Duke University Hospital

Community Health Needs Assessment

FY25 Progress Report and FY26 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, 2024, DUHS provided $1.021 billion in community benefit and community investment.

James P. Duke's vision laid the cornerstone for Duke University 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. DUH is an active partner with patients, neighborhoods, community organizations and governments in 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. Duke Health was a founding member of the Partnership in 2004. Faculty and staff of DUH as well as faculty and staff from across Duke University serve on Partnership for a Healthy Durham Committees and work in numerous roles to complete the Assessment and develop the subsequent strategies.

This report reflects the assets and needs identified by the Durham Community Health Assessment conducted in 2022-2023 and published by Durham County in 2024. The Community Health Assessment Team — comprised of representatives from Duke University Health System, local 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 process included 205 resident surveys from randomly selected households and 175 surveys through the Communidad Latina CHA. Listening sessions conducted throughout Durham displayed survey results and engaged community members in determining the top health priorities. Eighty-six individuals contributed to writing the Durham Community Health Assessment document.

The assessment identified five health priorities for 2024-2027:

1.) Affordable Housing
2.) Access to Care
3.) Community Safety and Wellbeing
4.) Mental Health
5.) Physical Activity, Nutrition and Food Access

The five health priority areas for 2024-2027 remain the same as those identified in 2020-2023 except for the third priority. In 2020-2023, the third health priority was poverty. In this latest assessment, "violent crime" was the third health priority named, but in consideration of utilizing an assets-based approach, the priority broadened to "community safety and wellbeing".

The full Community Health Assessment can be found on the DUHS website https://corporate.dukehealth.org/community and on the Partnership for a Healthy Durham Website: https://healthydurham.org/health-data-2.

All of the programs described in the following implementation plan align with the five health priorities with many of the programs addressing combinations of the five health priorities. 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 Health or Duke University.

FY25 IMPLEMENTATION PLAN

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. Forty-four percent of renters in Durham are cost-burdened (i.e., paying more than 30% of their monthly income for housing).

DUH has collaborated with Habitat for Humanity of Durham on a number of home builds. Additionally, affordable housing is a focus of the larger Duke University. Duke University's Office of Durham and Community Affairs leads Duke's work related to Affordable Housing. For insight into this and other work led by the Office of Durham and Community Affairs see: https://community.duke.edu/our-focus-areas/neighborhoods-housing-and-infrastructure/.

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, and cost. Medicaid expansion in NC has helped some uninsured secure insurance coverage, but gaps still exist.

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 by physicians, hospitals including DUH, labs, clinics and other providers participating in the PADC network.

FY25 PLANS: Based upon previous accomplishments, PADC anticipates serving 2,000 people in 2025 providing more than 3,000 episodes of care from specialty physicians and other providers. PADC's Durham Homeless Transitions Program anticipates working with more than 40 unhoused persons and its Health Equipment Loan Program anticipates providing 1,000 pieces of durable medical equipment to PADC clients.

FY25 PROGRESS: PADC met with success in reaching its anticipated level of services for FY25.

FY26 PLANS: PADC anticipates serving the same number of people and providing more than 3,000 episodes of care in FY26.

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. Southern High School's student population is 100% total economically disadvantaged and 47% of its student population identifies as Hispanic/Latino.

Just for Us (JFU) provides in-home care for low-income, frail elderly and persons with disabilities. 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. JFU also utilizes mobile lab and imaging services. The health care team consists of a clinical provider (PA, NP or MD), occupational therapist, registered dietitian, social worker, phlebotomist, and community health worker. JFU also offers facilitated telehealth specialty visits – a JFU team member, JFU patient, and the specialist conduct a joint telehealth visit, ensuring continuity of information between patient, JFU provider and the medical specialist.

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.

FY25 PLANS: Based upon previous utilization, the Southern High School Wellness Center, JFU and the Neighborhood Clinics anticipate at least 12,000 visits in FY25.

FY25 PROGRESS: The Southern High School Wellness Center, JFU and the Neighborhood Clinics experienced some staffing shortages in FY25, but were still able to realize more than 10,500 patient visits in 2025.

FY26 PLANS: The Southern High School Wellness Center, JFU and the Neighborhood Clinics anticipate filling staff openings in FY26 and anticipate at least 10,000 visits in FY26.

Benefits Enrollment Counseling (BEC) receives grant funding ($250,000) 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, Vance and Person Counties. The program serves as a partner site for Duke Students participating in Duke Service-Learning, the School of Medicine's MBS Program and its Primary Care Leadership Track.

FY25 PLANS: The BEC will continue to educate student volunteers, providing opportunity for client engagement in longitudinal relationships, with training around Medicare, Social Security and benefit programs to undergraduate and graduate students alike. Based upon previous accomplishments the BEC anticipates serving 500 clients secure more than $1.5 million in benefits in FY25.

FY25 PROGRESS: BEC served 448 clients in FY25-just short of its goal of 500. However, the value of benefits secured for clients far exceeded the goal for FY25. In FY25, BEC secured $2.85 million in benefits for its clients.

FY26 PLANS: BEC anticipates serving a similar number of clients in FY25.

3. Community Safety and Well-being

Durham Community Health Assessment survey respondents noted that neighborhood violence was a primary cause of stress (12%). Specifically, respondents noted violent crime (18%), theft (4.7%), and gang activity (4.2%) as having the greatest impact on quality of life.

