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Bridging the Postpartum Gap in California

A Consensus Framework for Transitioning from Maternity Care to Primary Care During the Postpartum Year

PBGH California Quality Collaborative

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The Postpartum-Primary Care Transitions Package

This issue brief serves as a primer for all stakeholders, including clinicians, payers, policymakers and state partners, such as California Department of Public Health and the California Maternal Quality Care Collaborative (CMQCC). It describes the problem, the development approach and the framework's design.

The implementation guide supports clinical teams implementing the recommendations. It explains how to navigate the recommendations, interpret evidence grades, apply clinical modifiers and use the Minimum Viable Pathways in practice.

The clinical recommendations provide condition-specific implementation-ready recommendations for clinical and operational leads building workflows across maternity and primary care settings.

A NOTE ON LANGUAGE

In this brief, framework refers to the overall consensus model for postpartum-to-primary care transitions: its principles, roles, timing, handoff expectations and condition-specific pathways. Recommendations refers to the specific clinical and operational actions teams should take within that framework.

These recommendations define a shared default and minimum floor for care. They are not regulatory standards, rigid protocols or substitutes for clinician judgment, patient preference or local adaptation.

When used, minimum viable handoff refers to the core information and follow-up steps needed to support a safe transition from maternity care to primary care.

Executive Summary

Strengthening the transition from maternity to primary care represents one of the most actionable opportunities to improve maternal health in California. Over 50 percent of maternal deaths occur between 1 week and 12 months postpartum, driven largely by preventable cardiometabolic and behavioral health conditions.[6] Black women bear a disproportionate burden.[6] Despite Medi-Cal coverage now extending through the full postpartum year, primary care follow-up rates remain critically low.[2]

CQC convened the California Primary Care Postpartum Clinical Workgroup in 2025 to close this gap and define minimum recommendations for transitioning patients from maternity care to primary care during the extended postpartum period, defined as 12 weeks to 12 months, when cardiometabolic and behavioral health risks peak and longitudinal, whole-person care is most needed.[2] The framework focuses on four conditions that drive a significant proportion of postpartum morbidity and maternal mortality, and respond well to structured primary care follow-up: gestational diabetes, type 2 diabetes, hypertensive disorders of pregnancy, and perinatal mood and anxiety disorders.

The resulting framework establishes clear ownership between maternity and primary care teams, standardized transition timing anchored to the American College of Obstetricians and Gynecologists (ACOG) comprehensive postpartum visit,[3] a minimum viable handoff with a required data set and confirmation loop and condition-specific follow-up pathways. These recommendations reflect team-based care, adapt to local practice and draw from clinical evidence and workgroup consensus.

In California, more than half of maternal deaths occur between 1 week and 12 months postpartum

Introduction

This issue brief defines the minimum clinical recommendations needed to safely and consistently transition patients from maternity care to primary care during the postpartum year. It reflects 18 months of structured clinical consensus building and payer engagement to clarify primary care's role in improving postpartum outcomes and maternal health.

Too many patients are discharged from maternity care without a reliable connection to ongoing primary care, even when clinical risk persists well beyond the fourth trimester.[1] [2] Maternity care teams anchor care during the first 6 to 12 weeks postpartum, but many settings lack a standard process for transitioning patients into primary care after that period. Although national bodies, including ACOG and the U.S. Preventive Services Task Force (USPSTF), as well as California's Department of Health Care Services (DHCS) Birthing Care Pathway, call for earlier and more continuous primary care follow-up in the extended postpartum period, they offer limited direction on how primary care re-entry should occur after 12 weeks postpartum.[3] [4] [5] Primary care teams are well positioned to manage the chronic disease, behavioral health needs and long-term risks that drive morbidity and mortality during this period, yet they often do not receive the information, guidance or workflows needed to engage postpartum patients effectively. As a result, postpartum risk management often depends on patients, clinicians and practices navigating fragmented systems individually rather than through standard workflows.

