



Original Investigation | Obstetrics and Gynecology

Postpartum Primary Care Engagement and Acute Care Use Secondary Analysis of a Randomized Clinical Trial

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Abstract

IMPORTANCE Patients are often monitored closely during pregnancy, then face barriers to transitioning to primary care after delivery. These barriers may contribute to a reliance on acute care for primary care–treatable concerns.

OBJECTIVES To evaluate the association of an intervention that increased postpartum primary care engagement over the first year after delivery with overall acute care (emergency department [ED] and urgent care center [UC]) use and acute care use for primary care–treatable concerns (ie, nonemergency conditions or conditions typically managed by a primary care practitioner [PCP]).

DESIGN, SETTING, AND PARTICIPANTS This is a nonprespecified secondary analysis of a randomized clinical trial (RCT) conducted from November 3, 2022, to October 11, 2023, at 1 hospital-based clinic and 5 community-based obstetric clinics at a large academic medical center. The 353 participants included English- and Spanish-speaking pregnant or recently postpartum adults with 1 or more comorbidities and an assigned PCP.

EXPOSURE This behavioral science–informed intervention included default scheduling of postpartum PCP appointments within 4 months post partum and tailored messages and reminders about the appointments and the importance of postpartum primary care.

MAIN OUTCOME AND MEASURES Main outcomes included the use of any acute care and the number of acute care visits during the postpartum period, as well as the use of acute care and the number of visits specifically for primary care–treatable concerns (based on the reason for visit). Ordinary least-squares regression, adjusted for randomization strata and patient demographic and health characteristics, was used to assess the association of the intervention with the use of acute care. Outcomes were analyzed using an intent-to-treat approach.

RESULTS A total of 353 patients (mean [SD] age, 34.1 [4.9] years) were enrolled in the RCT (control, 173 [49.0%]; intervention, 180 [51.0%]). The intervention had no statistically significant association with overall postpartum acute care use, but it was associated with decreased acute care use for primary care–treatable concerns (control, 70 of 173 [40.5%]; intervention, 53 of 180 [29.4%]); in the adjusted model, the intervention was associated with a 10.2–percentage point reduction in these visits (95% CI, –20.4 to –0.04 percentage points). The intervention was also associated with a reduced number of visits for primary care–treatable concerns (control: mean [SD], 0.7 [1.1] visits; intervention: mean [SD], 0.4 [0.8] visits), corresponding to a reduction of 0.3 visits (95% CI, –0.5 to –0.1 visits) in the adjusted model.

CONCLUSIONS AND RELEVANCE In this secondary analysis of an RCT, a behavioral science–informed intervention that increased postpartum primary care engagement was associated with decreased acute care use for primary care–treatable concerns. The results suggest that supporting

(continued)

Key Points

Question Was a behavioral science–informed intervention that increased postpartum primary care engagement associated with acute care use?

Findings In this nonprespecified secondary analysis of a randomized clinical trial with 353 postpartum patients, a bundled intervention that included default primary care practitioner visit scheduling and tailored messages was not associated with reduced overall acute care use. However, it was associated with reduced acute care use for treatable concerns typically managed by a primary care practitioner by 10 percentage points and with a reduced number of visits for these concerns by 0.3 visits within 12 months post partum.

Meaning This study suggests that a bundled intervention encouraging postpartum primary care engagement could reduce postpartum acute care use for primary care treatable concerns.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

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Abstract (continued)

postpartum transitions to primary care may reduce reliance on acute care, perhaps by facilitating greater care coordination and early detection and management of chronic conditions in the primary care setting.

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Introduction

The postpartum year is a medically complex time during which patients often undergo physical and mental health challenges as they recover from pregnancy and childbirth.¹ However, due to barriers hindering their access to care—including, but not limited to, administrative burdens² and the demands of caring for a newborn³—many postpartum patients do not obtain postpartum primary care in an in-office setting. Not having access to or receiving primary care may contribute to postpartum patients' high emergency department (ED) utilization rate.⁴⁻¹⁰ High postpartum ED and urgent care center (UC) utilization rates for nonemergency care are not ideal for several reasons, including greater costs to patients and the health care system,¹¹ as well as fragmented, often lower-quality care.¹² Ineffective transitions to primary care after delivery could be a contributing factor to increased reliance on EDs and UCs after the immediate postpartum period; transitions to primary care have been shown to reduce acute care use in other patient settings.¹³⁻¹⁵

