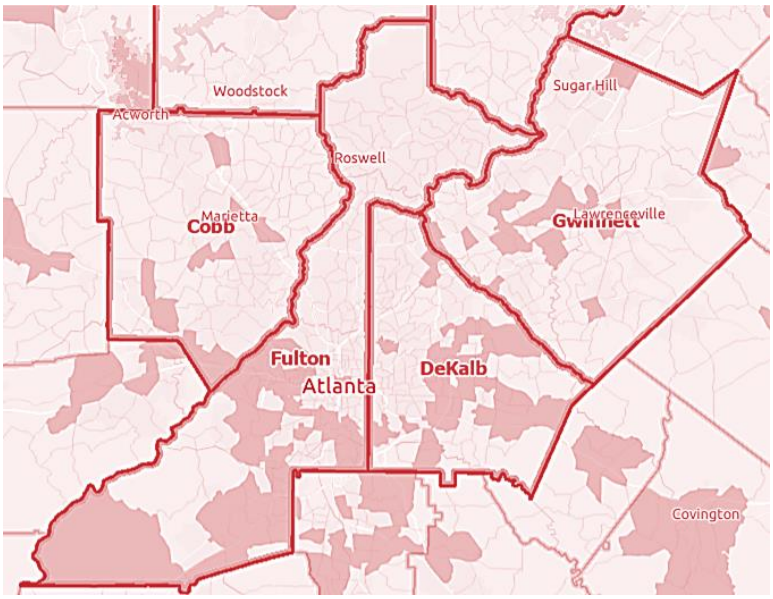



**Source:** Feeding America. (2025). Map the Meal Gap.

Another metric used to measure food insecurity is the presence of food deserts, which are defined by the USDA as low-income census tracts with a substantial number or share of residents with low levels of access to retail outlets selling healthy and affordable foods. Figure 19 shows census tracts throughout the service area that were denoted as food deserts by Fulton County Board of Health. Several specific neighborhoods were highlighted in the recent Access to Health Foods Report.[40] These included Oakland City, Pittsburgh, East Point, Fort McPherson, English Avenue (north of North Avenue), Cary Park, Adamsville and Oakcliff.

**FIGURE 19:FOOD DESERTS BY CENSUS TRACT (2018-2022**

[40]Morland, K., Roux, A.V.D. and Wing, S., 2006. Supermarkets, other food stores, and obesity: the atherosclerosis risk in communities study. *American journal of preventive medicine*, *30*(4), pp.333-339. Access to Healthy Foods Analysis | Fulton Performance




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

## Community & Social Context

Social support refers to the help someone receives emotionally or physically from their social network, including friends, family, coworkers, neighbors, health care providers, and other community workers. People who have strong relationships and trust others tend to live longer and healthier lives than those who are alone.[41] Support from family, friends, and coworkers helps people feel connected and ensures better long-term health and coping.

Low social support is associated with a number of poor health outcomes across diverse populations:

- People who are often alone have a higher risk of heart disease, dementia, diabetes, and depression.[42]
- Pregnant people who lack social support are at risk for depression, anxiety, and self-harm during pregnancy. (Mental health conditions, including suicide and overdose, are a leading cause of pregnancy-related death).[43] Low social support may also impact parenting behavior.[44]
- Childcare can be considered a form of social support; but, the cost of childcare is burdensome for many Georgia families and unattainable for some.[45]

[41] Centers for Disease Control and Prevention(2024, May 15). Social Connection. National Center for Chronic Disease Prevention and Health Promotion.
[42] The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community. (2023). Our Epidemic of Loneliness and Isolation.
[43] Centers for Disease Control and Prevention. (2022). Four in five pregnancy-related deaths in the US are preventable.
[44] Bedaso, A., Adams, J., Peng, W. *et al.* The relationship between social support and mental health problems during pregnancy: a systematic review and meta-analysis. *Reprod Health* **18**, 162 (2021). https://doi.org/10.1186/s12978-021-01209-5
[45] University of Wisconsin Public Health Institute. County Health Rankings and Roadmaps (2024). Data by County: Georgia Childcare Cost Burden.

About 20% of older adults are socially isolated, and 4% are severely isolated.[46] According to America's Health Rankings, Georgia has a social isolation index of 59, putting it 35th in the country. (The index examines a state's risk factors for social isolation [living in poverty; living alone; being divorced, separated or widowed; having never married; having a disability; and having independent living difficulty] among adults aged 65 and older and develops a normalized value between 1 to 100, with a higher value indicating greater risk).[47] Recently, the biggest drop in social connection has been among young people aged 15 to 24. Research indicates that young adults feel twice as lonely as older adults.[48]

# Mortality and Morbidity

## Top Causes of Death

Across the service area, the mortality rate from all top causes of death (Table 13) were generally lower than state averages, except for all other diseases of the nervous system, which was not a top five cause in the state. Covid-19 ranked 4th among the top causes of death; however, there were no documented deaths from Covid-19 in 2019, and death rates have dropped off since the height of the pandemic in 2021.[49]

**TABLE 13: TOP CAUSES OF DEATH BY COUNTY COMPARED TO STATE OUTCOMES (2020-2024)**

| CAUSE OF DEATH | FULTON RANK | DEKALB RANK | GEORGIA RANK |
|---|---|---|---|
| Ischemic Heart & Vascular Disease | 1 | 1 | 1 |
| Primary Hypertension & Hypertensive Renal, & Heart Disease | 2 | 2 | 3 |
| All Other Diseases of the Nervous System | 3 | 5 | 7 |
| Cerebrovascular Disease | 4 | 3 | 4 |
| COVID-19 | 5 | 4 | 2 |
| Alzheimer's Disease | 6 | 6 | 6 |
| Malignant Neoplasms of the Trachea, Bronchus, Lung | 7 | 8 | 8 |
| Accidental Poisoning & Exposure to Noxious Substances | 8 | 10 | 11 |
| Diabetes Mellitus | 9 | 7 | 9 |
| All COPD Except Asthma | 10 | 11 | 5 |
| All Other Endocrine, Nutritional and Metabolic Diseases | 11 | 9 | 10 |
| Assault (Homicide) | 12 | 12 | |
| Nephritis, Nephrotic Syndrome and Nephrosis | 13 | 14 | 12 |
| All Other Mental & Behavioral Disorders | 14 | 13 | 13 |
| Intentional Self-Harm (Suicide) | 15 | | |

[46] National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Health and Medicine Division; Board on Behavioral, Cognitive, and Sensory Sciences; Board on Health Sciences Policy; Committee on the Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. Washington (DC): National Academies Press (US); 2020 Feb 27. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK557969/

[47] America's Health Rankings analysis of U.S. Census Bureau, American Community Survey, 1-Year Dataset, United Health Foundation, AmericasHealthRankings.org, accessed 2025. Explore Risk of Social Isolation - Age 65+ in Georgia | AHR

[48] Kannan, V. D., & Veazie, P. J. (2022, December 25). US trends in social isolation, social engagement, and companionship—nationally and by age, sex, race/ethnicity, family income, and work hours, 2003–2020

[49] Georgia Online Analytical and Statistical Information System. Community Health Needs Assessment Dashboard: Top Causes of Age Adjusted Death. Georgia Department of Public Health-Office of Health Indicators for Planning (OHIP). App Version: 2.0.4, Content Version: 2.5.1

| CAUSE OF DEATH | FULTON RANK | DEKALB RANK | GEORGIA RANK |
|---|---|---|---|
| Motor Vehicle Crashes | | 15 | 14 |
| Septicemia | | | 15 |

**Source:** Georgia Department of Public Health. (2025). Online Analytical Statistical Information System.

Black residents had higher mortality rates from cerebrovascular disease and essential (primary) hypertension and hypertensive renal, and heart disease compared to other racial and ethnic groups in the service area (Table 14). White residents had higher mortality rates from all other diseases of the nervous system compared to other groups and the state. Black and Hispanic residents had the highest mortality rates from Covid-19 compared to other racial and ethnic groups in the service area.

**TABLE 14: SERVICE AREA DEATH RATES BY RACE/ETHNICITY COMPARED TO STATE BENCHMARKS (2019-2023)**

| CAUSE OF DEATH | WHITE | BLACK | ASIAN | HISPANIC/LATINO | GA |
|---|---|---|---|---|---|
| Ischemic Heart and Vascular Disease | 43.9 | 61.9 | 25.1 | 27.6 | 75.0 |
| Cerebrovascular Disease | 28.8 | 52.6 | 26.7 | 29.4 | 43.9 |
| All Other Diseases of the Nervous System | 42.7 | 31.1 | 14.4 | 19.7 | 35.2 |
| Covid-19 | 23.7 | 51.8 | 16.0 | 37.9 | 54.9 |
| Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease | 28.9 | 64.9 | 16.6 | 19.3 | 42.0 |
| Rates are age-adjusted per 100,000 population | | | | | |

**Source:** Georgia Department of Public Health. (2025). Online Analytical Statistical Information System.

## Top Causes of Years of Potential Life Lost (Premature Death)

Years of Potential Life Lost (YPLL) is used to measure the rate and distribution of premature death. Assault (homicide) was the number one cause of premature death in DeKalb and Fulton counties but did not appear in the top causes of YPLL at the state-level or in any other counties in the region, indicating an increased burden of violence not experienced by other counties. “Deaths of despair” including accidental exposure poisoning and exposure to noxious substances (most often associated with drug overdose) and intentional self-harm (suicide) ranked second and fourth among the top 5 causes of YPLL (Table 15).

**TABLE 15: TOP CAUSES OF YEARS OF POTENTIAL LIFE LOST BY COUNTY COMPARED TO STATE BENCHMARKS (2019-2023)**

| YPLL* CAUSES | FULTON COUNTY | DEKALB COUNTY |
|---|---|---|
| Assault (Homicide) | 9.63% | 10.1% |
| Accidental Poisoning and Exposure to Noxious Substances | 8.75% | 7.58% |
| Motor Vehicle Crashes | 5.45% | 6.23% |
| Intentional Self-Harm | 5.4% | 5.2% |
| Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease | 5.37% | 4.95% |

| YPLL* CAUSES | FULTON COUNTY | DEKALB COUNTY |
|---|---|---|
| * The YPLL Rate is the years of potential life lost before age 75 that occur per 100,000 population less than 75 years of age. | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

When looking at racial and ethnic groups in the service area, White residents had higher rates of YPLL for drug overdose compared to other groups and the state. Black residents had the highest rates of YPLL from assault and motor vehicle crashes compared to other racial and ethnic groups in the service area (Table 16).

**TABLE 16: YEARS OF POTENTIAL LIFE LOST IN THE SERVICE AREA BY RACE, ETHNICITY AND SEX (2019-2024)**

| LEVEL | CAUSE | ALL | WHITE | BLACK | ASIAN | HISPANIC | MEN | WOMEN |
|---|---|---|---|---|---|---|---|---|
| DeKalb | Assault/ Homicide | 17 | 1.8 | 30.4 | * | 13.5 | 30.3 | 4.6 |
| DeKalb | Accidental Poisoning | 18.9 | 15.9 | 23.6 | * | 14.2 | 29.9 | 9.2 |
| DeKalb | Motor Vehicle Crash | 13.8 | 4.7 | 21 | 10.6 | 14.4 | 20.4 | 7.7 |
| Fulton | Assault/ Homicide | 15.4 | 2.4 | 31.7 | * | 7.7 | 25.8 | 5.6 |
| Fulton | Accidental Poisoning | 18.1 | 13.8 | 26 | * | 7.3 | 25.8 | 10.9 |
| Fulton | Motor Vehicle Crash | 8.8 | 3.8 | 14.3 | 7.6 | 7.2 | 11.7 | 6.1 |
| Georgia | Assault/ Homicide | 9.1 | 3.4 | 20.2 | 1.8 | 4.6 | 14.6 | 3.6 |
| Georgia | Accidental Poisoning | 17.4 | 19.8 | 16.7 | 2.9 | 8.3 | 24 | 11 |
| Georgia | Motor Vehicle Crash | 13.3 | 13 | 15.3 | 6.6 | 10.6 | 20 | 7 |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

## Top Causes of Emergency Department Visits

Three of the top causes of emergency department use in the service area were all related to injury (all other unintentional injury, falls, and motor vehicle crashes) (Table 17). Across the service area, rates for all the top causes of emergency department visits were lower than state averages.

**TABLE 17: TOP CAUSES OF EMERGENCY ROOM VISIT BY COUNTY COMPARED TO STATE OUTCOMES (2019-2023)**

| RANK | DEKALB | FULTON | GA |
|---|---|---|---|
| #1 | Diseases Of the Musculoskeletal System and Connective Tissue- 2,769.0 | Diseases Of the Musculoskeletal System and Connective Tissue- 2,642.5 | Diseases Of the Musculoskeletal System and Connective Tissue- 2,774.6 |
| #2 | All Other Diseases of The Genitourinary System- 1,431.4 | All Other Unintentional Injury- 1,546.2 | All Other Unintentional Injury- 2,458.9 |
| #3 | All Other Unintentional Injury- 1,326.8 | All Other Diseases of the Genitourinary System- 1,455.0 | All Other Diseases of the Genitourinary System- 1,899.3 |
| #4 | Falls- 896.8 | Falls- 1,029.7 | Falls- 1,565.3 |
| #5 | Motor Vehicle Crashes- 859.5 | Motor Vehicle Crashes- 750.6 | Motor Vehicle Crashes- 907.1 |
| Rates are age-adjusted per 100,000 population | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

## Top Causes of Hospital Discharge Rates

Septicemia was the leading cause of hospital discharges across both counties and the state, but neither county's rate was higher than the state average (Table 18). DeKalb and Fulton counties had higher rates of all other mental and behavioral disorders than state rates and had higher hospital discharge rates of essential (primary) hypertension and hypertensive renal, and heart disease compared to the state. Cerebrovascular disease was a top 5 cause of hospital discharges in both counties but did not make the top five for state rates of hospital discharges.

**TABLE 18: TOP CAUSES OF HOSPITAL DISCHARGE BY COUNTY COMPARED TO STATE BENCHMARKS (2019-2023)**

| RANK | DEKALB | FULTON | GA |
|---|---|---|---|
| #1 | Septicemia- 490.5 | Septicemia- 546.2 | Septicemia- 604.4 |
| #2 | All Other Mental and Behavioral Disorders- 444.5 | All Other Mental and Behavioral Disorders- 415.0 | Essential (Primary) Hypertension and Hypertensive Renal, And Heart Disease- 360.9 |
| #3 | Essential (Primary) Hypertension and Hypertensive Renal, And Heart Disease- 371.7 | Essential (Primary) Hypertension and Hypertensive Renal, And Heart Disease- 389.6 | All Other Mental and Behavioral Disorders- 381.3 |
| #4 | Cerebrovascular Disease- 237.9 | Diseases Of the Musculoskeletal System and Connective Tissue- 251.9 | Diseases Of the Musculoskeletal System and Connective Tissue- 270.3 |
| #5 | Diseases Of the Musculoskeletal System and Connective Tissue- 232.8 | Cerebrovascular Disease- 230.6 | Ischemic Heart and Vascular Disease- 261.5 |
| Rates are age-adjusted per 100,000 population | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

# Health Priorities

## Access to Care

Secondary data and interview participants consistently identified Access as one of the biggest barriers to healthcare and ranked it as the highest priority. Access is a very broad topic that encompasses many issues. In an attempt to classify the many facets of access, in 1981, Penchansky and Thomas coined the *5 dimensions of access* (Figure 20). Primary data touched on all five of the dimensions. The secondary data we reviewed focused on availability and affordability.

**FIGURE 20: EXAMPLES OF THE 5 DIMENSIONS OF ACCESS**

| Available | Accessible | Affordable | Accomodating | Acceptable |
|---|---|---|---|---|
| •Health facilities are present<br>•Health providers are present | •Patients have reliable transportation so they reach care when its needed | •Patients can afford healthcare<br>•Patients are adequately insured | •Providers offer services outside typical working hours<br>•Parents can bring their children to appointments<br>•Providers can communicate with their patients based on their language as well as their health literacy | •Care is responsive to the unique needs of vulnerable groups<br>•Providers look like and share lived experience with their patients |

## Availability

### *Availability of health care facilities and providers*

Fulton and DeKalb counties have a number of health facilities, but face challenges with equitable access due to professional shortages and cost barriers. Portions of the population in both counties live in Health Professional Shortage Areas (HPSAs), and many residents report difficulties accessing necessary care.

In 2023, DeKalb County had 5 general hospitals with 1,752 beds, generating 389,427 inpatient days and 56,453 admissions (Table 19). Fulton County had nearly double the number of facilities, with 9 hospitals and 3,671 beds, resulting in over 1 million inpatient days and 174,014 admissions. Statewide, Georgia's 130 hospitals provided a total of 24,291 beds, 4.8 million inpatient days, and nearly 894,000 admissions.

**TABLE 19: GENERAL HOSPITAL AVAILABILITY AND CAPACITY (2023)**

| LOCATION | HOSPITAL FACILITIES | HOSPITAL BED CAPACITY | HOSPITAL TOTAL INPATIENT DAYS | HOSPITAL TOTAL ADMISSIONS |
|---|---|---|---|---|
| DeKalb | 5 | 1,752 | 389,427 | 56,453 |
| Fulton | 9 | 3,671 | 1,015,196 | 174,014 |
| **Georgia** | **130** | **24,291** | **4,833,057** | **893,593** |

**Sources:** GA Department of Community Health, Annual Hospital Questionnaire; GA Department of Community Health, Annual Nursing Home Questionnaire; U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) Program, Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States.

Georgia has fewer health care providers than the US average. Eight percent (8.0%) of DeKalb County residents and 19.8% of Fulton County residents live in an area affected by a health professional shortage

(Table 20). Of those, 64.1% in DeKalb County and 36.6% in Fulton County are underserved. According to the data, 5.0% of Fulton County residents are living in a health professional shortage for dental care.

**TABLE 20: HEALTH PROFESSIONAL SHORTAGES AND SERVICE PROVIDER RATES**

| | DEKALB | FULTON | GEORGIA | U.S. |
|---|---|---|---|---|
| Percentage of Population Living in an Area Affected by a Health Professional Shortage (2024)[1] | 8.0% | 19.8% | 26.3% | 22.3% |
| Percentage of Health Professional Shortage Population Underserved (2024)[1] | 64.1% | 36.6% | 60.7% | 51.6% |
| Percentage of Population Living in a Health Professional Shortage for Dental Care (2024)[1] | 0.0% | 5.0% | 18.6% | 16.7% |
| Addiction/Substance Abuse Providers (2024)*[2] | 7.1 | 5.3 | 7.9 | 28.3 |
| Buprenorphine Providers (2024)*[3] | 10.8 | 11.9 | 7.9 | 14.9 |
| Dentists (2022)*[4] | 62.4 | 76.1 | 53.9 | 74.3 |
| Mental Health Providers (2024)*[2] | 408.3 | 282.8 | 188.4 | 311.0 |
| Nurse Practitioners (2024)*[2] | 93.5 | 122.9 | 75.6 | 96.1 |
| Primary Care (2021)*[5] | 105.9 | 112.6 | 66.0 | 75.7 |
| *Rate per 100,000 Population | | | | |

**Sources:**

1. US Department of Health & Human Services. (2024) Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database.
2. Centers for Medicare and Medicaid Services, CMS. (2024) National Plan and Provider Enumeration System (NPPES).
3. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2024)
4. US Department of Health & Human Services, Health Resources and Services Administration, HRSA. (2022). Area Health Resource File.
5. CMS. (2020). Geographic Variation Public Use File.

## Affordability

### *Cost*

Healthcare costs (including premiums and deductibles, doctor visits, medical procedures and prescription drugs) in Georgia are expensive. According to a 2024 analysis, Georgia is the eighth most expensive state in terms of health care spending in the US.[50] From 2013 to 2021, the amount of healthcare spending per person in Georgia grew by 37%.[51] According to the CDC, almost 15% of people in Georgia reported making the decision to not see a doctor because they could not afford it.[52] And, in

[50] Horton, C., Smith, K.A., & Louis, P. (2024) *The Most (And Least) Expensive States For Health care 2024*. What Does Medicare Cover? Your Medicare Coverage Guide – Forbes Advisor

[51] Georgia Board of Health Care Workforce. (2022, May). *2020 Counties Without Primary Care Practitioners Report.*

[52] Centers for Disease Control and Prevention (2023, July 19). *BRFSS Prevalence & Trends Data; Location: Georgia, Topic: Health Care Access/Coverage*. National Center for Chronic Disease Prevention and Health Promotion. Division of Public Health

2021, 38% of Georgians did not fill prescriptions, cut pills in half, or skipped a dose of medicine because of cost.[53]

### *Insurance coverage*

Georgia has a higher percentage of uninsured residents than the US average (Table 24). Not having insurance is one of the biggest barriers to healthcare. People may be un- or under-insured due to:

- Cost,
- Eligibility,
- Unemployment,
- Lack of available plans that meet the individual's health needs, and

Barriers to signing up including language barriers, a lack of understanding of the financial impact of going without insurance, and limited health insurance literacy and knowledge about the market.[54]

While 16.1% of residents in DeKalb County and 12.8% of residents in Fulton County are uninsured (Table 21), there are census tracts throughout both counties where the percentage of uninsured residents is over 20% (Figure 21).

**TABLE 21: UNINSURED BY COUNTY (2022)**

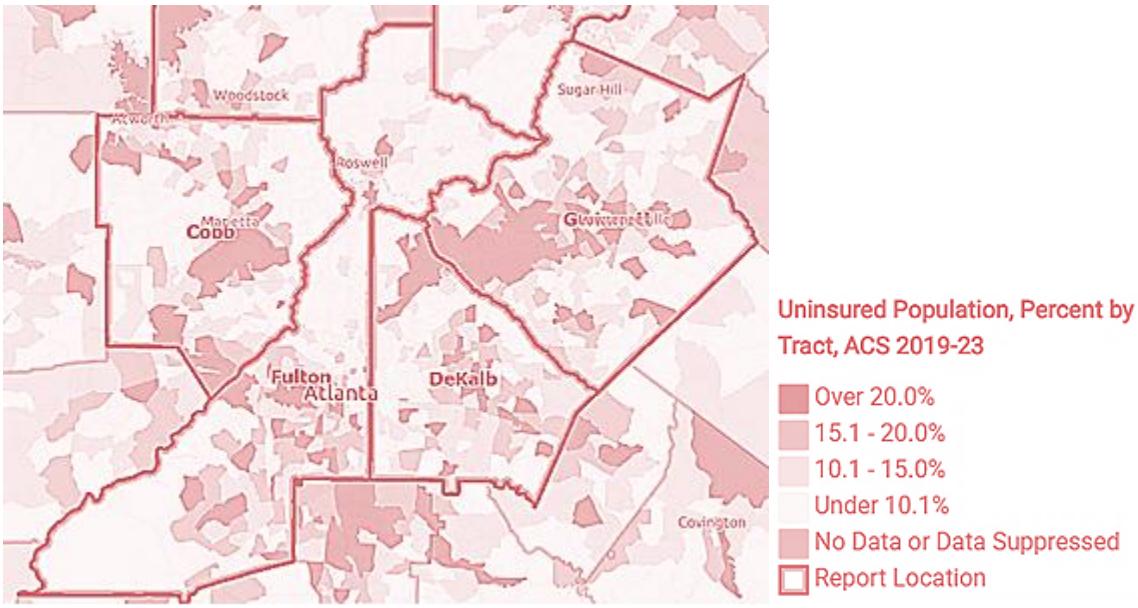
| | DEKALB | FULTON | GA | US |
|---|---|---|---|---|
| Uninsured (Percent) | 16.1% | 12.8% | 16.5% | 11.2% |
| Uninsured (Number*) | 75,907 | 87,660 | 1,076,981 | 22,229,770 |
| Rank in US | 2,403 of 3,133 | 1,854 of 3,133 | 48 of 51 | - |
| *All (includes Hispanic/Latino), Both Sexes, Ages 18-64 | | | | |

**Source:** National Institute on Minority Health and Health Disparities. (2025). HD*Pulse: An Ecosystem of Minority Health and Health Disparities Resources*.

