

The Georgia Hospital Accountability Project

Georgia nonprofit
hospitals, the
provision of
community benefits
and the vulnerable
patient

Hospitals are the central component of Georgia’s vast and complicated health care system. As key health care providers that offer a wide range of services, these hospitals have a unique opportunity to help reduce access disparities for vulnerable populations – particularly those that are low-income, uninsured and underinsured. Hospitals are able to address the barriers to affordable care that confront uninsured, underinsured and low-income consumers by working within their facility, the community and lawmakers to enact policies and create programs that will better the fiscal and physical health of their hospitals and patients. Through these programs, hospitals are able to boost the overall fiscal and physical health of its community.

Most of Georgia’s acute care hospitals are nonprofit entities, which mean they are exempt from paying many taxes, including sales, income and property taxes. The Congressional Budget Office (CBO) estimates that, nationally, nonprofit hospitals annually receive \$12.6 billion in tax exemptions, a figure that does not include at least \$32 billion in federal, state and local subsidies the hospital industry receives each year.ⁱ Local property tax exemptions account for the largest amount of savings for tax-exempt nonprofit hospitals and medical facilities at about 25 percent. State and local sales tax comprises the second largest percentage at 22 percent, federal and state income tax totals 24 percent and tax-exempt bond financingⁱⁱ comprises 14 percent.

In exchange for its tax-exempt status, a nonprofit hospital is required to:

- Have a mission that will benefit its community;
- Reinvest all surplus funds in the hospital in a way that benefits the community;
- Remain accountable to the community; and,
- Remain financially accountable to the community by not allowing any portion of its net earnings to benefit any private shareholder or individual.

In addition, these hospitals must operate a full-time emergency room that is available to all people, regardless of their ability to pay; provide non-emergency services to anyone able to pay; and, participate in Medicaid and Medicare.

In March 2010, the President signed into law the Patient Protection and Affordable Care Act (ACA), an expansive health law that puts into place certain regulations on the insurance industry and expands health coverage for millions of Americans. Through Section 9007, the law addresses the practices of private nonprofit hospitals, implementing crucial consumer protections in regards to billing, collections and alerting patients that financial assistance is available. In addition, the law requires hospitals to evaluate and address the needs of its community through tri-annual assessments and programs that will benefit its community – particularly those most vulnerable. This law was the first notable legislation governing nonprofit hospitals in more than 50 years.

Legislation and nonprofit hospitals

Hospitals first received the designation of nonprofit in 1894, when the designation was extended as a way to support their charitable missions of providing care to those otherwise unable to pay. Scant legislative action occurred with these hospitals until the 1946 passage of the “Hospital Survey and Construction Act,” better known as the Hill-Burton Act.ⁱⁱⁱ This notable legislation attempted to both develop hospital capacity in the rural communities as well as provide safety-net care to indigent populations by providing funds for construction and modernization projects. In exchange, these hospitals were to provide a reasonable volume of services to people unable to pay and were to make services available to all residents of the facility’s area. Hill-Burton did not require a minimum standard of care to be rendered.

A 1956 Internal Revenue Service (IRS) revenue ruling attempted to answer questions regarding the nonprofit hospital’s designation as a charitable organization by mandating that charity care must be provided “to the extent of their financial abilities.” After the passage of Medicare and Medicaid in 1965, it was hoped that the gap in the safety net would be closed, eliminating the need for mandated charity care established through the aforementioned policies. A 1969 IRS ruling thereby modified the charity care standard to a community benefit standard. The focus of this standard, however, remained on free emergency room care. Nonprofit hospitals were mandated to operate a full-time emergency room with no one needing care denied treatment, a similar provision to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 that required *all* full-service hospitals to stabilize and provide treatment to any patient presenting at their emergency room, regardless of ability to pay. This mandated uncompensated care to all hospitals, regardless of organization type, further diminishing the distinction between for-profit and nonprofit hospitals.

Additionally, revenue streams for nonprofit and for-profit hospitals are often similar, with each ownership type receiving similar reimbursements for similar programs. Throughout the years, the humble, single-building facilities reliant on federal funding and Medicaid reimbursement for survival have evolved into impressive, expansive complexes with some boasting exceptional profitability and executive compensation rivaling that of for-profit executives, all the while still maintaining their tax-exempt status.

