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Improving Diabetes Care With the Collaborative Model: The First North Carolina Diabetes Collaborative

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PEER REVIEWED

The planning, implementation, and outcomes of the North Carolina Diabetes Collaborative, modeled after the Bureau of Primary Health Care's Health Disparities Collaborative, is described.

The North Carolina Diabetes Collaborative is the result of a partnership between the North Carolina Diabetes Prevention and Control Program and the North Carolina Primary Health Care Association. An advisory council made up of strategic statewide partners complements this partnership. Fourteen teams from various health care settings across North Carolina were recruited to participate in this intervention, which focuses on improving the management of diabetes.

Participants receive technical assistance that includes learning sessions, monthly conference calls, distribution lists, and feedback on monthly reports. Teams address system-level changes and use monthly reports to track improvements in delivery of care and health outcomes. An electronic database helps the teams to identify effective interventions and to track outcomes using 8 required measures.

Improvements have been documented in the 8 required measures. Improvement has been most remarkable in the number of patients who have had their HbA1c levels checked twice per year, the number of patients with blood pressure levels below 135/85 mm Hg, the number of patients receiving foot exams, and those with low-density lipoprotein cholesterol levels below 100 mg/dL. During the first 6 months, the teams entered data on 907 patients into their disease management registries.

The North Carolina Diabetes Collaborative shows promise of increasing the quality of care for patients in participating sites. Next steps include obtaining funding for future collaboratives; expanding content area to include cardiovascular disease; incorporating feedback to improve the collaborative; and expanding the number of participants.

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