[53] Altarum Healthcare Value Hub. (2021, October). *Georgia Residents Worried about High Drug Costs–Support a Range of Government Solutions*. Healthy Future Georgia [embargoed not for public distribution]

[54] Chan, L. (2024, October 29). *Georgia's Pathways to Coverage Program: The First Year in Review*. *Georgia Budget & Policy Institute.*

**FIGURE 21: UNINSURED POPULATION BY CENSUS TRACT (2019-2023)**




**Source:** U.S. Census Bureau. (2024). American Community Survey, 2019-2023

Although the Affordable Care Act (ACA) helped many people get insurance, some fall into a coverage gap. These individuals make too much money to qualify for Medicaid; but not enough to receive federal subsidies in the ACA Marketplace.[55] Given that the ACA tax credit is set to expire at the end of 2025, many Georgians may no longer be able to afford their insurance, which would increase the number of uninsured people.

# Chronic Disease

Chronic Diseases are some of the leading causes of death in the country.[56] Most adults aged 18 and over have at least one chronic condition, with the likelihood of multiple increasing with age.[57] Chronic diseases affect groups differently according to race and social determinants of health.[58] The next section includes an overview of the more common chronic diseases affecting residents in the service region.

## Diabetes

Many of the top causes of death in the service area are associated with overweight and obesity (heart and vascular disease, hypertension and cerebrovascular disease). While obesity rates in DeKalb and

[55] Kaiser Family Foundation. (2023). KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion . *Status of State Medicaid Expansion Decisions: Interactive Map*.
[56] Leading causes of death. Centers for Disease Control and Prevention. Updated January 23, 2023. Accessed November 7, 2023. *https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm*
[57] Watson KB, Wiltz JL, Nhim K, Kaufmann RB, Thomas CW, Greenlund KJ. Trends in Multiple Chronic Conditions Among US Adults, By Life Stage, Behavioral Risk Factor Surveillance System, 2013–2023. Prev Chronic Dis 2025;22:240539. DOI: *http://dx.doi.org/10.5888/pcd22.240539*
[58] Centers for Disease Control and Prevention (2025). National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) | National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) | CDC.

Fulton Counties and Georgia are on par with or slightly lower than the national rate, both counties and the state have a higher percentage of adults aged 20+ with diagnosed diabetes (Table 22).

**TABLE 22: SELECT ADULT BODY MASS INDEX AND DIABETES INDICATORS (2019-2023, UNLESS OTHERWISE NOTED)**

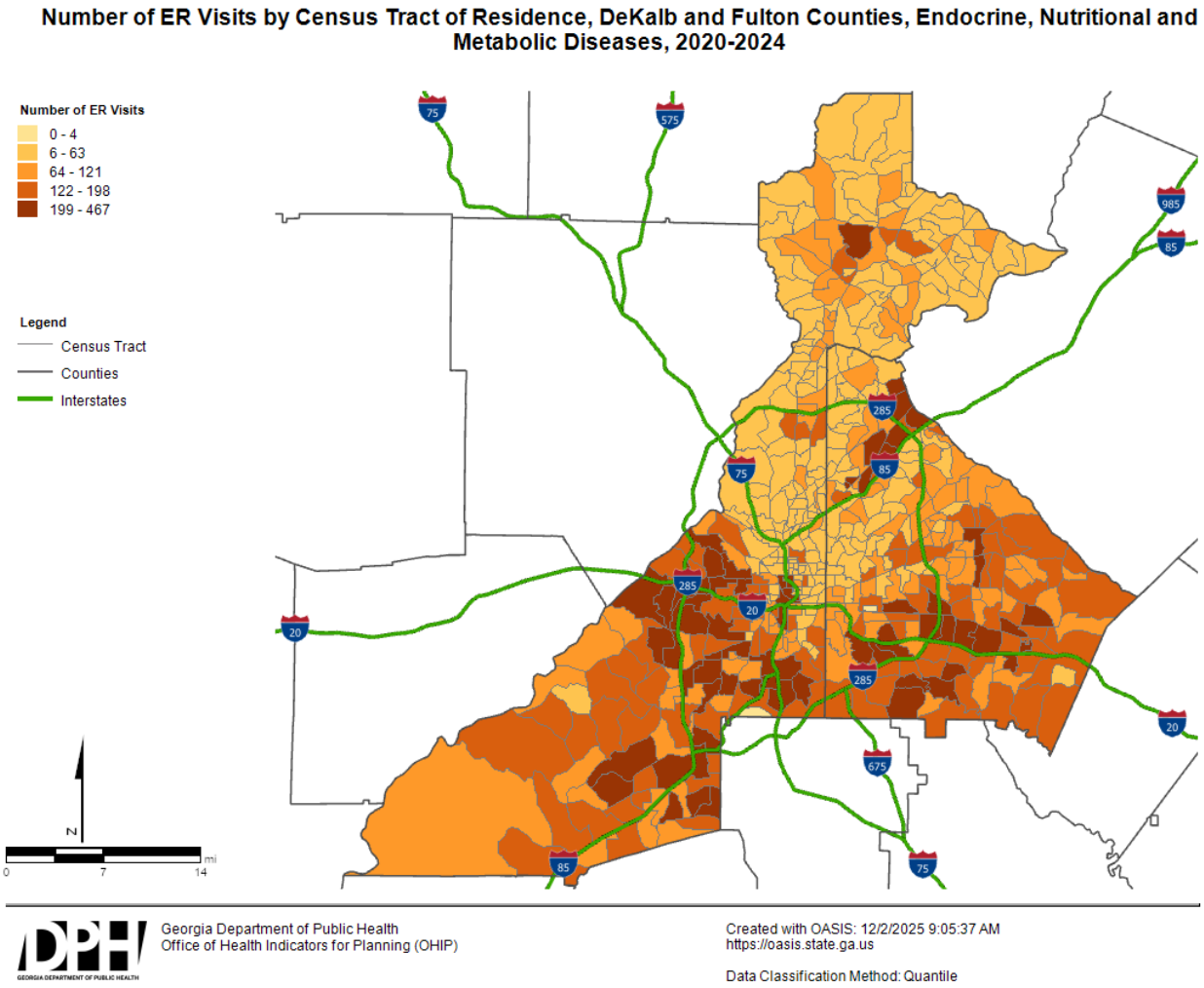
| | DEKALB | FULTON | GEORGIA | US |
|---|---|---|---|---|
| Adults with BMI > 30.0 (Obese), Percent (2021)[1] | 28.1% | 26.9% | 29.7% | 30.1% |
| Percentage of Adults Aged 20+ with Diagnosed Diabetes[1] (2021) | 10.7% | 9.0% | 9.6% | 8.9% |
| Diabetes ER Visit Rate[2]* | 290.6 | 294.2 | 309.9 | - |
| Diabetes Discharge Rate[2] * | 218.7 | 201.5 | 209.1 | - |
| Diabetes Mortality Rate[2]* | 23.9 | 20.7 | 22.4 | - |
| *Age-adjusted rates per 100,000 population | | | | |

**Sources:**

1. Centers for Disease Control and Prevention. (n.d.) National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps.
2. Georgia Department of Public Health Online Analytical Statistical Information System

As with many indicators, there are areas where disease burden is greater. Figure 22 indicates that census tracts in the southern and southwestern parts of the service area experience more diabetes-related complications than northern census tracts. The map highlights clear geographic disparities within the counties and suggests a need for geographically targeted interventions that support prevention and management and minimize emergencies. The data also illustrate racial and sex-related disparities. Black men have the highest mortality rates associated with diabetes followed by White men, then Black women and finally White women (Figures 23-24).

**FIGURE 22: NUMBER OF ER VISITS BY CENSUS TRACT, ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASE (2020-2024)**

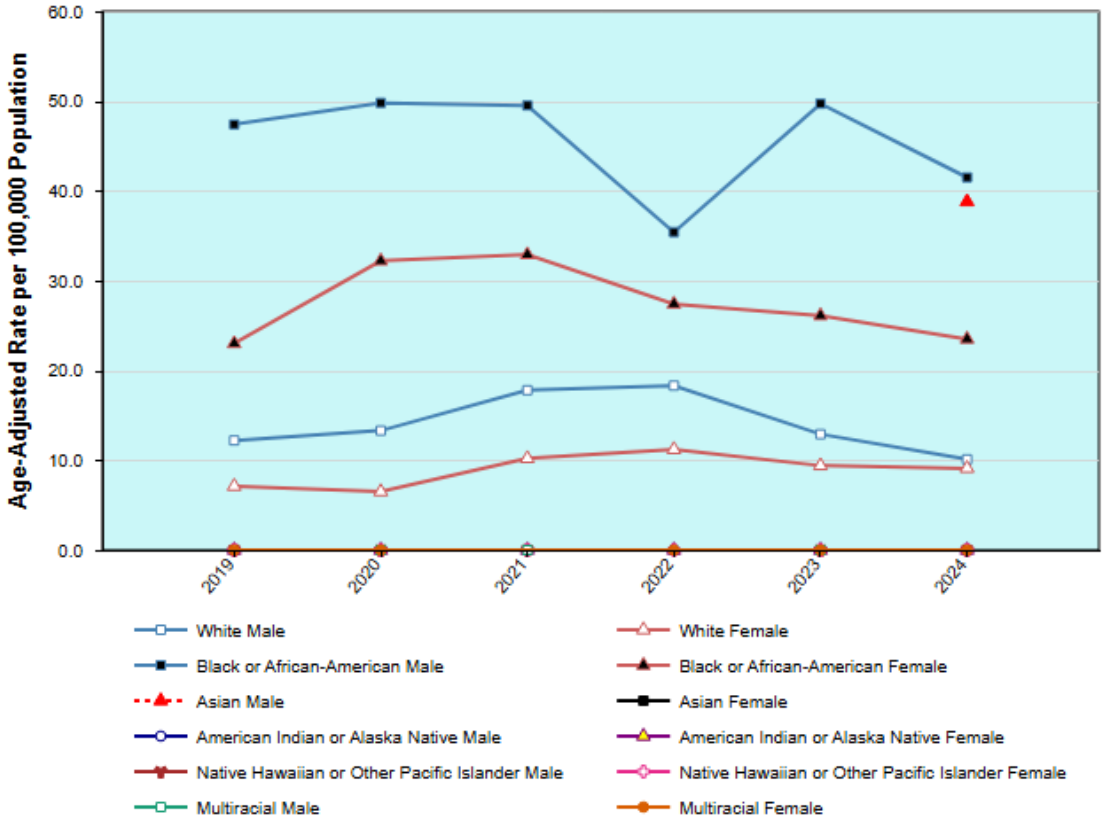



**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

*Well trained, well-funded community health workers within the community could deliver the needed diversity of support, referrals and interventions that a hypertensive patient needs. Support such as calling & checking on patients, nutrition education, cooking classes, chronic disease management, etc. -- basic info that a CHW can provide on care & support side including service navigation.*

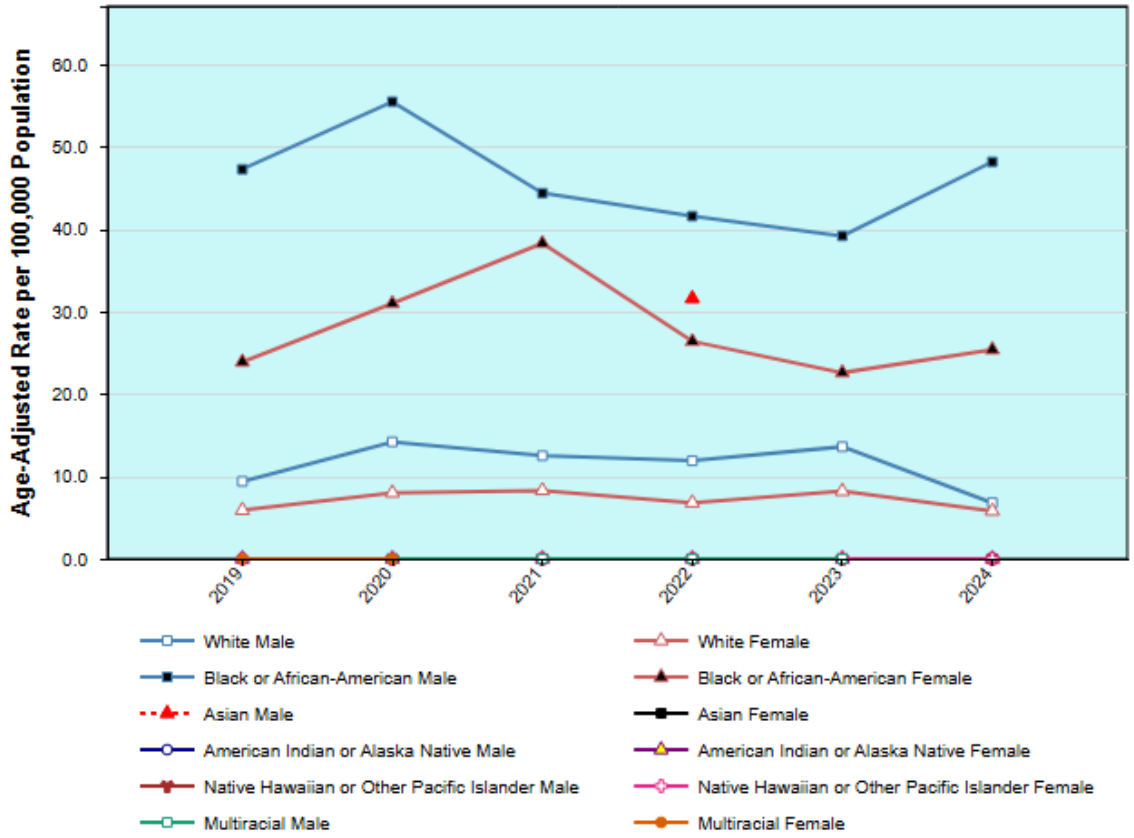
-Community Clinic Director

**FIGURE 23: AGE ADJUSTED MORTALITY OF DIABETES MELLITUS BY RACE/ETHNICITY IN DEKALB COUNTY (2019-2024)**




SOURCE: **GEORGIA DEPARTMENT OF PUBLIC HEALTH. (2024). ONLINE ANALYTICAL STATISTICAL INFORMATION SYSTEM.**

**FIGURE 24AGE ADJUSTED MORTALITY OF DIABETES MELLITUS BY RACE/ETHNICITY IN FULTON COUNTY (2019-2024)**




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

## Cerebrovascular Disease

Cerebrovascular disease (or stroke) is a broad category that encompasses chronic conditions that affect blood flow to the brain.[59] Rates of cerebrovascular disease are higher in Georgia compared to the United States. Georgia lies in a region commonly referred to as "The Stroke Belt," a part of the country that extends through the southern delta region from Louisiana to Virginia. According to the American Heart Association, these states have a large number of residents living in rural areas with fewer resources than urban/suburban areas. Residents' livelihoods, lifestyles and limited access to care put them at greater risk of being exposed to infections or inflammatory conditions than those living in other parts of the country.[60]

[59] Cleveland Clinic (2022, September 27). Cerebrovascular Disease: Types, Causes & Symptoms Cleveland Clinic Health Library: Diseases and Conditions. Clevelandclinic.org

[60] Howard, G., & Howard, V. J. (2020). Twenty years of progress toward understanding the stroke belt. *Stroke*, *51*(3), 742-750. Twenty Years of Progress Toward Understanding the Stroke Belt | Stroke

Hospital discharge data revealed residents aged 55-59 in Fulton County and 65-69 in DeKalb County were more likely to be admitted for stroke than any other age group. Men and multiracial individuals were more likely to go to the ER for stroke incidents (Table 23). Black residents were approximately three times as likely to experience a stroke as White residents in both counties.[61]

**TABLE 23: STROKE-RELATED ER VISIT, ER DISCHARGE AND MORTALITY RATES BY RACE/ETHNICITY (2018-2022)**

| | GA | WHITE | BLACK | ASIAN | MULTI-RACIAL | HISPANIC | MALE | FEMALE |
|---|---|---|---|---|---|---|---|---|
| Stroke ER Visit Rate | 57.9 | 51.0 | 70.0 | 23.7 | 107.5 | 35.5 | 64.0 | 52.7 |
| Stroke Hospital Discharge Rate | 241.9 | 199.8 | 325.7 | 114.8 | 602.7 | 135.4 | 270.7 | 216.9 |
| Stroke Mortality Rate | 44.0 | 41.6 | 55.0 | 28.8 | 10.9 | 27.8 | 45.4 | 42.2 |
| Age-adjusted rates per 100,000 population | | | | | | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

Across the service region, the rates of stroke-related ER visits, ER discharges and mortalities are approximately two times higher than the state average (Table 24).

**TABLE 24: STROKE-RELATED ER VISIT, ER DISCHARGE AND MORTALITY RATES BY LOCATION (2019-2023)**

| STROKE (AGE ADJUSTED RATE PER 100,00) | DEKALB | FULTON | GA |
|---|---|---|---|
| Stroke ER Visit Rate | 38.9 | 39.0 | 60.0 |
| Stroke Discharge Rate | 237.9 | 230.6 | 240.6 |
| Stroke Mortality Rate | 38.2 | 41.0 | 43.9 |
| Age-adjusted rates per 100,000 population | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

Trends in stroke mortality rates between different sexes races and ethnicities have shifted over time (Figures 25-26). For the most part, Black men and women in both counties experience higher rates of mortality than other races. White males and females experience some year-to-year variation but no dramatic spikes. The most striking fluctuation have been among Asian women in both counties. In DeKalb County, mortality rates among Asian were in a steady decline. But in 2024, the rate shot up over 20 points. Similarly in Fulton County, mortality rates among Asian women shot up over 40 points between 2019 and 2021, falling back down in 2022.

[61]Georgia Online Analytical and Statistical Information System. Community Health Needs Assessment Dashboard: Top Causes of Age Adjusted Death: Ischemic and Vascular Heart Disease. Georgia Department of Public Health-Office of Health Indicators for Planning (OHIP). App Version: 2.0.4, Content Version: 2.5.1
[61]

FIGURE 25: STROKE MORTALITY RATES IN DEKALB COUNTY BY SEX AND RACE/ETHNICITY 2019-2024

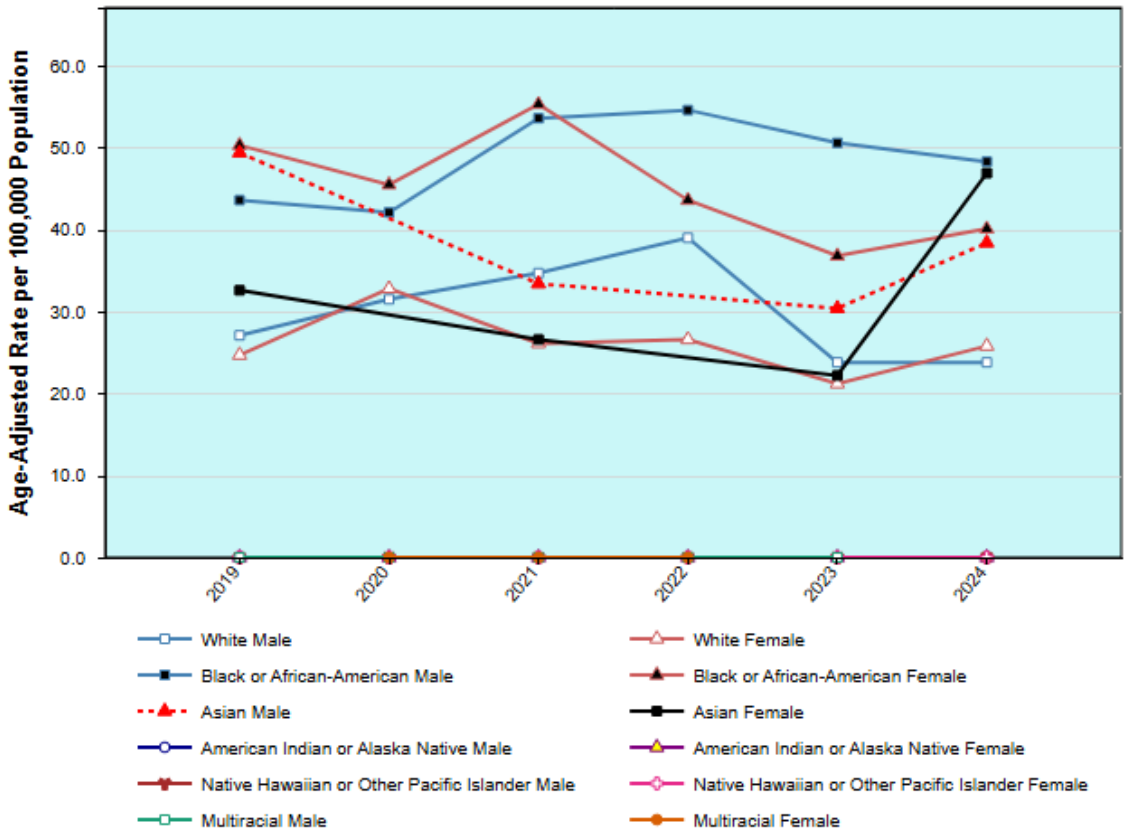
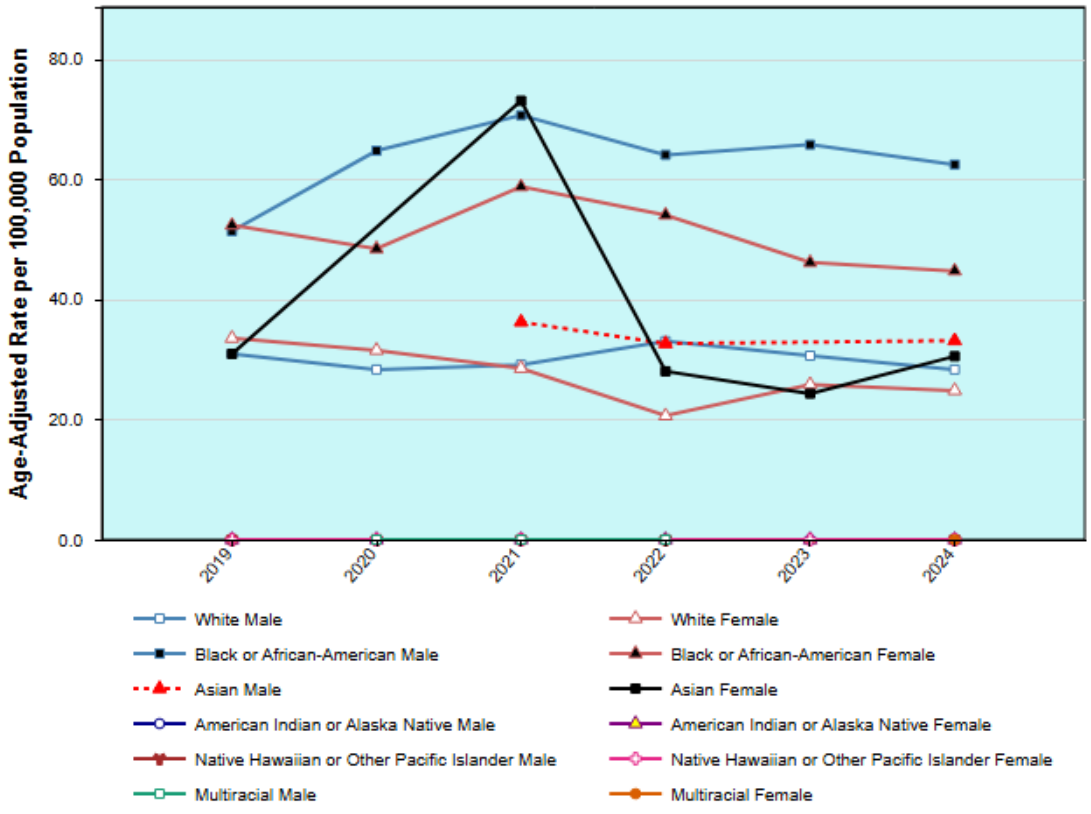



FIGURE 26STROKE MORTALITY RATES IN FULTON COUNTY BY SEX AND RACE/ETHNICITY 2019-2024




## Hypertension

Hypertension is in the top four cause of death in DeKalb and Fulton Counties, as well as the state. Nationally, hypertension is one of the most common chronic diseases among adults. It is estimated that half of men and almost 45% of women have hypertension.[62] Predictably, these counties and the state have high levels of ischemic heart and vascular disease caused primarily by hypertension. Over 75% of those who experienced ischemic episodes in Georgia had a history of hypertension. It is also a leading cause of complications in pregnancy, for which there have been collaborative initiatives focused on addressing this issue in the past few years.[63]

**TABLE 25: HYPERTENSION-ASSOCIATED ER VISIT, ER DISCHARGE AND MORTALITY RATES (2019-2024)**

| | DEKALB | FULTON | GA |
|---|---|---|---|
| High Blood Pressure ER Visit Rate | 519.5 | 517.9 | 512.6 |

[62] Centers for Disease Control and Prevention. Hypertension cascade: hypertension prevalence, treatment and control estimates among US adults aged 18 years and older applying the criteria from the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline—NHANES 2017–March 2020. Published 2023. Accessed May 3, 2024. *https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html*

[63] Georgia Perinatal Quality Collaborative (2019). Severe Hypertension Severe Hypertension Initiative. Georgiapqc.org

| | DEKALB | FULTON | GA |
|---|---|---|---|
| High Blood Pressure Discharge Rate | 21.0 | 18.2 | 20.2 |
| High Blood Pressure Mortality Rate | 9.1 | 10.5 | 11.6 |
| Age-adjusted rates per 100,000 population | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

The hospitalization and death rates of hypertension differ significantly by race and gender. Figures 27-28 demonstrate five-year trends of Age Adjusted Death Rates for Essential Primary Hypertension, hypertensive renal disease and heart disease for DeKalb and Fulton Counties (with men noted in blue and women noted in red).

