Postpartum Visit is one of two universal Maternal and Child Health (MCH) **National Performance Measures (NPMs)** for the Title V MCH Services Block Grant to States Program. This NPM is focused on increasing the percent of women* who 1) attended a postpartum checkup within 12 weeks of giving birth; and 2) received recommended care components (health care provider talked to them about birth control methods and what to do if they felt depressed or anxious).

For Postpartum Visit, there are 16 evidence-based strategies from MCHbest and 4 field-based practices from Innovation Hub (see page 3)

The **What Works Evidence Accelerators** provide background information and a summary of effective strategies to advance each of the NPM topic areas. The strategies support increased postpartum visits by reducing financial and logistical barriers, eliminating discrimination, and educating providers and patients on the importance of timely postpartum preventive care that addresses physical, psychological, behavioral, and reproductive health needs. See also: Postpartum Contraception Use | Postpartum Mental Health Screening Accelerators.

Overview.

The postpartum period is a critical time for parents and infants, setting the stage for a lifetime of health and well-being.[1] Untreated chronic conditions and pregnancy-related complications increase the risk of severe maternal morbidity and mortality.[2,3] Data from Maternal Mortality Review Committees in 36 U.S. states show that more than half of pregnancy-related deaths occur between one week and one year postpartum; the majority of pregnancy-related deaths are preventable.[4] For this reason, it is important that those who have recently given birth receive a health checkup that allows a provider to assess their physical recovery; evaluate their mental health status; diagnose and treat any acute pregnancy-related issues; and manage chronic conditions, such as diabetes or hypertension.[5] A positive postnatal experience—where new parents receive the support, reassurance, and information they need within a culturally respectful context[6]—will increase the likelihood that they will continue to seek recommended health care in the future.

The American College of Obstetricians and Gynecologists (ACOG) recommends that everyone have contact with their maternal health provider within the first three weeks postpartum, followed by a comprehensive postpartum visit within 12 weeks after birth.[1] The follow-up appointment provides an opportunity to improve maternal health by offering screening, counseling, and health care services management that adheres to professional guidelines and national quality standards.[1,7,8] Family planning services, including contraceptive counseling, and preliminary screening for anxiety and depression are among the key components recommended.[1,7,9]

Optimizing care and support for postpartum women requires policy changes that view postpartum care as an ongoing process rather than an isolated checkup.[1] Systematic data collection efforts aligned with new guidelines for postpartum care are also needed to determine if a comprehensive postpartum visit has occurred and whether recommended services and counseling were received.[10]

Data Sources.

This NPM is measured through data collected from the Pregnancy Risk Assessment Monitoring System (PRAMS). In 2020, approximately 88% of mothers surveyed said they had received a postpartum health checkup.[11] These self-reported rates are higher than those gathered by health administrators, with those rates ranging anywhere from 24.9% to 96.5%, depending on the clinical setting, sociodemographic factors, and insurance status.[10] Postpartum care attendance among Medicaid recipients also varies widely, depending on the state.[12] Regardless of insurance status, the majority of postpartum women do not receive all recommended components of care, including contraception counseling and depression screening.[8,13]

Social Determinants of Health (SDOH).

Access to adequate perinatal and postpartum care varies as a result of the social, economic, and environmental conditions that influence individual health care experiences and outcomes. Factors such as low socioeconomic status, racial discrimination, cultural differences, lack of social support, lack of adequate health insurance, and poor anticipatory guidance contribute to disparities in postpartum visits and health outcomes.[9,14] Strategies to address SDOH and enhance postpartum care include:

- Training providers to deliver respectful, culturally appropriate care for a diverse population.[15,16]
- Supporting maternal care models that are person-centered, coordinated, and integrated.[15]
- Adopting policies to improve access to health coverage during the postnatal period.[15,16]

Health Equity. There are significant differences in the number of postpartum women who seek preventive care after giving birth. Those with limited resources,[17,18,19,20,21] those who do not attend prenatal care visits,[20,21,22] and those who perceived discrimination during childbirth[23] are also less likely to attend a postpartum visit.[13] The comprehensiveness of the visit also varies, with Medicaid-insured patients, rural residents, and racial minority groups less likely to receive contraception counseling and depression screening than urban white people with private insurance.[7]

Universal screening and standardized forms for postpartum care may counteract clinician and policy biases that affect perception and clinical care.[7] Payment incentives to allow providers the time to deliver comprehensive care and expanded use of telehealth to help overcome logistical barriers may also improve access to postpartum care and address disparities in the receipt of recommended care.[7,15]

