Appendix A. Content Guidance for Elements of the Comprehensive Postpartum Visit

The information below provides additional detail about specific elements of postpartum care.

1. Gestational diabetes: follow up based on results of postpartum diabetes screening (screening may occur subsequent to the postpartum visit, depending on timing of that visit).
   - Women with **normal** tests: screen every 3 years
   - Women with **pre-diabetes**: screen every year and refer to a diabetes prevention program. See Appendix D, Resources.
   - Women with **diabetes**: refer to a primary care provider for management. There are diabetes self-management education programs throughout the state to which women with diabetes can also be referred. See Appendix D, Resources.

2. Hypertension: follow up based on results of postpartum blood pressure measurement.
   - **Normotensive (<120 systolic and <80 diastolic):** continue blood pressure screening every 2 years
   - **Pre-hypertensive (120-139 systolic or 80-90 diastolic):** suggest lifestyle modification and repeat screening every year
   - **Stage 1 Hypertension (140-159 systolic or 90-99 diastolic on average after two or more properly measured, seated blood pressures on two or more office visits):** encourage lifestyle modification and initiate or refer for treatment
   - **Stage 2 Hypertension (≥160 systolic or ≥100 diastolic):** refer to primary care physician or emergency department for emergent management of elevated blood pressure.
   - A postpartum referral to an internal medicine/family practitioner to establish long term follow up should be considered a good clinical practice in the context of suspected underlying/occult chronic hypertension needing medical therapy beyond the 6 week postpartum period.

3. Postpartum depression: follow up based on results of postpartum depression screening.

   - Develop a referral protocol for complicated and uncomplicated depression including routine and emergency referrals.
   - For all patients with a positive screen, determine if they have features of complicated depression. These include any one of the following:
     - Patients with a history of bipolar illness
     - Patients with severe anxiety, insomnia or delusions about themselves, the baby or others
     - Patients who indicate that they are having thoughts about harming themselves, their baby or others
   - Patients who specifically indicate thoughts or plans of harming themselves, the baby or others should be referred emergently to a local Mobile Crisis Management

Unit (if known) or to the local LME/MCO Screening, Triage and Referral (STR) line with the patient present. The LME/MCO will conduct an assessment and connect the patient to Mobile Crisis services if appropriate and available. LME/MCO STR contact information by county can be found here: http://www.ncdhhs.gov/mhddsas/lmeonblue.htm. Alternatively, the patient can be referred to the Emergency Department for evaluation.

- Patients with a positive screen and one or more features of complicated depression should be referred to a behavioral health provider.
    - If a behavioral health provider is known to the practice, a referral can be made directly to that provider, preferably by phone with the patient present, or using whatever existing local referral process is already in place.
        - When speaking with the behavioral health provider, request an appointment for the patient to receive an assessment and service recommendations
    - If the practice does not know of a behavioral health provider, call the local LME/MCO Screening, Triage, and Referral (STR) line (http://www.ncdhhs.gov/mhddsas/lmeonblue.htm) with the patient present. The LME/MCO will conduct an assessment and link the patient to a behavioral health provider in the community.
    - Engage Pregnancy Care Managers to assist with the referral process
- Patients with a positive screen and no features of complicated depression may be managed by the postpartum provider or may be referred to a behavioral health provider using clinical judgment and depending on the referral protocol developed by the provider.

4. Reproductive Life Planning: timing for safe use of contraceptives after birth [2].
    - **Intrauterine device:** insertion immediately postpartum or ≥4 weeks postpartum
    - **Implant:** no restrictions for non-breastfeeding women; ≥4 weeks postpartum if breast feeding
    - **Combined oral contraceptive pills, contraceptive patch and contraceptive ring:** 21 days postpartum if no risk factors for venous thromboembolism (VTE); 42 days with risk factors for VTE
    - **Depo Provera:** no restrictions
    - **Progestin-only oral contraceptive pills:** no restrictions
    - **Condoms:** no restrictions
    - **Diaphragm:** fit ≥6 weeks after delivery

5. Tobacco Use: utilize the "5 A's" for postpartum follow up with patients who currently smoke or who quit during pregnancy. *See the PMH Care Pathway: Management of Perinatal Tobacco Use (hyperlink) for detailed guidance about addressing tobacco use during pregnancy and the postpartum period, including the use of postpartum pharmacotherapy*.
   - **ASK**: the patient about her smoking status.
   - **ADVISE**: provide clear strong advice to quit with personalized messages about the impact of the tobacco use on mother and baby.
   - **ASSESS** the patient's readiness and willingness to make a quit attempt within the next 30 days.
     - **5 Rs:** If patient is not ready to quit within the next 30 days, provide motivational interviewing relating to the relevance of smoking cessation, the risks of tobacco use, the rewards of quitting, and the roadblocks to quitting. Repeat.
   - **ASSIST** the patient who is interested in quitting by suggesting and encouraging the use of problem-solving methods and skills, providing social support as part of the treatment, arranging for support in the smoker's environment such as proactive referral to QuitlineNC (1-800-QUIT-NOW), providing parent-specific self-help cessation materials, and providing a supportive clinical environment while encouraging patients to quit.
   - **ARRANGE** a follow-up appointment to assess tobacco use and quit status.

6. Healthy lifestyle behavioral advice
   a. Management of obesity
      - Refer obese women to comprehensive weight loss programs. Intensive programs should include 6 hours or more of instruction. See Appendix D, Resources, for referral options.
      - Refer obese women to medical nutrition therapy.
      - Review weight loss guidelines with women who are breastfeeding [2]**.** 1800 kcal/day is the minimum necessary to support breastfeeding. Two pounds of weight loss per month should not interfere with breastfeeding.

   b. Physical activity
      - 2 hours and 30 min (150 min) of moderate intensity physical activity (e.g. brisk walking, mowing the lawn) per week AND muscle strengthening activities on 2 or more days
      - OR, 1 hour and 15 min (75 min) of vigorous intensity physical activity (e.g. jogging, swimming laps) per week AND muscle strengthening activities on 2 or more days
      - OR, an equivalent mix of the above.
      - All activity that occurs for at least 10 minutes at a time can be applied to meeting physical activity recommendations.

c. Healthful diet for all women regardless of weight loss intentions
   - Consume 8-10 servings per day of fruits and vegetables
   - Consume ≥3 servings a day of whole grains in place of refined grains
   - Consume ≥2 servings a week of oily fish.
   - Consume 4-5 servings a week of nuts.
   - Consume 2-6 servings a day of vegetable oils.
   - Avoid all intake of trans fats.
   - Consume <2 servings a week of processed meats.
   - Consume <5 cups per week of sugar-sweetened beverages.
   - Consume 1 or fewer servings per day of alcohol.