



PARTICIPANT HANDOUTS
**CHAMPS Maternal Health 101 Workshop:
Practical Prenatal & Postpartum Care for
Community Providers**

Thank you for attending today's training. By doing so, you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, high-quality primary health care services.

Presented by:

Karen Ruby Brown MSN, CNM, IBCLC, MSCP, [Denver Health](#)

Live Event Date/Time:

Wednesday, June 17, 2026

11:00–1:00PM Mountain Time /12:00–2:00PM Central Time

Target Audience:

This workshop is designed for Region VIII health center medical providers as well as behavioral health providers, nurses, case managers, and anyone supporting pregnant and postpartum individuals who would like an overview of perinatal health care.

Event Overview:

This practical, case-based workshop is designed for community and rural healthcare providers who may not routinely provide maternity care—as well as those who do but seek greater confidence in their skills. Participants will learn to recognize normal versus high-risk conditions, manage common prenatal and postpartum concerns, and identify when to escalate care.

Learning Objectives:

At the end of this session, participants will:

1. Differentiate between normal and high-risk findings in prenatal and postpartum patients, including recognition of key warning signs that require urgent evaluation or referral.
2. Apply simple, practical frameworks to manage common prenatal and postpartum conditions in community settings.
3. Utilize local resources and referral networks to support the care of the spectrum of patients.
4. Increase confidence in providing prenatal and postpartum care, regardless of prior experience level.

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CHAMPS Archives

This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date. For information about all CHAMPS archives, please visit <https://champsonline.org/events-trainings/distance-learning/online-archived-champs-distance-learning-events>.

Description of CHAMPS

Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII federally-designated Community Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. Staff and board members of [CHAMPS Organizational Members](#) receive targeted benefits in the areas of business intelligence, networking and peer support, recognition and awards, recruitment and retention, training discounts and reimbursement, and more.

For over 40 years, CHAMPS has been an essential resource for Community Health Center training and support! Be sure to take advantage of CHAMPS' programs, products, resources, and other services. For more information about CHAMPS, please visit www.CHAMPSonline.org. The Happenings box in the middle of the CHAMPS home page highlights the newest CHAMPS offerings, while the CHAMPS Membership box on the lower part of the home page lists current benefits for CHAMPS Organizational Members.

Speaker Biography

Karen Ruby Brown MSN, CNM, IBCLC, MSCP has been a Certified Nurse Midwife since 2002, providing midwifery/OB-GYN care in a variety of settings including tertiary care teaching centers, community clinics and out of hospital settings. She earned her MSN in midwifery from Yale University and practiced for many years with the University of California San Diego Midwives before opening a private midwifery practice in San Diego. She later continued working in community health care in Colorado, including at Stride Community Health Center, and currently practices at Denver Health. As a past National Health Service Corps award recipient, she is passionate about expanding access to high-quality maternity care, as well as teaching and mentoring students and residents. Outside of work she is an adventurer, reader, singer, dog mom and human mom to two adult children on opposite coasts.



MATERNAL HEALTH 101 WORKSHOP: PRACTICAL PRENATAL AND POSTPARTUM CARE FOR HEALTH CENTER PROVIDERS

Wednesday, June 17, 2026

The AAFP has reviewed Maternal Health 101 Workshop: Practical Prenatal & Postpartum Care for Health Center Providers and deemed it acceptable for up to 2.00 Live AAFP Prescribed credit(s). Term of Approval is from 06/17/2026 to 06/17/2026. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



Maternal Health 101 Workshop

**PRACTICAL PRENATAL & POSTPARTUM CARE
FOR HEALTH CENTER PROVIDERS**

JUNE 17, 2026

KAREN RUBY BROWN MSN, CNM, IBCLC

KARENRUBY.BROWN@DHHA.ORG



I have no
conflicts of
interest.

Objectives

- ▶ Recognize normal vs. high risk obstetric conditions
- ▶ Manage common prenatal and postpartum concerns
- ▶ Identify warning signs requiring escalation and referral
- ▶ Utilize local resources and referral networks to best support patients
- ▶ Increase your confidence in providing prenatal and postpartum care

...and a bonus objective!

- ▶ Apply team-based approaches to maternal health

Goals of Maternity Care

- ▶ The major goal of prenatal care is to ensure the birth of a healthy newborn while minimizing maternal risk. There are several components involved in achieving this objective [1].
- ▶ The three main components of prenatal care are: risk assessment, health promotion and education, and therapeutic intervention [2]. High-quality prenatal care can prevent or lead to timely recognition and treatment of maternal and fetal complications. Complications of pregnancy and childbirth are the leading cause of morbidity and mortality in females of reproductive age globally [3].

Core Principles of Safe Maternity Care

Evidence-based practices

Respectful and trauma-informed care

Dignity and confidentiality

Cultural sensitivity

Agency and autonomy

Shared and informed decision-making

Family-centered care

CHCs: An Essential Part of the Maternal-Child Health Safety Net

CHAMPS Region VIII States (estimated annual impact)

~200,000–220,000 pregnancies

27,351 patients received prenatal care in CHCs (per HRSA UDS)

Estimated 30,000–35,000 pregnant patients received pregnancy-related care in CHCs

Thousands more receive postpartum, primary care, behavioral health, and care coordination services

The community health center is the front door to the maternity care system, and often to the health care system itself.

