

Evidence Base Supporting the Consensus Recommendations for Clinical Actions in the Transition from Maternity Care to Primary Care

Citations and Quality-of-Evidence Grading

October 2026

This companion document presents the published citations and quality-of-evidence grading underlying each recommendation. Rows are cross-referenced by condition and recommendation number and mirror the Consensus Recommendations. Evidence tiers are defined in this grading key.

Grading Key

Tier	Category	What It Means
A	High Evidence / Guideline-Endorsed	Explicitly recommended by major national guidelines (ACOG, ADA, AHA, USPSTF, WPSI) or supported by multiple high-quality studies (RCTs, large cohorts, meta-analyses). Clear benefit, well-established.
B	Moderate Evidence / Strong Rationale	Strong overall evidence with some variation in study design, population, or feasibility; may combine guideline-aligned elements with components not directly tested in this exact form.
C	Emerging Evidence / Consensus / Innovation	Supported by early evidence, real-world feasibility, or expert consensus; not yet backed by large trials or formal guideline endorsement. Reflects less mature evidence, not lower importance.
I	Implementation / Health Systems / Operational	Supported by implementation science, quality-improvement studies, and population-health data. RCTs are often not feasible for these infrastructure actions, but they are operationally essential.

Evidence and Citations by Condition

Universal

Rec #	Component	Tier	Key Finding	Citations
Rec 1	Collecting pregnancy and birth history to personalize primary care across the lifespan to health needs identified during pregnancy and birth	A	Pregnancy functions as a window to future health, so pregnancy and birth history should be documented and used to personalize lifelong primary care risk assessment. The 2019 ACC/AHA Primary Prevention guideline names a detailed pregnancy history as integral to CV risk assessment, with preeclampsia and gestational diabetes conferring ~3–6-fold higher risk of subsequent hypertension and ~2-fold higher risk of ischemic heart disease/stroke; AHA scientific statements detail these adverse-pregnancy-outcome–CVD associations (Parikh 2021; Lewey 2024). Metabolically, prior GDM confers markedly elevated long-term risk of type 2 diabetes (Vounzoulaki 2020 meta-analysis) and higher total and cardiovascular mortality (Wang 2023). Documenting this history at the first primary care visit after birth enables risk-appropriate screening and prevention.	Arnett DK, Blumenthal RS, Albert MA, et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease. <i>Circulation</i> . 2019;140(11):e596–e646. doi:10.1161/CIR.0000000000000678 Parikh NI, et al. Adverse Pregnancy Outcomes and Cardiovascular Disease Risk. <i>Circulation</i> . 2021;143(18):e902–e916. doi:10.1161/CIR.0000000000000961 Lewey J, et al. Opportunities in the Postpartum Period to Reduce CVD Risk After Adverse Pregnancy Outcomes. <i>Circulation</i> . 2024;149(11):e330–e346. doi:10.1161/CIR.0000000000001212 Wu P, et al. Preeclampsia and Future Cardiovascular Health. <i>Circ Cardiovasc Qual Outcomes</i> . 2017;10(2):e003497. doi:10.1161/CIRCOUTCOMES.116.003497 Vounzoulaki C, et al. Progression to type 2 diabetes in women with a known history of gestational diabetes: systematic review and meta-analysis. <i>BMJ</i> . 2020;369:m1361. doi:10.1136/bmj.m1361 Wang Y, et al. Association of Gestational Diabetes With Subsequent Long-term Risk of Mortality. <i>JAMA Intern Med</i> . 2023;183(10):1073–1082. doi:10.1001/jamainternmed.2023.4401 Fu J, Retnakaran R. The life course perspective of gestational diabetes. <i>EClinicalMedicine</i> . 2022;45:101294. doi:10.1016/j.eclinm.2022.101294
Rec 2	Establishing ongoing, longitudinal primary care after birth improves postpartum engagement and outcomes	A	ACOG explicitly recommends that postpartum care transition to ongoing, longitudinal primary/well-woman care with an identified clinician (CO 736). Supporting effectiveness evidence: a facilitated postpartum-to-primary-care transition was associated with higher primary care utilization within the first year (Delgado 2025), and a dedicated transition clinic improved first-year outcomes (Malhotra 2025).	ACOG Committee Opinion No. 736: Optimizing Postpartum Care. <i>Obstet Gynecol</i> . 2018;131(5):e140–e150. doi:10.1097/AOG.0000000000002633 Delgado A, Liang P, Bender T, Ray A, James KE, Ganguli I, Cohen JL, Clapp MA. Primary Care Utilization Within 1 Year After a Facilitated Postpartum-to-Primary Care Transition. <i>Obstet Gynecol</i> . 2025;145(4):409–416. Malhotra R, Parikh A, Sous N, Thomas P, Gittens-Williams L, Feurdean M. Bridging the Postpartum Cliff—First Year Outcomes of a Postpartum Transition to Primary Care Clinic. <i>Womens Health Rep (New Rochelle)</i> . 2025;6(1):978–987.

