



Community Care  
OF NORTH CAROLINA

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# Pregnancy Medical Home Program Care Pathway

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Postpartum Care &  
the Transition to Well  
Woman Care

September 2019

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## Note

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Pregnancy Medical Home Care Pathways are intended to assist providers of obstetrical care in the clinical management of problems that can occur during pregnancy. They are intended to support the safest maternal and fetal outcomes for patients receiving care at North Carolina Pregnancy Medical Home practices. This pathway was developed after reviewing the Society for Maternal-Fetal Medicine and the American College of Obstetricians and Gynecologists resources such as practice bulletins, committee opinions, and Guidelines for Perinatal Care as well as current obstetrical literature. PMH Care Pathways offer a framework for the provision of obstetrical care, rather than an inflexible set of mandates. Clinicians should use their professional knowledge and judgment when applying pathway recommendations to their management of individual patients.

# Background

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Postpartum care offers an opportunity to promote the health and well-being of women. While there is incomplete evidence on optimal content and timing of postpartum care, a number of elements of well-woman care are evidence-based. These include postpartum depression screening, reproductive health planning to promote healthy birth spacing, screening for chronic diseases, promoting smoking cessation, and providing appropriate vaccinations. The postpartum period is an important opportunity to provide preventive care and to promote a smooth transition to well woman care.

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*Special thanks to Rachel Peragallo Urrutia, MD, MS, Division of Women's Primary Health Care, Department of Obstetrics and Gynecology, UNC, for her contributions to this pathway.*

# 1 | Care Transitions in the Postpartum Period

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Prior to discharge from the hospital post-delivery, provide contact information for the postpartum care provider and educate about reasons to contact the provider. Reasons may include but are not limited to lactation difficulties, signs of infection, hemorrhage, or signs/symptoms of postpartum preeclampsia.

- **Review immunization history** prior to discharge and provide necessary counseling and vaccines. Ideally, indicated vaccines should be given during pregnancy (influenza, Tdap) or prior to discharge from the hospital (MMR, varicella).
- **Address smoking cessation strategy**, if indicated; give pneumococcal vaccine to smokers who were not previously vaccinated
  - See [PMH Care Pathway: Management of Perinatal Tobacco Use](#)
- **Signs and symptoms of preeclampsia warrant timely evaluation.** When associated with new onset hypertension, close observation, and consideration of anti-hypertensive therapy and/or magnesium sulfate therapy are indicated.
- Discuss the importance of **postpartum care** and recommended **postpartum follow-up schedule**

## Postpartum Follow Up Recommendations

- All women should receive contact from a maternal care provider within the first 3 weeks postpartum to complete the initial postpartum assessment. This assessment need not occur as an office visit.
- The initial assessment should be followed by ongoing care as needed.
- Schedule a comprehensive postpartum visit for ALL women before 42 days post-delivery. The comprehensive postpartum visit should be completed no later than 12 weeks after birth. See pages 3-5 for an outline of the content of the comprehensive visit.
  - Visit completion rate may improve by scheduling a first visit early enough to allow rescheduling if necessary.
  - Women with specific characteristics, including multiparous women and those who experienced a poor birth outcome, are more likely to miss the postpartum visit and may merit targeted interventions to improve adherence to the visit.
  - Engage Pregnancy Care Managers to promote postpartum visit attendance.

## Postpartum Follow Up Recommendations

- **Gestational hypertension or preeclampsia** in the index pregnancy<sup>1</sup>
  - Women with gestational hypertension, preeclampsia, or superimposed preeclampsia should have their blood pressure monitored in the hospital or

equivalent outpatient surveillance should be performed for at least 72 hours postpartum and again 7-10 days post-delivery.<sup>1,4</sup>

