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

These recommendations are part of a broader set of companion materials designed for different audiences and uses. The [companion issue brief](#) provides the policy and systems context for postpartum-to-primary care transitions, the [one-page visual tools](#) offer a quick overview of the clinical model and workflow, and this document serves as the detailed implementation reference for clinical and operational teams. Together, these materials are intended to help stakeholders move from problem definition to workflow design and clinical action.

Purpose: This document presents consensus recommendations for the clinical actions, handoffs, and follow-up needed to support patients through the extended postpartum period. It focuses on four high-risk conditions that drive maternal morbidity and long-term cardiovascular and behavioral health risk. Recommendations also include universal practices essential for every postpartum patient's transition to primary care.

Scope: These recommendations address postpartum care from delivery through 12 months after birth and are intended to guide workflow design between maternity care teams (MCT) and primary care teams (PCT). They are designed for health systems, clinical leaders, and quality improvement teams building handoff processes, transition workflows, EHR tools, and accountability structures for extended postpartum care. They do not address intrapartum management, contraceptive guidance, pediatric pathways, or detailed chronic disease treatment algorithms.

Key Touchpoints: These recommendations align with guidance from the American College of Obstetricians and Gynecologists (ACOG) and emerging national standards for extended postpartum care. Key transition touchpoints include the comprehensive postpartum visit, which should occur no later than 12 weeks postpartum, and the Primary Care Postpartum Transition Visit (PTS) with the primary care team, timed according to clinical need.

Conditions Covered

- **Universal** practices applicable to all postpartum patients
- **Gestational diabetes (GDM)**
- **Type 2 diabetes (T2D)**
- **Hypertensive disorders of pregnancy (HDP)**, including chronic hypertension, gestational hypertension, preeclampsia, preeclampsia with severe features, HELLP syndrome and postpartum preeclampsia/eclampsia.
- **Maternal mental health (MMH)**, including patients with positive perinatal screens, new or pre-existing diagnoses, active psychiatric treatment, or a history of serious mental health conditions.

How to Use This Document: This document serves as the master reference for the clinical and operational elements of postpartum transitions. It is not a stepwise clinical algorithm. Rather, it defines the minimum viable handoff that applies across conditions and clarifies shared accountability between teams across the postpartum year. Each recommendation is organized to support operational use, with clear fields for condition, action type, recommendation, owner, timing, and the clinical information primary care needs to safely assume care.

For the citations and quality-of-evidence grading underlying each recommendation, [see evidence base](#).

Minimum Viable Handoff: Every condition-specific pathway below assumes a minimum viable handoff between the MCT and PCT. The handoff has four parts:

- **Data.** A required data set, listed in the *PCT data needs* column for each condition.
- **Communication.** An explicit statement of what needs follow-up and when, confirmation of receipt by the receiving team, and direct contact information for clarification.
- **Scheduling.** The MCT schedules or initiates the next touchpoint, where feasible.
- **Documentation.** Both teams document completion and any exceptions, including patient preference or access barriers.

Optional data elements strengthen the handoff but should not delay or block it. Missing required data should be flagged with a plan to close the gap, not held until complete.

Index Component Definitions

- **Condition** identifies the clinical issue or diagnosis prompting postpartum follow-up.
- **Action type** identifies the category of clinical engagement represented by the recommendation, such as handoff/ownership, timing, testing, education, PCT follow-up, long-term follow-up, or emergencies.
- **Recommendation** states the consensus clinical action.
- **Owner** identifies the team accountable for executing the action: maternity care team (MCT), primary care team (PCT), or both when responsibility is shared.
- **Timing** specifies the recommended window for the action, based on best available evidence and national guidance where applicable. Handoff to primary care is centered around the comprehensive postpartum visit (see key touchpoints).
- **PCT data needs** identifies the clinical information the primary care team needs from the maternity care team to safely assume ownership and continue care (see minimum viable handoff section).