Property and sales taxes are key drivers in local economies, and the absence of those tax dollars affects the county’s bottom line. Often hospitals are among the largest employers in a given community, and while the economic impact of a hospital can prove high through this role (employee’s purchasing goods and homes), the direct loss of tax funds can significantly affect schools and other government-funded services, including firefighter and police forces.

Although nonprofit hospitals are charged with addressing the health needs of those most in needs, the distinction between those hospitals and their for-profit counterparts is often blurred. Policymakers and

advocates have now begun to ask, “What are these hospitals doing to justify these massive tax expenditures? What benefit are they truly providing?”

Community benefits

Community benefits are goods, services and programs provided to the community without the expectation of reimbursement and are meant to address community-identified needs, particularly those of the more vulnerable populations. At its core, community benefit programs and assessments should establish a strong partnership between the hospital and its communities, with the community playing an active role in identifying its needs and establishing the priorities for what the hospital should address. Specifically, community benefit programs should accomplish at least one of the following:

- Address community need
- Improve access to health services
- Enhance population health
- Advance knowledge
- Demonstrate charitable purpose

These programs generally generate a low or negative margin, respond to the need of often disenfranchised populations (frail elderly, minorities, special needs and low-income), supply services and programs that would likely be discontinued if the program was conducted solely for financial gain, and involve education or research that potentially benefits community health. A community benefit program can be as simple as hospital bill financial assistance to funding for volunteer clinics to the rehabilitation of housing for low-income populations, for example. But, regardless, these programs should boost the overall health of its community while increasing access to necessary services for those who need it most.

Financial assistance offerings at hospitals

First and foremost, financial assistance for qualifying patients is the most substantial way a hospital can serve its community. Through an accessible financial assistance program, hospitals are able to address the most basic of need – access to necessary care. The fiscal burden on low-income uninsured patients would be lessened, and medical debt is more likely to be avoided.

Financial assistance can provide to hospital a better understanding of the communities most in need. For example, if a pattern emerges among patients living within a particular zip code and their uninsurance status, the hospital should then take note that attention should be paid to this community, as there may be underlying health needs that could be addressed through additional community benefit programs.

It is important to note that, per ACA regulations, nonprofit hospitals must now limit the amount qualifying patients are charged for necessary care to equal the amount those with insurance would pay for the same care. This means that patients’ initial bill will reflect the same discount given to insurance companies (which generally ranges from 50 to 65 percent), which would then be discounted further if eligible for financial assistance. This important measure emphasizes the need for affordable and accessible care for those who most need it –uninsured and low-income patients.

Notifying patients of financial assistance

Nonprofit hospitals are required by federal law to notify patients of the availability of available financial assistance, and all Georgia hospitals participating in the Indigent Care Trust Fund are required to notify patients of this assistance.

Unfortunately, many do not. In a site audit of approximately 50 nonprofit hospitals during a nine-month period,^{iv} only about half had any signs advertising the availability of free care, and only 12 hospitals provided detailed information about their policy.

In October 2011, only one-quarter of the 146 acute care hospitals examined provided more than a brief mention of financial assistance on their website, though most did not provide a copy of their financial assistance policy. Thirty hospitals did mention assistance, but either provided a number for more information or just simply stated assistance may be available. Sixty-five hospitals, including several large systems, did not mention the availability of any financial assistance.

Not all consumers have web access, especially low-income individuals, as internet access is directly correlated with a household's combined annual income, as well as their education level.^v In addition, internet access is lowest in Hispanic and African-American households, and the former of which is already at a disadvantage as so few hospitals provide information on their sites in Spanish—only 23 of the hospitals examined had any information available online in Spanish, and often that was just a mention that assistance was available. That said, the internet does play a key role for many consumers seeking information on available programs, and hospitals should place information about assistance on their website, particularly when the hospital already has a webpage on billing, as most do.

Going beyond indigent and charity care

Community benefits should not just include free or subsidized care for qualifying patients. Through clinic support, health screenings and necessary follow-up care, and other such benefits, health conditions can be more affordably treated in setting outside the emergency room, and conditions with a potential for high fiscal and physical impact will have more swift action, and, ideally, will not require expensive hospital care. A goal of a strong community benefits program is to have fewer unreimbursed indigent and charity care expenditures, as these patients are in better health and are receiving care in more appropriate settings.