Gestational Diabetes (GDM)

Rec #	Component	Tier	Key Finding	Citations
Rec 1	Preferred postpartum test and timing (75 g OGTT at 4–12 weeks)	A	ADA recommends that individuals with prior GDM receive a 75 g OGTT at 4–12 weeks postpartum to detect persistent diabetes or prediabetes; OGTT is more sensitive than A1c before 12 weeks because A1c is confounded by peripartum blood loss and rapid red blood cell turnover.	ADA. 15. Management of Diabetes in Pregnancy—2026. Diabetes Care. 2026;49(Suppl 1):S321–S338. doi:10.2337/dc26-S015
Rec 1	Quality metric for postpartum diabetes screening after GDM	A	SMFM special statement defines a quality metric for postpartum diabetes screening after GDM and reiterates ACOG/ADA guidance that all patients with GDM should receive a 75 g, 2-hour OGTT at 4–12 weeks postpartum, followed by ongoing screening every 1–3 years. U.S. data summarized in the statement show postpartum screening rates typically <50%, with <10% receiving an OGTT within 12 weeks and <25% any diabetes test within one year.	Patient Safety and Quality Committee, Society for Maternal-Fetal Medicine. Quality metric on the rate of postpartum diabetes screening after pregnancies with gestational diabetes mellitus. Am J Obstet Gynecol. 2023;228(4):B2–B9. doi:10.1016/j.ajog.2022.12.315
Rec 1	Postpartum testing completion rates and recommended frequency	A	WPSI recommends that individuals with a history of GDM receive diabetes screening in the first year postpartum (as early as 4–6 weeks) and at least every 3 years for at least 10 years, and notes that current U.S. postpartum screening is highly variable and often suboptimal, with missed opportunities for prevention.	Women's Preventive Services Initiative. Screening for Type 2 Diabetes after Pregnancy. 2022 Evidence Review. https://www.womenspreventivehealth.org/recommendations/diabetes-after-pregnancy/
Rec 1	Postpartum testing completion rates – modeling study	B	A large cohort study found that only 50.6% of patients with GDM saw a primary care clinician in the year postpartum (vs. 67.2% of those with preexisting type 2 diabetes), with correspondingly low postpartum diabetes-related testing, reflecting frequent missed opportunities for screening and prevention despite high long-term diabetes risk.	D'Amico R, Dalmacy D, Akinduro JA, et al. Patterns of Postpartum Primary Care Follow-up and Diabetes- Related Care After Diagnosis of Gestational Diabetes. JAMA Netw Open. 2023;6(2):e2254765. https://doi.org/10.1001/jamanetworkopen.2022.54765
Rec 1	Postpartum testing completion rates – qualitative barriers	B	Qualitative study in a safety-net context identified multiple socioecological and system-level barriers to postpartum diabetes screening and prevention after GDM (insurance gaps, transportation, childcare, competing priorities, fragmented care), helping explain persistently low follow-up in high-risk populations and supporting the need for structured transitions.	Sinha DD, et al. Barriers and facilitators to diabetes screening and prevention after a pregnancy complicated by gestational diabetes. PLoS One. 2022;17(11):e0277330. doi:10.1371/journal.pone.0277330

