# Duke University Hospital

# Community Health Needs Assessment

# FY21 PROGRESS REPORT AND FY22 IMPLEMENTATION PLAN

## 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 healthcare 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, 2021, DUHS provided $823 million in community benefit and community investment.

James P. Duke's vision 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 health care.

## 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 Community Health Assessment and develops strategies to address identified needs. Faculty and staff of the Duke Division of Community Health, members of the DUH Senior Leadership Team and faculty and staff from across Duke University serve on Partnership for a Healthy Durham Committees.

This report reflects the needs identified by the Durham Community Health Assessment conducted in 2017 and published by Durham County in 2018 and the Durham Community Health Assessment conducted in 2019-2020 and published by Durham County in 2021. The assessment process for the published in 2018 included 358 resident surveys from randomly selected households and three community listening sessions with 42 community members. The survey was also conducted in person at grocery stores, libraries, Durham County Department of Public Health clinics and bus stations during January and February 2018. Ninety-three individuals contributed to writing the Durham Community Health Assessment document. The Community Health Assessment Team — comprised of

representatives from Duke University Health System, 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 five health priorities for 2018-2020:

1. Affordable housing
2. Access to healthcare and health insurance
3. Poverty
4. Mental health
5. Obesity, diabetes and food access

As the Community Health Assessment Process takes approximately 2 years to complete Duke University Hospital was proud to partner with Durham County Department of Public Health and the Partnership for a Healthy Durham to conduct the 2020 Durham Community Health Assessment (CHA) published in 2021. The 2020 survey was conducted between May and September 2019, and carried out by 243 community volunteers, Partnership members, and staff from Durham County Department of Public Health and Duke Health. The county wide survey sample size was doubled in 2019 to analyze data by race and ethnicity. The assessment included 612 resident surveys in county wide and Hispanic or Latino neighborhood samples. Community Listening Sessions were conducted via ZOOM due to COVID19 restrictions. The 2020 Community Health Assessment report is the first to disaggregate data by race and ethnicity for Black and white residents. The 2020 Community Health Assessment was published by Durham County in 2021. The five health priorities for 2021-2023 remained the same as those of the previous assessment cycle:

1. Affordable housing
2. Access to healthcare and health insurance
3. Poverty
4. Mental health
5. Obesity, diabetes and food access

The full Community Health Needs Assessments for 2017 and 2020 can be found on the DUHS website at: https://corporate.dukehealth.org/sites/corporate.dukehealth.org/files/2017%20Durham%20County%20Community%20Health%20Assessment_compressed.pdf and on the Partnership for a Healthy Durham Website: https://healthydurham.org/health-data

All of the programs described in the following progress report and implementation plan are aligned with the five health priorities with many of the programs addressing combinations of the five health priorities. A brief excerpt from the Community Health Needs Assessment describing each priority is included in this implementation plan. DUH considers this document to be a "working plan" that will continue to evolve over the three year period in order to ensure the efficacy of strategies intended to meet expressed community health needs. This implementation plan may note, but does not contain

detailed descriptions of, the community health improvement work carried out by other components of the larger Duke University Health System or Duke University. This implementation plan is intended to highlight Duke Hospital's continually evolving activities and support to improve health with the Durham Community.

## FY21 PROGRESS AND FY22 IMPLEMENTATION PLANS

Together with its partners, DUH asks about and listens to concerns, explores barriers to care, analyzes healthcare utilization and costs, 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 this Implementation Plan includes new and long-standing programs.

### 1. Affordable Housing

Affordable housing, as defined by HUD, requires no more than 30% of a family's monthly income. If a family spends more than 30% of income on housing, they are less able to pay for other expenses, such as food and health care. The increased cost burden of unaffordable housing adds to psychosocial stressors that can negatively impact a family. Renters make up 40% of households in Durham, and almost half of them are defined as cost-burdened (i.e., paying more than 30% of their monthly income for housing).

DUH has partnered with Habitat for Humanity of Durham on a number of home builds. Additionally, affordable housing is a focus of DUH as part of the larger Duke University. In 2018, funding from Duke University and the AJ Fletcher Foundation provided the opportunity to develop two acres of prime downtown Durham land into multi-unit affordable housing.