Second to financial assistance, the most common example of community benefits in Georgia are free health screenings, an activity most of the state's hospitals undertake. These screenings often occur at health fairs or are made available to the public during certain health awareness month and are tied to the specific disease, such as prostate cancer screenings during September, which is prostate cancer awareness month. Some hospitals engage in more intensive screening efforts, such as mobile mammography units that travel to specific communities to provide on-sight mammography to women. These units specifically target communities and businesses where women are more likely to be low-

Comparing hospitals

A general benchmark for evaluating how much uncompensated financial assistance a hospital provides is to calculate those offerings as a percentage of their adjusted gross revenue (AGR). Per the Georgia Department of Community Health's 2010 Annual Hospital Financial Survey, Georgia hospitals provided a combined \$2.57 billion in uncompensated indigent and charity care charges in 2010, which represents about 8 percent of total hospital adjusted gross revenue, or about \$695.5 million in actual cost to hospital. Georgia hospitals examined in this study provided an average 8 percent of their AGR in uncompensated indigent or charity care charges in 2010. Nonprofit and authority-owned facilities provided a higher average of uncompensated indigent and charity care than their for-profit counterparts — 8 percent versus 4.5 percent,

income, uninsured or likely to forgo a yearly screening (such as shift workers, whose schedules may not allow for weekday appointments). Women with a positive mammogram would then receive appropriate follow-up care, such as a biopsy, as soon as possible and in the most appropriate care setting at the cost of hospital, if the patient qualifies for assistance.

Hospitals can go beyond basic screenings and further into their community through fiscal support and staffing of a local free clinic, which can broaden access to basic primary care for low-income populations. These clinics are then better able to care for the patients who need their free or discounted services, providing to the uninsured the opportunity to access care or, even better, establish a medical home. Hospitals could also help support clinic services to provide specialty care or ongoing care for chronic conditions. For uninsured and underinsured Georgians, non-emergency specialty care is often out of reach, as options for care are limited and, in some communities, nonexistent. This is particularly true in Georgia's rural communities where services for the uninsured are limited but health challenges formidable. Hospitals are often well-equipped to help address these issues through their support of community clinics.

Georgia's hospitals could also undertake additional efforts that target minorities who may face health inequities due to language barriers. For example, as established through IRS regulations, hospitals are also able to undertake certain community building activities that include leadership development and skill building activities for community members, which could include training for medical interpreter skills for community residents.

Other community building activities include economic development, community support, environmental improvements, community health improvement advocacy, and workforce development. Specific activities could include: programs to assist small business development in neighborhoods with vulnerable populations; violence prevention programs; the alleviation of water or air pollution; participation in community coalitions and other collaborative efforts with the community to address health and safety issues; efforts to support policies and programs to safeguard or improve public health, access to health care services; and, the recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, to name a few.

For example, some Georgia hospitals participate in prescription assistance programs, staff school health programs, provide housing rehabilitation services and help sexual assault victims find necessary counseling. In 2010, an Athens hospital donated ambulances to needy nonprofit community groups, and a northeast Georgia hospital led a coalition that provides affordable safety equipment such as car seats and bike helmets to children in need.

It is important to note what does not constitute a community benefit program. Community benefit programs are not programs for which the hospital itself would directly benefit, such as advertising and marketing efforts, medical administration, information technology, customer service and claims administration. Fundraisers for the hospital, such as golf classics, should also not be considered a community benefit. A hospital should not consider any activity necessary for accreditation a community benefit, nor should it count activities that ultimately boost its own bottom line.

Measuring benefits

Georgia does not require nonprofit hospitals to meet a minimum standard of community benefits in exchange for these tax-exempt breaks, nor does it require a nonprofit facility to provide information on those benefits beyond basic reporting of its indigent and charity care expenditures to the Georgia Department of Community Health (DCH), which compiles this information in a database that available to the public for a fee.^{vi}

In 2008, the IRS issued a newly-revamped IRS Form 990 Schedule H, which captures crucial community benefits information in a more organized, comprehensive, easily-comparable and consistent manner. The IRS Form 990 is the yearly tax filing hospitals must make and, previously the form did not require hospitals to report key community benefit information. Information on unreimbursed indigent and charity care, community building activities and financial assistance policies are now captured in Schedule H, as are specifics on how a hospital advertises the availability of assistance, how the hospital determines its community and how the hospital assesses the need of that community. The form has undergone additional revision, but unfortunately was deemed optional for hospitals for Fiscal Year 2010, and many hospitals have not completed it.^{vii}

As of October 2011, only about a quarter of Georgia's nonprofit acute care hospitals and systems had completed at least a portion of Schedule H for their Fiscal Year 2010 IRS Form 990 filing.^{viii} An analysis of those facilities, though, show that all provide free care for patients with incomes levels up to at least 125 percent of federal poverty guidelines (FPG), and that many hospitals provide subsidized care for patients at varying percentages of the FPG above that initial percent. All report to have a written financial assistance policy, though requests for copies of these policies often went unanswered.

