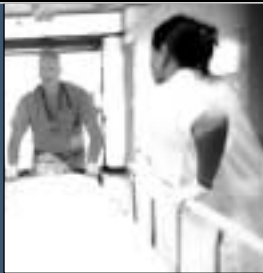


AN ASSESSMENT OF THE

SAFETY NET

in Atlanta, Georgia



Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

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The *Urgent Matters* safety net assessment team would like to thank our community partner, the National Center for Primary Care, for its help in identifying key safety net issues in Atlanta and connecting us with stakeholders in the community. At the National Center for Primary Care, George Rust, MD, MPH, FAAFP, was instrumental in coordinating our site visits, interviews and focus groups and an essential resource through the course of the project.

The National Center for Primary Care at the Morehouse School of Medicine promotes excellence in primary care practices and community health programs in an effort to eliminate health disparities in underserved populations. More information on the National Center for Primary Care can be found at www.msm.edu/ncpc/ncpc.htm.

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The Department of Health Policy is the home for health policy research and studies at the George Washington University Medical Center, School of Public Health and Health Services. The Department of Health Policy is dedicated to providing policymakers, public health officials, health care administrators, and advocates with the information and ideas they need to improve access to quality, affordable health care. This report and other *Urgent Matters* safety net assessments are available at the Department of Health Policy website www.gwhealthpolicy.org or the *Urgent Matters* website www.urgentmatters.org.

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By Jennel Harvey, MHSA
Marsha Regenstein, PhD
Karen Jones, MS

Urgent Matters
Safety Net Assessment Team
The George Washington University Medical Center
School of Public Health and Health Services
Department of Health Policy

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FOREWARD

After several years of decline, the number of Americans without health insurance is climbing rapidly. Meanwhile erosion in tax revenues is driving states to cut funding for Medicaid. Both trends are hitting all health care providers hard, as they simultaneously attempt to cope with a nursing shortage, escalating labor costs, and the adoption of expensive new technologies.

These forces are felt the most in the health care safety net. These providers of care for the poor, uninsured and other vulnerable populations have not had to face such a confluence of challenges in recent memory. They must survive in an industry in upheaval, while attempting to serve the ballooning numbers of our fellow Americans in need. They must also continue to provide a set of highly specialized services, such as burn, trauma and neonatal care to a broad swath of their local communities.

It is against this backdrop that we have assessed the “state of the safety net” in Atlanta. Due to the foresight of the Robert Wood Johnson Foundation, a team of researchers at The George Washington University Medical Center led by Marsha Regenstein, PhD, MCP, has assessed the health of the safety net in ten United States communities. In each community we worked with a Community Partner—a local organization that helped us to identify the key issues and stakeholders. In Atlanta, we are deeply indebted to the National Center for Primary Care at Morehouse School of Medicine. These community partners have also committed to convening opinion leaders and others in their region to discuss the implications of the reports’ findings. All of this was done as part of the *Urgent Matters* project, a national program designed to spur awareness of safety net issues while finding practical ways to relieve one symptom of distress—crowded emergency departments.

Our goal is to provide new analysis and information on what is happening today in the critical systems of care for the underserved in these communities. By doing so we seek to inform the health care discussions in these places and the nation, and to lay a foundation for rational change and improvement. We do not presume to know all the answers. But we believe that an objective analysis by an unbiased team can be immensely helpful to communities in need of a critical analysis of their safety net. This report seeks to meet this need.

Bruce Siegel, MD, MPH
Director, *Urgent Matters*
Research Professor
The George Washington University Medical Center
School of Public Health and Health Services
Department of Health Policy

EXECUTIVE SUMMARY

The *Urgent Matters* program is a new national initiative

of The Robert Wood Johnson Foundation, designed to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. *Urgent Matters* examines the interdependence between emergency department (ED) use and the health care safety net in ten communities throughout the United States. One component of this program was the development of comprehensive assessments of the safety nets in each of the ten communities that served as the focus of this study. This report presents the findings of the Atlanta, Georgia, safety net assessment.

Each of the *Urgent Matters* safety net assessments was prepared by a research team from The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the project staff from the hospitals selected for this study and a community partner. The Atlanta assessment draws upon information collected from interviews with senior leaders in the Atlanta health care community and from on-site visits of safety net facilities. The research team also met with key stakeholders in Atlanta as well as with residents who use safety net services.

To set the context for this study, the team drew upon secondary data sources to provide demographic information on the populations in Atlanta, as well as data on health services utilization, coverage statistics, and related information. The assessment includes an analysis of data that indicates the extent to which the emergency department at the Grady Health System provides care that could safely be provided in a primary care setting.

This report examines issues that shape the health care network available to uninsured and underserved residents in Atlanta. It provides background on the Atlanta health care safety net and describes key characteristics of the populations served by the safety net. It then outlines the structure of the safety net and funding mechanisms that support health care safety net services. The report also includes an analysis of challenges facing providers of primary and specialty care services and specific barriers that some populations face in trying to access them.

KEY FINDINGS AND ISSUES FOR CONSIDERATION: IMPROVING CARE FOR UNINSURED AND UNDERSERVED RESIDENTS OF ATLANTA

The safety net assessment team's analysis of the Atlanta safety net generated the following key findings:

- The viability of Grady Health System is crucial to the Atlanta health care safety net. Grady's base of financial support, however, is being chipped away, challenging its ability to provide care for the residents of Fulton and DeKalb counties. In terms of access to specialty and diagnostic services, Grady is virtually the sole source of care for the uninsured and underserved in a vast expanse that is much broader than its official service area.
- Low-income and uninsured residents of Atlanta appear to have numerous options for accessing primary care services. Primary care providers in private practices and clinics, in community health centers, and in hospital outpatient departments actively compete for Medicaid and privately insured patients. They also compete for some uninsured patients who pay out-of-pocket for certain services. These competitive forces create disincentives for collaboration and coordination across providers.

- Despite the availability of primary care, a significant percentage of emergency department visits at Grady Health System are for patients whose conditions are non-emergent. Over one-quarter (26 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions. Nearly another quarter (23.6 percent) were for patients whose conditions were emergent but could have been treated in a primary care setting.
- Access to specialty care, mental health services and dental care is extremely limited for uninsured and low-income individuals in Atlanta. The Grady Health System provides the largest volume of specialty services to these individuals but is overburdened and patients often face long waits to receive needed care. The shortage of dentists who care for uninsured and low-income populations is particularly acute; it is not uncommon to see unused dental operatories in clinics and other settings because of provider unavailability.
- Referral arrangements across primary and specialty care providers are haphazard and at times misaligned. Some of this dysfunction is a result of the competitive environment that creates incentives for specialty or other providers to “hold onto” patients instead of referring them back to their original or primary care provider.
- These competitive forces notwithstanding, some of the difficulty associated with referring patients across services is the result of deep and longstanding distrust within the safety net provider community. As long as such feelings continue, efforts to coordinate care, leverage scarce resources and build strong networks will fail to result in meaningful improvements for Atlanta residents who depend on safety net services for their care.
- The Atlanta area has the resources and expertise to create a more cohesive network of safety net providers. Such an effort could better leverage the resources in the community to work more effectively on behalf of low-income and uninsured Atlanta residents.

The Urgent Matters safety net assessment team offers the following issues for consideration:

- Safety net providers in Atlanta should make a commitment to work together on behalf of uninsured and underserved residents. The Grady Health System, other hospitals, FQHCs, faith-based clinics and other providers are all dedicated to serving safety net populations, but have not developed meaningful connections to facilitate access, coordinate services, or enhance continuity of care for their patient populations.
- A working group of safety net providers should be formed to develop proposals to improve coordination and integration of existing resources. With increasingly limited funding to the safety net, Atlanta providers must develop mechanisms to stretch tight resources and manage current services more effectively.
- The safety net providers in Atlanta should undertake a study of the availability of specialty care for uninsured and underserved residents and identify mechanisms to link patients in need of care with providers. Given the resources in the safety net and the numbers of medical and surgical specialists in the Atlanta area, better access to timely and affordable specialty care should be possible.
- The implications of a decade of steadily declining funding to the Grady Health System are not fully understood and should also be the subject of a thorough study and review.
- Any consideration for growth in service delivery for uninsured and underserved residents should prioritize mental health and dental services. Efforts to expand primary care capacity should be directed toward services that are undersupplied in the marketplace.
- As Atlanta's communities become more diverse in terms of language and ethnicity, safety net providers must develop programs to provide language services, health education, and culturally appropriate outreach that effectively meet the needs of the population.



INTRODUCTION

In 2000, the Institute of Medicine (IOM) published a report on the health care system serving uninsured and underserved individuals in the United States. Entitled *America's Health Care Safety Net: Intact but Endangered*, the report examined the viability of the safety net in the face of major changes in the financing and delivery of health care. The IOM report concluded that the safety net in America is under significant pressure from changing political and financial forces, including the growth in the number of uninsured, the reduction or elimination of subsidies funding charity care, and the growth of mandated managed care.

