Original Research

Primary Care Utilization Within 1 Year After a Facilitated Postpartum–to–Primary Care Transition

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OBJECTIVE: To evaluate the effect of a behavioral science–informed intervention designed to facilitate postpartum–to–primary care transitions on primary care visits and screenings within 1 year postpartum for individuals with chronic conditions or pregnancy conditions with long-term health risks.

METHODS: This was a planned secondary analysis of a randomized controlled trial of a behavioral science–informed intervention designed to increase primary care practitioner (PCP) visits within 4 months postpartum compared with routine care. The intervention included default PCP visit scheduling with nudge reminders and use of tailored language. The primary outcome for this secondary analysis was attending an annual examination or health care maintenance visit with a PCP within 1 year postpartum. Visits with a PCP for any reason and receipt of screenings or services by a PCP (eg, weight, blood pressure, mood screening) were also compared. Outcomes were compared between groups with χ^2 testing.

RESULTS: All 353 participants were followed through 1 year after their due dates: 173 in the control group and 180 in the intervention group. More patients in the intervention group attended an annual examination with a PCP within 1 year compared with the control group (59.0% vs 39.3%, $P<.001$) and had a PCP visit for any reason (72.8% vs 61.3%, $P=.02$). A significantly higher rate of mental health disorder screening was observed in the intervention group (63.9% vs 55.5%, $P=.046$); significant differences in other screenings were not observed.

CONCLUSION: This relatively simple and low-cost intervention designed to facilitate transition from postpartum to primary care within the first 4 months demonstrated benefits for PCP engagement within the first year postpartum.

CLINICAL TRIAL REGISTRATION: ClinicalTrials.gov, NCT05543265.

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Postpartum–to–primary care transitions are important for individuals with ongoing care needs after pregnancy, but there are many barriers

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to effective transitions in practice.[1–7] Previously, we demonstrated that a behavioral science–informed intervention, which consisted of default (opt-out) scheduling of primary care appointments, along with patient-directed tailored messages and nudge reminders, increases the percentage of postpartum individuals attending a primary care visit within 4 months postpartum by 18.7% compared with those receiving standard care.[8] It was also associated with increased receipt of recommended screenings and services by a primary care practitioner (PCP) such as blood pressure and mental health screenings.[8]

The evaluation of this intervention did not extend past the 4 months after delivery, and it is unknown whether the increase in primary care visits among the intervention group persisted when visits within the first year postpartum were examined. Thus, the primary objective of this study was to understand whether the intervention resulted in more individuals attending a primary care visit overall or, alternatively, simply shifted the timing of the first PCP visit after delivery to within 4 months among those who would have already attended a PCP visit within the upcoming year. Secondarily, our objective was to determine whether the intervention increased the receipt of routine screening and services by a PCP and if the intervention increased ongoing PCP engagement within the first year postpartum. We hypothesized that the intervention would increase PCP visits within the first year postpartum, increase receipt of PCP screenings and services, and increase ongoing PCP engagement.

METHODS

This was a planned secondary analysis of an individual-level randomized controlled trial of a behavioral science–informed intervention to improve the postpartum–to–primary care transition compared with routine care (NCT05543265) completed between November 2022 and October 2023.[8] Individuals were eligible if they had a chronic or pregnancy-related comorbidity with known long-term health risks, which included prepregnancy body mass index (BMI, calculated as weight in kilograms divided by height in meters squared) of 30 or higher, anxiety or depression, chronic or pregnancy-related hypertension, or preexisting or gestational diabetes mellitus. In addition, individuals had to have a PCP identified in the electronic health record (EHR) to be enrolled because this study was focused on re-establishing primary care; the intervention was not designed to find and establish care with a new PCP, as discussed in detail in the discussion of primary trial results.[8] Characteristics of patients enrolled in the primary trial, including race and ethnicity, are reported in the intervention and control groups to facilitate interpretation.