**FIGURE 27: : AGE ADJUSTED DEATH RATES BY SEX AND YEAR FOR ESSENTIAL PRIMARY HYPERTENSION, HYPERTENSIVE RENAL AND HEART DISEASES DEKALB COUNTY (2019-2024)**

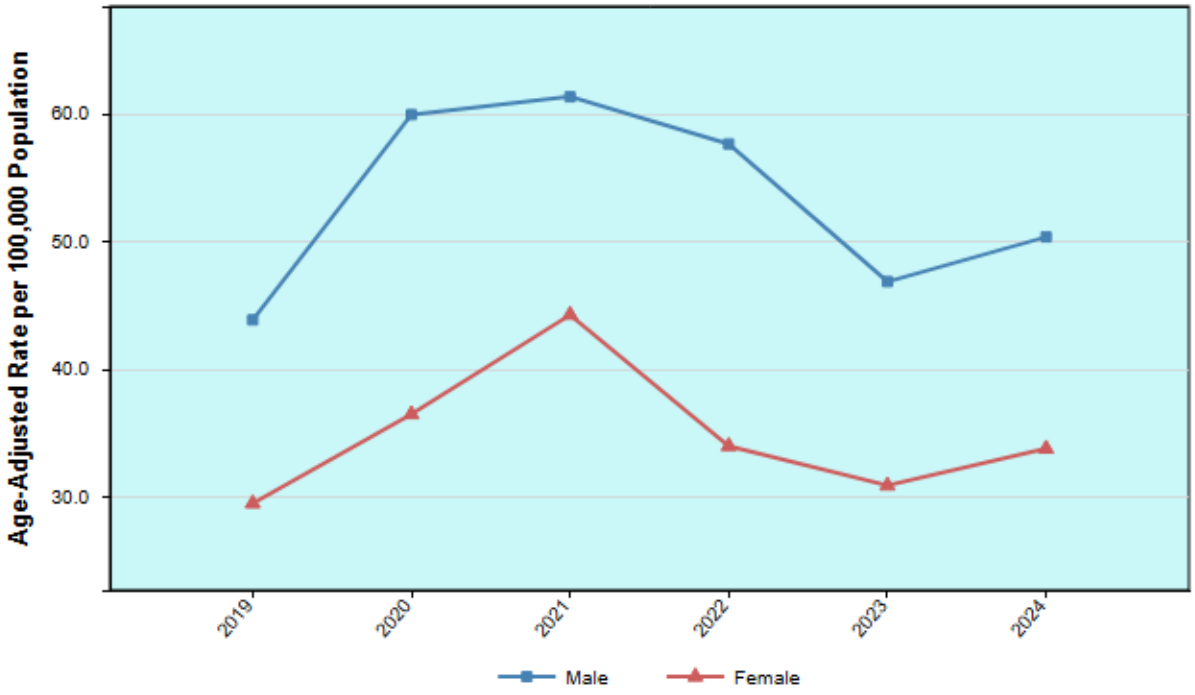
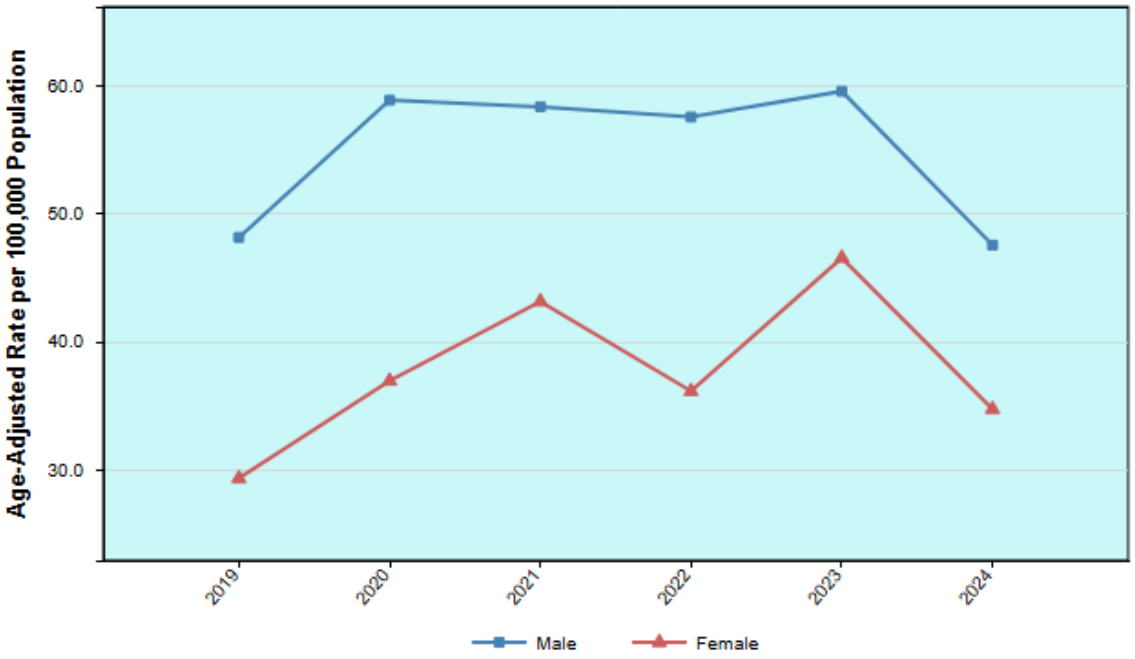



**FIGURE 28: AGE ADJUSTED DEATH RATES BY SEX AND YEAR FOR ESSENTIAL PRIMARY HYPERTENSION, HYPERTENSIVE RENAL AND HEART DISEASES FULTON COUNTY (2019-2024)**

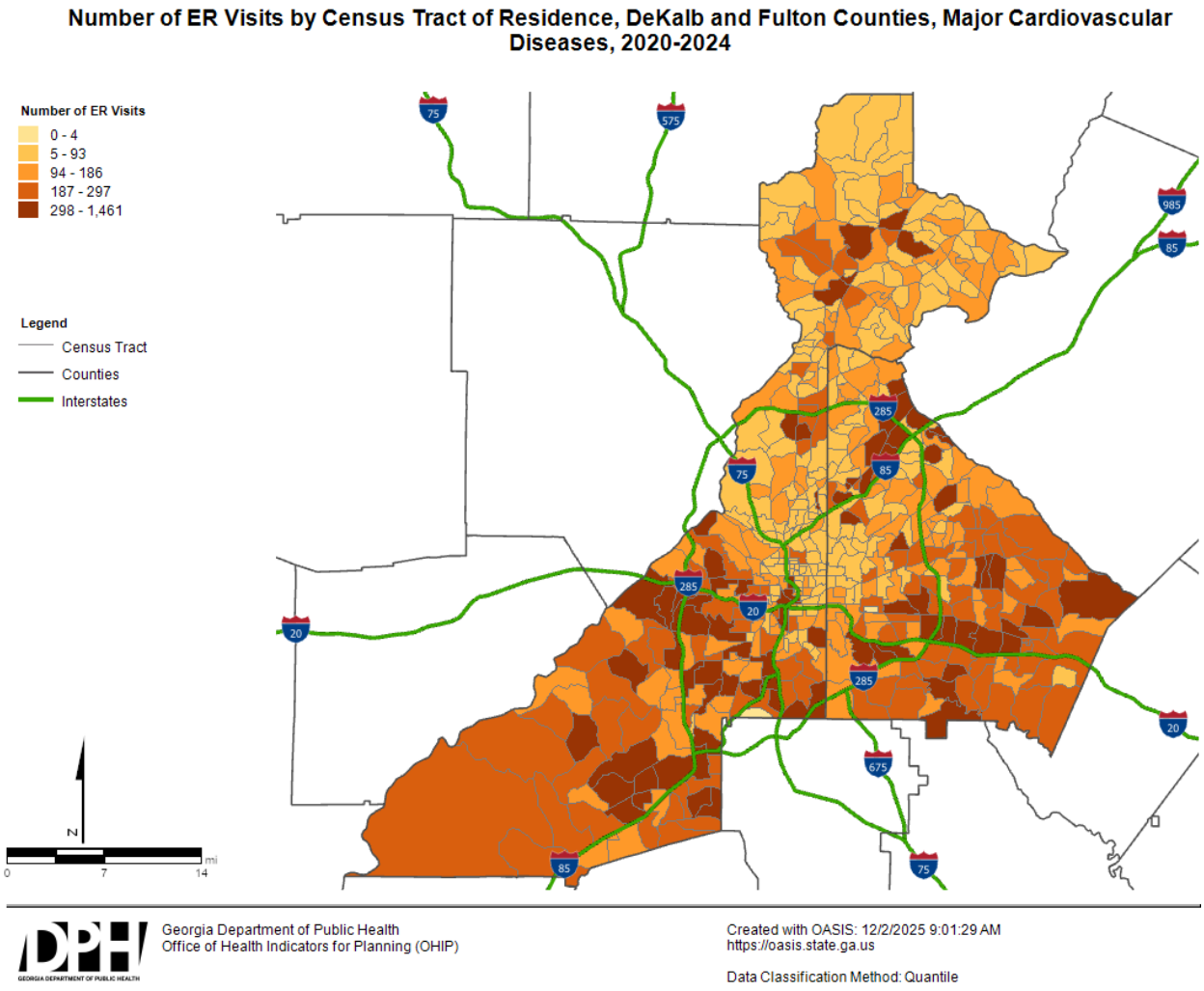



## Cardiovascular Disease

Cardiovascular disease is a broad category that includes diseases of the heart, hypertension, and stroke. Over 8% of adults in Georgia have been diagnosed with cardiovascular disease (CVD), more commonly known as heart disease. According to a report by United Health Care, the state is 26th in the nation for heart disease prevalence.[64] Men are more likely to experience heart disease than women. CVD in Georgia results in more than 28,000 deaths annually and over 160,000 YPLL.[65] The number of emergency department or emergency room (ER) visits associated with cardiovascular disease vary across the service area with some census tracts seeing between 298-1,461 visits from 2020-2024 (Figure 29).

**FIGURE 29 NUMBER OF ER VISITS, MAJOR CARDIOVASCULAR DISEASE (2020-2024)**

[64] America's Health Rankings analysis of U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2025
[65] Georgia Department of Public Health (2024, October 3). Heart Disease | Georgia Department of Public Health. Georgia Department of Public Health Chronic Disease Prevention. Accessed 2025




66

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

# Sexual Health

Sexual health care includes testing, as well as prevention education, disease management, medication support, and social services. Care is offered in different ways, including in-person visits, mobile units, community support groups, and community health workers. Some local organizations provide care starting at age 16, as allowed by state law. However, Interviewees shared that recent hospital and clinic closures in the Atlanta metro area have made it harder for residents to receive sexual health care from trusted providers. Residents have to travel longer distances; and those with limited access to reliable transportation are most affected.

[66] Georgia Department of Public health (2024, October 7). Diabetes | Georgia Department of Public Health. Georgia Department of Public Health: Chronic Disease Prevention. Dph.georgia.gov. Retrieved 2025

The most common sexually transmitted infection (STI) in Georgia is chlamydia. Georgia has higher STI rates than the country and DeKalb and Fulton have higher rates than the state (Table 26). In addition to more common STIs, interviewees shared concerns about increases in congenital syphilis rates.

**TABLE 26SEXUALLY TRANSMITTED DISEASE RATES BY LOCATION 2024**

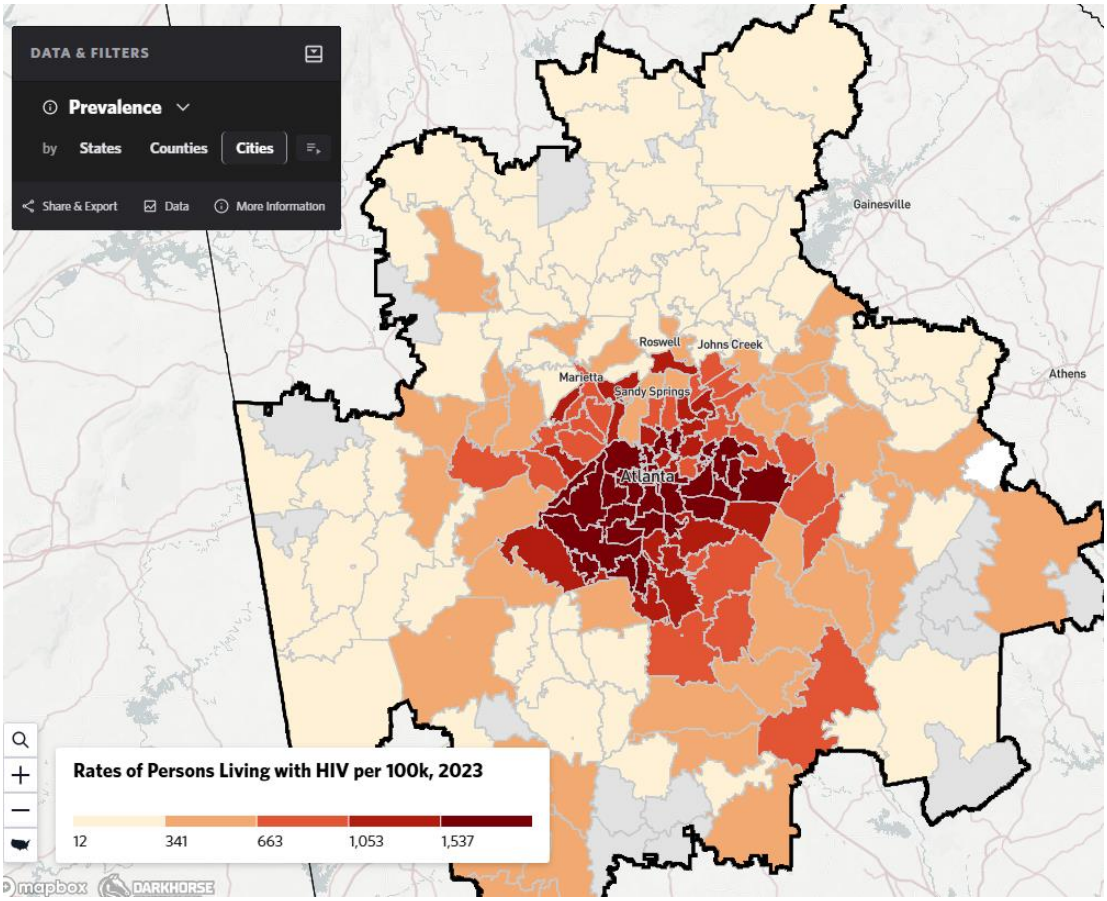
| | DEKALB | FULTON | GEORGIA | US |
|---|---|---|---|---|
| Chlamydia | 834.2[1] | 958.7[1] | 639.5[1] | 492[3] |
| Gonorrhea | 390.6[1] | 466.9[1] | 260.4[1] | 194.4[3] |
| HIV Incidence (new diagnosis) | 56[2] | 55[2] | 27[2] | 11.3[3] |
| Age-adjusted rates per 100,000 population | | | | |

**Sources:** 1. Georgia Department of Public Health. (2024). **Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System. 2. AIDSVu 2022. 3. CDC 2022.

Georgia has the highest rate of new HIV infections in the US.[67] In 2022, there were 63,984 people with HIV in Georgia (rate: 586/100,000). Currently South Atlanta-Decatur has the highest rates of HIV cases, 346% worse than the national average, followed by North Atlanta-Sandy Springs at 306% worse than the national average.[68]

**FIGURE 30FIGURE 30: RATES OF PERSONS LIVING WITH HIV PER 100K POPULATION (2023)[2]**

[67] Grapevine, R. (2025). *Georgia leads in U.S. HIV cases. Here's why the lifesaving drug PrEP faces barriers in the state*. *Georgia Public Broadcasting.*
[68] Kaiser Permanente. (2025). *Community Health data platform*.

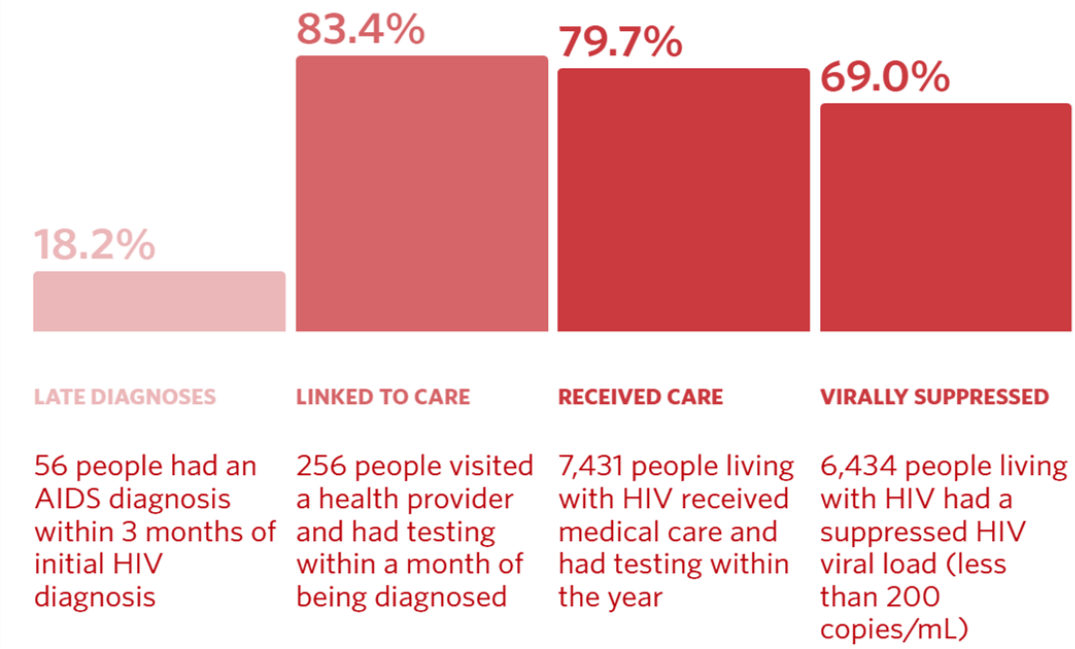



**Source:** AIDSVu. (2023).

There continue to be a high number of late-stage diagnoses in both counties. Approximately 20% of people who were diagnosed with HIV were not linked to care within a month of diagnosis, which contributes to the high prevalence of people who have not yet achieved viral suppression. (Viral suppression is characterized by a viral load of less than 200 copies/ mL.[69]) Figures 31-32 show the percentage of people who were late diagnosed with HIV (and subsequently re-categorized with an AIDs diagnosis within three months), the percentage of those linked to care within 30 days of an HIV diagnosis, the percentage of people with HIV who received medical care within the year of diagnosis, and the percentage of those who achieved viral suppression in DeKalb and Fulton Counties respectively.

