

## **Duke University Hospital**

### **Community Health Needs Assessment and Implementation Plan – Updates for 2013 and 2014**

#### **Introduction:**

In 1925, James B. Duke willed \$4 Million to establish Duke University Hospital (DUH) and its medical and nursing schools. His goal: to improve health care in the Carolinas, then a poor rural region lacking in hospitals and health care providers. Duke Hospital has devoted itself to that goal ever since, making sure that people across the region are able to get the medical care they need regardless of their ability to pay. Duke is both the predominant health care provider in Durham and the county's largest employer. Part of a full-service tertiary and quaternary academic medical center, DUH is the largest hospital in Duke University Health System (DUHS). For the fiscal year ended June 30, 2012, DUHS provided \$291million in community benefit and community investment. Of that figure, \$170million represents the community benefit categories identified by the Internal Revenue Service.

James P. Duke's vision 87 years ago laid the cornerstone for today's Duke Hospital and serves as a guide as DUH reinvests in supporting the greater community. DUH's commitment extends beyond the health care services provided in DUH facilities. DUH also benefits the community through highly regarded medical education programs and through the research conducted to discover new ways to treat illness and disease and to facilitate the translation of that research into population health improvement. Even beyond that, DUH reaches out and is an active partner with patients, neighborhoods, community organizations and governments in innovative efforts to improve to create innovative efforts to improve health and healthcare.

#### **Community Health Needs Assessment:**

DUH collaborates with the Partnership for a Healthy Durham (the State Certified Healthy Carolinians Group) and the Durham County Health Department to conduct the Durham County Health Assessment and develops strategies to address identified needs.

The most recent assessment process compiled valid and reliable information about the health of Durham. It included 207 citizen surveys from randomly selected households and 10 community listening sessions with 283 community members. The Community Health Assessment Team – comprised of more than 95 members representing, Duke University Hospital and Duke Regional Hospital (formerly Durham Regional Hospital), universities, local government, schools, non-profit organizations and businesses – worked to direct the activities of the assessment and provide written content and expertise on issues of interest. The assessment identified six health priorities for 2012 – 2015:

1. Obesity and chronic illness
2. Access to Medical and Dental Care
3. Mental Health and Substance Abuse
4. HIV and Sexually Transmitted Infections
5. Poverty
6. Education

All of the programs described in the following implementation plan are aligned with the six health priorities with many of the programs addressing combinations of the six health priorities.

### **Implementation Plan:**

Together, with its partners, DUH asks about and listens to concerns, analyzes healthcare utilization and costs, explores barriers to care, identifies partner needs and resources, plans/redesigns services, tracks outcomes, and shares accountability in order to develop effective programs to improve the health of the Durham community. As such the Implementation Plan includes new and long-standing programs.

### **Durham Health Innovations**

Emanating out of a planning grant, the Durham Health Innovations Implementation and Information Technology Steering Committee (DHI IITC) was launched in 2008 and is chaired by the Durham County Manager and the Executive Vice President for Clinical Affairs of the Duke University Health System (of which DUH is the largest hospital entity). With the committee membership comprised of the executive directors of the county's health and human services entities including: public health, social services, mental health, the superintendent of the school system as well as the executive director of Durham's FQHC, Lincoln Community Health Center, the DHI IITC now serves as a strategic planning body for DUH's efforts to address identified community health priorities. The DHI IITC has taken a number of steps to coordinate implementation efforts based on the recommendations culled from the DHI planning grant phase and in conjunction with the Partnership for a Healthy Durham and a range of other community partners, a DHI Community Assessment Team (CAT) was formed in the fall of 2010 to review all previous health assessment materials, compile updated information on neighborhood infrastructure, assets and resources in central Durham neighborhoods, and conduct key informant interviews with community residents and leaders. The information was utilized in the 2011 Durham County Health Assessment Process and incorporated in the 2012 Community Health Needs Assessment. As a result of this intensive and collaborative assessment process, seven neighborhoods (in Southwest Central Durham and Northeast Central Durham) were chosen for the DHI pilot and the following goals were established:

1. Increase access to health care in each Durham neighborhood with an integrated health care infrastructure: community health organizers, community ambassador sites, community clinics and services and community experts of Durham/Duke health care delivery system.
2. Improve health outcomes of Durham residents with local health campaigns.
3. Increase appropriate utilization of Durham/Duke Health Care delivery system
4. Address social determinants, particularly poverty, housing, education, transportation and other critical variables that contribute directly to neighborhood health.

