The Fulton-DeKalb Hospital Authority
Owner of Grady Health System

Meeting of the CIP Committee
Regular Session – 2024 Q3

Date: Wednesday, August 14, 2024
Time: 11am
Location: 145 Edgewood Ave | 2nd Floor | Sandra Holliday Conference Room
Presiding Trustee: Dr. Patrice Basanta Henry

MEETING MINUTES

Call to Order
The meeting was called to order, by Dr. Basanta Henry, at 11am.

ROLL CALL
Voting Members/Trustees

Present
Rick Shackelford, Dr. Patrice Basanta Henry, Pastor Eric Thomas
Absent
Dr. Karen Bennett
Others Present

FDHA Staff	Guests	Legal Counsel
Jevon Gibson, CEO	Jarvis Gray, Member of Public	Maggie Costello , AGG
Shelby Bennett, Office Coordinator		
Christine Wiggins, VP Community Health Systems		
Beverly Register, Executive Liaison		
Roger Reese, VP Finance		

Chair's Remarks
A motion was made by Trustee Shackelford to approve the Q2 meeting minutes. The motion was seconded by Pastor Thomas and carried, with no opposition.

Public Comments
Jarvis Gray, a member of the public, attended the meeting via Zoom as an observer and expressed interest in potentially volunteering in the future.

CIP Updates
Christine Wiggins, VP Community Health Systems and *Jevon Gibson*, CEO

- *Exhibit A*: CIP Co-Op Numbers & CHW Quarterly Data
- *Exhibit B*: Improved Health Outcomes

The Q1 and Q2 final numbers for the CHW initiative were presented. Of note, there has been a high number of referrals for housing for this year, with no known cause. In response, the CHW's continue to use a wide range of contacts for help with housing assistance, mainly ARCHI.

Access to Care & Mental Health

Preliminary data and reports

- Total people connected to health and wellness resources: 3,133
- 572 medical linkages were made and 444 were completed (77% completion rate)
- 645 housing linkages were made and 206 were completed (32% completion rate)
- 1,989 individuals were connected to SDOH resources

CHW Updates

- Approximately 50% of total referrals were for housing and living expenses
- 254 individuals received health and social services referrals from FDHA CHW's.
- 710 individuals received direct education from the CHW's at outreach events.
- 701 total referrals were made to the community with 9% for dental services, 2% for vision services and 6% for food assistance.

EMT Program

During the second EMS/EMT cohort, tutoring will be offered as a part of the scholarship benefits.

Career Development

Conversations are being held about training young adults and high school students to become CHW's, through the Morehouse School of Medicine program. The plan is to partner with third-party organizations to better reach goals like developing and training the CHW advisor program. CEO Gibson shared that what was formally known as the annual report, will now be called the Impact Report. This report will highlight organizational data from the previous year and the initial Impact Report is scheduled for release during Q1 of 2025. Additionally, CEO Gibson presented a mind map with data on how Improved Health Outcomes have been leveraged.

Endowment Funding Updates

Nursing

Relationship based care training for nursing is ongoing.

Office of Population Health

Through collaboration with Queenie Jordan, Manager of Senior Services at Grady, the Office of Population Health remains in partnership with the FDHA.

IVYY Program

Members from the IVYY Project will participate in the next upcoming CPR training.

Flowing with Blessings

The mobile showers and laundry services are on-going and stationed at Grady every Tuesday. Security has been arranged to be present during working hours, to help ensure safety.

New Business

The Q4 CIP meeting is scheduled for Wednesday, November 6 @ 11am

Adjournment

There being no further business to discuss, the meeting was adjourned at 12:05 pm.

Submitted by,	Reviewed by,	Approved by,
_____	_____	_____
Beverly Register FDHA Executive Liaison	Eric Thomas FDHA Board Secretary	Dr. Patrice Basanta Henry FDHA Committee Chair

Exhibit A:

- 2024 CIP Co-Op Agreement 2nd Quarter Numbers
- 2024 Q1 and Q2 Community Health Worker

2024 CIP Co-Op Agreement 2nd Quarter Numbers

Final Numbers

July 30, 2024

Total number of people connected to health and wellness resources.

3,133 Individuals

The total number of individuals connected to SDOH resources

1,989 Individuals

572 medical linkages made and 444 were completed

77% Completion Rate

645 housing linkages provided and 206 were completed.

32% Completion Rate

Majority of partner clients who participated in FDHA funded projects are between the ages of 36-54, Black, made less than $34,999/year, and on Medicaid.

More Demographics

Fulton: 2,047
DeKalb: 1,305
Other: 471

County Resident Demographics

The Fulton-DeKalb Hospital Authority

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2024 Q1 and Q2 Community Health Worker Initiative

50%

Approximate percentage of total referral requests were for living expenses (33%) and housing resources (18%)
(Based on Social Services Form Responses)

254 Individuals

The number of people who have received health and social service community referrals from FDHA CHWs.