Because so few hospitals have completed Schedule H for Fiscal Year 2010, and those that did generally did not complete the entire section, there is little comparative information available on the community benefit offerings of Georgia's nonprofit hospitals past the information provided by those facilities. Instead, policymakers, consumers and advocates seeking to understand what their hospitals do provide to the community must rely on hospital-generated reports to the community and self-report indigent/charity care expenditure data that is self-reported to DCH. These expenditures annually to DCH at charge, not cost, and the latter of the two would provide a more accurate view of what the hospitals are spending on their low-income patients. The use of charges disrupts the idea of an "apples to apples" comparison, as mark-ups vary widely between facilities, giving us a potentially inaccurate view of the true cost of indigent/charity care to the hospital. Reports to the community also vary from hospital to hospital, and often utilizes anecdotal stories to illustrate their impact. Because of this, it is difficult to calculate what benefit hospitals truly do provide to their communities.

Community Health Needs Assessment

Beginning in 2012, per ACA regulations, all nonprofit hospitals must conduct a community health needs assessment (CHNA) at least once every three years and adopt an implementation strategy to meet the community health needs identified in such assessment. A CHNA helps hospitals identify the concerns and strengths of a community, and to develop programs that address those needs. The CHNA must take into account input from persons who represent the broad interests of the community (including special knowledge of public health) and must be made widely available to the public.

Conducting a CHNA can create opportunities for community buy-in and generate authentic input from stakeholders. The process can create opportunities for new alliances and connections with new partners. A hospital can ensure that its services meet the needs of the community and that it is not simply spinning its wheels and wasting resources. CHNAs can guide board governance in sound decision-making as well as guide staff training and education. Finally, conducting a CHNA helps an organization develop a picture of best practices as well as identify who is working on existing issues and where gaps in community services exist.

Defining community

The first step is to determine the hospital's community, which can be defined through several methods. The definition of community is important in establishing the parameters of which the CHNA will be conducted.

Geography: Because nonprofit hospitals are exempt from paying property taxes in the county in which they are located, these hospitals hold an obligation to the entire county that forfeits those tax dollars. This may prove beneficial in crowded service delivery areas, as it prevents hospital 'cherry picking' of community with high incomes and greater rates of insurance, which could lead to the establishment of programs that primarily benefit patients who do not necessarily need assistance.

A geographical approach could also lead to greater collaboration between hospitals in addressing common community problems, and lead to broader programs that include a multitude of stakeholders. This method could be restrictive, though, in rural communities, as a single facility may serve several counties either because it has more services than a smaller facility or it is the only hospital within a wide geographical area.

Utilization: Some hospitals determine their community based on the individuals that come through their doors for service, regardless of their county of residence or financial situation. This is often drilled down by zip code. A challenge to this approach, though, would be that some patients may not have access to the facility as they should.

Demography: Finally, the hospital can choose a targeted 'community in need' which could be benefit from a strategy to expand health care access. A community defined by demographics should include the uninsured population, those below a certain income level or members of certain racial and ethnic minorities.

Hospitals can also use a mix of these approaches, creating their own approach to best serve the community at hand. In our analysis of IRS Form 990 Schedule H for Fiscal Year 2010, most Georgia hospitals reported using a combination of the above methods, with emphasis placed first on utilization and, secondarily, geography.

Health assessments

Once the community has been identified, its health status must be assessed in order to determine the best use of community benefit dollars. This involves collecting demographic data on the defined community, which would include available information on the community's uninsured and underinsured individuals. It should include a breakdown of income levels, a breakdown of any immigrant populations (which could help determine a need for second language and culturally competent care and programs) and unemployment data. This information can be gleaned from a variety of sources, including the US Census and the US Department of Labor, as well as state agencies.