FY20 PROGRESS: The project broke ground in July 2019 with an anticipated completion date of December 2020. The larger Duke University also committed $3 million with the City of Durham to develop an Affordable Housing Loan Fund.

FY21 PLANS: The multi-unit affordable housing is expected to be completed and occupied in 2021.

FY21 PROGRESS: The multi-unit affordable housing complex was finished and occupied in 2021.

FY22 PLANS: Duke's work related to Affordable Housing is and will continue to be led by Duke University's Office of Durham and Community Affairs. For insight into this and other work led by the Office of Durham and Community Affairs see: https://community.duke.edu/programs-initiatives/housing-neighborhoods/

### 2. Access to Healthcare and Health Insurance

Access to health care in a community refers to the ability of residents to find a consistent medical provider for their primary care needs, to find a specialty provider when needed and to be able to receive that care without encountering significant barriers. Although there are many medical providers, which include a number of low cost and free clinics in Durham County, there are still many Durham residents who have trouble accessing care when they need it. Barriers to obtaining

health care include issues with transportation, language barriers, or distrust of the healthcare system. The top reasons identified by Durham County residents for why they or someone in their household could not access necessary healthcare included insurance didn't cover service, copay was too high, lack of insurance, couldn't get an appointment, didn't know where to go or provider didn't take their insurance.

A number of long-standing programs supported by DUH seek to increase access to care for uninsured, underinsured and/or vulnerable individuals and families including:

***Project Access of Durham County (PADC)*** links eligible low-income, uninsured Durham County residents to specialty medical care fully donated to the patients by the physicians, hospitals including DUH, labs, clinics and other providers participating in the PADC network. PADC celebrated its 10$^{th}$ anniversary of service in April 2019.

FY20 PROGRESS: While FY20 began as yet another successful year for PADC, many services in the latter part of FY20 were disrupted/delayed as a result of COVID19. PADC, like many other programs, focused energy and resources to address basic needs of patients and community members as they struggled with the impact of COVID19 – health, income, housing, food.

FY21 PLANS: PADC will continue to focus on COVID19 response efforts and provide as many specialty services as possible given ongoing COVID19 disruptions/delays.

FY21 PROGRESS: PADC continued to focus on COVID19 response efforts and partnered with numerous community organizations to help individuals impacted by COVID19. PADC continued to link as many uninsured individuals as possible to specialty services in spite of disruptions/delays that continued as a result of COVID19 in FY21.

FY22 PLANS: Continue COVID19 response efforts and navigate disruptions/delays in specialty services that may occur due to COVID19.

***Local Access to Coordinated Healthcare (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.

FY20 PROGRESS: Despite reduced staffing in 2020 and COVID19, LATCH still provided care management services to 335 individuals.

FY21 PLANS: Continue care management services and COVID19 response efforts.

FY21 PROGRESS: LATCH continued to partner with various Duke and community organizations in COVID19 response efforts in FY21. In addition, LATCH provided care management services to 772 individuals.

FY22 PLANS: LATCH will continue care management services and COVID19 response efforts to address the needs of its patient population given the resources available.

***The Complex Child Program (CCP)*** provides the coordination of medical and co-management of medical care for children with multiple medically complex issues that require the interaction with multiple specialists. On average these children work with 13 specialists. Before the Complex Child Program, care could seem fragmented as patients/families had no central "quarterback" helping to oversee the big picture.

Through the CCP parents now have direct phone access to a complex care service (CCS) provider or RN 24/7. The CCP team works with parents to create a comprehensive "complex care plan" that is placed in the Child's medical record and given to the parents. In addition, the CCP team coordinates inpatient intensive care transitions prior to discharge and conducts intensive outpatient "between-visit" contacts (phone, clinic visits, and in some cases, home visits).

FY20 PROGRESS: CCP has served 156 children since inception and continues to provide ongoing care to 106 patients. The volume/census of the program depends upon the children who need the service, and staffing volume flexes to meet the needs of the children and their families.