Rec #	Component	Tier	Key Finding	Citations
Rec 1	Alternative timing/modality — Day-2 (delivery-hospitalization) inpatient OGTT when outpatient follow-up feasibility is low	B	A randomized controlled trial (DIP; 104 individuals with GDM) found that performing the OGTT before delivery discharge rather than within 12 weeks postpartum increased completion from 26.9% to 92.3% (RR 3.43). A systematic review and meta-analysis (7 studies, 2,254 individuals, 13 hospitals) and a single-institution implementation study (83.3% vs. 30.5%) corroborate that delivery-hospitalization testing substantially increases completion. Inpatient testing detects more early glucose abnormalities but has variable sensitivity vs. the 4–12-week test, supporting it as a feasibility-driven alternative, not a replacement for standard timing.	Ciomperlik H, Harper M, Hossain MF, Turrentine MA. Administration of the Postpartum Glucose Tolerance Test During the Delivery Hospitalization Compared With 4–12 Weeks Postpartum: A Systematic Review and Meta-Analysis. <i>O&G Open</i> . 2024;1(3):e033. doi:10.1097/OG9.0000000000000033 Ayala NK, Fain AC, Smith MM, Schlichting LE, Hamel MS, Werner EF. Implementation of In-Hospital Postpartum Glucose Tolerance Testing for People With Gestational Diabetes. <i>Am J Perinatol</i> . 2024;41(8):969–974. doi:10.1055/a-2257-3341 Field C, Venkatesh KK, et al. Diabetes Testing Immediately Postpartum After Gestational Diabetes Mellitus: A Randomized Controlled Trial. <i>Obstet Gynecol</i> . 2026;147(5):735–744. doi:10.1097/AOG.0000000000006236
Rec 2	Default (opt-out) scheduling of postpartum primary care appointments	B	Randomized trial of default postpartum primary care scheduling plus tailored messages for high-risk pregnant/postpartum patients (including those with GDM and pregnancy-related hypertension) showed ~19 percentage point increase in primary care visit completion within 4 months postpartum vs usual care, supporting automatic, opt-out scheduling of PTS visits for high-risk postpartum patients.	Clapp MA, Ray A, Liang P, James KE, Ganguli I, Cohen JL. Postpartum Primary Care Engagement Using Default Scheduling and Tailored Messaging: A Randomized Clinical Trial. <i>JAMA Netw Open</i> . 2024 Jul 1;7(7):e2422500. doi: 10.1001/jamanetworkopen.2024.22500. PMID: 39012630; PMCID: PMC11252898.
Recs 2 + 3	Risk-stratified timing for PTS after GDM	B	ADA and ACOG recommend early postpartum assessment and ongoing surveillance after GDM but do not specify risk-stratified PTS timing. The before 6-month timing is consensus-based, extrapolating from the natural history of diabetes progression and the need to re-engage patients in primary care while postpartum coverage and motivation are high.	ADA. 15. Management of Diabetes in Pregnancy—2026. <i>Diabetes Care</i> . 2026;49(Suppl 1):S321–S338. doi:10.2337/dc26-S015
Rec 4	Education impact on screening completion	A	A randomized controlled trial found that adding prenatal counseling about future diabetes risk and the need for postpartum testing significantly increased completion of postpartum glucose screening (86.4% vs 50.7%; Phaloprakarn 2023). A systematic review and Bayesian network meta-analysis confirmed that educational and antenatal group interventions significantly improve screening uptake after GDM, while reminders alone do not (Huang 2023).	Huang J, Forde R, Parsons J, et al. Interventions to increase the uptake of postpartum diabetes screening among women with previous gestational diabetes: a systematic review and Bayesian network meta-analysis. <i>Am J Obstet Gynecol MFM</i> . 2023;5(10):101137. doi:10.1016/j.ajogmf.2023.101137 Phaloprakarn C, et al. Effect of prenatal counseling on postpartum follow-up and contraceptive use in women with gestational diabetes mellitus: a randomized controlled trial. <i>Am J Obstet Gynecol MFM</i> . 2023;5(10):101107. doi:10.1016/j.ajogmf.2023.101107

Rec #	Component	Tier	Key Finding	Citations
Rec 4	Patient knowledge of long-term diabetes risk after GDM and impact of education	A	An overview of reviews concluded that postpartum interventions incorporating education and support can improve risk perception, lifestyle behaviors, and participation in follow-up after GDM (Momsen 2021). Evidence that such interventions prevent progression to type 2 diabetes is mixed, with an equivocal pooled effect in a systematic review and meta-analysis (Lee 2024).	Lee et al. The efficacy of interventions to prevent type 2 diabetes among women with recent gestational diabetes mellitus—A living systematic review and meta-analysis. J Diabetes. 2024. doi:10.1111/1753-0407.13590 Hedeager Momsen, A. M., Høtoft, D., Ørtenblad, L., Friis Lauszus, F., Krogh, R. H. A., Lynggaard, V., Juel Christiansen, J., Terkildsen Maindal, H., & Vinther Nielsen, C. (2021). Diabetes prevention interventions for women after gestational diabetes mellitus: an overview of reviews. Endocrinology, diabetes & metabolism, 4(3), e00230. https://doi.org/10.1002/edm2.230
Rec 5	Long-term diabetes screening after normal postpartum test	A	ADA recommends ongoing screening every 1–3 years after a normal postpartum OGTT due to persistent long-term type 2 diabetes risk in individuals with prior GDM, even when the initial postpartum test is normal.	ADA. 15. Management of Diabetes in Pregnancy—2026. Diabetes Care. 2026;49(Suppl 1):S321–S338. doi:10.2337/dc26-S015
Rec 5	Long-term GDM-associated T2DM risk (meta-analysis)	A	Large meta-analysis (>1.3M individuals) found that women with prior GDM have approximately 9.5-fold increased relative risk of type 2 diabetes (95% CI 7.14–12.67), with elevated risk persisting for more than 35 years after pregnancy.	Vounzoulaki C, et al. BMJ. 2020;369:m1361. doi:10.1136/bmj.m1361 Diaz-Santana MV, O'Brien KM, Park YM, Sandler DP, Weinberg CR. Persistence of Risk for Type 2 Diabetes After Gestational Diabetes Mellitus. Diabetes Care. 2022 Apr 1;45(4):864–870. doi: 10.2337/dc21-1430. PMID: 35104325; PMCID: PMC9016728.
Rec 5	GDM-associated CVD and mortality risk	A	30-year Nurses' Health Study II cohort (91,426 women) found that a history of GDM was associated with increased total mortality (adjusted HR 1.25, 95% CI 1.11–1.41) and higher cardiovascular mortality (HR 1.59, 95% CI 1.03–2.47), underscoring the importance of long-term primary care follow-up and risk factor management after GDM.	Wang Y, et al. JAMA Intern Med. 2023;183(10):1073–1082. doi:10.1001/jamainternmed.2023.4401

