

Postpartum-to-Primary Care

Clinical Quick Guide

Ownership

Condition-specific actions for maternity and primary care teams in the year after birth

MCT

PCT

SHARED

Foundations

Clear Ownership

Standardized Timing

Minimum Viable Handoff

Condition-Specific Pathways

Universal: Applies to every postpartum patient, regardless of condition**MCT:** Confirm or establish a primary care provider during pregnancy.**PCT:** Document pregnancy and birth history; use it to assess long-term risk at first preventive visit after delivery, regardless of when it occurs.**GDM** *Gestational diabetes —long-term type 2 prevention and cardiovascular risk reduction*

SHARED	Educate patient on long-term T2D and cardiovascular risk; reinforce from late pregnancy through preventive visits.
MCT	Complete postpartum glucose testing: 75g OGTT at 4–12 wks; Day-2 inpatient OGTT if follow-up unlikely; A1c ≥12 wks if OGTT declined.
MCT	At comprehensive postpartum visit or by 12 wks, send structured handoff (glucose results/test status, treatment history, metabolic risk factors, monitoring plan) + schedule PTS.
PCT	Complete PTS: risk stratified, no later than 6 mo PP.
PCT	For normal screen, repeat diabetes screening every 1–3 years; for abnormal results, confirm and initiate management.

HDP *Hypertensive disorders of pregnancy —cardiovascular risk reduction*

SHARED	Educate patient on long-term cardiovascular risk after adverse pregnancy outcomes; reinforce across settings.
MCT	At comprehensive postpartum visit or by 12 wks, send structured handoff (HDP labs, BP trajectory, medications, BP plan); manage BP until handoff + schedule PTS.
PCT	Complete CV risk assessment at PTS: risk stratified, generally around 3–6 mo PP, earlier for higher acuity.
PCT	Annual CV reassessment based on severity.

PTS—Primary Care Postpartum Transition Visit. A structured primary care visit that establishes or re-establishes the patient in longitudinal, whole-person care and completes the transition from maternity care.

These recommendations define a shared default and a minimum floor. They do not override clinician judgment, patient preference, or AHA, ADA, ACOG, or USPSTF guidance. For citations, please refer to the [Evidence Base](#) supporting the [Consensus Recommendations for Clinical Actions in the Transition from Maternity Care to Primary Care](#).

T2D *Pre-existing type 2 diabetes —resuming chronic disease care*

MCT	At comprehensive postpartum visit or by 12 wks, send structured handoff (pre-pregnancy A1c, postpartum insulin adjustments, glucose trends, discharge meds) + schedule PTS
PCT	Complete PTS: risk stratified, generally 3–6 mo PP, to resume chronic disease management.
PCT	Activate or reactivate patient in diabetes registries and panel queries.
PCT	Resume chronic disease protocols per ADA/ACOG; retest A1c, review meds, reinforce screening cadence; adjust for breastfeeding.

MMH *Maternal mental health —depression, anxiety, behavioral health continuity*

MCT	Initiate treatment and manage until handoff; reassess at 1–2 wks (new/uncontrolled) or 6–12 wks (stable). Stabilization not required before handoff.
MCT	At comprehensive postpartum visit or by 12 wks, send structured handoff (PHQ-9, EPDS, GAD-7, treatment history, current meds, BH plan) + schedule PTS based on clinical need.
PCT	Complete PTS; timed by clinical acuity; earlier for new or worsening symptoms, later when stable. Safety concerns (suicidality, psychosis) require immediate response.
PCT	In first year, screen at every clinical interaction plus outreach at 6 & 12 mo PP (PHQ-9, EPDS, GAD-7); initiate severity-based treatment; act on positive screens from pediatrics, lactation, etc.

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Timeline Workflow

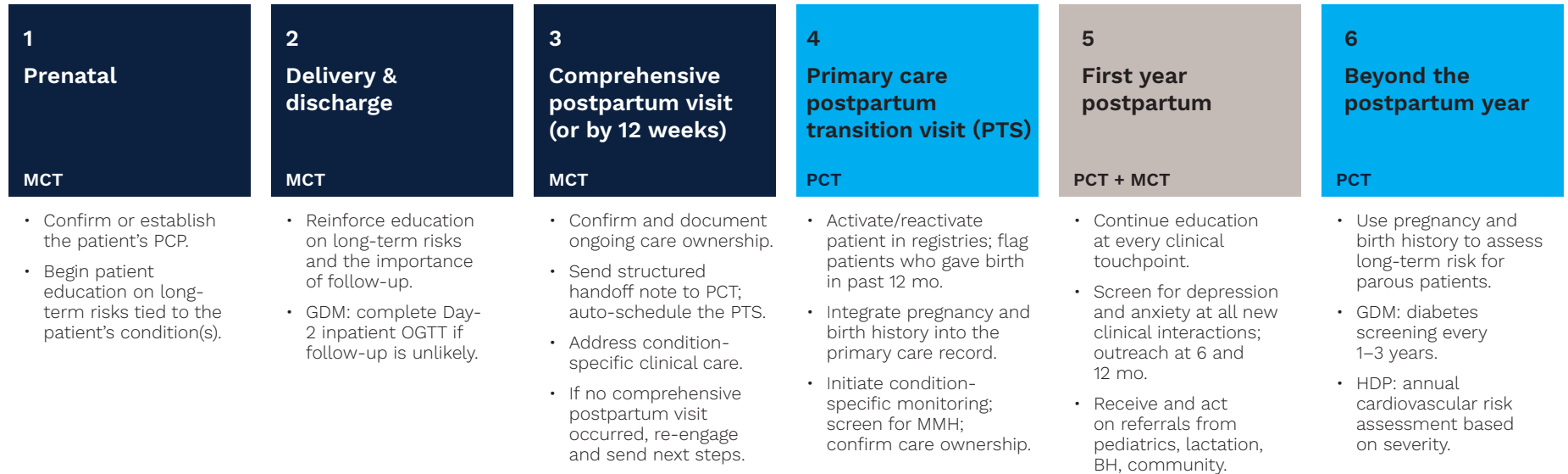
A timing-based view of clinical actions across the postpartum year

Ownership

MCT

PCT

SHARED



PTS Timing by Condition

Typical window is 12 wks–6 mo postpartum. Condition-specific timing aligns with AHA, ADA, and ACOG guidance and risk stratification.

GDM	risk stratified; no later than 6 mo PP
T2D	chronic disease re-protocoling at 3–6 mo
HDP	risk stratified; typically 3–6 mo PP, earlier for higher acuity
MMH	based on clinical need; MCT reassesses at 1–2 wks if uncontrolled, 6–12 wks if stable; immediate care for suicidality, psychosis, or safety concerns.

Structured Handoff Note

Brief clinical assessment + key risks or concerns + next steps. Plus condition-specific data:

GDM	glucose results or testing status, treatment history, metabolic risk factors, monitoring plan
T2D	pre-pregnancy A1c, insulin adjustments and glucose trends, discharge medications
HDP	HDP labs, BP trajectory, current medications, BP management plan
MMH	PHQ-9 / EPDS / GAD-7, treatment history, current medications, behavioral health plan

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