Condition: Universal

Action Type	Recommendation	Owner	Timing	PCT data needs
Patient History	For all parous patients, document pregnancy and birth history if not already in the record. At first primary care visit following a birth, regardless of timing, use this history to assess risk for future long-term primary care conditions (e.g., CVD, diabetes, mental health).	PCT	Any Well Woman Visit or Preventive Care Visit	<ul style="list-style-type: none"> • Discharge medications • Pregnancy history + adverse pregnancy complications • Screening dates and scores for PHQ-9/GAD-7/EPDS, ACEs, DV, SUD • Specialist referrals • Adverse postpartum complications
Handoff/ownership	During pregnancy, confirm the patient's current primary care provider. If no PCP is identified, encourage patient to select one for ongoing health needs. Designated PCP could be the maternity care team if they are equipped to serve as patient's ongoing primary care needs.	MCT	Prenatal Visit	

Condition: Gestational Diabetes

Action Type	Recommendation	Owner	Timing	PCT data needs
Testing	<p>Complete postpartum glucose testing before transition to PCT using one of the following:</p> <ul style="list-style-type: none"> • 75g OGTT at 4–12 weeks (typically 6–12 in practice), or • Day-2 inpatient OGTT when follow-up feasibility is low. • If the OGTT is declined or unavailable, the MCT or PCT should complete an A1c at ≥12 weeks postpartum. 	MCT or PCT, if OGTT not completed	<ul style="list-style-type: none"> • Before discharge • Comprehensive postpartum visit • PTS 	
Handoff/ownership	<p>At the comprehensive postpartum visit, or by 12 weeks postpartum if no visit occurs, the MCT aligns on and documents who owns care after 12 weeks postpartum. If care transfers to the PCT, the MCT schedules follow-up and sends a structured note to the PCT with relevant labs and tests (e.g., postpartum glucose results or testing status if not completed, pregnancy treatment history, and relevant metabolic risk factors), a brief clinical assessment summarizing current status, key risks/concerns, next steps, and a GDM management/monitoring plan.</p> <p>If the comprehensive postpartum visit or postpartum glucose testing has not occurred, MCT re-engages the patient and sends the PCT a structured note by 12 weeks postpartum with missing items and next steps.</p>	MCT	Comprehensive postpartum visit	<ul style="list-style-type: none"> • Glucose Test Date (Modality + Results) • Type of GDM treatment (diet vs metformin vs insulin) • Degree of control prenatally • Delivery complications (shoulder dystocia, neonatal hypoglycemia) because they affect counseling • Education the patient actually received and their understanding • Screening dates and scores for PHQ-9/GAD-7/ EPDS, ACEs, DV, SUD • Recommended next steps

Condition: Gestational Diabetes

Action Type	Recommendation	Owner	Timing	PCT data needs
PTS timing	MCT automatically schedules a Primary Care Postpartum Transition Visit (PTS) with the PCT at the comprehensive postpartum visit (or designated handoff). Appointment timing is risk-stratified based on postpartum glycemic results, pregnancy treatment intensity, and other metabolic risk factors, with earlier follow-up for higher-acuity patients. The PTS occurs no later than 6 months postpartum. Follow-up may occur with a PCT clinician and/or appropriate team members (e.g., health educator, dietitian, nutritionist), as clinically appropriate.	MCT or PCT, if pregnancy provider unable	Depends on risk factors, no later than 6 months postpartum	<ul style="list-style-type: none"> • Discharge medications • Breastfeeding status • Adverse pregnancy, delivery, and postpartum complications
Education	MCT and PCT deliver patient education on the association between GDM and risk for T2D and long-term cardiovascular risk and evidence-based prevention strategies. Education begins in late pregnancy, is reinforced at discharge and the comprehensive postpartum visit by the MCT, and continues at PTS and subsequent preventive visits with the PCT.	MCT + PCT	<ul style="list-style-type: none"> • Prenatal Care • Discharge • Comprehensive Postpartum Visit • PTS • Primary Care Preventive Visits, Every 1-3 Years 	
Long-term follow-up	For patients with a normal postpartum glucose screen, PCT performs diabetes screening every 1-3 years depending on present risk factors. For patients with abnormal postpartum glucose screen, PCT confirms the results and initiates appropriate management, including lifestyle modification and pharmacotherapy as needed.	PCT	Well woman visit or Primary Care Preventive Visits, Every 1-3 Years	Adverse pregnancy and delivery complications

