Reducing Administrative Burden for Postpartum Individuals Accessing Primary Care in the United States

Sector(s): Health

J-PAL office: J-PAL North America

Location: Boston, Chelsea, Revere

Sample: 353 patients

Target group: Women and girls

Outcome of interest: Health outcomes Maternal health

Intervention type: Health care delivery

AEA RCT registration number: AEARCTR-0010071

Research Papers: Postpartum Primary Care Engagement Using Default Scheduling and Tailored Messag...

Partner organization(s): Massachusetts General Hospital

Individuals with chronic and mental health conditions typically have frequent contact with obstetrical care providers while pregnant but often are largely left to navigate ongoing care needs on their own after delivery—referred to as the 'postpartum cliff." Among other factors, this 'cliff' is caused by administrative burdens, such as appointment scheduling and navigating insurance, which make it difficult for individuals to seek care. Researchers at the Harvard School of Public Health and Massachusetts General Hospital evaluated the impact of auto-scheduling appointments with targeted messages and nudge reminders on primary care engagement within four months after delivery for postpartum individuals with diabetes, hypertension, mental illness, or obesity. Individuals who received this intervention were substantially more likely to have a primary care visit than those who did not, highlighting the potential of low-cost interventions to improve the transition of ongoing care needs after pregnancy to primary care clinicians.

Policy issue

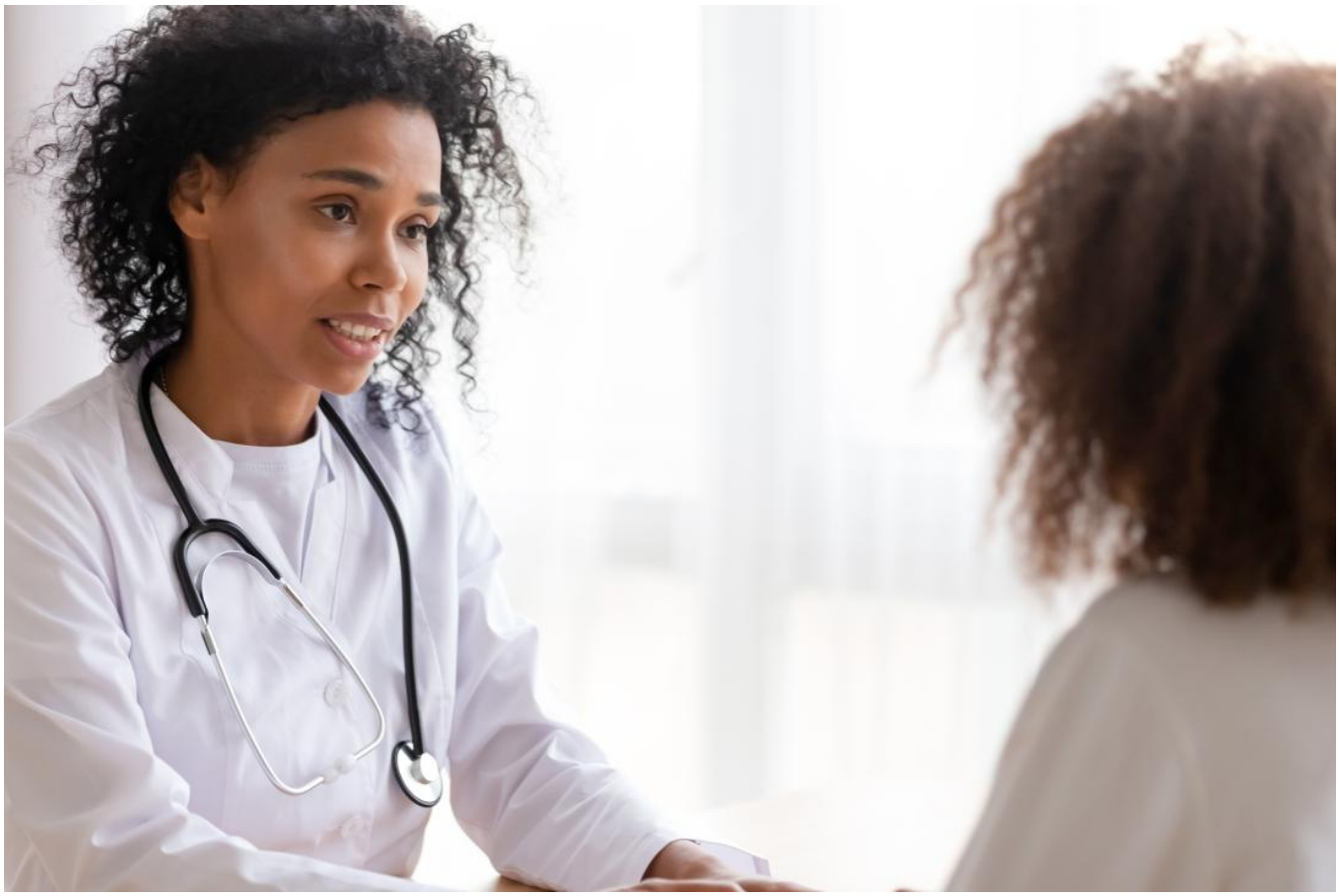
While pregnant, individuals are typically in frequent contact with health care providers and are monitored closely. However, after pregnancy, many individuals face financial and systemic barriers to continuing access to health care, leading to a "postpartum cliff" in health system engagement.[1] While many comorbidities complicating pregnancies (e.g. diabetes, hypertension and depression) require ongoing care following delivery, few individuals continue to receive the recommended care following delivery. Structural factors due to systemic racism, access to insurance, and geographic barriers to health care access can exacerbate these gaps in care for Black and Latino/a individuals and those living in rural areas.[2] As a large share of pregnancy-related mortality and morbidity occurs in the postpartum period, this "cliff" presents a missed opportunity to help address the maternal health crisis in the United States.[3]

