The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

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Presidential Task Force on Redefining the Postpartum Visit
Committee on Obstetric Practice

The Academy of Breastfeeding Medicine, the American College of Nurse-Midwives, the National Association of Nurse Practitioners in Women's Health, the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice in collaboration with task force members Alison Stuebe, MD, MSc; Tamika Auguste, MD; and Martha Gulati, MD, MS.

Optimizing Postpartum Care

ABSTRACT: The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. It is recommended that all women have contact with their obstetrician–gynecologists or other obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her obstetrician–gynecologist or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit. Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable all women to recover from birth and nurture their infants. This Committee Opinion has been revised to reinforce the importance of the "fourth trimester" and to propose a new paradigm for postpartum care.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
- Anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care.
- Prenatal discussions should include the woman's reproductive life plans, including desire for and timing of any future pregnancies. A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.
- All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.

- The timing of the comprehensive postpartum visit should be individualized and woman centered.
- The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being.
- Women with pregnancies complicated by preterm birth, gestational diabetes, or hypertensive disorders of pregnancy should be counseled that these disorders are associated with a higher lifetime risk of maternal cardiometabolic disease.
- Women with chronic medical conditions, such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, mood disorders, and substance use disorders, should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care.
- For a woman who has experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician–gynecologist or other obstetric care provider.
- Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit.

Introduction

The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. During this period, a woman is adapting to multiple physical, social, and psychological changes. She is recovering from childbirth, adjusting to changing hormones, and learning to feed and care for her newborn (1). In addition to being a time of joy and excitement, this "fourth trimester" can present considerable challenges for women, including lack of sleep, fatigue, pain, breastfeeding difficulties, stress, new onset or exacerbation of mental health disorders, lack of sexual desire, and urinary incontinence (2–4). Women also may need to navigate preexisting health and social issues, such as substance dependence, intimate partner violence, and other concerns. During this time, postpartum care often is fragmented among maternal and pediatric health care providers, and communication across the transition from inpatient to outpatient settings is often inconsistent (5). Home visits are provided in some settings; however, currently, most women in the United States must independently navigate the postpartum transition until the traditional postpartum visit (4–6 weeks after delivery). This lack of attention to maternal health needs is of particular concern given that more than one half of pregnancy-related deaths occur after the birth of the infant (6). Given the urgent need to reduce severe maternal morbidity and mortality, this Committee Opinion has been revised to reinforce the importance of the "fourth trimester" and to propose a new paradigm for postpartum care.

Redefining Postpartum Care

Following birth, many cultures prescribe a 30–40-day period of rest and recovery, with the woman and her newborn surrounded and supported by family and community members (7). Many agrarian cultures enshrine postpartum rituals, including traditional foods and support for day-to-day household tasks. These traditions have been sustained by some cultural groups, but for many women in the United States, the 6-week postpartum visit punctuates a period devoid of formal or informal maternal support. Obstetrician–gynecologists and other women's health care providers are uniquely qualified to enable each woman to access the clinical and social resources she needs to successfully navigate the transition from pregnancy to parenthood.

To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. Indeed, in qualitative studies, women have noted that there is an intense focus on women's health prenatally but care during the postpartum period is infrequent and late (8). Rather than an arbitrary "6-week check," the American College of Obstetricians and Gynecologists recommends that the timing of the comprehensive postpartum visit be individualized and woman centered. To better meet the needs of women in the postpartum period, care would ideally include an initial assessment, either in person or by phone, within the first 3 weeks postpartum to address acute postpartum issues. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive well-woman visit no later than 12 weeks after birth (Fig. 1). Insurance coverage policies should be aligned to support this tailored approach to "fourth trimester" care (see Policy and Postpartum Care).

Increasing engagement

Currently, as many as 40% of women do not attend a postpartum visit. Underutilization of postpartum care impedes management of chronic health conditions and access to effective contraception, which increases the risk of short interval pregnancy and preterm birth. Attendance rates are lower among populations with limited resources (9, 10), which contributes to health disparities.

Increasing attendance at postpartum visits is a developmental goal for Healthy People 2020. Strategies for increasing attendance include but are not limited to the following measures: discussing the importance of postpartum care during prenatal visits; using peer counselors, intrapartum support staff, postpartum nurses, and discharge planners to encourage postpartum follow-up; scheduling postpartum visits during prenatal care or

before hospital discharge; using technology (eg, email, text, and apps) to remind women to schedule postpartum follow-up (11); and increasing access to paid sick days and paid family leave.