To begin addressing the DHI pilot goals, two Community Health Organizers (CHOs) were hired in Fall 2011 to map out specific assets and needs by neighborhood and begin aligning DHI strategies with neighborhood priorities. The CHOs have since networked within the pilot neighborhoods to identify local resources and gaps in resources as a continuous extension of the assessments undertaken throughout the 3-year project period. Infrastructure-building has largely centered on identifying Health Ambassador Sites (e.g., churches, community centers, recreation centers, etc.) as safe places for residents to receive health services and engage in education, screenings and health activities. Health Ambassador Sites, along with local businesses, are to serve as health information hubs for neighborhoods so that new and

ongoing health opportunities are communicated through common neighborhood pathways. CHOs have already effectively mobilized 12 Health Ambassador Sites in seven Durham neighborhoods.

#### **FY 13 Activities/Goals:**

1. Develop proactive community-based, county-wide Resource and Referral system that connects community members, patients and providers to resources to address the social determinants of health;
2. Facilitate Monthly Resource Roundtables:
  - i. Community Organization Roundtables: organizations that offer health-related services exportable to “Health Ambassador Sites.” Monthly meetings will facilitate partnerships that will lead to increased health promotion efforts in Durham neighborhoods.
  - ii. Service Agency Roundtables: Durham agencies that serve the population’s health and social service needs (e.g., primary care, mental health, social services, criminal justice, housing authority, etc.) will convene for monthly, one-hour “grand rounds” to conduct programmatic continuous quality improvement which may result in new services, redesigned services, or reduction of duplicative services so as to best utilize resources to improve health.
3. Expand “Health Ambassador Sites” throughout Durham County and supply Ambassador Sites with current information on local resources.
4. Design a “volunteer system” utilizing college students to work in practices and community settings to assist patients with social determinant barriers (e.g., Health Leads).

**FY 13 Updates: All activities noted above with the exception of #4 were launched/expanded in 2013 and continue in 2014. DUH and partners are currently reviewing a number of “volunteer system” programs that are in place in other communities and began a series of exploratory meetings to determine how such a system could be implemented in Durham. DUH also assisted in the completion and dissemination of the 2013 State of the County Health Report and together with our partners began work on the Community Health Needs Assessment that will be the basis of the FY 2016 Strategic Planning Process.**

**FY 14 Updates: Work continued on conducting the full CHNA as the full CHNA typically takes 2 years to complete. Planning began for a community-wide forum to review potential “volunteer systems” in early FY 15.**

#### **Local Access to Coordinated Healthcare (LATCH)**

Local Access to Coordinated Health Care (LATCH) was initiated in 2002 with Healthy Communities Access Program (HCAP) funding from the US Health Resources and Services Administration (HRSA) to Duke’s Division of Community Health, Department of Community and Family Medicine. The founding and sustaining LATCH Partnership includes DUH (which now provides the majority of operating funds), Lincoln Community Health Center, the Durham County Departments of Health and Social Services, El Centro Hispano, and a number of CBOs. Through community-based, linguistically and culturally-relevant

care management, LATCH aims to improve health knowledge and self-care, access to health care and health services utilization outcomes among Durham County's uninsured. Care Management services include: health services coordination and navigation (medical, social, behavioral); post-hospitalization follow-up; patient education; chronic disease management; psycho-social support; access to benefits (Medicaid/SSI/SSDI); bills assistance; interpretation/translation; and, transportation coordination. In partnership with other community stakeholders—health care and social service providers, local government and community-based organizations—LATCH monitors health care trends, identifies barriers facing uninsured patients, and, working as a consortium, addresses and eliminates barriers.