Once demographic data has been collected, the hospital can then gather key public health data, such as the prevalence and incidence of chronic conditions such as asthma, cardiovascular disease, diabetes, or certain types of cancer, as well as mortality and life expectancy. The Centers for Disease Control and Prevention, US Health and Human Services, the National Center for Health Statistics, among others, actively collects this information on a regular basis. Other sources used define the needs of the population could be surveys, hospital utilization records, or school and law enforcement records. Hospitals are required to engage local public health officials and representatives in their assessments. These individuals and groups can prove especially helpful in establishing certain key local health

information and indicators. This type of work has long been a core function of local public health departments.

Once there is adequate quantitative data to define the population's economic and health status, it is important to obtain qualitative data from the community itself. This is necessary to measure the communities' perception of what their needs are. This will ensure that community benefit programs are tailored to include interventions the population would welcome and utilize. This data can be obtained through surveys, town meetings, or focus groups with both community members, those who utilize services, and outreach providers (such as clinics, churches and advocacy groups).

Who should be involved in a CHNA:

- Public health leaders and workers
- Hospital leadership
- Community leaders
- Advocacy organizations
- Lawmakers and local officials
- Church leaders, particularly those with minority congregations
- Employers, particularly those with a high percentage of shift workers and part-time employees

Advocates especially can play a key role in these discussions. They can help institutionalize the consumer voice in key conversations, represent entire demographics, and help identify inroads and opportunities to truly get inside the community.

Once qualitative and quantitative research is conducted, the hospital must then select its priorities. Among the most pressing medical concerns identified through the data collection process is the identification of specific activities that the hospital has the capacity to undertake and measure for effectiveness. It must select the interventions it believes will be most successful in improving health outcomes.

These programs must be built with evaluation in mind, and be flexible enough to respond to shifting patient need. Hospitals must be able to measure a baseline, such as current tobacco use among adults, and then, through a program that undertakes activities to curb tobacco use, be able to measure an end result after a period of time. In this example, that would be the number of adults who quit smoking and remained smoke-free. Public health professionals can be utilized for sophisticated methods of analysis that can track health indicators and compare them with state and national benchmarks.

Conclusion

Georgia hospitals can play a role outside of simply providing affordable treatment of acute medical conditions; instead, they can step to the forefront of tackling prevention and health promotion. At a time when resources are scarce and budgets are low, such assessments and programs should strongly encourage collaboration between hospitals, health departments, advocates and the community to truly improve the health of its community.

Suggested legislative policy

Several policy measures could be taken to better establish guidelines for community benefit activities in Georgia. Specific policy recommendations are:

Development and passage of Georgia-specific consumer benefits legislation: The Georgia legislature should pass comprehensive community benefits legislation that would:

- 1) Establish clear guidelines as to what state and local government should receive in exchange for the tax exemptions extended to hospitals, which would include provisions for prioritized benefits, such as unreimbursed patient care for low-income populations, direct assistance to health clinics serving uninsured and low-income populations and programs that assist local public health entities, such as reduced-cost immunization to qualifying children and school nursing programs;
- 2) Require each nonprofit hospital to annually file with the Georgia Department of Revenue a community benefits report that would quantify, via line item, the benefits provided to the community at cost and identify the populations served by each benefit; and,
- 3) Create the framework for the formation of a community advisory board that is separate from any other board affiliated with the hospital, and that will include at least three consumers representing the community's more vulnerable members, at least three community and/or consumer advocacy group representatives acting on behalf of their members and/or constituents and at least one representative of the county and/or state public health system.

All information about community benefits should be made available to the public onsite at the hospital, as well as online on the hospital's website in a prominent location within fifteen (15) days of being filed. Additionally, the hospital is to make available online and onsite at the hospital its indigent and charity care financial assistance policy, as well as information on other community benefits so eligible patients are aware such programs exist. It is also to be filed with the Department of Revenue.

Assessments to evaluate the real value of tax-exempt status: State and county taxing authorities should annually assess the property holdings of tax-exempt nonprofit hospitals, and this information should be made publicly available. This information will better enable policymakers, advocates and the community to request benefits commensurate with the value of the hospital's tax exemption.

Suggested organizational policy

Community Health Needs Assessments: Hospitals should actively engage their community, local health departments and other key stakeholders throughout its community health needs assessment. The assessment – and the programs that come from it – should be made widely available to the community it serves.