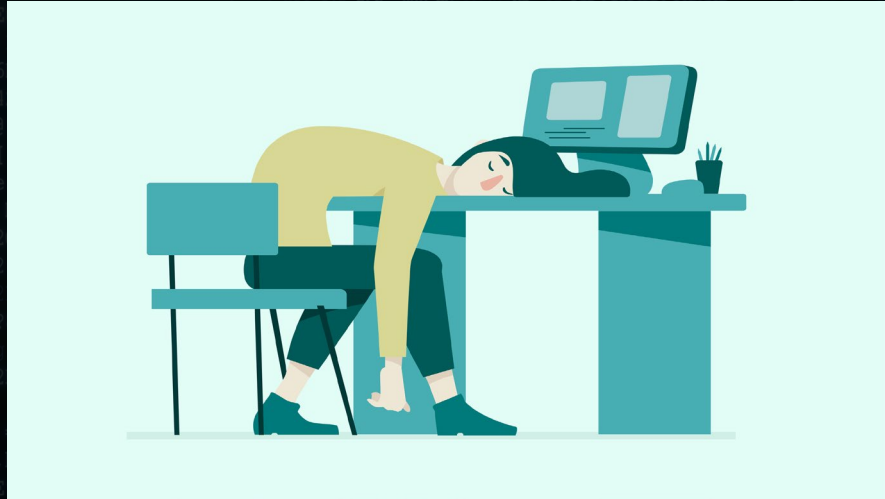
➤ ACOG
Antenatal
Record

Why did this work so well?

- Trends visible at a glance
- Spatial organization
- Cognitive aid, not just documentation
- The chart was the checklist



Pixels!



**More
information ≠ more
clarity!**

Information spread across tabs.

Copy forward errors.

Documentation burden, or "the feeding and watering of the EHR."

Fear of stepping on others' toes in team-based care.

Fear of missing something!

We don't have any sort of standardized checklist there.

so are things missed all the time at [redacted] or does everyone just keep it in their brain? Or is it prompted within the chart?

No automatic chart prompts

I mean, I feel like it's more old school. They get their basics- prenatal panel, anatomy scan, 2hr, TDaP (most of the time), and GBS. People remember those. Other things get missed.

Old school paper charts had a list of everything, and you would just fill it all in

Oh right! I remember the ACOG form

But back then, we did one u/s at 20wk, and there was no NIPT/ Carrier Screen/ AFP, RSV or COVID vaccines. There was so much less to do!



exactly! You have just stated the central thesis of my presentation! There was AFP :-)

Delivered

Right?!???

Conversation with a colleague



So much
to do, so
little time

Staying organized

- ▶ Problem lists
- ▶ Checklists
- ▶ Clinical guidelines
- ▶ Prenatal records

**What organization tools does your clinic utilize? What works?
What doesn't? What do you need to change?
HOW are you going to change it?**

Problem Lists Matter

- ▶ Why?
 - Continuity
 - Communication
 - Risk management
 - Team-based care
 - Cognitive off-loading

Meet our patient: Brenda

- ▶ Brenda (she/her) is a 26 yo G4P1113 who presents to clinic today as a walk-in for a pregnancy test.
- ▶ LMP unknown, conceived while breastfeeding with no return of menses following birth 8 months ago. She missed her last depo.
- ▶ Brenda took a home pregnancy test last week after her mother suggested she might be pregnant due to symptoms of nausea, sensitivity to smells, significant fatigue and worsening HAs.
- ▶ Accepting of surprise pregnancy. Stable housing and supportive partner and family.
- ▶ Current sx's: N/V, migraines, spotting, fatigue, LLQ pain waxes and wanes x 2_days, worse with certain movements ie rolling over in bed

Brenda continued

- ▶ Brenda is a prior patient in your practice, so you have the following info already:
- ▶ Ob Hx:
2022 uncomplicated term NSVD 3372g
2023 1st T SAB, no complications (same FOC)
10/17/2025 36w2d twins, CS for PPRM with Baby A in transverse lie.
Delivery c/b PPH d/t uterine atony for which she received all the antihemorrhagics
and a blood transfusion.
Pregnancy c/b gHTN, elevated 1hGCT with normal 3hGTT and severe anemia which responded well to iron infusions. Pt had been unable to tolerate PO FeSO4.
New FOC.
- ▶ Gyn Hx:
Hx CT in G1
Has never had a pap

Brenda continued

Med/Surg Hx

- ▶ Pre-gravid BMI 28
- ▶ Hx asthma as a child, no current meds or s/s
- ▶ Hx migraines which have worsened in pregnancy. Has been Rxd sumatriptan in the past.
- ▶ Hx anemia
- ▶ Hx blood transfusion
- ▶ Hx LTCS

Fam Hx

- ▶ Mother and sister with DM2
- ▶ Mother with hx cervical cancer, doing well post treatment
- ▶ Brother with T21, thriving in an adult independent living facility
- ▶ Father with HTN

Brenda's Problem List

- ▶ Pregnancy of unknown gestational age
- ▶ LLQ pain
- ▶ Spotting in early preg
- ▶ Hx 1st T SAB
- ▶ NVP
- ▶ Hx asthma
- ▶ Hx CS
- ▶ Hx anemia
- ▶ Hx twins
- ▶ Hx PPH
- ▶ Hx blood transfusion
- ▶ Hx gHTN
- ▶ Elevated BP w/o diagnosis of HTN
- ▶ Short pregnancy interval
- ▶ Migraines
- ▶ FH Trisomy 21

Healthy ≠ Simple

What Brenda does NOT have

- ▶ Diabetes
- ▶ Known chronic hypertension
- ▶ Lupus
- ▶ Renal disease
- ▶ Major psychiatric illness
- ▶ Substance use disorder

What Brenda DOES have

- ▶ 15+ problem-list items

Modern maternity care...