LATCH currently has 10,136 “active” enrollees which is defined as having received direct contact with a LATCH care manager within the last two years. The majority of enrollees are Hispanic/Latino (64.4%) and black (25.6%) between the ages of 19-45 (71.9%), with a growing population of non-Latino adults over 45 years of age. For the period July 1, 2011-June 30, 2012, LATCH received a total of 3794 referrals and of these, enrolled 3,006 or 79%. Referral sources include: El Centro Hispano, Duke and Durham Regional Hospitals, Duke clinics, county departments of health and social services, Lincoln Community Health Center (FQHC) and its satellite clinics (Walltown, Lyon Park, and Holton). A total of 3,257 unique patients received 11,722 telephonic and 1,528 in-person encounters, with a trend toward more intensive care management due to an increase in patients with complex medical and psycho-social needs. Over a third of patients required 3 or more contacts from LATCH care managers to fully address their complex issues. LATCH secured patients' access to more than \$30,633 of patient medical supplies including \$22,305 in prescriptions and \$4,299 of durable medical equipment. LATCH care managers made 805 referrals to primary care and facilitated access to specialty care, mental health services, social services and other community resources. In FY '12 the program responded to growing requests from the patients for basic needs assistance. LATCH care managers secured access to \$8,895 for rent, electricity, water, gas and food.

Working through a consortium of community agencies has helped create a more integrated system of care and has been the catalyst for many positive and sustainable changes in health care delivery for the uninsured. A culturally and linguistically-appropriate delivery model, in a community context, has been effective in serving the program's uninsured Latino population. Disease management efforts are more successful when aligned with patients' priorities and providers' treatment plan. Lower levels of formal education make it difficult for many patients to obtain, process, and understand basic health information and services, thus necessitating the development and use of low-literacy tools (video, picture books). LATCH has developed and disseminated many of these tools.

**FY 13 Activities/Goals:** LATCH will expand SOAR (SSI/SSDI Outreach, Access, and Recovery) activities to provide more individuals with short-term disability application assistance and facilitate the coordination of a “SOAR hub” to provide technical assistance to other agencies doing this work; implement transitional care services for hospitalized patients; and intensify disease management for patients with chronic disease.

**FY 13 Updates:** LATCH successfully recruited and hired an additional SOAR worker to its staff and began a process of educating other agencies about the available assistance. LATCH continued to provide intensive care coordination to an increasingly aging uninsured population. The population between the ages of 19-45 (58.60%) declined by 13%, whereas the population over 45 served was 39%, an increase from FY12. Our Latino community is aging in place.

LATCH received 3,944 referrals, a 4% increase from FY12. Referral sources include: El Centro Hispano, Duke and Duke Regional Hospitals, Duke Clinics, county departments of health and social services, Lincoln Community Health Center (FQHC) and its satellite clinics (Walltown, Lyon Park, and Holton) and Project Access of Durham County. 1560 enrollees received focused care management (1 encounter/month), 867 received intermediate level (2 encounters/month) and 1,201 received extensive support (>3 encounters/month). LATCH secured enrollees access to more than \$11,823 of patient medical supplies including prescriptions and durable medical equipment. For FY13, the program responded to growing requests from the enrollees for basic needs assistance. LATCH care managers secured access to \$11,055 for rent, electricity, water, gas, dental and food.

#### **FY 14 Updates:**

LATCH successfully recruited and hired an additional SOAR worker to its staff and began a process of educating other agencies about the available assistance. The Lead SOAR worker for LATCH continued to assist individuals and provided community education at the annual Durham Health Summit held in April 2014.

