Spotlight on the Safety Net

A Community Collaboration
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North Carolina Diabetes Collaborative

In 1998, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the Institute for Healthcare Improvement (IHI) joined together to create the national Health Disparities Collaboratives program. The program focuses on "decreasing health disparities through adoption of improvement processes by health centers."[1] A major focus of the Health Disparities Collaboratives program has been diabetes, which is far more prevalent among African Americans and Latinos than among Whites. The National Diabetes Collaborative has been in place since 1999 and has been implemented in more than 260 health centers nationwide.[2] The North Carolina Diabetes Collaborative was founded in 2003 to address the needs of diabetic patients utilizing North Carolina's safety net organizations. The North Carolina Diabetes Collaborative is part of the Southeast Atlantic Cluster of the National Diabetes Collaborative and is currently in place in health centers throughout the state. This *Spotlight on the Safety Net* highlights 2 programs participating in the Collaborative.

Blue Ridge Community Health Services

Blue Ridge Community Health Services (BRCHS) provides reduced-cost health care services for North Carolinians living in the Hendersonville area. BRCHS has 4 sites, including a family practice site, a pediatric site, a dental center, and a school-based health center. As a community health center, Blue Ridge Community Health Services serves patients who are low-income, uninsured, and underinsured.

The family practice site of BRCHS has been a part of the North Carolina Diabetes Collaborative since 2004. The clinic team works with the Chronic Care Model,[3] as well as an improvement process model called PDSA (Plan, Do, Study, Act), as a way to improve goals and patient care. As Collaborative participants, the clinic staff collect data, report to HRSA monthly, attend quarterly meetings and learning sessions with other programs in the state, and also attend an annual HRSA/Health Disparities Collaboratives national meeting.

Since its inception in 2004, BRCHS has tracked over 500 diabetic patients. BRCHS sees a largely Latino population (47.9%) followed by White (44%) and African American (6.9%). Diabetic patients are entered into a database application that is designed to assist care providers as well as management in tracking the quality of care provided to patients. The database tracks clinical indicators such as their hemoglobin A1Cs and intermediate density lipoproteins (IDLs). Glomerular filtration rates (GFRs) are also tracked for all patients who have certain blood panels run. A record of recommended screenings, such as foot exams, as well as the patient's self-management goals are recorded as well.

A care management team convenes monthly to review reports that are generated from the database and check for any goals that are not being reached, any gaps in services, or any potential warning signs that the disease could be worsening. The team then selects 1 or 2 goals to focus on, such as hemoglobin A1C levels. The indicator is then examined for all diabetic patients over the previous several months. Patients are followed up with accordingly and may be contacted to schedule an appointment. The team works to ensure that each diabetic patient comes into the clinic every 3 months for a diabetic check. Before each visit, the team does a chart review to check if the patient needs any lab work, immunizations, eye exams, or other services.

If a patient starts to show signs of chronic kidney diseasae (CKD), the case management team refers them to a kidney doctor and monitors their labs. They may also make referrals to local specialists and work with patients to help them afford needed care. Finally, BRCHS provides diabetes education in addition to

contracting with a 340B pharmacy to assist patients in getting reduced price glucose test strips. The program has made an impact in preventing chronic kidney disease as it has made providers, staff, and patients more aware of the disease.

Bertie County Rural Health Association

The Bertie County Rural Health Association is a federally-qualified health clinic that was founded in 1984 in Windsor, North Carolina. The Bertie County Rural Health Association (BCRHA) provides sliding fee scale services including primary care, dental care, diagnostics, and emergency services. The clinic also has arrangements for patients to receive pharmaceuticals and transportation at reduced or no cost. The association serves a large underserved area and provides care to a population that is overwhelmingly African American and/or living in poverty.

With support from the Kate B. Reynolds Charitable Trust, the BCRHA started the Diabetes Collaborative program in 2003. The program is part of the National Diabetes Collaborative and the North Carolina Diabetes Collaborative. Since 2003, the BCRHA has tracked more than 900 patients with diabetes. Bertie County is home to a large number of diabetic and CKD patients, many of whom face additional challenges such as geographic and rural isolation, lack of transportation, and poverty. The collaborative began as a response to these issues.

Diabetic patients have some type of medical exposure (ie, physician visit or health education session) at least once every 6-8 weeks. The staff check hemoglobin A1C levels and ensure that medications are being taken. BCRHA also provides free glucose monitors and a hotline for patients to call if they are concerned their blood sugar is rising.

The Bertie County Rural Health Association also places a high value on health education. In addition to running an educational video in the waiting room of the clinic, a health educator holds a monthly program at the clinic to discuss nutrition as well as any new developments in the treatment of diabetes. The health educator discusses realistic food options so that patients are more likely to adhere to a nutrition plan. Additionally, health educators and physicians strongly encourage their diabetic patients to use the walking trails around the local elementary schools. Health educators also make house calls to discuss diabetes with the diabetic patient as well as his or her family. The hope is that greater family involvement will lead to improved outcomes for the patient and also for the rest of the family. The Bertie County Rural Health Association also maintains close relationships with the local African American churches and uses these relationships as a conduit to conduct outreach and health education through events such as screenings and health fairs.

The Bertie County Rural Health Association is seeing fewer patients on dialysis as a result of the Diabetes Collaborative. Staff also report seeing significant weight loss, fewer ulcers, and less surgery needed for diabetes-related conditions such as gangrene. But perhaps most importantly, the BCRHA patients are now more actively engaged in their health due, in part, to the concern and attention that the BCRHA staff show their diabetic patients as a result of the Collaborative and the improved diabetes protocol.

REFERENCES

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3 The Chronic Care Model. Improving Chronic Illness Care Web site. http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2. Accessed May 27, 2008.

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