Women in Control of Diabetes (WICO)

Prisma Health – Midlands

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Summary of the Project

WICO implements a team-based, multidisciplinary care model for women of childbearing age. Our project aims to serve as a critical safety net for women in the postpartum period, an often-overlooked stage when many face significant challenges beyond the vulnerable time of adjusting to life with a new baby.

Primary Goals

- To reduce risk of diabetes and its complications

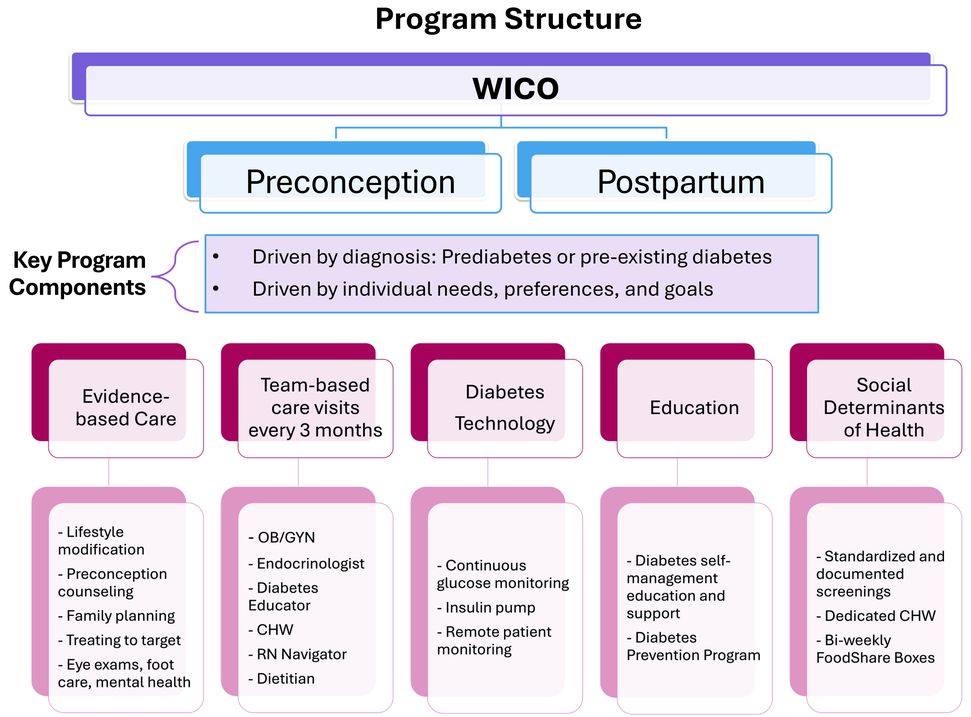
Long-term vision

- Prevent or delay future onset of diabetes in South Carolina

Expected outcomes

1. Improved glycemic control for women with T1DM or T2DM
2. Prevention of T2DM for women with prediabetes or history of gestational diabetes
3. Achieve optimal weight after pregnancy
4. Improve maternal and fetal outcomes by increasing the number of women receiving preconception counseling
5. Increase knowledge related to diabetes prevention and disease management across all population groups by increasing rates of DSMES and DPP completion

Program Structure



Impact & Key Outcomes

90% ≥1 SDOH risk factor	**20%** documented mental health disorder	**80%** <$75K annual household income	**42%** lost >5% of their body weight at 12m

Community Impact

>85% documented reproductive life plan	**>800** FS produce boxes provided	**100%** SDOH screening completed	**49%** MOMs patients enrolled postpartum	**>200** Hygiene Bags Distributed

Type 1 and 2 Diabetes

287 Diabetes Assessments	**76%** ≥1education session	**8.5%** mean A1C at time of referral	**7.4%** mean A1C at 6 months	**105** group education classes

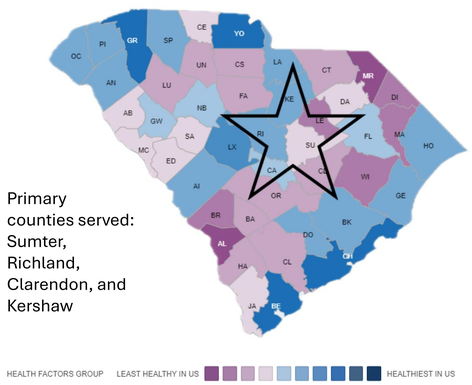
Prediabetes

31 Completed DPP program	**6%** Avg weight loss	**174** Avg minutes/week of physical activity	**18.5** Avg sessions completed out of 23

Community and State Partners

FoodShare South Carolina	USC Arnold School of Public Health	Project ECHO SC Pregnancy Wellness:	Diabetes Initiative of South Carolina:	MOMs in Control	Mom's IMPACTT	Other CRO's
• Access to fresh produce • Collaboration to meet clinic needs • Significant positive impact on patient-healthcare team relationship	• Jihong Liu, PhD, provides external evaluation support for program quality and improvement	• Builds provider capacity through a monthly statewide platform that promotes evidence-based care and stakeholder engagement	• Facilitates statewide communication and networking to leverage resources and build future partnerships	• Continuation of care for MOMs participants • Continuity of care • Transitional care coordination	• Option for patient initiated referral • Access to real-time coordinator • Individualized options for support	• Healthy Start • Services of Hope • Go Baby Go – diaper bank • March of Dimes – Hygiene pantry expansion

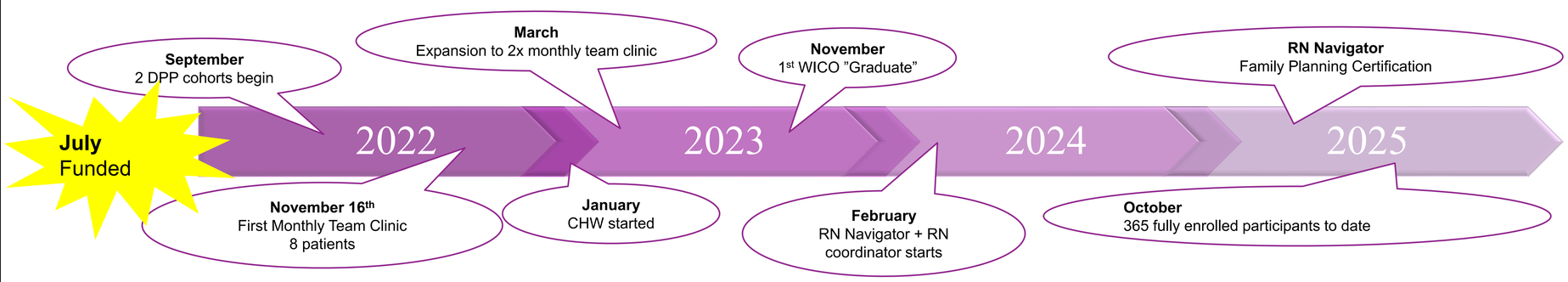
Location



Primary counties served: Sumter, Richland, Clarendon, and Kershaw

Demographics

		Total Patients (n=365)
Life-Stage	Preconception	14 (4%)
	Postpartum	135 (34%)
	General Women's Care	216 (62%)
Diabetes Type	Prediabetes	79 (22%)
	Type 1	35 (10%)
	Type 2	251 (68%)
Race	Caucasian	134 (37%)
	African American	212 (58%)
	Hispanic	12 (3%)
	Other	7 (2%)
Language	English	359 (98%)
	Spanish	6 (2%)



Contact

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