West Virginia Division of Health Promotion and Chronic Disease Gestational Diabetes Management Collaborative: Better Data, Better Care

West Virginia was one of nine states chosen to participate in the Centers for Disease Control and Prevention and the National Association of Chronic Disease Directors multi-state collaborative "Gestational Diabetes Management Collaborative: Better Data, Better Care" to improve the awareness and management of gestational diabetes (GDM). In West Virginia, The Division of Health Promotion and Chronic Disease (HPCD) and our partners established a GDM Collaborative of twenty-five internal and external partners to develop an action plan to improve the care of high risk women through better identification, greater awareness, improved health systems processes, increased referrals to NDPP, follow-up care, and more.

The action plan was implemented with key components including professional development to improve recording of GDM, health care provider assessments, development and delivery of provider education, and strategies to increase post-partum visits, including resource development and health system changes. The plan's implementation showed that increased knowledge and education improved identification and postpartum care for those at high risk for type 2 diabetes.

Lessons Learned

- Home visitation is a strong resource for providing education/information to high-risk prenatal clients
- Collaboration with any program that touches a woman with GDM is essential to increase awareness and the need for follow-up care. For example: Education in the Women's Infants and Children's' (WIC) offices reminds women to follow-up if they were diagnosed with GDM, and a presentation at the WV Academy of Family Practice provides education on postpartum follow-up of women with GDM.
- While providers know there is an increased risk of type 2 diabetes in those with GDM, not all are following up with those patients postpartum. This shows a care gap between obstetric and primary care, demonstrating the need for better referral practices.

Impact

- Home visitation is a strong resource for providing education/information to high-risk prenatal clients
- Using survey results, the West Virginia Collaborative created an hour long webinar for public health and other healthcare professionals to enhance GDM awareness, knowledge and the importance of the postpartum visit and screening. Currently over 600 individuals have taken the online course, including 24 physicians. CE's and CME's are offered to participants.

- In the CAMC high risk prenatal clinic, postpartum visits increased from 50% to 89% and post-partum glucose testing orders increased from 10% to 39% after the first year. The team continues to monitor the processes with a focus on sustaining changes and if necessary modifying when necessary, The Collaborative developed a clinical practice improvement toolkit based on these positive outcomes.
- Results from these projects have been used to develop professional education programs and websites for providers and patients.

For more information, please visit www.wvdiabetes.com, or contact Jessica Wright, jessica.g.wright@wv.gov or 304-356-4193.