Type 2 Diabetes (T2D)

Rec #	Component	Tier	Key Finding	Citations
Rec 1	Early postpartum contact and structured communication for patients with preexisting T2D	B	Recommends that all postpartum patients, especially those with chronic conditions such as diabetes, have contact with their obstetric care provider within 3 weeks postpartum, followed by ongoing care and a comprehensive visit by 12 weeks. Emphasizes individualized, condition-driven follow-up and transition to ongoing care.	ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstet Gynecol. 2018;131(5):e140–e150. doi:10.1097/AOG.0000000000002633
Rec 1	Postpartum insulin adjustment and close follow-up for preexisting T2D	B	Insulin requirements fall sharply immediately postpartum and must be actively re-titrated; breastfeeding and disrupted sleep increase hypoglycemia risk; close follow-up is needed to adjust insulin and resume long-term regimens.	ADA. 15. Management of Diabetes in Pregnancy—2026. Diabetes Care. 2026;49(Suppl 1):S321–S338. doi:10.2337/dc26-S015
Rec 2	Timing of Primary Care Postpartum Transition Visit (PTS) for preexisting T2D	B	ACOG 736 calls for initial contact by 3 weeks and comprehensive postpartum visit by 12 weeks, with timing individualized by clinical need and chronic disease status. ADA pregnancy standards describe rapid fall in insulin needs immediately postpartum, return of insulin sensitivity over 1–2 weeks, and need for ongoing follow-up, hypoglycemia prevention (particularly with breastfeeding), and resumption of long-term diabetes care. The 3–6 months timing for primary care reentry is consensus-based operationalization rather than directly tested cut-points.	ADA. 15. Management of Diabetes in Pregnancy—2026. Diabetes Care. 2026;49(Suppl 1):S321–S338. doi:10.2337/dc26-S015
Rec 2	Default (opt-out) scheduling of postpartum primary care appointments for patients with preexisting T2D	B	RCT of default PCP scheduling plus tailored messages for high-risk pregnant/postpartum patients (including those with diabetes and pregnancy-related hypertension) showed ~19 percentage point increase in primary care visit completion within 4 months postpartum vs usual care, supporting automatic, opt-out scheduling of PTS visits.	Clapp MA, Ray A, Liang P, James KE, Ganguli I, Cohen JL. Postpartum Primary Care Engagement Using Default Scheduling and Tailored Messaging: A Randomized Clinical Trial. JAMA Netw Open. 2024 Jul 1;7(7):e2422500. doi: 10.1001/jamanetworkopen.2024.22500. PMID: 39012630; PMCID: PMC11252898.
Rec 3	Use of diabetes registries and panel management flags for recent postpartum patients with T2D	B	Postpartum patients with chronic conditions such as T2D are at high risk for loss to follow-up; ACOG 736 and WPSI emphasize the need for deliberate transition to ongoing primary care and proactive chronic disease management. Chronic disease registries and panel management systems are widely used to improve diabetes care in primary care, and qualitative work on postpartum transitions identifies registries and automated recall as key strategies to reduce missed follow-up, although postpartum-specific RCT evidence is limited.	ACOG Committee Opinion No. 736. doi:10.1097/AOG.0000000000002633 WPSI. Screening for Type 2 Diabetes after Pregnancy. 2022. https://www.womenspreventivehealth.org/recommendations/diabetes-after-pregnancy/

Rec #	Component	Tier	Key Finding	Citations
Rec 4	Resumption of guideline-directed chronic T2D management postpartum, including A1c monitoring and medication adjustment	A	ADA Standards provide clear, guideline-level recommendations for long-term T2D management, including regular A1c monitoring (at least twice yearly, more frequently if therapy changes), medication adjustment, and comprehensive cardiovascular risk reduction. ADA pregnancy standards recommend re-evaluating insulin needs immediately postpartum and then transitioning patients with preexisting T2D back to standard chronic disease protocols. ACOG 736 and Interpregnancy Care guidance frame the postpartum period as a key opportunity to optimize chronic disease management and future cardiometabolic health.	ADA. 15. Management of Diabetes in Pregnancy—2026. Diabetes Care. 2026;49(Suppl 1):S321–S338. doi:10.2337/dc26–S015 ACOG Committee Opinion No. 736. doi:10.1097/AOG.0000000000002633
Rec 4	Long-term cardiometabolic risk reduction and complication screening in T2D postpartum	A	Standard T2D care includes BP management, lipid control, kidney function monitoring, retinopathy screening, and lifestyle counseling. These should resume in the postpartum period as part of ongoing primary care, with particular attention to individuals with pregnancy complications (e.g., preeclampsia) that further elevate long-term CVD risk.	ADA. 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes—2024. Diabetes Care. 2024;47(Suppl 1):S179–S218. doi:10.2337/dc24–S010