Brenda

- ▶ 26 years old
- ▶ Healthy
- ▶ Stable housing
- ▶ Supportive family

Requires

- ▶ Management of 15+ active issues
- ▶ 4 trimesters of care
- ▶ Multiple screenings
- ▶ Vaccines
- ▶ Ultrasounds
- ▶ Labs
- ▶ Referrals and community support
- ▶ Postpartum follow-up

...is a thousand small details.

What's next for Brenda?

Initial OB vs. amenorrhea visit

- ▶ Why choose an amenorrhea visit?
Early Pregnancy Evaluation for bleeding and LLQ pain
 - Differential diagnosis
 - Ectopic**
 - Early pregnancy failure
 - Implantation bleeding
 - Vaginal infection
 - UTI
 - Round ligament/MSK pain
 - Workup
 - Labs
 - Ultrasound
 - Follow-up

Good News for Brenda! SIUP 7w3d.

Onward to Prenatal Care and Beyond

- ▶ Initial prenatal visit (1st T ideally)
 - Can be split into two visits,
 - **Intake** (with RN/MA/perinatal coordinator or provider)
 - **Exam**
- ▶ Monthly until 30w
- ▶ Every 2-3 weeks until 35w
- ▶ Weekly 36- 41w
- ▶ Additional visits as needed (ie, for high risk conditions, ANT as needed, etc)
- ▶ Alternative/reduced care models
 - Reduced: Clinically safe, but lower patient satisfaction.
 - Group Care (ie Centering Pregnancy): positively reviewed by patients and clinicians

What happens when

**Intake and
Initial Visit**



10-14w
(ASA, NIPT,
NT)



18-22w
(Anat US,
AFP, FM)



24-28w
(CBC, GCT,
RPR, TDaP,
Rho)



32w (breast
pump, RSV,
FMCs)



35-37w
(GBS,
position,
birth plan,
car seat,
peds)



Setting the Stage: The Initial Prenatal Visit

H&P

- Confirmation of pregnancy
- Dating
- History (Careful questioning)
- Exam
- 5P and depression screening (ie, EPDS)
- Labs
- Imaging
- ROI as appropriate
- Problem List!!

Education

- Education and Anticipatory guidance
- Safe meds list
- How to communicate with the clinic
- Warning/danger signs and how/where to seek urgent care
- Vaccines
- Oral Health
- Referrals
- Breastfeeding
- Contraception

Next Steps

- Follow-up
- Communication
- Systems
How to manage notification of abnormal labs or USs, Do you have a RN in your practice? Patient navigator? Patient messages? Patient portals?

Brenda's Initial Encounter(s)

- ▶ Dating and viability: done! Now 9w3d. Document dating criteria clearly in the chart.
- ▶ PE: FH, doptones? Possible at 9w. though most providers wait till 11-12w. Does she need another US?
- ▶ Offer pap if not done at amenorrhea visit.
- ▶ Labs: prenatal panel, baseline PreE labs b/c of gHTN (vs preexisting).
- ▶ Rx: PNV, Fe? LDA, B6/doxylamine, APAP
- ▶ Vax: flu, covid
- ▶ Breastfeeding twins, okay to continue?
- ▶ NVP
- ▶ Any education or resources needed?
- ▶ Referrals? Genetics, MFM, nutrition, lactation, PT?
- ▶ TOLAC counseling (higher risk d/t short pregnancy interval)

At Every Subsequent Visit

- ▶ Interval History
- ▶ How is mom? (VS, weight, bleeding, pain/contractions, PreE s/s, mental health, etc)
- ▶ How is baby? (fundal height, FHTs, FM p ~18w)
- ▶ Trimester/EGA-appropriate education
- ▶ To do:
 - Labs
 - USs
 - Referrals
 - Education

Key counseling and education: Trimester-appropriate!