An earlier study showed that a behavioral economics-informed intervention that included facilitated postpartum primary care practitioner (PCP) appointments, patient messages on the importance of transitioning to primary care post partum, and appointment reminders increased postpartum primary care engagement by 18.0 percentage points in the intervention group.¹⁶ The intervention also increased the receipt of postpartum blood pressure, mood, and weight screenings. One year after the intervention, higher levels of PCP engagement persisted.¹⁷ The objective of this study was to assess the association between primary care engagement post partum and the use of acute care (ED and UC). We hypothesized that improved transitions to primary care after the postpartum period would be associated with lower overall acute care use and acute care use for primary care-treatable concerns.

Methods

This was a secondary analysis of a randomized clinical trial (RCT) designed to increase postpartum patients' engagement with primary care by reducing administrative burden and motivating continued health activation through an intervention based on insights from behavioral economics.¹⁶ This analysis was not prespecified in the trial protocol (Supplement 1). For patients randomized into the RCT's intervention group, a study staff member scheduled an annual or health maintenance appointment for the patient with the PCP listed in their electronic health record (EHR) within 4 months of their expected due date (EDD). Randomization into the RCT's intervention group did not depend on the patient's PCP being affiliated with the large academic medical center where the RCT took place; study staff members scheduled appointments for patients in the intervention group with their listed PCPs regardless of the PCP's affiliation. The intervention also included messaging patients about the importance of transitioning to primary care post partum and sending appointment reminders. Patients provided verbal consent to participate in the RCT and were compensated for their time with a \$20 Amazon or Starbucks gift card. Additional details related to the RCT's design are in the study by Clapp et al.¹⁶ The Mass General Brigham institutional review board approved this study. The Consolidated Standards of Reporting Trials (CONSORT) reporting guideline¹⁸ was

followed in reporting the RCT and its results; see eFigure 1 in Supplement 2 for the CONSORT diagram.

The study population included patients recruited from 1 hospital-based obstetric clinic and 5 community-based obstetric clinics affiliated with a large academic medical center from November 3, 2022, to October 11, 2023.¹⁶ At the time of recruitment, patients were pregnant or recently post partum, within 14 days of delivery, and had at least 1 of the following comorbidities: obesity (prepregnancy body mass index ≥ 30 [calculated as weight in kilograms divided by height in meters squared]), anxiety or depressive mood disorder, type 1 or 2 diabetes, chronic hypertension, gestational diabetes, or pregnancy-related hypertension. These patients were included because they were more likely to have ongoing health care needs during the postpartum year. Only patients with a PCP listed in their EHR were eligible for the study; the barriers to primary care reengagement postpartum differ from those of establishing care with a new PCP. The study was also limited to patients who were English or Spanish speaking.

Statistical Analysis

First, we assessed overall acute care use (any ED or UC use) within the first year post partum, which we considered to be any use within 12 months after a patient's EDD. Acute care use was assessed through EHR review. Any ED or UC use within the larger health system (not just the study institution) or its affiliated practices was observed via a common EHR. We do not observe acute care visits that occurred outside of the health system that were not captured through the EHR system record sharing. We examined acute care use as a binary variable and as the total number of postpartum ED and UC visits over the postpartum year. Due to sample size limitations, we were unable to examine ED and UC care separately; the original study was not designed to be powered to detect differences in ED and UC use.

We also assessed acute care use for primary care–treatable concerns within 12 months after a patient's EDD. Primary care–treatable concerns are nonemergency conditions or conditions typically managed by a PCP. When available, *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)* codes associated with the visits were ascertained; if the diagnosis codes were not known, and this was common, the primary presenting symptom was abstracted from the clinical documentation. Visits were categorized based on the primary presenting symptom using the Johns Hopkins University Revised/Expanded New York University Emergency Department Visit Classification Algorithm (hereafter, the *classification algorithm*).¹⁹ Specifically, we classified the visits into 1 of 2 categories: (1) primary care treatable (which included nonemergency issues and emergency, primary care–treatable issues) and (2) ED or UC required (which included preventable and not preventable issues that require acute care, such as injuries, psychiatric issues, and issues related to alcohol and drug use). Examples of visits classified as primary care treatable are acute pharyngitis, cough, headache, and rash. Classification was performed by the first author (A.G.) and validated by primary care physician coauthors (I.G. and A.R.). eTable 1 in Supplement 2 maps the ED and UC visit reasons to their associated classification algorithm category. We also examined any acute care use for primary care–treatable concerns (binary) and the number of acute care visits for primary care–treatable concerns.