Optimal postpartum care provides an opportunity to promote the overall health and well-being of women, and evidence suggests that current care falls short of that goal. In a national survey, less than one half of women attending a postpartum visit reported that they received enough information at the visit about postpartum depression, birth spacing, healthy eating, the importance of exercise, or changes in their sexual response and emotions (12). Of note, anticipatory guidance improves maternal well-being: In a randomized controlled trial, 15 minutes of anticipatory guidance before hospital discharge, followed by a phone call at 2 weeks, reduced symptoms of depression and increased breastfeeding duration through 6 months postpartum among African American and Hispanic women (13, 14).

Prenatal Preparation

To optimize postpartum care, anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care (15) (Table 1). Anticipatory guidance should include discussion of infant feeding (16, 17), "baby blues," postpartum emotional health, and the challenges of parenting and postpartum recovery from birth (18). Prenatal discussions also should address plans for long-term management of chronic health conditions, such as mental health, diabetes, hypertension, and obesity, including identification of a primary health care provider who will care for the patient beyond the postpartum period. Within this guidance, health care providers should discuss the purpose and value of postpartum clinical care as well as the types of services and support available.

Reproductive Life Planning

Beginning in prenatal care, the patient and her obstetrician–gynecologist or other obstetric care provider should discuss the woman's reproductive life plans, including desire for and timing of any future pregnancies (19). Women should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months (20). Short interpregnancy intervals also are associated with reduced vaginal birth after cesarean success for women undergoing trial of labor after cesarean (21).

A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options (22). Shared decision-making brings two experts to the table: the patient and the health care provider. The health care provider is an expert in the clinical evidence, and the patient is an expert in her experiences and values (23). As affirmed by the World Health Organization, when making choices regarding the timing of the next pregnancy, "Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences" (24). Given the complex history of sterilization abuse (25) and fertility control among marginalized women, care should be taken to ensure that every woman is provided information on the full range of contraceptive options so that she can select the method best suited to her needs (26).

The Postpartum Care Plan

Beginning during prenatal care, the woman and her obstetrician–gynecologist or other obstetric care provider should develop a postpartum care plan and care team,

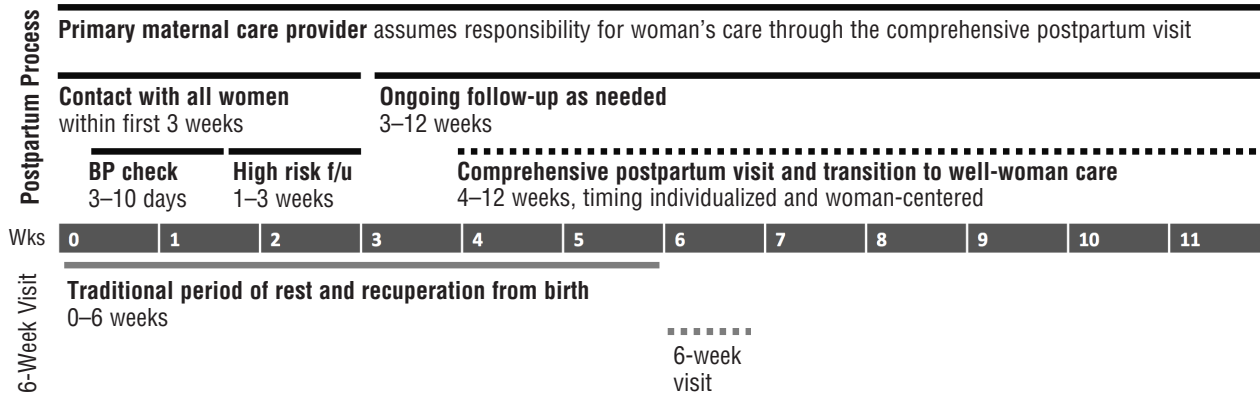

Figure 1. Proposed paradigm shift for postpartum visits. The American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice propose shifting the paradigm for postpartum care from a single 6-week visit (bottom) to a postpartum process (top). Abbreviations: BP, blood pressure; f/u, follow-up. ⇦

inclusive of family and friends who will provide social and material support in the months following birth, as well as the medical provider(s), who will be primarily responsible for care of the woman and her infant after birth (19). Suggested components of the postpartum care team and care plan are listed in Table 1 and Table 2. The care plan should identify the primary care provider and other medical providers (eg, psychiatrist) who will assume care of chronic medical issues after the postpartum period. If the obstetrician–gynecologist serves as the primary care provider, then transition to another primary care physician is unnecessary.

