



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

# COMMITTEE OPINION

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## Committee on Obstetric Practice

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Alison Stuebe, MD and Ann E. Borders, MD, MSc, MPH, and the Association of Women's Health, Obstetric and Neonatal Nurses' liaison member Debra Bingham, DrPH, RN.*

*This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

## Optimizing Postpartum Care

**ABSTRACT:** In the weeks after birth, postpartum care often is fragmented among maternal and pediatric health care providers, and communication between inpatient and outpatient settings is inconsistent. To optimize postpartum care, anticipatory guidance should begin during pregnancy. During antenatal care, it is recommended that the patient and her obstetrician–gynecologist or other obstetric care provider formulate a postpartum care plan and identify the health care professionals who will comprise the postpartum care team for the woman and her infant. Ideally, during the postpartum period, a single health care practice assumes responsibility for coordinating the woman's care. At discharge from maternity care, the woman should receive contact information for her postpartum care team and written instructions regarding the timing of follow-up postpartum care. It is recommended that all women undergo a comprehensive postpartum visit within the first 6 weeks after birth. This visit should include a full assessment of physical, social, and psychological well-being. Systems should be implemented to ensure each woman can receive her desired form of contraception during the comprehensive postpartum visit, if not done earlier. At the conclusion of the postpartum visit, the woman and her obstetrician–gynecologist or other obstetric care provider should determine who will assume primary responsibility for her ongoing care. 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.

## Recommendations

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

- Currently, as many as 40% of women do not attend a postpartum visit. Active engagement in patient-centered, maternal postpartum care has the potential to improve outcomes for women, infants, and families and support ongoing health and well-being.
- To optimize postpartum care, anticipatory guidance should begin during pregnancy. During antenatal care, it is recommended that the patient and her obstetrician–gynecologist or other obstetric care provider formulate a postpartum care plan and identify the health care professionals who will comprise the postpartum care team for the woman and her infant.
- Ideally, during the postpartum period, a single health care practice assumes responsibility for coordinating the woman's care. At discharge from maternity care, the woman should receive contact information for her postpartum care team and written instructions regarding the timing of follow-up postpartum care.
- Early postpartum follow-up is recommended for women with hypertensive disorders of pregnancy. Early follow-up also may be beneficial for women at high risk of complications.
- It is recommended that all women undergo a comprehensive postpartum visit within the first 6 weeks after birth. This visit should include a full assessment of physical, social, and psychological well-being.
- Systems should be in place to ensure that women who desire long-acting reversible contraception or any other form of contraception can receive it during the comprehensive postpartum visit, if immediate postpartum placement was not done earlier.

- Recommended anticipatory guidance at the postpartum visit includes infant feeding, expressing breast milk if returning to work or school, postpartum weight retention, sexuality, physical activity, and nutrition.
- Any pregnancy complications should be discussed with respect to risks for future pregnancies, and recommendations should be made to optimize maternal health during the interconception period.
- At the conclusion of the postpartum visit, the woman and her obstetrician–gynecologist or other obstetric care provider should determine who will assume primary responsibility for her ongoing care. 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.

In the weeks after birth, a woman must adapt to multiple physical, social, and psychological changes. She must recover from childbirth, adjust to changing hormones, and learn 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, depression, lack of sexual desire, and urinary incontinence (2–4). Women also may need to navigate preexisting health 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 between inpatient and outpatient settings is inconsistent (5). Although home visits are provided in some settings, most women in the United States must independently navigate the postpartum transition until the first postpartum visit 4–6 weeks after delivery.

All women should attend a postpartum visit; however, attendance is poor at visits scheduled for 4–6 weeks after birth, with as many as 40% of women not attending a postpartum visit. Attendance rates are lower among populations with limited resources (6, 7), which contributes to health disparities. Increasing attendance at postpartum visits is a developmental goal for Healthy People 2020, and postpartum visit rates are tracked as a Healthcare Effectiveness Data and Information Set measure. Strategies for increasing attendance include, but are not limited to the following measures: discussing the importance of the postpartum visit during prenatal care; 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; and using

technology (eg, e-mail, text, apps) to remind women to schedule postpartum follow-up (8). When women do attend postpartum visits, they report unmet needs: less than one half of women report that they received enough information at their postpartum visit about postpartum depression, birth spacing, healthy eating, the importance of exercise, or changes in their sexual response and emotions (9). Active engagement in patient-centered, maternal postpartum care has the potential to improve outcomes for women, infants, and families and support ongoing health and well-being.

