Postpartum In Practice

2021

A guide for program directors, clinicians, and health care teams.

UNC School of Social Work Jordan Institute for Families

UNC School of Medicine

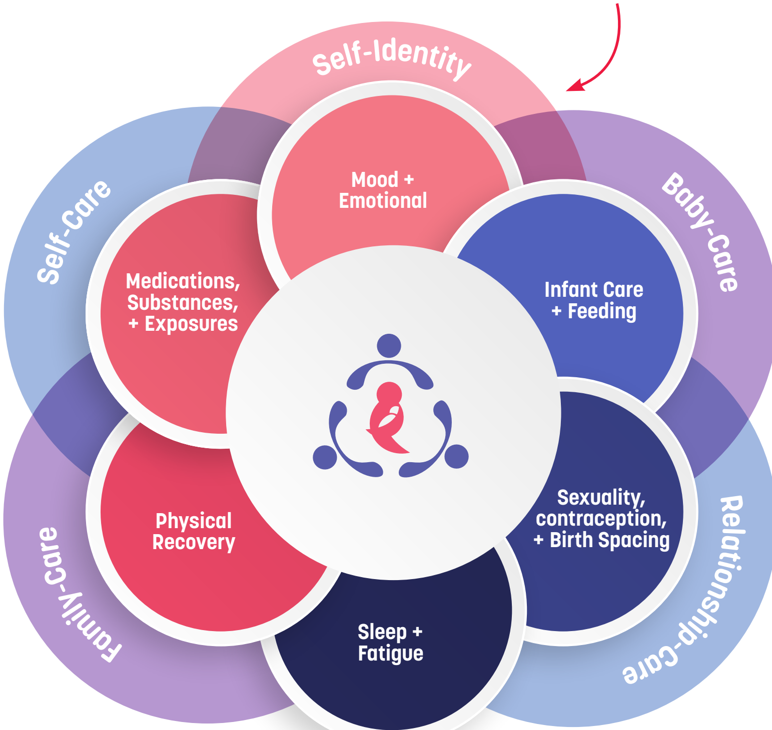
NewMomHealth.com

Welcome

Our mission is to transform the lived experience of the 4th Trimester for ALL women by sparking real, sustained change.

The "4th Trimester" is defined as the days, weeks, and months following birth. This is a really important time in the life of a woman and her family. New mothers undergo many changes with their bodies, feelings, and relationships during this time. Too often, women are left to navigate their health and care without enough information or support. New mothers and families face many challenges during the postpartum period. The journey from pregnancy through birth and the postpartum period often includes feelings of isolation, unrealistic infant and self expectations, limited access to needed services, stigma around issues such as mental health, challenges with infant feeding and more. Postpartum in Practice highlights ways in which the health care team can address some of the universal but largely neglected postpartum experiences. This work is critically important. North Carolina continues to have almost 28 maternal deaths per 100,000 births every year. And for every woman that dies from pregnancy-related causes, 20 or 30 more experience acute or chronic maternal morbidity. This guide is designed to offer resources and supports to improve the way postpartum care and support is provided to all women.

Whole person care is important for shared decision making and achieving goals.



Find citations and links to resources found within this document at NewMomHealth.com/practice-guideline-links

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Tips for Whole Person Care

- Acknowledge that new motherhood is hard for everyone. Not being ok all the time is expected.
- Women need assurance and support to recognize that using resources and asking for help are signs of strength.
- Tell birthing parents what happens to their bodies after they give birth. Most new mothers report are not prepared.
- New mothers often prefer that their health care provider bring up what can otherwise feel like awkward or uncomfortable questions, such as those about incontinence.
- New moms are vulnerable, often receiving conflicting messages and feeling judged. Validate what is working well and build from there.

Establishing Equity in Maternal Care

Women of color are treated differently than white women. This is fact. This is happening in clinics and hospitals in North Carolina. Systemic racism permeates all facets of American life. Acknowledging this as truth and committing to actively engaging in change is an essential first step in improving care. Health care teams need to advance their own ongoing learning and efforts to be antiracist. They also need to track processes as well as outcomes and metrics by race and ethnicity. This data can help guide practice strategies to address disparities in care and outcomes. Teams need to listen to their patients, particularly those experiencing care differences. Further, teams need to consider their own diversity and how well they are doing supporting equity and inclusion. Patients observe the way the clinic team works together. If certain members of the team are treated differently or disrespectfully, the patients will know. Advocacy for systems change at multiple levels is needed.

Listening to the people and communities we serve and proactively working to earn and deserve trust is critical. We want mothers to not just survive, but thrive.

> “...There is no answer to solving this crisis that Black women do not already know. It is in their lived experiences and resilience that drives innovation and belonging – and we as stakeholders should take heed.” –SCOTT, BRAY, ASIODU, MCLEMORE

Respectful Care

Respectful maternity care focuses on addressing patient needs in a way that offers them dignity and quality care.

Offering dignity includes addressing patients how they wish to be addressed. While we refer to “women” throughout this document, it is important to remember that not all birthing people identify as women. Ask each patient how they wish to be addressed (i.e. their preferred pronouns, if they would like you to use their name instead of referring to them as “mom”, etc.)