- Initiate or adjust anti-hypertensive medication if blood pressure is >150 systolic or >100 diastolic [1].
- Consider home blood pressure monitoring or return visit for blood pressure measurement in 1-2 weeks following adjustment or initiation of antihypertensive therapy.
- **High risk for postpartum depression.**<sup>2</sup> Conduct a depression screening with a validated tool at 7-14 days postpartum for patients meeting one or more of the following criteria (see Appendix A for guidance on management of depression screening results):
  - History of depression or other psychiatric illness
  - Lack of social support
  - Recent stressful life event, including adverse pregnancy outcome or birth experience
  - Other patients may be deemed at elevated risk at the judgment of the postpartum care provider, particularly if they have additional social stressors, such as childcare difficulties, history of trauma, and/or low self-esteem.
- **Other factor(s)** which the provider feels warrant an early follow-up visit, such as operative delivery, 3rd or 4th degree perineal lacerations, diabetes, lactation difficulties or other chronic conditions.
- All women who do not already have an early visit scheduled for one of the above reasons should have contact with a maternal care provider within the first 3 weeks postpartum. (Assessment need not occur as an office visit but could include nurse phone call and/or home visit).
- **Schedule follow-up diabetes screening at 6 to 12 weeks postpartum for patients with gestational diabetes.** Perform either a fasting blood glucose or a 2-hour glucose tolerance test with a 75-gram glucose load.<sup>3</sup>
  - See Appendix A for guidance on follow-up of patients with gestational diabetes based on diabetes screening results in the postpartum period
- **Coordinate the transition to primary care.** Provide all patients with guidance about value and timing of primary care follow-up.
  - Yearly visits for all women
  - More frequent for women with medical complications such as diabetes or hypertension
  - Identify appropriate care setting for continuing primary care outside of pregnancy, within the current practice or provide referral.
    - See Appendix B for information about coverage beyond the postpartum period for patients in the Medicaid for Pregnant Women category.

## 2 | Content of the Comprehensive Postpartum Visit

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**Review any complications of pregnancy and/or delivery.** Educate the patient about risks for future pregnancies and any long-term health implications. Examples may include cesarean delivery with information on labor after cesarean, gestational diabetes, growth restriction, preterm birth, hypertension, fetal anomalies.

**Discuss necessary follow-up for chronic conditions and mental health disorders, including a review of medications and how these may or may not impact lactation.** Arrange a follow-up plan and care home for women with preexisting chronic diseases and mental health disorders.

**Blood pressure screen:** The comprehensive postpartum visit includes blood pressure measurement, performed after the patient has rested for 5 minutes.

- See Appendix A for guidance on how to conduct a brief intervention

**Postpartum depression screening:** Screen all patients for postpartum depression using a validated tool.

- See Appendix A for screening tools, management of positive screen and resources for referral

**Sexuality:** Provide guidance regarding sexuality, management of dyspareunia and resumption of intercourse.

**Fecal and/or Urinary incontinence assessment** and referral as appropriate.

**Reproductive life planning:** Encourage all women (and their partners, if available) to discuss their pregnancy intentions in the short and long term and their chance of conceiving (whether intended or not). See Appendix D for reproductive life planning questions for providers, a printable provider tool, and a patient worksheet.

- **Encourage patients to consider the following factors in their reproductive life plan:** age, educational goals, career plans, living situation, financial situation, social support, relationship with partner, readiness to parent additional children, current health status, breastfeeding status, hereditary risk factors, and health behaviors
- For women who anticipate future pregnancy, **promote optimal birth spacing** (conception in 18 months to 5 years after a previous birth) to decrease risk of preterm birth and other complications in future pregnancies. Conception less than 6 months after delivery is associated with the strongest risk of low birth weight and preterm birth.<sup>6</sup>

- Assist women to select a **contraceptive method that aligns with their reproductive life plan**. See Appendix A for information about timing of safe use for different contraceptives in the postpartum period.
- **Provide access to the patient's preferred contraceptive method**. Create a referral plan for all methods not provided by your practice.

**Conduct immunization review and provide necessary vaccinations.** See [CDC Guidelines for Vaccinating Pregnant Women](#) for recommended vaccinations.

- Review influenza, Tdap, MMR and varicella immunization status and provide counseling and immunization if indicated
- Additional vaccines may be indicated for women of reproductive age who have specific risk factors. These include Pneumococcal vaccines, Meningococcal vaccine, Hepatitis A vaccine, Hepatitis B vaccine, Haemophilus Influenza type b vaccine and Human Papilloma Virus.