110 Individuals Seeking Health Services Referrals

144 Individuals Seeking Social Services Referrals

Referrals Made to Community

701 Total Referrals Provided →

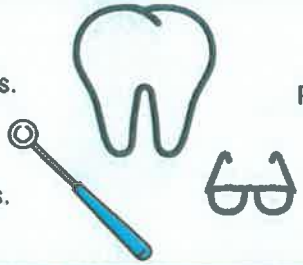
513 Health Referrals and **188** Social Service Referrals

9%

Requested assistance with dental services.

2%

Requested assistance with vision services.
(Based on Health Services Form Responses)



6%

Requested assistance with food resources.
(Based on Social Services Form Responses)

710 Individuals

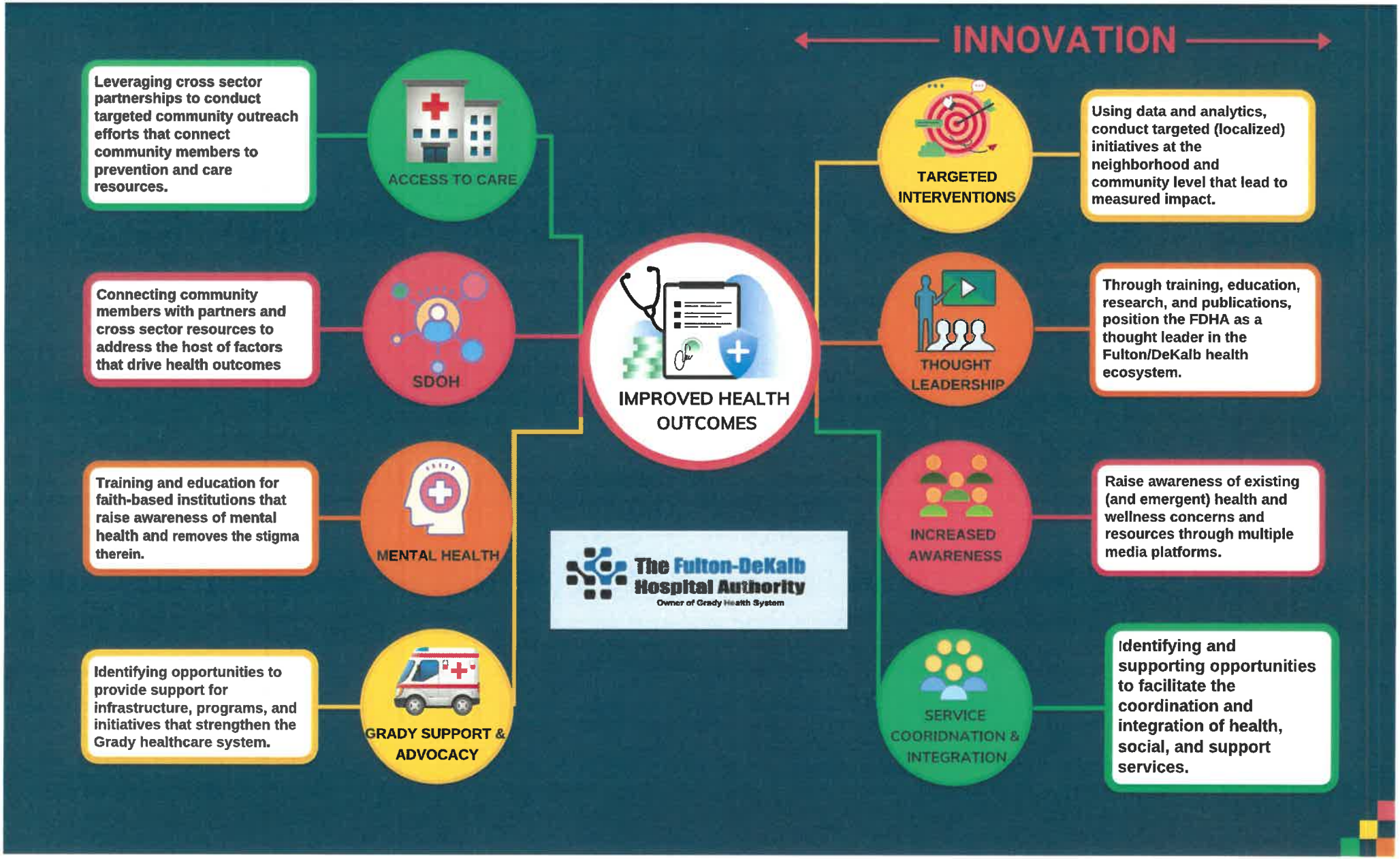
The number of people who have received direct education from CHWs at Outreach Events.