We examined a series of patient socioeconomic and demographic characteristics. These included age (continuous), racial and ethnic group (Asian, Black, White, and other [American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander], including given known racial and ethnic disparities in maternal health outcomes), marital status, educational attainment (categorical), personal car ownership, prepregnancy physical and mental health status (measured using a 5 point Likert scale: excellent, very good, good, fair, poor), and having multiple comorbidities (measured using a binary variable equal to 1 if the patient had more than 1 of the study eligibility morbidity conditions), whether the patient had a PCP visit within 3 years prior to their EDD, and the primary site of their prenatal care (a hospital or community-based obstetric clinic). Racial and ethnic group, educational attainment, personal car ownership, and prepregnancy physical and mental health status

were self-reported at enrollment. Whether the patient had a PCP visit within 3 years prior to their EDD and the primary site of their prenatal care were stratification variables in the intervention randomization process and were defined a priori.

Cumulative acute care use (any use and the number of primary care–treatable visits) over the postpartum year for the intervention and control groups was plotted to visualize patterns in care seeking. Outcomes were analyzed using an intent-to-treat approach. We compared the above outcomes between the intervention and control groups using ordinary least-squares regression models with robust standard errors, controlling for the randomization strata and the patient characteristics of age, racial and ethnic group, marital status, educational attainment, personal car ownership, prepregnancy physical and mental health status, and having multiple comorbidities. Covariate adjustment was performed due to the known variation in acute care use based on socioeconomic and demographic characteristics.^{4,6}

To confirm the robustness of our findings, we repeated our analyses using logistic regression for our binary outcomes (any acute care use and any acute care use for primary care–treatable concerns) and Poisson regression for our count outcomes (number of acute care visits and number of visits for primary care–treatable concerns), both estimated with robust standard errors. Because the association of the intervention with acute care use could vary for different patient populations, we also performed separate, ordinary least-squares regressions for the following subgroups: (1) patients with commercial, private insurance; (2) patients insured by Medicaid; (3) patients with 1 chronic condition; (4) patients with more than 1 chronic condition; (5) patients who had a PCP visit within 3 years prior to their EDD, a group likely more connected with primary care; and (6) patients who received prenatal care at a hospital-based clinic. We included subgroups 5 and 6 in our analyses to assess if use varied based on the stratification variables used to randomize patients into the intervention.

Stata, version 19.5 (StataCorp LLC) was used for the analysis. All *P* values were from 2-sided tests and results were deemed statistically significant at *P* < .05.

Results

A total of 353 patients (mean [SD] age, 34.1 [4.9] years; 24 Asian [6.8%], 26 Black [7.4%], 242 White [68.6%], 53 other [15.0%], 8 declined to answer [2.3%]) were enrolled in the RCT (control, 173 [49.0%]; intervention, 180 [51.0%]) (Table). Patient characteristics were balanced across the intervention and control groups. Forty-one patients (11.6%) rated their prepregnancy physical health as fair or poor, while 69 patients (19.6%) rated their prepregnancy mental health as fair or poor. A total of 140 (39.7%) patients had 2 or more comorbidities. The most common comorbidities in the study population were anxiety and/or depression (266 [75.4%]), obesity (body mass index ≥ 30 ; 144 [40.8%]), chronic or gestational diabetes (69 [19.6%]), and hypertension (57 [16.2%]). Most patients (232 [65.7%]) had a PCP visit within 3 years prior to their EDD. A total of 250 patients (70.8%) received prenatal care from a hospital-based clinic and 103 (29.2%) received prenatal care from a community-based clinic.