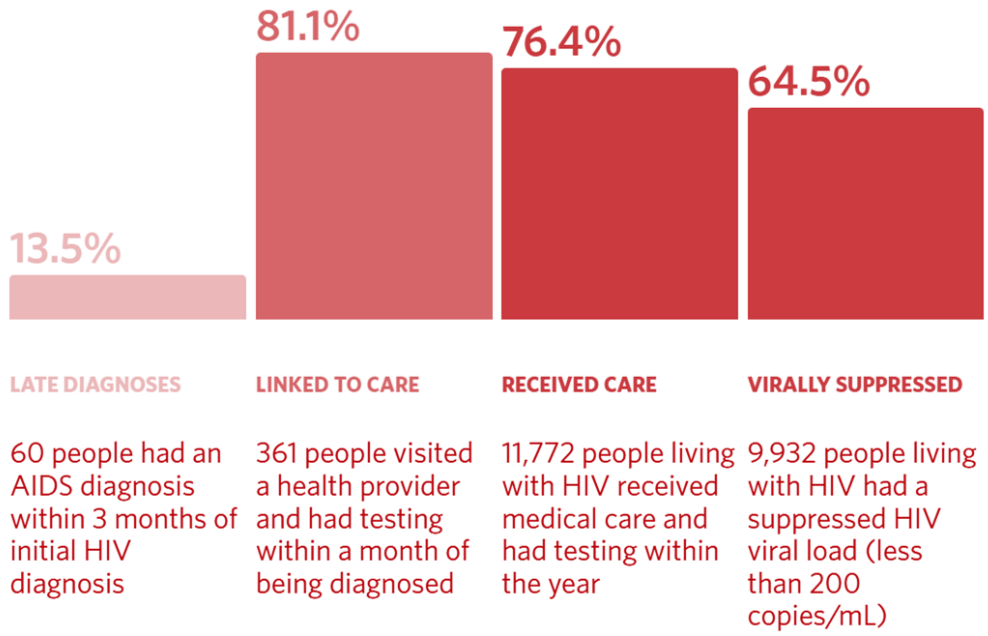
**FIGURE 31PERCENTAGE OF PEOPLE WITH HIV IN DEKALB COUNTY IN THE CONTINUUM OF CARE (2023)**

[69]Georgia Department of Public Health, HIV Epidemiology Section, 2022 HIV Surveillance Summary, Georgia, https://dph.georgia.gov/epidemiology/georgias-hivaids-epidemiology-section/hivaids-case-surveillance, *Health HIV Surveillance Report*. Published March 2024 Accessed 2025




**Source:** AIDSVu. (2023). Continuum of Care Report: DeKalb County.

**FIGURE 32: PERCENTAGE OF PEOPLE WITH HIV IN FULTON COUNTY IN THE CONTINUUM OF CARE (2023)**




**Source:** AIDSVu. (2023). Continuum of Care Report: Fulton County.

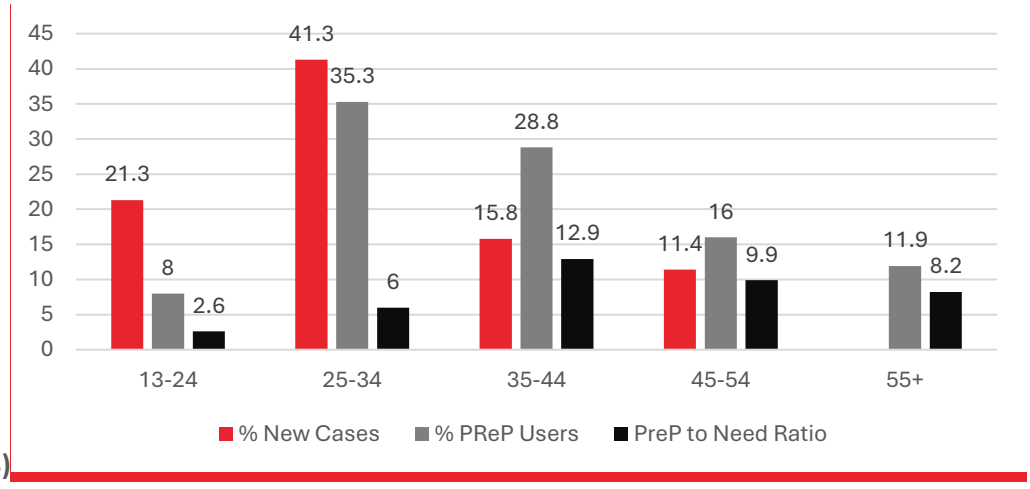
Georgia public health districts with the highest rates of people with HIV in 2022 were Fulton (1,579.6) and DeKalb (1,339.6). People with HIV were more likely to be cisgender male (75%), non-Hispanic Black (68%), men-who-have-sex-with-men (63%), ages 30+ (89%) (Figure 33).[70]

**FIGURE 33: NEW HIV DIAGNOSES BY SELECT DEMOGRAPHICS (2022)**


**Source:** Georgia Department of Health. (2022). *HIV Epidemiology Surveillance Summary, Georgia*.

Local public health agencies, community organizations and GHS have been actively trying to address the high prevalence of people living with HIV that is not virally suppressed. In their efforts, they are tracking prevention, testing, diagnosis and treatment efforts. The aim is to increase the number of people who take preventive measures such as regular testing and use of prophylaxis like PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis) (Figures 34-35). Once diagnosed, focus shifts to continuing regular care and trying to keep patients on medication, in hopes of successfully moving them to a state of viral suppression and non-transmission.

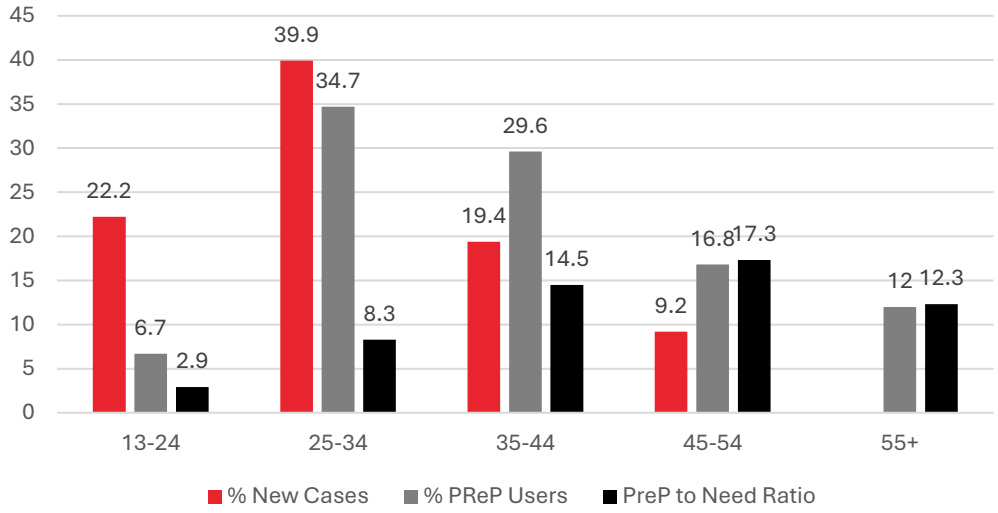
**FIGURE 34: PERCENT OF NEW HIV CASES, PREP USE AND PREP TO NEED RATIO FOR DEKALB COUNTY (2023)**




**Source:** AIDSVu. (2023). DeKalb County Prevention and Testing Summary Report.

[70] Georgia Department of Public Health, HIV Epidemiology Section. (2023). *HIV Surveillance Highlights Fact Sheet, Georgia*. Georgia HIV Surveillance Data | Georgia Department of Public Health

FIGURE 35PERCENT OF NEW HIV CASES, PREP USE AND PREP TO NEED RATIO FOR FULTON COUNTY (2023)




**Source:** AIDSVu. (2023). Fulton County Prevention and Testing Summary Report.

County-level reports from AIDSVu revealed for ages 13+ there is still opportunity to have more people on PReP to support collective viral suppression. In the service area, the age groups with the highest percentage of new cases, as well as the highest percentage of PreP users were 25-34-year-olds, followed by 35–44-year-olds.

# Maternal and Child Health

Pregnancy and birth rates are higher in DeKalb County when compared to Fulton County and the state (Table 27). Country-level indicators did not use the same age ranges as the state level data; however, for comparison, the general fertility rate in the US in 2023 was 54.5 for women aged 15-45 and 13.1 for teenagers aged 15-19.[71]

TABLE 27: PREGNANCY AND BIRTH RATES ACROSS AGE GROUPS AND COUNTIES (2019-2023)

| | DEKALB | FULTON | GEORGIA |
|---|---|---|---|
| **All Ages 10-55 years of age** | | | |
| Pregnancy Rate | 51.8 | 45.1 | 46.1 |
| Birth Rate | 38.9 | 30.5 | 36.3 |
| **Adults 19-55 years of age** | | | |
| Pregnancy Rate | 66.9 | 58.4 | 57.3 |
| Birth Rate | 46.6 | 36.6 | 43.9 |
| **Minors 10-17 years of age** | | | |
| Pregnancy Rate | 5.2 | 3.9 | 4.1 |

[71] Martin JA, Hamilton BE, Osterman MJK. Births in the United States, 2023. NCHS Data Brief, no 507. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/158789.

| | DEKALB | FULTON | GEORGIA |
|---|---|---|---|
| Birth Rate | 3.4 | 2.3 | 2.9 |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

While maternal and child health were not among the top 5 causes of morbidity and mortality in the service area, many interviewees identified MCH as a health priority. Georgia has more adverse birth outcomes when compared to national outcomes; and, DeKalb and Fulton Counties have more adverse birth outcomes when compared to the state (Table 28). These disproportionately high numbers may be due in part to insufficient prenatal care. Between 2019-2023, 11.3% and 10.7% of pregnant people received late or no prenatal care in DeKalb and Fulton Counties respectively, more than the state (9.1%) and the country (7.0%) (Table 28). These trends persisted within the Grady service area and show marked inequities in prenatal care and birth outcomes by community (Figures 36 and 37).

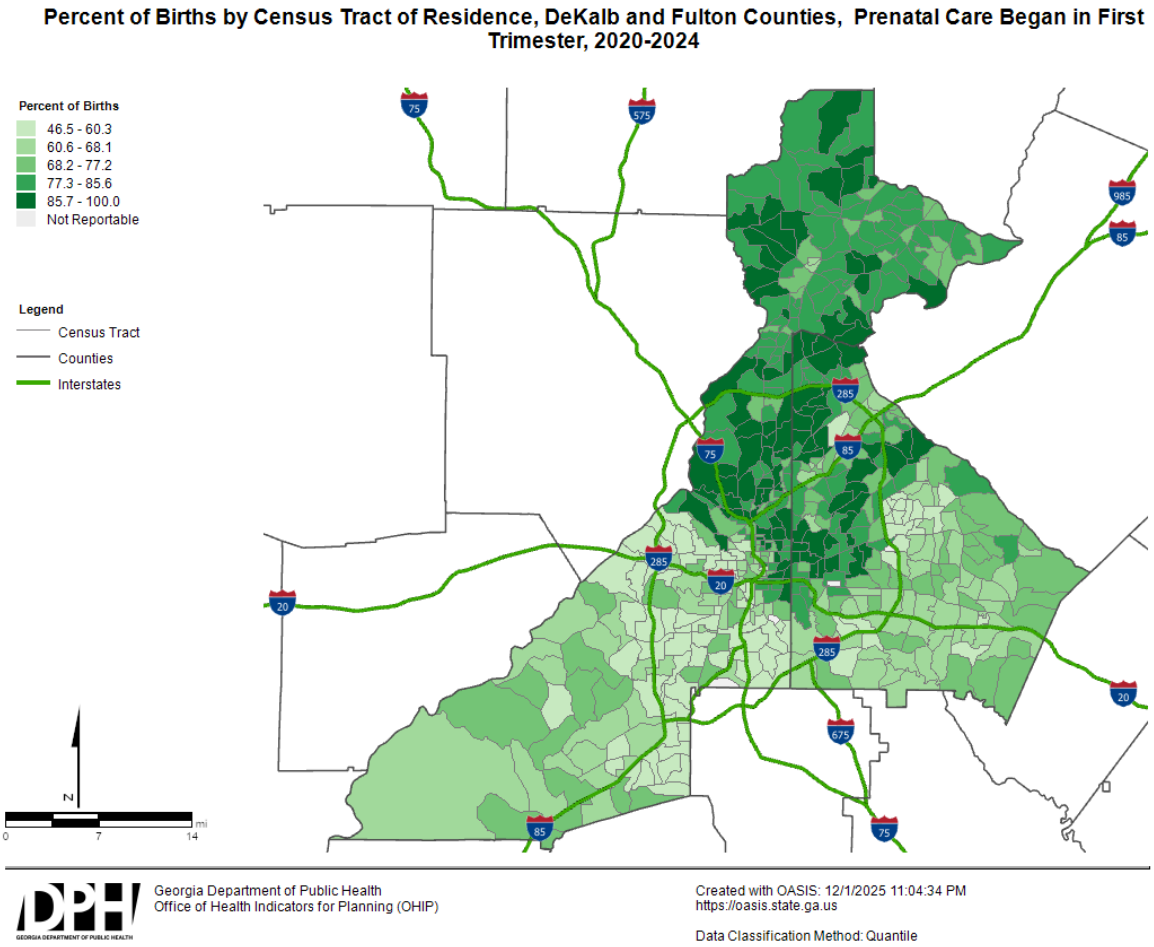
**TABLE 28SELECT MATERNAL AND CHILD HEALTH OUTCOMES (2019-2023)**

| | DEKALB[1] | FULTON[1] | GEORGIA[1] | US |
|---|---|---|---|---|
| **Prenatal Care** | | | | |
| % Births with late or no prenatal care | 11.3% | 10.7% | 9.1% | 7.0%[2] |
| % Births with <5 prenatal Care visits | 11.1% | 10.1% | 7.8% | N/A |
| **Premature Births** | | | | |
| % Premature births | 11% | 11.6% | 11.7% | 10.4%[2] |
| **Low Birthweight** | | | | |
| % Low Birthweight Births | 10.7% | 11.3% | 10.3% | 8.6%[2] |
| % Very Low Birthweight | 1.9% | 1.9% | 1.8% | 1.36%[2] |
| **Infant Mortality** | | | | |
| Infant Mortality Rate* | 6.3 | 7.0 | 6.8 | 5.61[3] |
| Neonatal Mortality Rate* | 3.9 | 4.0 | 4.1 | 3.65[3] |
| Postnatal Mortality Rate* | 2.5 | 3.0 | 2.7 | 1.96[3] |
| *Age Adjusted Rates per 100,000 | | | | |

**Sources:**

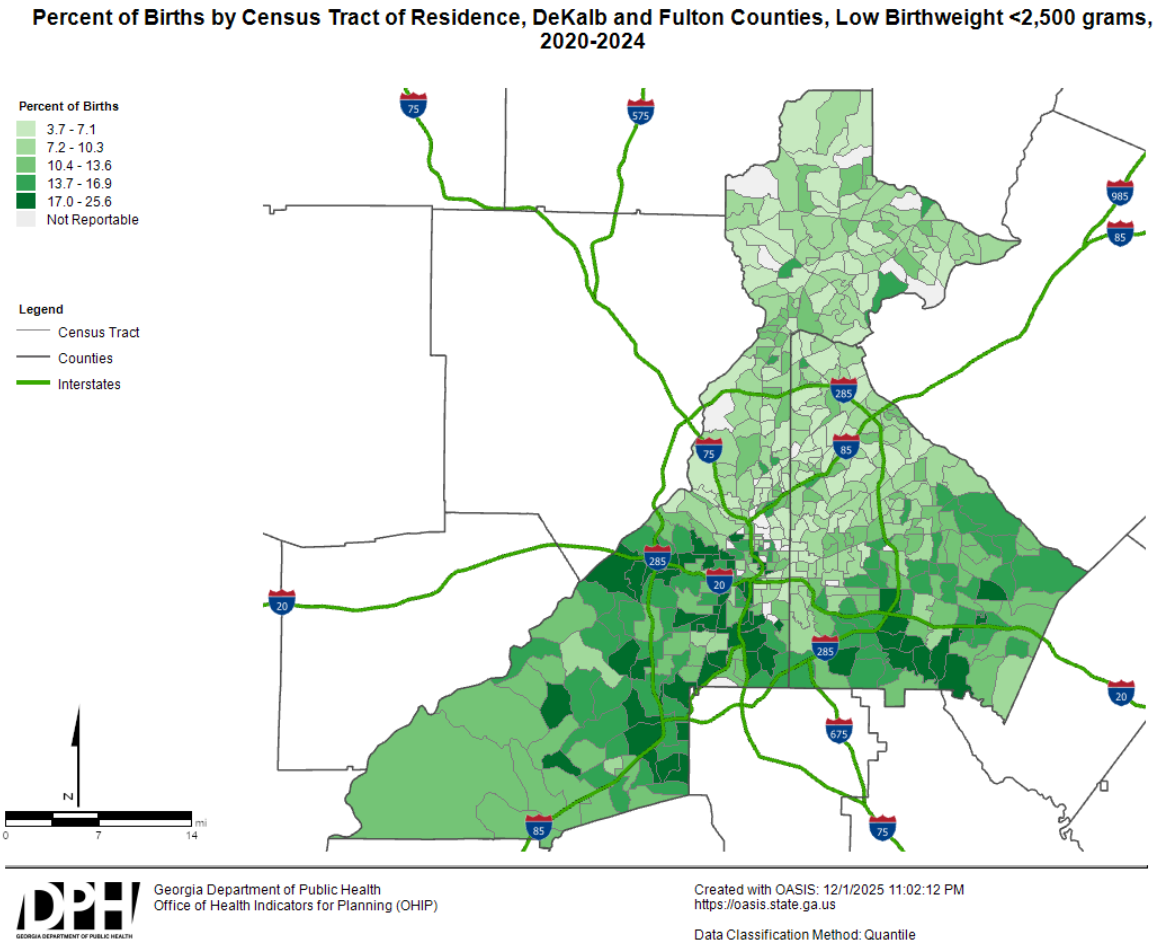
1. **Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.
2. *March of Dimes*, 2023
3. *CDC Vital Statistics*, 2023

**FIGURE 36PERCENT OF BIRTHS BY CENSUS TRACT, PRENATAL CARE BEGAN IN FIRST TRIMESTER (2020-2024)**




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

**FIGURE 37PERCENT OF BIRTHS BY CENSUS TRACT, LOW BIRTHWEIGHT < 2,500 GRAMS (2020 - 2024)**




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

There are pronounces racial disparities in prenatal care and birth outcomes. Black, Hispanic and multiracial pregnant people are more than twice as likely to have no, late, or fewer than 5 prenatal visits (Table 29). Black families within the service area experience more than two times the rate of infant mortality and low infant birth weight than their White peers. Black, non-Hispanic infants had the highest percentage of low-birth-weight rates in the state of Georgia, which was twice as high as the rates of their White, non-Hispanic counterparts. Asian and multiracial, non-Hispanic infants also had higher rates of low birth weight.

**TABLE 29BIRTH OUTCOMES BY SELECT RACE AND ETHNICITY IN THE SERVICE AREA (2019-2023)**

| | ALL | WHITE | BLACK | ASIAN | HISPANIC /LATINO | MULTIRACIAL |
|---|---|---|---|---|---|---|
| **Prenatal Care** | | | | | | |
| % Births with late or no prenatal care | 11.0% | 6.6% | 14.6% | 8.8% | 13.0% | 13.4% |

| | | | | | | |
|---|---|---|---|---|---|---|
| % Births with <5 prenatal Care visits | 10.5% | 5.4% | 14.7% | 8.6% | 11.0% | 12.4% |
| **Premature Births** | | | | | | |
| % Premature births | 11.3% | 8.5% | 13.8% | 9.4% | 9.3% | 11.2% |
| **Low Birthweight** | | | | | | |
| % Low Birthweight Births* | 11.0% | 6.5% | 14.6% | 10.1% | 7.7% | 10.4% |
| % Very Low Birthweight | 1.9% | 0.8% | 2.9% | 1.2% | 1.1% | 1.7% |
| **Mortality** | | | | | | |
| Infant Mortality Rate* | 6.7 | 3.0 | 10.5 | 2.3 | 4.5 | 2.2 |
| Neonatal Mortality Rate* | 4.0 | 2.1 | 5.9 | 2.1 | 2.9 | - |
| Postnatal Mortality Rate* | 2.7 | 0.9 | 4.6 | - | 1.7 | 1.6 |
| *Age Adjusted rate per 100,000 population | | | | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

A recent March of Dimes report covering 2016-2023 revealed preterm births at rates of 12.2% and 11.4%[72] in Fulton and DeKalb counties respectively compared to the national average of 10.4%.[73]

Preterm births and low birth rate births are often correlated with higher infant mortality. The most recent available infant mortality data from Georgia DPH revealed that Georgia and Fulton and DeKalb Counties experienced higher percentages of low-birth-weight births and infant deaths than the country (Table 30).

**TABLE 30LOW BIRTH WEIGHT AND INFANT MORTALITY BY LOCATION (2023 AND 2024)**

| MEASURE NAME | US AVG | GA AVG | DEKALB | FULTON |
|---|---|---|---|---|
| Low birth weight births (<2500 g or 5.5 lbs) | 8.2% | 9.9% | 10.7%<br>n=1,044 (2024)<br>87 Asian<br>635 Black<br>20 Multiracial<br>302 White<br>(2024) | 11.8%<br>N=1,310<br>92 Asian<br>831 Black<br>108 Multiracial<br>279 White<br>(2024) |
| Infant deaths | 5.5% | 7.0% | 7.02%<br>702.5/100,000 | 6.8%<br>684.1/100,000 |

[72] National Center for Health Statistics, final natality data. Retrieved July 28, 2025, from www.marchofdimes.org/peristats.
[73] Centers for Disease Control and Prevention (2024, November 8). Preterm Birth | Maternal Infant Health | CDC. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP); Division of Reproductive Health.

| MEASURE NAME | US AVG | GA AVG | DEKALB | FULTON |
|---|---|---|---|---|
| | | | (2023) | (2023) |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

From 2019-2021, the maternal death rate in Georgia was 35.7 per 100,000 births compared to the US average of 25.6.[74] The causes of these deaths included heart problems, complications associated with COVID-19, severe bleeding, mental health and substance use issues, and blood clots. One report found that nearly 85% of pregnancy-related deaths were preventable.[75]

National data from 2021 estimates that the maternal mortality rate is three times higher for Black pregnant people than it is for White pregnant people.[76] Data from the Georgia Department of Health Maternal Mortality Report for 2019-2021 found that Black women in Georgia are more than twice as likely to die from pregnancy-related causes than white women and six times more likely than Hispanic women (Table 31).[77]

**TABLE 31PERCENTAGE OF PREGNANCY-RELATED DEATHS BY SELECT DEMOGRAPHICS IN GEORGIA (2019-2021)**

| | PREGNANCY-RELATED DEATHS |
|---|---|
| Black | 76% |
| White | 39% |
| Hispanic / Latino | 11% |
| Other | 7% |

**Source:** Georgia Department of Public Health. (2025). Maternal Mortality 2019-2021 Case Review

In Georgia, 45% of women are insured by Medicaid at the time of birth.[78] In 2024 the Centers for Medicare and Medicaid Services (CMS) released a Maternity Care Action Plan that identified social supports as an important need and gap for individuals receiving maternity care.[79] It specifically noted that CMS was identifying approaches for state agencies to link Medicaid members to services such as tenancy-related services, housing vouchers, and nutrition services.

# Behavioral Health

Mental and behavioral health concerns in Georgia present a complex landscape marked by significant challenges and ongoing efforts toward improvement. As outlined in the *Mortality and Morbidity* section, "Deaths of despair" including accidental exposure poisoning and exposure to noxious substances (most often associated with drug overdose) and intentional self-harm (suicide) ranked second and fourth among the top 5 causes of YPLL. County Health Rankings & Roadmaps (2025) reports DeKalb County

[74] Georgia Department of Public Health. (2025, January 2). Maternal Mortality Report. dph.georgia.gov/maternal-mortality
[75] Georgia Department of Public Health. (2025, January 2). Maternal Mortality Report. dph.georgia.gov/maternal-mortality
[76] Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023.
DOI: https://dx.doi.org/10.15620/cdc:124678
[77] Georgia Department of Public Health. (2025, January 2). Maternal Mortality Report. dph.georgia.gov/maternal-mortality
[78] March of Dimes. (2025).Preterm Birth Overview. *Health insurance/income Data for Georgia*.
[79] Centers for Medicare and Medicaid Services. (2024). *Maternity Care Action Plan*. Cms.gov

residents reported 5.3 poor mental health days per month up from 3.6 in 2020 (Table 32). In Fulton County, residents reported 4.8 poor mental health days per month, up from 3.4 days in 2020.