In California, more than half of maternal deaths occur between 1 week and 12 months postpartum, driven largely by preventable cardiometabolic and behavioral health conditions.[6] Black women face the highest risk for cardiovascular disease in the first year postpartum and stand to benefit substantially from stronger postpartum primary care engagement.[7] Even though California extended Medi-Cal postpartum coverage from 60 days to 12 months in 2022, care models have not adapted to match the duration of risk or coverage.

Risk remains high well beyond the traditional postpartum care window. Among patients with preeclampsia, 42 to 50 percent develop persistent hypertension by one year postpartum[8] and women with hypertensive disorders of pregnancy are 4 to 7 times more likely to develop chronic hypertension within 12 months.[9] [10] After gestational diabetes, 5 to 10 percent of women develop type 2 diabetes within 6 to 12 months postpartum, with elevated risk persisting over time.[11] [12] [21]

Pregnancy complications have implications that extend beyond the postpartum year. Adverse pregnancy outcomes, including GDM and HDP, are associated with increased cardiovascular risk over the life course, with recent data suggesting that risk may rise as early as two years postpartum. [7] [18] [26] [27] Conditions identified during pregnancy and the postpartum period can mark the beginning of chronic disease trajectories that primary care will manage over decades, underscoring the importance of timely reentry into primary care as a bridge to long-term prevention.

Primary care is already measured, and increasingly paid, on many of the outcomes that drive postpartum morbidity, including depression follow-up, blood pressure control and diabetes management.[13] As primary care continues to shift toward value-based payment and the Office of Health Care Affordability (OHCA) advances accountability for total cost of care and key health outcomes, failing to adapt primary care models for postpartum populations will carry increasing clinical and financial consequences.

To address this gap, California Quality Collaborative (CQC) proposes actionable, clinically grounded recommendations for postpartum-to-primary care transitions. The recommendations focus on four conditions that drive substantial postpartum morbidity and respond to high-quality primary care follow-up: gestational diabetes (GDM), type 2 diabetes (T2D), hypertensive disorders of pregnancy (HDP), and maternal mental health disorders (MMH).

These recommendations establish:

- Role clarity between maternity and primary care teams
- Evidence-informed timing for primary care engagement
- Minimum data for safe transitions
- Condition-specific follow-up expectations based on risk
- Core clinical principles to guide care in the extended postpartum year

This framework is not an implementation plan and does not address payment, interoperability or system-wide adoption.

The Problem and Context

The Extended Postpartum Period

The extended postpartum period describes the 12 weeks to 12 months after childbirth when acute recovery has largely stabilized and longer-term cardiometabolic and mental health risks emerge.[14] This period includes:

- Elevated risk of progression from GDM to type 2 diabetes,[10] from HDP to chronic hypertension and cardiovascular disease[8] and from transient symptoms to clinically significant MMH disorders[15]
- A shift from maternity-specific recovery to whole-person, longitudinal risk management that aligns with primary care's core functions

National guidance defines core expectations for the fourth trimester—birth through 12 weeks postpartum—anchored by ACOG's recommended initial check-in by 3 weeks and comprehensive postpartum visit by 12 weeks.[2] No national body has defined how clinicians should structure care for the subsequent nine months, even though risk remains high for many patients.

These recommendations endorse establishing a unique Primary Care Postpartum Transition Visit (PTS), distinct from the annual well-woman visit. The PTS is a structured primary care visit that establishes proposed or re-establishes the patient in longitudinal, whole-person primary care and formally completes the transition from maternity care. The visit builds on the core elements of the annual well-woman visit by integrating pregnancy and postpartum history into the patient's ongoing primary care record; initiating condition-specific monitoring and risk management and confirming care ownership for the extended postpartum period and beyond. Timing is based on clinical need and ideally occurs between 12 weeks and 6 months postpartum.