The use of acute care increased steadily and substantially throughout the postpartum year for both the intervention and control groups (Figure 1A), with 72 of 173 patients (41.6%) in the control group and 65 of 180 patients (36.1%) in the intervention group having at least 1 UC or ED visit within the year. We found a similar pattern for the cumulative number of acute care visits for primary care–treatable concerns over this time period (Figure 1B); 70 of 173 patients (40.5%) in the control group and 53 of 180 patients (29.4%) in the intervention group had at least 1 acute care visit for a primary care–treatable concern by the end of the postpartum year. Of the 255 acute care visits, 197 (77.3%) addressed primary care–treatable concerns (nonemergency, 110 [43.1%]; and emergency, primary care–treatable, 87 [34.1%]; eFigure 2 in Supplement 2). The remaining 58 visits (22.7%) were for emergency concerns such as kidney stones and chest pain. Among patients in the control group, there were 145 postpartum acute care visits; 122 of the visits (84.1%) were for primary care–treatable

concerns (Figure 2). In comparison, in the intervention group there were 110 acute care visits and 75 (68.2%) were for primary care–treatable concerns.

In unadjusted and adjusted analyses, we found no statistically significant association of the intervention with overall acute care use (adjusted model, −4.8 percentage points; 95% CI, −15.1 to 5.5

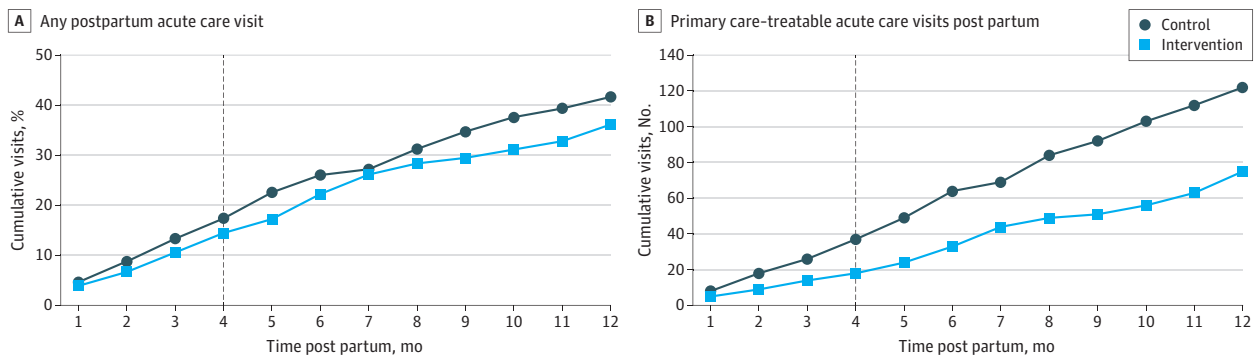
Table. Baseline Characteristics of the Analytical Sample

Characteristic	Patients, No. (%)		
	Full sample (N = 353)	Control (n = 173)	Intervention (n = 180)
Age at expected due date, mean (SD), y	34.1 (4.9)	34.0 (5.0)	34.2 (4.8)
Race and ethnicity (self-reported)			
Asian	24 (6.8)	13 (7.5)	11 (6.1)
Black	26 (7.4)	12 (6.9)	14 (7.8)
White	242 (68.6)	115 (66.5)	127 (70.6)
Other ^a	53 (15.0)	28 (16.2)	25 (13.9)
Declined or not reported	8 (2.3)	5 (2.9)	3 (1.7)
Marital status			
Married	242 (74.2)	125 (72.3)	137 (76.1)
Unmarried	111 (25.8)	48 (27.8)	43 (23.9)
Educational attainment			
Less than high school	16 (4.5)	9 (5.2)	7 (3.9)
High school graduate	36 (10.2)	21 (12.1)	15 (8.3)
Some college	33 (9.4)	11 (6.4)	22 (12.2)
Associate's or bachelor's degree	140 (39.7)	69 (39.9)	71 (39.4)
Graduate degree	128 (36.3)	63 (36.4)	65 (36.1)
Has a personal car	311 (88.1)	152 (87.9)	159 (88.3)
Self-reported mental health status (year before pregnancy)			
Excellent, very good, or good	284 (80.5)	136 (78.6)	148 (82.2)
Fair or poor	69 (19.6)	37 (21.4)	32 (17.8)
Self-reported physical health status (year before pregnancy)			
Excellent, very good, or good	312 (88.4)	151 (87.9)	161 (89.4)
Fair or poor	41 (11.6)	22 (12.7)	19 (10.6)
>1 Comorbidity	140 (39.7)	73 (42.2)	67 (37.2)
Primary site of prenatal care			
Hospital-based clinic	250 (70.8)	121 (69.9)	129 (71.7)
Community-based clinic	103 (29.2)	52 (30.1)	51 (28.3)
PCP visit within previous 3 y	232 (65.7)	121 (69.9)	111 (61.7)

Abbreviation: PCP, primary care practitioner.