Comprehensive Postpartum Care. In studies, women have noted that there is an intense focus on women's health prenatally but care during the postpartum period is infrequent and late.[1,24] ACOG states that the timing of postpartum visits should be individualized and woman centered.[1] An initial postpartum visit can occur within the first three weeks after birth or earlier for women with comorbidities and/or complications.[1,25] During the early postpartum period, providers were primarily concerned about complications such as infection and bleeding while women tended to be most concerned with issues such as pain and discomfort, fatigue, and emotional lability.[24,26] The most commonly provided components of postpartum care—depression screening and contraceptive counseling—have existing national quality standards, which are often tied to financial incentives.[7,8,27,28] Comprehensive postpartum care should also include discussions about physical recovery from birth; mood and emotional well-being; sexuality and birth spacing; sleep and fatigue; chronic disease management; health maintenance; and infant care and feeding.[1] With half of women reporting not receiving all the care they wanted and 30% reporting feeling rushed,[7,29,30] new mothers have multiple unmet clinical needs during the "fourth trimester."[24] A team-based approach among providers may improve the focus of clinical interactions to address the interrelated health issues most important to women as they recover physiologically and psychologically from birth.[24,25]

Key Resources. Effective strategies that increase access, extend coverage, and help ensure the continuity and quality of postpartum care continue to emerge. ACOG's Committee Opinion #736 outlines strategies aimed at providers and support personnel, while the Centers for Medicare and Medicaid Services (CMS) provides recommendations for maternal and infant health quality improvement (QI) in Medicaid. CMS' Improving Postpartum Care also highlights QI initiatives to increase and improve postpartum care.

Search the Established Evidence database for peer-reviewed research articles related to increasing postpartum visit attendance and receipt of care.

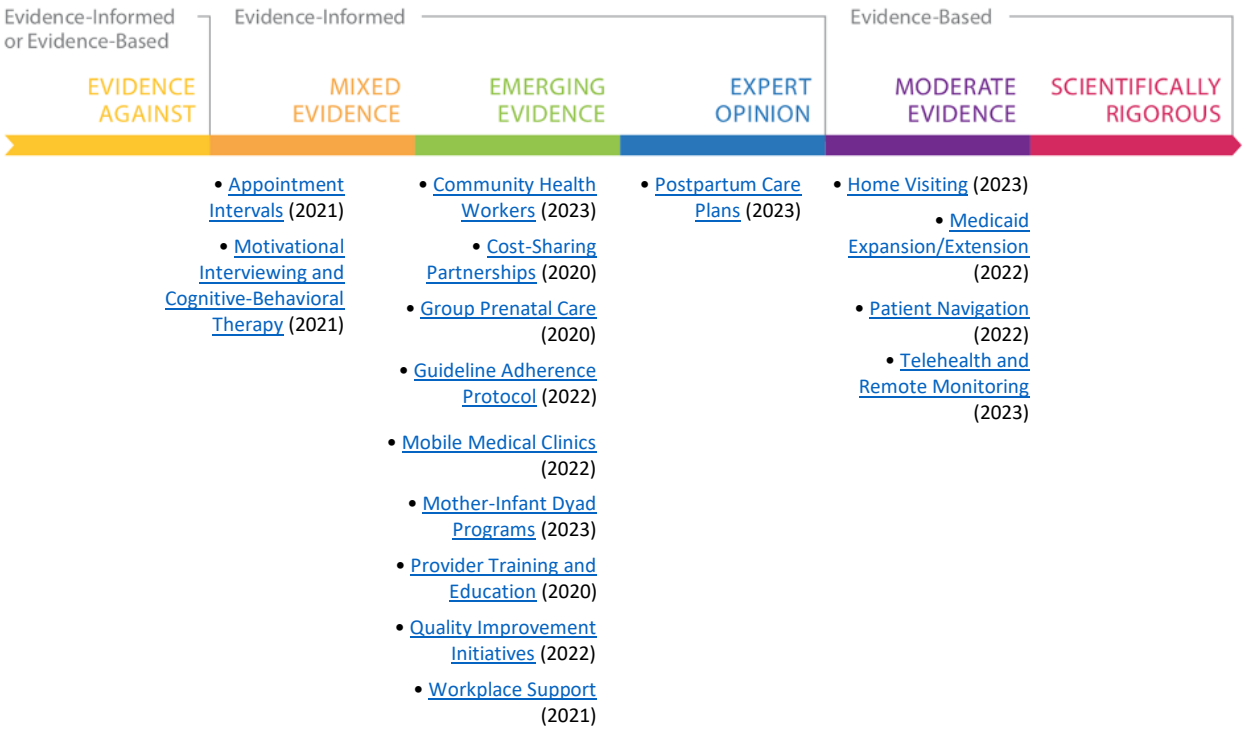
Find field-based resources focused on improving preventive postpartum care relevant to Title V programs in the MCH Digital Library.

