Original Article

It's Best to Test in Hospital: Improved Testing Rates with Immediate Postpartum Diabetes Testing in Patients with Gestational Diabetes in a Community–Academic Medical Center

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ABSTRACT

Objective Immediate postpartum diabetes (IPD) testing on day 1 or 2 shows similar diagnostic value to testing at 4 to 12 weeks' postpartum and achieves higher completion rates. Our institution implemented IPD testing on December 1, 2023, before the American College of Obstetricians and Gynecologists' endorsement, to compare pre and postimplementation testing rates and to assess associated maternal and neonatal outcomes.

Study Design We conducted a retrospective cohort study of patients with gestational diabetes mellitus (GDM) who delivered at our community–academic medical center before (September 1, 2022–November 15, 2023) and after (December 1, 2023–October 31, 2024) IPD implementation. The preimplementation group underwent outpatient testing 4 to 12 weeks' postpartum. The postimplementation group was tested in-hospital 1 or 2 days' postpartum. Both groups received a 2-hour glucose challenge test. Electronic medical records were queried for demographics, medical and obstetric history, GDM information, and postpartum diabetes testing results. Completion rates, maternal, and neonatal factors were compared across and within cohorts using chi-square tests and *t*-tests.

Results Across 155 patients (63 preimplementation, 92 postimplementation), baseline characteristics were similar, excluding age. Testing completion increased nearly 5-fold postimplementation (14.3% [9/63] vs. 68.5% [63/92], $p < 0.01$). In the postimplementation group, 49% of tested patients had abnormal results (43% impaired glucose metabolism, 6% overt diabetes). Non-English speakers and those with a postpartum length of stay > 1 day were more likely to be tested (22.2 vs. 3.45%, $p = 0.02$; 98.4 vs. 48.3%, $p < 0.01$). Neonates in the tested group had a lower mean birth weight (3,137.1 ± 665.1 vs. 3,374.4 ± 484.7 g; $p = 0.05$), longer nursery stay (2.55 ± 2.2 vs. 1.83 ± 0.69 days; $p = 0.03$), and more neonatal intensive care unit admissions (20.63 vs. 0%; $p = 0.01$).

Conclusion IPD testing dramatically improved testing and identified a high prevalence of persistent dysglycemia immediately postpartum. Hospital systems should consider implementing this practice change to improve testing rates and early intervention in postpartum care of patients with GDM.

Keywords gestational diabetes, Type 2 diabetes, IPD testing, postpartum period, postpartum care, glucose tolerance test, practice change, practice implementation

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Introduction

Gestational diabetes mellitus (GDM) represents a significant and growing public health challenge. In the United States, its prevalence has risen from 6.0% in 2016 to 8.3% in 2021,[1] reflecting trends influenced by increasing maternal age, obesity, and demographic diversity.[2,3] This condition poses both immediate- and long-term risks, including neonatal macrosomia, preeclampsia, and a heightened lifetime risk of type 2 diabetes mellitus (DM2) for affected individuals.[2,4] The burden of GDM extends well beyond pregnancy, necessitating strategies that address both maternal and offspring health outcomes.

Postpartum diabetes testing is critical for early identification of individuals at risk of progressing to DM2, enabling timely interventions that can mitigate complications such as cardiovascular disease and renal failure. Traditionally, guidelines recommend testing between 4 and 12 weeks' postpartum using a 2-hour oral glucose tolerance test (GTT).[5] Despite these recommendations, adherence remains low. Nationally, fewer than 50% of individuals with a history of GDM complete postpartum diabetes testing.[6–8] National analyses of U.S. commercial insurance claims reveal that only 36.2% of these individuals completed blood glucose testing and diabetes-associated visits within 12 months after delivery.[9]

Key Points

- IPD testing is a feasible and replicable practice.
- IPD testing increased rates nearly 5-fold compared with traditional timing.
- Persistent dysglycemia was identifiable immediately postpartum.
- Longer hospital stays increased the likelihood of testing.
- In-hospital testing may reduce language barriers.