The intervention included the following components: 1) default scheduling of an annual examination with the patient's PCP within 4 months of a patient's estimated due date (EDD) or 1 year after their last annual examination if they had a recent annual examination, 2) salient labeling of the PCP appointment as the pregnancy–to–primary care transition appointment, 3) targeted language (eg, "appointment has been reserved for you"),and 4) nudge reminders for the appointment delivered through SMS and EHR messaging 2 weeks postpartum and at 4 weeks and 1 week before the appointment. Of note, the study scheduled only annual examination visits on a patient's behalf (as opposed to a follow-up or "problem" visit) because these visits are recommended annually and offered without cost sharing. In communications, patients were instructed to contact their PCP's office or research staff to cancel or change the appointment if necessary. The control group received routine pregnancy and postpartum care. Complete details of the original trial and the intervention have previously been published.[8]

The primary outcome in this secondary analysis was attending an annual examination by a PCP within 1 year after a patient's EDD. Practitioners classified as PCPs included physicians and advanced practice clinicians affiliated with the following medical specialties: internal medicine, family medicine, pediatrics and adolescent medicine, and gynecology. The clinical documentation from each PCP encounter was reviewed; visits were classified as an annual examination or health care maintenance visit if the terms appeared in the notes or encounter-specific affiliated diagnosis codes. We also examined PCP visits for any reason (ie, not limited to annual examinations).

We examined the time to the first PCP visit at two intervals: 0–4 months after the patient's EDD (the primary trial's follow-up period, when the majority of the intervention group participants had their appointment scheduled and received nudge reminders) and 5–12 months (the remaining months in the first year postpartum). As a measure of engagement with primary care, we compared PCP visit frequency between the two groups, categorized as no visits with PCP, one PCP visit, or two or more PCP visits. Finally, we examined the receipt of routine screenings and services by a PCP: weight

measurement, blood pressure assessment, mental health disorder screening, and documentation of a discussion or plan for diabetes screening and contraception.

All outcomes were compared between the two groups (intervention and usual care) with χ^2 tests. Although this was a preplanned secondary analysis, the primary trial was not specifically powered for the primary outcome of this secondary analysis. Sample size calculations for the primary trial were previously published.[8] As a sensitivity analysis, we limited the cohort to individuals whose PCP was affiliated with the same health system as where they received their obstetric care. This smaller group represents a cohort in which the likelihood was low that a patient attended a PCP visit that was not ascertained in the EHR review (ie, a PCP visit occurred at a clinic that is not integrated with the health system's EHR and thus was not observed during EHR review).

The STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) reporting guidelines were followed. The Mass General Brigham IRB reviewed and approved the original trial and its planned secondary analyses. Stata 16.1 was used for the statistical analyses. $P<.05$ was considered statistically significant.

RESULTS

All 353 participants in the primary trial were followed up through 1 year after their due dates: 173 in the control group and 180 in the intervention group. A comparison of patient demographics at the time of enrollment between the two groups is included in Table 1. Individuals had a mean±SD age of 34.1±4.9 years, and the distribution of self-reported races was as follows: 7.4% Asian, 6.8% Black, 15.0% multiple races or other, and 68.6% White; 2.3% declined to report their race. Overall, 75.8% had anxiety or depression, 15.9% had a chronic or pregnancy-related hypertensive disorder, 19.8% had preexisting or gestational diabetes mellitus, and 40.4% had a prepregnancy BMI of 30 or higher; some participants met more than one eligibility criterion. Medicaid was the primary payer for the delivery encounter for 21.9% of patients, and 93.2% attended a postpartum care visit between 4 and 8 weeks postpartum.

More patients in the intervention group received an annual examination with a PCP within 1 year compared with the control group (59.0% vs 39.3%, $P<.001$) (Table 2). Similarly, there was a significant increase in a primary care visit for any reason (72.8% vs 61.3%, $P=.02$). Findings were similar in the sensitivity analysis limiting the cohort to the group of patients with PCPs affiliated with the same health system (Table 2).