THE EXTENDED POSTPARTUM PERIOD

12 WEEKS TO 12 MONTHS POSTPARTUM

Risk remains elevated

Cardiometabolic and behavioral health risks may emerge, persist or worsen.

Care needs shift

From maternity-focused recovery to whole-person, longitudinal care.

Guidance is limited

Structured follow-up after the comprehensive postpartum visit is not well defined.

This framework fills the gap

By defining clear clinical roles, transition timing, handoff expectations and condition-specific pathways.

The Role of Primary Care in Addressing the Postpartum Care Gap

In interviews conducted with stakeholders of the CQC payers and clinicians alike repeatedly described postpartum follow-up as "everyone's job." Maternity teams may expect primary care to take over cardiometabolic and behavioral health risk after the 6 to 12 weeks postpartum visit. Primary care teams often assume maternity clinicians will continue monitoring until stability is clear. Neither team receives shared expectations, standard workflows or reliable handoffs for the 12-week to 12-month period. High-risk patients move through a year of elevated risk without a clearly accountable clinical home.

This lack of ownership stands in sharp contrast to how primary care manages similar risks in other populations. Primary care teams track A1C, blood pressure, depression screening and cardiovascular risk. They build registries, use team-based outreach and close gaps between visits. Payers measure performance through value-based arrangements and quality measures.

The framework defines a shared default and a minimum floor for safe transitions that teams can adapt based on local capacity, clinical judgment and patient preference.

Postpartum patients with GDM, HDP or MMH disorders rarely benefit from those same structures, even though they face comparable risk. Many patients with GDM never see a primary care clinician within the first year,[16] despite evidence that early engagement identifies persistent dysglycemia and opens a prevention window for type 2 diabetes.[17] Many patients with HDP miss systematic blood pressure monitoring and cardiovascular risk assessment in primary care, even as plans routinely measure those activities for nonpregnant adults.

By naming primary care as a usual owner for the extended postpartum period and defining minimum expectations for a structured handoff, this framework brings postpartum patients into the same proactive, measured population health infrastructure that already exists for other high-risk adults. The recommendations make postpartum care expectations explicit and measurable, with defined accountability and concrete clinical steps.

Health care is local, however, and teams can and should match patients to the right clinical home based on health needs, practice capacity and patient preferences. These recommendations do not override patient preference, the ability of maternity care clinicians to provide broader women's health care or the realities of workforce supply, including primary care shortages and long appointment wait times. The framework defines a shared default and a minimum floor for safe transitions that teams can adapt based on local capacity, clinical judgment and patient preference.

Policy Context

This care gap also matters in California's broader accountability environment. As OHCA advances total cost of care targets, primary care and behavioral health investment expectations and quality and equity reporting, improving postpartum care becomes a practical strategy across all three domains:

- Total cost of care: stronger postpartum follow-up can reduce avoidable hospital use and emergency care in the first year after birth while helping prevent longer-term escalation of chronic disease and mental health conditions.
- Primary care and behavioral health investment: postpartum care offers a concrete opportunity to direct investment toward team-based primary care and behavioral health infrastructure with measurable clinical value.
- Quality and equity performance: improving postpartum transitions can strengthen

performance on common cardiometabolic, behavioral health and equity-related measures used by OHCA, the California Department of Managed Health Care and purchasers.

Postpartum patients with GDM, HDP and MMH disorders should be managed through the same quality and population health infrastructure already used for other high-risk adults. Aligning postpartum transitions with existing quality and payment infrastructure allows health systems and payers to improve outcomes without creating parallel accountability structures.

Condition-Specific Background

The recommendations focus on four conditions that drive a significant share of postpartum morbidity, respond well to structured primary care follow-up and disproportionately affect Medi-Cal populations, Black patients and Pacific Islander patients.