Immediate postpartum diabetes (IPD) testing, conducted on postpartum day 1 or 2, has emerged as a promising intervention to overcome these barriers.[10] Dinglas et al.[11] and Waters et al.[12] assessed the accuracy of immediate postpartum glucose testing. However, Werner et al. performed the sentinel study demonstrating that this approach yields diagnostic accuracy comparable to traditional outpatient testing while significantly increasing testing completion rates, reaching up to 99%.[13] Building on this work, Ayala et al.—with Werner as senior author—reported that when implemented as part of routine in-hospital care following a GDM diagnosis, 83.3% of patients completed early glucose tolerance testing before hospital discharge, a substantial improvement over traditional rates.[14]

The American College of Obstetricians and Gynecologists (ACOG) formally endorsed IPD testing in July 2024 as a reasonable alternative to traditional testing 4 to 12 weeks' postpartum.[15] Our institution—a hybrid community–academic hospital distinct from the academic site where Werner et al.'s was conducted—implemented universal IPD testing as part of routine postpartum care in December 2023, 6 months before the ACOG's endorsement. This study evaluates the real-world implementation of this practice change by comparing testing completion rates before and after implementation, identifying factors influencing completion, and determining the prevalence of abnormal glucose tolerance. In doing so, we offer a structured, scalable model for integrating IPD testing in diverse clinical settings.

Materials and Methods

Preimplementation

We conducted a study comparing pre- and postimplementation of IPD testing at our institution. Before the practice change, our institutional guideline recommended routine outpatient diabetes testing in patients with a history of GDM at 4 to 12 weeks' postpartum. Due to concerns about low testing rates, the Principal Investigator (V.M.P.) reviewed the data supporting the diagnostic efficacy of the 2-day postpartum GTT—particularly Werner et al.'s. Following the review, she collaborated with department leadership, physicians, nurses, and phlebotomists to develop and implement the immediate diabetes testing protocol. The protocol was approved by the hospital and disseminated to all department personnel. With the aid of an education pamphlet (available upon request) developed by the hospital's Diabetes in Pregnancy Program, the Diabetes in Pregnancy team educated patients about the practice change during routine third-trimester diabetes clinic visits.

Implementation

The practice change was piloted in November 2023 to resolve any issues before its official rollout on December 1, 2023. During the 30-day pilot phase, physicians, midwives, and nurses were educated on the importance and logistics of the intervention. The new protocol offered a 2-h GTT to patients with GDM on postpartum day 1 or 2. As part of the process, the resident physician placed the 2-h GTT order. Nursing staff educated the patient on the test procedure, including the need to fast, and coordinated blood draws with phlebotomy. To avoid prolonged fasting, the test was performed at 6 a.m. All patients with GDM, regardless of postpartum testing status, were encouraged to follow-up with their primary care physician postpartum.

Evaluation

The primary objective of the evaluation was to compare postpartum diabetes testing rates before and after implementation of IPD testing. Secondary objectives were to evaluate pregnancy outcomes associated with the practice change, identify factors associated with IPD completion, assess the prevalence of abnormal glucose tolerance, and evaluate maternal and neonatal outcomes in the postimplementation group.

For the evaluation, we conducted a retrospective cohort study of patients aged 18 to 55 with GDM who received care at a hospital-based clinic and delivered at our hybrid community–academic medical center. Patients from private clinics were excluded because preimplementation GTT data were not available. For analysis, patients were grouped by delivery date: September 1, 2022 to November 15, 2023 (Preimplementation) and December 1, 2023 to October 31, 2024 (Postimplementation). The preimplementation group underwent standard outpatient diabetes testing 4 to 12 weeks' postpartum, whereas the postimplementation group received in-hospital IPD testing on postpartum day 1 or 2. Both groups were screened using a 2-h 75-g GTT. Fasting glucose $\geq$ 100 mg/dL or 2-h glucose $\geq$ 140 mg/dL was considered indicative of impaired glucose metabolism, whereas fasting glucose $\geq$ 126 mg/dL or 2-h glucose $\geq$ 200 mg/dL was suggestive of diabetes.

