

### **Building on Partnerships to Achieve Goals in Massachusetts**

Reducing the prevalence of gestational diabetes and improving health outcomes for women of reproductive age requires a comprehensive and integrated public health strategy. “Viewing people not as disease states, but from a more holistic approach, is the way of the future,” says Terri Mendoza, director of the Massachusetts Diabetes Prevention and Control Program (DPCP).

What’s more, the same strategy that targets gestational diabetes also reduces risk factors for a plethora of other chronic diseases. “Many chronic diseases share risk factors as well as remedies,” Mendoza says. Therefore, adopting a comprehensive and integrated public health strategy—rather than one that focuses on a specific disease—offers greater returns on public health investments. By pooling resources for a common public health strategy, programs are able to achieve more together than they could on their own.

Massachusetts’ Gestational Diabetes Mellitus (GDM) Project underscores the value of integrating chronic disease prevention strategies for the maternal and child health population. By engaging a broad-based group of public, private, and nonprofit stakeholders, the DPCP leverages resources to address some of their most pressing needs related to gestational diabetes prevention and treatment.

### **Convening Stakeholders to Develop a Blueprint for Action**

In 2007, the DPCP, with support from the CDC and ASTHO, convened public health agencies, public and private health insurers, consumers, healthcare providers, and community based organizations at a Gestational Diabetes Summit in Framingham, Massachusetts. The 85 participants identified missed opportunities for screening, managing, and follow-up of gestational diabetes and worked together to develop an action plan to realize those opportunities.

Three priorities rose to the top of the list:

- Increasing patient and provider awareness about GDM diagnosis and treatment.
- Improving continuity of care for women diagnosed with GDM and their children.
- Improving surveillance systems to gather accurate and timely data.

The meeting succeeded in garnering interest and buy-in for continued work on gestational diabetes. About half of the meeting attendees signed on to continue work around the three focus areas. “We have an incredible amount of interest, externally, and a very committed internal group,” says Patricia Daly, health systems specialist in the DPCP. With the resources and expertise of engaged partners and a plan for moving forward, the stakeholders have maintained momentum around gestational diabetes activities.

### **Improving Surveillance by Linking Existing Data Systems**

Surveillance moved along a fast track, partly because good data is needed to inform programs and interventions, but also because a lot could be done with existing data systems. Building on public health surveys, such as the Pregnancy Risk Assessment Monitoring System (PRAMS), to improve what is known about gestational diabetes was a good starting point.

PRAMS surveys a sample of women who have recently given birth and collects information on maternal attitudes and experiences before, during, and shortly after delivery. According to Mendoza, “We’ve used PRAMS to explore more about women’s views and what is happening with GDM.” For example, the internal GDM workgroup developed a PRAMS question that asked women with gestational diabetes to participate in a follow-up phone survey. The call-back survey asks women about the type of care they received during pregnancy and postpartum through follow-up testing and interventions. Daly says, “It’s all about the continuum of care, beginning before pregnancy and going through to postpartum.” The survey will provide important information about current practices and inform state health department officials about what providers and patients need most in terms of education and support.

Linking existing databases offers additional opportunities to expand what is known about gestational diabetes. The Massachusetts Department of Public Health (DPH), the CDC, and the Boston University School of Public Health developed the Pregnancy to Early Life Longitudinal (PELL) Data System to link all birth and fetal death certificate records with birth-related hospital discharge records for mothers and their babies. With more than 640,000 births and fetal deaths between 1998 and 2005, PELL is a powerful tool for tracking the prevalence of GDM.

In addition, the quality of GDM data is expected to improve as a result of a new, standardized, electronic birth certificate that replaces the old form, which varied from county to county. This transition presented another opportunity for gathering data about gestational diabetes. According to Mendoza, “There was a field for diabetes before, but a lot of work has been done to differentiate gestational diabetes from preexisting diabetes on the birth certificate.” As a result, Mendoza says, “The new birth certificate will be a truer reflection of GDM prevalence.”