Figure 1 shows the timing of PCP visits for an annual examination (Fig. 1A) and visits for any reason with a PCP (Fig. 1B) in the overall cohort (solid lines) and in the subgroup of individuals whose PCP was in the same health system (dashed lines). The PCP visit rates were higher for the intervention group than the control group throughout the year postpartum, but the gap grew fastest within the first 0–4 months after delivery and then remained steady in the 5–12 months after delivery. When stratified by follow-up period, the rates of the annual examination with a PCP were 35.6% compared with 14.5% from 0 to 4 months ($P<.001$) and 23.9% compared with 24.9% ($P=.83$) from 5 to 12 months postpartum between the intervention and control group, respectively.

Figure 2A compares the receipt of common services and screenings with a PCP within 12 months postpartum. Those in the intervention group were more likely to receive mental health disorder screening than participants in the control group (63.9% vs 55.5%, $P=.046$); other services were numerically higher in the intervention group but not statistically different. Figure 2B shows the same comparisons in the subgroup analysis. Among individuals with PCPs within the same health system, those in the intervention group were more likely to have a blood pressure screening (79.5% vs 67.2%, $P=.03$), weight assessment (78.6% vs 65.6%, $P=.03$), and a mental health disorder screening (50.8% vs 65.0%, $P=.03$) and to have a documented plan about depression or mental health in the EHR (63.2% vs 47.5%, $P=.02$) than those in the control group.

Engagement with a PCP was measured by comparing the number of PCP visits between the groups. The distribution of PCP visits between the two groups is shown in Table 2 for the overall cohort and for the sensitivity analysis. In the overall cohort, 67 individuals (37.2%) in the intervention group compared with 53 individuals (30.6%) in the control group had more than one PCP visit within 12 months postpartum ($P=.07$ for the comparison of the distribution of visits between the groups). In the sensitivity analysis including only participants with PCPs in the health system, 54 of 117 (46.2%) in the intervention group compared with 42 of 122 (34.4%) in the control group had more than one PCP visit ($P=.01$ for the comparison of the distribution of visits between the groups).

Table 1. Characteristics of Individuals in the Control and Intervention Groups at the Time of Enrollment

Characteristic	Control Group (n=173)	Intervention Group (n=180)
Patient age at EDD (y)	34.0±5.0	34.2±4.8
Primary site of prenatal care		
Hospital-based clinic	121 (69.9)	129 (71.7)
Community-based clinic	52 (30.1)	51 (28.3)
PCP visit within 3 y before enrollment	121 (69.9)	111 (61.7)
PCP affiliation		
PCP within health care system	122 (70.5)	117 (65.0)
Health condition		
Anxiety or depression	128 (74.0)	138 (76.7)
Chronic or gestational hypertensive disorder	26 (15.0)	31 (17.2)
Chronic or gestational diabetes mellitus	38 (22.0)	31 (17.2)
Obesity (prepregnancy BMI 30 or higher)	75 (43.4)	69 (38.3)
Race*		
Asian	13 (7.5)	11 (6.1)
Black	12 (6.9)	14 (7.8)
Multiple races or other†	28 (16.2)	25 (13.9)
White	115 (66.5)	127 (70.6)
Declined or not reported	5 (2.9)	3 (1.7)
Ethnicity*		
Hispanic	41 (23.7)	37 (20.6)
Non-Hispanic	127 (73.4)	139 (77.2)
Not reported	5 (2.9)	4 (2.2)
Preferred language*		
English	161 (93.1)	167 (92.8)
Spanish	12 (6.9)	13 (7.2)
Marital status*		
Married	125 (72.3)	137 (76.1)
Not married	48 (27.7)	43 (23.8)
Education*		
High school graduate or some high school	30 (17.3)	22 (12.2)
Some college	11 (6.4)	22 (12.2)
Bachelor's or Associate's degree	69 (39.9)	71 (39.4)
Graduate school degree	63 (36.4)	65 (36.1)
Individual annual earnings ($)*		
Less than 30,000	32 (18.5)	36 (20.0)
30,000–$74,999	37 (21.4)	55 (30.6)
75,000 or more	82 (47.4)	76 (42.2)
Not reported	22 (12.7)	13 (7.2)
Primary payer for delivery hospitalization		
Medicaid	40 (23.1)	35 (19.4)
Private or other	130 (75.1)	138 (76.7)
Unknown	3 (1.7)	7 (3.9)
Mode of delivery		
Vaginal	107 (61.9)	117 (65.0)
Cesarean	66 (38.2)	63 (35.0)
Preterm delivery	10 (5.8)	16 (8.9)
Attended obstetric postpartum care visit	163 (94.2)	166 (92.2)

EDD, estimated due date; PCP, primary care practitioner; BMI, body mass index.
Data are mean±SD or n (%) unless otherwise specified.
* Self-reported.
† Patients could select "other" as a race option if they did not self-identify with the other options: American Indian or Alaska Native, Asian, Black, Native Hawaiian or Other Pacific Islander, or White.