LATCH received 3,762 referrals. Referral sources include: El Centro Hispano, Duke and Duke Regional Hospitals, Duke Clinics, county departments of health and social services, Lincoln Community Health Center (FQHC) and its satellite clinics (Walltown, Lyon Park, and Holton) and Project Access of Durham County. 2,461 enrollees received focused care management (1 encounter/month), 572 received intermediate level (2 encounters/month) and 396 received extensive support (>3 encounters/month). Enrollees received 11,356 telephonic and 1,255 in-person encounters. LATCH secured enrollees' access to more than \$13,065 of patient medical supplies including prescriptions and durable medical equipment. LATCH care managers made 906 referrals to primary care and facilitated access to specialty care, mental health services, social services and other community resources. For Fiscal Year 2013-2014, the program responded to growing requests from the enrollees for basic needs assistance. LATCH care managers secured access to \$15,156 for rent, electricity, water, gas, and food. A majority of enrollees were Hispanic/Latino (53.42%) and black (30.46%). The population between the ages of 19-45 (57%) has declined by 1%, whereas the population over 45 served was 40%, an increase from FY13.

#### **School-Based Health Centers**

DUH supports four school-based health centers (SBHCs) in Durham Public Schools. The SBHCs are located at Glenn, George Watts, and E.K. Powe Elementary Schools, and Southern High School and are operated by Duke's Division of Community Health. All of the SBHCs operate only during the school year; however, year-round, round-the-clock backup to the clinics is provided by Duke Medical Center, including DUH. In addition to medical services the SBHCs offer co-located mental health services through contracts with the Center for Child and Family Health and/or the Child Development and Behavioral Health Clinic. The elementary SBHCs offer a full spectrum of bilingual, culturally competent mental health services designed specifically for immigrant families and children (prevention, early intervention, and treatment). At Southern three types of mental health/social support services are provided: (1) individual therapy; (2) Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) groups, an evidence-based group therapy specifically designed to teach effective coping skills to adolescents who have been exposed to chronic stressors such as interpersonal and community violence, and (3) Healthy Families in which a Family Support Worker makes weekly home visits to home-bound pregnant girls and to girls who have delivered in the last three months. The goals of the SBHCs are to increase student access to primary care, respond to immediate health needs, and preempt

adverse health and educational outcomes including unnecessary use of the ER and student absences from school and missed parental work hours.

The four SBHCs had a total of 3,712 encounters in 2011-12. Satisfaction results for the elementary SBHCs revealed that in the absence of the SBHC, 41% of parents would have taken their child to another provider, 35% would have taken their child to the ER to receive care, and 8% would not or would have delayed treatment for their child (6%). The High School respondents reported that since the beginning of the school year, most had visited the clinic 1-5 times. The high school results revealed In the absence of the SBHC, 11% of respondents would not have received treatment (for concerns including mental health issues, medication, and injury care), 57% would have experienced a delay in care (for concerns including injury care, sexual health needs, and sports physicals), 43% would have left school to receive treatment (for concerns including sports physicals, sexual health and injury care) and 22% would have gone to the ER to receive care (for concerns including prenatal care, sexual health needs and injury care). Staff at each elementary school identified the top three benefits resulting from the SBHC as: 1) A student who would otherwise have had to go home in the middle of the day because of an illness or injury was able to go to the school clinic and return to class, 2) a student who would otherwise not have received medical help for an illness or injury received help, 3) I [the respondent] was able to reduce the disruption to my class, lunch, or other school activity caused by having a sick or injured student. Staff at Southern identified the top two benefits as: 1) A student who would otherwise have had to go home in the middle of the day because of an illness or injury was able to the school clinic and return to class, and 2) a student got help with managing an ongoing health condition (e.g. diabetes or asthma).

**FY 13 Activities/Goals:** DUH will partner with the Durham County Health Department and Durham Public Schools to add services at two additional schools and create an enhanced role nurse model to serve a higher volume of students. The SBHCs and the enhanced role nurse model will continue to provide important healthcare services at each school and coordinate referrals to specialists and other services where necessary with special emphasis on services and referrals for mental health.

