The US maternal mortality rate rose to 32.9 per 100,000 live births in 2021, an 89% increase from 2018. For as long as maternal mortality has been measured, racial disparities have been stark and persistent: non-Hispanic Black women and birthing people are 3 to 4 times more likely than non-Hispanic White women to die from pregnancy-related causes. Although interventions to improve maternal health and reduce disparities have historically focused on pregnancy and childbirth, recent data show that the majority of pregnancy-related deaths occur in the year after birth, and more than 3 in 5 deaths are preventable.

The reconceptualization of the postpartum year as a period of high maternal health risk is driving rapid innovations across the health system. New models for postpartum health care delivery are being tested leveraging technology (eg, mobile health applications for remote patient monitoring, texts, or electronic health record reminders for screening and follow-up) and using health-system-based models (eg, medical home, patient navigation). Policy makers are also actively intervening. Half of states have adopted a new federal option to extend pregnancy Medicaid coverage from 60 days to 1 year post partum, and others are experimenting with initiatives such as expanding coverage for doulas and value-based payment for postpartum care. High-quality research on the success of these strategies is urgently needed to inform evidence-based policy and practice.

The timely systematic review conducted by Saldanha and colleagues analyzes published literature on one of the leading approaches aimed to improve postpartum health outcomes: health insurance expansion. The robust review includes 28 studies, yet the conclusions that can be drawn are severely limited by the outcomes measured. The majority of studies assessed only postpartum care visit attendance, an early postpartum outcome with unclear implications for maternal health. Health outcome measures were limited to a few studies that reported impacts on hospitalizations (a marker for an adverse event) and depressive symptoms, again in the early postpartum period. As the authors note, their review highlights the urgent need for more research on the impact of clinical and policy interventions on a broader array of postpartum outcomes.

Fulfilling this call for more research from Saldanha et al will require 2 significant developments. First, there is a need to clearly define the outcomes that ought to define the success of postpartum interventions. These may include maternal mortality, severe maternal morbidity, and postpartum readmissions, but the rarity of these events presents statistical power issues and fails to capture measures of the precursors to morbidity that could be intervened on. They also do not capture the patient-reported outcomes that postpartum people may value most (eg, well-being, physical function, pain, fatigue). Health care access and use outcomes need to extend beyond the traditional, single postpartum visit to capture the known challenges faced after birth such as transitions to primary and specialty care, and guideline-concordant follow-up for patients with specific conditions. Patient experiences should also be centered as key outcomes, including discrimination, mistreatment, respect, and satisfaction in health care settings. Beyond health and health care outcomes, social and economic outcomes (eg, housing stability, food security, and labor force participation) are important structural drivers of maternal health disparities and could be important metrics for the success of community-based and policy interventions. Moreover, it is critical that any
intervention for postpartum health also be evaluated on the extent to which it advances health equity across all of these outcome domains.

Once goals are clearly defined, a larger challenge lies in ensuring outcomes are captured using high-quality data and validated measures. The postpartum population has not been of historical public health, clinical, or policy focus. Although infant health is universally captured with birth certificate data, and prenatal risk factors are captured with the CDC Pregnancy Risk Assessment Monitoring System, there is no equivalent data infrastructure for monitoring outcomes in the postpartum year. There is also a dearth of validated instruments; for example, while measures of mistreatment⁶ and obstetric racism⁷ have been developed for intrapartum hospital care, corresponding measures do not exist for postpartum care. Existing administrative data sets such as insurance claims or electronic health records could be leveraged but will also require the development of validated measures of postpartum care use and quality in both inpatient and outpatient settings.

To improve maternal health after birth, we cannot simply rely on implementing existing evidence-based practice and policy. There is a dearth of research on the needs of the postpartum population and on the clinical, programmatic, and policy investments that will meaningfully drive improvements in postpartum health and health equity. Investments to advance measurement and data to support this research is urgently needed—just as sorely as investments in the interventions themselves—to ensure that implemented strategies are meeting their defined goals. If they are not, postpartum people deserve for us to chart a new course. If they are, we will need strong evidence to advocate for change and continued investment in the long-overlooked postpartum year, which is foundational not only for maternal health, but for the health of US children, families, and communities.

REFERENCES