Disparities in health outcomes reflect inequities in society and within health care. Language, education, income, age, race, ethnicity, gender-identity, and sexual orientation should not impact respectful care – but it does. If providers want to see improved outcomes, they have to shift how they work. Building positive relationships, listening to mothers with humility, and facilitating shared decision making are key principles to improving care for moms.

Demonstrate Respect

- Do not make assumptions about women.
- Promote and support continuity of care whenever possible.
- Consider access and experiences of people experiencing disparities. Improving systems for them will improve care for all.
- Be fully present with your patients. Listen to them. Make eye contact. Show that you hear them so that assessments and planning do not feel like checklists.
- Trust that patients know their own bodies.
- Provide clear information about the physical and emotional changes they might experience.
- Provide opportunities for honest feedback about the care your team is providing.

Earned Trust

Building and maintaining trust is critical for a positive patient-provider relationship. People's engagement or disengagement can be influenced by experiences with how things are set up in the health care system (structural factors) and how it feels to interact with health care team members (interpersonal factors). Trust takes time and consistency to build.

Humility

Approaching patients with humility is an active effort to not make assumptions about people, suspend judgement, and to embrace different ways of knowing and doing. Each one of us has a personal view of the world that shape our interactions. Know that your view is only one of many views. Be curious about other ways of thinking and living.

Shared Decision-Making

Shared decision-making brings at least two experts to the table: women/families and their health care providers. Working as a team honors the experiences and knowledge of both groups and can lead to decisions and care plans that are achievable and align with patient preferences and quality clinical care. Refer to the **Center for Shared Decision Making** for more information and resources.

> "The goal of equity in care and outcomes can be accomplished only if it is treated the same as the goal of other quality improvement initiatives - namely, as a desired end in and of itself, embedded within a culture of safety that is specifically acknowledged, discussed, measured, monitored, and the subject of continuous quality improvement efforts."
>
> –HOWELL ET AL. DOI:10.111/JMWH.12756

> "If a Black person feels like they're not being listened to, they're not being respected, their autonomy is not being centered, they have very little decision-making power in their labor and pregnancy and postpartum care-what impact does that have on someone's agency?"
>
> –DR. MIMI NILES, NATAL DOCUSERIES

Shift away from thinking of a patient as "non-compliant"

This label is harmful and ignores the many hurdles and concerns women experience in accessing care and acting on recommendations.

This label blames women instead of identifying the shared responsibility of the provider, clinic and larger systems.

Use language such as 'The patient was not able to comply with the plan of care.'

Health in Context

Time with patients is limited, and there are many topics to cover. Health needs are often complex and urgent, and social determinants of health (SDoH) are often a factor. Asking about issues such as food, housing and safety can be important for quality clinical outcomes. Here are some tips:

- If you are going to screen, ask every patient not just the people you think have a problem. This helps avoid bias.
- Don't ask about problems for which you can't offer help.
- Helping can be as simple as offering a list of resources that the woman can contact to help them.
- Normalize financial, relationship and other real life challenges – many new families are surprised by the costs on all levels of having a baby.
- When addressing SDoH, remember to be gentle, relaxed, unhurried and clear. Do not require patients to "admit" to problems.

Some things you might say when screening for SDoH include:

- "We ask all patients about [topics] because these are common issues, and we want to provide everyone with information that might be helpful."
- "Is everything still ok with [topic]? Would you like more information on…?"
- "If [topic] becomes an issue, here are some resources you can access."
- To begin compiling a resource list for you patients, check out **NC 2-1-1** and **NCCare360** for their resource databases. We also suggest you reach out to the health department and any local mom to mom support programs, home visiting programs, or doula groups who often know about great local resources.

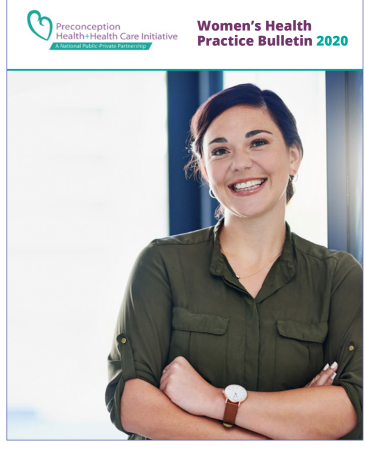
Redesigning Postpartum Care

The American College of Obstetricians and Gynecologists (ACOG) and Council on Patient Safety have created **postpartum guidelines and toolkits** to transform postpartum care. The number and timing of visits is a key part of this redesigned care. Women should be contacted much earlier and should receive care when they need it. A revised approach emphasizes:

- A blood pressure check within 3-10 days
- Follow-up for high-risk women within 1-3 weeks
- Contact with all women within the first 3 weeks
- Ongoing follow-up care should be individualized to the woman during weeks 3-12, and a transition to well-woman care should happen during this time
- Consider making appointments at least 30- 45 minutes long so that women can have their needs and concerns adequately addressed

Telehealth should be considered as a method to promote continuity of care and remove barriers to care access during the postpartum period.