**FY 13 Updates:** The transformation to the enhance role nurse (ERN) model began with the collaborative process of identifying the two new Durham Public schools which would receive the services of an ERN in addition to the three existing elementary school-based health centers.

**FY 14 Updates:** The Duke Division of Community Health secured a grant from HRSA to construct clinical sites in the two newly identified schools. The Durham County Health Department hired additional school nurses and the County and DUH paid for the additional training required for the ERN certification. DUH continued to provide funding for the mental health services and the initial start-up of this new model.

**For the Southern High School Wellness Center, DUH transitioned from staffing it with a PNP to a PA thereby expanding the clinic from a pediatric practice to a family practice model which allows the Wellness Center serve Durham Public School System employees, parents, and other related adults of DPS students.**

### **Just for Us**

“Just For Us”, an in-home care program for low-income, frail elderly and disabled, launched in 2002 as a collaboration of Duke, Lincoln Community Health Center, Durham Department of Social Services (DSS), the local area mental health entity, and the Durham Housing Authority. DUH provides the majority of ongoing support for the program. Through Just for Us, an interdisciplinary team of providers serves clients in their homes, providing medical care, management of chronic illnesses, and case management.

Each participant receives a home visit every 5 weeks unless there is an acute episode or a hospital discharge, for which a visit is scheduled immediately. Visits include medication reconciliation, social issues, support services, chronic disease management, and post-hospital care. The health care team consists of a clinical provider (PA, NP or MD), occupational therapist, registered dietitian, social worker, phlebotomist, and community health worker.

Annual enrollment averages 350 participants and the average age of Just for Us participants is 71. Sixty-three percent of Just for Us participants are women, 81% are African American, and the average annual income of participants is below \$7,000. Most participants rely on personal care assistance, public transportation, and food assistance. The typical participant has multiple co-morbidities, most commonly diabetes, heart disease and COPD. Forty-four percent of the participants have a Mental Health/Substance Abuse diagnosis. In the quarterly Just for Us participant surveys, the most important services participants cited were provision of medications, diet and nutritional information. A review of clinical and health care utilization data over a one-year period found that ambulance, ED and IP costs declined by almost half while prescription and home health cost increase 25% and 52%. At the same time, 79% of participants with hypertension were in control (BP <140/90) and 84% of participants with hypertension and diabetes were in control. The partners are pleased with such results as they indicate improvement in health and an increase in supportive services that help participants remain as independent as possible.

A successful in-home model for aging and disabled individuals requires a financial mechanism that covers the cost of direct care and time for providers to plan and work together. It also requires the medical provider to accept and adopt the paradigms of the mental health and social services system. Understanding a population's capacity and ability to perform ADL's and IADL's is key to designing effective transitional care strategies. With future payment structures such as bundle payments, health plans and hospital systems will be reaching out to integrate these programs into their transitional care system. The future success of in-home clinical care will depend on how well they effectively and efficiently integrate Palliative Care into their clinical and behavioral team, and how well they can impact their local health systems transitional care outcomes.

**FY 13 Activities /Goals:** DUH will support the implementation of Just for Us in additional sites and translate the model to new populations.

**FY 13 Updates:** The JFU program piloted a Personal Care assessment template to ascertain its value in standardizing primary care geriatric treatment. The JFU Gero MD and SW collaborated to complete and disseminate the extensive tool. JFU continued to maintain a very high patient satisfaction score.

**FY14 Updates:** JFU continued to serve its population in senior public and subsidized housing with a newly hired MD and NP team. With the opening of a CMS - PACE (Program of All inclusive Care for the Elderly) in Durham, JFU care team assessed their patients for a referral to PACE. PACE provides intensive medical and social care for Dually (Medicare/Medicaid) eligible frail elderly. Less than a dozen JFU patients met the Financial or Medical criteria indicating its continued value providing primary care to homebound low income elderly and disabled of Durham. JFU continued to maintain a very high patient satisfaction score.