Data were extracted from each patient's electronic medical record. Variables included demographics, medical history, GDM details, pregnancy outcomes, and postpartum diabetes testing results. GDM control was defined as good when at least 80% of fasting and postprandial fingerstick glucose values met the ACOG-recommended glycemic target[5] in the last 4 weeks of pregnancy. Conversely, GDM control was defined as poor when fewer than 80% of these glucose values met these targets during the same period. We compared testing completion rates and pregnancy outcomes between preimplantation and postimplantation cohorts. Then, we analyzed differences between patients in the postimplementation cohort who were tested and untested. Statistical analyses included chi-square tests for categorical variables and *t*-tests for continuous variables. A two-sided *p*-value of <0.05 was considered statistically significant. All analyses were

Table 1 Patient characteristics between preimplementation and postimplementation cohorts

Patient characteristics (%)	Preimplementation ($n = 63$)	Postimplementation ($n = 92$)	p-Value
Age, mean (SD)	31.59 (5.63)	34.25 (5.80)	**<0.01**
BMI, mean (SD)	35.83 (5.28)	36.13 (6.69)	0.75
Insurance, *n* (%)			0.89
Medicaid	39 (61.90)	58 (63.04)	
Private	24 (38.10)	34 (36.96)	
Marital status, *n* (%)			0.90
Single	27 (42.86)	36 (39.13)	
Married	34 (53.97)	53 (57.61)	
Divorced	2 (3.17)	3 (3.26)	
Primiparity, *n* (%)	16 (25.40)	25 (27.17)	0.81
Language, *n* (%)			0.24
English	58 (92.06)	77 (83.70)	
Spanish	4 (6.35)	9 (9.78)	
Other	1 (1.59)	6 (6.52)	
Race, *n* (%)			0.36
White	16 (25.40)	28 (30.43)	
Black	25 (39.68)	24 (26.09)	
Asian	9 (14.29)	17 (18.48)	
Other	13 (20.63)	23 (25.00)	
Ethnicity, *n* (%)			0.35
Hispanic	13 (20.63)	25 (27.17)	
Non-Hispanic	50 (79.37)	67 (72.83)	

Abbreviations: BMI, body mass index; SD, standard deviation.

conducted using SAS statistical software (SAS Institute, Cary, North Carolina, United States), version 9.4.

Results

A total of 155 patients were included: 63 in the preimplementation group and 92 in the postimplementation group. Baseline characteristics are presented in **Table 1**. Across the preimplementation and postimplementation groups, the two cohorts were similar in demographic and clinical variables, except for age, which was significantly higher in the postimplementation group (34.25 ± 5.80 vs. 31.59 ± 5.63 years; $p = 0.01$). No significant differences were observed in body mass index (BMI), insurance status, marital status, gravidity, parity, language, race, or ethnicity ($p > 0.05$) as shown in **Table 1**.

Postpartum diabetes testing rates, as shown in **Table 2**, increased markedly following implementation, with 68.48% of patients tested postimplementation compared with 14.29% preimplementation ($p < 0.01$). Mode of delivery, postdelivery length of stay, gestational age at GDM diagnosis, GDM type, and glycemic control did not differ significantly between groups ($p > 0.05$). Pregnancy complications were similar overall. Preeclampsia with severe features occurred more frequently postimplementation (10.87 vs. 4.76%) but did not reach statistical significance ($p = 0.09$). Use of GDM medications showed a trend toward decreased insulin use postimplementation (27.17 vs. 46.03%; $p = 0.07$). Induction of labor was significantly less common in the postimplementation group (38.04 vs. 55.56%; $p = 0.03$; **Table 2**).

