Building on Seeds of Change in West Virginia

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—Denise Smith, Director, Division of Perinatal and Women's Health, West Virginia Department of Health and Human Services

Between 1996 and 2005, the percentage of births to women with gestational diabetes increased from 2.9 percent to 4.1 percent in West Virginia, according to the 2007 report *Pregnancy and Diabetes in West Virginia*. "There is an upward trend in the prevalence of [gestational diabetes] in West Virginia women," says Denise Smith, director of the Division of Perinatal and Women's Health at the West Virginia Department of Health. "The potential for complications for both mother and baby greatly increase with gestational diabetes, and these complications often result in life-long health concerns."

In what amounts to an all-hands-on-deck approach, a statewide gestational diabetes collaborative project has steadily widened the net of stakeholders to include representatives from the Division of Health Promotion and Chronic Disease, the Division of Perinatal and Women's Health, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid, and external partners, including healthcare providers and researchers from the Charleston Area Medical Center's Center for Health Services and Outcomes Research (CHSOR).

While programs within the Department of Health and Human Services had worked together in the past, the state's participation in a national gestational diabetes collaborative project paved the way for meaningful collaboration among a growing list of stakeholders. "The integrated approach between chronic disease and the MCH populations is essential to improving health outcomes for women and children," Smith says.

Starting Small: Focusing on Data as a "Seed of Change"

In 2010, West Virginia was selected as one of three states to participate in a collaborative sponsored by the National Association of Chronic Disease Directors**.** The project provided some funding, but mainly support, technical assistance, and a forum to learn how other states were improving data systems around gestational diabetes.

According to Mary Emmett, director of CHSOR, a lack of consistent data about the number of women with gestational diabetes and their quality of care was a serious problem. In addition to discrepancies among existing data sources—with the Pregnancy Risk Assessment Monitoring System, hospital discharge files, and WIC data all telling a different story—there were gaps related to patient and provider awareness about gestational diabetes prevention, management, and follow-up care. With so much to learn, Emmett explains that addressing low-hanging fruit—problems that could be fixed quickly, for large impact—were the first priorities. Improving data provided a realistic focal point for the project's partners; early successes with data planted "seeds of change" for subsequent work, Emmett says: "We started out with something really simple. Change grows over time."

The Diabetes Prevention and Control Program and the Office of Maternal, Child, and Family Health partnered with the WIC program to administer a survey to WIC clients with a history of gestational

diabetes. These women completed a survey during a visit to the local WIC office shortly after they delivered their babies. The survey assessed each woman's knowledge about her current blood sugar level and asked questions about follow-up care with the woman's primary care provider. Emmett said that survey results will help stakeholders develop research-based interventions next year. With two-thirds of West Virginia women enrolled in the WIC program, the partnership between chronic disease, the Office of Maternal, Child, and Family Health, and WIC is a "terrific collaborative," Emmett says. "Our ultimate goal is to prevent Type 2 diabetes, so focusing on women's health is our big effort and that's why we look at the WIC population as a potential intervention."

Focusing on data is an effective starting point: Not only does it inform solutions, but it provides the evidence needed to change behaviors. "Data speaks to physicians; they are driven to change if you can show them concrete [evidence]," Emmett says. Moreover, Emmett explains that it was a catalyst for bringing people together: "Data was the seed that produced action. Because we had the seed, we were able to forge relationships."

In addition to the WIC survey, the collaborative is working with healthcare providers and clinics to make process and quality improvements, one step at a time. The change theory is based on identifying a problem, finding the right team to work on it, acting, and then measuring the change.

Working in an outpatient obstetrics clinic, for example, provides a laboratory for identifying problems and testing solutions in a real-world clinical setting. With process improvements, Emmett says it's good to "look at where you can get a lot of gain quickly." To date, the team has streamlined the process for identifying and documenting gestational diabetes and developed strategies for educating women and providers about the risks of developing Type 2 diabetes and the need for postpartum testing. "We are looking at the cycles of change and knowing that we have to continuously change because providers change, technologies change," Emmett said.