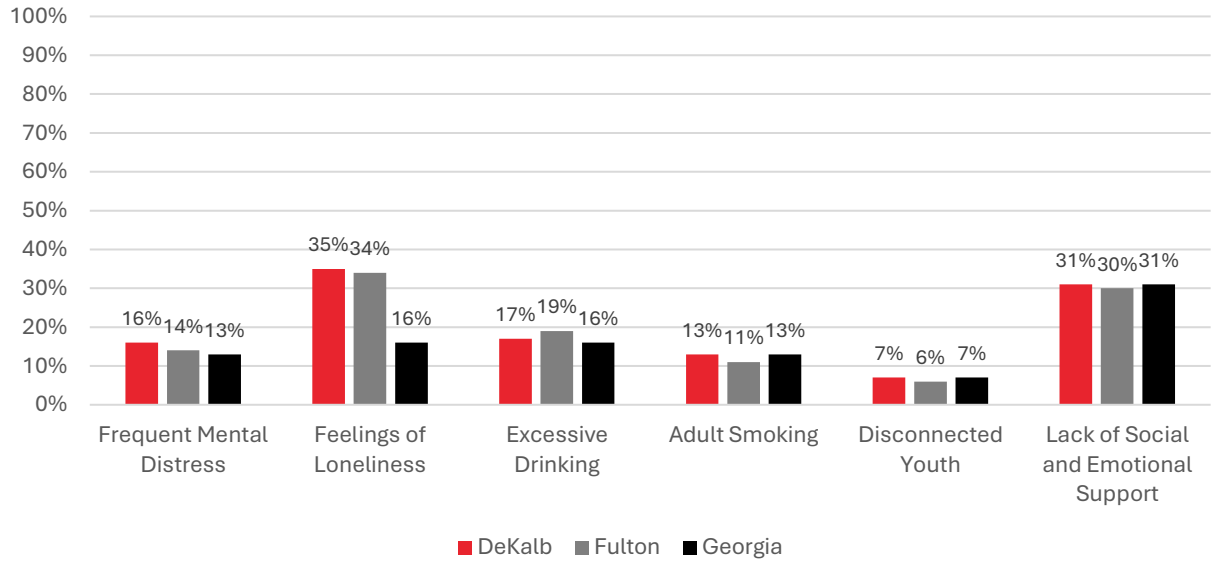
**TABLE 32SELECT MENTAL & BEHAVIORAL HEALTH INDICATORS BY COUNTY (2025)**

| | DEKALB | FULTON |
|---|---|---|
| Poor mental health days per month | 5.3 | 4.8 |
| Mental- and behavioral-health-related ER visit rate* | 900.9 | 1,169.8 |
| People scoring positive for PTSD* | 10.8 | 10.5 |
| People reporting frequent suicidal ideation* | 30.36 | 32.22 |
| *Age Adjusted rate per 100,000 | | |

**Source:** County Health Rankings & Roadmaps. (2025).

County Health Rankings, OASIS and Mental Health America have tracked quality of life measures and their impacts on overall mental health and substance use. Figure 38 details the percentage of individuals experiencing frequent mental distress, loneliness and lacking social support, social disconnection, and smoking and drinking behaviors in each county and the state.

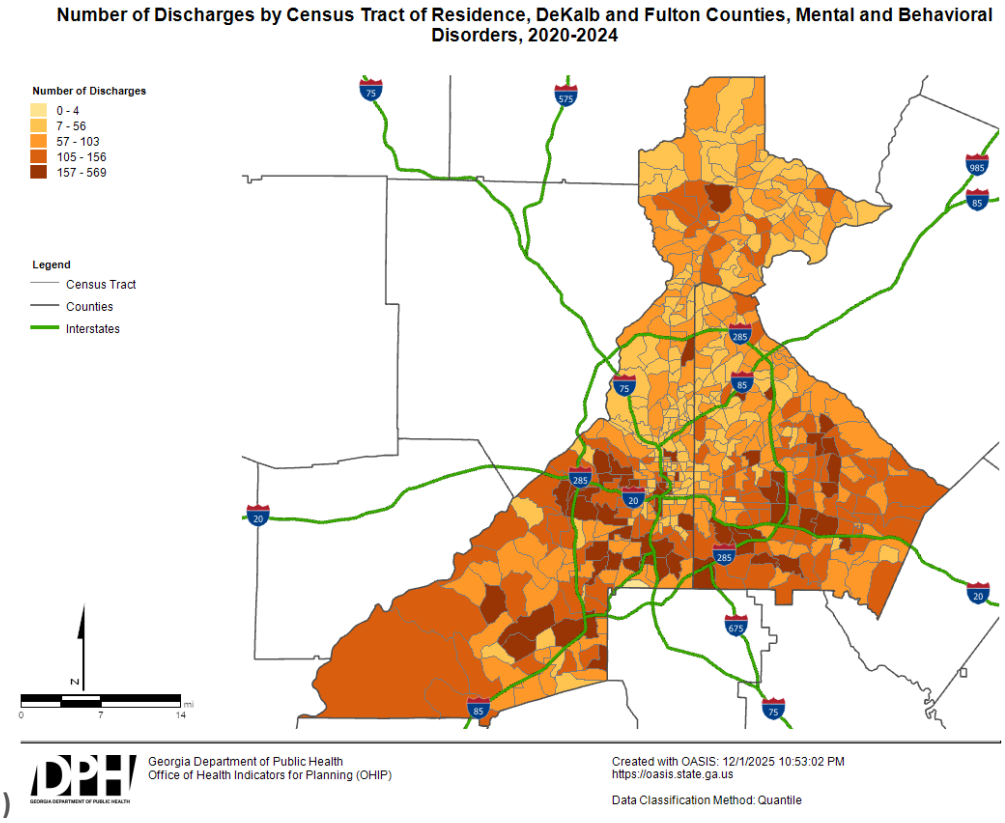
**FIGURE 38QUALITY OF LIFE MEASURES BY LOCATION (2022)**




SOURCES: **COUNTY HEALTH RANKINGS & ROADMAPS; GEORGIA DEPARTMENT OF PUBLIC HEALTH. (2024). ONLINE ANALYTICAL STATISTICAL INFORMATION SYSTEM; MENTAL HEALTH AMERICA**

The number of people seeking inpatient treatment for mental and behavioral disorders varies within the service area with an increased proportion of discharges in the southern part of the service area (Figure 39).

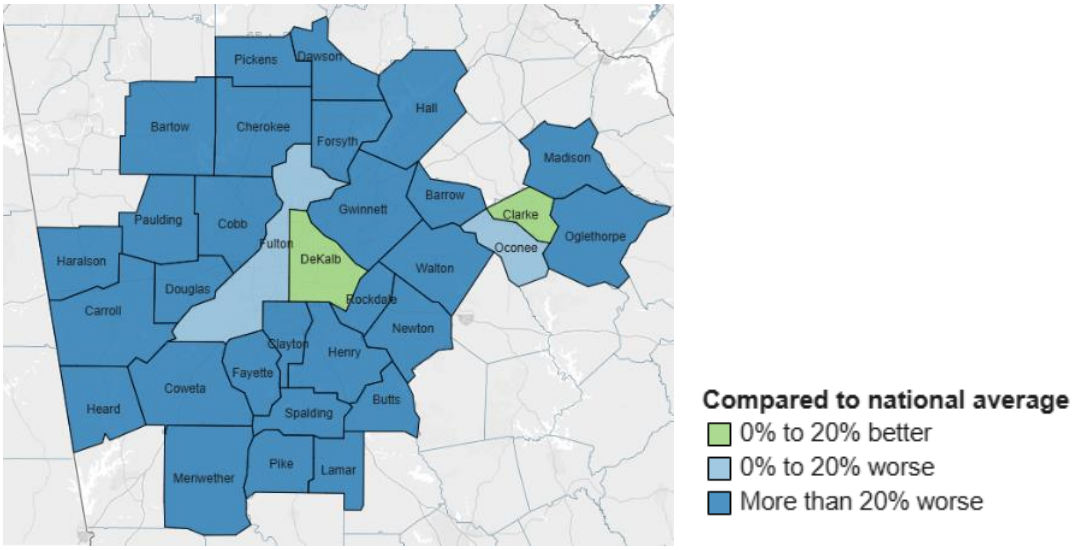
**FIGURE 39NUMBER OF DISCHARGES BY CENSUS TRACT, MENTAL AND BEHAVIORAL DISORDERS (2020 – 2024**




The availability of mental health providers is 0-20% higher in DeKalb County when compared to the national average (Figure 40). However, in Fulton County, availability is 0-20% lower than the national average.

Limited mental health provider availability impacts not only individual well-being but also the overall health of families and communities. When individuals struggle to access mental health care, their ability to engage in work, relationships, and community life is diminished. Addressing these shortages is critical to improving mental health outcomes and ensuring equitable access to care.

**FIGURE 40MENTAL HEALTH PROVIDERS PER 100,000 POPULATION (2022)**




SOURCE: **ATLANTA REGIONAL COMMISSION, MIND THE GAP: MENTAL DISTRESS AND THE PROVIDER LANDSCAPE**

Mental health affects individuals of all backgrounds. While the overall rate of frequent mental distress in the region aligns with the national average, disparities exist among different groups. The 2024 State Health Assessment revealed Black, multi-racial and female Georgians have higher emergency room visit rates for mental health and behavioral health conditions than other groups.[80] The assessment also revealed that more and more pregnant people are hospitalized for emotional health needs like depression, anxiety, severe emotional stress and substance use disorder after birth. Perinatal mood disorders, including postpartum depression and anxiety are increasing.[81] This has been particularly concerning given that maternal mental health is a leading cause of maternal death in the state.[82]

Males showed more likelihood of dying by suicide than females. Death by suicide is in the top five reasons for years of potential life lost for males. White males aged 30-34 are most likely to die by intentional self-harm in the state (Table 33).[83]

**TABLE 33: INTENTIONAL SELF-HARM YPLL RATES BY RACE, COUNTY AND STATE (2024)**

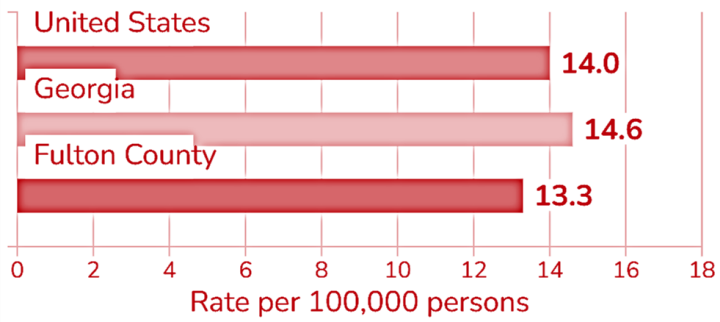
[80] Georgia Department of Public Health and Georgia Health Policy Center. (2024). *Georgia State Health Assessment* (SHA). The SHA is not currently publicly available. Findings included herein are being provided by GHPC on a preliminary basis until the full report is publicly available.
[81] Mental Health America of Georgia's Project Healthy Moms. *Perinatal mood and anxiety disorders: A fact sheet*. Georgia Department of Behavioral Health and Developmental Disabilities
[82] Georgia Department of Public Health. (2025). *Maternal Mortality Georgia 2020-2022*. dph.ga.gov/maternal-mortality
[83] Georgia Department of Public Health Online Analytical and Statistical Information System (2025). Community Health Needs Assessment Dashboard. *OASIS*.

| | WHITE | BLACK | ASIAN | HISPANIC | DEKALB | FULTON | GA |
|---|---|---|---|---|---|---|---|
| Intentional Self-harm (Suicide) | 368.2 | 572.0 | 175.8 | 336.6 | 444.4 | 444.5 | 475.2 |
| Age Adjusted Rates per 100,000 | | | | | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

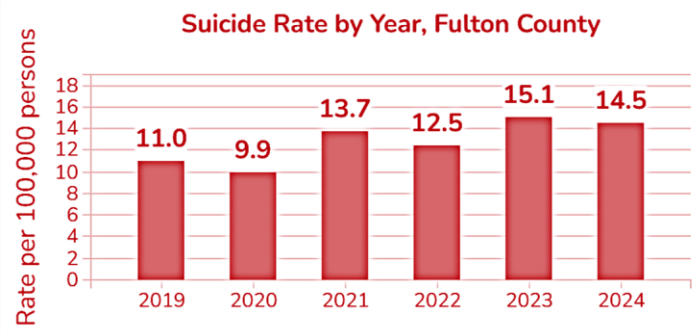
According to CDC's Department of Violence Prevention, suicide rates in Fulton and Dekalb Counties are lower than the state and country outcomes (Figures 41-42). Fulton County's suicide rates have fluctuated between 2019 and 2024, ultimately increasing from 11.0 in 2019 (per 100,000) to 14.5 (per 100,000) in 2024 (Figure 42). DeKalb's suicide rates have also fluctuated year over year with rates ranging from a low of 8.8 (per 100,000) in 2020 to 14.0 (per 100,000) in 2021 (Figure 43). It should be noted that the relatively low rates in 2020 may be due to the pandemic's effect on population surveillance.

**FIGURE 41COMPARISON OF FULTON COUNTY, STATE AND COUNTRY SUICIDE RATES (MAY 2024-APRIL 2025)**



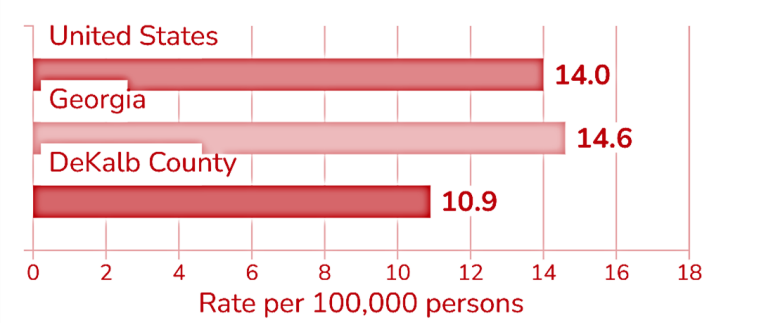

**Source:** Mapping Injury, Overdose, and Violence Dashboard | Injury and Violence Data | CDC

**FIGURE 42ANNUAL SUICIDE RATES IN FULTON COUNTY FROM 2019 TO 2024**



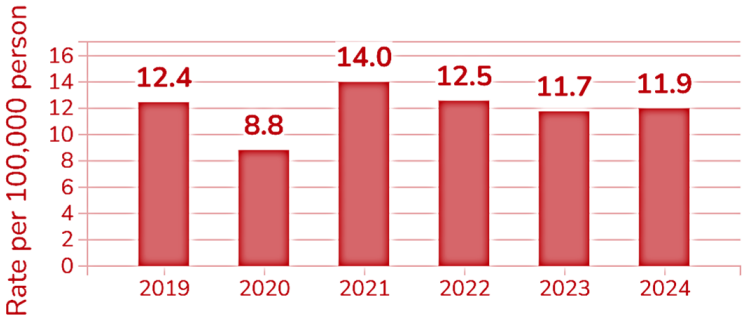

**Source:** Mapping Injury, Overdose, and Violence Dashboard | Injury and Violence Data | CDC

**FIGURE 43: COMPARISON OF DEKALB COUNTY, STATE AND COUNTRY SUICIDE RATES (MAY 2024-APRIL 2025)**




**Source:** Mapping Injury, Overdose, and Violence Dashboard | Injury and Violence Data | CDC

**FIGURE 44ANNUAL SUICIDE RATES IN DEKALB COUNTY FROM 2019 TO 2024**




**Source:** Mapping Injury, Overdose, and Violence Dashboard | Injury and Violence Data | CDC

As the state navigates how the health care landscape has changed since the pandemic, there is a growing need to balance virtual and in-person mental health services. Telehealth has provided a convenient option for many, but there is increasing demand for in-person engagement and support.

## Substance Use

The Georgia Department of Health tracks substance use related incidents by health district and categorizes exposures as "accidental injury due to exposure to noxious substances (overdose)" or as a subcategory of "intentional injury due to exposure to noxious substances (self-harm/ suicide)."[84]

Hospitalizations and overdose deaths associated with substance use have increased over the past 10 years across the service area. Psychoactive stimulants and synthetic opioids, particularly illegally manufactured forms of fentanyl, make up the most substance-use-related emergency room visits and deaths.[85] Accidental poisoning due to noxious substances (overdose) is among the top five causes of

[84] Georgia Department of Public Health Online Analytical Statistical Information System. Emergency Room Visits Definitions. Retrieved from oasis.state.georgia.us on November 24, 2025.
[85] NIDA. 2024, August 21. Drug Overdose Deaths: Facts and Figures. Retrieved from https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates on 2025, November 18

death in DeKalb and Fulton Counties and the state, and the number one leading cause of YPLL in the state.[86]

The service area, particularly Fulton County, has a higher rate of hospital visits and deaths due to substance use than other counties across the state (Table 34). The numbers have steadily increased in the past several years.

**TABLE 34ER VISIT RATES FOR DISORDERS RELATED TO SUBSTANCE USE BY LOCATION (2019-2023)**

| YEAR | DEKALB | FULTON | GEORGIA |
|---|---|---|---|
| 2019 | 12.8 | 12.3 | 12.9 |
| 2020 | 14.0 | 17.0 | 17.9 |
| 2021 | 20.7 | 22.4 | 22.5 |
| 2022 | 24.2 | 24.0 | 24.8 |
| 2023 | 23.0 | 26.9 | 23.1 |
| Age Adjusted rates per 100,000 | | | |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

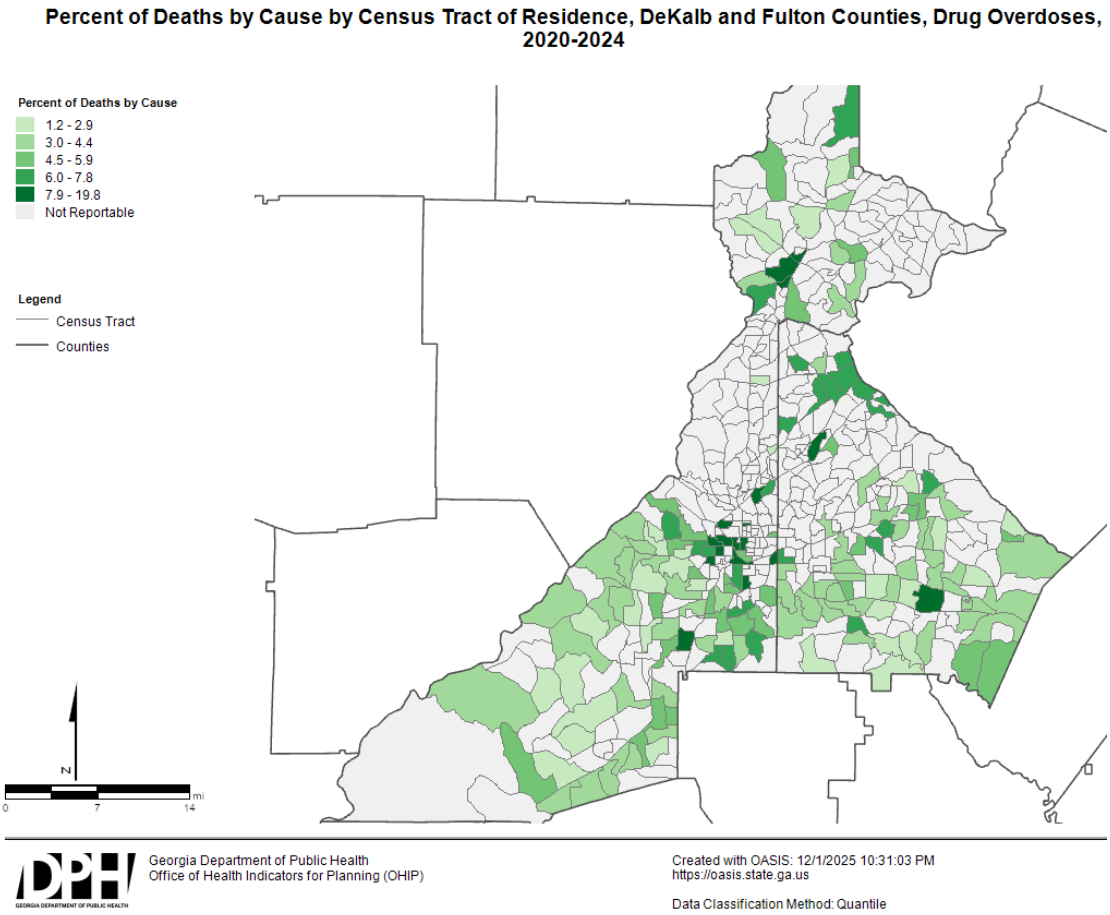
At the state-level, 15–24-year-olds were more likely to visit the emergency room for drug overdose in 2024 when compared to other age groups (Figure 46). Other age groups fluctuated by month. A yearly comparison between July 2024 and July 2025, uncovered a decrease in emergency room visits for overdose among 10-14-year-olds.

When tracked by zip code, drug overdose related emergency department visits were more concentrated in Fulton and DeKalb counties than other areas around the state, possibly due to the location of services.[87] Figure 45 below illustrates the distribution of overdose related deaths by census tract in Fulton and DeKalb counties.

[86] Georgia OASIS

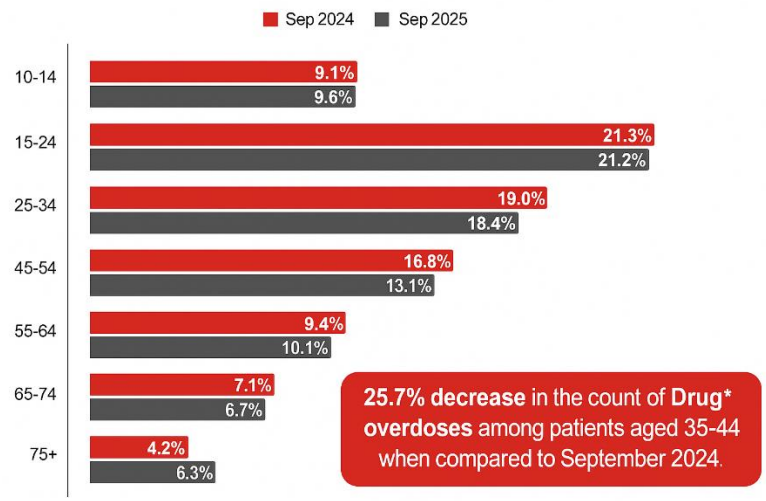
[87] Georgia Department of Public Health: Epidemiology (2025, September) Syndromic Surveillance Drug Overdose Emergency Department Visits Brief. Georgia State Electronic Notifiable Disease Surveillance System. Retrieved from Drug Surveillance | Georgia Department of Public Health on November 24, 2025

## FIGURE 45: PERCENT OF DEATHS BY DRUG OVERDOSE BY CENSUS TRACT OF RESIDENCE (2020 – 2024)




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

**FIGURE 46: FIGURE 46: COMPARING PERCENTAGES OF ALL DRUG OVERDOSE EMERGENCY ROOM VISITS BY AGE GROUP (SEPTEMBER 2024-SEPTEMBER 2025)**




**Source:** Georgia Department of Public Health. (2024). Drug Surveillance | Georgia Department of Public Health: Syndromic Surveillance Overdose Monthly Report. (Retrieved November 25, 2025.)

The group with the highest rate of opioid related overdose deaths in Fulton County was 35-44-year-olds. Those aged 25-64 in Fulton County all exceeded the state rates of death, for their respective age categories (Table 35). In DeKalb County, the age group that experienced the most opioid-related deaths in 2023 was 35–44-year-olds. In DeKalb County, overdose deaths for residents aged 15-44 exceed the state rates.[88]

**TABLE 35NUMBER AND RATE OF OPIOID-ASSOCIATED OVERDOSE DEATHS BY LOCATION (2023)**

| AGE | FULTON COUNTY | | DEKALB COUNTY | | GA RATE |
|---|---|---|---|---|---|
| | NO. DEATHS | RATE | NO. DEATHS | RATE | |
| <1 | 0 | -- | 0 | -- | -- |
| 1-4 | 1 | -- | 0 | -- | -- |
| 5-14 | 1 | -- | 1 | -- | -- |
| 15-24 | 10 | 6.8 | 17 | 18.1 | 10.8 |
| 25-34 | 44 | 23.9 | 24 | 19.4 | 30.4 |
| 35-44 | 66 | 41.6 | 52 | 46.9 | 40.1 |
| 45-54 | 52 | 35.9 | 23 | 24.2 | 26.9 |
| 55-64 | 36 | 29.3 | 17 | 19.2 | 19.5 |
| 65-74 | 18 | 21.3 | 4 | -- | 8.2 |
| 75-84 | 1 | -- | 1 | -- | 1.1 |
| 85+ | 0 | -- | 0 | -- | -- |
| TOTAL | 230 | 21.5 | 139 | 18.5 | 18.1 |
| Rates are age-adjusted per 100,000 population | | | | | |

[88] Georgia Department of Public Health Drug Surveillance Unit- Epidemiology Section. (2025, January 29). Opioid Overdose Surveillance Preliminary District Report Georgia, 2023). Georgia Department of Public Health- Division of Health Protection. Retrieved from Drug Surveillance | Georgia Department of Public Health on November 24, 2025

**Source:** Georgia Department of Public Health. (2023). Opioid Overdose Surveillance Preliminary District Report, Georgia.