FY21 PLANS: Continue the CCP serving children with multiple medically complex issues and their families.

FY21 PROGRESS: As in FY20 CCP continued to maximize services to children with multiple medically complex issues and their families.

FY22 PLANS: Continue the CCP serving children with multiple medically complex issues and their families.

***Southern High School Wellness Center*** provides comprehensive primary care and mental health services at Southern High School to students at the school and is open to all students and staff of Durham Public Schools. Operated by Duke's Division of Community Health on behalf of DUH, the Southern High School Wellness Center celebrated 25 years of service in 2020. Durham Public Schools closed for in-person learning in March of 2020 as result of COVID 19. The Southern High School Wellness Center pivoted to providing telehealth services (via phone/video visits) in 2021.

***Just for Us (JFU)*** provides in-home care program for low-income, frail elderly and disabled. JFU was 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.

In late December of 2019 reports of carbon monoxide poisonings began at the McDougald Terrace Apartment Complex. By early January 2020 the Durham Housing Authority had relocated hundreds of residents to 15 hotels across Durham. The Just for Us team deployed to provide health care for residents across the 15 hotel sites during January and February. Almost all of the Just for Us in home visits ceased in March of 2020 as a result of COVID 19. As a result, the JFU team conducted frequent well-check calls and provided telehealth services (via phone/video visits).

***Neighborhood/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 open 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.

At the onset of Durham's stay-at-home orders, the Holton Wellness Center had to close as it is located in a school and multi-purpose center. The team was able to move to the other neighborhood/community clinic locations and all of the neighborhood/community clinics added telehealth services (via phone/video) in addition to in-person visits.

FY20 PROGRESS: In spite of the disruption caused by COVID 19, the Southern High School Wellness Center, Just for Us, and the Neighborhood/Community Clinics provided more than 12,000 clinical encounters in 2020.

FY21 PLANS: The Southern High School Wellness Center, Just for Us, and the Neighborhood/Community Clinics hope to return to pre-pandemic levels of clinical encounters of 13,000+

FY21 Progress: The Southern High School Wellness Center, the micro-clinics and Just for Us continued to adjust to the impacts of COVID19 and provided 10,049 in person and video/telehealth patient visits.

FY22 PLANS: Utilizing lessons learned during COVID19, the Southern High School Wellness Center, the micro-clinics and Just for Us will continue to find ways to improve and expand video/telehealth patient visits as the COVID19 pandemic continues.

## 3. Poverty

Poverty has a strong impact on health and is an important concern for Durham residents. Research now shows that even the risk of an adverse change in material conditions — economic and housing insecurity, as well as un- or underinsured health insurance coverage — affect health outcomes. Reasons for the association between economic insecurity and health include the health effects of stress resulting from economic insecurity, effects of stress and spending limitations on food consumption, and restricted use of health services.

***Increase in Minimum Wage:*** Effective July 1, 2019, Duke University and Health system increased the minimum wage to $15 per hour for all employees and expects all contractors with employees working full-time on campus to do the same and on July 1, 2019.

***Second Chances:*** Since September 2018, Duke no longer requires job applicants to disclose criminal history during the application process.

***SSI/SSDI Outreach, Access and Recovery (SOAR):*** helps patients who are chronically homeless, or at risk of homelessness access health insurance, a stable income, and medical care by assisting these individuals in applying for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). The homeless population and those reentering the community from an institution face numerous challenges in accessing services. Approval on initial SSI and SSDI applications for these at-risk populations, who have no one to assist, is about 10-15 percent. For those with mental illness, substance abuse issues, and/or co-cognitive impairment, the application process is even more difficult. Even with assistance, the application process can take up to six months. Through SOAR, these individuals with complex needs are provided case management for home, hospital, and clinic visits; are provided with a step by step explanation and completion of all applications for federal disability benefits; receive expedited applications for monthly income and Medicaid/Medicare; and are linked to community resources. DUH currently funds two SOAR Case Managers who have successfully helped more than 100 patients in the last 3 years.