ACOG Alternate & Reduced Visit Guide with telehealth recommendations



Transition to the Primary Medical Home

Postpartum care should be an extension of well-woman, preconception and prenatal care. If you aren't her PCP, teams must help women follow-up or establish care with one so that she receives risk-appropriate, ongoing routine care.

- Home visiting programs can help reinforce the connection to the primary medical home during the postpartum period.
- NC Pregnancy Medical Home provides a list of primary care safety net providers: **List of local free clinics** and **Federally Qualified Health Centers**
- Refer to the Women's Health Practice Bulletin and **beforeandbeyond.org** for preventive health and chronic disease management anticipatory guidance and management considerations.

Best Practices to Help Women to Attend their Postpartum Visits

Proactively Scheduling Appointments for Moms	Coordinate postpartum visits during prenatal visits or at the time of hospital discharge.
Provide Phone Number	Ensure families know how to contact the health care provider, including normal business hours or weekends, in the event of a postpartum emergency.
Provide scheduled reminders	Use email, text, and patient portals such as MyChart to send reminders about postpartum follow-up appointments. The more reminders the better. Track and follow-up with missed appointments.
Plan ahead for barriers to care	Remind her to reach out to her Primary Care Provider early in pregnancy if she will be transitioning from her OB provider to another PCP– many Family Medicine providers can have a waitlist for patients, so it is important that she is in their system as early as possible. Schedule her first visit before hospital discharge. Make sure that she has transportation for the visit and that she knows she can bring her newborn to the visit (policies may vary). Help her think through care for other children.
Collaborate	Engage peer counselors, home visitors, public health nurses, postpartum doulas, lactation consultants, and other resources to support women in getting the care they need.

Who's responsible for NICU moms? You are.

A 4th Trimester Project study found that NICU moms are twice as likely to have delivered by cesarean section and experience severe maternal morbidity. These moms are also at increased risk for perinatal mood disorders and anxiety. With high concerns for their infants, these moms often sacrifice self-care and recovery to remain at their baby's bedside.

- Postpartum women in your practice with NICU infants should be a priority population for follow-up and attention.
- Make sure medical charts are up to date and flagged so providers know if the infant has died or is still hospitalized to prevent asking insensitive questions.
- Ask about birth trauma, provide referrals for mental health services.
- Make sure she is able to have her blood pressure monitored.
- Strategize with her around pain management and self-care.

"My physical recovery had a lot of bladder incontinence. I kept thinking, 'I am never going to be able to feel the need to pee again.'"
–4TH TRIMESTER MOM

Post Birth Warning Signs

All women and their families MUST know the post birth warning signs and what to do if they are experiencing these symptoms. Providers need to make sure that their systems are prepared to take mothers seriously when they express concerns and help them quickly. The Association of Women's Health Obstetrics and Neonatal Nursing (AWHONN) Post Birth Warning signs (PBWs) materials are helpful. The Enhancing Review and Surveillance to Eliminate Maternal Mortality (ERASE) Maternal Mortality project is assisting North Carolina hospitals to implement PBWs. Contact Kimberly Harper at kimberly_harper@med.unc.edu for more information.

Birth Trauma

Providers need to ask women about their birth experience and give them space to debrief and have their story heard. A referral should be made as appropriate.

Resources:

FOR WOMEN

- NewMomHealth.com Childbirth Trauma and Maternal Near Miss page
- Maternal Near Miss Survivors Facebook Group

FOR PROVIDERS:

- National Perinatal Association course on Trauma-Informed Care during COVID-19
- Birth Trauma Support Center

Women's Priorities

Women struggle in the first weeks with symptoms that may not be life threatening but are life altering. These common complications of the postpartum period should be discussed during the prenatal period.

Common issues include:

- Urinary and fecal incontinence
- Bleeding
- Hemorrhoid
- Engorgement
- Pelvic Floor issues
- Pain

These conditions should be prioritized and managed, including referral to appropriate specialists such as urologist, pelvic physical therapist and others.

Women report postpartum pain in the vagina, perineum, breasts, c-section incisions, back, neck and abdomen. We know that women of color are less likely to be assessed for pain, yet report more pain than white women and still receive less pain medication. Make sure that you are assessing every woman for pain.

Safety at Home: Intimate Partner Violence Screening

Intimate partner violence (IPV) is a serious and preventable public health problem that affects millions of people across the lifespan. Data from the National Intimate Partner and Sexual Violence survey indicate that **nearly one in four (23%) adult women** experience severe physical violence (i.e. being kicked, beaten, choked, burned, or have a weapon used against them). Providers must remember that the woman is the expert on her situation and must defer to her plans.

Sample Intimate Partner Violence Screening Questions

While providing privacy, screen for intimate partner violence during new patient visits, annual examinations, initial prenatal visits, each trimester of pregnancy, and the postpartum checkup.