The Robert Wood Johnson Foundation established the *Urgent Matters* program in 2002 to further study the dynamics of the health care safety net. While the IOM report focused its review principally on ambulatory and primary care settings, the *Urgent Matters* program takes IOM's research a step further and examines the interdependence between the hospital emergency department (ED)—a critical component of the safety net—and other core safety net providers who “organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.”¹

The purpose *Urgent Matters* is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. The program consists of three key components: 1) technical assistance to ten hospitals whose EDs serve as critical access points for uninsured and underserved patients; 2) demonstration grants to four of these ten hospitals to support innovative and creative solutions to patient flow problems in the ED; and 3) comprehensive assessments of the safety nets

The purpose Urgent Matters is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents.

in each of the communities that are home to the ten hospitals. This report presents the findings of the safety net assessment in Atlanta, Georgia.

Each of the *Urgent Matters* safety net assessments has been prepared by researchers at The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the hospital ED project staff and a community partner—an organization that is well positioned to convene key stakeholders in the community to work together to strengthen safety net services on behalf of community residents. The *Urgent Matters* grantee hospitals and community partners are listed on the back cover of this report.

These assessments have been developed to provide information to communities about the residents who are most likely to rely on safety net services. They are designed to highlight key issues affecting access to care for uninsured and underserved residents, as well as to identify potential opportunities for improvement.

The safety net assessments were conducted over the summer and fall of 2003. Each assessment draws upon information developed through multiple sources.

The Atlanta assessment team conducted a site visit on August 18-21, 2003, touring safety net facilities and speaking with numerous contacts identified by the community partner and others. During the site visit, the community partner convened a meeting of key stakeholders who were briefed on the *Urgent Matters* project, the safety net assessment, and the issues under review. This meeting was held on August 18, 2003, at the National Center for Primary Care.



Through the site visits and a series of telephone conferences held prior to and following the visit to Atlanta, the assessment team interviewed many local informants, including senior leaders at hospitals and health systems, community health centers and other clinics, public health and other service agencies and mental health agencies. Individual providers or provider groups, advocates, and policymakers were interviewed as well. The team also drew upon secondary data sources to provide demographic information on the population in Atlanta as well as data on health services utilization and coverage.

While in Atlanta, we conducted two focus groups with residents who use safety net services. One of the focus groups was held in Spanish and the other was in English. The assessment team worked with the community partner to recruit patients who were likely to use safety net services. The assessment also included an application of an ED profiling algorithm to emergency department data from the Grady Health System. The algorithm classifies ED encounters as either emergent or non-emergent cases.

Section one of the Atlanta safety net assessment provides a context for the report, presenting background demographics on Atlanta, DeKalb, and Fulton Counties. It further describes the structure of the safety net, identifying the providers and facilities that play key roles in delivering care to the underserved. Section one also outlines the financial mechanisms that support safety net services. Section two discusses the status of the

safety net in Atlanta based on the site visits, telephone conferences and in-person interviews. This section examines challenges to the safety net, highlighting problems in access to needed services, growing burdens on hospital emergency departments, stresses on safety net providers, declining rates of insurance coverage, and other barriers to care faced by the underserved.

Section three presents findings from the focus groups and provides insights into the challenges that uninsured and underserved residents face when trying to access services from the local health system. Section four includes an analysis of patient visits to the emergency department at the Grady Health System. This analysis includes demographic information on patients who use the emergency department and examines the extent to which the emergency department at the Grady Health System may be providing care that could safely be provided in a primary care setting. Finally, Section five presents key findings and issues that safety net providers and others in the Atlanta area may want to consider as they work together to improve care for the uninsured and underserved residents in their communities.



BACKGROUND

Atlanta, located in northern Georgia in Fulton and DeKalb Counties, is one of the fastest growing cities in the U.S. Over the past decade, the population in Fulton and DeKalb Counties grew over 25 and 21 percent, respectively,² and over a 15-month period in 2001-2002, Atlanta's population increased 2.1 percent.³ The city is the headquarters for large corporations such as CNN and Delta Airlines, government agencies such as the Centers for Disease Control and Prevention, and academic institutions such as Emory University and Morehouse School of Medicine. In addition, the city experienced many new opportunities for growth and development as a result of its hosting the 1996 Summer Olympics.

Table 1 A Snapshot of Atlanta, Fulton and DeKalb Counties, and Georgia

Select Demographics, 2002	Atlanta	Fulton County	DeKalb County	Georgia
Population	382,831	794,254	663,118	8,186,453
Density: Persons/square mile	N/A	1,543.5	2,482.7	141.4
Race				
White	38.9%	50.9%	35.4%	65.2%
Black	58.6%	43.7%	56.4%	28.3%
Asian	1.8%	3.4%	3.9%	2.3%
Other ⁴	0.7%	2.0%	4.2%	4.2%
Latino origin and race	5.7%	6.8%	9.2%	6.0%
Birthplace/Language				
Foreign born	6.3%	10.4%	15.1%	7.7%
Language other than English spoken at home	10.1%	13.4%	16.9%	9.9%
Age				
18 years and over	75.1%	74.4%	74.8%	72.8%
65 years and over	9.2%	8.1%	7.4%	9.2%
Median age (in years)	32.4	33.3	33.2	33.7

Source: 2002 American Community Survey, U.S. Census Bureau, 2003.

N/A: Data not available.

Atlanta and the two counties that house most of its residents, Fulton and DeKalb, are more diverse in terms of the racial/ethnic composition of the population than the state of Georgia.⁵ Nearly three out of five Atlanta residents are black as are nearly the same proportion of DeKalb County residents, compared to about two of five residents in Fulton County, and about one in four in the state. Fulton and DeKalb Counties also have growing Latino populations. Georgia's Latino population has grown more than 300 percent over the past decade.⁶ Ten percent of Fulton County residents were born in countries other than the U.S. and 13.4 percent speak a language other than English in the home (see Table 1). In DeKalb County, 15.1 percent of residents were foreign born and nearly 17 percent speak a language other than English in the home. In Fulton County, about half of the foreign born population are from Latin America and 25 percent are from Asia.⁷ Over 60 percent of foreign-born residents have been in the U.S for less than 10 years and less than 30 percent are naturalized citizens.

Table 2 Income, Poverty Levels and Insurance Coverage in Atlanta, Fulton and DeKalb Counties, and the State of Georgia

	Atlanta	Fulton County	DeKalb County	Georgia
Income and Poverty				
Living below poverty [^]	25.9%	15.7%	9.7%	13.1%
Median household income	\$39,802	\$47,482	\$42,536	\$42,069
Insurance Coverage[#]				
Commercial	N/A	59.7%	61.2%	61.4%
Medicare	N/A	9.4%	9.0%	10.5%
Medicaid and PeachCare [*]	N/A	13.6%	12.7%	12.3%
Uninsured	N/A	17.2%	17.1%	15.8%

Source: U.S. Census, 2002, American Community Survey Data unless otherwise noted.

[^] Percent living below poverty in past 12 months.

[#] Source: Resources to Expand Access to Community Health (REACH) Data, 2000, National Association of Community Health Centers.

N/A indicates that the data are not available.

^{*} PeachCare is Georgia's State Children's Health Insurance Program.

Table 2 presents income and poverty level data and insurance coverage for Atlanta, Fulton County, DeKalb County and Georgia. One out of six residents in both counties are uninsured; county residents are more likely than residents statewide to be uninsured (about 17 compared to 15.8 percent).⁸ Likewise, higher percentages of Fulton County residents are covered by public programs compared to residents statewide (13.6 versus 12.3 percent) or residents in DeKalb County (13.6 versus 12.7 percent).^{9,10}

Atlanta and Fulton and DeKalb Counties have significant concentrations of poverty. Residents in Atlanta have a median income of \$39,802, which is \$7,680 less than the median income in Fulton County.¹¹ According to estimates from the U.S. Census Bureau, 25.9 percent of residents in Atlanta are living in households with incomes below the federal poverty level.¹² This figure is much higher than the percentage in Fulton County (15.7 percent), the State of Georgia (13.1 percent), or DeKalb County (9.7 percent).

Like so many other states in the country, the Georgia economy has been affected by the downturn in the U.S. economy. In 2002, the state tapped \$620 million of its reserves to balance its budget.¹³ Currently, the state is facing a projected budget shortfall of between \$440 million and \$1 billion.¹⁴ State agencies have already cut their budgets by 2.5 percent and are being required by Governor Sonny Perdue to cut an additional 5 percent for a projected savings to the state of more than \$300 million in spending in 2004. In response to mandated cuts, several state agencies have considered furloughing employees and downsizing agencies. In fact, South Georgia's health departments are reviewing proposals to cut health department hours of operation as well as the pay of over 300 employees.¹⁵ Other state agencies, including the Department of Corrections, have already implemented one day every other month furloughs of their 5,000 employees. Proposals to increase state revenue include casino gambling in certain counties.¹⁶

Table 3 lists the ten largest employers in both Fulton and neighboring DeKalb Counties.^{17,18} Included among these employers is the Grady Health System, which is also one of the top five employers in Fulton County.¹⁹ Fulton County's economic health is critical to the greater Atlanta area, since 70 percent of Fulton County residents and 37 percent of Dekalb residents are employed in Fulton County. In comparison, 13 percent of Fulton county residents and 47 percent of Dekalb residents are employed in Dekalb County.²⁰

Close to 9 percent of Fulton County residents age 16 and over are unemployed, up from only 3.7 percent in 1997.²¹ Proportionally fewer residents (about 5.5 percent) are unemployed statewide. Approximately 94,000 Georgians were laid off in 2002; most of these individuals live in the metro Atlanta area.²²

Table 3 Ten Largest Employers in the Atlanta Area, 1997

Employer	County
AT&T Communications	Fulton
Bellsouth	DeKalb
Coca Cola Company	Fulton
Cox Enterprises	Fulton
Delta Airlines	Clayton/Fulton
Emory University	DeKalb
General Motors Corporation	DeKalb
Georgia Institute of Technology	Fulton
Grady Health System	Fulton
Lockheed Corporation	Cobb

Source: Georgia Department of Labor, *Fulton County Employment, 1997*.