Hypertensive Disorders of Pregnancy (HDP)

Rec #	Component	Tier	Key Finding	Citations
Rec 1	Early postpartum contact and structured communication for patients with hypertensive disorders of pregnancy	B	ACOG 736 recommends that all postpartum patients, especially those with chronic conditions such as HDP, have contact with their obstetric care provider within 3 weeks postpartum. ACOG PB 222 recommends blood pressure evaluation no later than 7–10 days postpartum for women with HDP, with ongoing monitoring through 12 weeks. Structured data note is a consensus operationalization of these principles.	ACOG Committee Opinion No. 736. Obstet Gynecol. 2018;131(5):e140–e150. doi:10.1097/AOG.0000000000002633 ACOG Practice Bulletin No. 222. Obstet Gynecol. 2020;135(6):e237–e260. doi:10.1097/AOG.0000000000003891 Hauspurg A, Venkatakrishnan K, Collins L, et al. Postpartum Ambulatory Blood Pressure Patterns Following New-Onset Hypertensive Disorders of Pregnancy. JAMA Cardiol. 2024;9(8):703–711. doi:10.1001/jamacardio.2024.1389
Rec 2	3–6 months timing of primary care reengagement after HDP	B	ACOG recommends early contact (by 3 weeks) and blood pressure evaluation by 7–10 days for HDP, with comprehensive postpartum visit by 12 weeks, individualized by severity and clinical stability. Best-practice reviews emphasize closer follow-up and blood pressure monitoring for severe features (e.g., preeclampsia with severe features, HELLP, postpartum preeclampsia). The 3–6 month timing of primary care reentry is consensus-based operationalization of these principles, not directly tested in RCTs.	ACOG Committee Opinion No. 736. doi:10.1097/AOG.0000000000002633 ACOG Practice Bulletin No. 222. doi:10.1097/AOG.0000000000003891 Ackerman-Banks CM, Grechukhina O, Spatz E, et al. Seizing the Window of Opportunity Within 1 Year Postpartum: Early Cardiovascular Screening. J Am Heart Assoc. 2022;11(8):e024443. doi:10.1161/JAHA.121.024443



High Evidence /
Guideline-Endorsed



Moderate Evidence /
Strong Rationale



Emerging Evidence /
Consensus / Innovation



Implementation / Health
Systems / Operational

Rec #	Component	Tier	Key Finding	Citations
Rec 2	Default (opt-out) scheduling of postpartum primary care appointments for patients with HDP	B	RCT of default PCP scheduling plus tailored messages for high-risk pregnant/postpartum patients (including those with pregnancy-related hypertension) showed ~19 percentage point increase in primary care visit completion within 4 months postpartum vs usual care, supporting automatic, opt-out scheduling of PTS visits.	Clapp MA, Ray A, Liang P, James KE, Ganguli I, Cohen JL. Postpartum Primary Care Engagement Using Default Scheduling and Tailored Messaging: A Randomized Clinical Trial. JAMA Netw Open. 2024 Jul 1;7(7):e2422500. doi: 10.1001/jamanetworkopen.2024.22500. PMID: 39012630; PMCID: PMC11252898.
Rec 3	Education on long-term cardiovascular disease risk after adverse pregnancy outcomes (APOs), including HDP	A	AHA scientific statement provides comprehensive review of evidence linking adverse pregnancy outcomes—including all forms of HDP—to 2- to 4-fold increased risk of future chronic hypertension, and 2-fold or greater risk of stroke, heart failure, and coronary heart disease. Statement explicitly recommends counseling on long-term cardiovascular risk and ongoing surveillance, starting in the postpartum period. Earlier AHA Presidential Advisory similarly identifies HDP as a CVD risk enhancer requiring lifelong monitoring.	Lewey J, et al. Opportunities in the Postpartum Period to Reduce Cardiovascular Disease Risk After Adverse Pregnancy Outcomes: A Scientific Statement From the American Heart Association. Circulation. 2024;149(11):e330–e346. doi:10.1161/CIR.0000000000001212 Parikh NI, et al. Adverse Pregnancy Outcomes and Cardiovascular Disease Risk: Unique Opportunities for Cardiovascular Disease Prevention in Women. Circulation. 2021;143(18):e902–e916. doi:10.1161/CIR.0000000000000961
Rec 4	Comprehensive cardiovascular risk assessment postpartum (BP, BMI, glucose, lipids after 12 weeks, lifestyle counseling, contraception)	B	AHA statement recommends postpartum cardiovascular risk assessment for individuals with APOs, including BP, glucose, lipids (after 12 weeks postpartum to avoid unreliable early lactation values), and lifestyle counseling using Life's Essential 8 framework. ACOG 736 emphasizes comprehensive postpartum visit by 12 weeks with attention to chronic disease management. Best-practice reviews highlight need for BP weaning, lipid/glucose screening, and contraceptive counseling. Specific 3-month lipid timing is consensus-based to balance clinical need with postpartum lipid physiology.	Lewey J, et al. Circulation. 2024;149(11):e330–e346. doi:10.1161/CIR.0000000000001212 ACOG Committee Opinion No. 736. doi:10.1097/AOG.0000000000002633 Kumar NR, Hirshberg A, Srinivas SK. Best Practices for Managing Postpartum Hypertension. Curr Obstet Gynecol Rep. 2022;11(3):159–168. doi:10.1007/s13669-022-00343-6
Rec 5	Use of cardiovascular registries and panel management flags for recent postpartum patients with HDP	I	Postpartum patients with HDP are at high risk for loss to follow-up and development of chronic hypertension and CVD risk factors; ACOG 736 and AHA statement emphasize the need for deliberate transition to ongoing primary care and proactive cardiovascular risk management. Cardiovascular registries and panel management systems are widely used to improve chronic disease care in primary care, and quality-improvement work on postpartum HDP transitions identifies registries and automated recall as key strategies to reduce missed follow-up, although postpartum-specific RCT evidence is limited.	ACOG Committee Opinion No. 736. doi:10.1097/AOG.0000000000002633 Lewey J, et al. Circulation. 2024;149(11):e330–e346. doi:10.1161/CIR.0000000000001212