**Offer breastfeeding support:** In addition to benefits to the infant, breastfeeding leads to decreased risk of breast cancer, ovarian cancer, diabetes, hypertension and myocardial infarction, yet up to 60% of mothers wean earlier than recommended.<sup>7</sup> Providers should promote alignment in their delivery facilities with **baby-friendly recommendations**, such as encouraging skin-to-skin contact at delivery, including cesarean deliveries, and discouraging routine separation of mother and baby. <https://www.babyfriendlyusa.org/for-facilities/practice-guidelines/10-steps-and-international-code/>

- **Evaluate and treat breastfeeding problems promptly.** After discharge, the perinatal care provider's office should be a resource for 24-hour assistance with breastfeeding problems or should provide links to other resources in the community. [8] See Appendix D for additional resources, including WIC.
- At the comprehensive postpartum visit, ask about **infant feeding and childcare strategies** and how these may impact return to work.

**Screen for substance use disorder and refer as indicated using a validated instrument such as the 5Ps tool.**<sup>12</sup>

**Screen for smoking and address smoking cessation for patients who are current smokers and for those who quit during pregnancy.** See the [PMH Care Pathway: Management of Perinatal Tobacco Use](#) for details. Ask all patients about current smoking status:

- **For current smokers:** Provide a brief intervention (see Appendix A for an overview of the 5 A's model), consider pharmacotherapy as it improves quit rates, and initiate a referral to the North Carolina Quitline.<sup>9</sup> See Appendix D, Resources, for details about how to make a proactive referral and other assistance available from NC Quitline.

- **For patients who quit during pregnancy:** Focus on the benefits of staying quit on the woman's own health and on that of her infant, and consider nicotine replacement therapy as appropriate, due to the high rate of postpartum recidivism to smoking

**Screen for intimate partner violence using a validated tool and refer appropriately.**

**Provide healthy lifestyle behavioral advice. pressure screen:** See Appendix A for detailed guidance.

- Calculate BMI at the comprehensive postpartum visit and provide weight loss counseling to women with a BMI  $\geq$  25
- Recommend adequate physical activity<sup>10</sup>
- Recommend a multivitamin with at least 400mcg of folic acid daily
- Recommend a high quality, healthful diet for ALL women.<sup>11</sup> Breastfeeding women should expect to add 500kcal/day to their normal diet

**Perform pap smear only if indicated.<sup>13</sup>**

- Every 3 years for women 21-65
- Do not do HPV screening for women <30 years old
- Women 30-65 may have pap smears with high risk HPV screening every 5 years if both tests are negative

**Assess perineal or cesarean incision and provide guidance.**



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## Appendix A: Content Guidance for Elements of the Comprehensive Postpartum Visit

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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** ( $\geq$ 160 systolic or  $\geq$ 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](#). 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](#) 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.<sup>2</sup>

- Intrauterine device: insertion immediately postpartum or  $\geq 4$  weeks postpartum
- Implant: no restrictions for non-breastfeeding women;  $\geq 4$  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  $\geq 6$  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](#) 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

- **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.
- **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.
- **Healthful Diet for All Women Regardless of Weight Loss Intentions**
  - Consume 8-10 servings per day of fruits and vegetables
  - Consume  $\geq 3$  servings a day of whole grains in place of refined grains
  - Consume  $\geq 2$  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

- 7. Substance Use Screening:** The Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model is recommended to be used in pregnancy. The health care professional conducts a brief assessment for risky substance use behaviors using a validated tool. The professional then provides a brief intervention and finally refers to treatment or therapy as indicated.

## Appendix B: Ongoing Health Insurance Coverage and Care Beyond the Postpartum Period

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Approximately two-thirds of patients with Medicaid coverage in pregnancy are in the Medicaid for Pregnant Women category. Medicaid for Pregnant Women coverage ends on the last day of the month in which the 60th postpartum day occurs. Some of these women may be eligible for Medicaid coverage in another category. Some of these women may be eligible to obtain subsidized coverage through the health insurance exchange.

For patients who **will have ongoing health insurance coverage**, ensure the patient is connected to a primary care provider if she will not be receiving ongoing primary care in the current practice.

For patients who **will not have comprehensive insurance coverage** beyond the postpartum period, provide information about Medicaid Family Planning coverage (see below) and recommend a provider if the current practice does not serve patients with this coverage. Provide referral to safety net resources to meet other healthcare needs.