Condition: Type 2 Diabetes

Action Type	Recommendation	Owner	Timing	PCT data needs
Handoff/ownership	At the comprehensive postpartum visit, or by 12 weeks postpartum if no visit has occurred, the MCT confirms who owns care after 12 weeks postpartum. If care is transferring to the PCT, the MCT schedules postpartum follow-up and sends a structured data note to the PCT. The note includes relevant labs and tests (e.g., pre-pregnancy A1c, postpartum insulin adjustments and glucose trends, discharge medications), a brief clinical assessment summarizing current status, key risks/concerns, and what should happen next.	MCT	Comprehensive postpartum visit	<ul style="list-style-type: none"> • Pregnancy medications • Delivery date and inpatient glucose trends • Postpartum insulin changes • Discharge medications • Breastfeeding status + plans • Pregnancy complications • Screening dates and scores for PHQ-9/GAD-7/EPDS, ACEs, DV, SUD

Condition: Type 2 Diabetes

Action Type	Recommendation	Owner	Timing	PCT data needs
PTS timing	MCT automatically schedules a postpartum transition appointment with the PCT at the comprehensive postpartum visit (or designated handoff). Appointment timing is risk-stratified, with earlier follow up for patients with uncontrolled diabetes, insulin dependence, or significant pregnancy complications. MCT continues diabetes management as needed until PTS appointment occurs.	MCT or, if pregnancy provider unable, PCT	Risk-stratified; generally 3–6 months postpartum for transition to longitudinal diabetes care. Earlier if diabetes is uncontrolled, medication needs are unstable, or maternity care cannot continue management.	
PCT follow-up	PCT reactivates patient in primary care diabetes registries at PTS. Update panel management queries to flag patients who have given birth in the past 12 months to close care gaps and initiate proactive outreach.	PCT	PTS	
Long-term follow-up	At PTS, resume chronic disease protocols in accordance with ADA/ACOG guidance, considering breastfeeding status: <ul style="list-style-type: none"> •Retest A1c to reestablish baseline. •Review of antihyperglycemic meds, possible deprescribing. •Reinforce regular cadence of screenings per DM guidelines. •Resume standard care for controlled/uncontrolled. 	PCT	At PTS, 3–6 months postpartum	Adverse pregnancy and delivery complications

Condition: Hypertensive Disorders of Pregnancy

Action Type	Recommendation	Owner	Timing	PCT data needs
Handoff/ownership	At the comprehensive postpartum visit, or by 12 weeks postpartum if no visit occurs, the MCT aligns on and documents who will own care after 12 weeks postpartum. If care transfers to the PCT, the MCT schedules follow-up and sends a structured note to the PCT with HDP-relevant labs/tests, a brief clinical assessment summarizing current status, key risks/concerns, next steps, and a BP management/monitoring plan. The MCT manages early postpartum blood pressure monitoring and medications until handoff to PCT.	MCT	Comprehensive postpartum visit	<ul style="list-style-type: none"> • Prenatal BP (average or readings) • Delivery/postpartum inpatient BP readings • Postpartum BP trends • Adverse pregnancy and delivery complications • Degree of hypertension • Discharge medications • Screening dates and scores for PHQ-9/GAD-7/EPDS, ACEs, DV, SUD