Final Numbers From January-June 2024

	Quarter1 #	Quarter2 #	Quarter3 #	Quarter4 #	2024 Total		
Q5_Total #	2399	3133			5532		
Q6_MedTotal #	504	572			1076	60.78	61% Completion Rate for Medical Linkages
Q6_MedComp #	210	444			654		
Q6_GradyMed	3	44			47		
Q7_Den.Total #	2	195			197	81.22	81% Completion Rate for Dental Services
Q7_Dent.Comp #	2	158			160	Big Jump in dental referrals	
Q7_GradyDent. #	2	1			3		
Q8_Vis.Total #	12	138			150	46.00	46% Completion Rate for Vision Resources
Q8_Vis.Comp #	11	58			69	Big Jump in vision referrals	
Q8_GradyVis #	0	0			0		
Q9_BHSTotal #	468	456			924	70.24	70% Completion Rate for Behavioral Health Services
Q9_BHSComp. #	320	329			649		
Q9_GradyBHS #	0	81			81		
Q10_OtherLink	0	66			66		
Q11_Total#SDOH	2189	1989			4178		
Q12_HouseTotal #	474	645			1119	59.79	60% Completion Rate for Housing Resources
Q12_HouseComp. #	463	206			669	Housing referrals increased but less follow up for confirmation of those being completed	
Q13_Trans.Total #	469	449			918	64.81	65% Completion Rate for Transportation Resources
Q13_Trans.Comp #	159	436			595		
Q14_FoodTotal #	1866	2823			4689	70.14	70% Completion Rate for Food Resources
Q14_FoodComp. #	1447	1842			3289	Churches have been bringing these numbers up on in their pantry/food drives	
Q15_Ed.Total #	1	1132			1133		
Q15_ Ed.Comp. #	1	277			278		
Q16_OherSDOH #	3	18			21		
Q17_# NewPart.	15	23			38		
Q18_Fulton #	908	2047			2955		
Q18_DeKalb #	985	1305			2290		
Q19_OtherCounties #	328	471			799		
Q20_Age0-17	739	648			1387		
Q20_Age18-35	477	941			1418		
Q20_Age36-54	775	1150			1925	Increase in the number of black, men,those that make less than $35,000 and residents in Fulton County. Also bug jump in senior referrals	
Q20_Age55+	334	1109			1443		
Q21_GenderF #	475	1224			1699		
Q21_GenderM #	442	1964			2406		
Q21_GenderTrans #	9	49			58		
Q22_AA/Black	2018	3614			5632		
Q22_Foreign Born	92	98			190		
Q22_White	141	302			443		
Q22_Hispanic	131	243			374		
Q22_Asian/PI	58	91			149		
Q22_AI/AN	0	3			3		
Q22_MultiRacial	7	3			10		
Q22_UnknownRace	0	43			43		
Q22_Other	0	0			0		
Q23_OtherSpecify	0	0			0		
Q24_Income1	1172	1952			3124		

Exhibit B:

- Mind Map: Improved Health Outcomes
- Theory of Change: Beyond Our Walls


INNOVATION
Leveraging cross sector partnerships to conduct targeted community outreach efforts that connect community members to prevention and care resources.
ACCESS TO CARE
Connecting community members with partners and cross sector resources to address the host of factors that drive health outcomes
SDOH
Training and education for faith-based institutions that raise awareness of mental health and removes the stigma therein.
MENTAL HEALTH
Identifying opportunities to provide support for infrastructure, programs, and initiatives that strengthen the Grady healthcare system.
GRADY SUPPORT & ADVOCACY
IMPROVED HEALTH OUTCOMES
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TARGETED INTERVENTIONS
Using data and analytics, conduct targeted (localized) initiatives at the neighborhood and community level that lead to measured impact.
THOUGHT LEADERSHIP
Through training, education, research, and publications, position the FDHA as a thought leader in the Fulton/DeKalb health ecosystem.
INCREASED AWARENESS
Raise awareness of existing (and emergent) health and wellness concerns and resources through multiple media platforms.
SERVICE COORDINATION & INTEGRATION
Identifying and supporting opportunities to facilitate the coordination and integration of health, social, and support services.

THEORY OF CHANGE: Beyond Our Walls

STRATEGIES/ACTIVITIES

Access to Care: Leveraging partnerships to conduct targeted community outreach efforts that connect community members to prevention and care resources.

Social Determinants of Health: Engaging and connecting partners from various sectors with community members to address the host of factors that drive health outcomes.

Mental Health: Training and education for faith-based institutions that raise awareness of mental health and remove the stigma therein.

Grady Support & Advocacy: Identifying opportunities to provide support for infrastructure, programs, and initiatives that strengthen the the Grady healthcare system.

OUTPUTS

Fulton and DeKalb residents are connected to trusted prevention and care resources

Vulnerable populations are linked to vital social resources including (not limited to) housing and food.

Churches increase their knowledge of mental health, mental health related issues and how to respond.

Grady increases capacity to respond to issues related to population health and equitable health outcomes.

INTERMEDIATE OUTCOMES

Residents of Fulton and DeKalb are connected to a more coordinated system of prevention and care.

Increased communication and coordination within and among health related resources within Fulton and DeKalb.

Gaps in the health ecosystem are identified.

IMPACT

Decreased incidence of chronic and/or preventable illness due to issues related to social determinants of health and/or care coordination.

Residents of Fulton and DeKalb are healthier and empowered to take ownership of their own health outcomes.

LONG-TERM OUTCOMES

All residents of Fulton and DeKalb have access to a coordinated system of prevention and care and have agency over their health regardless of their life circumstances.

The health ecosystem in Fulton and DeKalb is stronger with fewer service gaps and barriers to access.