- ▶ Nutrition
- ▶ Activity
- ▶ Physiological discomforts
- ▶ Danger/warning signs
- ▶ How to seek urgent care
- ▶ Fetal movement
- ▶ Vaccines
- ▶ Birth planning
- ▶ Support Systems
- ▶ Breastfeeding
- ▶ Contraception

Common Prenatal Concerns

Physiologic

- ▶ NVP
- ▶ Urinary frequency
- ▶ Mild anemia
- ▶ RLQ pain r/t RLP
- ▶ LLQ pain r/t constipation
- ▶ Mid back pain r/t MSK
- ▶ Leukorrhea
- ▶ Tension HA
- ▶ Labile emotions "baby blues"

Pathologic

- ▶ HG
- ▶ UTI/Pyelo
- ▶ Severe anemia
- ▶ RLQ pain r/t appy
- ▶ LLQ pain r/t, say, ovarian cyst
- ▶ Flank pain r/t pyelo
- ▶ Vaginitis discharge or ROM
- ▶ PreE HA or migraine
- ▶ PP depression

Recognizing abnormalities

- ▶ Fetal Growth
- ▶ Bleeding
- ▶ Pain
- ▶ Headache/PreE ssx
- ▶ Abnormal discharge
- ▶ Fever, flu-like s/s
- ▶ PTL/PPROM
- ▶ Fluid: oligo/poly
- ▶ Fetal movement
- ▶ Mood d/o
- ▶ HTN
- ▶ GDM
- ▶ Delayed PP Hemorrhage
- ▶ PP Depression/psychosis

Hypertensive disorders of pregnancy (HDP)

- ▶ Chronic hypertension
- ▶ Gestational hypertension
- ▶ Preeclampsia
 - Without severe features
 - With severe features
 - Superimposed
 - HELLP/atypical HELLP



Photo: University of Chicago Photographic Archive, Special Collections
Research Center, University of Chicago Library

Diabetes

- ▶ Preexisting (Type I or II): continue to manage per usual throughout pregnancy and beyond
- ▶ Gestational: Early 1hGCT (50g) if risk factors, 3hGTT (100g) if 1h failed.
 - A1GDM
 - A2GDM: insulin is preferred treatment. Metformin reasonable if pt declines insulin.
- ▶ If +GDM > postpartum 2h GTT (75g)
- ▶ Refer to nutrition.
- ▶ Additional USs (3rd T growth)
- ▶ Antenatal testing depending on glycemic control
- ▶ Induction plan depending on glycemic control

Preparing for birth and baby

- ▶ GBS
- ▶ Fetal position
- ▶ EFW
- ▶ Childbirth education
- ▶ S/s labor, precautions, when to go to hospital
- ▶ Birth plan
- ▶ Labor and PP support
- ▶ Breastfeeding
- ▶ Car seat
- ▶ FMLA/STD
- ▶ Pediatric care



The Fourth Trimester

Physical
Recovery

Feeding

Psychosocial
support

Mood

Family
Planning

Matrescence

Matrescence

"Matrescence is a term that describes the physical, emotional, and psychological transition a woman goes through when she becomes a mother. Much like adolescence marks the transition from childhood to adulthood, matrescence marks the transition to motherhood. This period is filled with growth, challenges, and a complete restructuring of your sense of self."

Postpartum Warning Signs

- ▶ Bleeding
- ▶ Pain
- ▶ Incision/laceration
- ▶ Infection
- ▶ Hypertension
- ▶ Infection
- ▶ DVT/PE
- ▶ Mood/IPV/SUD