DISCUSSION

An intervention designed to facilitate the postpartum–to–primary care transition among individuals with chronic conditions resulted in higher rates of PCP annual visits and visits for any reason within the first year after delivery compared with routine postpartum care. This increase was driven largely by individuals in the intervention group reconnecting with a PCP

Table 2. Comparison of Primary Care Practitioner Visits for the Control and Intervention Groups Within 1 Year Postpartum

Outcome	Control Group	Intervention Group	*P*
Overall cohort	n=173	n=180	
Primary outcome			
Annual examination within 1 y	68 (39.3)	107 (59.4)	<.001
0–4 mo	25 (14.5)	64 (35.6)	<.001
5–12 mo	43 (24.9)	43 (23.9)	.83
Secondary outcomes			
Visit for any reason	106 (61.3)	131 (72.8)	.02
PCP engagement			
No visits	67 (38.7)	49 (27.2)	.07
1 visit	53 (30.6)	64 (35.6)	
2 or more visits	53 (30.6)	67 (37.2)	
Individuals with PCPs in the health system	n=122	n=117	
Primary outcome			
Annual examination within 1 y	60 (49.2)	85 (72.6)	<.001
0–4 mo	20 (16.4)	52 (44.4)	<.001
5–12 mo	40 (32.8)	33 (28.2)	.44
Secondary outcomes			
Visit for any reason	87 (71.3)	101 (86.3)	.005
PCP engagement			
No visits	35 (28.7)	16 (13.7)	.01
1 visit	45 (36.9)	47 (40.2)	
2 or more visits	42 (34.4)	54 (46.2)	

PCP, primary care practitioner.
Data are n (%) unless otherwise specified.

within the first 4 months postpartum, which is likely attributed to the components and design of the bundled intervention, including default scheduling of the PCP visit within 4 months, tailored messaging, and nudge reminders.[8] Patterns of primary care use between the groups were similar between 5 and 12 months postpartum.

Other studies have examined primary care utilization after pregnancy and interventions to improve care transitions. Multiple studies have examined the role of postpartum care navigators for individuals with risk factors or with specific conditions.[9–13] These programs have largely been effective in assisting patients in receiving recommended care after their delivery, although they can be resource intensive and thus may have limited scalability to a larger population. More similar to our study, Cameron et al[14] evaluated the effect of a referral scheduling pathway for patients with diabetes or hypertensive disorders and found an increase of 48.1% in attending a PCP visit in the first