^a Patients could select "other" as a race and ethnicity option if they did not identify as Asian, Black, or White. "Other" included American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander.

Figure 1. Line Graphs Showing Acute Care Utilization Over the First Year Post Partum Between Treatment Groups

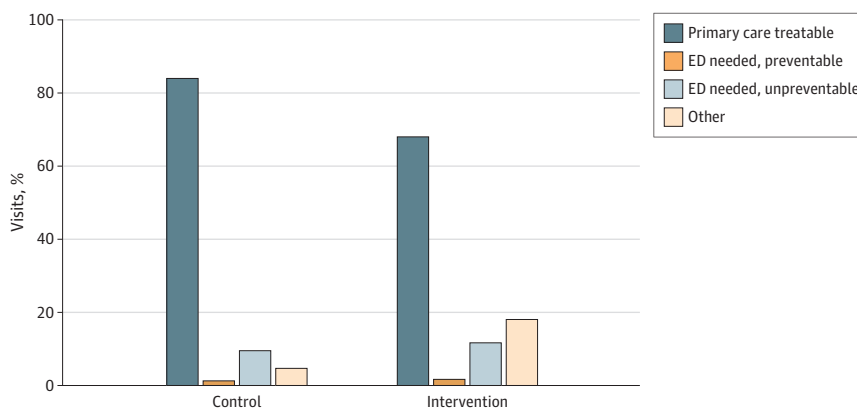


A, Any postpartum acute care visit (cumulative percentage). B, Cumulative number of primary care–treatable acute care visits post partum. The postpartum period is 12 months from the expected due date. The end of the primary study's intervention period (4 months after the expected due date) is represented by the vertical dashed line.

percentage points; $P = .36$) (Figure 3; eFigure 3 in Supplement 2) or with the overall number of acute care visits (adjusted model, -0.2 visits; 95% CI, -0.5 to 0.01 visits; $P = .06$) (Figure 4; eFigure 4 in Supplement 2). It is possible that the sample was underpowered to detect significant associations of the intervention with the overall number of acute care visits; this result is slightly over the threshold for statistical significance. However, the intervention was associated with a change in acute care use for primary care-treatable concerns by -10.2 percentage points (95% CI, -20.4 to -0.04 percentage points; $P = .049$) (Figure 3). The intervention was also associated with a reduced number of acute care visits for primary care-treatable concerns (control: mean [SD], 0.7 [1.1] visits; intervention: mean [SD], 0.4 [0.8] visits), corresponding to a reduction of 0.3 visits (95% CI, -0.5 to -0.1 visits; $P = .007$) (Figure 4). Unadjusted analyses for the other acute care use visit categories are reported in eTable 2 in Supplement 2.

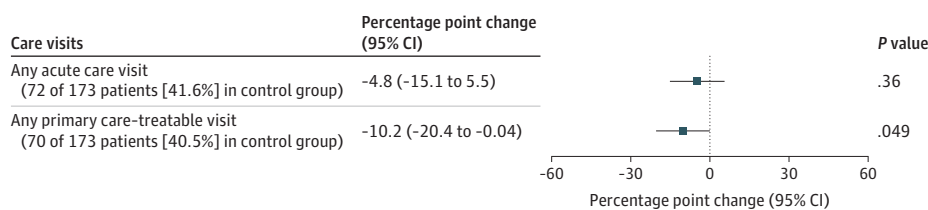
The results of logistic and Poisson regressions (eFigure 5 and eFigure 6 in Supplement 2) were qualitatively similar to that of the main results (Figure 3 and Figure 4). There was no statistically significant association between the intervention and overall acute care use (-4.2 percentage points; 95% CI, -14.1 to 5.7 percentage points; $P = .40$) (eFigure 5 in Supplement 2) or the overall number of acute care visits (0.2 visits; 95% CI, -0.47 to 0.02 visits; $P = .07$) (eFigure 6 in Supplement 2).