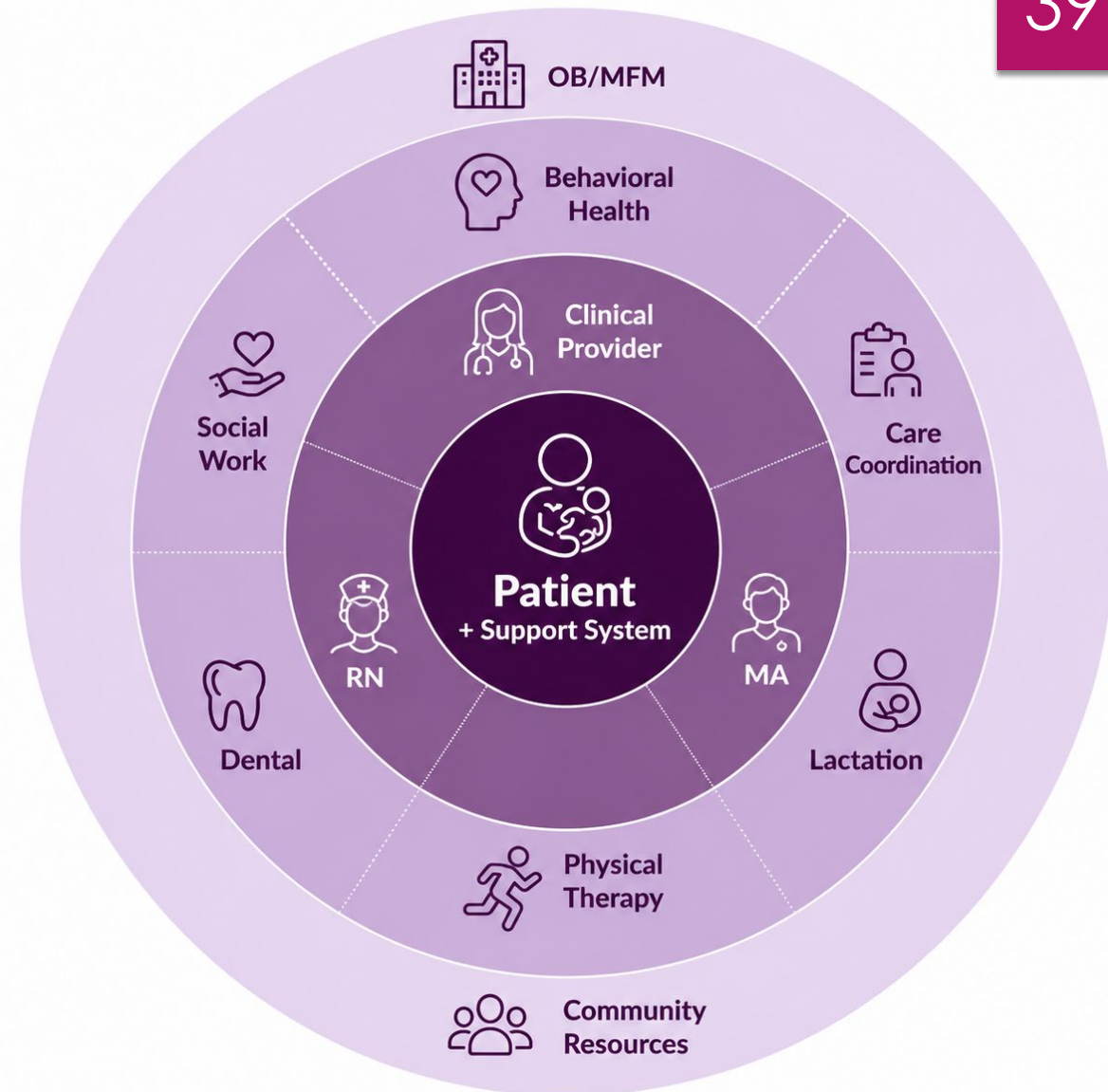


What does Brenda need postpartum?

- ▶ Brenda once again developed gHTN. A CS was scheduled but she went into spontaneous labor
- ▶ She had speedy and uncomplicated term NSVD upon arrival to the hospital
- ▶ Post-placental LNG-IUD was placed.
- ▶ Her twins had stopped breastfeeding soon after pregnancy was diagnosed, and she is breastfeeding her new baby without problems.
- ▶ She is feeling overwhelmed with her 3 other children, but FOC, sis and mom are helping as much as they can.
- ▶ She is concerned about finances and supporting her large family.

Maternal health care is a team sport

Safe maternity care happens when information, responsibility, and support are shared across the team.



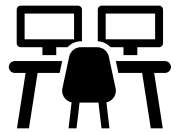
What I hope you will take back to your clinic

- ▶ Complexity is cumulative: it's not any one thing, it's all the things!
- ▶ Healthy patients are not necessarily simple patients.
- ▶ Use systems, not memory.
- ▶ Keep the problem list current.
- ▶ Share the work across the team.
- ▶ Build consultation and referral relationships before you need them.
- ▶ The goal is not a perfect problem list. The goal is a reliable system for managing complexity and providing safe patient care.

In closing



Questions?



Office hours:
July 1, 15, 29
12-12:30



Thank you!



References

1. Tailored Prenatal Care Delivery for Pregnant Individuals: ACOG Clinical Consensus No. 8. *Obstet Gynecol.* 2025 May 17;145(5):565-577. doi: 10.1097/AOG.0000000000005889. PMID: 40245426.
2. Rosen MG, Merkatz IR, Hill JG. Caring for our future: a report by the expert panel on the content of prenatal care. *Obstet Gynecol.* 1991 May;77(5):782-7. PMID: 2014096.
3. Linden K. Expanding the concept of safety in antenatal care provision. *Lancet.* 2021 Jul 3;398(10294):4-5. doi: 10.1016/S0140-6736(21)00785-6. PMID: 34217398; PMCID: PMC9755560.
4. Image courtesy of the Papyrus Carlsberg Collection, University of Copenhagen. Used for educational presentation purposes.
5. Martha Ballard Diary, 1785–1812. Reproduced from *Martha Ballard's Diary Online*, DoHistory.org. Accessed June 2026
6. Matrescence & The Lifetime Impact of Motherhood, Lauren Hays Psychiatric NP, PMHNP

Suggested further reading. See References handout for more!

- ▶ The Checklist Manifesto — Atul Gawande
- ▶ A Midwife's Tale — Laurel Thatcher Ulrich
- ▶ To Err Is Human — Institute of Medicine
- ▶ Mothershift: Reclaiming Motherhood As A Rite-of-Passage by Jessie Harrold
- ▶ Matrescence: On the Metamorphosis of Pregnancy, Childbirth and Motherhood - Lucy F. Jones



Thank you for joining us for the Maternal Health 101 Workshop!

To view the **event archive** of this and other past CHAMPS events, visit:

<http://champsonline.org/events-trainings/distance-learning/online-archived-champs-distance-learning-events>

To learn about other **upcoming CHAMPS events**, visit:

<http://champsonline.org/events-trainings/distance-learning/upcoming-live-distance-learning-events>

You must evaluate today's session to receive Continuing Medical Education (CME) Credits or a participation certificate. Attendees who request a certificate will receive them within two weeks of the survey's close.

The Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS) provided financial support for this program. The award totaled \$863,984 and provided 80% of total overall CHAMPS costs. The contents are those of the author(s). They may not reflect the policies of HRSA, HHS, or the U.S. Government.