FY20 PROGRESS: The SOAR Program anticipated at least 100 referrals in 2020. Unfortunately, program staffing was limited to one SOAR Case Manager. Since the application process often takes a year to complete, COVID19 had a significant impact on progress. Only 22 applications were fully processed.

FY21 PLANS: Return to pre-pandemic levels of referrals and completed applications.

FY21 PROGRESS: FY21 did not bring the relief from the COVID 19 pandemic that the world had hoped for, but the SOAR program was able to service 20 cases.

FY22 PLANS: Continue to adjust to COVID19 disruptions and maintain a minimum of 20 cases.

***Benefits Enrollment Counseling (BEC):*** In FY 16 the Duke Division of Community Health launched the Benefits Enrollment Counseling Program (BEC) with grant funding through the National Council on Aging to help seniors and those with disabilities and a limited income find and enroll in all the benefit programs for which they are eligible. The goal of the service is to enable older adults to enjoy life and live independently in their homes and communities for as long as possible. For those with limited

income and resources, additional support can be critical in maintaining their health and avoiding costly hospitalizations. The benefits provide clients served with access to healthy food, needed medical care and prescriptions, as well as other supportive services. The benefits also provide a community economic stimulus, as benefits are spent locally in pharmacies, grocery stores, utility companies, and health care providers. To increase the reach of the program beyond grant funding, BEC staff train volunteers (from partner community based organizations and Duke) to assist clients in Durham, Granville and Person Counties. BEC currently works with 26 Duke undergraduates and medical students. These students engage in service, outreach, and advocacy efforts, as well as build meaningful intergenerational relationships.

In 2019 BEC launched the COPE initiative (Community Outreach, Prevention, and Education), which offers health screening and education in the community, and initiatives that directly address gaps in senior hunger prevention through teaching self-sufficient, sustainable gardening practices and the provision of cooking classes at senior centers.

FY20 PROGRESS: Even with the disruption of COVID19, BEC assisted 622 individuals with an average of 1.7 applications per person for benefit programs. The total value of benefits was $2,304,359.00. BEC made a great deal of progress in clearing two acres on the roof of a parking garage to prepare it for the installation of irrigation for a community garden. On site physical work on the area came to a halt in March 2020 as a result of COVID19, but planning for the proper irrigation continued and on site work will pick up as soon as allowed. Efforts related to the COPE program focused on COVID19 response assistance for seniors and included weekly well-check calls as well as the delivery of prepared meals and food boxes.

FY21 PLANS: Continue COVID19 response assistance and BEC. Return to community garden work when allowed.

FY21 PROGRESS: As COVID19 continued to upend numerous activities, work on the community garden did not continue in 2021. BEC did assist in COVID19 response efforts (see COVID Response Section at the end of this report) and continued to connect eligible individuals to resources. BEC assisted 475 individuals with an average of 1.29 applications per person for benefit programs. The total value of benefits was $1,957,098.00.

FY22 PLANS: Continue COVID response assistance and BEC. Return to community garden work when feasible.

### 4. Mental Health

Mental health and substance use disorders have indirect costs such as prevention, treatment, and recovery supports. But, there are also indirect costs such as motor vehicle accidents, premature death, comorbid health conditions, disability, lost productivity, unemployment, poverty, school difficulties, engagement with social service, juvenile justice, criminal justice systems, and homelessness, among other problems. DUH partners with and supports a number of collaborative initiatives to improve access to mental health services and reduce substance abuse.

DUH continues to serve as a key partner in the following activities:

- ***Community Coalitions:*** Durham Crisis Collaborative; Partnership for a Healthy Durham Mental Health Committee and Durham Together for Resilient Youth; Durham County Leadership Forum on Substance Abuse and Mental Health.

- ***Naloxone Outreach:*** Pharmacies (Duke South, Clinic Pharmacy, Main Street, Gurley's, Josef's, & Duke Cancer Specialty); Durham County Department of Public Health; Durham Mobile Crisis Unit.

- ***Provider Education:*** Provider Toolkits and CME Education; Use of Pain Agreements; Use of Controlled Substance Reporting System (CSRS); Chronic Pain Provider Consultation Calls.

