

Building Capacity in Federally Qualified Health Centers to Improve Postpartum Diabetes Screening

PURPOSE

To build the capacity of health centers to provide diabetes screening and contraception counseling to postpartum women with gestational diabetes mellitus (GDM)-affected pregnancies and to disseminate evidence-based prevention and management guidelines.

BACKGROUND

Both pre-existing diabetes and GDM during pregnancy increase the risk for adverse maternal and infant health outcomes. According to the Centers for Disease Control and Prevention (CDC), GDM is the most common problem of pregnancy in the United States, affecting about four percent of all pregnancies. Data from 2016 show significant racial and ethnic disparities in rates of both pre-existing diabetes and GDM during pregnancy. Rates of pre-existing diabetes were highest among American Indian/Alaskan Native and Native Hawaiian/Pacific Islander women. Rates of gestational diabetes were recorded as highest among Asian women. Both pre-existing and gestational diabetes are more common among women who are obese or overweight. About half of all women who have gestational diabetes get type 2 diabetes later in life.

Gestational diabetes can be controlled during pregnancy with a treatment plan that involves healthy eating, physical activity, regular blood sugar monitoring, and regular visits to a health care provider. Attention to GDM extends to the postpartum period and includes a blood sugar check soon after delivery and again six weeks after delivery, and counseling on contraceptive method choice and related family planning services.

GOAL

Increase knowledge of clinical workflows, measures, and provider awareness of clinical guidelines related to postpartum diabetes screening and family planning. Compile models and resources for identifying and treating GDM in health centers.

POPULATION OF FOCUS

Postpartum women with GDM-affected pregnancies.

APPROACH

Collaborate with four health center and two health center controlled networks (HCCNs) to improve screening, treatment, referral, and tracking of postpartum women with gestational diabetes affected pregnancies, including counseling on contraceptive method choice and related family planning services. The first year of the project will use supporting data to focus on planning, assessing, and designing a systems approach to screening and tracking systems:

- Identify evidence-based and promising practices for



TIMELINE | 1/1/2019 – 7/31/2019



FUNDING | CDC



TYPE OF INTERVENTION

Population health focused intervention to improve health outcomes

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- postpartum women with GDM-affected pregnancies, including postpartum contraception counseling
- Crosswalk best practices with a systems approach that includes infrastructure, care delivery, and people
- Establish key national strategic partnerships, including with the CDC, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Diabetes Association
- Assess provider awareness of relevant clinical guidelines (US Medical Eligibility Criteria for Contraceptive Use (MEC) and US Selected Practice Recommendations for Contraceptive Use (SPR))
- Map clinical workflows for screening women with GDM-affected pregnancies for diabetes, and tracking referrals and follow-up
- Crosswalk clinical guidelines with structured data in the electronic health record
- Analyze crosswalk and workflows to identify facilitators/barriers; develop recommendations to improve GDM-affected pregnancy and postpartum contraception workflows and other data sets for analyses and develop written summary of crosswalk and work
- Present results to CDC

MEASURES

- Not defined yet

CDC	Project Officer. Financial and technical support.
NACHC	Establish national leadership role around GDM for HCCNs and health centers. Project design, support, and management. QI strategies for improving postpartum management of GDM and data reporting.
HCCN	Analyze datasets and clinical workflows for screening, referrals, and tracking of GDM. Engage participant health centers to discuss guidelines, provider awareness strategies, and workflows.
Health Center	Partner with associated HCCN to improve postpartum management of women with GDM during pregnancy.
ATSU	Design project evaluation, manage IRB, and support analysis of provider awareness assessment of relevant clinical guidelines.