Maternity Care 101 Workshop

CHAMPS

June 17, 2026

Problem List Examples

Utilize these to build best practice
problem lists/check lists/roadmaps for your clinical sites and states.

Example 1

Diverse patient population, mixed providers (OB, CNM, Fam Med) large medical center

Note: this is the long version. This practice has whittled their most-oft used problem list to just a few items given the strict requirements for CNM care eligibility. To-do's are prompted from within the visit notes, a good example of utilization of the EHR to keep track of "all the things."

*** is a *** yo G***P*** @ (EGA) by ___

Pregnancy complicated by ***.

Blood Type: ___

Ab Screen: ___

Hgb: ___

Rub: ___

Hep B: ___

Gonorrhea: ___

Chlamydia: ___

HIV: ___

HgA1c: ___

Syphilis Screen: ___

Hep C: ___

Lead: ___

Pap: ___

HPV: ___

Urine Culture: ___

OB PE:

Pre-Gravid BMI: 19.53

Initial Labs

OB anatomy scan

5P Screening

Initial EPDS

The thought of harming myself has occurred to me: ____

HITS total score: ____

Flu shot (seasonal)

COVID vaccine

If unvaccinated, measles IgG

10-12w:

Genetic testing

Low dose aspirin initiated

16-21w6d:

AFP (if late registrant or late anatomy scheduled)

24-28w:

Repeat EDPS

TDAP

Tubal ligation?

3rd Trimester Labs:

1hr GTT

3rd trimester CBC

3rd trimester Syphilis Screen

32w:

Breast pump ordered

RSV vaccine (seasonal)

35-37w:

Discuss car seat

GBS (results valid x 5w)

Cephalic by US?

Breastfeeding ____

PPBCM ____

WIC Status ____

NFP/Family Connects

Delivery plan: (Hospital, provider, TOLAC, CS, pain plan, etc)

Example 2

Midwifery practice within a large medical center with option for in-hospital birth center, staffs outside FQHCs

Note: this is the long version. This practice has whittled their most-oft used problem list to just a few items given the strict requirements for CNM care eligibility. To-do's are prompted from within the visit notes, a good example of utilization of the EHR to keep track of "all the things."

Pt offered 9 Visit Pathway for Prenatal Care []

[] new OB [] transfer of care @

[] Initials of 36 wk labs/Prenatal record review

Dating:

Baby:

FOB:

Labs:

@PRENATAL@

[] MBT/Ab [] Rubella [] Varicella [] Hep B [] HIV [] RPR

[] GC/CT [] UC

[] Pap [] hx of abnormal

[] H/H/Plts/MCV =

[] HgA1C/fasting BS =

[] Quantiferon/PPD

[] EDS =

[] 1st T screen/NT

[] SIS#2:

[] CF

[] Genetics consult

[] 2hr GTT

[] 3rd T hgb

[] GBS date [] Rpt

[] 36 wks presentation

Education:

[] CNM on-call#

[] Nutrition/Exercise

- MTM/Tour
- FMC
- CBE
- BF
- Newborn procedures
- Pediatrician-list given date:
- BCM
- Doula
- Med student/interns
- BC eligible
- Previous client

Vaccines:

- TdaP
- Flu

Example 3

Hospital-based CNM practice

TO DO:

Father of Baby: Baby:

Peds: Accepts blood transfusion:

Last ultrasound on:

New OB

Dating criteria:

Pre preg BMI >30 EKG. >35 Echo.

Aspirin risk:

OB labs, Rh status

Carrier screening labs

Noninvasive perinatal testing

NT scan

Pap

Quantiferon

1st tri LCSW

15-21 Weeks

AFP

Flu Vaccine

Covid Vaccine

18-22 Weeks

Anatomy Scan

Tour/CBE

2nd tri LCSW

26-28 Weeks

GDM Screen

3rd Tri labs (RPR, CBC)

28-32 Weeks

TDAP Vaccine

Family Planning/contraception info

32-34 Weeks

RSV Vaccine (Sept-Jan)

Breast pump

3rd tri LCSW

Has met all CNMs

36 Weeks

HSV prophylaxis indicated

GBS

Antenatal Testing indicated (BMI or age >35 -> 37wk, BMI or age 40 -> 34wk).

Pregnancy Disability

Last day of work: SDI at 36w0d until 6w0d postpartum, then PFL for an additional 8w0d

Postpartum Problem List Example

Pt is a __yo G__P__ at PPD # __ s/p __

Prenatal complication:

Birth complications:

EPDS:

Feeding:

Peds:

Contraception:

Pap:

Support:

Social determinants of health considerations:



Checklist and Roadmap of Care

Initial Steps

- Consult (consult welcome letter and service agreement)
- Mutually agree to work together
- Activate client portal (Client Care for BiB; Maternity Neighborhood for home birth)
- Complete history and intake
- Review agreements and consents
- Sign medical records release
- Medelelect Patient Advocate (VOB and claims options)

Initial visit

- Orientation to practice
- Visits (every 4-6w through 28w, every 2w 28-36w, every week till birth)
- Mutual expectations
- How to contact midwife
- Sign: Service Agreement, Informed Consent, HIPAA, Bill of Rights
- Insurance info
- Deposit (HB)
- Payment Plan