STRUCTURE OF THE SAFETY NET

Fulton County has a relatively high supply of primary care and specialty physicians compared to statewide and DeKalb County figures (see Table 4). There are proportionally more than twice as many adult primary care providers in the county compared to the state, more than two and a half times as many pediatricians, obstetricians and gynecologists, and surgical specialists, and over three times as many medical specialists compared to state figures. Fulton County also has proportionally higher rates of inpatient beds, hospital admissions and emergency department visits, compared to state rates and to neighboring DeKalb County.

Table 4 Physician and Hospital Supply, Fulton and DeKalb Counties and Georgia

Supply Capacity	Fulton County	DeKalb County	Georgia
Physician supply (per 100,000 population) [^]			
Adult primary care providers	138.2	56.6	66.6
Pediatricians	152.3	76.2	56.0
OB/GYN	85.0	25.4	31.6
Medical specialist	71.8	22.0	22.3
Surgical specialist	93.4	26.4	34.6
Supply/utilization (per 1,000 population)			
Inpatient beds	3.79	1.63	2.59
Admissions	152	70	97
ED visits	399	172	346

Source: Data are for 1999. Billings and Weinick. *Monitoring the Health Care Safety Net Book II: A Data Book for States and Counties*, Agency for Healthcare Research and Quality, 2003.

[^] Figures apply to 100,000 persons who would be the provider's patient population. Adult primary care providers represent the number of providers per 100,000 individuals 18 years of age.

There are 18 hospitals located within the city of Atlanta and over 3,000 physicians and 650 dentists.²³ The Atlanta metro area has 63 hospitals and 85 nursing homes; over 4,000 physicians are located in the metro area along with 1,350 dentists.²⁴ In terms of dental supply, Georgia has over 4,000 licensed dentists; 73 percent are in general dentistry and 27 percent practice in the Atlanta metro area.²⁵

Grady Health System: The Grady Health System is the centerpiece of the Atlanta safety net. Grady consists of Grady Memorial Hospital, the Hughes Spaulding Children's Hospital, nine primary care clinic sites, many subspecialty clinics and an urgent care center. Grady operates the only Level 1 trauma center in the greater Atlanta region. Grady provides a significant amount of the uncompensated care delivered each year to the residents of Georgia. Statewide, Georgia

hospitals provided nearly \$1 billion in uncompensated care in 2001;²⁶ approximately one-quarter of that care (\$245 million) was provided by Grady.²⁷

Grady Memorial Hospital has 748 staffed beds.²⁸ One-third of Grady's discharges are for patients who are uninsured and another 37 percent are for patients covered by Medicaid. Only 10 percent of discharges are for commercially insured patients and 20 percent are for patients on Medicare.²⁹ Grady also operates

One-third of Grady's discharges are for patients who are uninsured and another 37 percent are for patients covered by Medicaid.



very busy ambulatory clinics. Grady provided over 800,000 outpatient visits in 2003, split fairly evenly across primary care and specialty services.³⁰ More than half of these visits were for uninsured patients.³¹

Other Safety Net Providers: Several other area hospitals and clinics provide care to uninsured and underserved Atlanta residents. Among these are Children's Healthcare of Atlanta,³² Southwest Community Hospital, South Fulton Hospital, and DeKalb Medical Center. In addition to these hospitals, there are three Federally Qualified Health Centers (FQHCs) that are central to the health care safety net.³³ These include the West End Medical Center, the Southside Medical Center and Oakhurst Medical Center. West End serves approximately 23,000 patients per year, over half of whom have incomes under 100 percent of poverty.³⁴ Southside sees about 28,000 patients per year, about half of whom are uninsured. Oakhurst, located in DeKalb County, serves a largely uninsured and Medicaid-covered population and provided about 18,000 patient visits in 2003.³⁵

In addition to Grady's clinics and the FQHCs, two faith-based organizations also deliver services to the uninsured in Atlanta. St. Joseph's Mercy Care provides primary care, health education and social services primarily to homeless individuals through mobile units and clinics that are located within other agencies. St. Joseph's sees about 11,000 patients per year.³⁶ The Good Samaritan Health Center provides medical and dental services to uninsured residents. Good Samaritan provided services to about 16,000 patients in 2003; during that time, its dental clinic provided over 22,000 dental encounters.³⁷ Several other private clinics have developed busy practices serving largely immigrant patient populations and charging competitive rates for prenatal care and other primary care services.

Public Health: The Georgia Department of Health also plays a role within the Atlanta safety net. All health department facilities within Fulton and DeKalb Counties provide some aspect of primary care that tends to focus on preventive services for women and children.

Statewide, more than 400,000 clinic services were provided by the county health departments in 2002.³⁸ For example, the Health Department in DeKalb County provides traditional public health services as well as preventive and broader medical services in six clinics, some of which are operated in collaboration with Grady Health System. The Fulton County Health Department provides population specific and traditional public health services such as adult male health and women's health services and STD screening and treatment.

Behavioral Health Care: Behavioral health services for the uninsured are provided through the individual counties. The state Department of Human Resources oversees the state's mental health system; each county has a mental health board that coordinates general mental health, mental retardation and substance abuse services. Grady Health System is the primary provider of mental health services for the uninsured as services are provided through its network of community health centers. In addition, Grady operates the only emergency intake mental health facility for uninsured residents in Atlanta. Primary mental health services for adults and children are provided on Grady's main campus and a few satellite primary care sites provide services for children. Limited mental health services are also available through FQHCs or faith-based clinics that see uninsured and underserved patients.

Dental Care: Several safety net providers offer dental services for uninsured and underserved patients. For example, several FQHC sites, the Grady Health System/Fulton County Health Department community sites, and the Good Samaritan Health Center run dental clinics primarily for uninsured patients. Primary dental services are provided in Ryan White care programs at Grady as well as at the Hughes Spaulding Children's Hospital. The Fulton County Health Department operates a dental clinic one day per week in one FQHC that is funded through a Community Access Program³⁹ grant. The DeKalb County Department of Health operates a dental care program with sliding scale fees in facilities where services are delivered by staff dentists.

In addition to direct service providers, Atlanta includes a well-developed research environment that addresses issues related to the health status of individuals in the area. The National Center for Primary Care, housed at Morehouse School of Medicine and headed by former U.S. Surgeon General David Satcher, concentrates on program development and policy analysis to eliminate

health disparities nationwide. The Centers for Disease Control and Prevention, and other research organizations such as Emory and Clark Universities and the University of Georgia focus on health status assessment, gauging access to health services, and other topics related to the health and well-being of area residents.

FINANCING THE SAFETY NET

The safety net in Atlanta is funded through multiple sources including federal, state and local dollars:

Local Support to Grady Health System: The Grady Health System receives funding from DeKalb and Fulton Counties as part of a 30-year contractual agreement that is set to expire in 2013. The agreement mandates that uninsured patients be seen on a sliding fee scale according to federal poverty guidelines. This means that uninsured patients who have incomes under 100 percent of the federal poverty level receive care at Grady on a reduced fee basis. Other uninsured patients are billed for services, although many of these patients are unable to cover the costs of care and add to the uncompensated care provided each year.

DeKalb and Fulton Counties divide the costs of care according to a formula based on the number of patients from each county who are served by Grady. County funding represents 18-20 percent of Grady's total budget and is appropriated and approved by both counties' Boards of Commissioners each year. Grady is extremely dependent on county funds to operate. In 2003 DeKalb County provided \$22.3 million; this amount is \$700,000 less than Grady's requested amount and \$1.5 million less than the county provided a decade earlier.⁴⁰ DeKalb has proposed an allocation of \$21.6 million for 2004.⁴¹

Table 5 Grady Health System Funding from Fulton and DeKalb Counties, 1994, 1999, 2004 (projected) in Millions*

	1994	1999	2004 (Projected)	Percent Change 1994-2004	Percent Change 1994-2004, Adjusted for Medical Inflation
Fulton County	\$83.1	\$73.5	\$79.8	(4.0)	(40.8)
DeKalb County	\$23.9	\$21.5	\$21.6	(9.6)	(55.7)
Total	\$107.0	\$95.0	\$101.4	(5.2)	(48.5)

Source: Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004. See also Fulton County Tentative FY2004 Budget presented to the Fulton County Board of Commissioners.

* Values in parentheses represent negative numbers.

Grady receives about three times this amount from Fulton County and, like DeKalb's allocation, this amount has been decreasing steadily over the past decade (see Table 5). Fulton's proposed allocation for 2004 is \$79.8 million, down \$1.7 million from 2003 and 4.0 percent lower than a decade earlier.

The decreases are even greater when adjusted for medical inflation. Grady's funding from Fulton and DeKalb Counties has decreased nearly 50 percent in real dollars over the past decade. If Grady's funding had stayed flat, rising only to keep step with the consumer price index for medical services, its 2004 funding from the two counties would be \$142.7 million.⁴²

These decreases in funding are resulting in immediate cuts to the Grady workforce. In December 2003, the Grady Health System announced that it will lay off up to 300 employees, or close to 6 percent of its total workforce.⁴³ This move is part of a package of cuts designed to reduce costs by \$11 million.

