



**DUKE UNIVERSITY MEDICAL CENTER
AND HEALTH SYSTEM
DURHAM, NC
February 2004**

Executive Summary

Rather than seeking health care from a primary care physician, many of Durham County's economically disadvantaged, elderly, and minorities obtained treatment through the Emergency Department. In order to improve the quality and consistency of the delivery of primary care, the Duke University Medical Center and Health System initiated Promising Practices. Promising Practices' initial objective was to establish a proactive solution in the form of a "new type of house call." Promising Practices delivers primary care in the patient's home or nursing care facility. The objectives have since expanded to include providing health education in the areas of diabetes, hypertension and asthma, and screening for disease and indicators of future disease.

Since its inception, hospitals in the Duke University Health System have reported a significant decrease in the number of patients with non-emergency illnesses seen in the Emergency Department, an increase in compliance with medical prescriptives, and financial savings. Patients have benefited from an increase in preventative treatment for disease and are pleased with the continuity of care they are now able to receive.

Organization Size: 1,500 beds

Program/Initiative Description

Promising Practices: The Duke University Health System recognized that there was a significant number of patients coming to the emergency room for treatment that would be better delivered at a physician's office. Many patients were single mothers, minorities, and the elderly who chose to go to the emergency room rather than a primary care physician because of a lack of insurance or an inability to pay. Apparently, those residents weren't getting the primary care they needed to stay out of the hospital, or were going to primary care appointments, but having trouble following the caregiver's instructions at home. Initially, the health system responded by setting up several urgent care facilities. These urgent care centers were strategically located in minority or lower income areas of the city. While some of the strain on the emergency room was removed, the problem of delivering excellent primary care was not fully achieved. The need to fully resolve the problem led to the establishment of "Promising Practices." The concept behind Promising Practices was to create a "new kind of house call." Rather than patients going to a physician's office, the physician or nurse practitioner would go to them.

The first issue addressed was who should be invited to join the program. The first step was to focus on those patients who were using the emergency room for their primary care. In searching the health care system's database, it was soon discovered that the majority of the patients were coming from and lived in a few specific areas. Residence in those areas became the first qualification requirement. Additional qualifications included the inability to pay for health services and a diagnosis of diabetes, hypertension, or asthma. Once those criteria were established, qualified patients were contacted and informed about the program.

Promising Practices was soon expanded to include health education and screening programs for the diseases of diabetes, hypertension, and asthma. Periodic health screenings and information sessions were launched at senior citizen living communities, churches, barbershops, nail salons, and community events like the State Fair. Community screening gave even more people an opportunity to receive information in the areas of health concern with the intent of shifting the focus to disease prevention and prospective health.

Establishment of Program/Initiative: 1999

Racial or Ethnic Disparities Problem the Program/Initiative Was Designed to Address: A high percentage of the population was not receiving necessary health care treatment or preventative information.

Major Objectives

- Establish a program to give patients much needed health care in an alternative setting
- Educate the community in prevention and treatment of diabetes, hypertension, and asthma
- Launch screening programs that would reach the maximum number of people with the goal of preventing future disease rather than treating after diagnosis

Significant Results

- Decrease in the number of non-emergency patients seeking care at the emergency room
- Increase in compliance with medical instructions and follow-up treatment

External Partners in the Program/Initiative

- Lincoln Community Health Center
- Durham County Department of Social Services
- Durham County Housing Authority
- Durham County Health Department
- Durham County Asthma Coalition

Limitations or Problems Encountered

- Funding
- Introducing the program to the community in a way that would establish enthusiastic participation
- Ensuring the longevity of the program through the establishment of an advisory board and participation from community leaders and patients

Estimated Cost of the Program, To Date: \$4 Million for three years

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