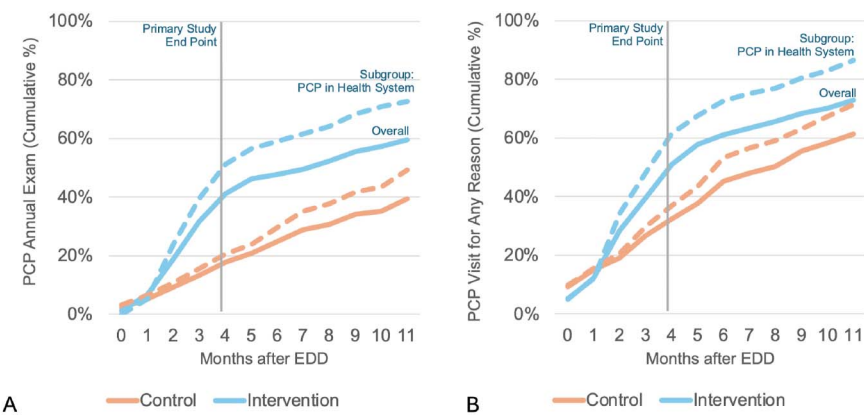

Fig. 1. Time to first primary care practitioner (PCP) visit within 12 months postpartum for the intervention and control groups. Annual visits (**A**) and visits for any reason (**B**). The cumulative distribution of annual visits (**A**) and visits for any reason with a PCP (**B**) are shown for the control (*orange lines*) and intervention (*blue lines*) groups for the overall cohort (*solid lines*) and the subgroup of individuals with PCPs affiliated with the same larger health care system as their obstetric practice (*dashed lines*). EDD, estimated due date.

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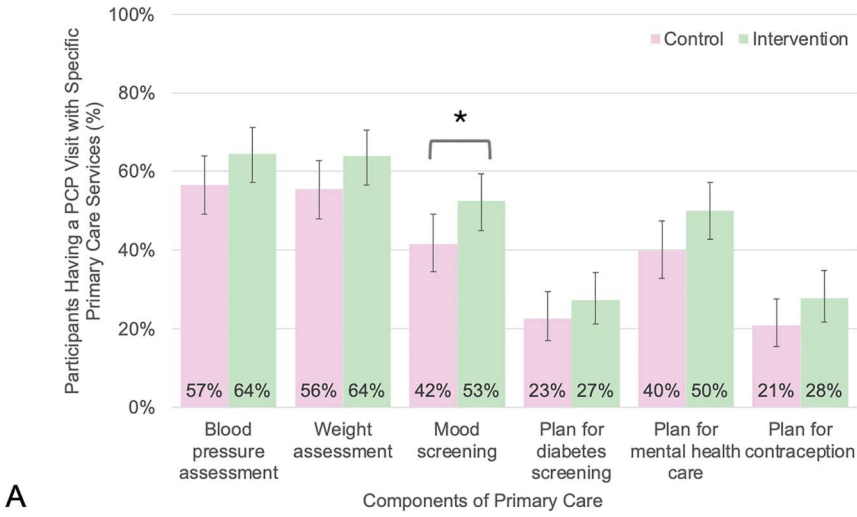

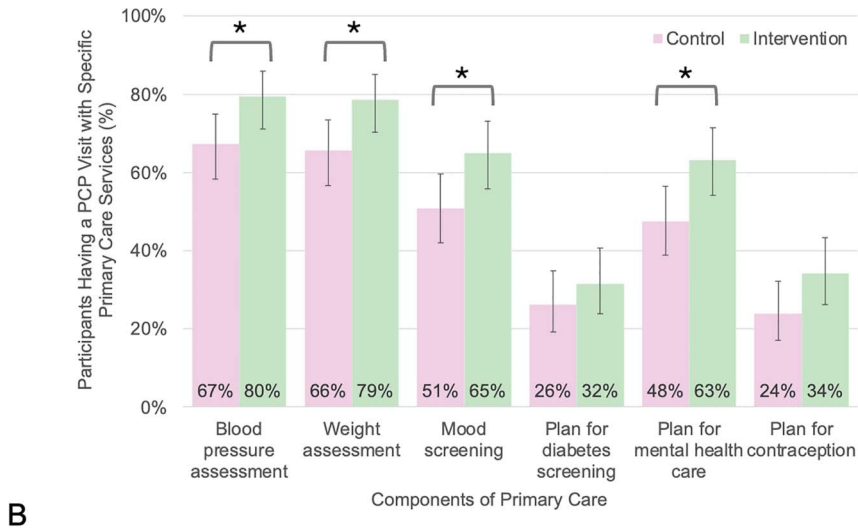

Fig. 2. Comparison of receipt of primary care services at a primary care practitioner (PCP) visit within 12 months postpartum for intervention and control group participants. Overall cohort (**A**) and subgroup (**B**). Components of primary care screenings and assessment for the intervention and control groups of the overall cohort (**A**) and the subgroup of individuals with PCPs affiliated with same larger health care system as their obstetric practice (**B**). *$P<.05$.