- ***Diversion Control:*** Permanent Drop Boxes in 5 of 6 counties (Durham, Franklin, Person, Granville,Vance).

- ***Chronic Pain Patient Support:*** Chronic Pain Self-Management Workshops at Lincoln Community Health Center; Chronic Pain Management Resources; Key community presentations.

- ***County-wide Adverse Childhood Experiences (ACEs) and Community Resiliency Model (CRM):*** activities and training.

FY20 PROGRESS: Partnership in the activities listed above supported the continuation of a number of initiatives including the placement of peer support specialists for the DUH Emergency Department; A Medication Assisted Therapy Program in the Durham County Jail. In addition, chronic pain self-management workshops continued at Lincoln Community Health Center and the activities and training in ACES and CRM continued across the County.

FY21 PLANS: Continue to serve as a key partner in the collaborative activities to reduce substance misuse and increase access to mental health services.

FY21 PROGRESS: Durham Detention Center MAT Program now provides induction treatment services (Phase II of MAT) for individuals with SUD. They also received approval from the State to begin an Opioid Treatment Program within the Detention Center. Detention Center has hired a Licensed Clinical Additions Specialist (LCAS) and Peer Support Specialist to continue care coordination of services.

Durham Department of Public Health by way of Alliance Health provided Opioid Use Disorder (OUD) Provider Training Series in May 2021. Several Duke Providers were among the presenters for the training. An updated Substance Use Disorder Resource Guide on Public Health's website under the DJT Task Force Section. This was a collaboration with the Durham Joins Together (DJT) Prevention Education Committee.

Alliance purchased Naloxone (Narcan) and disseminated to partnering organization to help with the shortage of naloxone access. Alliance providing additional funding to support efforts with Detention Center MAT and Peer Support Specialists (PSS) services.

FY22 PLANS: Mental Health Treatment Committee will continue work and identify SUD Housing resources for individuals in active MAT treatment programs. Alliance providing Additional funding to

support efforts. Current listing for MAT Housing resources is on Durham Public Health website under the DJT Task Force Section.

Peer Support Specialist provided by DRRC to begin supporting inpatient services in Duke University Hospital and Duke Regional Hospital. Using technology resources to promote DRRC services for patients Such as the expansion of DRRC's OBOT program.

Durham Public Health plans to have the SUD Resource Guide translated in Spanish.

***DUHS Safe Opioid Task Force*** was created **t**o improve the safety of pain management by encouraging clinical practice standardization, where clinically appropriate, when opioid therapy is designated for treatment. The Opioid Safety Task Force provides recommendations for the initiation and management of opioid therapy across Duke University Health System (DUHS) to improve personal and community safety and reduce harm associated with the high risk treatments while engaging patients in their own care. DUH along with Duke Regional and Duke Raleigh Hospitals serves as a pivotal player in all aspects of the work of the Task Force.

FY20 PROGRESS: Training providers across Duke in Medication Assisted Therapy (MAT) continued with more than 100 providers now trained.

FY21 PLANS: Continue the work of the Task Force.

FY21 PROGRESS: Active Duke MAT providers are listed in EPIC (Duke Electronic Health Record) for the scheduling of patients requiring MAT services. This greatly enhances the ability to get patients quickly scheduled with MAT providers.

FY22 PLANS: Continue efforts to support treatment options for individuals living with OUD/SUD.

## 5. Obesity, Diabetes, and Food Access

As of 2016, 65% of adults in the Piedmont region, which includes Durham, were overweight or obese. Additionally, 12% of Durham high schoolers were obese as of 2014. Obesity is a strong contributor to diabetes. In 2015, 14.1% of Durham County residents aged 18 years or older who received some level of care from Duke Health and/or Lincoln Community Health Center had diabetes. Many diseases are linked to nutrition, including obesity, hypertension, high cholesterol, diabetes, and some cancers. Food insecurity, the state of being without reliable access to a sufficient quantity of affordable, nutritious food, has a large impact on a person's diet. It is estimated that 17.9% of Durham residents (51,710 people) are food insecure.