First Trimester

- Labs: PN panel (T&S, CBC, RPR, HBsAg, Rub), HIV, HCVab HgbA1c, FBS, Vit D, UC, GC/CT, VZV prn pap prn
- Genetic counseling/screening CPSP/NT NIPT CF carrier screening MSAFP
- Natera.com Call 888.476.5661 to schedule blood draw. Let the service know that they need a kit mailed to them or provided by the mobile phlebotomist. Service rep Emily Mortimer 858.344.9502
- Refer to MFM as needed
- Ultrasound
- Prenatal vitamins DHA/EFA Vit D Other supplements, probiotics
- Mother to Baby, teratogen information services, <http://mothertobaby.org/affiliates/article/california/california-home/>
- EPDS
- Dental letter
- Consult Plan

Education: miscarriage precautions and danger signs, nausea/vomiting (doxylamine/B6, diclegis, complementary tx), common discomforts, nutrition; cats, unpasteurized cheeses/foods, Zika, deli meats, hot tubs, CDC vaccine recommendations., exposures, safer meds, sexuality).

Websites (several include podcasts):

- www.avivaromm.com
- www.chriskresser.com
- www.evidencebasedbirth.com
- www.spinningbabies.com
- www.pregnantchicken.com
- www.kellymom.com
- www.balancedbreastfeeding.com

Books:

- All Natural, by Nathanael Johnson
- Mindful Birthing, by Nancy Bardacke
- Birthing from Within, by Pamela England
- How Big is a Placenta Bowl, by Renee Moilanen
- Essential Home Birth, by Jane E. Drichta
- The Birth Partner, by Penny Simkin

Second Trimester

- MSAFP
- Ultrasound
- Nutrition/hydration
- Dietary log
- Breast pump Rx (for Tricare: <http://www.tricare.mil/LifeEvents/Baby/NewbornWellBaby/BreastPumps>)
- Education: PTL, Pre-E, GTT.
- Vaccines (TDaP, flu)
- Classes: CBE, BF, Newborn, baby wearing, yoga/exercise, CPR.
- Doula

Third Trimester

- Labs: GTT, 3rd T CBC
- Abs and Rhogam prn
- Common discomforts (maternity belt ie: www.itsyoubabe, Serola SI belt (www.serola.net), belly wrapping (search YouTube)
- Fetal kick counts (www.countthekicks.org/how-to-count-kicks)
- Sleep (www.sleepwithmepodcast.com)
- Optimal fetal positioning (Spinning Babies, Body Balancing with Nicole Morales, belly wrapping)
- Stop fish oil 36w, resume postpartum
- Home visit 36w (home birth): organize supplies, plan set up, tub location, run through, when and how to contact midwife
- Car seat
- Postpartum instructions
- Door note "This home has a new baby"
- Birth Control
- PP meal prep, 1st week expectations and support
- Birth kit for home birth
- Birth certificate packet (home birth)
- Placenta Encapsulation
- Breastfeeding, lactation support
- Pediatrician
- Newborn procedures: eye abx, vit K, NBS, CCHD, HT (ie: www.besthearingsandiego.com), Hep B
- Circumcision
- Vit D
- Infant chiro/PT prn pp
- Education: PTL, Pre-E, GBS, Spinning Babies, doulas, indications for transfer, freezer meals, SDI, WIC, Labor and birth, when and how to call, latent and early phase variations, who will be present during labor and birth and what are the expectations of them? NB procedures, BCM)

Postdates

- Labor encouragement (castor oil, labor massage, acupuncture)
- ANT by 41+3w, transfer to hospital care at 42w if not in labor.
- "Ripening" herbs (ie, Dr. Christopher's or Wishgarden Labor Prep), EPO, red raspberry leaf tea, dates)

Emotional wellness

- EDPS
- Postpartum expectations and support
- Postpartum mood disorders
- Birthing from Within/Birth Story Medicine
- Therapist

Postpartum

- schedule pediatrician visit within the 1st week of life (discuss hearing test and Hep B)
- schedule appt at Vital Records for birth certificate (home birth)
- schedule hearing test
- 12 hour phone call
- 24-48 hour home visit (CCHD, NBS)
- 1-2 week home visit
- 4-6w postpartum visit at office
- Superbill/invoice/Medelect
- Client questionnaire
- Birth story/photos

Maternity Care 101 Workshop

CHAMPS

6/17/26

Case Study:

Brenda is a 26 yo G4P1113 presenting with pregnancy of unknown gestational age.

Unknown LMP, conceived while breastfeeding and with no return of menses following birth 8 months ago.

Missed last depo.

Took a home pregnancy test last week at mom's suggestion after experiencing new onset nausea, sensitivity to smells, significant fatigue and worsening HAs.

Accepted, surprise pregnancy. Supportive FOC and family.

C/o N/V, migraines, vaginal spotting, fatigue, LLQ pain x 2 days which comes and goes, worse with certain movements such as rolling over in bed.

Brenda is known to your practice, so you have the following info already.

History

Ob Hx:

-2022 uncomplicated term NSVD

-2023 8w SAB, no complications (same FOC)

-2025 36w2d twins, CS for PPRM with Baby A in transverse lie.