Figure 2. Bar Graph Showing Postpartum Acute Care Visit Classification Distribution



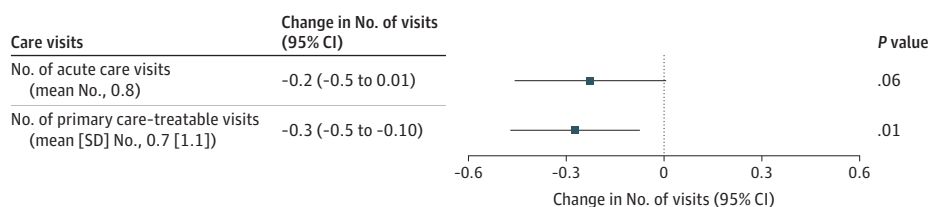
Primary care-treatable visits were visits that were classified as either (1) emergency, primary care-treatable or (2) nonemergency. Emergency department (ED) needed, preventable, and ED needed, unpreventable, were visits that required acute care and were classified as such using the algorithm. Visits classified as "other" were associated with 1 of the following categories: injury (nonsevere and severe), psychiatric, alcohol use, drug use, or were unknown from the electronic health record. There were 145 postpartum acute care visits among patients in the control group and 110 visits among patients in the intervention group.

Figure 3. Dot Plot Showing Regression Coefficient Estimates of the Association of the Intervention and Postpartum Acute Care Use (Binary Measures)



Ordinary least-squares regressions with robust standard errors were estimated. Patient socioeconomic and demographic characteristics and randomization strata were included in the model as covariates. Outcomes of interest are binary variables measuring if the patient had any emergency department or urgent care use post partum and if the patient used these settings for a primary care-treatable concern. *Post partum* refers to the 12 months after the patient's expected due date.

Figure 4. Dot Plot Showing Regression Coefficient Estimates of the Association of the Intervention and the Number of Postpartum Acute Care Visits (Count Measures)



Ordinary least-squares regressions with robust standard errors were estimated. Patient socioeconomic and demographic characteristics and randomization strata were included in the model as covariates. The outcomes are count variables: the number of emergency department and urgent care visits a patient had post partum and the number of postpartum visits they had in these settings to address a primary care-treatable concern. *Post partum* refers to the 12 months after the patient's expected due date.

However, as in the main results, we found that the intervention was associated with decreased acute care use for primary care–treatable concerns by 9.9 percentage points (95% CI, –19.5 to –0.4 percentage points; $P = .04$) and with a decreased number of acute care visits for primary care–treatable concerns by 0.3 visits (95% CI, –0.5 to –0.1 visits; $P = .01$). There was no statistically significant difference in care use among the following subgroups of interest: patients with commercial, private insurance; patients insured by Medicaid; patients with 1 chronic condition; patients with more than 1 chronic condition; patients who had a PCP visit within 3 years prior to their EDD; and patients who received prenatal care at a hospital-based clinic (eFigure 7 and eFigure 8 in Supplement 2).

Discussion

In this secondary analysis of an RCT, we found that a bundled intervention designed to increase primary care visits within the first 4 months after delivery was not associated with decreased overall acute care use; however, the intervention was associated with reduced acute care use and visit rates for primary care–treatable concerns by 10.2 percentage points (95% CI, –20.4 to –0.04 percentage points) over the first year post partum. This corresponded to a mean of 0.3 fewer visits (95% CI, –0.5 to –0.1 visits) to UCs and EDs for concerns that are generally managed outside an acute care facility.

The primary trial showed that this relatively simple bundled intervention increased primary care use by 18.7 percentage points in the first 4 months post partum¹⁶ and by 19.7 percentage points in the first year post partum.¹⁷ Our study builds on prior evidence linking primary care with reduced acute care use, showing that facilitated primary care transitions can benefit postpartum patients with complex health needs.^{13–15,20,21} Together, the findings of fewer visits for primary care–treatable concerns suggest that primary care visits during this vulnerable period may provide an opportunity for PCPs to manage patients' conditions so that they do not escalate, thereby avoiding the need for acute care. In addition, facilitated care transitions may also increase the likelihood that a patient seeks care from their PCP (either during the facilitated postpartum visit or through another touchpoint) instead of presenting at an ED or UC if they have recently seen their PCP for a routine visit.