Gestational Diabetes (GDM) and Type 2 Diabetes (T2D)

GDM and preexisting T2D identify patients with elevated cardiometabolic risk who benefit from structured postpartum follow-up. In California, roughly 10 percent of births involve GDM or diabetes in pregnancy, although less than one percent of patients have preexisting T2D.[18] [19] A meaningful share of patients with GDM will develop T2D. About 5 to 10 percent progress within 12 months postpartum and risk rising substantially beyond the first year.[10] Women with prior GDM have approximately a 9.5-fold increased relative risk of T2D over the long term,[20] and a history of GDM is associated with increased total mortality and higher cardiovascular mortality.[7]

The first postpartum year is a time-limited prevention window, but primary care follow-up remains inconsistent, especially after GDM. Only 50.6 percent of patients with GDM see a primary care clinician in the year postpartum, compared with 67.2 percent of those with preexisting T2D.[16] Early primary care engagement after GDM can identify persistent dysglycemia, reinforce cardiometabolic risk reduction and reduce loss to follow-up at a point when intervention may delay or prevent progression to T2D.[17] Although attendance remains low, one randomized trial found that default scheduling of postpartum primary care visits increased attendance by about 20 percent.[21]

Practice realities make this gap worse. Postpartum glucose testing completion is low across settings, reflecting the demands of caring for a newborn, logistical barriers and friction of arranging time-sensitive testing.[22] Data fragmentation compounds missed care: glucose testing results, pregnancy diabetes course, medication histories and diabetes education often do not reach primary care charts, and responsibility for diabetes follow-up after maternity care ends is frequently unclear. The recommendations prioritize default scheduling of a primary care transition visit and feasible lab follow-up, structured diabetes handoff and flagging pregnancy-related diabetes risk in primary care registries for longitudinal tracking.

Hypertensive Disorders of Pregnancy (HDP)

HDP signals both near-term risk (persistent hypertension) and long-term risk (cardiovascular disease). HDP contributes meaningfully to postpartum morbidity and mortality, particularly among Black mothers and birthing people.[6] A substantial share of patients with preeclampsia develop persistent hypertension by one year postpartum,[9] [23] and HDP markedly increases the likelihood of developing new chronic hypertension within the first postpartum year.8 HDP is one of the strongest early indicators of future cardiovascular disease.[24] [25]

Blood pressure monitoring and medication adherence commonly decline after 6 to 12 weeks when maternity care ends.[28] Primary care teams frequently report they do not receive the HDP diagnosis, severity markers, relevant lab results or a clear postpartum plan. Many postpartum patients do not understand the long-term cardiovascular implications of HDP[26], which makes counseling and follow-through harder without repeated reinforcement across settings.[27]

The recommendations emphasize early transmission of an HDP summary to primary care, a follow-up prompt at the 6 to 12 weeks postpartum mark and

positioning HDP follow-up as the first step in lifelong cardiovascular prevention.[28] [29]

Maternal Mental Health Disorders (MMH)

MMH affects a large share of birthing people across pregnancy and the postpartum period. Up to 1 in 5 experience a maternal mental health disorder in the perinatal period, and serious risk often emerges well after delivery.[30] Suicide risk is especially concentrated in the later postpartum period: 88 percent of maternal suicides occur after 6 weeks postpartum, and 47 percent occur between 6 and 12 months postpartum.[31] [32] MMH includes not only depression and anxiety but also postpartum PTSD, OCD, panic symptoms and significant adjustment disorders. Symptoms can evolve over time, and deterioration may occur after an initially reassuring early postpartum screen.[13]

Screening guidance reflects the importance of ongoing surveillance and follow-up, but expectations for postpartum screening remain uneven, particularly in the extended postpartum period. ACOG recommends screening once during the postpartum period, while the American Academy of Pediatrics (AAP) extends screening opportunities through early well-child visits and Postpartum Support International (PSI) recommends screening through 12 months postpartum.[33] [34] Research on the yield of screening beyond 6 months postpartum remains limited, but the timing of risk supports continued clinical attention beyond the standard postpartum visit. Screening environments are also fragmented: obstetric care, primary care, pediatrics, lactation support, emergency care and home visiting may all identify symptoms, yet results and clinical context often do not follow the patient across settings.