Rec #	Component	Tier	Key Finding	Citations
Rec 6	Long-term annual cardiovascular risk assessment for patients with history of HDP	A	Multiple large cohort studies and meta-analyses demonstrate that women with a history of HDP—particularly preeclampsia—have significantly elevated lifetime risk of cardiovascular disease, including 2- to 4-fold increased risk of chronic hypertension, ~2-fold increased risk of stroke and coronary heart disease, and ~4-fold increased risk of heart failure. AHA scientific statement explicitly recommends lifelong cardiovascular surveillance and risk factor management for individuals with history of HDP, with annual BP, glucose, and lipid screening as part of routine preventive care.	Lewey J, et al. Circulation. 2024;149(11):e330–e346. doi:10.1161/CIR.0000000000001212 Bellamy L, et al. Pre-eclampsia and risk of cardiovascular disease and cancer in later life: systematic review and meta-analysis. BMJ. 2007;335(7627):974. doi:10.1136/bmj.39335.385301.BE Wu P, et al. Preeclampsia and Future Cardiovascular Health. Circ Cardiovasc Qual Outcomes. 2017;10(2):e003497. doi:10.1161/CIRCOUTCOMES.116.003497

Maternal Mental Health (MMH)

Rec #	Component	Tier	Key Finding	Citations
Rec 1	Structured handoff communication for patients meeting risk criteria (positive screen, diagnosis, treatment initiation, or serious mental illness history)	A	USPSTF recommends screening for depression and anxiety in all adults, including pregnant and postpartum persons. ACOG recommends perinatal mental health screening at initial prenatal visit, later in pregnancy, and at postpartum visits using validated tools, with systems in place for timely follow-up and treatment. AAP recommends pediatricians screen mothers for postpartum depression at 1-, 2-, 4-, and 6-month infant well-child visits. High-quality cohort studies show perinatal depression and anxiety are common, often undetected after 6 weeks, and significantly improved by structured screening and coordinated care transitions. Risk-factor–based handoff criteria (positive screens, treatment history, serious mental illness) are strongly supported by established predictors of postpartum psychiatric emergencies and suicide.	USPSTF. Screening for Depression and Suicide Risk in Adults. JAMA. 2023;329(23):2057–2067. doi:10.1001/jama.2023.9297 ACOG Clinical Practice Guideline No. 4: Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum. Obstet Gynecol. 2023;141(6):1232–1261. doi:10.1097/AOG.0000000000005200 AAP Policy Statement: Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. Pediatrics. 2019;143(1):e20183259. doi:10.1542/peds.2018-3259