**Medicaid Family Planning Coverage:** In North Carolina, individuals with incomes at or below 195% of the Federal Poverty Level (based on Modified Adjusted Gross Income) may be eligible for Medicaid Family Planning Coverage if they do not qualify for more comprehensive Medicaid coverage in another category. Medicaid Family Planning coverage is known as the “Be Smart” program. Coverage is for a limited set of services and is intended to reduce unintended pregnancies and promote improved birth outcomes through pregnancy planning and spacing.

Coverage is available for women and men who are residents of North Carolina, are U.S. citizens or qualified aliens, and are not inmates of a public institution. Individuals apply for Be Smart coverage using the same application as for other types of Medicaid coverage. Co-payments should not be applied to services covered under the Be Smart program. Patients should be referred to local safety net providers for services not covered under the Be Smart program.

Be Smart coverage includes:

- Annual exams and periodic office visits
- Certain laboratory procedures, including pap smears and pregnancy tests
- Almost all birth control methods, procedures, supplies, and devices are covered by Medicaid, including long-acting reversible contraceptives and the insertion and removal of these devices (diaphragm fitting is covered but the diaphragm itself is not)
- HIV screening as part of the annual exam
- Screening for and treatment of specific sexually transmitted infections as part of the annual exam
- Voluntary sterilization (in accordance with federal sterilization guidelines)

The [NC Division of Medical Assistance](#) has more information, including the 2014 Clinical Coverage Policy for Family Planning, a fact sheet, and a bulletin article about Medicaid Family Planning coverage.

Safety net providers: Local DSS agencies can provide a list of primary care safety net providers in the community. The following websites list [local free clinics](#) and [Federally Qualified Health Centers](#) (FQHCs).

The Edinburgh Postnatal Depression Scale can be found [here](#).

<http://www.wpspublish.com/store/p/2902/postpartum-depression-screening-scale-pdss>

## Appendix C: Medicaid Reimbursement in the Postpartum Period

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Medicaid reimbursement for postpartum care is included in the “OB package” codes that are used to bill for maternity care. These include:

- 59400 – Global fee (vaginal delivery); antepartum, delivery and postpartum care
- 59510 – Global fee (cesarean delivery); antepartum, delivery and postpartum care
- 59410 – Postpartum package (vaginal delivery); delivery and postpartum care
- 59515 – Postpartum package (cesarean delivery); delivery and postpartum care
- 59430 – Postpartum only package; postpartum care

In order to bill the Pregnancy Medical Home postpartum incentive payment (S0281), the **same billing provider** has to have a paid claim on file for postpartum care using one of the package codes above. The PMH postpartum incentive payment should include a date of service that reflects the date of the comprehensive postpartum visit and will only pay if the visit occurs within 60 days of the delivery.

NC Medicaid covers a range of services in the postpartum period, including sterilization and contraception. Insertion fees for long-acting reversible contraceptive (LARC) methods can be billed in addition to the device itself. LARC insertion can occur at the time of the comprehensive postpartum visit and be billed on that date.

Patients in the Medicaid for Pregnant Women category are eligible for a more limited set of services in the postpartum period that directly relate to treatment of pregnancy-related complications, whereas women with other categories of Medicaid coverage do not have these restrictions in the postpartum period.

See [NC DMA Clinical Coverage Policy 1E5: Obstetrics](#) for more details about billing Medicaid for obstetrical services.



## Appendix D: Resources for Postpartum Care

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### Diabetes

[North Carolina recognized diabetes prevention programs](#): CDC website with information about the National Diabetes Prevention Program, with a list of organizations in North Carolina that are recognized diabetes prevention programs.

[Diabetes Self-Management Education Programs](#): Website provides background on the establishment of the Diabetes Education Recognition Program. General information on how the program functions in order to promote Diabetes Self-Management Education throughout North Carolina is available. Contact [info@diabetesnc.com](mailto:info@diabetesnc.com) to locate programs.

### Postpartum Depression

ACOG Committee Opinion No. 453, Screening for Depression During and After Pregnancy (February 2010), describes recommended depression screening tools in the perinatal setting

ACOG webpage for the [Perinatal Depression Initiative](#), including links to screening tools and a comprehensive Perinatal Depression Toolkit from ACOG District II.