Transition From Intrapartum to Postpartum Care

The postpartum care plan should be reviewed and updated after the woman gives birth. Women often are uncertain about whom to contact for postpartum concerns (27). In a recent U.S. survey, one in four postpartum women did not have a phone number for a health care provider to contact for any concerns about themselves or their infants (12). Therefore, it is suggested that the care plan include contact information and written instructions regarding the timing of follow-up postpartum care. Just as a health care provider or health care practice leads the woman's care during pregnancy, a primary obstetrician–gynecologist or other health care provider should assume responsibility for her postpartum care (15). This individual or practice is the primary point of contact for the woman, for other members of the postpartum care team, and for any maternal health concerns noted by the infant's health care provider. When the woman is discharged from inpatient care but prolonged infant hospitalization remote from the woman's home is anticipated, a local obstetrician–gynecologist or other health care provider should be identified as a point of contact and an appropriate hand off should occur. Such a referral should occur even if delivery did not take place at a local hospital.

Substantial morbidity occurs in the early postpartum period; more than one half of pregnancy-related maternal deaths occur after the birth of the infant (6). Blood pressure evaluation is recommended for women with hypertensive disorders of pregnancy no later than 7–10 days postpartum (28), and women with severe hypertension should be seen within 72 hours; other experts have recommended follow-up at 3–5 days (29). Such assessment is critical given that more than one half of postpartum strokes occur within 10 days of discharge (30). In-person follow-up also may be beneficial for women at high risk of complications, such as postpartum depression (31), cesarean or perineal wound infection, lactation difficulties, or chronic conditions such as seizure disorders that require postpartum medication titration. For women

Table 1. Suggested Components of the Postpartum Care Plan*

Element	Components
Care team	Name, phone number, and office or clinic address for each member of care team
Postpartum visits	Time, date, and location for postpartum visit(s); phone number to call to schedule or reschedule appointments
Infant feeding plan	Intended method of infant feeding, resources for community support (eg, WIC, Lactation Warm Lines, Mothers' groups), return-to-work resources
Reproductive life plan and commensurate contraception	Desired number of children and timing of next pregnancy Method of contraception, instructions for when to initiate, effectiveness, potential adverse effects, and care team member to contact with questions
Pregnancy complications	Pregnancy complications and recommended follow-up or test results (eg, glucose screening for gestational diabetes, blood pressure check for gestational hypertension), as well as risk reduction recommendations for any future pregnancies
Adverse pregnancy outcomes associated with ASCVD	Adverse pregnancy outcomes associated with ASCVD will need baseline ASCVD risk assessment, as well as discussion of need for ongoing annual assessment and need for ASCVD prevention over lifetime.
Mental health	Anticipatory guidance regarding signs and symptoms of perinatal depression or anxiety; management recommendations for women with anxiety, depression, or other psychiatric issues identified during pregnancy or in the postpartum period
Postpartum problems	Recommendations for management of postpartum problems (ie, pelvic floor exercises for stress urinary incontinence, water-based lubricant for dyspareunia)
Chronic health conditions	Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up

Abbreviations: ASCVD, atherosclerotic cardiovascular disease; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

*A Postpartum Care Plan Template is available as part of the ACOG Pregnancy Record.

Table 2. Postpartum Care Team*

Team Member	Role
Family and friends	• Ensures woman has assistance for infant care, breastfeeding support, care of older children • Assists with practical needs such as meals, household chores, and transportation • Monitors for signs and symptoms of complications, including mental health
Primary maternal care provider (obstetrician–gynecologist, certified nurse midwife, family physician, women's health nurse practitioner)	• Ensures patient's postpartum needs are assessed and met during the postpartum period and that the comprehensive postpartum visit is completed • "First call" for acute concerns during postpartum period • Also may provide ongoing routine well-woman care after comprehensive postpartum visit
Infant's health care provider (pediatrician, family physician, pediatric nurse practitioner)	• Primary care provider for infant after discharge from maternity care
Primary care provider (also may be the obstetric care provider)	• May co-manage chronic conditions (eg, hypertension, diabetes, depression) during postpartum period • Assumes primary responsibility for ongoing health care after comprehensive postpartum visit
Lactation support (professional IBCLC, certified counselors and educators, peer support)	• Provides anticipatory guidance and support for breastfeeding • Co-manages complications with pediatric and maternal care providers
Care coordinator or case manager	• Coordinates health and social services among members of postpartum care team
Home visitor (eg, Nurse Family Partnership, Health Start)	• Provides home visit services to meet specific needs of mother–infant dyad after discharge from maternity care
Specialty consultants (ie, maternal–fetal medicine, internal medicine subspecialist, behavioral health care provider)	• Co-manages complex medical problems during postpartum period • Provides prepregnancy counseling for future pregnancies