In the postimplementation group only, we compared demographic and clinical factors among women who underwent IPD testing and those who did not (**Tables 3** and **4**). No significant differences were observed between tested and untested patients with respect to age, BMI, insurance type, marital status, gravidity, parity, race, ethnicity, delivery mode, pregnancy complications, or GDM type ($p > 0.05$). Patients who underwent IPD testing were significantly more likely to be non-English speakers (22.2% [14/63] vs. 3.15% [1/29]; $p = 0.02$), diagnosed with GDM earlier in pregnancy ($28^{0/7}$ vs. $31^{0/7}$ weeks; $p = 0.03$), and have a postpartum length of stay greater than one day (98.4% [62/63] vs. 48.3% [14/29]; $p < 0.01$) compared with those who were not tested. Neonates of women who were tested had a lower mean birth weight ($3{,}137.1 \pm 665.1$ vs. $3{,}374.4 \pm 484.7$ g; $p = 0.05$), longer nursery stay (2.55 ± 2.2 vs. 1.83 ± 0.69 days; $p = 0.03$), and more neonatal intensive care unit (NICU) admissions [20.63 vs. 0%; $p = 0.01$]). Among the tested patients in the postimplementation cohort, 43% (27/63) had impaired glucose metabolism and 6% (4/63) had results suggestive of overt diabetes.

Discussion

This study demonstrated that IPD testing in a hybrid academic-community hospital significantly improved adherence to recommended testing for patients with GDM. Despite similar baseline characteristics and pregnancy outcomes between pre- and postimplementation cohorts, IPD testing resulted in a nearly 5-fold increase in testing rates compared with traditional 4 to 12 weeks' postpartum testing. These findings underscore the effectiveness

Table 2 Postpartum diabetes testing rate and pregnancy characteristics in the pre- and postimplementation cohorts

Patient characteristics, *n* (%)	Preimplementation (*n* = 63)	Postimplementation (*n* = 92)	*p*-Value
Tested, *n* (%)	9 (14.29)	63 (68.48)	**<0.01**
Type of delivery, *n* (%)			0.58
Spontaneous vaginal	31 (49.21)	42 (45.65)	
Cesarean	29 (46.03)	48 (52.17)	
Vacuum-assisted vaginal	1 (1.59)	0 (0.00)	
Vaginal birth after cesarean	2 (3.17)	2 (2.17)	
Postdelivery LOS, *n* (%)			0.61
1 d	9 (14.29)	16 (17.39)	
>1 d	54 (85.71)	76 (82.61)	
Pregnancy complications, *n* (%)			0.09
None	42 (66.67)	67 (72.83)	
Preeclampsia with severe features	3 (4.76)	10 (10.87)	
Preeclampsia	4 (6.35)	6 (6.52)	
Gestational hypertension	2 (3.17)	3 (3.26)	
Chronic hypertension	11 (17.46)	5 (5.43)	
GA at GDM diagnosis, mean (SD)	$28^{0/7}$ ($6^{5/7}$ wk)	$28^{6/7}$ (7 wk)	0.44
GDM type, *n* (%)			0.28
GDMA1	30 (47.62)	52 (56.52)	
GDMA2	33 (52.38)	40 (43.48)	
GDM control, *n* (%)			0.37
Good	48 (76.19)	64 (69.57)	
Poor	15 (23.81)	28 (30.43)	
GDM medication, *n* (%)			0.07
None	29 (46.03)	50 (54.35)	
Insulin	29 (46.03)	25 (27.17)	
Metformin	5 (7.94)	13 (14.13)	
Insulin + metformin	0 (0.00)	4 (4.35)	
Induction of labor, *n* (%)			**0.03**
Performed	35 (55.56)	35 (38.04)	
Not performed	28 (44.44)	57 (61.96)	

Abbreviations: A1, diet-controlled; A2, medication-controlled; BMI, body mass index; GA, gestational age; GDM, gestational diabetes; LOS, length of stay; SD, standard deviation.

of implementing IPD as a strategy to address historically low postpartum testing rates.

Our findings align with those of Ayala et al., who demonstrated that offering in-hospital postpartum glucose tolerance testing significantly improved adherence compared with traditional 4- to 12-week testing.[14] Both studies confirm that immediate postpartum testing addresses barriers to outpatient follow-up and represents a scalable strategy to improve care for patients with GDM. Additionally, similar to Ayala et al., nearly half of the patients had abnormal postpartum GTT values (i.e., impaired glucose metabolism and diabetes), underscoring the high burden of persistent dysglycemia immediately after delivery and highlighting the urgent need for close postpartum follow-up and early intervention to prevent progression to or worsening of type 2 diabetes.