Depression screening tools:

- [Postpartum Depression Screening Scale](#) (PDSS)
- [Patient Health Questionnaire](#) (PHQ-9)
- [Center for Epidemiologic Studies Depression Scale](#) (CES-D)
- [Edinburgh Postnatal Depression Scale](#)

All tools are available in Spanish; several, including Edinburgh and PHQ-9, are available in other languages. Each has a different scoring methodology.

For an example of a referral and management protocol based on the Edinburgh Postnatal Depression Screen, please see [UNC postpartum depression screening](#).

[North Carolina LME/MCO Screening, Triage and Referral](#) (STR) lines by county.

[North Carolina Perinatal Mood Disorders Clinic and Inpatient Facility](#) is located at UNC Healthcare in Chapel Hill, NC. They accept referrals from across the state for perinatal mood disorders. There is also 24-hour on-call psychiatric care available at UNC Healthcare for emergency referrals.

- UNC Crisis Psychiatry Service: M-F 8-4:30: 919-966-2166 or 919-966-5217
- Perinatal Mood Disorders Clinic: 919-966-5217
- After hours: Call 919-966-4131 and ask for Psychiatry on call team

## Reproductive Life Planning and Contraception

Reproductive life planning webinar link [here](#).

[Bedsider](#): Bedsider.org is an online birth control support network for women 18-29 operated by the [National Campaign to Prevent Teen and Unplanned Pregnancy](#), a private non-profit organization. Bedsider's goal is to help women find the method of birth control that is right for them and learn how to use it consistently and effectively.

[Bedsider for providers](#) is a website with free materials and tools to healthcare offices, clinics, classrooms, and health centers. Bedsider is a tool for women to learn about their birth control options, better manage their birth control, and in the process avoid getting pregnant until they are ready.

[CDC Medical Eligibility Criteria \(MEC\) for contraception](#): CDC website with information for providers regarding contraceptive criteria. CDC's patient guide to contraceptive effectiveness can be found [here](#).

[US Department of Health and Human Services contraceptive fact sheet](#): Summary of different contraceptive methods, including information on how each works, failure rates, and frequently asked questions.

## Tobacco Use

[NC Quitline](#): 1-800-QUIT-NOW (1-800-784-8669). Provides free telephone counseling 7 days a week, 24 hours a day.

[NC Quitline for Providers](#): Website to make referrals and access additional provider resources including tools, counseling methods, referral forms, and references to assist with tobacco use screening and intervention.

## Breastfeeding

The [Baby-Friendly Hospital Initiative](#) is a joint initiative of UNICEF and the World Health Organization to certify birth centers which employ all ten steps to successful breastfeeding. These steps must be met and maintained in order for hospitals and birthing centers to receive Baby-Friendly designation. Hospitals in North Carolina that are "Baby Friendly" link [here](#).

The [Carolina Global Breastfeeding Institute at UNC-Chapel Hill](#) assists hospitals in moving through the Ten Steps and also offers provider training.

[WIC](#) is a safety net resource that provides education, lactation consultants, breastfeeding peer counsellors (86 counties), and breast pumps to breastfeeding WIC participants. Consult the NC WIC County Directory for contract information for local programs.

UNC lactation has on-call lactation consultants 7 days a week (1-866-428-5608) and a breastfeeding clinic staffed by lactation consultants and obstetric providers for women with breastfeeding concerns.

[ZipMilk](#) provides zip code specific lactation support services: List of lactation support services by zip code available in the area by type, such as medical professionals, WIC breastfeeding coordinators, and support groups.

## Healthy Lifestyle

[Eat Smart Move More Weigh Less](#): NC DHHS offers a 15-week online group class (also available in person in select counties): \$225 for 15 sessions, with discounts for NC teachers and members of the State Health Plan. Computer needed. Eat Smart Move More NC meal planners and activity logs link [here](#).

[Weight Watchers](#): Weight loss program is available online and in-person.

[USDA My Plate materials](#): Available resources include information on food groups, weight management, physical activity, and healthy eating, trackers, printable materials, and other tools.

[Consider a customizable lifestyle prescription pad](#): Interactive pdf that can include provider's information on top of prescription pad along with information such as a class or workshop on bottom section.

## Substance Use

[There are several validated tools](#) to screen for perinatal substance use. The 5 P's is available [here](#).