The Indigent Care Trust Fund (ICTF): The Georgia Disproportionate Share Hospital (DSH)⁴⁴ payment program operates through the Indigent Care Trust Fund (ICTF). ICTF has been in existence for 12 years and is administered through the Department of Medical Assistance, which also manages the Medicaid and State Children's Health Insurance Programs. ICTF is funded through voluntary intergovernmental transfers or contributions from participating public hospitals and other government entities and matching federal funds. The Georgia Department of Medical Assistance requires that each hospital use 15 percent of its ICTF to expand primary care in its community; only one-third of this amount may be spent on capital costs, such as building a primary care center at the participating hospital. In FY 2002, 89 qualifying hospitals (statewide) participated in ICTF and shared a total of \$433.5 million.⁴⁵ Grady Health System received approximately \$132 million in FY 2002, the largest amount given to any single hospital in the state. The second largest amount, \$49.5 million, went to Medical College of Georgia Healthcare, located in Richmond County.⁴⁶ Table 6 lists the hospitals in Fulton and DeKalb Counties that received ICTF funding in 2002 and the primary care funding associated with the payments.

Table 6 Fulton and DeKalb County Hospitals Receiving ICTF Funding, 2002

Hospital	County	ICTF Funds (Dollars in Thousands)	Funding for Primary Care (Dollars in Thousands)
Grady Health System	Fulton	\$132,000	\$19,800
Atlanta Medical Center	Fulton	7,700	1,155
Children's Healthcare of Atlanta at Egleston	DeKalb	7,500	1,125
DeKalb Medical Center	DeKalb	5,800	870
Hughes Spalding Children's Hospital	Fulton	4,800	720
Crawford Long Hospital	Fulton	4,200	630
South Fulton Medical Center	Fulton	2,500	375
Children's Healthcare of Atlanta at Scottish Rite	Fulton	2,200	330
Southwest Hospital and Medical Center	Fulton	1,200	180

Source: State Fiscal Year 2002 Annual Report. Georgia Department of Community Health. www.communityhealth.state.ga.us.

In addition to these sources, Georgia's public health infrastructure also receives support from a state-sponsored funding program, known as General Grants in Aid, and special categorical program funding, such as the Ryan White Program. The Department of Health has begun to institute additional use fees to support several of its programs that cannot be continued on current levels of county or state support.

Medicaid: In 2002, the state Medicaid program provided services for approximately 1.37 million Georgia residents.⁴⁷ The program covers pregnant women and children under the age of 1 who live in households with incomes up to 185 percent of the FPL; children ages 1-6 are eligible up to 133 percent of poverty and children between ages 6 and 19 are eligible up to 100 percent of poverty. The number of Medicaid recipients increased by nearly 10 percent over the 2001-2002 period.⁴⁸

According to the Department of Community Health, approximately 153,000 Fulton County residents received Medicaid services in FY 2002 at a cost of \$406.6 million. An additional 100,280 DeKalb County residents also received Medicaid services, which totaled approximately \$275 million. Over 11 percent of the Medicaid recipients in the state reside in Fulton County.⁴⁹ Current budget pressures at the state level have resulted in recommended changes to the Governor's budget that would lower income eligibility, potentially disenrolling thousands of children and pregnant women from the Medicaid program. These cuts would be on top of proposed decreases in funding for adult dental services.

State Children's Health Insurance Program (SCHIP)/PeachCare: PeachCare covers children from birth through age 18 who live in households with family incomes at or below 235 percent of the federal poverty level. Families with children ages 6 through 18 are subject to a monthly premium; this premium was increased recently, and varies depending on household income.⁵⁰ PeachCare is administered as a separate SCHIP plan that offers coverage that is very similar to the Medicaid program, with the exception of a few services.⁵¹ For example, PeachCare does not cover emergency transportation, targeted case management, and some services

that, if required and found eligible, would essentially qualify a child for Medicaid by virtue of a disability.⁵² According to the Department of Community Health, the vast majority of eligible children are enrolled in the program. Approximately 13,000 children in Fulton County and 18,000 children in DeKalb County received services from PeachCare in 2002; payments for such care totaled nearly \$8.5 million and \$11.7 million, respectively.⁵³

Both the Medicaid program and PeachCare are facing significant budget shortfalls. The Medicaid program projects a \$172 million shortfall for fiscal year 2004; estimates for FY 2005 are twice as large if spending continues at current levels.⁵⁴ PeachCare projects a shortfall of \$17 million in FY 2004 and an additional \$30 million in FY 2005. The Department of Community Health is considering a number of changes to cut costs and slow growth in both programs.

Community Access Program (CAP): CAP grants are awarded by the federal Health Resources and Services Administration to help health care providers coordinate safety net services for uninsured and underinsured populations. The Fulton County Government Board of Commissioners is the grantee for Georgia's most recent CAP grant of \$998,000. The program, the Atlanta Community Access Coalition (ACAC), is a coalition of twelve health care and social service agencies that was formed to develop plans for a community based health care system designed to improve access to health care services throughout Fulton and DeKalb Counties for uninsured and underinsured residents. ACAC plans to develop a shared, Internet-based management information system that can provide a uniform referral and intake process and provide coordinated medical and psychosocial services for participating patients. ACAC has adopted PATHWAYS COMPASS®, a case-management system that utilizes the latest secure technology to make client information readily available. A portion of the funding has also been used to establish a dental clinic within one of the county's community clinics. Services are offered one day a week; to date, the clinic has served approximately 300 adult patients.⁵⁵

The safety net assessment team conducted interviews with key stakeholders in the Atlanta health care community and visited several safety net facilities. Our analysis of the Atlanta safety net was greatly informed by the interviews with safety net providers and local stakeholders. Informants discussed important changes in local health policy and programs, emergency department use and crowding, issues related to access to care, and significant barriers that patients face.

ACCESS TO CARE

The Atlanta safety net has experienced a steady erosion in funding aimed at care for uninsured and underserved residents. This is especially visible in funding for the Grady Health System, which has diminished over the past decade despite growing demand for its services. Stagnant revenues, increased costs associated with pharmaceuticals, and cuts to funding have hit Grady particularly hard; Grady recorded losses of \$33 million in 2002 and ended 2003 with an additional loss of close to \$30 million.⁵⁶

Grady recently made several difficult decisions designed to stave off further threats to its financial viability. A substantial amount of care provided by Grady to uninsured residents is supported by DeKalb and Fulton Counties and, although the majority of Grady's patients reside in these two counties, large numbers of uninsured patients from adjacent counties are seeking care at Grady as well. Grady operates the only Level 1 trauma center in northern Georgia and one of two burn units in the entire state. These services alone make Grady a magnet for complex cases statewide. In 2004, Grady will stop providing free care to uninsured patients who live outside of DeKalb and Fulton Counties. Grady will continue providing free care to uninsured patients who require trauma services or emergency care.

Grady is tightening its own belt as well, with the layoff of close to 6 percent of its workforce.⁵⁷ Although Grady promises that these layoffs will not involve direct health care providers, such a move comes at a time when pressures on the state and local economies are likely to increase demand for safety net services.

The Atlanta safety net has experienced a steady erosion in funding aimed at care for uninsured and underserved residents.

Grady and other safety net providers have also been hit by cuts in Medicaid payments and there are indications that these programs will be cut back even further. The Georgia Department of Community Health, which runs the Medicaid and PeachCare programs, has identified four goals for the coming year—to increase access to health insurance for Georgians; capitalize on the efficiencies of the public and private sectors; maximize federal funds; and enhance the safety net infrastructure.⁵⁸ These are clearly challenging goals, especially given budget pressures at state and local levels. Georgia has been a model for SCHIP enrollment and currently ranks fourth in the nation in numbers of enrolled children.⁵⁹ The state budget deficit, however, threatens to constrain growth in both Medicaid and PeachCare. The Department of Community Health began fiscal year 2004 with a deficit because of a \$150 million reduction in its state appropriated budget. Estimates indicate that the programs will show a \$493 million deficit in FY 2003; this deficit is projected to grow to \$1 billion by FY 2005.⁶⁰

The Department of Community Health is currently weighing options regarding its mandated budget cuts that include cutting enrollment and optional services for both programs. The state spends about \$1.66 billion for optional services such as pharmacy services, dental care and podiatry. Some of these services are already among a proposed set of cuts included in the Governor's budget.

PeachCare's costs also continue to grow, in part because of higher-than-anticipated enrollment, which exceeded its budgeted allocation at the state level.⁶¹ Recent increases in premiums, from \$7.50 to \$10 and from \$15 to \$20 per month, depending on income and the age and number of eligible children, are an attempt to capture some of the costs of care but may also serve as a disincentive to enrollment. Other changes being considered include instituting a one-month waiting



period following enrollment for benefits to begin and instituting a six-month waiting period for those who drop private health insurance to join PeachCare.