Condition: Hypertensive Disorders of Pregnancy

Action Type	Recommendation	Owner	Timing	PCT data needs
PTS timing	MCT schedules a Primary Care Postpartum Transition Visit (PTS) with the PCT at the comprehensive postpartum visit (or designated handoff). Follow-up timing is risk-stratified based on diagnosis severity, BP trajectory, and clinical stability, occurring around 3-6 months postpartum, with earlier follow-up for higher-acuity patients. Follow-up may occur with a PCT clinician and/or appropriate team members (e.g., health educator, dietitian, nutritionist), as clinically appropriate.	MCT	Risk-stratified; generally 3–6 months postpartum for transition to longitudinal BP and cardiovascular risk management. Earlier when BP remains elevated or medication needs are changing.	<ul style="list-style-type: none"> • Medication list at discharge • Previous and planned touchpoints • Adverse pregnancy and delivery complications
Education	MCT and PCT deliver patient education on the association between adverse pregnancy outcomes and long-term cardiovascular risk and evidence-based prevention strategies. Education begins in late pregnancy, is reinforced at discharge and the comprehensive postpartum visit by the MCT, and continues at PTS and subsequent preventive visits with the PCT.	MCT + PCT	<ul style="list-style-type: none"> • Prenatal Care • Discharge • Comprehensive Postpartum Visit • Primary Care Preventive Visits 	In addition to the above: <ul style="list-style-type: none"> • Breastfeeding status • Pregnancy history
PCT follow-up	At PTS, PCT completes cardiovascular risk assessment and counseling, including BMI, BP, lipids (after 3 months postpartum), glucose, diet, sleep, and tobacco use. Titrate medication, as necessary.	PCT	PTS	Adverse pregnancy and delivery complications
PCT follow-up	PCT activates/reactivates patient in primary care cardiovascular registries/dashboards and population health management workflows for follow-up and outreach. Update panel management queries to flag patients who have given birth in the past 12 months to close care gaps and initiate proactive outreach.	PCT	PTS	
Long-term follow-up	Depending on severity, PCT conducts annual cardiovascular risk assessments for patients with a history of HDP, which may include BP, glucose, lifestyle factors, and lipids.	PCT	Primary Care Preventive Visits	

Condition: Maternal Mental Health

These recommendations refer to patients who:

- Screened positive at or before the postpartum OB visit (e.g., PHQ-9 ≥ 10 , EPDS ≥ 10 , or suicidal thoughts)
- Screened positive by another provider during the postpartum period (e.g., pediatrician, lactation consultant, ED, or behavioral health provider)
- Diagnosed during pregnancy or early postpartum with depression, anxiety, OCD, PTSD, perinatal adjustment disorder, or other behavioral health concern
- Initiated psychiatric treatment during pregnancy or early postpartum (e.g., antidepressants, therapy, or behavioral health referrals)
- Have a history of serious mental illness documented prenatally or in OB record (e.g., prior suicide attempt, bipolar disorder, psychosis)

Action Type	Recommendation	Owner	Timing	PCT data needs
Handoff/ownership	At the comprehensive postpartum visit, or by 12 weeks postpartum if no visit occurs, the MCT aligns on and documents who owns care after 12 weeks postpartum. If care transfers to the PCT, the MCT schedules follow-up and sends a structured note to the PCT with relevant labs and tests, a brief clinical assessment summarizing current status, key risks/concerns, next steps, and a behavioral health management/monitoring plan.	MCT	Comprehensive postpartum visit	<ul style="list-style-type: none"> • MMH screening scores and severity assessment • Other screening assessments including ACEs, DV, SUD • Adverse pregnancy complications • Current treatment including therapy and medications • Outstanding BH referrals
PTS timing	<p>MCT initiates treatment and schedules a PTS with the PCT based on clinical need, keeping in mind that a new diagnosis or uncontrolled symptoms should be reassessed at 1–2 weeks and stable or managed symptoms reassessed at 6–12 weeks.</p> <p>MCT should manage behavioral health follow-up through handoff and remain available for consultation. If the patient prefers and the MCT is equipped to provide ongoing care, the MCT may continue treatment.</p> <p>Note, patient does not need to be stabilized before handoff.</p>	MCT	Timed by clinical acuity. Suicidality, psychosis or safety concerns require immediate response and must not wait for the PTS. Otherwise, earlier for newly identified or worsening symptoms and later if symptoms are stable and managed.	<ul style="list-style-type: none"> • Medication list at discharge • BH coordination plan • Education provided and social support programming • Previous and planned touchpoints
Education	Provide standardized patient education on stress management, self-care, and the importance of social support, and refer eligible patients to structured programs (e.g., parenting groups, peer support, mindfulness apps). Education should begin in pregnancy and be reinforced at discharge, postpartum, and primary care preventive visits.	MCT + PCT	<ul style="list-style-type: none"> • Prenatal Care • Discharge • Comprehensive Postpartum Visit • PTS • Primary Care Preventive Visit 	In addition to the above: <ul style="list-style-type: none"> • Breastfeeding status • Pregnancy history