In the absence of evidence-based studies of optimal maternal and infant postpartum management, the measures for anticipatory guidance and care coordination suggested in this Committee Opinion are based largely on expert opinion and observational studies. Ongoing research is needed to determine how to most effectively address the unmet needs of women during the postpartum transition.

To optimize postpartum care, anticipatory guidance should begin during pregnancy, with discussion of family planning, infant feeding, and postpartum recovery from birth. This guidance should include discussion of the purpose and value of the postpartum visit. 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 (10). The optimal interval between delivery and subsequent pregnancy is 18 months to 5 years; the greatest risk of low birth weight and preterm birth occurs when the interconception interval is less than 6 months (11, 12). The patient’s reproductive life plan provides context for discussing contraceptive options (13). Comprehensive prenatal counseling also addresses infant feeding plans (14) and offers anticipatory guidance about the challenges of parenting and recovery from childbirth (15). The primary source of support for a pregnant or postpartum woman is often her family. The term “family” as it is used here includes the expectant woman and her support system, which may include any or all of the following individuals: a spouse or partner, relatives, and friends (16). To the extent that the woman desires, her family should participate with her and her obstetrician–gynecologist or other obstetric care provider in formulating a postpartum care plan (17) (Table 1). This plan identifies the family members and health professionals who will support the woman and the infant after birth (Table 2). In addition, the plan identifies the primary care provider 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.

The postpartum care plan should be reviewed and updated after birth. Women are often uncertain about whom to contact for postpartum concerns (18). In a recent U.S. survey, one in four postpartum women did

**Table 1.** Suggested Components of the Postpartum Care Plan ↩

Element	Components
Care team	Name, phone number, 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	Desired number of children and timing of next pregnancy
Contraceptive plan	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)
Mental health	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 health conditions and the care team member responsible for follow-up

Abbreviation: WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

**Table 2.** Postpartum Care Team\* ↩

Team Member	Role
Family (woman's support system, inclusive of spouse or partner, relatives, and friends)	<ul style="list-style-type: none"> <li>• Ensures woman has assistance for infant care, breastfeeding support, care of older children</li> <li>• Assists with practical needs such as meals, household chores, and transportation</li> </ul>
Primary maternal care provider (obstetrician–gynecologist, certified nurse midwife, family physician, women's health nurse practitioner)	<ul style="list-style-type: none"> <li>• Ensures patient's postpartum needs are met and postpartum visit is completed</li> <li>• "First call" for acute concerns during postpartum period</li> <li>• May also provide ongoing routine well-woman care after postpartum visit</li> </ul>
Infant's provider (pediatrician, family physician, pediatric nurse practitioner)	<ul style="list-style-type: none"> <li>• Primary care provider for infant after discharge from maternity care</li> </ul>
Primary care provider (also may be the obstetric provider)	<ul style="list-style-type: none"> <li>• May co-manage chronic conditions (eg, hypertension, diabetes) during postpartum period</li> <li>• Assumes primary responsibility for ongoing health care after postpartum visit</li> </ul>
Lactation support (professional IBCLC, certified counselors and educators, peer support)	<ul style="list-style-type: none"> <li>• Provides anticipatory guidance and support for breastfeeding</li> <li>• Co-manages complications with pediatric and maternal providers</li> </ul>
Care coordinator/case manager	<ul style="list-style-type: none"> <li>• Coordinates health services among members of postpartum care team</li> </ul>
Home visitor (eg, Nurse Family Partnership, Health Start)	<ul style="list-style-type: none"> <li>• Provides home visit services to meet specific needs of mother–infant dyad after discharge from maternity care</li> </ul>
Specialty consultants (ie, maternal–fetal medicine, internal medicine subspecialist, behavioral health provider)	<ul style="list-style-type: none"> <li>• Co-manages complex medical problems during postpartum period</li> <li>• Provides preconception counseling for future pregnancies</li> </ul>