The state has also renewed its interest in developing capitated managed care products for the Medicaid program in the Atlanta area. In the past, the state's Medicaid population could enroll in a managed care plan on a voluntary basis. Such an arrangement resulted in low Medicaid managed care enrollment, which in turn caused managed care plans to withdraw from the market.⁶² With increasing pressures to reduce Medicaid expenditures, there are indications that the state may turn again to managed care as a way to stem cost escalation.⁶³ Such a move could take place as early as FY 2005.⁶⁴

PRIMARY AND SPECIALTY CARE

The Atlanta area has a large number of health care providers who see uninsured and underserved patients. In fact, many safety net providers are under capacity and actively market their services to patients, regardless of their insurance status.⁶⁵ With no-show rates up to 50 percent of visits, providers have significant blocks of time that could accommodate many more patients. This is particularly true for primary care providers.

Residents in Atlanta have numerous sites of care from which to choose. FQHCs and other clinics that regularly see uninsured and underinsured patients are located in many Atlanta neighborhoods, making care fairly accessible. Relatively few sites have clinic hours in the evening or on the weekend, which can create access problems for residents who work during those hours or who cannot otherwise seek care during those time periods. One exception to this is La Clinica de la Mama, a private clinic that specializes in women's health and prenatal care. La Clinica is open seven days a week. The Good Samaritan Health Center is considering adding a Saturday clinic schedule to its current Monday through Friday operations.

Some residents have difficulty accessing care because of language barriers and seek out providers or organizations that employ interpreters or bilingual staff. According to informants, however, there are too few interpreters within the Atlanta safety net to handle what has been a rapid increase in the number of Spanish-speaking residents. Hospitals and community clinics are having difficulty finding bilingual clinical and administrative staff. La Clinica de Mama employs mostly Spanish-speaking staff and markets heavily to Latina residents, most of whom are uninsured but able to pay out of pocket for care at the clinic.

Unlike primary care, the availability of specialty care is extremely limited. According to informants, despite large numbers of medical and surgical specialists, few providers are available for uninsured and underserved Atlanta residents. Most safety net primary care providers refer patients to Grady for specialty care or sophisticated diagnostic services. The vast majority of this care takes place on the Grady main campus, adjacent to the hospital and emergency department.

As a teaching hospital, Grady benefits from large residency programs that provide opportunities for specialty care for patients. Even with these teaching programs and its own attending staff, Grady does not have the resources to provide all the specialty care that is needed. As a consequence, depending on the specialty and the needs of the individual patient, some patients must wait weeks or several months to obtain an appointment with a specialty provider. At the time of our site visit, appointments with ophthalmologist and gastroenterologists were particularly difficult to obtain.

Not surprisingly, some patients choose to go directly to the emergency department to obtain care. Reportedly, primary care providers often suggest that patients go to the ED if they need to access specialty care at Grady. An ED visit gets a patient into the Grady system and can result in a referral to a specialist provider. Grady also operates an urgent care clinic that accepts walk-ins from 7:00 am to 7:00 pm and is using an advice nurse as a point of entry to help ease the strain on Grady's outpatient clinics.

Residents who are covered by Medicaid or PeachCare also receive specialty care at Grady, as well as other sites in the Atlanta area. Primary care providers refer patients to Grady, local community hospitals and other specialists. Some of these private providers see uninsured patients as well, but generally in very small numbers. During our interviews, one of the most commonly mentioned concerns of primary care providers was their ability to link uninsured patients with timely and affordable specialty care.

While Grady was generally the place for specialty care for the uninsured, many primary care providers were reluctant to refer to Grady because of poor communication and ineffective referral mechanisms across Atlanta safety net providers.⁶⁶ Providers do not share information about patients and exist as parallel sources of care with little interaction between the parties. Referring physicians do not generally send patient information to specialist physicians; consequently, patients frequently repeat primary care visits or laboratory and diagnostic tests prior to seeing Grady specialists. Once seen, patients do not always return to their primary care physician and instead continue to receive primary and specialty care through Grady's on-site and community-based clinics. With primary care providers vying for patients, however, this situation creates discord across safety net providers and is not conducive to improving patient coordination and continuity.

Grady has plans to improve its ability to share information across its own sites of care that will eventually allow providers to access patient information on inpatient, ED, urgent care and primary care visits via a secure Internet site. Improved communication internally could also have benefits for sharing information with providers outside of the Grady Health System as well.

MENTAL HEALTH AND DENTAL CARE

Despite the availability of mental health services for the uninsured through Fulton County community clinics, many individuals have significant difficulties accessing care.⁶⁷ Community mental health services are not readily available to the uninsured, who often need several levels of review to access care and may require expensive behavioral health medications. Grady Health System operates a very busy on-site outpatient pharmacy where Grady patients can access pharmaceuticals with minimal co-payments. Because of the difficulty obtaining appointments with mental health professionals, many Atlanta residents with mental health needs delay care, try to obtain care through private providers, or forgo care completely.

Atlanta's safety net includes several sites that offer some dental services to uninsured residents; however, most are at capacity and not accepting new patients. In addition, several dental operatories are ready for patients but go empty because dentists and dental hygienists are unavailable to staff them. Patients with complex dental needs are referred to Grady Hospital where surgery is provided at the hospital's main campus. The wait time for a routine dental appointment varies, but generally ranges from three weeks for preventive care to about six months or more for certain services. Many individuals reportedly go without dental care for years. When one local provider opened its dental service to new patients, over 150 patients showed up at the site on the first day to try to access care.

COLLABORATION AMONG PROVIDERS

Despite facing many of the same challenges in treating uninsured and underserved populations, safety net providers have few mechanisms in place to work collaboratively on behalf of residents. Unlike some other communities that have developed a network in which providers meet regularly and share strategies associated with their safety net mission, members of the Atlanta safety net community operate quite independently, often with little knowledge or interest in other providers' programs or initiatives. Throughout our discussions with key stakeholders, we observed a distrust among safety net providers that inhibits progress in improving coordination of services and collaboration across delivery sites.

At least two factors work together to inhibit such collaboration. First, many safety net providers have been operating in the Atlanta area for long periods of time and have tried, unsuccessfully, to work together on past projects. Second, the Atlanta safety net is a competitive one, with multiple providers actively vying for patients. Throughout our interviews, we observed that many key stakeholders are reluctant to take the initiative to develop relationships with others in the safety net community.

Uninsured and underserved residents of Atlanta would benefit greatly, however, from such relationships. With increasingly tight state and local budgets, cuts to safety net providers, and growing demand for services, integration of existing resources is an essential component of a strategy to maintain a healthy and adequate safety net.



The safety net assessment team conducted two focus groups with residents who receive their care from safety net providers in the Atlanta area. The focus groups were held on August 20 and 21, 2003, at the Grady Health System and the Good Samaritan Health Center. Focus group participation was voluntary. Participants were recruited with the help of the local community partner, the National Center for Primary Care at the Morehouse School of Medicine, and involved displaying flyers announcing the sessions and their schedules. Participants received \$25 each in appreciation of their time and candor. A total of 20 individuals participated in the focus groups. One group was conducted in Spanish and one was in English.

The results of these groups illustrate the difficulties that many uninsured and underserved residents have in accessing timely and affordable health services in Atlanta. Their comments addressed issues related to primary care and prevention, access to specialty and inpatient services, their use of the ED for emergent as well as non-emergent care, their understanding of the health care system and the opportunities that are available to them, and their feelings about the provider community.

ACCESS TO HEALTH SERVICES

Focus group participants in both groups found primary care to be relatively easy to access, especially if they were familiar with the Grady Health System and its services. Many participants in the English-speaking group also received health services from FQHCs in Fulton or DeKalb County. Most of the participants found these services to be very accessible, although several stated that health centers⁶⁸ were not located in their neighborhoods. One focus group participant reported that she lived in Decatur but traveled to the health center in downtown Atlanta because none was available in her neighborhood. Another participant reported that providers are located too far apart, “I need one I can get to...they need to put [a health center] in every neighborhood.” Another participant reported that there were areas within the city where there were no health centers. This made getting to and from

appointments with doctors and other health care providers more difficult, although most of the participants said that this was a matter of convenience, not necessity.

The majority of patients in the Spanish-speaking focus group did not know the location of community sites affiliated with the Grady system or other community health centers in the area. They were generally unaware that they could be seen at some sites such as Federally Qualified Health Centers, regardless of their ability to pay. Most of these patients accessed care through the Grady ED or the International Clinic located on Grady’s main campus.⁶⁹

Participants who received care at community health centers reported that it was usually easy to get an appointment for primary care. As one woman stated, “*Appointments aren’t hard to get. You take your chances if you walk in because people with appointments are always seen first.*” All focus group participants expressed frustration with the lack of access to services that were not available at their primary care sites, such as specialty care and diagnostic services. Likewise, dental care, mental health services and access to pharmaceuticals were also mentioned frequently as difficult to access for uninsured residents. For example, one participant complained that she tried to get services through the county but said, “*You have to go through so many stops to get treatment that I was afraid that I was going to have a nervous breakdown before I got any help.*” Another patient said that he had to seek care from a private physician to get medication for his attention deficit disorder after trying to get care at a local emergency department and being inaccurately diagnosed.



“You have to go through so many stops to get treatment that I was afraid that I was going to have a nervous breakdown before I got any help.”