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year postpartum; this intervention used a team member to contact and schedule patients once referred by an obstetrician but did not provide reminders. The findings from the Cameron et al[14] study and our study highlight that the removal of administrative burden on patients may have a positive effect on primary care engagement while recognizing there are still unaddressed barriers in the highest-risk groups. Compared with health care navigators, a less resource-intensive intervention such as the bundle tested in this study may be a scalable solution to increase primary care engagement in the postpartum period.

Unlike in the primary analysis, which focused on the first 4 months postpartum, only the rate of mental health disorder screening by a PCP was significantly different between the intervention and control group over the full postpartum year, with other PCP screenings numerically, but not significantly, higher in the intervention arm. However, in the sensitivity analysis restricted to individuals with PCPs within the study health system–in which outcome ascertainment is strongest–we observed significantly higher rates of blood pressure, weight, and mental health screenings and documentation of a plan for mental health concerns or depression in the intervention group. This finding highlights that individuals generally receive these screenings as part of PCP visits for any reason, not just annual examinations. This study was not

designed or powered to measure the effect on longer-term health outcomes or the effect of attending an annual examination compared with a visit for another reason (eg, urgent visit for respiratory illness). This study also highlights that a significant share of individuals did not receive an annual visit within the 12 months after their pregnancy, highlighting the need for ongoing work and strategies to reduce barriers, catalyze increased health activation, and encourage ongoing care for chronic health conditions after pregnancy.

Although this was a planned secondary analysis of a randomized controlled trial that enrolled individuals at a large hospital and its outlying affiliated community clinics, the fixed sample size may limit the detection of true differences between the groups. The study did not require individuals to have a PCP within the same health system, which ultimately may have limited ascertainment of outcomes for individuals who did have a PCP visit outside the health system; thus, it is likely that the sensitivity analysis limited to individuals who have an affiliated PCP more accurately represent the rates of PCP visits.

In addition, several factors limit the generalizability of these findings. First, we excluded individuals without a PCP listed in the EHR because the administrative burdens associated with establishing care with a new PCP differ from the burdens associated reconnecting or transitioning back to an established PCP. Before the primary trial, our initial review demonstrated that more than 90% of patients had a PCP listed in the EHR; thus, only a minority were excluded from enrollment because of this stipulation. Of note, we did not require patients to have ever seen the listed PCP to be eligible, and some patients were unaware that they had an assigned PCP. Second, the majority of obstetric clinics default schedule a postpartum visit around 6 weeks. Thus, our population had high rates of obstetric postpartum visit attendance (more than 90%); however, similar rates are reported in the Pregnancy Risk Assessment Monitoring System survey on postpartum visit attendance.[15] Last, the study recruited from multiple sites, including community health centers, and provided all study materials in English and Spanish. However, because of the catchment area and size of the main obstetric clinic, there was a relatively high percentage of individuals who self-reported their race as White, were privately insured, and had a college degree. We acknowledge that the study was underpowered to examine subgroup-specific treatment effects; however, results from the primary trial show similar effect sizes in individuals who speak Spanish as a primary language, who have Medicaid insurance, and who report lower annual incomes.[8] Further work through a larger trial is underway to examine the intervention effects among at-risk populations, particularly those likely experiencing higher administrative burdens.

A relatively low-resource intervention designed to reduce patient administrative barriers and to facilitate an individual's transition from postpartum to primary care increased PCP visits within the first year postpartum. The intervention also showed signs of increasing ongoing engagement with primary care, as assessed by multiple visits with a PCP. Ongoing follow-up will be required to determine whether this type of facilitated transition improves health outcomes after pregnancy and sparks long-term engagement with primary care in individuals with conditions that are known to affect their lifelong health.