Framing Statement

"We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health."*

Confidentiality

"Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what you tell me unless…North Carolina mandatory reporting laws*

Sample Questions

- "Has your current partner ever threatened you or made you feel afraid?" (Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages.)†
- "Has your partner ever hit, choked, or physically hurt you?" ("Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)†

> "Violence is a chronic issue and it will take time. The provider is there to help and support, not to judge."
> —DR. DESHANA COLLETT

Recommendations for Positive Screen

- Thank her for having enough trust to disclose the abuse.
- Nearly one in four adult women experience severe physical violence. Screen for intimate partner violence during new patient visits, annual examinations, initial prenatal visits, each trimester of pregnancy and the postpartum checkup.
- Assess for immediate danger, assist with development of a safety plan, or consult with specialists.
- Offer community resources and referrals:
  - Domestic Violence Agencies
  - Rape Crisis Centers
- As appropriate, assist with the process for informing law enforcement if the patient is agreeable (see NC mandatory reporting for certain wounds, injuries and illnesses)
- Document the abuse, health effects or injuries relevant to her care
- Maintain clinical follow-up
- Consider making a report to child protective services if children are involved (North Carolina mandatory reporting laws)

Mental and Emotional Wellbeing

Normalizing perinatal mental health needs is a priority for the postpartum period. NC Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources and, Screening Better) program provides real-time, perinatal psychiatric consultation, resources, and referral services. The MATTERS program aims to support identification and management of pregnant and postpartum patients' mental health and substance use concerns. The algorithm below and other resources can be found on the NC Maternal Mental Health MATTERS page.

Perinatal Screening and Treatment

Nurse/MA asks patient to complete screening questionnaires(s)

Nurse/MA enters patient responses in EPIC/EHR

Provider reviews patient responses and follows-up on scores

Assess for Safety Q10 of EPDS Q9 of PHQ-9

"We are asking all of our pregnant and postpartum patients to complete this short questionnaire."

ACOG recommends screening take place at least once during pregnancy and once postpartum

Depression	Anxiety	Substance	Patient Reports
PHQ-9 > 10	GAD-2 > 2	Use Modified	feeling stressed
EPDS >12	GAD-7 > 7	P5s >0	or overwhelmed

No

Counsel that depression/anxiety are common during pregnancy, encourage to contact usual provider if any concerns

Discuss stress relief / coping strategies, self-care, sleep hygiene.

Call NC-PAL (919) 681-2909

Yes

Clinician alarmed by psychiatric situation or intent/plan for self harm?

No

Offer counseling, with or without medications

Review Medication Algorithm

Call NC-PAL (919) 681-2909

Yes

Call NC-PAL (919) 681-2909

If concern for immediate harm to self or others, arrange for patient to be escorted to nearest emergency department.

Visit Diagnosis Code: 648.4 Mental disorders complicating pregnancy, childbirth or puerperium

EPDS Interpretation Charge: CPT 96127 Administration and interpretation of health right assessment instrument

ACOG recommends seeking follow-up from mentall health providers on women referred for treatment

Postpartum Support International recommends that providers screen at:

- The first prenatal visit
- At least once in second trimester
- At least one in third trimester
- First postpartum visit
- 6 or 12 months postpartum in OB or primary care setting
- 3,9,12 month pediatric visits

Normalize self-care for new moms

Remind her that it is not selfish to take time for her. Emphasize the importance of going back to the basics such as taking a shower and leaning on her support network.

- Refer to the LME/MCO Screening, Referral and Triage Line for Pregnancy Medical Home patients in crisis or to make a referral to a behavioral health provider in the area.
- For non-crisis situations, Postpartum Support International offers a "Warmline" Help Line in English and Spanish where women can connect with a Support Coordinator: 1-800-944-4773. While not a substitute for professional care, it can help her feel understood and validated with what she's experiencing.

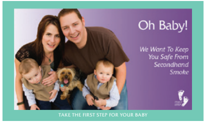
Support Tobacco-Free and Substance-Free Living

Tobacco is the most used substance among pregnant women. Perinatal use rates are over 20% in some areas of North Carolina. Check your bias and be aware of how it may come out when talking to women about tobacco and other substance use - be careful not to shame or criticize. For many reasons including, stress, lack of sleep, the desire to lose weight, and the return of other triggers, nearly 80% of women who quit smoking during their pregnancy return to tobacco use in the first year postpartum.

Women need consistent, ongoing support and counseling to prevent returning to tobacco use during the postpartum period. For more information on evidence-based resources available for tobacco cessation counseling and treatment in North Carolina, please visit **YouQuitTwoQuit.org** to review the Tobacco Cessation Practice Bulletin, which includes information on pharmacotherapy during pregnancy and lactation, and access the patient education materials described below, free of charge.

E-Cigarettes & Vaping
For pregnant women and mothers on risks associated with e-cigarettes and self-help guidance for quitting.

If You Smoke and Are Pregnant
For women who are pregnant or thinking about pregnancy.



Oh Baby! On avoiding secondhand smoke while pregnant, creating a smoke-free home and car after the baby is born.

You Quit, Two Quit
Helpful tips for new mothers on staying tobacco free.