While a variety of drugs contribute to overdose, hospitalization and mortality, according to state surveillance, the drugs contributing most to morbidity and mortality are prescription opioids, heroin and fentanyl (Figures 47-48).[89]

**FIGURE 47QUARTERLY OVERDOSE DEATHS BY DRUG TYPE IN FULTON COUNTY (2021-2023)**

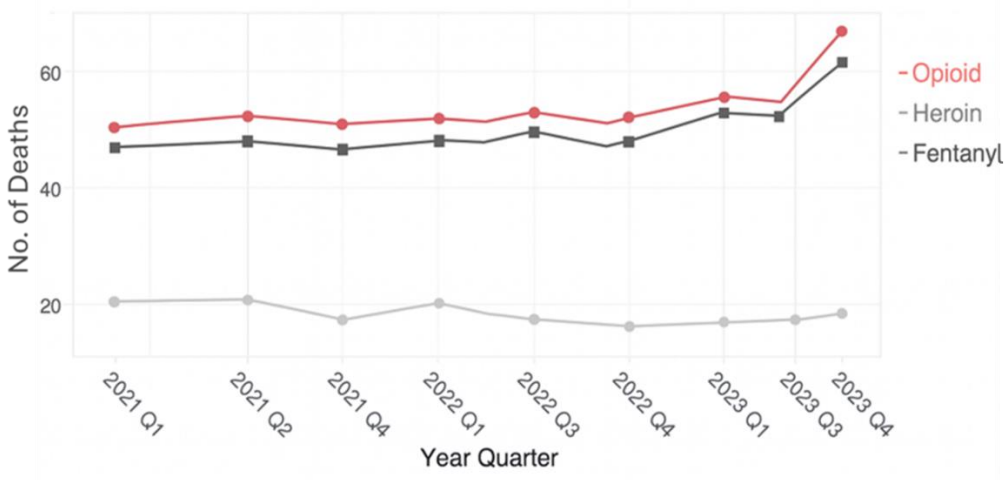
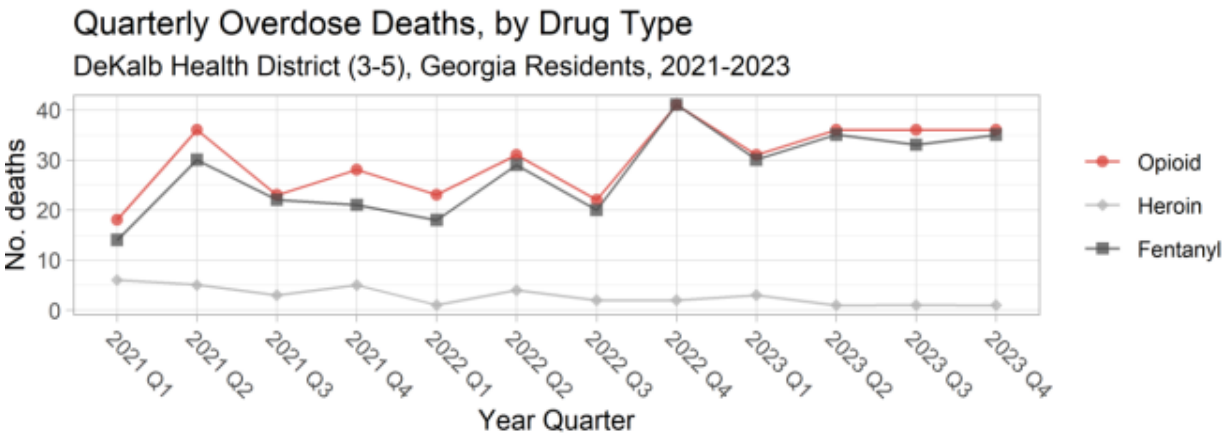



**FIGURE 48QUARTERLY OVERDOSE DEATHS BY DRUG TYPE IN DEKALB COUNTY (2021-2023)**




Within the service area, death rates vary depending on age, race, location and sex (Table 36). Men were approximately two and three times more likely to experience overdose than women in Fulton and DeKalb Counties respectively. In 2024, White residents had the highest rates of overdose when

[89] Georgia Department of Public Health Drug Surveillance Unit- Epidemiology Section. (2025, January 29). Opioid Overdose Surveillance Preliminary District Report Georgia, 2023). Georgia Department of Public Health- Division of Health Protection. Retrieved from Drug Surveillance | Georgia Department of Public Health on November 24, 2025

compared to other races/ethnicities. In Fulton County, overdose was highest among Black residents when compared to other races/ethnicities.

**TABLE 36MORTALITY RATE DUE TO OVERDOSE BY LOCATION, RACE & SEX (2024)**

| LOCATION | ALL | WHITE | BLACK | ASIAN | HISPANIC | TOTAL MALES | TOTAL FEMALES |
|---|---|---|---|---|---|---|---|
| Georgia | 17.8 | 19.9 | 17.4 | 4.0 | 8.0 | 24.2 | 11.7 |
| DeKalb | 20.6 | 17.3 | 25.9 | * | 12 | 32.1 | 10.4 |
| Fulton | 21.0 | 16.4 | 28.6 | * | 7.7 | 29.7 | 12.8 |

**Source:** Georgia Department of Public Health, Office of Health Indicators for Planning OASIS

Neonatal Abstinence Syndrome was classified as a notifiable condition as of January 1, 2017.[90] This may be due to the estimated 5% of pregnant people who use more than one substance during pregnancy.[91]

# Cancer

According to the Georgia Department of Health, cancer-related illnesses were the second leading cause of death in Georgia in 2023, killing 18,435 Georgians: "The leading causes of cancer-related death among men in Georgia are lung, prostate, colon, and pancreatic cancer. The leading causes of cancer-related death among women in Georgia are lung, breast, colon, and pancreatic cancer. These cancers account for almost 50% of cancer deaths in Georgia."[92]

Georgia's cancer incidence and mortality rates are both higher than the national rates (Table 37). The American Cancer Society estimates that Georgia will diagnose 66,210 new cases of cancer and experience 19,090 deaths from cancer in 2025.[93]

**TABLE 37COMPARISON OF CANCER INCIDENCE AND MORTALITY RATES IN GEORGIA AND THE U.S. (2018-2022)**

| | INCIDENCE | MORTALITY |
|---|---|---|
| Georgia | 480 | 150.9 |
| US | 455.6 | 146 |

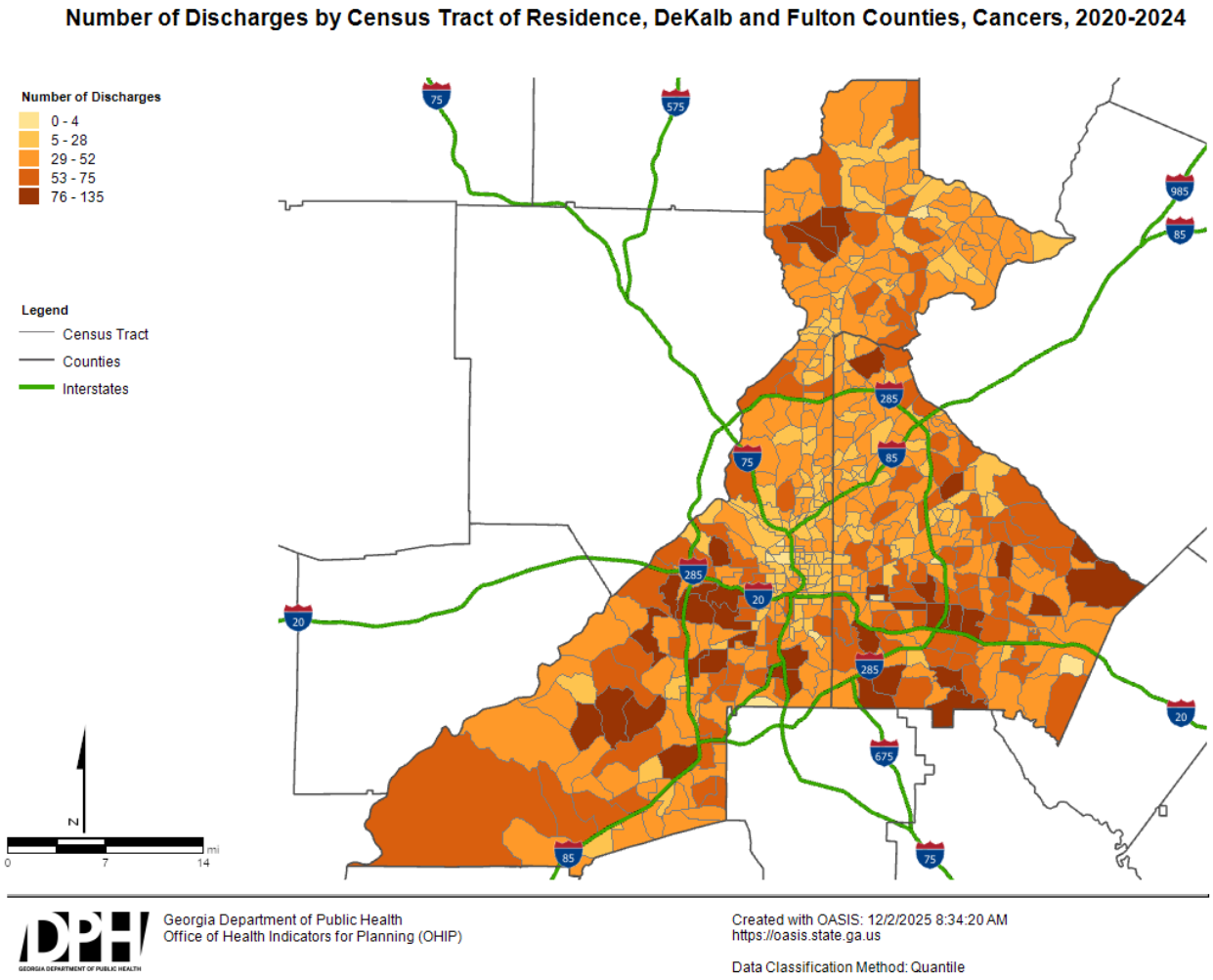
Source: American Cancer Society. (2025) Georgia Cancer Statistics.

[90] GA Code § 31-12-2 (2024) Section 31-12-2. Reporting disease; confidentiality; reporting required of pharmacists; immunity from liability as to information supplied; notification of potential bioterrorism, Chapter 12. Control of hazardous conditions, preventable diseases, and metabolic disorders, Title 31. Health, Georgia Code
Notifiable diseases and conditions are those which by law must be reported to public health agencies or officials. This can be due to their ability to be transmitted easily between people, or their potential impact on public health or safety.
[91] Policy Center for Maternal Mental Health. (2025, March). Substance Use Disorder and Maternal Mental Health [Fact Sheet]. https://www.doi.org/10.69764/SUDF2025
[92] Georgia Department of Public Health. (2023). Cancer Prevention and Control.
[93] Source: American Cancer Society. (2025) Georgia Cancer Statistics.

Table 38 compares cancer indicators in DeKalb County, Fulton County, and Georgia. Overall, cancer outcomes in the two counties are similar to each other. For all cancers combined, both DeKalb (132.1) and Fulton (131.7) have lower mortality rates than the state (148.3). ER discharge rates for all cancers in both Counties (DeKalb: 218.4; Fulton: 219.1) are higher than the state's (201.4), which may indicate limited access to primary or oncology care and a resulting reliance on emergency services

. Additionally, inpatient discharges related to Cancer vary across the service area (Figure 49).

**FIGURE 49NUMBER OF DISCHARGES BY CENSUS TRACT, CANCERS (2020-2024)**




**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

Outcomes vary by cancer type. For example:

- Mortality rates of breast and prostate cancers are higher in DeKalb and Fulton Counties than they are across the state.
- Cervical cancer mortality rates are the same across both counties and the state.
- Colon/rectal and lung cancers are lower in the counties than the state.

- The largest difference between the counties and the states' rates is lung cancer mortality, with DeKalb's mortality rate at 22.0, Fulton's at 24.0 and the state's at 32.3.

**TABLE 38ER VISIT, ER DISCHARGE AND MORTALITY RATES BY TYPE OF CANCER AND LOCATION (2019-2023)**

| | DEKALB | FULTON | GA |
|---|---|---|---|
| **All Site Cancer** | | | |
| All Site Cancer ER Visit Rate | 24.6 | 24.6 | 29.9 |
| All Site Cancer Discharge Rate | 218.4 | 219.1 | 201.4 |
| All Site Cancer Mortality Rate | 132.1 | 131.7 | 148.3 |
| **Breast Cancer** | | | |
| Breast Cancer ER Visit Rate | 2.1 | 2.0 | 2.0 |
| Breast Cancer Discharge | 8.2 | 9.0 | 6.7 |
| Breast Cancer Mortality Rate | 13.5 | 12.1 | 11.6 |
| **Cervical Cancer** | | | |
| Cervical Cancer ER Visit Rate | 0.3 | 0.4 | 0.5 |
| Cervical Cancer Discharge Rate | 1.9 | 1.9 | 2.0 |
| Cervical Cancer Mortality Rate | 1.3 | 1.3 | 1.3 |
| **Colon and Rectal Cancer** | | | |
| Colon and Rectal Cancer ER Visit Rate | 1.8 | 1.7 | 2.2 |
| Colon and Rectal Cancer Discharge Rate | 27.4 | 27.8 | 29.7 |
| Colon and Rectal Cancer Mortality Rate | 12.9 | 12.5 | 13.9 |
| **Lung and Bronchus Cancer** | | | |
| Lung Cancer ER Visit Rate | 2.4 | 2.8 | 3.9 |
| Lung Cancer Discharge Rate | 20.7 | 23.1 | 22.4 |
| Lung Cancer Mortality Rate | 22.0 | 24.0 | 32.3 |
| **Prostate Cancer** | | | |
| Prostate Cancer ER Visit Rate | 1.7 | 1.4 | 1.2 |
| Prostate Cancer Discharge Rate | 7.5 | 7.3 | 6.0 |
| Prostate Cancer Mortality Rate | 9.6 | 9.3 | 8.6 |
| Age-Adjusted rate per 100,000 population | | | |

**Sources:** Georgia Health Data Hub, State Cancer Profiles, 2023; OASIS, Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP)

As with most health outcomes, cancer rates differ between races/ethnicities. Table 39 illustrates the racial and ethnic disparities in cancer mortality rates within the service area. Black residents have the highest death rates across most cancer types, including overall cancer mortality (151.7), breast cancer (16.3), cervical cancer (1.6), colon and rectal cancer (15.6), and prostate cancer (13.5), where the rate is roughly double that of White residents (6.7). White residents have the second highest mortality rates across racial/ethnic groups except for with lung cancer, where the mortality rate is very similar between White and Black residents.

**TABLE 39SELECT CANCER MORTALITY RATES BY RACE/ETHNICITY (2019-2023)**

| | WHITE | BLACK | ASIAN | HISPANIC | MULTIRACIAL |
|---|---|---|---|---|---|
| All Site Cancer Mortality Rate | 125.4 | 151.7 | 85.7 | 86.5 | 65.1 |
| Breast Cancer Mortality Rate | 10.1 | 16.3 | 6.5 | 7.1 | 6.9 |
| Cervical Cancer Mortality Rate | 0.9 | 1.6 | 0.5 | 1.4 | 0.0 |
| Colon and Rectal Cancer Mortality Rate | 11.2 | 15.6 | 7.6 | 9.5 | * |
| Lung Cancer Mortality Rate | 23.8 | 26.3 | 13.2 | 9.5 | 13.6 |
| Prostate Cancer Mortality Rate | 6.7 | 13.5 | 3.0 | 5.6 | * |

**Source:** Georgia Department of Public Health. (2024). Online Analytical Statistical Information System.

# What Grady Can Do

Interviewees, focus group and community participants, and survey respondents were asked to provide their opinions on what Grady could do to impact population and community health in the region over the next three years. The feedback centered on the following specific themes:

***Community Health Workers (CHW) and Care Coordination:*** CHWs are critical for care coordination and navigation in a complex healthcare environment. Ensuring that CHWs can support all aspects of care coordination is important including helping patients manage referrals, transportation, medication, language services, etc. To be most effective, CHWs need flexibility to support and coordinate the healthcare process for patients seeking care.

***Customer Service:*** Most of the feedback about Grady care and support was overwhelmingly positive with many community members saying basically, "just do more of what you're already doing." Just over 14% of survey respondents (second only to access to care) said customer service and respect is where Grady Health System should take action to support community health. Customer service feedback focused on two themes: 1) create a friendly, welcoming environment in the hospital and clinic settings, 2) ensure that patient facing professionals speak to all patients in an engaged and respectful manner. Respecting and getting support with dialect, language and culture was also mentioned here to ensure health management instructions were clear and able to be followed.

***Health Care Workforce:***

- ***Policy:*** Georgia has a severe healthcare professional shortage. Grady could collaborate on legislation that fast tracks medical graduates from other countries to see patients semi-autonomously under the guidance of a U.S. licensed and trained physician.
- ***Training:*** Grady is a vital training ground for future healthcare professionals. Working with Georgia Board of Healthcare Workforce and Georgia-based corporations and health systems to support loan repayment programs for future medical professionals is noted as critical, especially for students who train in Georgia health professional programs. Working with local high school career and technical programs (CTAE) to support learning opportunities for future healthcare professionals is another training strategy. Finally, sending new Grady staff to see partner

### Grady is Great!

*In my community, Grady is thought of as the best place for help after your worst day (fire, gunshot, significant trauma).*

-Survey Respondent

*We like the community clinics Grady is building. The hospital is crowded – this is reaching people where they are.*

-Key Informant

*Thank you very much, Grady.*

-Survey Respondent

*Being the safety net hospital for the area is critical – we couldn't live without Grady. We need more than 1.*

-Key Informant

organizations in action, that is refugee-serving clinics, FQHCs and school-based health centers, would build knowledge of referral pathways.

***Community Partnerships:*** There are several opportunities for Grady to establish strategic partnerships to expand community access to affordable, quality healthcare and to ensure achievement of vital conditions for health and well-being. The feedback focused on the "who" and the "how" of collaboration:

1) ***Who?*** Faith-based institutions, local clinics and care management organizations, community services (libraries, parks, etc.), schools, and public health were noted as potential partners.

2) ***How?*** First, several KIIs recommended that Grady participate in existing coalitions and community collaborations to be informed about community-based initiatives. This strategy has the advantage of ensuring Grady can present their services and resources to a large audience. Second, working with existing community clinics on a referral pipeline and care coordination strategy could help manage patient volume, especially when it comes to specialty care. Finally, feedback is clear that bringing care to the community is an important function of Grady. Working with partners to situate new clinics and to offer mobile health services and screenings is important to residents in the region.

***Primary Care Access:*** About 20% of survey respondents noted access to primary care is an important need. Urgent or ER care is often used in place of primary care for myriad reasons. To promote primary care use, innovations were recommended by several groups. Extending primary care clinic day and weekend hours for those working two jobs or non-day positions. Expanding community paramedicine programs to meet people in community, in homes, and in common gathering locations was also suggested. Finally, help in navigating technology such as patient portals to look at test results and cancel or book appointments was important in navigating primary care.

> *"Critical is getting more access to primary care. However, new clinics may have negative and positive effects on health departments. One of the new Grady facilities is opening across the street from a public health clinic. Why?"*
>
> - Social Service Organization Clinician

***Social Determinants of Health (SDOH):*** As with prior CHNA's, SDOH concerns rose to the top for community members with poverty being the number one concern in the survey results. Other top SDOH concerns this CHNA cycle are economic stability, transportation (especially for medical appointments), housing safety and affordability, and healthy, affordable food located in community were top priorities. Grady has been assessing SDOH needs among patients over the past nine years and more patients are requesting referrals to SDOH services. Tracking and following up on those referrals is one suggestion by

community to ensure that needs are met and that referral sources are reliable and supportive. While this strategy is maybe labor intensive, the health system may find that patients are more adherent to clinical recommendations and prescription management due to the follow-up. Using Find Help and other technology tools to make SDOH referrals easy and rapid were important to respondents.

# Summary

This Grady Community Health Needs Assessment report includes a summary of more than 70 indicators in 10 categories: healthcare access and affordability, mental health, economic stability, sexual health, health behaviors, maternal and child health, neighborhood and built environment, chronic conditions, and social and community context including social determinants of health.

The data presented identify important patterns and trends. Grady's existing community benefit investments and secondary data analysis integrated with information gathered from the voices of Georgians and nonprofit and health professionals identified health priorities (see Figure 1). Top priorities were access to all types of care (primary, mental, specialty, oral) and actions to prevent and control chronic diseases including heart disease, obesity, diabetes, hypertension, and cancer. The assessment results also emphasized the importance of addressing mental healthcare availability, maternal health and mortality, and mental health concerns (suicide, self-reported poor mental health, reducing stigma associated with care). Sexual health, including HIV, AIDS, and STIs were identified as priorities for action in Fulton and DeKalb Counties (Table 40). Finally, other priorities included action to address social determinants of health, specifically housing, food, and transportation.

**TABLE 40: GRADY CHNA PRIMARY AND SECONDARY HEALTH PRIORITIES FOR 2025-2028**

| GRADY CHNA PRIORITIES 2025-2028 | |
|---|---|
| ***Primary Health Priorities*** | ***Secondary Health Priorities*** |
| Access to care | Chronic conditions (diabetes, hypertension) |
| Social determinants of health (economic stability/mobility, housing, food, transportation) | Violence and injury |
| Mental health | Cancer |
| HIV | |
| Maternal and child health | |

# APPENDICES

## Appendix A: Key Informant Interview Guide

**Key Informant Interview (KII) Guide**

**Grady Health System 2025 Community Health Needs Assessment**

| | |
|---|---|
| **Key Informant Name/Title:** | |
| **Organization:** | |
| **Industry/sector/focus of work:** | |
| **County(ies) Representing:** | |
| **Interview Date and Time:** | |
| **Interviewer:** | |
| **Zoom Link:** | |

**INTRODUCTION**

*Thank you for agreeing to do this interview today. My name is [NAME] with the Georgia Health Policy Center. I will be conducting the interview today on behalf of Grady Hospital for their Community Health Needs Assessment process.*

*[KEY INFORMANT NAME], how would you like me to address you [first name, full name, nickname]?*

*Grady Health System is conducting a Community Health Needs Assessment or CHNA. A CHNA is a systematic examination of health indicators that will be used to identify key problems and assets in a community and develop strategies to address community health needs. You are an important contributor to this assessment because of your knowledge of community needs and resources. We greatly value your input.*

*You should have received an informed consent document prior to the interview. We ask that you read, sign, and return the document via email.*

*We expect this interview to last approximately 50 minutes. Interviews are being conducted over Zoom for convenience. The information you provide today will not be reported in a way that would identify you. To improve the accuracy of our notes and any quotes that might be used for reporting purposes, we would like to record the interview.*

*Do we have your permission to record the interview? [YES / NO]*

*Do you have any questions before we get started? [YES / NO]*

**KEY INFORMANT BACKGROUND INFORMATION**

*Now, I would like to ask a few questions about you.*

1. Tell me in a few sentences what [organization] does and how it serves the community?
    - Probe: if not shared, what is their role & how long they have been with the organization?
2. How would you describe the geographic areas, specifically Fulton/Dekalb counties, you serve?
3. How would you describe the populations you serve?