REFERENCES

1. Kyle MA, Frakt AB. Patient administrative burden in the US health care system. Health Serv Res 2021;56:755–65. doi: 10.1111/1475-6773.13861
2. Cohen JL, Daw JR. Postpartum cliffs-missed opportunities to promote maternal health in the United States. JAMA Health Forum 2021;2:e214164. doi: 10.1001/jamahealthforum.2021.4164
3. D'Amico R, Dalmacy D, Akinduro JA, Hyer M, Thung S, Mao S, et al. Patterns of postpartum primary care follow-up and diabetes-related care after diagnosis of gestational diabetes. JAMA Netw Open 2023;6:e2254765. doi: 10.1001/jamanetworkopen.2022.54765
4. Bellerose M, Rodriguez M, Vivier PM. A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. Health Serv Res 2022;57:775–85. doi: 10.1111/1475-6773.14008
5. Admon LK, Daw JR, Interrante JD, Ibrahim BB, Millette MJ, Kozhimannil KB. Rural and urban differences in insurance coverage at prepregnancy, birth, and postpartum. Obstet Gynecol 2023;141:570–81. doi: 10.1097/AOG.0000000000005081
6. Ruderman RS, Dahl EC, Williams BR, Davis K, Feinglass JM, Grobman WA, et al. Provider perspectives on barriers and facilitators to postpartum care for low-income individuals. Womens Health Rep (New Rochelle) 2021;2:254–62. doi: 10.1089/whr.2021.0009
7. Johnston EM, McMorrow S, Alvarez Caraveo C, Dubay L. Post-ACA, more than one-third of women with prenatal Medicaid remained uninsured before or after pregnancy. Health Aff (Millwood) 2021;40:571–8. doi: 10.1377/hlthaff.2020.01678
8. Clapp MA, Ray A, Liang P, James KE, Ganguli I, Cohen JL. Postpartum primary care engagement using default scheduling and tailored messaging: a randomized clinical trial. JAMA Netw Open 2024;7:e2422500. doi: 10.1001/jamanetworkopen.2024.22500
9. McKenney KM, Martinez NG, Yee LM. Patient navigation across the spectrum of women's health care in the United States. Am J Obstet Gynecol 2018;218:280–6. doi: 10.1016/j.ajog.2017.08.009

10. Schwartz J, Bocour A, Tang L, Pene F, Johnson N, Lazaroff J, et al. Telephone patient navigation increases follow-up hepatitis B care in the postpartum period for immigrants living in New York city. J Immigr Minor Health 2021;23:1179–86. doi: 10.1007/s10903-021-01240-5

11. Yee LM, Williams B, Green HM, Carmona-Barrera V, Diaz L, Davis K, et al. Bridging the postpartum gap: best practices for training of obstetrical patient navigators. Am J Obstet Gynecol 2021;225:138–52. doi: 10.1016/j.ajog.2021.03.038

12. Green HM, Carmona-Barrera V, Diaz L, Yeh C, Williams B, Davis K, et al. Implementation of postpartum navigation for low-income individuals at an urban academic medical center. PLoS One 2023;18:e0282048. doi: 10.1371/journal.pone.0282048

13. Yee LM, Martinez NG, Nguyen AT, Hajjar N, Chen MJ, Simon MA. Using a patient navigator to improve postpartum care in an urban women's health clinic. Obstet Gynecol 2017;129:925–33. doi: 10.1097/AOG.0000000000001977

14. Cameron NA, Birdsell H, Niznik CM, Michon R, Donelan E, Yee LM, et al. An enhanced postpartum transition program to primary care. J Womens Health (Larchmt) 2024;33:1417–22. doi: 10.1089/jwh.2023.0465

15. Danilack VA, Brousseau EC, Paulo BA, Matteson KA, Clark MA. Characteristics of women without a postpartum checkup among PRAMS participants, 2009-2011. Matern Child Health J 2019;23:903–9. doi: 10.1007/s10995-018-02716-x

Authors' Data Sharing Statement

Will individual participant data be available (including data dictionaries)? *Yes.*

What data in particular will be shared? *Deidentified data from the primary trial will be publicly available through the Harvard Dataverse* (https://dataverse.harvard.edu/).

What other documents will be available? *Study protocol.*

When will data be available (start and end dates)? *Anticipated August 2026 or sooner, depending on completion of planned secondary analyses.*

By what access criteria will data be shared (including with whom, for what types of analyses, and by what mechanism)? *Data will be publicly available for research use in accordance with policies and guidelines established by the repository.*

PEER REVIEW HISTORY

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