In practice, continuity often breaks down. Maternity care teams frequently screen but do not reliably transmit scores, screening history or clinical context to other treating clinicians.[35] Behavioral health integration remains uneven across care settings, maternal mental health specialists are in short supply and referral pathways may be slow or fragmented even when symptoms are identified. Patients may also face repeated screening across settings without clear coordination or follow-through. These recommendations do not endorse one clinical home over another for ongoing MMH management. Rather, they call on maternity care teams, primary care teams, pediatricians and behavioral health providers to define how screening, monitoring and coordination will continue beyond the fourth trimester. The right clinical home should reflect patient need, local capacity and honest assessment of what each setting can manage.

The recommendations emphasize continuity, better information flow and escalation pathways, including bidirectional screening data exchange, clearer referral pathways, embedded brief interventions and collaborative care models where feasible and ensuring that receiving clinicians have the historical context needed to detect deterioration early.

A Note on Substance Use Disorder

These recommendations did not develop a substance use disorder (SUD) pathway and named this as a significant gap. While overdose and SUD-related deaths represent a leading cause of maternal mortality between 6 and 12 months postpartum,[29] [36] SUD was ultimately excluded due to scope constraints and the need for additional specialized expertise and infrastructure inside maternal health and primary care teams to adequately address needs. CQC and partners regard this as a priority area for future work.

A Consensus Framework for Postpartum-Primary Care Transitions

To address the care gap between 12 weeks and 12 months postpartum, CQC convened a multidisciplinary clinical workgroup in 2025 to define minimum recommendations for transitioning patients from maternity care to primary care. The workgroup included OB/GYNs, MFMs, family physicians, internists and state and quality improvement partners from diverse practice environments across California, with additional input from subject matter experts and planned review by national and state partners.

The workgroup focused on populations with the most to gain or lose from engagement with primary care in the year after giving birth. Condition selection prioritized:

- Prevalence and risk if missed
- Primary care actionability and strength of evidence
- Feasibility across real-world settings
- Potential to reduce inequities

The framework draws on major guidance from ACOG, CMQCC, PSI, the American Diabetes Association and the American Heart Association and incorporates diverse perspectives to support practical, equity-centered recommendations that teams can adapt to local practice patterns.

To include a recommendation in the framework, participants required that it:

- Align with evidence and major guidelines where available
- Reflect practice realities across California
- Work through team-based workflows
- Advance equity for populations facing highest risk
- Translate into specific, actionable steps that teams can operationalize.

Ownership is defined at the team level rather than by individual clinicians. Teams should assign tasks based on scope of practice, staffing models, practice capacity and patient preference.

Guiding Principles

Four principles shaped the design of this framework and should guide how readers interpret and apply the recommendations.