Rec #	Component	Tier	Key Finding	Citations
Rec 2	Timing for postpartum transition to primary care based on severity	A	ACOG and APA guidelines endorse immediate initiation of therapy or medication without waiting for symptom stabilization, and strong evidence shows early treatment improves remission and reduces harm. Clinical guidelines for depression/anxiety management support early follow-up (within 1–2 weeks) to assess safety, adherence, and symptom change after treatment initiation or when symptoms worsen. Transferring ongoing management to primary care—rather than requiring stabilization before handoff—aligns with best practices for continuity and safety. Strong evidence that untreated moderate-to-severe MMH increases maternal and infant morbidity.	ACOG Clinical Practice Guideline No. 4. doi:10.1097/AOG.00000000000005200 American Psychiatric Association. Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition. APA. 2010. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf Robbins CL, Ko JY, D'Angelo DV, et al. Timing of Postpartum Depressive Symptoms. Prev Chronic Dis. 2023;20:230107. doi:10.5888/pcd20.230107 California Department of Public Health. Pregnancy-Associated Suicide Fact Sheet (2019) Goldman-Mellor S, Margerison CE. Maternal drug-related death and suicide are leading causes of postpartum death in California. Am J Obstet Gynecol. 2019;221(5):489.e1-489.e9. doi:10.1016/j.ajog.2019.05.045
Rec 3	Patient education on stress management, self-care, social support, and referral to structured programs (parenting groups, peer support, mindfulness apps)	B	ACOG and APA emphasize the importance of psychoeducation, support, and early intervention as part of comprehensive perinatal mental health care. Cochrane reviews and other systematic reviews show that structured psychosocial and peer-support interventions (e.g., parenting groups, home visiting, mindfulness programs) can reduce depressive and anxiety symptoms and improve maternal well-being, though effect sizes vary. Education is a core component of stepped-care models and is recommended alongside screening and treatment.	ACOG Clinical Practice Guideline No. 4. doi:10.1097/AOG.00000000000005200 Dennis CL, Hodnett E. Psychosocial and psychological interventions for treating postpartum depression. Cochrane Database Syst Rev. 2007;(4):CD006116. doi:10.1002/14651858.CD006116.pub2
Rec 4	Opportunistic screening for MMH at any new PCT clinical interaction in the first year postpartum, using validated tools (PHQ-9, EPDS, GAD-7)	B	USPSTF, WPSI, and AAP endorse repeated screening across the perinatal period because a significant number of cases emerge after early postpartum visits. AAP recommends maternal depression screening at 1-, 2-, 4-, and 6-month infant well-child visits. Epidemiologic data show that a meaningful number of MMH cases emerge after 6 weeks, and suicide, overdose, and mental-health hospitalizations peak between 6–12 months, particularly among marginalized populations. Evidence supports opportunistic screening throughout the first year, though routine screening after 6 months is not universally guideline-endorsed. The clinical rationale is strong even if guideline alignment is mixed; however, increased screening may increase risks of screening fatigue for patients.	USPSTF. doi:10.1001/jama.2023.9297 ACOG CPG #4. doi:10.1097/AOG.00000000000005200 Women's Preventive Services Initiative. Screening for Perinatal Depression. 2022. https://www.womenspreventivehealth.org AAP. doi:10.1542/peds.2018-3259

Rec #	Component	Tier	Key Finding	Citations
Rec 4	Stepped-care treatment algorithm matching intensity to severity (mild → psychoeducation/support; moderate → therapy ± pharmacotherapy; severe/suicidality → urgent psychiatric referral, with treatment initiated before referral completes)	A	ACOG Clinical Practice Guideline #5 provides guideline-level recommendations for managing perinatal depression and anxiety through stepped care that matches treatment intensity to symptom severity. Mild symptoms warrant psychoeducation, reassurance, and supportive interventions; moderate symptoms warrant therapy and/or pharmacotherapy based on patient preference, functional impairment, and breastfeeding considerations; severe symptoms or suicidality require immediate escalation, safety assessment, and urgent psychiatric referral, with treatment initiated before the referral is completed. USPSTF supports coupling screening with adequate treatment and follow-up.	ACOG Clinical Practice Guideline No. 5: Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum. Obstet Gynecol. 2023;141(6):1262–1288. doi:10.1097/AOG.0000000000005202
Rec 4	Perinatal psychiatry access programs to build front-line provider capacity for perinatal mental health care	I	Perinatal psychiatry access programs build front-line clinician capacity to screen, assess, and treat perinatal depression and anxiety through provider training, telephonic psychiatric consultation, and care coordination (Schaefer 2024). A longitudinal analysis of MCPAP for Moms (2014–2020; 1,006 clinicians) found higher program use was associated with higher rates of clinicians treating perinatal mood disorders (Masters 2023). California's program, PROMISE, is modeled on MCPAP for Moms.	Schaefer AJ, et al. Increasing Access to Perinatal Mental Health Care: The Perinatal Psychiatry Access Program Model. Health Aff (Millwood). 2024;43(4):557–566. doi:10.1377/hlthaff.2023.01439 Masters GA, Yuan Y, Li NC, Straus J, Moore Simas TA, Byatt N. Improving front-line clinician capacity to address depression and bipolar disorder among perinatal individuals: a longitudinal analysis of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms. Arch Womens Ment Health. 2023;26(3):401–410. doi:10.1007/s00737-023-01324-1
Rec 5	Monitor treatment response with early reassessment (within 2–4 weeks of initiating treatment) and ongoing monitoring every 4–6 weeks until remission; maintain treatment for 9–12 months after remission or until after weaning and return of menstruation, whichever is later	A	ACOG guidelines support early reassessment (within 1–2 weeks for moderate/severe symptoms and 2–4 weeks for most treatment initiations) and ongoing monitoring every 4–6 weeks to guide titration and detect relapse. Extensive depression and anxiety literature shows that maintaining treatment for 9–12 months after remission significantly reduces recurrence, with similar patterns observed in perinatal populations. Evidence also supports more frequent monitoring during medication tapering to prevent relapse during physiologic transitions such as weaning and menstrual return.	ACOG CPG #5. doi:10.1097/AOG.0000000000005202 American Psychiatric Association. Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition. APA; 2010. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