Compliance with existing laws: Hospitals should ensure they act in accordance with existing regulations to best serve their patients and themselves. Key regulations include:

- Availability of written financial assistance policy and signage indicating the availability of financial assistance: A written copy of the hospital's financial assistance policy and income guidelines must be made available upon request, per ICTF obligations for participating hospitals and per ACA provisions for nonprofit facilities. The policy should include income eligibility thresholds and other pertinent information about the hospital's financial assistance policy. This information should be written in clear and easy-to-understand language, and should be provided in the appropriate languages for the populations the hospital serves. Hospitals should ensure signage indicating the availability of financial assistance is placed at key areas throughout the hospital – the admissions desk, the emergency room, the financial office and the cashier's desk.

- Language services: Hospitals and other providers should ensure they act in accordance with existing regulations to best serve their patients, including the translation of all key written materials and signage indicating the availability of financial assistance and other key hospital programs and policies.

ⁱ Congressional Budget Office (CBO), “Nonprofit Hospitals and the Provision of Community Benefits,” December 2006.

ⁱⁱ A bond, issued by a municipal, county or state government, whose interest payments are not subject to federal income tax, and sometimes also state or local income tax. Of the \$50 billion in tax-exempt private-activity bonds issued by state and local governments in 2002, about \$10 billion went to nonprofit hospitals. Access to tax-exempt financing lowers the cost of capital for nonprofit hospitals. The Congressional Budget Office (CBO) estimates that, in 2006, the cost of capital for nonprofit hospitals was 10.8 cents per dollar of investment, compared with 12.9 cents per dollar for for-profit hospitals.

ⁱⁱⁱ The Hill-Burton Act is a US federal law passed during the 79th United States Congress, and sponsored by Senator Harold Burton of Ohio and Senator Lister Hill of Alabama.

^{iv} These audits were conducted anonymously, but were uniform in approach. The project representative completed a visual audit of the hospital, and then asked staff for information on available financial assistance. The visits were conducted at various times throughout late 2010 and early 2011.

^v <http://www.marketingcharts.com/interactive/home-internet-access-in-us-still-room-for-growth-8280/nielsen-internet-access-household-income-february-2009jpg/>

^{vi} As of October 2009, this fee was \$100 per database, annually. The purchaser of the database would also need certain software (specifically, Microsoft Access) to open the file and then, most likely, some basic knowledge of hospital finances to then understand the data.

^{vii} Per a weekly survey of Guidestar.org, an online database of IRS Form 990s, as filed by nonprofit entities.

^{viii} Hospitals that completed Schedule H for Fiscal Year 2010 are: Union General Hospital, Taylor Regional Hospital, Stephens County Hospital Authority, Saint Joseph’s Hospital, Southern Regional Health System, Southeast Georgia Health System’s Brunswick and Camden campuses, Phoebe Worth Medical Center, Phoebe Putney Memorial Hospital, Northside Hospital, Piedmont Newnan Hospital, Murray Medical Center, The Medical Center, Meadows Regional Medical Center, Henry Medical Center, Hamilton Medical Center, Gwinnett Hospital System, DeKalb Medical Center, Piedmont Fayette Hospital, Evans Memorial Hospital, Donalsonville Hospital, Crisp Regional Hospital, Chatuge Regional Hospital and Candler Hospital. Taylor Telfair Hospital did answer two of the questions on Schedule H, stating it did not have a charity care policy and did not prepare an annual community benefit report.

About the Georgia Hospital Accountability Project

Through outreach, advocacy and education, Georgia Watch’s Georgia Hospital Accountability Project broadens accessibility to affordable, quality health care for uninsured, underinsured and low-income Georgians. Created in 2007, the Georgia Hospital Accountability Project has released more than a dozen reports and conducted numerous consumer workshops that have empowered consumers, educated policymakers and engaged key stakeholders. We promote pro-consumer policies at our state’s hospitals, and work to ensure that existing laws protecting vulnerable patients are honored and upheld. We often work with policymakers to help strengthen and build existing regulations, and we continually forge partnerships with community groups and advocacy organizations to create innovative solutions to the health challenges facing most Georgians.

The project is funded in part by a grant from Healthcare Georgia Foundation. Created in 1999 as an independent, private foundation, the Foundation’s mission is to advance the health of all Georgians and to expand access to affordable, quality healthcare for underserved individuals and communities.