Widening the Net of Partners to Achieve Goals

Before the gestational diabetes project, Emmett says there was "less collaboration and more people operating in silos. The project brought about relationships and helped them grow and look beyond their own programs." The network of partners has expanded beyond the original health department participants to include a statewide group of public, private, and nonprofit stakeholders, including Medicaid, WIC, West Virginia University, the state's primary care association, and the state chapter of the American Congress of Obstetricians and Gynecologists. Engaged partners have worked toward achieving two primary goals: promoting provider awareness about gestational diabetes testing and follow-up care and improving patients' awareness of gestational diabetes as a major risk factor for Type 2 diabetes.

Educating Providers. The Diabetes Prevention and Control Program and the Office of Maternal, Child, and Family Health teamed up to develop and distribute clinical guidelines for gestational diabetes to hospitals and birthing centers. The guidelines define recommended provider practices related to screening and diagnosis, nutrition and physical activity, medication, and postpartum follow-up.

Educating Women. The Office of Maternal, Child and Family Health, the Diabetes Prevention and Control Program, and the Division of Immunization Services worked together to tweak an existing immunization

reminder postcard to remind women with gestational diabetes about the need for postpartum care. According to Smith, more than 12,000 cards have been distributed and the programs plan on pooling resources to print more. Smith points out that, rather than reinventing the wheel, retooling an existing communications strategy enabled the team to publicize an important message. "This is an example of using an avenue that was already there and just adding to it," Smith says.

Challenges and Lessons Learned

Without dedicated funding and staffing, the process of change can be slow and often incremental. "We have other projects on our to-do list, but [we haven't gotten to them] because we're strapped for time and for the most part, we're volunteering," Emmett says. "It takes time to move forward."

In this context, piggybacking on other public health strategies has proved an important strategy. Case in point: Partnering with WIC on the patient survey "allowed the GDM project to reach part of the target population without additional cost," Emmett said. Moreover, Emmett's group at the Charleston Area Medical Center provides research tools and survey instruments.

Engaged and committed stakeholders continue to drive the project forward. Starting with low-hanging fruit kicked off the improvement process and gradually brought more partners into the mix. "The key is finding where people can work together, where there is real strength in teamwork," Emmett says.

Looking ahead, Smith sees more opportunities for collaboration between program areas: "Thinking more broadly than pregnancy itself … chronic disease and MCH have a place together with preconception issues: getting women to be healthy before [they become] pregnant, visiting their doctor, getting their weight in control, and getting physically healthy before [they] put [their] body through pregnancy."

For more information on West Virginia's Chronic Disease and MCH Integration and related initiatives:

West Virginia Department of Health and Human Resources
http://www.wvdhhr.org/

Office of Community Health Systems and Health Promotion
http://www.wvochshp.org/

Division of Health Promotion and Chronic Disease
http://www.wvhealthpromotion.org/

West Virginia Diabetes Prevention and Control Program
http://www.wvdiabetes.org/

Postpartum Reminder Card, West Virginia Department of Health and Human Resources
http://www.wvdiabetes.org/Portals/12/WV%20Postpartum%20reminder%20card%20(GDM%20and%20Immunizations).pdf

"Clinical Guidelines for Gestational Diabetes," West Virginia Department of Health and Human Resources
http://www.wvdiabetes.org/Portals/12/WV%20GDM%20Guidelines%201-19-11.pdf

Pregnancy and Diabetes in West Virginia, West Virginia Department of Health and Human Resources, 2007
http://www.wvdiabetes.org/Portals/12/Final%20pregnancy%20and%20diabetes%20(Nov%2015).pdf

Center for Health Services and Outcomes Research, Charleston Area Medical Center Health Education and Research Institute
http://camcinstitute.org/research/chsor/default.htm