Patients reported seeking care at a number of hospitals in Atlanta. Most participants believed that their hospital stays were shorter if they were uninsured; many in the groups had experience being uninsured and also being covered by Medicaid or commercial insurance through an employer. The majority of participants had also accessed the emergency department at least once and complained about long wait times. Most reported going to the ED because they either believed their condition was urgent, or they were in pain and had nowhere else to go. Although they knew that going to the ED meant that they would likely face a very long wait for care, they also knew that they could not be refused care if they could not pay upfront and believed that the care would be of very high quality. They viewed the wait time as a consequence of being uninsured and having few resources to pay out of pocket. Also, participants across both groups viewed ED services as being free of charge. One man stated, *“Anytime something is free, they feel like they can make you wait.”* Many seemed to take comfort in the fact that they could be seen in the ED regardless of the ability to pay. One person stated, *“If you get desperate go to the ER because you know they’ll see you.”*

Some participants had very good experiences with hospitals and the local emergency departments. For example, one participant stated, *“I was referred to [one of the hospitals] from the homeless shelter. It was easy to get assistance and they helped me out a lot. They met all of my needs.”* Several participants, however, were

unhappy with the way they were treated at some of the local hospitals, saying that the quality of the experience depended on who was at the desk or “on” in the emergency department that night. Although all of our focus group participants recognized the value of the care they received, many believed that they were treated poorly. Many reported that they were spoken to rudely or handled harshly by staff, and had to almost beg to have their concerns addressed. One participant stated, *“Customer service is awful but I’m satisfied with the quality of care.”* Another stated, *“We are poor and broke so they treat us like nothing.”*

Participants in the Spanish-speaking group complained about the lack of providers, especially for specialty care, who were available in the Atlanta area. They said that interpreter services are not generally accessible at private providers’ offices; also interpreter services at the hospitals and emergency departments are not always available. Even when they are available, some physicians or other providers do not want to use an interpreter because it can add to wait times or to the length of the encounter. Several participants talked about using interpreters on certain visits; others said they often did not use an interpreter, despite seeing some in the waiting rooms prior to seeing the doctor. All of the participants in the Spanish-speaking group said that when they used an interpreter, the quality of the visit was substantially better and that interpreters in the area were well-trained and sensitive to the patients’ needs.

OVERVIEW

The emergency department plays a critical role in the safety net of every community. It frequently serves as the safety net's "safety net," serving residents who have nowhere else to go for timely care. Residents often choose the ED as their primary source of care, knowing they will receive comprehensive, quality care in a single visit. When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations and the accessibility of timely care outside of the ED. Whether it serves as a first choice or last chance source of care, the ED provides a valuable and irreplaceable service for all community residents, including low-income underserved populations.

Problems arise, however, when using the ED leads to crowding and ambulance diversion. When the ED is too crowded, quality of care and patient safety can be compromised. Many factors cause crowding, including limited inpatient capacity, staff shortages, physicians' unwillingness to take call, and increased demand for services from uninsured as well as insured patients. It is important to focus on all these issues when trying to address the problem.

In this section of the report, we provide an analysis of ED use at the Grady Health System. Using a profiling algorithm,⁷⁰ we were able to classify visits as either emergent or non-emergent. We were able to further identify what portion of those visits were primary care treatable, preventable/avoidable or non-preventable/non-avoidable. Communities should use this information to further understand the dynamics of health care delivery. These data, however, do not tell the whole story and should not be viewed as a comprehensive analysis of emergency department use in the community.

When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations and accessibility of timely care outside of the ED.

THE ED USE PROFILING ALGORITHM

In 1999, John Billings and his colleagues at New York University developed an *emergency department use profiling algorithm* that creates an opportunity to analyze ED visits according to several important categories.⁷¹ The algorithm was developed after reviewing thousands of ED records and uses a patient's primary diagnosis at the time of discharge from the ED to apportion visits to five distinct categories. These categories are:

1. Non-emergent, primary care treatable
2. Emergent, primary care treatable
3. Emergent, preventable/avoidable
4. Emergent, non-preventable/non-avoidable
5. Other visits not classified according to emergent or non-emergent status

According to the algorithm, ED visits are classified as either emergent or non-emergent. Emergent visits are ones that require contact with the medical system within 12 hours.

Emergent visits are further classified as either needing ED care or treatable in a primary care setting. Visits classified as "primary care treatable" are ones that could have been safely provided in a setting other than an ED. These types of visits are ones that generally do not require sophisticated or high-tech procedures or resources (such as CAT scans or certain laboratory tests).

Visits that are classified as needing ED care are classified as either non-preventable/non-avoidable or preventable/avoidable. The ability to identify visits that would fall in the latter category may offer opportunities to reduce costs and improve health outcomes: patients who



present with emergent but preventable/avoidable conditions should be treated earlier and in settings other than the ED.

A significant percentage of visits remain unclassified by the algorithm in terms of emergent status. Visits with a primary ED discharge diagnosis of injury, mental health and substance abuse, certain pregnancy-related visits and other smaller incidence categories are not assigned to algorithm classifications of interest.

The data from the ED utilization category must be interpreted cautiously and are best viewed as an indication of utilization rather than a definitive assessment. This is because the algorithm categorizes only a portion of visits and does not include any visits that result in an inpatient admission. For many hospitals, visits that result in an inpatient admission are not available in ED electronic databases. Presumably, since these visits warrant inpatient treatment, none would fall into the non-emergent category. Excluding these visits may inflate the primary care treatable (both emergent and

non-emergent) categories. However, ED visits that result in an inpatient admission generally do not comprise more than 10-20 percent of total ED visits and would likely have a relatively small effect on the overall findings. A larger effect could occur if more visits were categorized by the algorithm. Since a sizeable percentage of ED visits remain unclassified, percentages or visits that are classified as falling into one of the four emergent or non-emergent categories should be interpreted as a conservative estimate and may understate the true values in the population.

ED USE AT GRADY HEALTH SYSTEM

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at Grady Health System for the period July 1 through December 31, 2002. There were 60,876 ED visits for the six-month period that did not result in an inpatient admission.⁷² Table 7 provides information on these visits by race, coverage, age and gender.

Table 7 Demographic Characteristics of ED Visits

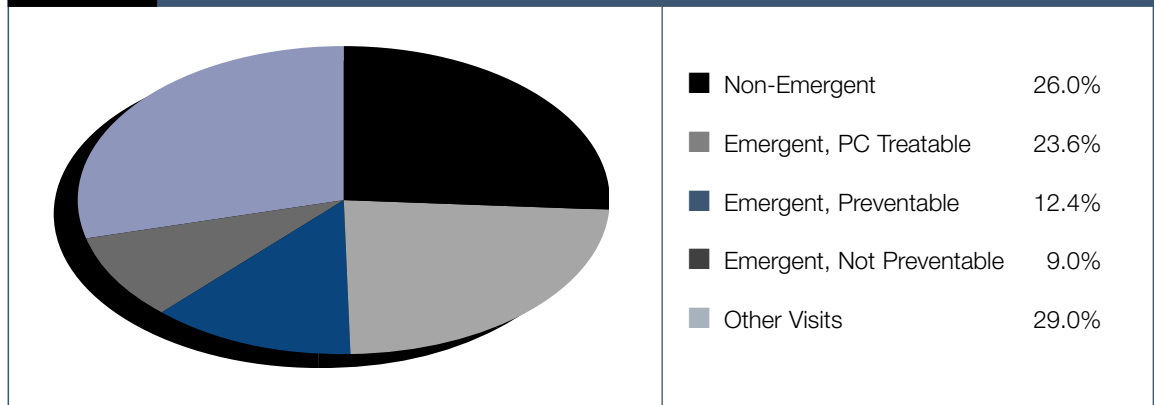
Race		Coverage		Age		Gender	
Black	87.4%	Commercial	1.9%	0-17	41.0%	Female	43.9%
White	6.1%	Medicaid	41.2%	18-64	54.9%	Male	56.0%
Latino	4.4%	Medicare	7.2%	65+	4.1%		
Other/unknown	2.1%	Uninsured	41.7%				
		Other/Unknown	8.0%				

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Grady Health System emergency department.

* The uninsured category includes patient visits under the payer category "credit bureau." This designation refers to those patients without sources of coverage who enter into payment arrangements with the Grady Health System.

KEY DEMOGRAPHIC CHARACTERISTICS OF ED VISITS

- About five of six ED visits at Grady were for patients who were black. Approximately 10.5 percent of visits were for patients who were either white or Latino.
- Approximately four out of ten visits to GHS were for patients who were uninsured.
- More than two-fifths (41 percent) of Grady's ED visits were for children.
- Grady had a relatively high number of visits by male patients

Figure 1 Visits by Emergent and Non-Emergent Categories

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by Grady Health System emergency department.

A significant percentage of visits to the Grady Health System ED could have been treated in settings other than the ED. As Figure 1 demonstrates, 26.0 percent of ED visits at Grady were non-emergent and another 23.6 percent were emergent but primary care treatable. Thus, half of all ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.

Table 8 compares the rate of visits that are emergent, that require ED care, and that are not preventable or avoidable against rates for other categories of visits. For every visit that is in the emergent, not preventable category, there are nearly three non-emergent visits and more than two emergent but primary care treatable visits.