Condition: Maternal Mental Health

These recommendations refer to patients who:

- Screened positive at or before the postpartum OB visit (e.g., PHQ-9 ≥ 10 , EPDS ≥ 10 , or suicidal thoughts)
- Screened positive by another provider during the postpartum period (e.g., pediatrician, lactation consultant, ED, or behavioral health provider)
- Diagnosed during pregnancy or early postpartum with depression, anxiety, OCD, PTSD, perinatal adjustment disorder, or other behavioral health concern
- Initiated psychiatric treatment during pregnancy or early postpartum (e.g., antidepressants, therapy, or behavioral health referrals)
- Have a history of serious mental illness documented prenatally or in OB record (e.g., prior suicide attempt, bipolar disorder, psychosis)

Action Type	Recommendation	Owner	Timing	PCT data needs
PCT follow-up	<p>In the first year postpartum, the PCT screens for MMH at any new clinical interaction (well visits, acute care, chronic disease management) and initiates treatment using validated tools (PHQ-9, EPDS, GAD-7).</p> <ul style="list-style-type: none"> • Mild symptoms (PHQ-9 5–9, EPDS 7–9, or GAD-7 5–9): provide psychoeducation, reassurance, sleep and support strategies, and refer to peer or parenting groups; arrange routine follow-up. • Moderate symptoms (PHQ-9 10–14, EPDS ≥ 10, or GAD-7 10–14): refer to therapy and/or initiate antidepressants based on patient preference, functional impairment, and breastfeeding considerations; reassess within 1–2 weeks. • Severe symptoms (PHQ-9 ≥ 15, EPDS ≥ 13, or GAD-7 ≥ 15): initiate antidepressants if appropriate and arrange urgent referral to psychiatry or higher-level behavioral healthcare, ensuring treatment begins before referral is completed. • Any positive self-harm item (EPDS Question 10 ≥ 1 or PHQ-9 item 9 > 0), intrusive thoughts with distress suggestive of postpartum OCD, or symptoms concerning for postpartum psychosis require same-day safety assessment and activation of emergency protocols. Consider same-day psychiatry or ED referral if safety cannot be assured in outpatient setting. <p>Utilize psychiatric access programs (e.g., PROMISE -HRSA) when MMH symptoms are severe, treatment fails, or additional clinical guidance is needed.</p>	PCT	<ul style="list-style-type: none"> • PTS • Any new clinical interaction with PCT team in 12 months postpartum 	<p>In addition to the above:</p> <p>Pregnancy history</p>

Condition: Maternal Mental Health

These recommendations refer to patients who:

- Screened positive at or before the postpartum OB visit (e.g., PHQ-9 ≥ 10 , EPDS ≥ 10 , or suicidal thoughts)
- Screened positive by another provider during the postpartum period (e.g., pediatrician, lactation consultant, ED, or behavioral health provider)
- Diagnosed during pregnancy or early postpartum with depression, anxiety, OCD, PTSD, perinatal adjustment disorder, or other behavioral health concern
- Initiated psychiatric treatment during pregnancy or early postpartum (e.g., antidepressants, therapy, or behavioral health referrals)
- Have a history of serious mental illness documented prenatally or in OB record (e.g., prior suicide attempt, bipolar disorder, psychosis)