\*Members of the care team may vary depending on the needs of the mother–infant dyad and locally available resources. Abbreviation: IBCLC, international board certified lactation consultant.

not have a phone number for a health care provider to contact for any concerns about themselves or their infants (9). 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 professional or health care practice leads

the woman's care during pregnancy, a primary maternal care provider should assume responsibility for her postpartum care (17). 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 prolonged infant hospitalization is anticipated and is far from the woman's home, it is recommended that a local maternity health care provider be identified for postpartum care and support, even if delivery did not take place at a local hospital.

### Timing of Postpartum Visits

There is considerable variation in recommendations for timing of postpartum visits (4). Early follow-up is recommended for women with hypertensive disorders of pregnancy, with blood pressure evaluation no later than 7–10 days postpartum (19); other experts have recommended follow-up at 3–5 days (20). Early follow-up also may be beneficial for women at high risk of complications, such as postpartum depression (21), cesarean or perineal wound infection, lactation difficulties, or chronic conditions such as seizure disorders that require postpartum medication titration. These problem-oriented visits, which in some cases may be conducted through home nursing evaluations, do not obviate the need for a comprehensive postpartum visit. Phone support during the postpartum period appears to reduce depression scores, improve breastfeeding outcomes, and increase patient satisfaction, although evidence is mixed (22, 23).

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 (24). Earlier focused or comprehensive postpartum visits, however, provide the opportunity to address concerns that arise before 6 weeks postpartum, and earlier visits also allow time to reschedule any missed appointments. At all visits, obstetrician–gynecologists and other obstetric care providers should consider the need for future follow-up and time additional visits accordingly. Whenever it occurs, the comprehensive postpartum visit includes a full assessment of physical, social, and psychological well-being, with screening for postpartum depression using a validated instrument, such as the Edinburgh Postnatal Depression Scale (21, 25). Birth spacing recommendations and reproductive life plans should be reviewed and a commensurate contraceptive method provided. Systems should be in place to ensure that women who desire long-acting reversible contraception or another form of contraception can receive it during the comprehensive postpartum visit if immediate postpartum placement was not done earlier. Vaccination history should be reviewed and immunizations provided as needed. Women should be asked about common postpartum concerns, including perineal or cesarean wound pain, incontinence, dyspareunia, fatigue, depres-

sion, anxiety, and infant feeding problems (26); identified concerns should be addressed. Suggested topics for anticipatory guidance include infant feeding, expressing breast milk if returning to work or school (14), postpartum weight retention, sexuality, physical activity, and nutrition. Smoking and substance use cessation should be addressed.

The postpartum visit provides an opportunity for women to ask questions about their labor, childbirth, and any complications (17). These complications should be discussed with respect to risks for future pregnancies, and recommendations should be made to optimize maternal health during the interconception period (27). It is important that women with gestational diabetes, hypertensive disorders of pregnancy, or preterm birth be counseled that these disorders are associated with a higher lifetime risk of maternal cardiometabolic disease (28, 29). It is recommended that women with gestational diabetes undergo glucose screening with a fasting plasma glucose or 75 g, 2-hour oral glucose tolerance test (30). Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, and renal disease should be counseled regarding the importance of follow-up with their primary care provider in a timely fashion for ongoing coordination of care.

For women experiencing a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician–gynecologist or other obstetric care provider. 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 (31).

At the conclusion of the postpartum visit, the woman and her health care provider should adapt her postpartum care plan to identify the health care professional who will assume primary responsibility for her ongoing care in her primary care medical home. If the obstetrician–gynecologist or other obstetric care provider also is 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. Documentation of any history of pregnancy complications in the woman's electronic medical record is suggested to facilitate effective transition of care and to inform future screening and treatment. 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.

## 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/Optimizing-PostpartumCare](http://www.acog.org/More-Info/Optimizing-PostpartumCare).

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 web site, or the content of the resource. The resources may change without notice.

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