Overall, acute care use was high in both groups (control group, 41.6%; vs intervention group, 36.1%) within the first year post partum, representing the ongoing health needs that individuals have beyond the first few weeks after their delivery. This analysis did not find that a facilitated transition was associated with reduced overall acute care use, which may be due to an inadequate sample size or reflect the medical complexity of our study's patient population (ie, all patients in our study had at least 1 preexisting comorbidity), which made it more likely that they would require unscheduled care post partum. Future work is needed to examine factors associated with acute care use in the postpartum period and their potential preventability.

Limitations

This study has several limitations. As previously mentioned, the original study was not designed to be powered to detect differences in postpartum ED and UC use. Due to the small sample size, we were unable to distinguish the association of the intervention with ED and UC use separately. We also did not observe the *ICD-10* codes associated with each patient's ED and UC visits if the visits occurred outside of the health system in which the RCT was conducted; instead, we used the ED and UC visit reasons reported in the patients' EHRs to classify the visits using the classification algorithm. However, it has been shown that *ICD*-based classification algorithms' assignment of primary care–treatable concerns does not correspond to Emergency Severity Index triage system severity classifications.²² Therefore, using reported visit reasons instead of *ICD-10* codes to classify acute care visits may be more appropriate in this setting. We also cannot observe acute care visits outside the health system that were not captured in the EHR system through record sharing, leading to

underreporting; however, we do not expect this to disproportionately affect 1 of the study groups. Last, some patient characteristics were self-reported (eg, race and ethnicity, health status) and ascertained at the time of enrollment; as there was universal completion of the enrollment survey for participants, there was no concern for reporting bias between the groups.

Conclusions

In this secondary analysis of an RCT, a behavioral science–informed intervention bundle designed to increase postpartum primary care engagement was associated with a reduction in acute care use for primary care–treatable concerns among patients with or at high risk for chronic conditions. Our results suggest that a facilitated primary care transition may be a useful strategy to increase overall primary care engagement and reduce reliance on emergency and urgent care. Future studies should focus on addressing whether facilitated primary care transitions can lead to improved health outcomes among postpartum patients with complex health needs.

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Author Contributions: Drs Gangaram and Clapp had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Drs Clapp and Cohen were joint contributors to this article.

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Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Gangaram, Bald.

Critical review of the manuscript for important intellectual content: Gangaram, Ganguli, Ray, Liang, Clapp, Cohen.

Statistical analysis: Gangaram, Bald, Clapp, Cohen.

Obtained funding: Clapp, Cohen.

Administrative, technical, or material support: Ray, Liang, Bald, Clapp.

Supervision: Cohen.

Conflict of Interest Disclosures: Dr Clapp reported holding equity in and serving on the scientific advisory board for Delfina Care; and receiving personal fees from Novocuff and the American College of Obstetricians and Gynecologists outside the submitted work. No other disclosures were reported.

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Data Sharing Statement: See Supplement 3.

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SUPPLEMENT 1.

Trial Protocol and Statistical Analysis Plan

SUPPLEMENT 2.

eTable 1. NYU-JHU Emergency Department Algorithm (EDA) Category Mapping to the Postpartum Emergency Department and Urgent Care Center Visits

eTable 2. Regression Coefficient Estimates of the Impact of the Intervention on Postpartum Acute Care Use (All Categories - Unadjusted)

eFigure 1. Postpartum Primary Care Engagement and Emergency Department and Urgent Care Center Use: Secondary Analysis of Randomized Clinical Trial

eFigure 2. ED and UC Postpartum Visit Classifications

eFigure 3. Regression Coefficient Estimates of the Impact of the Intervention on Postpartum Acute Care Use (Unadjusted)

eFigure 4. Regression Coefficient Estimates of the Impact of the Intervention on the Number of Postpartum Acute Care Visits (Unadjusted)

eFigure 5. Regression Coefficient Estimates of the Impact of the Intervention on Postpartum Acute Care Use (Logit)

eFigure 6. Regression Coefficient Estimates of the Impact of the Intervention on the Number of Postpartum Acute Care Visits (Poisson)

eFigure 7. Regression Coefficient Estimates of the Impact of the Intervention on Overall Postpartum Acute Care Use by Subgroup

eFigure 8. Regression Coefficient Estimates of the Impact of the Intervention on the Total Number of Postpartum Acute Care Visits by Subgroup

SUPPLEMENT 3.

Data Sharing Statement