Action Type	Recommendation	Owner	Timing	PCT data needs
PCT treatment	Monitor treatment response and ensure follow-up until remission is achieved. Extended care team reassesses symptoms within 2-4 weeks of initiating treatment, and every 4-6 weeks thereafter, adjusting treatment or escalating care based on symptom progression. Maintain treatment for 9-12 months after symptoms resolve or until after weaning and return of menstruation, whichever occurs later. During tapering, reassess every 1-3 months and escalate care if concerns arise.	PCT or MCT, if managing BH team co-manages	<ul style="list-style-type: none"> • Comprehensive postpartum visit • Check-in every 4-6 weeks until remission 	<ul style="list-style-type: none"> • PHQ-9/GAD-7/EPDS trends, social screening assessments including ACEs, DV • Current treatment including therapy and medications and adherence • Outstanding BH referrals
PCT follow-up	PCT activates/reactivates patient in primary care depression registries/dashboards.	PCT	PTS	<ul style="list-style-type: none"> • PHQ-9/GAD-7/EPDS trend or screening results • BH History
PCT follow-up	PCT receives and acts on positive MMH screens or referrals from pediatricians, lactation consultants, behavioral health providers, or community providers. Timing of follow-up depends on screen severity. For severe screens, follow up within 24 working hours.	PCT	For at least 12 months postpartum	
Long-term follow-up	Screen all postpartum patients for depression/anxiety 6 and 12 months after delivery via outreach call or message and initiate follow-up based on symptom severity.	PCT	6 and 12 months after delivery	Delivery date
Emergencies	Respond immediately to psychiatric emergencies and coordinate post-crisis care. If suicidality, psychosis, or risk to the infant is identified, activate the emergency protocol (e.g., 911, ED referral, crisis team). Following stabilization, PCT should monitor ongoing behavioral healthcare and recovery. If MCT is the primary care team at the point of crisis, immediate coordination and transition to PCT is required to ensure continuity of care.	First identifying provider; PCT owns follow-up after crisis	As needed	<ul style="list-style-type: none"> • Document emergency event • Facility referred to, outcome • Follow-up appointments • HEDIS FUH metrics

Practical Modifiers and Exceptions

The recommendations above define shared expectations for safe transitions, not a rigid step-by-step protocol. Clinical judgment governs how teams apply them in practice. The following modifiers address common situations where standard pathways require adaptation.

Multiple high-risk conditions. For patients meeting criteria for more than one condition, teams should use the earliest applicable transition timing and address all conditions within a unified handoff note and care plan. Consolidating visits is appropriate when doing so does not delay critical actions.

Patient-driven deferral. When a patient requests to defer or consolidate visits due to caregiving responsibilities, transportation, work, or other constraints, teams should document the preference, ensure interim safety monitoring where indicated, and reschedule within a clinically acceptable window.

Fragmented records or missing data. When the ideal handoff is not possible, teams should send the information available, identify what is missing, and document the next step for closing the gap. Missing optional data should not delay urgent clinical follow-up.

No identified primary care team. When no PCT is identified, the MCT should support PCP identification, document the plan, and ensure interim monitoring or follow-up until a clinical home is confirmed.

Equity considerations. Teams should prioritize outreach and transition support for patients facing the greatest structural barriers and highest clinical risk, including Medi-Cal enrollees, Black and Pacific Islander patients, and patients in rural or underserved communities.

These recommendations were developed with input and guidance from the California Primary Care Postpartum Clinical Workgroup, convened by CQC and co-led by Brynn Rubinstein and Crystal Eubanks.

About the California Quality Collaborative (CQC)

For nearly two decades, health plans, providers and purchasers have entrusted the California Quality Collaborative to bring stakeholders together to align and co-design common solutions to shared challenges. This drives scalable, sustainable improvement across the healthcare delivery system.

CQC works with health plans and delivery system partners serving more than 20 million Californians, translating collective action into measurable improvements in quality, equity and outcomes across the state.