These findings differ across various categories. Visits by patients on Medicaid are much more likely to be for non-emergent conditions—for each Medicaid visit that is emergent and non-preventable, there are four visits that are non-emergent and nearly the same number that are emergent but primary care treatable. The high rates seen in the Medicaid population are at least in part a result of the large percentage of children who seek care at Grady's ED. Interestingly, commercial and uninsured patients have almost identical rates of use of the ED for non-emergent conditions.^{73,74}

Table 8 Relative Rates for ED Visits at Grady Health System

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/Avoidable	Emergent, ED Care Needed Not Preventable/Not Avoidable
Total	2.89	2.62	1.38	1.00
Insurance Status				
Commercial	2.55	2.07	1.12	1.00
Medicaid	3.90	3.76	1.70	1.00
Medicare	1.75	1.65	1.32	1.00
Uninsured	2.56	2.19	1.21	1.00
Age				
0-17	5.08	4.66	1.73	1.00
18-64	2.13	1.91	1.27	1.00
65+	1.70	1.59	1.12	1.00
Race				
Black	2.96	2.70	1.45	1.00
Latino	3.45	3.13	0.84	1.00
White	1.97	1.65	0.88	1.00
Sex				
Female	2.52	2.22	1.42	1.00
Male	2.60	2.22	1.33	1.00

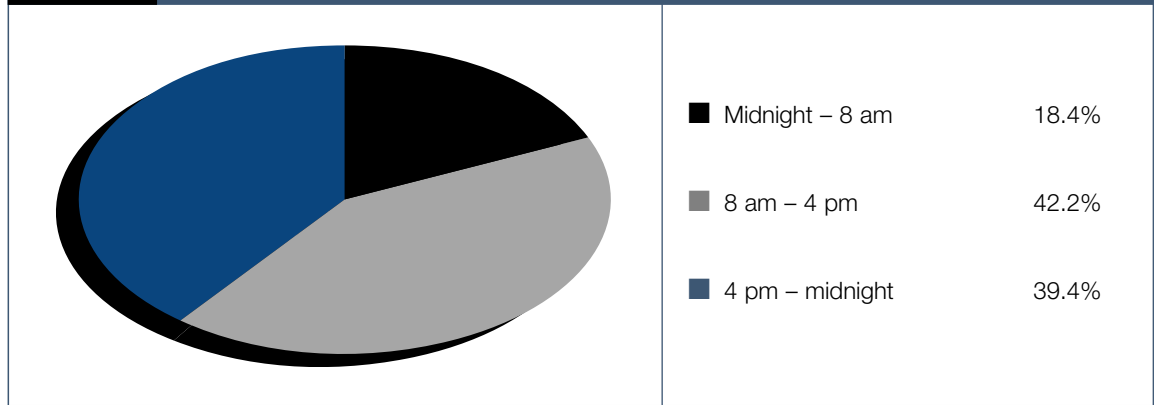
Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by Grady Health System emergency department.

Patients who are Latino have higher rates of ED use for non-emergent conditions, compared to black patients, and white patients have much lower rates of use of the ED at Grady compared to the other patient groups. Very large differences are also seen across age groups, with children five times more likely to be in the ED for primary care treatable conditions than for emergent, non-preventable ones.

Children are more than twice as likely as adults and three times as likely as seniors to use the ED for conditions that could safely be treated in a primary care

setting. Children also tend to use the ED for emergent but primary care treatable conditions at much greater rates than adults and elderly patients (4.66 times the rate of emergent, non-preventable conditions, compared to 1.91 times the rate for adults and 1.59 times the rate for the elderly). This trend was common to several of the *Urgent Matters* sites.

Most ED visits at Grady Health System occur during the hours of 8:00 am to midnight. As figure 2 illustrates, only about 18.4 percent of visits that do not result in an inpatient admission occur between midnight and 8:00 am.

Figure 2 ED Visits by Admit Time

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Grady Health System emergency department.

Interestingly, many visits to the ED for primary care treatable conditions occur during business hours that commonly coincide with physician and clinic availability. Table 9 illustrates the rates of use of the ED for emergent and non-emergent conditions according to three time periods—8:00 am to 4:00 pm; 4:00 pm to midnight; and midnight to 8:00 am. Patients used the ED for primary treatable conditions at relatively comparable rates during “regular business hours” and the hours of 4:00 pm to midnight.

Table 9 Relative Rates for ED Visits at Grady Health System, by Admit Time to the ED

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/Avoidable	Emergent, ED Care Needed Not Preventable/Not Avoidable
Total	2.56	2.23	0.86	1.00
Admit Time				
8 am – 4 pm	3.07	2.76	1.48	1.00
4 pm – midnight	3.00	2.69	1.35	1.00
Midnight – 8 am	2.34	2.26	1.21	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by Grady Health System emergency department.

These data support the assertion that patients are using the ED at Grady Health System for conditions that could be treated by primary care providers, at times during the day when primary care providers are likely to be available. The data show that children are especially likely to use the ED for primary care treatable emergent and non-emergent conditions. This suggests that there are opportunities to improve care for patients in Atlanta while also addressing crowding in the ED at Grady Health System. While this analysis does not address ED utilization at other Atlanta hospitals, these findings are similar to other analyses of large urban ED populations and are likely to be similar to patterns at other hospitals in the area.

KEY FINDINGS

After examining important components of the Atlanta safety net, the assessment team identified the following key findings:

- The viability of Grady Health System is crucial to the Atlanta health care safety net. Grady's base of financial support, however, is being chipped away, challenging its ability to provide care for the residents of Fulton and DeKalb counties. In terms of access to specialty and diagnostic services, Grady is virtually the sole source of care for the uninsured and underserved in a vast expanse that is much broader than its official service area.
- Low-income and uninsured residents of Atlanta appear to have numerous options for accessing primary care services. Primary care providers in private practices and clinics, in community health centers, and in hospital outpatient departments actively compete for Medicaid and privately insured patients. They also compete for some uninsured patients who pay out-of-pocket for certain services. These competitive forces create disincentives for collaboration and coordination across providers.
- Despite the availability of primary care, a significant percentage of emergency department visits at Grady Health System are for patients whose conditions are non-emergent. Over one-quarter (26 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions. Nearly another quarter (23.6 percent) were for patients whose conditions were emergent but could have been treated in a primary care setting.
- Access to specialty care, mental health services and dental care is extremely limited for uninsured and low-income individuals in Atlanta. The Grady Health System provides the largest volume of specialty services to these individuals but is overburdened and patients often face long waits to receive needed care. The shortage of dentists who care for uninsured and low-income populations is particularly acute; it is not uncommon to see unused dental operatories in clinics and other settings because of provider unavailability.
- Referral arrangements across primary and specialty care providers are haphazard and at times misaligned. Some of this dysfunction is a result of the competitive environment that creates incentives for specialty or other providers to "hold onto" patients instead of referring them back to their original or primary care provider.
- These competitive forces notwithstanding, some of the difficulty associated with referring patients across services is the result of deep and longstanding distrust within the safety net provider community. As long as such feelings continue, efforts to coordinate care, leverage scarce resources and build strong networks will fail to result in meaningful improvements for Atlanta residents who depend on safety net services for their care.
- The Atlanta area has the resources and expertise to create a more cohesive network of safety net providers. Such an effort could better leverage the resources in the community to work more effectively on behalf of low-income and uninsured Atlanta residents.

ISSUES FOR CONSIDERATION

The *Urgent Matters* safety net assessment team offers the following issues for consideration:

- Safety net providers in Atlanta should make a commitment to work together on behalf of uninsured and underserved residents. The Grady Health System, other hospitals, FQHCs, faith-based clinics and other providers are all dedicated to serving safety net populations, but have not developed meaningful connections to facilitate access, coordinate services, or enhance continuity of care for their patient populations.
- A working group of safety net providers should be formed to develop proposals to improve coordination and integration of existing resources. With increasingly limited funding to the safety net, Atlanta providers must develop mechanisms to stretch tight resources and manage current services more effectively.
- The safety net providers in Atlanta should undertake a study of the availability of specialty care for uninsured and underserved residents and identify mechanisms to link patients in need of care with providers. Given the resources in the safety net and the numbers of medical and surgical specialists in the Atlanta area, better access to timely and affordable specialty care should be possible.
- The implications of a decade of steadily declining funding to the Grady Health System are not fully understood and should also be the subject of a thorough study and review.
- Any consideration for growth in service delivery for uninsured and underserved residents should prioritize mental health and dental services. Efforts to expand primary care capacity should be directed toward services that are undersupplied in the marketplace.
- As Atlanta's communities become more diverse in terms of language and ethnicity, safety net providers must develop programs to provide language services, health education, and culturally appropriate outreach that effectively meet the needs of the population.