Duke University Hospital Violence Recovery Program launched in September 2022 reframes violence as a preventable healthcare issue. Four team members support residents in the city of Durham and Durham County who have experienced violence, with the goal of preventing readmission to the Duke Trauma Center.

Intensive case management starts in the emergency department with the patient and family members. Throughout a hospital stay, program staff meet with the patient and family. Team members follow residents for up to one year. During that time, case management support includes tackling concerns around housing, transportation, mental health, employment, life skills and more.

FY25 PLANS: Having increased from 3 to 4 team members over the last year, the DUH Violence Recovery Program will continue to support victims of violence and their families to ensure connections to the services that will best assist them in accomplishing the goals that the victims and their families set forth.

FY25 PROGRESS: The Office of Community Health serves on the Steering Committee. Our work centers on supporting efforts to unify research and practical efforts across Duke. while also facilitating the work of our three specialized subcommittees focused on research, feasibility for a new center, and pediatric health responses.

FY26 PLANS:

In FY26, the Steering Committee will conduct a Community Needs Assessment to evaluate if a permanent Duke Gun Violence Prevention Center is the most effective model for long-term support and city-wide alignment.

4. Mental Health

Most Durham Community Health Assessment survey respondents (67.1%) reported that they had fewer than six bad days in the past 30 days. Unfortunately, almost 10% reported they had greater than 20 bad days in the past 30. Forty percent of respondents noted that their mental health worsened since March of 2020. In terms of stress, financial stress was the most reported reason followed by work and personal relationships.

In 2021, Duke opened the Duke Behavioral Health Center on Duke Regional Hospital's Campus and expanded the hospital's emergency room. The $102.4 million Center and expanded emergency room consolidated inpatient, outpatient and emergency behavioral health services on Duke Regional's campus, with the goal of providing better coordination of care for behavioral health patients in Durham and regionally. The Center incorporates meeting space specially designed for community-based organizations providing services for behavioral health patients and their families

FY25 PLANS: Continue to provide coordinated behavioral health services across Duke Health and in partnership with local government and community-based organizations providing services for behavioral health patients and their families.

FY25 PROGRESS:

Integrated Emergency Room Diversion Program: Duke Health and Alliance Health collaborate through an integrated emergency room diversion program that includes embedding contract social workers and crisis liaisons directly within Duke's Emergency Departments to streamline transitions to specialized care.

Durham Familiar Faces Initiative: Duke Health is an active and central partner in the Durham Familiar Faces Initiative (DFFI). This program is specifically designed to address the needs of "high utilizers", individuals who frequently cycle through the emergency department (ED), the county jail, and homeless shelters due to untreated mental health or substance use disorders.

Pediatric Emergency Department Extension Area: The Pediatric ED extension area which opened in early 2024, served approximately 250 youth ranging from 6 to 17 years old its first 10 months. Clinical data showed that moving children to this dedicated space led to a marked decrease in the need for rapid behavioral response interventions.

FY26 PLANS:

5. Physical Activity, Nutrition, and Food Access

Most Durham Community Health Assessment survey respondents reported that walking was their primary form of exercise followed by lifting weights and gardening. Time and Cost were the most common reasons for not eating healthy, but 83.1% of respondents reported that they never worried about food running out before they could buy more.

Duke Health, in partnership with the Durham County Department of Public Health, secured a multi-year grant totaling $750,000 from The Duke Endowment to become a part of the Endowment's Healthy People, Healthy Carolinas Initiative. The Initiative supports coalitions aimed at improving the health and well-being of communities to reduce chronic disease. The coalitions place significant emphasis on physical activity, nutrition and food access. Durham's coalition is the Partnership for a Healthy Durham's Physical Activity, Nutrition, and Food Access Committee.

Several Healthy People, Healthy Carolinas-related initiatives forward during the first implementation year. The food recovery program saved over 2000 pounds of food, feeding 1725 people. The vaping prevention program was successfully introduced into one elementary school in the spring, teaching 33 students. Six leaders and eight community members trained in self-management skills for chronic illness in a train the trainer model. PANFA collaborated with City transportation staff to install a bike fix-it station, a free resource for bicyclists to fix mechanical issues, connecting multiple parks. PANFA members engage in the City's Vision Zero plan and the joint City and County Bike and Pedestrian plan, both aiming to improve safety of streets and access to safe activity

FY25 PLANS: Continue efforts to increase physical activity in children. Work with the eleven parks and schools that expressed interest in installing painted activities outside for children's use. Install activity stickers in waiting areas at the health department, where children often utilize screen time for entertainment. In addition, the coalition will collaborate with public libraries for physical activity and healthy eating programs, work with local government departments to host Open Streets events and increase visibility and utilization of walking groups in the area.

FY25 PROGRESS: PANFA encouraged children to engage physical activity by making enhancements to school and public playgrounds. Four hundred thirteen children participated in tracking physical activity and teachers were surveyed regarding physical activity levels and any other impacts of the enhancements. Seventy-two percent of the students got 30-60 minutes of activity compared to 68% before the enhancements. The percentage of time the students spent being active while outside increased from 68% to 86%. Teachers noted fewer discipline issues during recess as more students engaged in physical activity. Teachers also noted that students seemed more interested and engaged in class.

FY26 PLANS: Continue efforts to increase activity in children through collaborative community-centric approaches.