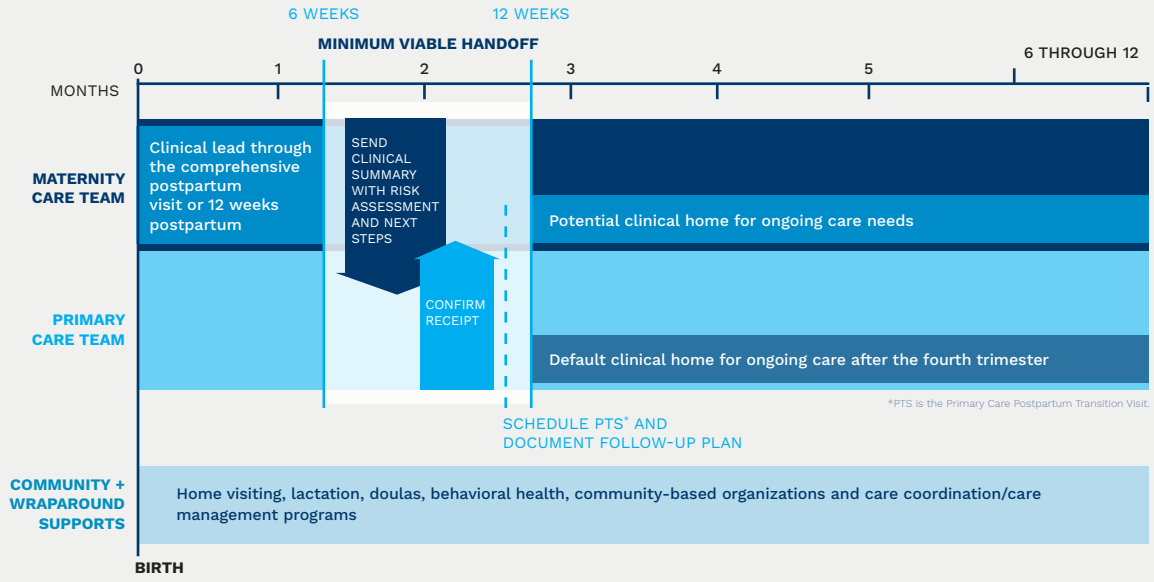
1. **Care is delivered by teams, not individuals.** The recommendations assign accountability at the team level, maternity care teams and primary care teams, rather than to individual clinicians. Medical assistants, nurses, care coordinators and other staff can and should complete many of these actions.

2. **Patient preference governs the clinical home.** This framework establishes primary care as an accountable setting for the extended postpartum period. It does not endorse selecting a primary care provider on a patient's behalf or override a patient's choice to continue care with a maternity clinician who provides broader women's health services. These recommendations define a shared default and a minimum floor, they are not a mandate.

3. **Transition timing is anchored to ACOG's comprehensive postpartum visit.** The framework assumes the maternity care team completes a comprehensive in-person postpartum visit consistent with ACOG guidance, which recommends an initial check-in by 3 weeks and a comprehensive visit by 12 weeks postpartum.[3] Handoff communication and primary care engagement are timed relative to that visit. Earlier engagement may occur based on clinical risk, patient need or patient preference.

4. **These are principles, not protocols.** The framework establishes minimum recommendations and clinical direction. Specific timing examples and illustrative ranges support workflow planning but do not function as rigid requirements. Individual cases rest with the clinical judgment of the maternity and primary care teams managing them. These recommendations do not supersede clinician expertise or local practice realities.

POSTPARTUM-TO-PRIMARY CARE TRANSITION: CLEAR CLINICAL ROLES ACROSS THE POSTPARTUM YEAR



Default pathway: The patient may designate the maternity care team as the ongoing clinical home when clinically appropriate and supported by practice capacity.

Core Elements

The four components below describe what the framework delivers, and the minimum structure for a safe, accountable transition from maternity to primary care.

- **Clear ownership.** Maternity and primary care teams explicitly own defined windows and actions across the postpartum year. Ownership is assigned at the team level, not to individual clinicians, so accountability survives staffing change and scheduling variability. At the comprehensive postpartum visit, the maternity care team designates who owns care after the fourth trimester, schedules primary care follow-up and ensures that key data needed by the receiving team is available and ready to transmit. Where a patient does not have an established primary care clinician, the maternity care team should support PCP identification before or at the comprehensive postpartum visit.
- **Standardized timing.** The in-person comprehensive postpartum visit serves as the anchor for transition planning. At that visit, the maternity care team designates care ownership, schedules the PTS Visit with primary care team, and ensures that key clinical information is sent to the receiving primary care team. The PTS is timed according to clinical need, typically between 12 weeks and 6 months postpartum.
- **Minimum viable handoff.** Teams use a concise, required data set to ensure the receiving team has what it needs to take action. Communication and data sharing initiate at the final maternity care visit, typically the comprehensive postpartum visit. The handoff is only complete with confirmation of receipt and documented next steps.
- **Condition-specific pathways.** Follow-up actions reflect the clinical profile of each condition, including labs, screening, counseling and longitudinal monitoring. Each pathway specifies what good care looks like in the extended postpartum period. The full pathways are in the accompanying recommendations and implementation guide.