Our study adds significant new insights. Unlike the implementation study by Ayala et al., which was conducted at the same large tertiary academic center as Werner et al.'s sentinel study,[13,14] our study took place in a hybrid community–academic hospital setting, suggesting that early IPD testing is feasible across diverse sites of care and enhancing the generalizability of our results. Additionally, our study identified unique operational factors influencing testing uptake, including early discharge and language barriers. For example, patients with shorter hospital stays were less likely to be tested before discharge. This finding highlights an opportunity for future interventions to integrate IPD testing workflows for patients pursuing early discharge. Furthermore, non-English speakers were more likely to be tested, suggesting that inpatient testing may mitigate language-related barriers to outpatient follow-up, an important consideration for health equity.

An original approach to our study is the examination of neonatal outcomes within the postimplementation cohort. We observed significant differences in birth weight, length of stay, and NICU admission between neonates of tested and untested mothers. We hypothesize that infants of tested mothers were more likely to be clinically complex or require additional monitoring. This increased neonatal acuity may have precluded early discharge and thereby increased the likelihood of in-hospital testing. These observations underscore the interplay between maternal and neonatal factors and operational workflows in shaping postpartum care delivery.

Our study has other strengths. By reflecting real-world clinical practice, we demonstrate that IPD testing can be successfully integrated into routine. The structured approach to workflow integration and stakeholder engagement provides a practical model for other hospitals seeking to implement IPD testing.

Table 3 Patient characteristics between postimplementation tested and not tested population

Patient characteristics (%)	Tested ($n = 63$)	Untested ($n = 29$)	p-Value
Age, mean (SD)	33.81 (6.08)	35.21 (5.11)	0.29
BMI, mean (SD)	35.83 (6.89)	36.79 (6.31)	0.52
Insurance, *n* (%)			0.29
Medicaid	42 (66.67)	16 (55.17)	
Private	21 (33.33)	13 (44.83)	
Marital status, *n* (%)			0.22
Single	27 (42.86)	9 (31.03)	
Married	33 (52.38)	20 (68.97)	
Divorced	3 (4.76)	0 (0.00)	
Primiparity, *n* (%)	20 (31.75)	5 (17.24)	0.15
Language, *n* (%)			0.02
English	49 (77.78)	28 (96.55)	
Other	14 (22.22)	1 (3.45)	
Race, *n* (%)			0.09
White	18 (28.57)	10 (34.48)	
Black	18 (28.57)	6 (20.69)	
Asian	8 (12.70)	9 (31.03)	
Other	19 (30.16)	4 (13.79)	
Ethnicity, *n* (%)			0.15
Hispanic	20 (31.75)	5 (17.24)	
Non-Hispanic	43 (68.25)	24 (82.76)	

Abbreviations: BMI, body mass index; SD, standard deviation.

Table 4 Pregnancy and neonatal outcomes between postimplementation tested and not tested population