**CONTEXT**

4. If you were to compare the current state of your community to two years ago, how would you rate it and why?

| | |
|---|---|
| Improved over the past 2 years | About the same |
| Declined over the past 2 years | Don't know |

    a. Probe: Are there specific health issues that have gotten better or worse over the past 2 years?
        1. Health could include physical health, mental health, sexual health, nutrition, exercise, access to healthy food, or anything else that impacts the overall well-being of the population you serve.

**HEALTH NEEDS**

*Next, I would like to ask a few questions about the health needs in your community.*

5. In your opinion, what are the priority health needs in Fulton and Dekalb counties?
    a. Probe: Are there any other health-related needs that are of growing concern or impacting the communities or populations you serve?

6. What factors in Fulton and DeKalb counties are driving health issues and challenges?
    a. Probe: Are there any structural, policy or cultural factors that contribute to the priority health needs?
7. Are there certain people or groups of people in the area that you serve whose health may not be as good as others? Why?
    a. Probe: What do you think are some of the causes of these differences in experiences?
    b. Probe: Are there any other barriers to improving health in those populations or groups?
8. Are there any concerns that you have about the impact of technology on people's ability to be healthy?

**COVID-19**

*The impacts of COVID-19 have been felt across all sectors of society over the past few years.*

9. What have been the long-term impacts of the COVID pandemic on the populations your organization serves?
    a. Probe: Were there specific areas in the region you serve that experienced greatest impacts – positive or negative?

**ADDRESSING HEALTH PRIORITIES**

*Thank you for identifying some of the areas of concern in the community. I'd now like to ask you about developing solutions to these concerns.*

**SDOH List (CDC Domains & Grady Assessment):** (Facilitator - Share Lists)

| | |
|---|---|
| Health care access and quality | Education access and quality |
| Financial Resource Strain (Economic stability) | Utilities |
| Housing Stability | Neighborhood safety & built environment |
| Food Security | Transportation |
| Interpersonal Safety (verbal/physical) | |
| Social & community context (civic muscle, belonging) | |

**Health Concerns List:**

| | |
|---|---|
| • Alzheimer's disease and age-related dementia<br>• Cancer<br>• COVID-19 | • Respiratory conditions, including those impacted by environmental exposures such as pollution (e.g., asthma, chronic obstructive pulmonary disease, etc.) |

| | |
|---|---|
| • Diabetes<br>• Heart disease<br>• High blood pressure/hypertension<br>• Infant and children's health<br>• Obesity<br>• Maternal health<br>• Mental health, including suicide (e.g., depression, anxiety, etc.) | • Sexually transmitted infections, including HIV<br>• Stroke<br>• Substance misuse and drug overdose (e.g., opioids, alcohol, etc.)<br>• Violent deaths (e.g., homicide, assault, gun violence, etc.)<br>• Unintentional injuries (e.g., falls, motor vehicle accidents, etc.) |

10. If you could only pick 1 issue from the list, which health issue is the most important for Grady to address in the next year?
    a. Rephrase: What should be the immediate focus of improvement by Grady?
    b. Probe: What are the challenges to addressing this health issue?
11. If you could pick only 3, which health issues would be the most important for Grady to address over the next 3 to 5 years?
    a. Rephrase: What should be the focus of intervention by Grady in the coming 3-5 years?
    b. Probe: What are the biggest challenges to addressing this need?
    c. Probe: What strategies do you think will make a difference in addressing this issue?
12. Are there community resources, assets, or partnerships that can help Grady and their partners address these health issues?

**ACCESS TO CARE**

As you know, Grady is a health system and access to care is often identified as a priority (*alternative phrasing: you've identified access to care as a concern*).

13. For the populations served by your organization, tell us about their experiences in accessing care.
    a. What prevented them from accessing care? (potential probes: health insurance, health care professional availability, wait times, appointment availability, times/location availability)
    b. What supported them in being able to get care they needed?
    c. Do you have any other feedback about access to care?
14. Are you aware of the strategies and techniques Grady is using to address access to care?

**CLOSING**

15. Are there any other thoughts, comments, or suggestions you would like to share that we have not discussed?

Thank you <KEY INFORMANT NAME>. That is all that I have for you today. Grady will be developing their implementation strategy for investing resources to address critical health needs in your community over the next year. A final report of the community health needs assessment will be made available in 2026.

## Appendix B: Focus Group Guide

**Focus Group (FG) Discussion Guide**

**Grady Health System 2025 Community Health Needs Assessment**

**FG 1: Grady Patient Community Advisory Council**: August 13, 2025

**FG 2: Fulton County Community Members**: September 29, 2025

**FG 3: DeKalb County Community Members**: September 30, 2025

**Overview**

- Introduction: Facilitator introduces self and thanks those in attendance for participating.
- Slides: for screen sharing
- Purpose: Facilitator explains purposes of discussion

The project is being undertaken by Grady Health System. They are seeking ways to improve the health of residents in your community. They would like to hear from people who live in these counties. They are particularly interested in your feelings about the health and health needs of the community, how the health-related challenges might be addressed and what is already in place in your community to help make change happen. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of new initiatives or opportunities.

*Explain about focus groups:*

- Give and take conversation
- I have questions I want to ask, but you will do most of the talking
- There are no right or wrong answers
- You are not expected to be an expert on health care, we just want your opinion and your perspective as a member of this community
- You don't have to answer any questions you are uncomfortable answering
- It is important to speak one at a time because we are recording this conversation
- Your names will not be used when the tapes are transcribed, just male or female will appear on any transcript
- I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to “hold on a minute” while I hear from someone else, so don’t take offense
- Please remember that what people say in this group is confidential. I ask that you do not share what you heard from others outside of this group.
- You will be asked to talk about yourself, your family and your friends today. Please do not use anyone’s name in your comments.

- Here is an informed consent form for you to read along with me and then sign if you decide to participate today. It is important for you to know that your participation today is completely voluntary. You can stop your participation now, or at any time. (READ INFORMED CONSENT, COLLECT SIGNATURES)

**Participant Introductions** (10 minutes)

Please go around the table [screen] and introduce yourself using your first name. Tell us how long you have lived in [your county/community].

| Time | QUESTIONS | SLIDES |
|---|---|---|
| *22-24 minutes* | **Health Concerns in the Community** | |
| 5 minutes | What do you like about your community? What are its strengths? What is positive about where you live, work, play or worship? | NO SLIDE |
| 5 minutes | Do you think that most people in your community are healthy?<br>Why or why not?<br>*Probe for "why not" responses:* What is it about your community that may contribute to people having these types of issues? | NO SLIDE |
| 7 minutes | Do people in your community have access to the health services they need in order to control their health concerns such as chronic diseases or mental health? Why or why not?<br>*Probe:* What other health services are needed in your community for residents to achieve better health? (e.g., mental health, annual screenings, etc.) | NO SLIDE |
| 5 minutes | What is the role of Grady hospital or Grady Health System in addressing the health concerns and service needs you've talked about? | NO SLIDE |
| | ***Facilitator**: Present community-appropriate data summary in slides (or handouts for in-person FG) to participants.* | |
| 2 minutes (mins) | **DATA STORY: HEALTH ISSUES IMPACTING SERVICE AREA**<br>Grady Health System serves mainly DeKalb and Fulton Counties. So, we're going to share some information regarding the health of DeKalb and Fulton Counties. | **SLIDE 1** |

<table>
<tr><td></td><td>SLIDE 1: Population Characteristics<br><br>• Share a snapshot of Georgia, Fulton and DeKalb. Note: Georgia has grown over the past 30 years from 2 to 11 million people.<br><br>(Subset of data in table will be presented – see strikethrough on items to be deleted)<br><table><tr><th>Demographic Areas</th><th>Georgia</th><th>Fulton</th><th>DeKalb</th></tr><tr><td>Population **</td><td>11,029,227</td><td>1,079,105</td><td>762,992</td></tr><tr><td>% Below 18 Years of Age **</td><td>23.00%</td><td>20.60%</td><td>22.40%</td></tr><tr><td>% 65 and Older **</td><td>15.40%</td><td>13.10%</td><td>14.30%</td></tr><tr><td>% Female **</td><td>51.30%</td><td>51.40%</td><td>52.60%</td></tr><tr><td>% Asian **</td><td>4.90%</td><td>8.20%</td><td>6.50%</td></tr><tr><td>% Hispanic **</td><td>11.10%</td><td>8.20%</td><td>10.40%</td></tr><tr><td>% Non-Hispanic Black **</td><td>32.10%</td><td>44.00%</td><td>52.30%</td></tr><tr><td>% Non-Hispanic White **</td><td>49.60%</td><td>37.50%</td><td>28.70%</td></tr><tr><td>% Disability: Functional Limitations **</td><td>29%</td><td>23%</td><td>27%</td></tr></table></td><td></td></tr>
<tr><td>7 mins</td><td>SLIDE 2<br><br>We’re going to review this county level slide together. It has data for the United States, Georgia, Fulton County and DeKalb County.<br><br>(Data from table at end of guide will inform slide)<br><br>Numbers in red indicate that Fulton or DeKalb are worse than the state number.<br><br>(SLIDE NOTES & APPENDIX HAVE DEFINITIONS IF PARTICIPANTS ASK)<br><br>What is positive about this information?<br><br>Where do you have concerns?</td><td>SLIDE 2</td></tr>
<tr><td>5 mins</td><td>SLIDE 3<br><br>Areas of Strength<br><br>When we look at the strengths reflected in the data about DeKalb and Fulton, there is good news.<br><br>Which of these would you say is most important for a healthy community in your opinion?</td><td>Slide 3</td></tr>
<tr><td>3 mins</td><td>PARTICIPANT QUESTION<br><br>What other good things are promoting health in your communities?</td><td>NO SLIDE</td></tr>
</table>

| | | |
|---|---|---|
| | How do we make what's good in your communities, even better? | |
| 5 mins | SLIDE 4: Areas for Improvement<br><br>Please review the list on the slide.<br><br>Which topics would you say should be the top priority for improvement in your community?<br>*(Alternative Phrasing: Which topics would you say should be a priority for Grady to improve in your community over the next 3 years?)* | **Slide 4** |
| 4 mins | SLIDE 5: Healthcare Access / Healthcare Insurance – Show uninsured map<br><br>As you know, Grady is a health system and access to care and health insurance is often identified as a priority.<br><br>Tell us about their experiences in accessing care.<br><br>d. What prevented them from accessing care? (potential probes: health insurance, health care professional availability, wait times, appointment availability, times/location availability)<br>e. What supported them in being able to get care they needed? | **Slide 5** |
| 2 mins | SLIDE 6: Injury & Homicide Rates<br><br>Assault/homicide is the number 1 cause of premature death in the service region.<br><br>*Probe (if not mentioned):* I'd like to take a moment to talk about injury and violence specifically. We see higher rates of injury and violence in Fulton and DeKalb counties.<br><br>What is driving these higher rates? What are your opinions about or experiences with regard to injury and violence in Fulton and DeKalb counties? | **Slide 6** |
| 2 mins | SLIDE 7: Chronic Diseases<br><br>Let's talk about chronic conditions like heart disease, high blood pressure, obesity, diabetes and stroke. There are high rates of these diseases in Fulton and DeKalb counties.<br><br>What is driving the high rates of these chronic conditions? | **Slide 7** |

| | | |
|---|---|---|
| | What are your opinions and experiences in regard to these chronic diseases disease in Fulton and DeKalb counties? | |
| 2 mins | SLIDE 8: Sexual Health<br><br>Sexually Transmitted Infections & HIV/AIDS impacts a much higher percent of residents in Fulton & DeKalb compared to other counties.<br><br>What do think is causing these high rates of infection? What should be done to reduce the infection rates? | **Slide 8** |
| 2 mins | WHAT'S MISSING?<br><br>What health issues have we not yet talked about that are a concern to you? Are there health topics that you want to be sure that Grady considers for action? | NO SLIDE |
| 5 mins | SOLUTIONS:<br><br>Slide 9 Text: What are the most effective ways to begin to address these health concerns you've identified as important?<br><br>What suggestions do you have for making specific changes in your neighborhood or community? Probe Statement: *This is an opportunity to make suggestions about needed programs, changes in the community, educational campaigns, etc. that would best meet the needs of your particular community.* | **Slide 9** |
| 5 mins | PRIORITIES: *type on slide in real time as participants provide feedback*<br><br>Considering all of the information we've discussed today, along with your own experience with critical health needs here in Fulton and DeKalb, which 3 health issues should be the priorities for addressing over the next three years? | **Slide 10** |
| 2-3 mins | SLIDE 11: CLOSING QUESTIONS<br><br>How would you like your community to be different in 5 years for you and your family to live a healthy quality of life?<br><br>Are there any other thoughts, comments, or suggestions you would like to share that we have not discussed? | **Slide 11** |

**Facilitator: EXPRESS APPRECIATION TO FOCUS GROUP PARTICIPANTS!**

***Potential additions to table from OASIS:*** *sexual health/STI/HIV/AIDS; drug overdose; Alzheimer's and relate dementia; ER visits or ER discharge rates*

| Population Health and Well-being | | | | | |
|---|---|---|---|---|---|
| Length of life | Georgia | DeKalb, GA | Fulton, GA | United States | |
| Premature Death | 9,400 | 8,500 | 8,100 | 8,400 | Years of potential life lost before age 75 per 100,000 population (age-adjusted). |
| Quality of life | Georgia | DeKalb, GA | Fulton, GA | United States | |
| Poor Physical Health Days | 4 | 3.8 | 3.6 | 3.9 | Average number of physically unhealthy days reported in past 30 days (age-adjusted). |
| Low Birth Weight (< 2,500 g) | 10% | 11% | 11% | 8% | Percentage of live births with low birth weight (< 2,500 grams) [about 5.5 lbs] |
| Poor Mental Health Days | 5.2 | 5.3 | 4.8 | 5.1 | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). |
| Poor or Fair Health | 18% | 18% | 14% | 17% | Percentage of adults reporting fair or poor health (age-adjusted). |
| **Community Conditions** | | | | | |
| Health infrastructure | Georgia | DeKalb, GA | Fulton, GA | United States | |
| Flu Vaccinations | 45% | 48% | 52% | 48% | Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination |
| Access to Exercise Opportunities | 75% | 91% | 94% | 84% | Percentage of population with adequate access to locations for physical activity. |
| Food Environment Index 0=worst, 10=best | 6.3 | 8.1 | 8 | 7.4 | 1) Limited Access to Healthy Foods estimates the percentage of the population that is low income and does not live close to a grocery store; in rural areas, it means living less than 10 miles from a grocery store whereas in non-rural areas, it means less than 1 mile. 2) Food Insecurity estimates the percentage of the population without access to a reliable source of food during the past year. |
| Primary Care Physicians | 1,520:1 | 940:01:00 | 890:01:00 | 1,330:1 | Ratio of population to primary care physicians. |
| Mental Health Providers | 520:01:00 | 250:01:00 | 280:01:00 | 300:01:00 | Ratio of population to mental health providers. |
| Dentists | 1,860:1 | 1,610:1 | 1,320:1 | 1,360:1 | Ratio of population to dentists. |
| Preventable Hospital Stays | 3,083 | 2,745 | 2,845 | 2,666 | Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. |
| Mammography Screening | 42% | 36% | 40% | 44% | Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening. |
| Uninsured | 14% | 14% | 11% | 10% | Percentage of population under age 65 without health insurance. |
| Physical environment | Georgia | DeKalb, GA | Fulton, GA | United States | |
| Severe Housing Problems | 15% | 18% | 18% | 17% | Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. |
| Driving Alone to Work | 72% | 63% | 59% | 70% | Percentage of the workforce that drives alone to work. |
| Long Commute - Driving Alone | 42% | 50% | 40% | 37% | Among workers who commute in their car alone, the percentage that commute more than 30 minutes. |

| | | | | | |
|---|---|---|---|---|---|
| Air Pollution: Particulate Matter | | 8.8 | 9 | 9.5 | 7.3 |
| Broadband Access | | 89% | 92% | 92% | 90% |
| Social and economic factors | | Georgia | DeKalb, GA | Fulton, GA | United States |
| Some College | | 66% | 73% | 81% | 68% |
| High School Completion | | 89% | 91% | 94% | 89% |
| Unemployment | | 3.20% | 3.30% | 3.40% | 3.60% |
| Children in Poverty | | 19% | 18% | 17% | 16% |
| Injury Deaths | | 77 | 74 | 76 | 84 |
| Social Associations | | 8.8 | 7.3 | 9.7 | 9.1 |
| Child Care Cost Burden | | 23% | 27% | 22% | 28% |

Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).
Percentage of households with broadband internet connection.

Percentage of adults ages 25-44 with some post-secondary education.
Percentage of adults ages 25 and over with a high school diploma or equivalent.
Percentage of population ages 16 and older unemployed but seeking work.
Percentage of people under age 18 in poverty.
Number of deaths due to injury per 100,000 population.
Number of membership associations per 10,000 population.
Child care costs for a household with two children as a percent of median household income.

*Source: County Health Rankings & Roadmaps. Note: Blank values reflect unreliable or missing data.*

## Appendix C: Community Conversation Guide

**Grady Community Health Needs Assessment 2025**
**Community Conversation Discussion Guide**

**In-person Discussions:**
**Wednesday, September 24, 2025**
**DeKalb Board of Health, 445 Winn Way, Decatur, GA 30030**

*Conducted by Georgia Health Policy Center (GHPC) as part of the 2023-2024 Grady Health System Community Health Needs Assessment 2025*

GHPC Team Member Assignments:

| Name | Role |
|---|---|
| **Debra Kibbe** | Facilitator |
| **Kristina Ormond** | Co-Facilitator, Notetaker when not facilitating |
| **Kristina Ormond** | Slide Share/Management,<br>Address Secondary Data Questions, Notetaker Primary |

**Overview**

**Sign-in:**

- In-person - sign-in sheet with FG language and signature line upon receipt of gift card
- **Introduction**: GHPC Facilitator introduces self and Co-Facilitator. Welcome and thanks for taking the time to be with us today.
- **Slides**: for screen sharing
- **Purpose**: Facilitator explains purposes of discussion

The project is being undertaken by the Grady Health System. They are seeking ways to improve the health of people living in the Grady Service Region. Grady is particularly interested in your thoughts about the health needs, resources, and programs in the community in which you live. They are also interested in knowing what is already in place in your community to support good health. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of new initiatives or opportunities.

Explain about community conversations:

- Give and take conversation
- We have questions we want to ask, but you will do most of the talking either at your tables or in the larger group
- There are no right or wrong answers
- You are not expected to be an expert on health care, we just want your opinion and your perspective as a member of this community
- You don't have to answer any questions you are uncomfortable answering
- It is important to speak one at a time because we are recording this conversation
- Your names will not be used when the notes are transcribed,

- Please remember that what people say in this community discussion is confidential. I ask that you do not share what you heard from others outside of this group.
- You will be asked to talk about yourself, your family and your friends today. Please do not use anyone's name in your comments.
- This is a study and as such, I must read some consent language and receive your agreement prior to your participation. (READ INFORMED CONSENT, COLLECT AGREEMENT IN CHAT)

**Participant Introductions**

## Introductory Questions (Slide)

- Let's start by introducing ourselves at your tables. Please share your name, the town you live in, and one thing that you are proud of about your community.

## Definition: Health (Slide w/ examples)

Today we are going to be talking about health – all things that support Georgians being healthy. Throughout our discussion today, think about health very broadly – feel free to raise concerns about physical health, mental health, environmental health, social and economic health (like jobs, education, access to transportation or healthcare), and any other topic you think supports good health in your community.

## Description of the Community

- We would like to learn about the community where you live.
  - There are sticky notes on your table. Please take a few sticky notes and write down words that you think of as describing "your community".
    - GHPC facilitator will gather the sticky notes for placing on flip chart page.
  - At your tables, share the most positive things about where you live? What is your community "doing well?"
  - What do you like least about where you live?

## Community Health

- What makes a community healthy?
- What are the common health issues that you see in your community?
  - Among children?
  - Among adults?
  - Among seniors?
- Do you think there are specific factors (provide examples if needed) in your community that cause or influence the health concerns you have mentioned?

  EXAMPLES:
  - Access to food
  - Transportation
  - Housing
  - Unemployment
  - Literacy

- Violence
- Education Inequity
- Racism
- Mental health

## Barriers/Challenges/Needs

- What are the barriers or challenges to being healthy in your community?
  - Describe any resource gaps in your community.
- Are health needs more prevalent in a certain geographic area, or within certain groups of the community?
  - In which populations, if any, have you seen unequal impacts?
- What are some of the facilitators or drivers to your community being healthy?

## Priority Concerns

On the slide is a list of health concerns. Take 3 sticky notes and write 1, 2, and 3 on them. Then write your #1 health concern on the note with a 1, write your #2 health concern or priority on the note with a 2, and finally, write your third top health concern on the note with a 3.

Talk at your table about the 3 top health issues each table member listed. Which topics got the most votes? Which topics got the least votes?

As a whole group, we're going to vote on the top 3 health issues that Grady should address to improve the health of your community?

- Healthcare Access & Quality*
- Behavioral & Mental health
- Chronic Disease (Diabetes, CVD, HTN) & Cancers
- Healthy Eating & Healthy Food Access
- Maternal and Child Health
- HIV and STIs
- Substance Misuse
- Economic Stability* (housing cost, health insurance cost)
- Education Access & Quality*
- Neighborhood & Built Environment* & Active Living
- Social & Community Context* (violence, injury, systemic racism)

### Access to Care

- Tell us about experiences (your personal, friends, family, co-workers, etc.) using or attempting to use health care services in your community: What types of services, were you able to get an appointment, was there a long wait, etc.?
  - What prevents you (or your family) from accessing community health programs or going to doctor appointments?
  - What would make it easier for you (or your family) to access community health programs or go to a doctor's appointment?
  - *Probe if cost isn't already raised:* How does the cost of your health care influence decisions that you (or your family) make regarding your health?
- What resources or services exist to help residents and families access the care they need?

- What resources or services are lacking in your community to help residents and families access they care they need?

## Specific Topics to Ask About Based on What Community Conversation Participants Identify

Mental Health

- If you need mental or behavioral health help or services, do you know where to go?
- What resources (i.e. agencies, institutions, programs) does your community have that address mental health issues? Are there resources needed that aren't currently available?

Chronic Disease - Cancer

- In your opinion, what are some of the barriers experienced by residents seeking cancer screening? …treatment? Do you see disparities among people related to these barriers (e.g., racial/ethnic, gender, insurance status, etc.)? What would alleviate these barriers?
- Are there specific gaps in [insert] County where services are needed (type of cancer, geographical locations, etc.) but not available?

Chronic Disease – CVD, Hypertension, Diabetes

- If applicable: We see high rates of cardiovascular disease in [insert] County. Are you familiar with what is driving these rates? What do you think can or should be done to address these high rates?

Chronic Disease – HIV/AIDS

- If applicable: We see high rates of HIV/AIDS in [insert] County. Are you familiar with what is driving these rates? What do you think can or should be done to address these high rates?

Physical Activity and Nutrition

- What services exist to support residents and families when they are striving to eat healthy and live actively?
- Do residents in your community have access to safe places to play, walk, bike and exercise?
- What are the barriers to active living?

Alcohol/Substance Use

- Why did you identify alcohol or substance misuse as a problem?
- What resources (i.e agencies, institutions, programs) does your community have that address alcohol/substance abuse related issues?
- What other support and resources are needed that aren't currently available to help community residents with alcohol & substance misuse?

Urgent Care

- What health-related situations do you consider urgent? What do you do, where do you go in those situations (wait as long as I can, go to _ (insert nearest city)_, go somewhere else, etc.)?
- Are there any alternatives to care besides urgent care? If so, what are they?

Dental Care

- Can you/the people you know access dental care when you/they need it?
- Are there any reasons that people cannot access dental care when they need it?