### **Relying on Partnerships to Improve Communications and Awareness**

Increasing gestational diabetes awareness among women and healthcare providers is a top priority for the DPCP and its partners. The diabetes program launched a television and poster campaign to encourage Hispanic women who have been diagnosed with gestational diabetes to talk to their doctors about reducing their risk of developing Type 2 diabetes. Two new public service announcements aired in June 2011 encouraging women with a history of gestational diabetes to get follow-up screening, reinforcing the benefits of healthy lifestyles for women with gestational diabetes and their children, and encouraging an open dialogue with primary care doctors and pediatricians to prevent the onset of Type 2 diabetes.

The diabetes program also developed a poster in English and Spanish and is currently developing a resource guide to educate women about the risks of gestational diabetes. Mendoza and Daly are working closely with their partners in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to develop information about gestational diabetes for dissemination to their clients. “It’s been a nice way of building up partnerships,” Daly says. The partnerships enable the diabetes program to reach their target population through WIC and community health centers. “We’re not a direct service provider,” Mendoza says, “so we need to work through others to get the word out.”

In addition to internal partnerships, the DPH is collaborating with Brigham and Women’s Hospital in Boston on a research endeavor to develop and test an online behavioral change curriculum to reduce the risk for development of Type 2 diabetes in women with a recent GDM pregnancy. Once complete,

the DPH will help to disseminate findings and promote the curriculum to healthcare providers and the public.

The DPH also focuses on educating providers about management of GDM and prevention of Type 2 diabetes among women who have had gestational diabetes. For example, the DPCP has coordinated a work group of clinical experts in endocrinology, obstetrics, and nutrition to develop clinical guidelines that will help providers identify and treat women with gestational diabetes and prevent future development of Type 2 diabetes. “The GDM Guidelines will present a summary of the evidence to help guide management and treatment decisions,” Mendoza says.

Nearly five years after the first GDM Summit, the DPH credits its continuing success and ongoing momentum to strong and devoted partners working together to achieve clearly defined goals. According to Daly, maintaining momentum and active participation requires careful thinking about how and when to utilize a partner’s expertise and skills. “We have people we want to reach out to again and again,” Daly says, “but being able to identify how to best use that momentum with limited funding to support initiatives is a challenge.” Although funding constraints affect how fast things get done, GDM activities continue to move ahead, Daly says, because of the “internal and external partners who have been willing to dedicate expertise, time, and talent to ongoing gestational diabetes activities.”

### **For more information on Massachusetts’ Chronic Disease and MCH Integration and related initiatives:**

Massachusetts Diabetes Prevention and Control Program

[www.mass.gov/dph/diabetes](http://www.mass.gov/dph/diabetes)

Massachusetts Office of Health and Human Services

<http://www.mass.gov/?pageID=eohhs2homepage&L=1&L0=Home&sid=Eeohhs2>

Massachusetts Department of Public Health

<http://www.mass.gov/eohhs/gov/departments/dph/>

Bureau of Community Health and Prevention

<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health-and-prevention.html>

Division of Prevention and Wellness

<http://www.mass.gov/eohhs/consumer/wellness/>

Gestational Diabetes Television and Poster Campaign

<http://www.mass.gov/eohhs/consumer/wellness/disease-prevention/diabetes/diabetes-materials-and-media-campaigns.html>

Massachusetts Department of Public Health Integration Demonstration Project Logic Model, 2008

<http://blogs.cdc.gov/programintegrationondemand/files/2010/10/Massachusetts-Logic-Model.pdf>

Mass in Motion

[mass.gov/massinmotion](http://mass.gov/massinmotion)



## MCH and Chronic Disease Integration

BRFSS: Massachusetts Behavioral Risk Surveillance System

[www.mass.gov/dph/hsp](http://www.mass.gov/dph/hsp)

Massachusetts Health Promotion Clearinghouse (contains various educational materials and fact sheets)

[www.maclearinghouse.com](http://www.maclearinghouse.com)