Tobacco use, marijuana use, breastfeeding and harm reduction

Tobacco use is not a contraindication for breastfeeding. However, women and other caretakers should be counseled to never smoke or vape when the baby or other children are present and to thoroughly wash their hands and face and change clothes before handling the baby after using tobacco. Nicotine can be minimized in the breastmilk by feeding the baby first and using the nicotine product immediately after the feeding session. This allows the nicotine to move out of the breastmilk before the next feeding session.

As more states legalize marijuana, many pregnant and breastfeeding mothers are getting mixed messages as to whether it is safe to smoke marijuana. Data on the effects of marijuana and CBD exposure to the infant through breastfeeding are limited and conflicting. To limit potential risk to the infant, breastfeeding mothers should be advised not to use marijuana or marijuana-containing products in any form, including those containing CBD, while breastfeeding.

Alcohol/Drug Council of NC: Perinatal Substance Use Project

- Find residential facilities in NC that allow pregnant women and those with children 0-5 to stay together during treatment
- Provides screening and referrals for pregnant and parenting women in NC
- Information about bed availability for substance use services from the NC Perinatal Maternal and CASAWORKS Initiative
- Contact Judith Johnson-Hostler at **jjones@alcoholdrughelp.org** for more information
- Visit **alcoholdrughelp.org**
- Call 1-800-688-4232

NC Pregnancy & Opioid Exposure Project | ncpoep.org

Provides information for the public and professionals on opioids and pregnancy in North Carolina.

Infant Plan of Safe Care

Recent federal legislation has affected North Carolina policies related to infants who may have been exposed to substances during pregnancy. The goal of the federal legislation and subsequent state policies are to support the health of the infant, mother and family. Refer to **http://bit.ly/2tF9d5Y** for more information

Chronic Conditions and Postpartum

Health issues in pregnancy such as gestational diabetes, heart problems, or high blood pressure are likely to develop in the future. Women who experience such complications should have risk-appropriate collaborative care in the postpartum period. Education on the importance of the postpartum visit, what to expect during the visit and providers that they may encounter can help to increase visit attendance.

Postpartum Diabetes Management

Only about 40-50% of women get the appropriate glucose tolerance test follow-up. Screenings for diabetes should occur every 3 years, or yearly if postpartum test shows prediabetes. Women with diabetes tend to have more difficulties with breastfeeding. Consider referrals for lactation support in the postpartum period.

Hypertension in Pregnancy and Preeclampsia

Women with preeclampsia have an increased risk of recurrence in subsequent pregnancies. These women also have a two-fold increase risk of subsequent cardiovascular disease. Uncontrolled hypertension in the postpartum period increase of stroke. Long-term uncontrolled hypertension leads to end organ damage, renal disease, and cardiovascular disease such as heart attacks and strokes. Early follow up and close monitoring is important during the postpartum period.

Heart Health: The 3-month Cardiovascular Visit

Cardiovascular disease and cardiomyopathy are the leading cause of maternal mortality in North Carolina. The majority of cardiovascular disease mortality occurs after 42 days postpartum. A comprehensive postpartum cardiovascular visit should be scheduled at three months for patients with any of the conditions below:

- Chronic hypertension or hypertensive disorders of pregnancy
- Gestational Diabetes or Pregestational diabetes
- Intrauterine fetal growth restriction
- Idiopathic preterm birth
- Placental abruption
- Obesity, excessive pregnancy weight gain, or postpartum weight retention
- Sleep disorders or moderate-to-severe obstructive sleep apnea
- Maternal age older than 40 years.

Community Care of North Carolina Pregnancy Medical Home Program has developed a clinical pathway to care for women with complications. For more information on management and care of chronic illness and the transition click here.

Postpartum Follow-up Timeline

Severe Hypertension	Within 3-5 Days
Hypertensive Disorders	Within 7-10 Days
Heart Disease/ CV Disorders	Within 7-14 Days
All CV patients	3 Months

Provider Resources

- Algorithm for Postpartum CVD Assessment and Management: ACOG Pregnancy and Heart Disease Practice Bulletin No 212
- NC Pregnancy Medical Home Postpartum Blood Pressure Management Guidelines
- Guide to Contraception for Women with CVD
- Guide to CVD Medications for Pregnant and Breastfeeding Women
- Community Care of North Carolina info sheet on obtaining home blood pressure monitors

Patient Resources

- Women with diabetes and hypertensive disorders in pregnancy should be counseled about their substantially higher risk of future CVD. Give them this infographic sheet and post it in your clinic, available in English and Spanish.
- Community Care of North Carolina tip sheet for accurate home blood pressure monitoring.