Patient characteristics (%)	Tested ($n = 63$)	Untested ($n = 29$)	p-Value
Type of delivery, *n* (%)			0.17
Spontaneous vaginal	25 (39.68)	17 (58.62)	
Cesarean	37 (58.73)	11 (37.93)	
Vaginal birth after cesarean	1 (1.59)	1 (3.45)	
Postdelivery LOS, *n* (%)			<0.01
1 d	1 (1.59)	15 (51.72)	
>1 d	62 (98.41)	14 (48.28)	
Pregnancy complications, *n* (%)			0.55
None	43 (68.25)	24 (82.76)	
Preeclampsia with severe features	9 (14.29)	1 (3.45)	
Preeclampsia	5 (7.94)	1 (3.45)	
Gestational HTN	2 (3.17)	1 (3.45)	
Chronic HTN	3 (4.76)	2 (6.90)	
Cholestasis	1 (1.59)	0 (0.00)	
GA at GDM diagnosis, mean (SD)	$28^{0/7}$ wk ($7^{5/7}$)	$31^{0/7}$ wk ($4^{6/7}$)	0.03
GDM type, *n* (%)			0.47
GDMA1	34 (53.97)	18 (62.07)	
GDMA2	29 (46.03)	11 (37.93)	
GDM control, *n* (%)			0.06
Good	40 (63.49)	24 (82.76)	
Poor	23 (36.51)	5 (17.24)	
GDM medication, *n* (%)			0.87
None	34 (53.97)	16 (55.17)	
Insulin	18 (28.57)	7 (24.14)	
Metformin	9 (14.29)	4 (13.79)	
Both	2 (3.17)	2 (6.90)	

(*Continued*)

Table 4 (*Continued*)

Patient characteristics (%)	Tested ($n = 63$)	Untested ($n = 29$)	p-Value
Induction of labor, *n* (%)			0.63
Performed	25 (39.68)	10 (34.48)	
Not performed	38 (60.32)	19 (65.52)	
Newborn weight (g), mean (SD)	3,137.1 (665.1)	3,374.4 (484.7)	0.05
Apgar score, medium (IQR)			
1 min	8 (7–9)	9 (8–9)	0.07
5 min	9 (9–9)	9 (9–9)	0.10
Nursery length of stay, mean (SD)	2.55 (2.2)	1.83 (0.69)	0.03
NICU admissions, *n* (%)	13 (20.63)	0	<0.01

Abbreviations: A1, diet-controlled; A2, medication-controlled LOS, length of stay; BMI, body mass index; GA, gestational age; GDM, gestational diabetes; HTN, hypertension; IQR, Interquartile range; NICU, neonatal intensive care unit; SD, standard deviation.

Limitations include the exclusion of patients who received prenatal care in private offices because preimplementation postpartum testing data were unavailable, which reduced the completeness of baseline comparisons. However, all patients with GDM in our institution are offered universal IPD testing, regardless of their prenatal care site, minimizing variation in care, a key driver to closing the maternal health disparity gap. We are currently exploring patient and physician perspectives and identifying barriers to testing to inform future implementation strategies. Future studies should also evaluate the cost-effectiveness of IPD testing to support policy and resource allocation decisions.

Conclusion

IPD testing is an effective strategy to improve adherence to detect persistent dysglycemia early. By demonstrating feasibility in a hybrid community–academic setting, this study shows that IPD testing can be successfully implemented beyond tertiary academic centers. Our structured approach—integrating workflows and engaging stakeholders—offers a scalable model for adaptation in diverse clinical environments. Incorporating IPD testing into routine postpartum care can reduce missed diagnoses and improve long-term health outcomes for patients with GDM.

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Statements and Additional Information

Conflict of Interest V.M.P. received travel support from the Haas Grant to present at the Diabetes in Pregnancy Conference. M.B. received a monetary travel award from the Diabetes in Pregnancy Conference in recognition of this study being selected as one of the top three conference abstracts. D.W. received compensation through Trinity Health of New England Internal Haas Grant for statistical analysis and methodological support. All other authors report no additional conflicts of interest

Data Availability Statement The dataset generated and analyzed during this study involves protected health information from pregnant individuals with diabetes and cannot be made publicly available. Deidentified data may be obtained from the corresponding author upon reasonable request, in accordance with ethical and privacy safeguards for human subjects research. This study was reviewed and approved by the Institutional Review Board at our institution, and all procedures adhered to applicable regulatory and ethical standards.

Contributors' Statement V.M.P.: conceptualization, data curation, formal analysis, investigation, methodology, resources, supervision, writing—original draft, writing—review and editing. M.B.: data curation, investigation, writing—review and editing. N.B.: data curation, methodology, writing—review and editing. D.W.: formal analysis, software, writing—review and editing. R.C.: conceptualization, methodology, resources, supervision, writing—review and editing.

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