- 1 Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000): 21.
- 2 2002 Census Bureau, State and County Quick Facts, 2000, <http://quickfacts.census.gov>
- 3 J. Hairston, "Population edges up in Atlanta; 8900 new residents make biggest spurt since 1950s," *The Atlanta Journal-Constitution*, 16 August 2002.
- 4 Includes persons reporting more than one race.
- 5 Demographic and economic statistics were calculated using data from the 2002 American Community Survey, a project of the U.S. Census Bureau. The ACS is a sample survey subject to sampling variability. It has a 90 percent confidence interval. The ACS universe includes only household populations and excludes populations living in institutions, college dormitories and other group quarters. See: U.S. Census Bureau, *American Community Survey Profile 2002: Atlanta, DeKalb County, Fulton County, Profile of General Demographic, Social and Economic Characteristics* (Washington, DC: U.S. Census Bureau, 2003), www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/index.htm
- 6 G. Rust et al., *Georgia's Health Care Safety Net: Access to Primary Care for Georgia's Uninsured and Underserved* (Atlanta, GA: National Center for Primary Care, 2003).
- 7 Ibid.
- 8 National Association of Community Health Centers, Resources to Expand Access to Community Health (REACH) Data 2002 (Bethesda, MD: NACHC, 2002). The REACH data are based on Census Bureau data and provide estimates on the number of persons by poverty level, age, gender, race, and primary sources of health insurance for each county in the U.S. in 2000. Estimates are based on the 2000-2002 pooled data from the Census Population Survey and the 2000 Census of the United States which are provided by the Bureau of Census.
- 9 According to information published by the Georgia Department of Community Health, which runs the state Medicaid program, many more Fulton County residents are covered by Medicaid than the 13.6 identified by the Census Bureau. According to the Department of Community Health, 18.8 percent of Fulton County residents received Medicaid benefits at some point during FY 2002. The discrepancy may be a result of Georgia Medicaid counting any resident who received any Medicaid service during the reporting period, as compared to Census data, which generally refers to a point in time estimate.
- 10 National Association of Community Health Centers, REACH Data 2002.
- 11 American Community Survey Profile 2002, U.S. Census Bureau.
- 12 In 2003, the FPL was \$8,980 for an individual and \$18,400 for a family of four. (Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2003).
- 13 J. Salazar, "State is running on empty; reserve funds about out," *The Atlanta Journal-Constitution*, 19 November 2003.
- 14 Associated Press, "State reserve funds running dry, senators told," *The Atlanta Journal-Constitution*, 19 November 2003.
- 15 N. Badertscher, "Sixteen agencies may furlough employees," *The Atlanta Journal-Constitution*, 12 November 2003.
- 16 This proposal applies only to counties with a minimum of 800,000 residents. At present, Fulton is the only county that meets this requirement.
- 17 Ten largest employers represent businesses with largest workforce, defined by employment covered by unemployment insurance, excluding all government and public schools (except correctional institutions, state hospitals, and colleges and universities), all railroads and the U. S. Postal Service. Data shown for third quarter of 1997. Employers are listed alphabetically, not by employment size.
- 18 Georgia Area Labor Profile, Georgia Department of Labor. Data are from 1990 Census.
- 19 Grady Health System, which is the public hospital that serves as the principal Atlanta safety net institution, provides care to residents of DeKalb and Fulton Counties.
- 20 Georgia Area Labor Profile, Georgia Department of Labor. Data are from 1990 Census.
- 21 Ibid.
- 22 E. Stirgus, "More funds for Grady unlikely," *The Atlanta Journal-Constitution*, 6 June 2002, 6JA.
- 23 Georgia Department of Industry, Trade and Tourism, "Georgia Economic Profile. Georgia—The state of Business Today," 16 April 2002.
- 24 Ibid.
- 25 Georgia Board of Dentistry, see: www.sos.state.ga.us/plb/dentistry
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- 29 Ibid.
- 30 Grady Health System, unpublished data, 2004. See also: M. Regenstein, J. Shearer, *NAPH Ambulatory Care Source Book: Findings from the 2001 NAPH Ambulatory Care Survey* (Washington, DC: National Association of Public Hospitals and Health Systems, 2001).
- 31 Singer, et al.
- 32 This hospital is a merger of Eggleston Hospital and Scottish Rite.
- 33 Data on FQHC visits are from the Uniform Data System (UDS), a national database of patient and health center characteristics managed by the Health Resources and Services Administration. Data are from 2002.
- 34 Uniform Data System (UDS), a national database of patient and health center characteristics managed by the Health Resources and Services Administration. Data are from 2002.
- 35 Ibid.
- 36 St. Joseph's Mercy Care unpublished data, 2003.
- 37 Good Samaritan Health Center of Atlanta, Annual Summary of Patient Visits 1999-2003.

- 38 Rust, et al.
- 39 The Community Access Program grant is described on page 15.
- 40 E. Stirgis, "DeKalb funds for Grady Hospital debate: Figures decline in county participation for indigent care," *The Atlanta Journal-Constitution*, 27 June 2003, 1JA.
- 41 "DeKalb Notebook," *The Atlanta Journal-Constitution*, 25 December 2003, 2JA.
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- 43 H. Weber, "Grady Health System to Lay Off 300 People," *The Washington Post*, 5 December 2003.
- 44 Disproportionate Share Hospital payments provide additional funding to hospitals that provide a disproportionate amount of care to Medicaid and uninsured populations.
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- 49 Georgia Department of Community Health, *State Fiscal Year 2002 Annual Report*.
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- 51 Georgia Department of Community Health, *FY 2002 Annual Report by Commissioner Gary Redding*.
- 52 Ibid.
- 53 Georgia Department of Community Health, *State Fiscal Year 2002 Annual Report*. www.communityhealth.state.ga.us
- 54 A. Miller and J. Salzer, "Medicaid deep in red; \$172 million shortfall projected," *The Atlanta Journal-Constitution*, 14 August 2003, 1E.
- 55 Atlanta Community Access Coalition, 2003. www.acac.us
- 56 Ibid.
- 57 H. Weber, "Grady Health System to Lay Off 300 People."
- 58 Georgia Department of Community Health, 2003. www.communityhealth.state.ga.us
- 59 Enrollment rankings for SCHIP available at <http://www.communityhealth.state.ga.us>
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- 61 Ibid.
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- 63 A. Miller and J. Salzer, "Medicaid deep in red; \$172 million shortfall projected."
- 64 D. Williams, "State rethinks managed care."
- 65 Despite excess capacity at certain clinics, some clinic sites are reportedly considering expanding their services and opening new facilities without knowledge of what other health providers are planning and what services are already being provided.
- 66 These sentiments were echoed by many different providers who were not associated with the Grady Health System.
- 67 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 68 Throughout the discussions with local residents, the participants and the focus group facilitator used the terms community health center, health center and community clinic interchangeably. They generally distinguish care provided in a stand-alone clinic site from care provided on an out-patient basis at a hospital campus setting.
- 69 This clinic has providers who speak Spanish and serves a largely immigrant patient population.
- 70 The algorithm presented here uses a methodology that has been replicated in numerous communities in the country to categorize emergency department visits data. The algorithm does not address the issue of appropriate use of the ED for non-emergent and/or primary care treatable conditions. This issue has been discussed extensively in the peer-reviewed literature. For a summary of these discussions see: L. Richardson and U. Hwang, "Access to Care: A Review of the Emergency Medicine Literature," *Academic Emergency Medicine* (Volume 8, no. 11, 2001): 1030-1036.
- 71 For a discussion of the development of the algorithm and the potential implications of its findings, see J. Billings, N. Parikh and T. Mijanovich, *Emergency Room Use: The New York Story* (New York, NY: The Commonwealth Fund, November 2000).
- 72 There were an additional 6,144 ED visits that resulted in an inpatient admission.
- 73 It is important to note that these findings refer to the allocation of visits across emergent and non-emergent categories and do not address whether uninsured patients use the ED, per se, in greater numbers than insured patients. This assessment would not be possible in the absence of better data on ED use across many more hospitals in the Atlanta area to determine whether uninsured patients were using ED care at higher rates than insured patients.
- 74 This finding is consistent with recent research showing increases in the numbers of commercially insured patients relying on emergency departments for care. See: P.J. Cunningham and J.H. May, *Insured Americans Drive Surge in Emergency Department Visits, Issue Brief 70* (Washington, DC: Center for Studying Health Systems Change, October 2003).

URGENT MATTERS GRANTEE HOSPITALS AND COMMUNITY PARTNERS

Atlanta, Georgia

Community Partner: National Center for Primary Care, Morehouse School of Medicine

Project Director: George Rust, MD, MPH FAAFP

Grantee Hospital: Grady Health System

Project Director: Leon Haley, Jr., MD, MHSA, FACEP

Boston, Massachusetts

Community Partner: Health Care for All

Project Director: Marcia Hams

Grantee Hospital: Boston Medical Center

Project Director: John Chessare, MD, MPH

Detroit, Michigan

Community Partner: Voices of Detroit Initiative

Project Director: Lucille Smith

Grantee Hospital: Henry Ford Health System

Project Director: William Schramm

Fairfax County, Virginia

Community Partner: Fairfax County Community Access Program

Project Director: Elita Christiansen

Grantee Hospital: Inova Fairfax Hospital

Project Director: Thom Mayer, MD, FACEP, FAAP

Lincoln, Nebraska

Community Partner: Community Health Endowment of Lincoln

Project Director: Lori Seibel

Grantee Hospital: BryanLGH Medical Center

Project Director: Ruth Radenslaben, RN

Memphis, Tennessee

Community Partner: University of Tennessee Health Sciences Center

Project Director: Alicia M. McClary, EdD

Grantee Hospital: The Regional Medical Center at Memphis

Project Director: Rhonda Nelson, RN

Phoenix, Arizona

Community Partner: St. Luke's Health Initiatives

Project Director: Jill Rissi

Grantee Hospital: St. Joseph's Hospital and Medical Center

Project Director: Julie Ward, RN, MSN

Queens, New York

Community Partner: Northern Queens Health Coalition

Project Director: Mala Desai

Grantee Hospital: Elmhurst Hospital Center

Project Director: Stuart Kessler, MD

San Antonio, Texas

Community Partner: Greater San Antonio Hospital Council

Project Director: William Rasco

Grantee Hospital: University Health System

Project Director: David Hnatow, MD

San Diego, California

Community Partner: Community Health Improvement Partners

Project Director: Kristin Garrett, MPH

Grantee Hospital: University of California at San Diego

Project Director: Theodore C. Chan, MD