Abbreviation: IBCLC, international board certified lactation consultant.

*Members of the care team may vary depending on the needs of the mother–infant dyad and locally available resources.

with complex medical problems, multiple visits may be required to facilitate recovery from birth.

Of note, even among women without risk factors, problems such as heavy bleeding, pain, physical exhaustion, and urinary incontinence are common (12). World Health Organization guidelines for postnatal care include routine postpartum evaluation of all women and infant dyads at 3 days, 1–2 weeks, and 6 weeks (32). The National Institute for Health and Care Excellence guidelines recommend screening all women for resolution of the "Baby Blues" at 10–14 days after birth to facilitate early identification of and treatment for postpartum depression (15). Contact in the first few weeks also may enable women to meet their breastfeeding goals: Among women with early, undesired weaning, 20% had discontinued breastfeeding by 6 weeks postpartum (33), when traditionally timed visits occurred. To address these common postpartum concerns, all women should ideally have contact with a maternal care provider within the first 3 weeks postpartum.

Assessment need not occur as an office visit, and the usefulness of an in-person assessment should be weighed against the burden of traveling to and attending an office visit with a neonate. Additional mechanisms for assessing women's health needs after birth include home visits (34), phone support (35, 36), text messages (37), remote blood pressure monitoring (38, 39), and app-based support (40). Phone support during the postpartum period appears to reduce depression scores, improve breastfeeding outcomes, and increase patient satisfaction, although the evidence is mixed (35, 36).

The Comprehensive Postpartum Visit and Transition to Well-Woman Care

Visit Timing

The comprehensive postpartum visit has typically been scheduled between 4 weeks and 6 weeks after delivery, a time frame that likely reflects cultural traditions of 40 days of convalescence for women and their infants (41).

Today, however, 23% of employed women return to work within 10 days postpartum and an additional 22% return to work between 10 days and 40 days (42). Therefore, timing of the comprehensive postpartum visit should be individualized and woman centered, occurring no later than 12 weeks from birth. Timing also should take into account any changes in insurance coverage anticipated after delivery. At all postpartum encounters, obstetrician–gynecologists and other obstetric care providers should consider the need for future follow-up and time additional visits accordingly. However timed, the comprehensive postpartum visit is a medical appointment; it is not an "all-clear" signal. Obstetrician–gynecologists and other obstetric care providers should ensure that women, their families, and their employers understand that completion of the comprehensive postpartum visit does not obviate the need for continued recovery and support through 6 weeks postpartum and beyond.

Visit Components

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains (Box 1): mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

Box 1. Components of Postpartum Care

Mood and emotional well-being

- Screen for postpartum depression and anxiety with a validated instrument[1,2]
- Provide guidance regarding local resources for mentoring and support
- Screen for tobacco use; counsel regarding relapse risk in postpartum period[3]
- Screen for substance use disorder and refer as indicated[4]
- Follow-up on preexisting mental health disorders, refer for or confirm attendance at mental health-related appointments, and titrate medications as appropriate for the postpartum period

Infant care and feeding

- Assess comfort and confidence with caring for newborn, including
  - feeding method
  - child care strategy if returning to work or school
  - ensuring infant has a pediatric medical home
  - ensuring that all caregivers are immunized[5]
- Assess comfort and confidence with breastfeeding, including
  - breastfeeding-associated pain[6]
  - guidance on logistics of and legal rights to milk expression if returning to work or school[7,8]
  - guidance regarding return to fertility while lactating; pregnancy is unlikely if menses have not returned, infant is less than 6 months old, and infant is fully or nearly fully breastfeeding with no interval of more than 4–6 hours between breastfeeding sessions[9]
  - review theoretical concerns regarding hormonal contraception and breastfeeding, within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy[7]
- Assess material needs, such as stable housing, utilities, food, and diapers, with referral to resources as needed