Transportation
- Is lack of transportation a concern for any residents of your community? If so, who?
- What public transportation is available for those who do not have cars? Does it work well?

Income/Employment
- What are the reasons that you/people you know cannot secure stable, safe, employment that offers adequate pay?
- What services exist to support residents and families when they are not able to secure adequate employment or wages?
- Often residents with limited incomes or who are Black and Brown experience poorer health outcomes in Georgia. Why do you think this happens?

Education
- What services exist to support high school graduation? Post-secondary education? Learning a trade?
- What should be done to ensure that children in your community finish their education so they can attain higher-paying jobs?

Crime
- What crime or violence-related concerns have been impacting you/your family/your community? How do these concerns impact the health and wellbeing of residents?
- What services exist to support residents and families when they have become a victim of crime?

Housing and Homelessness
- Are residents that you serve able to easily find affordable housing (ownership or rentals)?
- What are the barriers to housing affordability?
- What services exist to support residents and families when they are housing insecure or even homeless?

English as a Second Language
- What programs or services are available for residents that speak English as a second language and New Americans?
- Are there specific gaps in your community where these services are needed but not available?

### Grady and Community Leader Impact
- What is Grady doing well? What services, supports, and resources that Grady provides are important to your community?
- Given what we discussed, should Grady Health System be doing anything else or anything different?
- Are there organizations that Grady should be collaborating with to improve services or to reach certain populations?

## Closing Questions

- Considering the information, we have discussed and your experience in this community, what two health issues should be prioritized by Grady Health System over the next five years?
- How would you like your community to be different in 5 years in order to be a healthier place for you and your family to live?
- Is there anything further anyone would like to add about any of the issues we've already discussed that you feel you've not had a chance to say?

## Appendix D: Community Survey (Qualtrics)

**Introduction:**
Your voice matters. Grady Health System is conducting a Community Health Needs Survey to better understand the health challenges, strengths, and priorities of residents in **Fulton and DeKalb Counties**.

By sharing your experiences and insights, you'll help guide future health programs, services, and investments that directly impact your community.

**Takes just 10–12 minutes**
**Completely confidential**
**For Fulton and DeKalb County residents only**

Together, we can build healthier, stronger communities—starting with your input.

**Consent:**

You are being asked to take part in a research study being conducted by the Georgia State University and Grady Health System. For the study, you are asked to complete this survey, which will require approximately 12 minutes of your time. Taking part in this survey is voluntary. Your feedback will help Grady identify health concerns and health priorities of importance to **Fulton and DeKalb County residents**. There are no known risks associated with completion of this survey. You may skip questions or stop participating at any time. Your responses will be kept strictly confidential.

If you have concerns or questions about this survey or would like additional information about the Grady CHNA process please contact: Debra Kibbe, Georgia Health Policy Center, 404-413-0287; dkibbe@gsu.edu.

If you agree to participate in this study, please respond yes and continue with the survey.

Do you consent to participating in this study?
- o Yes
- o No

Skip To: End of Survey If Do you consent to participating in this study? = No
End of Block: Introduction to Survey

Start of Block: Demographics

Section 1: Your Information
The information gathered from the questions in this section will be used to describe the group of participants

who provide feedback and will not be used to identify you personally.

1. Please select the county you live in from the drop-down menu.
   o I don't live in Fulton or Dekalb County
   o Fulton
   o Dekalb
   Skip To: End of Survey If Please select the county you live in from the drop-down menu. = I don't live in Fulton or Dekalb County

2. What is your zip code? _____

3. Please select your age group
   ▢ 18–24
   ▢ 25–34
   ▢ 35–44
   ▢ 45–54
   ▢ 55–64
   ▢ 65–74
   ▢ 75 or older
   ▢ Decline to answer

4. What language is mainly spoken at home?
   ▢ English
   ▢ Spanish
   ▢ Another language (please write below): _____

5. Do you identify as Hispanic?
   ▢ No
   ▢ Yes (option to specify) _____
   ▢ Decline to answer

6. Please select one or multiple categories that best describe your race.
   ▢ American Indian or Alaskan Native
   ▢ Asian (option to specify):_____
   ▢ Black or African American
   ▢ Native Hawaiian or Other Pacific Islander
   ▢ White
   ▢ **Multiple ethnicity** /Another option not listed (please specify):_____
   ▢ Prefer not to answer

7. Please select one or multiple categories that best describe your gender identity.
   ▢ Woman
   ▢ Man
   ▢ Transgender
   ▢ Non-binary or gender nonconforming
   ▢ Another option not listed (please specify): _____
   ▢ Decline to answer

8. What is the highest level of school that you have completed?
   - ▢ Less than high school
   - ▢ High school degree/GED
   - ▢ Some college/university
   - ▢ Associate degree
   - ▢ Vocational/trade school degree
   - ▢ Bachelor's degree
   - ▢ Master's degree
   - ▢ Doctoral degree (PhD, MD, JD, DDS, etc.)
   - ▢ Other (Please specify): _____

9. Which field best describes your MAIN area of work?
   - ▢ I work for myself
   - ▢ I take care of kids or teach in school
   - ▢ I work in health or help people
   - ▢ I work for the government
   - ▢ I work in a different kind of job (please specify): _____
   - ▢ Not working/Unemployed

10. **What do you do in your community?** (You can pick more than one.)
    - ▢ I take care of others (like kids or older adults)
    - ▢ I help or volunteer in my neighborhood
    - ▢ I go to school
    - ▢ I run a small business
    - ▢ I'm part of a group (like a church, club, or team)
    - ▢ I help plan or lead community activities
    - ▢ I live here but don't have a community role
    - ▢ Other (please write below):

11. **What kind of work do you do most of the time?**
    (Choose the one that fits you best.)
    - ❑ I work for myself
    - ❑ I take care of kids or teach in school
    - ❑ I work in health or help people
    - ❑ I work for the government
    - ❑ I work in a different kind of job (please write it below):
    - ❑ I'm not working right now

12. What type of health insurance do you have?
    - ▢ Medicaid
    - ▢ Medicare
    - ▢ PeachCare
    - ▢ Private insurance
    - ▢ Self-pay
    - ▢ I don't have insurance
    - ▢ Other (please specify): _____
    - ▢ Decline to answer

End of Block: Demographics

Start of Block: SHA Section

Section 2: Health Assessment

We would like your thoughts on the overall health of your county. This section asks about the health issues impacting your community and county as a whole.

13. Community is defined as the neighborhood in which you live. **What helps make a community healthy?** *(Select up to 3 things that matter most to you)*
    **Health & Services**
    ☐ Good health care and insurance
    ☐ Mental health support
    ☐ Accurate health information
    ☐ Social services and support programs
    **Basic Needs**
    ☐ Affordable housing
    ☐ Affordable food
    ☐ Affordable utilities
    ☐ Transportation options
    **Education & Childcare**
    ☐ Good schools
    ☐ Early education and childcare
    ☐ Job opportunities
    **Environment & Safety**
    ☐ Clean air and water
    ☐ Safe neighborhoods
    ☐ Free parks and places to exercise
    ☐ Emergency preparedness
    **Community & Culture**
    ☐ Strong family ties
    ☐ Religious or spiritual values
    ☐ Arts and cultural events
    ☐ Policies that support health
    ☐ Healthy behaviors
    ☐ Other (please specify): _____

14. **How would you rate the health of your community?**
    *Physical health:*
    ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
    *Mental/emotional health:*
    ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

15. **What are the top 3 places or services that help your community stay healthy?**
    *(Select up to 3)*
    - ☐ Churches
    - ☐ Community centers
    - ☐ Libraries
    - ☐ Parks
    - ☐ Schools
    - ☐ Clinics or hospitals
    - ☐ Social services
    - ☐ Housing support
    - ☐ Transportation
    - ☐ Other (please specify): _____
16. **What are the top 3 health or social problems in your neighborhood?**
    (Examples: poverty, racial inequality, access to education)
    - ☐ Problem #1_____
    - ☐ Problem #2_____
    - ☐ Problem #3 _____

17. **What makes it hard for you or others in your community to stay healthy?** *(Select up to 3)*
    ☐ Lack of insurance ☐ High cost of care ☐ Distance to health care
    ☐ Cultural beliefs or practices ☐ Discrimination or lack of trust
    ☐ Hard to understand health information ☐ Transportation issues
    ☐ Limited appointment times ☐ Language differences
    ☐ Caring for a family member ☐ Disability
    ☐ Other (please specify): _____
18. **Which health services are hardest to find or use in your neighborhood?** *(Select up to 3)*
    ☐ Regular doctor (primary care) ☐ Specialist doctor ☐ Urgent care
    ☐ Dental care ☐ Hospitals ☐ Mental health care
    ☐ Other (please specify): _____
19. **Do healthcare providers in your community understand and respect your culture, traditions, and values?**
    ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
20. **Do healthcare providers in your community offer services that can be used by extended family members?**
    ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ Not applicable
21. **Where do you and others in your community learn about health and available resources?** *(Select up to 3)*
    ☐ Hospitals, clinics, or public health departments
    ☐ Healthcare providers
    ☐ Friends and family
    ☐ Church or faith groups
    ☐ News and media
    ☐ Social media
    ☐ Other (please specify): _____
22. **Do health clinics, hospitals, and social services work well together in your community?**
    ☐ Very well ☐ Somewhat well ☐ Not very well ☐ Not at all ☐ Not sure
23. **How well is Grady Health System serving your community?**
    ☐ Very well ☐ Well ☐ Somewhat well ☐ Not well ☐ Not sure
    *Optional: Please share why you feel this way:*
24. **Is there anything else you'd like to share about health in your community?** *(Optional)*

End of Block: HA Section

Start of Block: Recommendations Section for Grady Health Improvement Planning:

Section 3: Recommendations Section for Grady Health Improvement Planning

**This section asks for your ideas and feedback about what's working well in your neighborhood and how Grady Health System and other partners can better support health in Fulton and DeKalb Counties.**

We want to hear about the strengths, resources, and opportunities in your community—and your recommendations for how to improve health and well-being over the next five years.

25. **What strengths or resources exist in your community that help improve health?** *(Open-ended)*

26. **What assets are most important for children and youth to be healthy?**
    *You may name any organizations doing this work.*

27. **What is one thing Grady Health System could do to better support your community's health?** *(Open-ended)*

Is there anything that has not yet been mentioned that may act as a barrier to achieving the best possible health for DeKalb or Fulton? If you are not aware of any, please type N/A in the text box.

_____
_____
_____
_____
_____

Recommendations Section for Grady Health Improvement Planning:

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| Organization Description | Hospital/ healthcare<br>Individual<br>Government<br>Community Based Organization<br>Social support<br>Immigration | Food security<br>Funder<br>Equity<br>Education/training<br>Family services<br>Other | |
| Access to Care | General/ Primary Care<br>Mental Health Care<br>Location | In-person<br>Telehealth/ Telemedicine/ Hotline<br>Mobile Health Team/ Unit<br>Emergency Services | How or where community members access health care. This includes descriptions of barriers and facilitators to access (e.g., affordability, availability, and acceptability of care).<br>Community use or issues related to the use of urgent care or emergency services. |
| Healthcare Workforce Capacity | Primary care physicians (per 100,000)<br>Dentists (per 100,000 population)<br>Mental health providers (per 100,000 pop)<br>Care Gaps<br>Care Navigation | | Preparedness of healthcare professionals to serve diverse patient populations. Training needs of healthcare professionals related to serving diverse patient populations.<br>Health care (providers, resources, services, etc.) that is needed but does not currently exist in the community. |
| Patient Experiences | | | Health care experiences of community members (e.g., the quality of interactions with health care providers). |
| CHNA Report Input | | | Input on the reporting and dissemination of the CHNA reports. Includes how the CHNA report content should be shared, and how the report can be (more) helpful to an interviewee's organization and the communities served. |
| Other Comments | | | Notable comments that cannot be assigned to an existing code. |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| Screening and Prevention | | | Comments related to preventive services, screening for or prevention of health concerns |
| Actions | | | Actions taken in communities to address poor health, health disparities, or to support health in general. Includes descriptions of the results of these actions. |
| Assets<br><br>Deficits | | | Community assets which may or may not be aligned with the core elements of Vital Conditions for Health and Well'-'Being framework (e.g., available necessities, helpful resources, services, organizations that support residents' health and well'-'being).<br>Missing community assets which may or may not be aligned with the core elements of Vital Conditions for Health and Well'-'Being framework (e.g., lack of necessities, resources, services, organizations needed to support residents' health and well'-'being). |
| Desired Change | | | Desired community change(s) to improve health or quality of life for residents. |
| Community Context | Community Safety-General | | |
| | | Violent crimes-County<br>Injury deaths-County<br>Motor vehicle crash deaths-County | |
| | Community Safety-Specific | Pedestrian accidents/ deaths-County | |
| | Built Environment | Walkability; Access to public transit; Exercise opportunities-County; Community issues pertaining to physical activity (access to safe places to walk, play, exercise) | |
| | Family & Social Support | Children in single-parent households-Tract<br>Access to Childcare/ affordable childcare<br>Limited English Proficiency-Tract | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | | Population 65 & older living alone-Tract (SOCIAL ISOLATION)<br>Gender/ race/ Group Specific Social Support | |
| | Community Barriers to health | Structural Racism<br>Stigma<br>language barriers<br>lack of health care providers/staff/specialists<br>State/ federal Policy<br>mistrust health providers/system/government<br>Immigration / family separation<br>Legal/ family separation- prison/ foster care<br>poor investments in infrastructure<br>Access to Internet/broadband<br>Distance from care/ transportation/ geography | |
| | Community Facilitators to Healthy Living | Physically active/wellness focus<br>trust in healthcare<br>good public health<br>sense of inclusion/ social connection | |
| Environment | Heat wave risk-Tract<br>Air pollution: PM2.5 concentration-Tract<br>Respiratory Hazard Need Rating-Tract<br>Other Environmental Concern | | |
| Health Insurance | Uninsured children<br>uninsured/underinsured residents- general<br>Medicaid/public insurance enrollment | | |
| Location | | | Any description of community location or geography. |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | Metro/urban | | Health issues, or conditions that affect health, that interviewees associate with metro/urban populations or areas. |
| | Rural | | Health issues, or conditions that affect health, that interviewees associate with rural populations or areas. |
| Community Health | | | |
| | Contributing Factors | | General contributing factors to the state of a community's health. |
| | Health Disparities | | Differences in health between groups of community residents. Includes contributing factors to differences in health, and any data collected or data needs related to health disparities. |
| | Issues | | Current or common community health issues. Includes context of the issues. |
| Mental/ Behavioral Health | General reference | | Community issues pertaining to mental health conditions, alcohol or substance use, social isolation, or loneliness. |
| | Mental health | Poor mental health (days per month) | |
| | Mental health | hospitalizations | |
| | Mental health | Suicide deaths | |
| | Behavioral Health | tobacco use | |
| | Behavioral Health | alcohol use | |
| | Behavioral Health | substance use | |
| | Behavioral Health | overdose deaths/ county | |
| Chronic Disease | General reference | | Community issues pertaining to chronic conditions such as cancer, cardiovascular diseases, pulmonary diseases, and HIV/AIDS. |
| | Hypertension | High blood pressure, sodium intake | |
| | Asthma | | |
| | Diabetes | | |
| | Heart disease | Heart disease deaths-County | |
| | Stroke | Stroke deaths-County | |
| | Poor physical health (days per month) | | |
| | Obesity, Adult | Adult | |
| | Obesity, Childhood | Childhood | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | Population with any disability | | |
| | Prevention of chronic disease | | |
| Cancer | General reference | | |
| | Breast cancer incidence-County | | |
| | Colorectal cancer incidence-County | | |
| | Cancer deaths-County | | |
| | Lung cancer incidence-County | | |
| | Prostate cancer incidence-County | | |
| COVID'-'19 | | | Lasting or current health impacts of COVID'-'19. This applies both to communities and the Health System. |
| Economy-Income-Employment | Economy-Income-Employment | | Economy, poverty, income, or employment related issues impacting the community. |
| | Disparity Measures | Children living in poverty-Tract | |
| | Disparity Measures | Poverty rate | |
| | Disparity Measures | Unemployment rate/ underemployment rate | |
| | Disparity Measures | Income inequality - Gini index-Tract | |
| | Disparity Measures | Young people not in school and not working-Tract | |
| | Disparity Measures | Jobs Proximity Index-Tract | |
| | Disparity Measures | Median household income-Tract | |
| | Disparity Measures | Neighborhood Deprivation Need Rating-Tract | |
| Housing | Housing Cost | Moderate housing cost burden-Tract | |
| | Housing Cost | Severe housing cost burden-Tract | |
| | Housing Cost | Median rental cost-Tract | |
| | Housing Cost | Home ownership rate-Tract | |
| | Housing Cost | Housing affordability index-Tract | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | Housing Cost | Percent of income for mortgage-Tract | |
| | Housing Availability | | |
| | Homeless/housing | | Housing or homelessness issues impacting the community. |
| | Housing instability/ Temporary/ Alternative Housing | | |
| Technology Access | Phone/ General | | |
| | High speed internet-Tract | Broadband access or speed | |
| Food and Nutrition Security/ Access | Food and Nutrition Security/ Access | | |
| | Food and Nutrition Security/ Access | SNAP enrollment-Tract | |
| | Food and Nutrition Security/ Access | Convenience stores per 1,000 pop-County | |
| | Food and Nutrition Security/ Access | Grocery stores per 1,000 pop-County (AVAILABILITY?) | |
| | Food and Nutrition Security/ Access | Low access to grocery store-County (ACCESS?) | |
| | Food and Nutrition Security/ Access | Supercenters & club stores per 100,000 pop-County | |
| | Food and Nutrition Security/ Access | Food insecure | |
| | Food and Nutrition Security/ Access | Free and reduced price lunch | |
| | Food and Nutrition Security/ Access | Food pantry utilization | |
| | Food and Nutrition Security/ Access | Community issues pertaining to nutrition (access or behaviors related to food). | |
| New Issues | | New community health issues. | |
| Other Issues | Health issues | | Health or non-health issues that do not fit any of the other subcodes under Community Health. |
| | Non-health issues | | |
| Past Issues | | Past community health issues. Includes context of the issues | Whether issues have gotten better, worse, or stayed the same |
| Priority Issues | | Priority/top issues that must be addressed to improve community health. | |
| Transportation | Long Commute | Transportation-related issues impacting the community. | |
| | Workers driving alone | | |
| | Public Transit | | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | Active Transit | | |
| | Lack of Transportation | | Lack of reliable, consistent transportation for daily needs |
| Overall Health | | What makes a community healthy. Includes descriptions of whether the community discussed is healthy and supporting reasons. | |
| Priority Populations | | Populations within hospital service areas. Code health issues relevant to specific populations to child codes. | |
| Demographics | Adults | | Specific health issues in the community that impact adults (22'-'64). |
| | Asian/AAPI | | Specific health issues in the community that impact Asians, Asian American and Pacific Islanders (AAPI) peoples. |
| | Black/African American | | Specific health issues in the community that impact Black/AA peoples. |
| | Hispanic/Latinx | | Specific health issues in the community that impact Hispanic/Latinx peoples. |
| | Indigenous | | Specific health issues in the community that impact Indigenous peoples. |
| | Infants & Toddlers | | Specific health issues in the community that impact infants and preschool children, under 5. |
| | People with Disabilities | | |
| | Seniors | | |
| | White/Caucasian | | Specific health issues in the community that impact White/Caucasian peoples. |
| | Younger Children | | Specific health issues in the community that impact younger children, K'-'8th (5'-'13). |
| | Youth & Young Adults | | Specific health issues in the community that impact youth & young adults (14'-'21). |
| | immigrants | | |
| | LGBTQ | | |
| | Disparity Measures | low income | |
| | Disparity Measures | Population density-Tract | |
| | Disparity Measures | Population age 65+-Tract GROWTH OR DECLINE? | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | Disparity Measures | Population under age 18-Tract GROWTH OR DECLINE? | |
| | Disparity Measures | Total population-Tract | |
| | Disparity Measures | Total households-Tract | |
| | Disparity Measures | Premature death (YPLL)-County | |
| | Disparity Measures | Life expectancy-Tract | |
| | Disparity Measures | Food insecure | |
| Community Strengths/ Assets | Strengths/ Assets | Commitment | |
| | | Favorable climate/outdoor access | |
| | | melting pot/diverse people | |
| | | motivated/work hard/strong work ethic | |
| | | multigenerational/family focused | |
| | | non-profit organizations/collaborations | |
| | | care/respect for the land | |
| | | Care/help each other | |
| | | Strong hospital/healthcare system | |
| | | Focus on kids, elders | |
| Grady Actions | | | Desired, recommended, or existing health system actions (including their results or impact) to improve health or quality of life for community residents or populations in service areas. |
| Grady System needs | | | Needed improvements to Grady Health System or specific locations. This includes needed improvements to meet community health needs (e.g., changes to workflows or collaboration between service lines). |
| Clinical integration | | | Recommended action in support of the "clinical integration" tactic. |
| Data driven | | | Recommended actions in support of the "data'-'driven community health strategies" tactic. |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| Public policy and advocacy' | | | Recommended actions for Grady to take in support of the "public policy and advocacy" tactic. |
| Strategic partnerships | | | Recommended actions in support of the "strategic partnerships" tactic. |
| Thought leadership | | | Recommended actions in support of the "thought leadership" tactic. |
| MCH | Maternal Health | | Background (e.g., function, focus, operations), community'-'facing programs, data collected, and data needs specific to maternal/child health |
| | Low birth weight births-County | | |
| | Pre-term births-County | | |
| | Infant deaths-County | | |
| | pre/perinatal health concerns/ complications | | |
| | post-partum health concerns/ complications | | |
| | teen births | | |
| Sexual/ Reproductive Health | | | |
| | STD | Chlamydia incidence-County | |
| | STD | Gonorrhea | |
| | STD | Syphilis | |
| | STD | General prevalence/ Other | |
| | HIV/AIDS | prevalence | |
| | HIV/AIDS | in care | |
| | HIV/AIDS | deaths | |
| Community Outreach | | | |
| | data | | |
| | health condition/ health education related | | |
| | communication | | |
| | specific population related | | |
| Education | General | | |
| | Preschool enrollment-Tract (COST? QUALITY? AVAILABILITY?) | | |
| | On-time high school graduation-County | | |
| | Elementary school proficiency index-Tract | | |
| | Adults with some college education-Tract | | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | Adults with no high school diploma-Tract | | |
| Solutions | community health education<br>provider education/ communication<br>Strategies/ Partnerships/ Investments | improve health literacy health knowledge, peer learning<br>advisory councils<br>provide health services relevant to community/cultural/traditional beliefs & practices<br>develop jobs/career pathways to well-paying jobs in health care<br>engage in community to overcome mistrust<br>focus on social determinants of health<br>partner/collaborate with community organizations (new/better...)<br>focus on climate and health<br>focus on prenatal/infant /early childhood care<br>housing/homeless assistance<br>more accessible health care<br>more accessible mental health services<br>employment/income/financial assistance<br>form partnerships<br>add interpreters/language services<br>nutrition education /food programs<br>improve infrastructure (roads, sidewalks, facilities, etc.)<br>employ community health workers<br>care and housing for seniors<br>education- non nutrition related<br>transportation to services<br>Telehealth/ Telemedicine | |

| Grady CHNA 2025 Codebook | | | |
|---|---|---|---|
| **Primary Code** | **Subcode** | **Sub-subcode** | **Description** |
| | | Mobile Clinic | |
| | | Care Navigation in Community | |
| | | coordinate/align services/bridge silos | |
| | | multiyear funding | |
| | | data to inform practices/policies | |
| | | Policy creation/ support- State or Federal | |
| | | provide internet access | |
| | | Other: Strategies/ Partnerships/ Investments | |