***Bull City Fit*** is a community-based wellness program and is part of the larger Duke Children's Healthy Lifestyles program. The Healthy Lifestyles program seeks to address weight-related health problems for children by offering caring providers, family-centered treatment programs, highly trained educators and researchers, and strong community partnerships. Bull City Fit helps in this effort by offering free evening and weekend activity sessions for the larger community. These sessions cover various themes that encourage and promote active living, such as fitness games, sport lessons, exercise routines, swimming, cooking, and gardening. Each activity is facilitated with the support of energetic staff and volunteers to create a positive and fun environment for all.

Bull City Fit empowers the whole family to increase knowledge and practice of physical activity and healthy eating; address current weight-related illness and prevent chronic disease through increased activity levels; improve quality of life by promoting healthy behaviors; increase confidence, support positive change, and build a lifelong commitment to a healthy lifestyle.

Partners include: Durham Parks and Recreation; Durham City Government; Durham County Department of Public Health; East Durham Children's Initiative; Lincoln Community Health Center; Community Nutrition Partnership; Veggie Van; Blue Pointe Yoga; Durham Public Schools; Partnership for a Healthy Durham; Duke Service Learning; Duke Family Medicine; Duke Children's Hospital and the UNC School of Social Work.

FY20 PROGRESS: Bull City Fit began expansion planning for additional sites in 2019-2020. At the onset of the COVID 19 pandemic in the latter part of FY 20, Bull City fit continued to provide services via ZOOM and other remote platforms.

FY21 PLANS: Continue to provide services via ZOOM and other remote platforms. Return to in person activities when allowed.

FY21 PROGRESS: Due to the ongoing COVID19 precautions, services continued via Zoom and other remote platforms, alternating between fun cooking and fitness activities.

FY22 PLANS: Continue online offerings. Return to in person activities when feasible.

## COVID19 Response:

All three DUHS hospitals provided extensive outreach, staffing and resources to advance equitable access to COVID19 testing and the distribution of vaccines. Two programs that illustrate unique and collaborative responses in Durham include:

DUHS-NCDHHS COVID19 Support Services Program: Between August of 2020 and May 2021, Duke University Health System (DUHS) served as lead entity for Region 3 of the NC DHHS COVID19 Support Services Program (SSP). Local Community Based Organizations (CBOs) provided services across a 7 county region, including Durham, Franklin, Granville, Nash, Vance, Wake and Warren. DUHS contracted with not only organizations with the best overall reach, but also with those who could generate impact within Highly Marginalized Populations (HMP) disproportionally affected by the pandemic. The accomplishments were the result of an intentionality of partnerships made to most effectively reach these areas. As of the program's conclusion, our network of CBOs served over 14,500 food boxes, over 65,000 meals and more than 13,000 packages of COVID supplies to households in our 7 counties. Additionally, nearly $4 Million in relief payments were dispersed to just under 5,000 households. In total the program served 8,199 unique households reaching approximately 35 thousand individuals. Survey results indicated that 88% of participants were able to quarantine safely from COVID-19 as a direct result of these services.

DUHS-Durham County COVID19 Testing Site: In July of 2020 Duke University Hospital, through the Duke Division of Community Health, partnered with the Durham County Health Department and Durham Public Schools to operate a COVID19 testing site in East Durham. This area consisted of two zip codes

experiencing Durham's highest burden of COVID19. The testing site was located at a trusted site, Holton Wellness Center, which is one of the Division of Community Health's clinics noted earlier in this report. The Durham County Health Department's Contact Tracers had the ability to directly schedule testing appointments – a unique feature that enabled individuals exposed to COVID19 to quickly access testing. Individuals without appointments were also welcome to utilize the site. It was the first community testing site in Durham to offer evening and Saturday hours. The majority of the site's staff were bilingual or bilingual-bicultural. Over a 9 month period, more than 4 thousand people were tested mostly (94%) essential workers and people of color. In addition to testing, the site offered food boxes through partnerships with the Food Bank, local food pantries, and Farmers' Foodshare and connections to other resources to help individuals and families impacted by COVID19.