Sexuality, contraception, and birth spacing

- Provide guidance regarding sexuality, management of dyspareunia, and resumption of intercourse
- Assess desire for future pregnancies and reproductive life plan[10]
- Explain the rationale for avoiding an interpregnancy interval of less than 6 months and discuss the risks and benefits of repeat pregnancy sooner than 18 months
- Review recommendations for prevention of recurrent pregnancy complications, such as 17α-hydroxyprogesterone caproate to reduce risk of recurrent preterm birth, or aspirin to reduce risk of preeclampsia
- Select a contraceptive method that reflects patient's stated needs and preferences, with same-day placement of LARC, if desired[11]

(continued)

Box 1. Components of Postpartum Care *(continued)*

Sleep and fatigue

- Discuss coping options for fatigue and sleep disruption
- Engage family and friends in assisting with care responsibilities

Physical recovery from birth

- Assess presence of perineal or cesarean incision pain; provide guidance regarding normal versus prolonged recovery[12]
- Assess for presence of urinary and fecal continence, with referral to physical therapy or urogynecology as indicated[13,14]
- Provide actionable guidance regarding resumption of physical activity and attainment of healthy weight[15]

Chronic disease management

- Discuss pregnancy complications, if any, and their implications for future childbearing and long-term maternal health, including ASCVD
- Perform glucose screening for women with GDM: a fasting plasma glucose test or 75 g, 2-hour oral glucose tolerance test[16]
- Review medication selection and dose outside of pregnancy, including consideration of whether the patient is breastfeeding, using a reliable resource such as LactMed
- Refer for follow-up care with primary care or subspecialist health care providers, as indicated

Health maintenance

- Review vaccination history and provide indicated immunizations, including completing series initiated antepartum or postpartum[17]
- Perform well-woman screening, including Pap test and pelvic examination, as indicated[18]

Abbreviations: ASCVD, arteriosclerotic cardiovascular disease; GDM, gestational diabetes mellitus; LARC, long-acting reversible contraceptive.

[1]Screening for perinatal depression. Committee Opinion No. 630. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:1268–71.

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[3]American College of Obstetricians and Gynecologists. Tobacco and nicotine cessation toolkit. Washington, DC: American College of Obstetricians and Gynecologists; 2016.

[4]Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e81–94.

[5]American Academy of Pediatrics. Protect infants against pertussis: cocooning through Tdap vaccination. Washington, DC: AAP. Available at: https://www.aap.org/en-us/Documents/immunization_protect_infants_against_pertussis.pdf. Retrieved January 23, 2018.

[6]Berens P, Eglash A, Malloy M, Steube AM. ABM Clinical Protocol #26: persistent pain with breastfeeding. Breastfeed Med 2016;11:46–53.

[7]Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127:e86–92.

[8]Breastfeeding in underserved women: increasing initiation and continuation of breastfeeding. Committee Opinion No. 570. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:423–8.

[9]Centers for Disease Control and Prevention. Lactational amenorrhea method. In: US medical eligibility criteria (US MEC) for contraceptive use. Atlanta (GA): CDC; 2017.

[10]Reproductive life planning to reduce unintended pregnancy. Committee Opinion No. 654. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127:e66–9.

[11]Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e32–7.

[12]MacArthur C, Winter HR, Bick DE, Lilford RJ, Lancashire RJ, Knowles H, et al. Redesigning postnatal care: a randomised controlled trial of protocol-based midwifery-led care focused on individual women's physical and psychological health needs. Health Technol Assess 2003; 7:1–98.

[13]Prevention and management of obstetric lacerations at vaginal delivery. Practice Bulletin No. 165. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e1–15.

[14]Urinary incontinence in women. Practice Bulletin No. 155. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e66–81.

[15]American College of Obstetricians and Gynecologists. Obesity toolkit. Washington, DC: American College of Obstetricians and Gynecologists; 2016.

[16]Gestational diabetes mellitus. ACOG Practice Bulletin No. 190. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e49–64.

[17]American College of Obstetricians and Gynecologists. Immunization for women. Washington, DC: American College of Obstetricians and Gynecologists; 2017.

[18]Conry J, Brown H. Well-Woman Task Force: Components of the Well-Woman Visit. Obstet Gynecol 2015;126:697–701.