Delivery c/b PPH d/t uterine atony; received all the antiemetics, JADA, and a blood transfusion.

Preg c/b gHTN, elevated 1hGCT with normal 3hGTT and severe anemia which responded well to iron infusions. Pt had been unable to tolerate PO FeSO4. New FOC.

Current pregnancy, unplanned but accepted/wanted (same, supportive FOC, supportive mom and sister)

Gyn Hx:

Hx CT in G1

Has never had a pap

Med/Surg Hx:

-Pre-gravid BMI 28

-Hx asthma as a child, no current meds or s/s

-Hx migraines which have worsened in pregnancy. Has been Rxd sumatriptan in the past.

-Hx anemia

- Hx blood transfusion
- Hx LTCS

Fam Hx:

Mother and sister with DM2

Mother with hx cervical cancer, doing well post treatment

Brother with T21, thriving in an adult independent living facility

Father with HTN

Problem List

Pregnancy of unknown gestational age

LLQ pain

Spotting in early preg

Hx 1st T SAB

NVP

Hx asthma

Migraines

Hx CS

Hx anemia

Hx late preterm birth (twins)

Hx PPH

Hx blood transfusion

Hx gHTN

Elevated BP w/o diagnosis of HTN

Short pregnancy interval

FH Trisomy 21

1st encounter:

Amenorrhea visit vs Initial prenatal?

I would do an amenorrhea visit. Why?

Primary concern:

Confirmation of pregnancy (UPT)

Dating (careful questioning, fundal height, bimanual exam, doppler, US)

Location of preg: LLQ pain and spotting > Ectopic?

DDx ectopic, threatened AB, implantation spotting, constipation, RLP, UTI vaginal infection, ectropion, subchorionic hemorrhage, other?

Exam:

VS 141/84, repeat 126/70. VSS otherwise normal.

Spec exam to visualize cervix, bimanual exam (for those comfortable dating pregnancies by size).

On exam, cervix looks mildly erythematous, no abnormal discharge, malodor or active bleeding.

Uterus palpated barely enlarged.

Plan:

1. VS: what is your thinking about the initial elevated BP, especially in the setting of known hx gHTN. ***If this was a correctly taken BP, add to the problem list “Elevated BP w/o diagnosis of HTN”**
2. Labs: UPT, UA, T&S, CBC if concern for heavy bleeding or systemic infection Quants q 48h (if you believe <8w EGA), wet prep, GC/CT, UA
3. Wet prep
4. Imaging: US for location, dating and viability
5. Referrals: 1st T clinic if available and significant concern
6. Rxs: PNVs? ASA? B6/unisom or other antiemetic
7. Education: Threatened AB, ectopic, 1st T handout, physiologic s/s, N/V, breastfeeding while pregnant
8. F/u: prn until viability and dating established with strict return/ED precautions. Then, New OB visit.

Outcome:

- Viable SIUP @ 7w3d > schedule New OB. Change problem list to some variant of “Supervision of Pregnancy”

- +Clue cells on wet prep > ?treat. Arguably symptomatic based on spotting.

However, clue cells alone are not diagnostic of BV. Shared decision making with patient.

Initial OB (scheduled 2 weeks later)

Dating and viability: done. Now 9w3d. Document this clearly in the chart.

PE: FH, doptones? Possible at 9w. though most providers wait till 11-12w. Does she need another US?

Offer pap if not done at amenorrhea visit.

Labs: prenatal panel, baseline PreE labs b/c of gHTN (vs preexisting).

Rx: PNV, Fe? LDA, B6/doxylamine, APAP

Vax: flu, covid

Follow-up/next visit

Education:

Breastfeeding?

NVP

Resources?

Referrals? Genetics, MFM, nutrition, lactation, PT

TOLAC counseling (higher risk d/t short pregnancy interval)

Ongoing Care

Q4-6w so

~14w. (Can order NIPT now for after 10w, if desired by pt)

~18w

Anat US 20-22w

~22w

~26w 1hgct, CBC, syphilis

~30w (TOLAC counseling, BTL counseling)

~32, 34, 36 (GBS), 37, 38, 39, 40

~IOL 41w

Postpartum: 2w optional (TH or in person), 6w for everyone

Continue to update the problem list. Keep it clean and tidy so things don't get lost in the shuffle.

Fast forward:

Brenda had an essentially uncomplicated prenatal course.

Mild anemia: Brenda worked with a nutritionist and took Slow Fe PO.

Elevated 1hGCT with nml 3hGTT.

However, at 36w she once again she developed gHTN without PreE. A repeat CS was scheduled at 37w due to short interval pregnancy with recent CS, but she went into labor spontaneously and had a pretty fast and uncomplicated NSVD shortly after presenting in labor to the hospital. QBL was 375. A post-placental LNG-IUD was placed.

Brenda and baby are breastfeeding without difficulty and enjoying bonding with FOC and family.

PP considerations and plan:

Family Connects

Lactation

Contraception: would recommend LARC or BTL

Check IUD strings, trim if necessary.

Pap if not done during pregnancy.

WIC/SNAP

Financial assistance

Clean up the problem list.

Add some variant of “Postpartum Care”

Resolve “Pregnancy Episode” at the 6w PP visit.

What else?