Chronic Conditions in the Postpartum Period

Condition	Background	Postpartum Test or Screening	Management Considerations	Follow-up Goals
Valvular heart disease	Congenital or rheumatic in origin	Pulse oximetry, daily weight, blood pressure, and pulse assessment auscultation, echocardiography and electrocardiography because arrhythmia also can be part of complex	Resolving physiologic changes may continue to place extra demands on function, multidisciplinary team approach Optimization of medication in the setting of breastfeeding*	Optimization of functional status, evaluate need for valvuloplasty or replacement
Atherosclerosis and ischemic heart disease	Comorbitities including obesity, and diabetes may increase risk of angina or myocardial infarction, or both	Pulse oximetry, daily weight, blood pressure, and pulse assessment auscultation in the immediate postpartum period Echocardiography, electrocardiography, stress testing, and cardiac catheterization, as needed, depending on baseline status	Optimization of medications in the setting of breastfeeding, including when to resume anti-lipids such as statins* Stent placement or bypass surgery	Management of comorbodities Weight control, nutritional consultation
Cardiomyopathy	Congenital, acquired, or peripartum Women may experience exacerbation in the postpartum period	Pulse oximetry, daily weight, blood pressure, and pulse assessment Serial echocardiography, B-Type Natriuretic Peptide Assay will help evaluate recovery of cardiac function	Multidisciplinary approach Medication optimization while breastfeeding, including inotropic agents, afterload reduction, and possible anti-coagulants*	Optimization of functional status
Atrial fibrillation	Valvular or nonvalvular/ idiopathic	Pulse oximetry, daily weight, blood pressure, and pulse assessment Electrocardiography, Holter monitor, electrophysiology studies may be needed ChA_2DS_2VASc score to assess stroke risk	Multidisciplinary approach Medication optimization while breastfeeding including antiarrhythmics and anticoagulation*	Optimization of functional status, electrophysiology studies
Nephrotic or nephritic syndrome	Idiopathic or related to underlying collagen vascular disorder or vasculitis Renal disease may worsen if pregnancy was complicated by preeclampsia	Daily weight, blood pressure assessment, renal function assessment As an outpatient, renal ultrasonography and protein-creatinine ratio, electrolytes, and other blood chemistries may be indicated to evaluate postpartum renal function and resolution of pregnancy-related impairment. A renal biopsy may be indicated.	Multidisciplinary approach Medication optimization while breastfeeding including biologics, steroids, and anticoagulation*	Optimization of renal function in the context of potential multiorgan involvement
Renal insufficiency	May result from acute or chronic insults Pregnancy-related insults include preeclampsia, hemolytic uremic syndrome, thrombotic thromocytopenic purpura	Daily weight, monitor input and urinary output, blood pressure assessment, assessment of serum and urine electrolytes A renal ultrasound examination or renal biopsy, or both, may be indicated	Multidisciplinary approach May need dialysis Medication optimization while breastfeeding*	Optimization of renal function: may require transplant
Renal Transplant	Renal failure related to underlying vasculopathy, collagen vascular disorder, or vasculitis	Daily weight, monitor input and urinary output, blood pressure assessment, assessment of serum and electrolytes, renal ultrasound examination, renal biopsy	Multidiscipllinary approach Medication dosages of antirejection/biologics will require levels and dosage changes	Transplant maintenance monitoring for rejection
Thyroid disease	Uncontrolled thyroid disease is associated with cardiovascular disease, arrhythmia, and depression Postpartum thyroiditis can occur in women who did not have thyroid disease	Monitor for symptoms or hyperthyroidism or hypothyroidism Repeat thyroid function tests at the postpartum visit	Adjust thyroid medication Referral for specialist treatment for women with newly diagnosed thyroid disease	Normalization of thyroid function tests Resolution of symptoms of thyroid dysfunction
Autoimmune disorders	Uncontrolled autoimmune disorders are associated with chronic morbidity, poor quality of life, disability and, in some cases, increased risk of cardiovascular disease The postpartum period may be marked by a flare-up of disease activity	Women should be asked about symptoms of a flare in the postpartum period	Multidisciplinary approach Medication optimization while breastfeeding* Medication dosages changed or adjusted as appropriate If underlying disorder affects activities of daily living, consider occupational therapy consultation to assist the woman in caring for her infant	Decrease disease activity Improve functional status Optimization of risk factors for cardiovascular disease

Sex, Birth Spacing, and Contraceptives

Talk about Sex

Let's talk about sex! While this may be the last thing on the mind of a tired new parent, it is a topic that is important to bring up. Conversations about sex after delivery should begin during prenatal visits. Some topics to discuss include:

- Sex and pelvic pain
- Vaginal tenderness and dryness
- Interest and readiness to resume intimacy

Conversations about sex after delivery should begin during prenatal visits. Providers should use a person-centered frame and provide space for women and their partners to think about intimacy after delivery.

Many women have noted that just because they might be "cleared" to have sex again at 6 weeks doesn't mean that they are mentally or physically prepared to do so. Women have feelings and concerns around intimacy including fear of pain, low body self esteem, and low desire. While some women may be eager to resume their sexual lives, others may not. Partners may also have a variety of experiences.

- Acknowledge that all of these feelings are common and okay.
- Provide information and guidance around pain and pleasure.
- Refer women to Pelvic Physical Therapy if pain during sex persists

Be Smart Family Planning

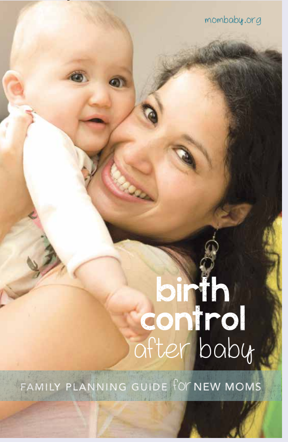
The Be SMART Family Planning Program is dedicated to increase access to contraception. Family planning/reproductive health services are provided to eligible men and women whose income is at or below 195% of the federal poverty level. For more information about this special Medicaid program, please visit North Carolina's Medicaid website.