The comprehensive postpartum visit provides an opportunity for a woman to ask questions about her labor, childbirth, and any complications (15). Relevant details should be reviewed and documented in the medical record. A traumatic birth experience can cause postpartum posttraumatic stress disorder, which affects 3–16% of women (43). Trauma is in the eye of the beholder, and health care providers should be aware that a woman may experience a birth as traumatic even if she and her infant are healthy. Complications should be discussed with respect to risks for future pregnancies, such as recommendations for 17α-hydroxyprogesterone caproate to reduce risk of recurrent preterm birth, or aspirin to reduce risk of preeclampsia. Any placental pathology reports should be reviewed and shared with the patient. Recommendations should be made to optimize maternal health during the interpregnancy period (44), such as controlling diabetes and attaining optimal weight (45).

Adverse Pregnancy Outcomes and Cardiovascular Risk

There are risk factors for cardiovascular disease that appear during pregnancy, and these risk factors are emerging as an important predictor of future arteriosclerotic cardiovascular disease (ASCVD) risk. Complications such as preterm delivery, gestational diabetes, gestational hypertension, preeclampsia, and eclampsia are associated with greater risk of ASCVD (46). Pregnancy is, therefore, a natural "stress test" identifying at-risk women, but because these conditions often resolve postpartum, the increased cardiovascular disease risk is not consistently communicated to women. These adverse pregnancy outcomes are also not assessed when using current ASCVD risk assessment tools. Therefore, women with pregnancies complicated by preterm birth, gestational diabetes, or hypertensive disorders of pregnancy should be counseled that these disorders are associated with a higher lifetime risk of maternal cardiometabolic disease. These women should undergo ASCVD risk assessment (47, 48), with particular attention to the effect of social determinants of health on cardiometabolic disease (49). All postpartum women with gestational diabetes should undergo glucose screening with a fasting plasma glucose test or a 75-g, 2-hour oral glucose tolerance test (45). Any history of pregnancy complications should be documented in the woman's electronic medical record to facilitate effective transition of care and to inform future screening and treatment.

Chronic Health Conditions

Women with chronic medical conditions, such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, mood disorders, and substance use disorders, should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care. Medications such as antiepileptics and psychotropic agents should be reviewed to ensure that the dosage has been adjusted to reflect postpartum physiology and that the agents selected are compatible for women who are breastfeeding. The U.S. National Library of Medicine's LactMed is a free online resource that provides high-quality guidance on medication safety during lactation (www.toxnet.nlm.nih.gov/newtoxnet/lactmed.htm).

Pregnancy Loss

For a woman who has experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician–gynecologist or other obstetric care provider. Key elements of this visit include emotional support and bereavement counseling; referral, if appropriate, to counselors and support groups; review of any laboratory and pathology studies related to the loss; and counseling regarding recurrent risk and future pregnancy planning (50).

Transition to Ongoing Well-Woman Care

During the postpartum period, the woman and her obstetrician–gynecologist or other obstetric care provider should modify her postpartum care plan to identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. Appropriate referrals to other members of her health care team should also be made during this transitional period. If the obstetrician–gynecologist or other obstetric care provider is also her primary care provider, no transfer of responsibility is necessary. If responsibility is transferred to another primary care provider, the obstetrician–gynecologist or other obstetric care provider is responsible for ensuring that there is communication with the primary care provider so that he or she can understand the implications of any pregnancy complications for the woman's future health and maintain continuity of care.

Written recommendations for follow-up for well-woman care and for any ongoing medical issues should be documented in the medical record, provided to the patient, and communicated to appropriate members of the postpartum care team, including her primary care medical home provider. By providing comprehensive, woman-centered care after childbirth, obstetrician–gynecologists and other obstetric care providers can enable every woman to optimize her long-term health and well-being.

Policy and Postpartum Care

Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit. More broadly, provisions for paid parental leave are essential to improve the health of women and children and reduce disparities. As one study (51) has noted, "The lack of policies

substantially benefitting early life in the United States constitutes a grave social injustice: those who are already most disadvantaged in our society bear the greatest burden." The American College of Obstetricians and Gynecologists endorses paid parental leave as essential, including maintenance of full benefits and 100% of pay for at least 6 weeks (52). Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable all women to recover from birth and nurture their infants.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob–gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/OptimizingPostpartumCare.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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