Rec #	Component	Tier	Key Finding	Citations
Rec 6	Activate/reactivate patient in primary care depression registries/dashboards upon receipt of handoff note or positive screen	I	ACOG emphasizes that mental health screening should be implemented with systems in place to ensure timely access to assessment, treatment, and follow-up. Chronic disease registries and panel management systems are widely used in primary care to improve depression and anxiety care (e.g., collaborative care models, measurement-based care), and quality-improvement work on postpartum mental health transitions identifies registries and automated recall as key strategies to reduce missed follow-up. However, MMH-specific RCT evidence for registry use is limited; this is an operationally essential health systems intervention.	ACOG CPG #4. doi:10.1097/AOG.00000000000005200
Rec 7	PCT receives and acts on positive MMH screens or referrals from pediatricians, lactation consultants, behavioral health providers, or community providers, with follow-up timing based on symptom severity	I	AAP recommends that pediatricians screen mothers for postpartum depression at infant well-child visits (1, 2, 4, and 6 months) and refer mothers who screen positive for treatment. ACOG emphasizes coordinated, team-based care and bidirectional communication among providers caring for the mother and infant. Effective transitions require clear pathways for communication and follow-up across settings (pediatrics, OB, primary care, community behavioral health), though specific protocols and timing are operationally determined rather than based on RCT evidence.	AAP. doi:10.1542/peds.2018-3259 ACOG CPG #4. doi:10.1097/AOG.00000000000005200
Rec 8	Outreach screening for MMH at 6 and 12 months postpartum via call or message, with follow-up based on symptom severity	B-/C+	Very limited studies evaluate screening after 12 weeks despite physiological risks. ACOG recommends screening once during the comprehensive postpartum visit, and no major guideline (ACOG, USPSTF, WPSI, AAP) recommends routine screening after 6 months. Epidemiologic data show that a meaningful number of MMH cases emerge after 6 weeks, and suicide, overdose, and mental-health hospitalizations peak between 6–12 months, particularly among marginalized populations. A PRAMS study found that 7.2% screened positive for depression/anxiety at 9–10 months, 57.4% of whom had not screened high at 2–6 months, indicating a consistent, biologically plausible, and clinically meaningful late-onset risk signal. This is a consensus recommendation driven by epidemiology and maternal mortality data, not RCT evidence.	Robbins CL, Ko JY, D'Angelo DV, et al. Timing of Postpartum Depressive Symptoms. Prev Chronic Dis. 2023;20:230107. doi:10.5888/pcd20.230107 California Department of Public Health. Pregnancy-Associated Suicide Fact Sheet (2019) Goldman-Mellor S, Margerison CE. Maternal drug-related death and suicide are leading causes of postpartum death in California. Am J Obstet Gynecol. 2019;221(5):489.e1-489.e9. doi:10.1016/j.ajog.2019.05.045

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Rec 9	Standardized emergency pathways for suicidality, psychosis, or risk to infant, with activation of emergency protocol (911, ED, crisis team) and comprehensive post-crisis follow-up	A	ACOG provides explicit guidance for immediate assessment and management of suicidality, self-harm, and postpartum psychosis, emphasizing same-day safety assessment and activation of emergency protocols. HEDIS FUH measures (follow-up within 7 and 30 days after psychiatric hospitalization) demonstrate that timely post-crisis follow-up reduces rehospitalization and mortality risk. Comprehensive follow-up after psychiatric emergencies is a nationally recognized quality and safety standard, supported by extensive suicide prevention and crisis intervention literature.	ACOG CPG #4. doi:10.1097/AOG.00000000000005200 ACOG CPG #5. doi:10.1097/AOG.00000000000005202 NCQA HEDIS Follow-Up After Hospitalization for Mental Illness (FUH). https://www.ncqa.org/HEDIS/measures/follow-up-after-hospitalization-for-mental-illness/