Ask about Her Plans

- Consider initiating this conversation with the question, "Are you thinking that you might want to have another baby in the future?"
- Let women know that there are risks if they become pregnant before their current baby is 6 months old and that waiting at least 18 months between pregnancies is recommended.
- Recognize that even thinking about getting pregnant again in the throes of the postpartum experience can feel overwhelming. Many women have concerns about taking hormones in general and the impact of hormones on breastfeeding.
- Provide information about fertility return and make sure she has a number to call when she is ready for a method.

Provider Resources

- Birth Control after Baby is a resource that can be ordered from the NC DPH Women's Branch. This booklet includes information to help couples talk about sex and how to decide together when they are ready.



- Bedsider.org is an interactive webpage that offers information on contraception.

Sex Drive and Body Image

The way that women feel about their body after birth can be complicated. Evolving into "mom" in addition to other roles in life, might not mix with feeling sexy at first. Leaking breasts can be a challenge. Baby blues, symptoms of postpartum depression or anxiety, and feeling worried can all lower interest in sex. Having an open and honest conversation with women and their partners can help them to make informed decisions.

Infant Feeding

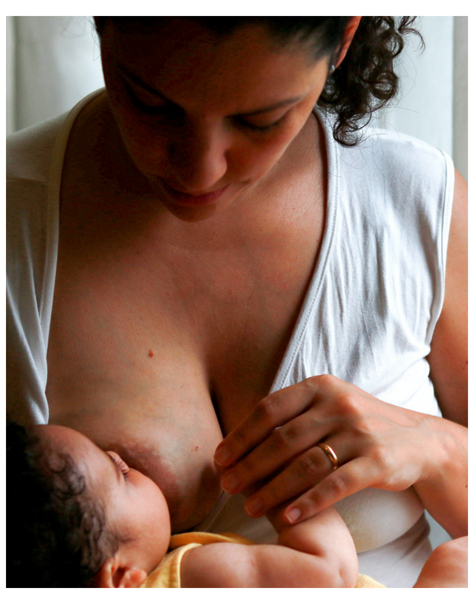
Some women have a prenatal plan for infant feeding and will stick to it, while others may change their minds once they have their baby. Many factors influence breastfeeding success, including pain, mental and emotional well-being, presence of support people in her life, and support at work. Early discussion about infant feeding can provided the needed support for a women's success. Here are some thoughts for starting the conversation:

- Use open-ended questions and reflective listening to understand her experiences
- Reach out early in the postpartum period to see how breastfeeding is going
- Celebrate what is going well first, then address challenges and barriers
- Talk with her about the benefits of breastmilk and breastfeeding
- Refer to the CDC's Webpage on Infant and Toddler Nutrition for information on breastfeeding and formula feeding, including how to properly mix formula and amounts to feed

Breastfeeding takes a village and requires support from family, friends and the community. Encourage her to join a local breastfeeding support group. Help her identify someone she can call, such as a peer-counselor or lactation consultant if she is having any difficulties, concerns or questions in the first few weeks. While breastfeeding is "natural", that does not mean it is easy and it is a new skill that needs to be learned and practiced.

Provider Resources

- Academy of Breastfeeding Medicine Mastitis Protocol
- Academy of Breastfeeding Medicine Engorgement Protocol
- Academy of Breastfeeding Medicine Persistent Pain Protocol



Triaging Breastfeeding Issues

Consider her health history, including chronic and pregnancy-related conditions, breast surgery, herbal and homeopathic therapies, caffeine and alcohol intake, tobacco use and nutritional needs.

Review all medications she is currently taking. LactMed has the most up-to-date information on individual medications and their use during lactation.

ENGORGEMENT

- Physiological engorgement is common in the first 3-5 days postpartum when the milk "comes in". This can feel uncomfortable. Refer moms to NewMomHealth.com/selfcare/engorgement for more information.
- Pathologic engorgement occurs when milk is not removed adequately from the breast and is best prevented by early, effective and frequent feeding. Pathologic engorgement makes it more difficult for the baby to latch and nurse and can progress and lead to mastitis or a permanent decrease in milk supply. Address pathologic engorgement immediately.

MASTITIS

- Generally unilateral inflammation of the breast.
- Best treated by frequent breast emptying – women should continue to breastfeed.
- If symptoms (including pain, redness, fever and flu-like symptoms) do not improve within 12-24 hours, the woman should contact her health care provider.
- Reassure the woman that she can and should continue to breastfeed even when taking antibiotics to treat mastitis.
- See NewMomHealth.com/selfcare/mastitis

Planning for the Postpartum Period

The best way to support new moms and families is through a combination of clinical care, enabling resources and community support. Unfortunately, many women don't know where to go for help, and they often end up getting referred to providers and resources that aren't accepting new patients or don't accept their insurance.

