Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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StratisHealth

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Rural Innovation Profile

Rural Hospital Community Outreach

What: The Richland Parish Hospital Pre-Diabetes Program (PDP).

Who: Richland Parish Hospital, Hospital Service District #1A of the Parish of Richland, Delhi, Louisiana.

How: Developing a health screening and follow-up model that supports patients in reducing health and lifestyle risk factors associated with diabetes.

Why: Prevent or delay early onset diabetes, improve community members' overall health, establish models that can be used to delay or prevent chronic health conditions, and decrease health care costs.

Key Points

- Establish strong working relationships with community partners to leverage resources and increase outreach.
- Offer programs at no cost and in locations where the target population lives, works, shops, and socializes in order to increase access.
- Fully integrate primary care providers into the community outreach model to ensure a seamless approach to identify, monitor, and meet patients' health care needs.
- Establish a strong rapport with patients through regular contact and follow-up so they remain engaged in the program and their own health outcomes.

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The PDP is a collaborative effort established in 2009 by the Richland Diabetes Prevention Collaborative. The program serves Richland Parish, located in northeast Louisiana. The program's lead agency and hub is Richland Parish Hospital; collaborative partners include community health care providers, law enforcement, and local businesses.

"We're sitting in a hotbed of diabetes."

Jinger Greer, Project Director

The PDP originated from a three-year cardiovascular outreach initiative at the Richland Parish Hospital funded by the Health Resources and Services Administration Office of Rural Health Policy (see p. 4). A review of patient screening results from this initiative revealed that a large percentage of patients had high cholesterol and elevated blood sugar levels. Although patients responded to provider concerns regarding high cholesterol, patients of all ages responded minimally if at all to provider concerns regarding elevated blood sugar levels, a risk factor for diabetes.

Using data and lessons learned from the cardiovascular outreach initiative, the PDP focused on pre-diabetes and sought to decrease the incidence of Type II diabetes among the population of Richland Parish. The PDP developed and implemented a protocol to reduce elevated blood sugar levels that included:

- Early detection of pre-diabetes blood sugar levels
- Repeated screenings
- Extensive health education involving behavior modification and self-management
- Regular and ongoing follow-up with patients

For project implementation and development purposes, a wellness team was established. The team included staff experienced in wellness program implementation, including nurse educators and an exercise physiologist. A nurse project manager and Paul Grandon, MD, an internal medicine physician at the Delhi Hospital and Rural Health Clinic, guided PDP development and operations. The team created databases and spreadsheets to track PDP participants and outcomes in the following areas:

- Demographics
- Body mass index
- Fasting blood glucose level
- Hemoglobin A1c level
- Weight, height
- Blood pressure
- Total cholesterol, LDL, HDL, triglycerides
- Medications
- Lifestyle changes (including exercise and diet)
- Family risk factors
- Other personal wellness data reported by enrollees at each screening

The project equipment is portable and moves with the team during pre-diabetes screenings and assessments. The team performs screenings at various sites around the service area, such as local businesses, faith-based organizations, schools, civic organizations, and shopping areas. PDP staff members collect demographic data, assess risk factors, and complete a blood sugar test for each participant.

Complementing the screening process, the team offers extensive and varied educational opportunities for the community and PDP enrollees, including:

"Everything we do is portable; we go everywhere."

Jinger Greer, Project Director

- Public awareness campaigns (e.g., direct contact with local organizations, flyer distribution, newspaper articles/ads, radio public service announcements, and television spots)
- Health care provider promotion/health education (e.g., distribution of educational materials, training events)
- Community health education (e.g., presentations, point-of-contact health education, monthly newsletters, and follow-up telephone contacts every-other-month)

The newsletters and telephone contacts are specifically designed to meet the needs of PDP enrollees by providing a new and regular opportunity to educate and support pre-diabetes patients and to promote adherence to diabetes prevention and lifestyle changes. Program staff contact each participant by telephone at least once a month, typically more often after initial enrollment, to check-in, follow-up, offer support, and answer any questions. Newsletters are mailed monthly.

"I'm sort of like a fly at a picnic: just when you think I'm gone, I show up."

Charlotte Poland, Program Coordinator

From 2009 to 2012, the PDP team conducted 2,147 initial screens (representing 18.4 percent of the total parish population between the ages of 18 and 64) and enrolled 255 patients in the PDP program. The PDP provided an additional 147 re-screenings, 92 referrals from the PDP to primary care providers, and 75 referrals from primary care providers to the PDP. Program evaluation revealed a "statistically significant association between participation in the PDP and a reduced rate of progression from pre-diabetes to true diabetes, when compared with prior reported progression rates in the medical literature. In fact, there was no progression to true diabetes in an enrollee who had a follow-up hgbA1c within 14 months of the initial screen."[1]

[1] Year 3 Evaluation Report, Richland Parish Hospital Health Education and Resource Center. Labrenz and Associates, July 2012.

Looking to the future, the program has conducted direct fundraising and is developing local partnerships and employer contracts for long-term program sustainability. The project will expand into additional parishes and will continue to gather patient outcomes and process data. Ongoing data collection offers the opportunity to provide long-term patient monitoring and demonstrate the positive impact of parish-wide pre-diabetic screening and education.

Project funding was initially made available through the Health Resources and Services Administration, Office of Rural Health Policy, Rural Health Care Services Outreach Program. "The purpose of the grant is to promote rural health services outreach by expanding health care delivery to include new or enhanced services in rural areas."
http://www.hrsa.gov/ruralhealth/about/community/careservicesoutreach.html

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