In addition to financial and systemic barriers, administrative burdens, such as scheduling appointments, dealing with insurance, and finding relevant health care information, have increasingly been recognized as a potential barrier to receiving needed and recommended health care. For example, in a 2013 survey, one in four postpartum individuals delayed care due to an administrative burden.[4] The postpartum period exacerbates these burdens as individuals recover from childbirth and manage a

new, demanding lifestyle with a newborn. Can reducing administrative burdens increase patient engagement with primary care?

Context of the evaluation

This study occurred at a large hospital in Massachusetts and its affiliated clinics. Participants were all pregnant or recently postpartum patients who had or were at risk of having a chronic condition, including obesity, type 1 or type 2 diabetes, chronic hypertension, gestational diabetes, anxiety or depressive mood disorder, and those who were at risk for hypertensive pregnancy disorders. Given the many benefits of ongoing and active primary care when managing chronic conditions, follow-up care is particularly important among this population.[5] Roughly twenty percent of patients in the study were insured under Medicaid. In Massachusetts, those with pregnancy-related Medicaid coverage continue to be covered for twelve months after their due date.



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Details of the intervention

Researchers conducted a randomized evaluation to assess the impact of reducing administrative burdens through a bundle of interventions, including auto-scheduling appointments and reminders, on primary care physician (PCP) engagement for postpartum individuals with chronic conditions. All participants had a PCP listed in their medical record and were enrolled to receive messages through the hospital's electronic health record (EHR) system.

Each individual was randomized into one of two groups:

1. *Intervention group:* This group received a bundle of interventions intended to reduce administrative burdens. The intervention bundle was composed of an initial text message that highlighted the importance of visiting their PCP after

pregnancy and informed them that a study staff member would schedule an appointment (their "Pregnancy-to-Primary Care Transition Appointment") on their behalf. Participants could opt out of the appointment and provide scheduling preferences. For those who did not opt out, study staff scheduled an appointment within four months of each participant's estimated due date. The four-month window was chosen to take advantage of the habits individuals gained of regularly attending medical appointments while pregnant. The chronic conditions of participants also informed this decision, as having a health condition requires more PCP visits after the traditional twelve-week postpartum period. If someone already had an appointment scheduled, a new appointment was still scheduled for them as soon as they were next eligible (one year after their last annual appointment), even if this new appointment fell outside the four-month window. Appointment reminder messages highlighting the importance of a PCP visit were sent to all patients in the intervention group.

2. *Comparison group*: This group received a generic message two weeks after each individual's estimated delivery date that recommended they visit their PCP after delivery, similar to the information they are supposed to receive from their pregnancy care provider.

The main outcome of interest was if individuals completed an appointment for routine annual exams or chronic illness management within four months after their estimated due date. Unscheduled visits for sick child care unrelated to the individuals' chronic and gestational health conditions were not included in this main outcome. The researchers were also interested in how the intervention bundle affected specific primary care services participants received during PCP visits and urgent care visits. The primary care services included weight, mood, and blood pressure screenings and planning for diabetes, mental health care, and contraception. Unscheduled care visits included obstetric triage visits, emergency or urgent care usage, and postpartum readmissions.

Data was collected through both administrative record review and participant survey. Administrative data was collected through a review of patient medical records five months after each participant's estimated due date. The researchers also sent surveys electronically to all participants five months after their estimated due date.

Results and policy lessons

Participants who received the intervention bundle were more likely to attend a PCP appointment and receive specific primary care services than the comparison group. Participants who received the bundle also had fewer postpartum readmissions than the comparison group, although there was no significant difference between both groups in other types of unscheduled care outcomes.

PCP engagement

Based on medical record review, participants in the intervention group visited their PCP for a routine or chronic illness management appointment four months after their estimated due date 18.0 percentage points more than the comparison group (81.8 percent increase from a baseline of 22.0 percent).

Specific primary care services

Participants who received the intervention bundle were more likely to have a PCP visit that included screenings for weight, blood pressure, and mood. The intervention group individuals were also more likely to have PCP visits that included planning for their mental health or contraception usage. There was no significant difference in diabetes planning between both groups.

Unscheduled care

Participants in the intervention group were 4.1 percentage points less likely to have a postpartum readmission than the comparison group (a 70.0 percent decrease from a baseline of 5.8 percent). There was no significant difference between the

intervention and comparison groups in the number of obstetric visits or emergency/urgent care usage.

Policy implications

These effects demonstrate that auto-scheduling appointments and targeted reminder messages can reduce the administrative burdens associated with visiting a PCP. These low-cost interventions make it easier for postpartum individuals to have a PCP appointment and present a scalable method to increase PCP engagement and the monitoring of chronic physical and mental health conditions for postpartum individuals.

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