## Community Clinics

DUH in partnership with Lincoln Community Health Center collaboratively operates three community health clinics; the Lyon Park Community Clinic, the Walltown Neighborhood Clinic and the Holton Wellness Center. The clinics were designed to provide primary care, health education, and disease prevention to the underserved populations of Durham. The clinics provide medical care for persons with and without health insurance. Those without insurance are seen based on a sliding fee scale. No patient is denied care based on inability to pay for services. The Lyon Park Clinic was the first of the collaborative neighborhood clinics, opening its doors for patient care in April 2003. The Walltown Clinic opened in January 2005 and the Holton Clinic opened in August 2009. Each clinic received start-up funds through a Duke Endowment grant. Clinics generate revenue through a contract with Lincoln Community Health Center and receive significant support from DUH. The clinics operate as Family Medicine Practices and are 5 days a week. Staffing includes Physician Assistants, Nurse Practitioners and Family Physicians, who serve as supervising doctors. Each clinic is supported by nursing staff: Certified Nursing Assistants, Licensed Practical Nurses, or Certified Medical Assistants and a staff assistant. The staff assistant performs all administrative tasks for the clinic including answering incoming phone calls, registration, scheduling, etc.

The clinics had a combined total of over 16,000 encounters in FY12. Approximately 82% of the patients are uninsured. In a post-visit survey of patients at Lyon Park (the first neighborhood clinic) in 2004, almost half of respondents reported that, had the clinic not existed, they might have delayed getting health care for the problem that brought them there, and one-fourth cited delaying care as their only option. One-third said they would have gone to the ED, and three-tenths of the patients cited the ED as the *only* alternative to Lyon Park. Annual surveys at all three clinics in years since continue to show significant indications of expanded access and ED diversion, although the numbers have gone down somewhat, presumably because the clinics now constitute an alternative to each other. For example, in November 2009, 15% of respondents at the three neighborhood clinics said that in the absence of the clinic, they would have gone to the ED for the health concern that brought them to the clinic that day. At the newest clinic, Holton, we have been analyzing data on the reasons new enrollees came to the clinic. In data collected from August 2009-January 2010, one-fifth reported never previously having a primary care doctor. 43% said that their enrollment was due to loss of insurance.

Providing clinical services in high-needs communities, planned in collaboration with the community, can lead to reductions in preventable visits to the ED by providing a more accessible and acceptable alternative. In addition, these clinics help develop community engagement and trust, by tangibly demonstrating a commitment to shared planning and action, around the needs, strengths, and values of the people and neighborhoods served.

**FY 13 Activities/Goals:** The clinics will be expanded through additional staffing and will further integrate with Durham Health Innovation efforts to continue to build neighborhood level capacity for the delivery of health care and health improvement efforts that are inclusive of addressing the social determinants of health.

**FY 13 Updates:** 14,495 visits; the community clinics patient satisfaction scores and quality metrics are consistent within its peer group. The FTE clinical capacity to see patients is filled.

**FY 14 Updates:** 12,348 visits; the community clinics patient satisfaction scores are consistent with its peer groups and due to integration of a new data collection system, HEDIS Metrics were not published for this fiscal year. The FTE clinical capacity to see patients is filled.



## **Mental Health and Substance Abuse Initiatives**

DUH has launched a number of collaborative initiatives to improve access to mental health services and reduce substance abuse.

### *Mental Health*

In 2012, DUH began an integrated model of primary care and mental health by introducing a dually-trained PA in its Outpatient Clinic. Early data shows this to be a promising model.

**FY 13 Activities/Goals:** DUH will grow the clinic starting with additions of social workers and advanced practice providers to assess patients and establish either medication management, therapy or combination care plans. DUH will continue to evaluate the model and anticipates expanding the model to additional primary care sites.

