# West Virginia Department of Health and Human Services
# West Virginia GDM Collaborative
# 2008-2014

**Strategic Focus:**
**Data Quality Improvement**
**Clinical Care Improvement**
**Provider and Consumer Education**

## Goals

- Improve management of gestational diabetes (GDM) by:
  - increasing awareness of GDM among patients and providers
  - improving testing and following care for high risk women
- Enhance availability, use and dissemination of GDM data
- Determine provider GDM knowledge, attitudes and practices
- Increase postpartum follow-up visits and glucose testing in women with GDM

**Target populations:** Women with GDM, GDM care providers

### Essential Partners

Chronic Disease (CD)
Diabetes Prevention and Control
Maternal and Child Health (MCH)
CD and MCH Epi
PRAMS
Immunizations
Right From the Start Home Visiting
Charleston Area Medical Center
WIC
Vital Records
Perinatal

## Program Planning Steps

The Divisions of Perinatal and Women's Health and Health Promotion and Chronic Disease established a GDM Collaborative of twenty-five internal and external partners to develop an action plan to address the issues identified through their participation in the GDM Data Validation Project. The leadership of the Center for Health Services & Outcomes Research, Charleston Area Medical Center (CAMC) contributed significantly to the successes of the Collaborative. After collection of baseline data, the plan was implemented and evaluation is currently being completed.

## Key Components

- To improve accuracy of documentation of GDM on the birth certificate, the Office of Maternal, Child and Family Health and the Center for Health Statistics partnered to provide a webinar on how to complete the new electronic birth certificate implemented 1/1/2014, the importance of the data and how the data from the birth certificate are used.
- To assess the practice of obstetric providers, a survey was sent to members of West Virginia (WV) Chapter of ACOG and certified nurse midwives via an emailed Survey Monkey in February 2014. Questions were asked regarding postpartum treatment and follow up of women with a history of GDM. This questionnaire was based on the surveys developed by the Departments of Health in Ohio and Utah.
- Surveys indicated additional provider education was needed. Working with hospital partners, the Collaborative developed a GDM care webinar for providers: "Connect to Care," and have made it available online and DVD. A speaker on GDM follow-up care was provided at the WV Academy of Family Physicians in summer 2014.
- The Collaborative implemented a variety of strategies to increase postpartum visits, including re-source development and health system changes. Partnering with CAMC prenatal clinic, the Collaborative demonstrated that changing and standardizing the clinic processes for identification and care for women with GDM improved screening, documentation and follow-up for GDM. These processes included:
    - providing GDM education for all clinic staff regarding GDM screening guidelines, the diagnosis algorithm, follow-up and postpartum care, marking and labeling charts appropriately, pulling charts and using a postpartum checklist
    - standardizing clinic procedures for screening and documenting GDM
    - providing type 2 diabetes risk education during prenatal visits
    - scheduling postpartum visits with glucose testing orders before discharge
    - performing glucose testing in the clinic during the postpartum visit
    - referring women with GDM to the clinic's Diabetes Center for education classes that focused on nutrition, self-monitoring and physical activity

## Key Components (cont.)

- To support clinical efforts to improve GDM prenatal education and increase postpartum visits and glucose testing, GDM information packets were provided to maternity care providers. The packet included ACOG postpartum reminder tear-off sheet. Education was provided to home care staff on how to educate women with GDM on the importance of follow-up during their one-on-one home visits. A DVD was also provided to the home care staff to aid in postpartum education for women with GDM.
- To assess GDM follow-up in the high-risk WIC population, the Collaborative conducted a point-in-time survey of 5852 WIC participants in 57 offices.
- West Virginia's newborn home visiting program, *Right From the Start*, added GDM to the nursing protocol

## Required Resources

**Staff**: Perinatal and chronic disease staff; epidemiology and statistical support from the CAMC Research Center (1.5 FTE)

**Funding:** CDC support to NACDD provided over $28,000 support. West Virginia Department of Health and Human Service and partners provided in-kind contributions of approximately $50,000

**Other:** Access to PRAMS linked data sets, WIC District Managers

### Challenges

- It was difficult to obtain email addresses for maternity care providers to conduct the web-based survey. Provider participation was limited.
- It is difficult to obtain provider participation

## Lessons Learned

- Comments and general responses from hospital staff/clerks indicated the training on how to complete the birth certificate was very much appreciated. Knowing how important the birth certificate information is and what it is used for made a difference in staff attitudes.
- 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 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.

## Lessons Learned

- Many of the providers know that there is an increased risk of type 2 diabetes in women with GDM. However, not all are consistently following up all patients with a history of GDM. Perhaps they are thinking that the woman will return to her medical home, internist or family physician and because of her history of GDM, she will be tested and followed there, emphasizing the care gap between obstetric and primary care and demonstrating the need for better referral practices

## Evaluation/Impact

- The Collaborative validated GDM prevalence data from the 2011 WIC Client and PRAMS surveys. Comparison of prevalence of self-reported GDM by WIC clients who completed a PRAMS survey showed the PRAMS data very closely matched the 2011 WIC survey data.

- Thirty-five (35) providers completed the Provider Practice Survey. When asked how many women would likely progress to type 2 diabetes within 2 years of delivery, the answers were anywhere between 10-60%. When asked if patients were tested for glucose during the 6 weeks checkup, 34% stated less than half; 16% did not know if their patients were tested for glucose; and 50% stated between half and all patients were tested. One-fourth of providers reported documenting discussing the increased risk of type 2 diabetes at the 6 week postpartum visit. To assure that women with a GDM history obtained a postpartum blood glucose test, 17% had e-alerts on patient charts, 54% explained the importance to the patient and 20% provided educational materials

- WIC survey showed that 85.8% of participants had been tested for GDM during the prenatal period and 9.4% had a diagnosis of GDM, but only 44% of participants with GDM received a postpartum glucose screen.

- 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.

## Products (See Appendix )

- West Virginia Prenatal Risk Screening Instrument
- West Virginia Reminder Postcard
- Questions for Women with Infants around 6 Months Old Survey
- Improving Care for Women with Gestational Diabetes By Improving the Process: A Toolkit