Partnership and the Role of Title V. Title V agencies can support postpartum visits through:
Home Visiting Programs. Title V can support the expansion of home visiting programs that reach out to underserved pregnant and postpartum women. Home visitors can provide culturally-sensitive education to support the needs of mothers and emphasize the importance of postpartum care.[31-33]
Community Outreach. Title V can collaborate with community-based organizations to connect postpartum women to local support services, such as childcare and transportation, to reduce care gaps.[15]
Extended Postpartum Coverage. Title V can partner with Medicaid to simplify enrollment, unbundle postpartum visits, expand eligibility, and extend Medicaid coverage beyond 60 days postpartum.[15,27,34]

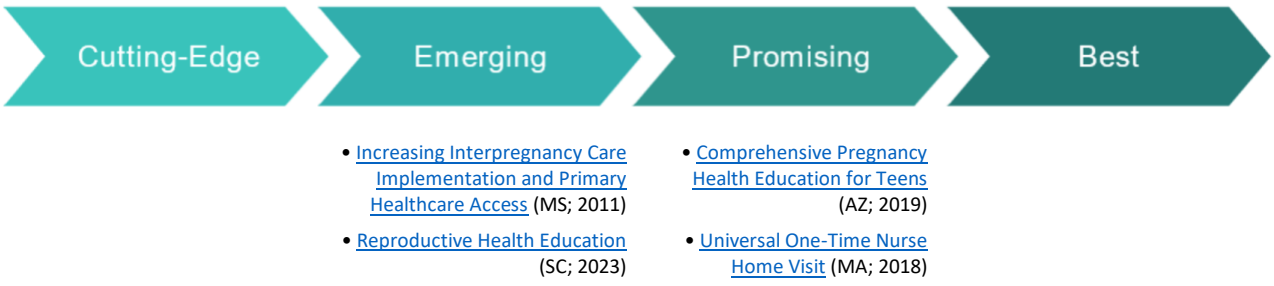
Postpartum Visit Strategies.

This page summarizes the latest strategies and practices that have emerged as potential approaches for increasing 1) the number of women who reported attending a postpartum visit within 12 weeks after giving birth; and 2) the number of women who reported attending a postpartum visit within 12 weeks and who received birth control counseling and were asked what to do if they felt anxious or depressed. It provides a framework to identify, understand, and implement "what works" in creating new Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

Evidence-Based/Informed Strategies. 16 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.



Field-Based Practices. 4 practices from state-/community-based programs have emerged as potential approaches for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program's (AMCHP's) Innovation Hub.



Key Findings.

The following are key findings emerging from the literature:

1. Appointment scheduling before hospital discharge can increase postpartum visit attendance, particularly for women with low incomes and limited English profiency.[35,36] After discharge, appointment reminders via text, email, or telephone are also effective.[37]
2. Community health workers (CHWs) can address SDOH and help reduce barriers by enhancing access to postpartum care, childcare support, transportation, and other community-support services.[38,39]
3. Policies that expand emergency Medicaid to include postpartum care or extend Medicaid to pregnant people beyond 60 days postpartum are likely to improve attendance rates.[40,41,42] A more generous paid family and medical leave policy also resulted in an increase in postpartum visit attendance, an increase in postpartum care among all women and women from underrepresented racial groups, and lower likelihood of postpartum depression symptoms.[43,44]
4. Home visiting programs—whether provided by a nurse, caseload midwife, or community health worker—increase the likelihood that new mothers will receive postpartum care.[39,45,46]
5. Adherence to postpartum care guidelines—including contraceptive counseling and screening for depression and anxiety—can be improved when providers use note templates and tools based on ACOG's Clinical Practice Guideline for Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum.[47,48]
6. Effective strategies that emerged during the COVID-19 pandemic include telehealth interventions, mobile medical clinics, and remote monitoring of postpartum patients diagnosed with hypertensive disorders of pregnancy.[49-54]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

- Utilizing data to inform policy, align postpartum care with a new standard, help to normalize concerns, address SDOH, and disaggregate health outcomes by race, ethnicity, and rurality.[27,55,56]
- Redesigning perinatal payment strategies in Medicaid to provide incentives for providers to perform postpartum checkups.[57]

Practice. The following tools can be used to translate evidence to action to advance this NPM:

- A Toolkit for Medicaid and CHIP Agencies (Medicaid) provides support to increase access, quality, and equity in postpartum care.
- New Mom Health (4th Trimester Project) provides postpartum health tools for mothers and providers.

Partnership. The following organizations focus efforts on increasing postpartum visits:

- The ACOG provides guidelines, patient education materials, and advocacy tools.
- The National Home Visiting Resource Center offers home visiting resources and technical assistance.

Frameworks and Tools for "What Works."

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help?

Contact us for training and technical assistance customized to your needs.

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* Note. Throughout this document, we use terms such as woman, women, and mother to describe people who have the biological capacity to become pregnant. We acknowledge that some pregnant and/or birthing people do not identify with these terms. However, we use these terms as a reflection of language used in the peer-reviewed research that predominantly refers to study participants as "women." Our findings are not meant to be exclusive of individuals who do not identify as female. Read more in NCEMCH's Gender Identity Statement.

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