**FY 13 Updates:** DUH maintained support of the Psych trained PA. The medically complex patients with a mental health condition were provided intensive clinical and care management including home visits. By the end of the fiscal year, the clinic was reengineered and DUH added a Med-Psych MD for FY 14.

**FY 14 Updates:** The clinically integrated team: Med-Psych MD, NP and SW team launched a program called HomePlace. HomePlace manages an on-going list of Emergency Department and Inpatient Familiar Faces (patients who frequently utilize the Emergency Department and Inpatient Units). Provisional evaluation indicates an 80% reduction in hospital utilization for these patients.

### *Pain and Narcotic Management Program*

In recent time across the United States, there has been a trend of increasing utilization of Opioids resulting in risks to the patient of dependency or overdose. Over the past year, DUH has been actively planning for the enhancement and improvement of Pain Management and Outpatient Pain Management services for our community. Often patients with these needs receive fragmented care and results in frequent visits to the Emergency Department. Patients who don't have insurance or are minimally insured are at greater risk, however, patients with insurance are also at risk due to the lack of continuity of medications and a medication management plan individualized for each patient.

The vision of DUH is to provide integrated and seamless care for these patients and to assist with transitioning them into the community post surgery. To do this, a physician leader specializing in Pain Management services has been identified and recruited to be the Medical Director. He has been working closely with many parts of DUHS and community programs to identify the needs of this population as well as primary care physicians and specialty physicians.

**FY13 Activities/Goals:** Develop a model and structure for providing effective Pain Management services to serve inpatients and outpatients and provide a seamless transition from one setting to the other. In addition, DUH will identify a clinic location and providers to support this program.

**FY 13 Updates:** DUH identified a physical location and hired clinical staff to begin operation in FY 14. This clinic accepts and manages patients with pain and substance abuse issue.

**FY 14 Updates:** DUH's new pain clinic continued to accept patients with pain who are at risk of addiction. It has accepted patients who are being managed in the DUH "Homeplace" program. Establishment of this intensive patient care services for a medical/mental complex patient meets a

**critical need in the community. Collaboration of patient care plans has successfully brought about a reduction in inappropriate utilization of health care services.**

Also in 2012, DUH as a lead partner, facilitated the expansion of the “Rethinking Pain and Opioid Prescribing Initiative” The goal of the initiative is to improve the treatment of chronic, non-malignant pain in its multiple dimensions, and to reduce the risks posed to the community by the use of prescription opioids for the treatment of chronic pain.

**FY 13 Activities/Goals:** DUH will partner in the development and dissemination of a series of tool kits with specific ideas about how to handle a variety of issues related to pain management for providers, emergency departments, and care managers. DUH will partner to provide training and technical support to the implement the tool kits.

**FY 13 Updates:** In recognition of the national issue and local impact, DUHS established a “Safe Opioid Task Force” to evaluate, develop, and disseminate provider education material. DUH began promoting the newly launched state wide “Controlled Substance Reporting System” among its providers.

**FY 14 Updates:** DUH continued to expand the work of the Task Force and has created patient education tools in addition to provider education. The Co-Chair of the DUHS Safe Opioid Task Force also serves as Co-Chair of the Durham Crisis Collaborative which brings together medical, mental health, and social services providers as well as emergency services, trauma services, law enforcement, and multiple non-profits to work address the complex medical, mental health and socio-economic issues of the community’s most vulnerable members.

**Health Priority Area Not Specifically Addressed: HIV and Sexually Transmitted Infections**

While DUH through its leadership and support of the programs described in this document does have mechanisms to address HIV and Sexually Transmitted Infections, it does not have a specific goal to address the rate of HIV and sexually transmitted infections, because considerable work is already being done through organizations within the community. Through the Partnership for a Healthy Durham, the HIV/STI Advisory Council brings together community members and agencies to focus on strategies to prevent the spread of syphilis and HIV/AIDS. In addition, Lincoln Community Health Center operates an Early Intervention Clinic for patients with HIV/AIDS at the Durham County Health Department.