Health system engagement plummets soon after childbirth in the US. Under current care practices, obstetric clinicians deliver a single postpartum visit within 12 weeks of delivery, after which patients are responsible for navigating the transition to primary care on their own. This abrupt end of routine care has been termed the postpartum cliff. In the current study, Clapp et al share the results of a randomized clinical trial designed to facilitate the transition from postpartum to primary care. The trial included patients with a current primary care practitioner and a condition indicative of continuing care needs (obesity, anxiety, depressive mood disorder, diabetes, or hypertension). Those randomized to the intervention group received default, opt-out scheduling of postpartum-to-primary care appointments, tailored messages emphasizing the value of primary care, and appointment reminders. Clapp et al found that this intervention increased the use of primary care within 4 months postpartum by 18.7 percentage points, a nearly 2-fold increase over the control group.

What caused this increase in primary care use? Clapp et al suggest that many postpartum people would like to receive ongoing care after delivery but face multiple barriers to engagement, including time constraints, limited knowledge of how to schedule an appointment with their primary care practitioner, and deprioritization of their personal health needs while caring for a newborn. Past research has shown that patients attribute delayed or forgone health care to burdensome administrative tasks roughly as often as to costs, with appointment seeking accounting for the greatest share of delays. By eliminating this administrative burden and introducing behavioral nudges to promote visit attendance, the intervention of Clapp et al successfully increased primary care use during the early postpartum period.

Interventions such as this could elevate the impact of recent state and federal policies designed to increase postpartum care continuity, including the postpartum Medicaid coverage extensions. Through the American Rescue Plan Act of 2021, states were granted the option to provide 12 months of continuous Medicaid coverage to low-income postpartum people—an increase from the formerly provided 2 months of coverage. This option was made permanent in 2023 and has been implemented by 46 states as of May 2024. Researchers estimate that this policy could extend Medicaid coverage to 720,000 additional adults if implemented by all states. However, as noted by others, without better coordination of the handoff between postpartum and primary care, we will not see the full value of extended Medicaid coverage. The findings of Clapp et al suggest that a relatively low-resource, scalable intervention including default scheduling of postpartum-to-primary care appointments and salient messaging could increase the use of primary care in the postpartum year to extend the effects of this policy.

Still, there is more work to be done to remove administrative barriers to care after delivery. While the intervention of Clapp et al nearly doubled the use of primary care within 4 months postpartum among the intervention group compared with the control group, primary care use remained low overall, with only 40.0% of the intervention group and 22.0% of the control group attending a visit. During the trial, study staff were unable to schedule a primary care visit for approximately 24% of the intervention group within 1 year of delivery, despite study participants having an identified primary care practitioner at the time of enrollment. Reasons the appointment could not be scheduled included the patient already having used their annual primary care visit, patients needing to reestablish care with their primary care clinician or identify a new clinician, study staff being unable to reach primary care offices for appointment scheduling, and primary care offices.
missing patient records or insurance information. Increasing the number of insurance-reimbursed primary care visits available to postpartum people with chronic conditions and providing patients with assistance establishing new connections with primary care practitioners might boost use.

Future work should also evaluate the differential effects of default scheduling of postpartum-to-primary care appointments within patient subgroups. While the trial of Clapp et al\textsuperscript{3} was not powered to detect differences between subgroups, their descriptive results suggest that there may be important differences in intervention efficacy by race and ethnicity, as well as health status. In particular, it would be valuable to assess the performance of this intervention among women with disabilities, as previous research has found that people with disabilities report greater administrative burdens related to health care seeking compared with people without disabilities.\textsuperscript{4} Overall, the trial by Clapp et al\textsuperscript{3} provides evidence that default scheduling of pregnancy-to-primary care appointments and tailored messaging is a promising step toward increasing care continuity during the postpartum year.

ARTICLE INFORMATION

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