Providers must help women create a postpartum plan early on during the pregnancy that connects her with key community resources and support depending on her individual needs.

NewMomHealth.com has a template women can use to build a postpartum plan and a great list of helpful postpartum supplies.

Building Social Capital

Remind new moms that accepting help is a sign of strength. For example, you might suggest that she accept offers of meals, child care, and light housekeeping. Help her brainstorm who she knows who she would be willing to call for support. If she is a member of a faith community, neighborhood association or other group, she might want to let people know when the baby arrives as these groups often have ways of providing meals and support. If she has a very limited or no support system, connect her with a social worker who can help her find resources for support. Talk with her about her plans for returning to work, if applicable. Help women think through strategies for managing lactation, pain, chronic conditions, hydration, fatigue or other conditions including information about her legal rights.

Postpartum Support International offers:

- Weekly, online support groups for many different types of people
- Postpartum doula search
- Resources for dad
- Support for Spanish-speaking and Arabic-speaking families
- Support for adoptive and birth mothers

FETAL LOSS Women who have experienced a fetal loss or still birth need additional support, including strategies for getting support and going back to work, if applicable.

Talk with women about how to reduce their risk of COVID-19 infection, including asking visitors to wear masks and wash their hands, limiting visitors, and meeting with friends and family outside instead of in the home. New mothers should be encouraged to wear masks, social distance, and wash their hands frequently when in public and to avoid large groups of people.

> “A proactive, honest, reality-based approach aimed at altering maternal expectations of the postpartum period could be directed at counteracting the feelings of inadequacy often experienced by new mothers.”
> –JENIFER FAHEY AND EDMOND SHENASSA

North Carolina Community Resources

Every patient should be provided a postpartum community resource sheet and resources should be highlighted throughout the clinic space. Bulletin boards can be helpful and can also be virtual if you have a clinic website or Facebook page. Handouts given to everyone can be helpful too. Key resources include:

- Childcare Resources. Reliable resources for childcare can be a major source of anxiety and concern. Many childcare spots have a year-long waitlist.
- North Carolina Diaper Bank
- Food Banks
- Family Friendly NC groups and other organizations
- WIC info
- NC Care 360 is an online platform where NC providers can connect patients with community resources. It will be operational in all counties in NC by the end of 2020.

Use Your Voices

Providers have a powerful voice and they need to use it. There are two key areas where your energy is urgently needed.

Speak up for policy changes

You can advocate in your role within your clinic/organization, as part of your professional association and/or as an individual. Policy changes need to happen at the local level such as in your health care system and at a macro level such as at the NC General Assembly. Issues such as paid family leave, paid sick leave, access to health / behavioral health care (e.g. Medicaid expansion), work place accommodations, and coverage that includes doula support, lactation support, physical therapy and other services. You can tackle these issues with your human resources and benefits office at the clinic level as well as with advocacy groups on behalf of populations of NC women. Pay attention to issues that relate to clean water, safe housing, affordable quality child care, perinatal incarceration, and economic supports in your community and state. Don't be afraid to speak up and share how you've seen the ways these supports help families as well as hurt them.

North Carolina is updating its **Perinatal Health Strategic Plan** as well as creating a Maternal Health Strategic Plan. These documents include policy-oriented action items that make speaking up easy. You can find them at NewMomHealth.com/providers. Connect with your NC professional association, **MomsRising**, NC Child, and the **Black Mamas Matter Alliance** to get started. You don't have to do it all. You just need to find your issue and do something!

Build your capacity to provide equitable care

We must have policies and systems that match our desire to heal. Be outraged and acknowledge that we have a broken system, not broken women and communities. Moving beyond simply being antiracist and providing equitable care requires ongoing work at the individual, interpersonal and organizational level.

This means:

- Do your inside work – **read, listen, learn** so you can better see your privilege and how to become an antiracist person.
- If your health care organization doesn't already have one, **form and support a diversity, equity and inclusion workgroup** with clear benchmarks for change.
- **Creating equity data dashboards** to find disparities and focus on closing them.
- **Supporting efforts to increase the diversity of health care professionals and funding for research investigators of color.** One organization working towards this is **White Coats for Black Lives**.
- **Be an ally to women of color**—not a savior—by centering and amplifying their voices. Follow and engage with organizations such as: the **National Birth Equity Collaborative** and **Shades of Blue**.
- **Get to know the women of color in your communities who are change agents and leaders.** Learn from them. Support them and their work.

NewMomHealth.com

The first national postpartum info source designed by moms for moms

SaludMama.com

Self Care | Building My Village | Baby Care | Mama Stories | Meeting New Moms | Getting Help

Expert-written, evidence-based, reality-centered, postpartum health information.

The website includes guidance for recovering from pregnancy and birth, postpartum planning, mom-centered infant care strategies, tips for navigating relationships, ideas for building a village of support, and ways to connect with other moms.

Help us spread the word

4thTrimesterProject 4thTriProject 4thTriProject

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