Equity, Challenges and Limitations

The selected conditions are common, high risk if missed and actionable in primary care. They also disproportionately affect populations facing the greatest inequities in postpartum outcomes, including Medi-Cal members, Black patients and Pacific Islander patients.[3] Workgroup discussions reflected persistent disparities in postpartum morbidity and mortality and the role of fragmented follow-up in widening those gaps. Strong primary care engagement during the extended postpartum period supports earlier detection and sustained management of cardiometabolic and behavioral health risk, reduces reliance on episodic acute care and improves longitudinal monitoring that often remains least accessible to patients facing barriers to continuity.[11]

This framework has limitations. Its narrow scope does not address many critical components of postpartum continuity, including patient-level barriers and broader social and structural determinants. The workgroup recognizes major system constraints that shape implementation feasibility:

- Data silos and privacy-related barriers to information exchange
- Inconsistent ability to identify or confirm a patient's primary care clinician
- Patients without an assigned PCP
- Misaligned incentives and limited reimbursement for coordination and transitions
- Behavioral health access gaps
- Workforce and capacity limitations across maternity and primary care

Clinical expectations for transitions often outpace the current payment landscape, which creates implementation risk without aligned financing. Evidence is also limited for condition-specific pathways beyond six months postpartum. Recommendations do not include an SUD-specific pathway and recognize this as a meaningful gap (see the condition-specific background section for additional context). The framework provides a baseline for standardization and shared accountability, with an expectation of continued refinement and broader clinical and community input over time.

Next Steps and Conclusion

What Comes Next

In 2026, CQC will focus on advancing adoption of these recommendations across California care settings. CQC will work with payers, policymakers and other stakeholders to identify the payment, policy and operational levers needed to advance integration and support implementation, while aligning this work with related maternal health efforts already underway in California, including the Transforming Maternal Health Model and the Birthing Care Pathway.

This framework also calls on providers and delivery systems to endorse these recommendations and adopt them within clinical workflows. To support implementation, CQC will develop practical tools and resources to help operationalize the recommendations.

Across its broader portfolio, CQC will continue to embed the needs of postpartum populations where relevant, including behavioral health and efforts to increase adoption of value-based payment models.

Conclusion

Strengthening postpartum-to-primary care transitions offers one of the most actionable opportunities to improve maternal health in California. Maternity care teams manage the critical fourth trimester, but the extended postpartum year is when many cardiometabolic and behavioral health risks emerge or persist, and when primary care becomes essential to longitudinal, whole-person care.

These recommendations provide a practical roadmap for shared accountability, clearer roles and minimum expectations for timely information sharing and follow-up. They are intentionally flexible across practice settings and grounded in team-based care that respects clinician judgment, practice capacity and patient preference.

Defining these clinical recommendations will not eliminate all barriers to postpartum continuity. Even so, these recommendations address some of the most persistent challenges, inconsistent handoffs, poor data visibility and unclear expectations after 12 weeks postpartum. With aligned action from maternity care, primary care, payers, state partners and community stakeholders, California can build a more connected and equitable postpartum care system that better matches postpartum risk with the full year of coverage patients now receive.

This framework focuses on one critical window for addressing maternal mortality and morbidity: the transition from maternity care to primary care during the postpartum year. But the larger opportunity extends beyond that period to improve women's health overall and narrow broader gender gaps in care. Pregnancy can reveal cardiovascular risk, metabolic vulnerability and mental health concerns years before they might otherwise come to clinical attention.[6,7] Yet, that information too often does not follow the patient into primary care or inform long-term care. As a result, clinicians manage future risk without access to one of the clearest early signals available. Closing the postpartum handoff gap is an essential first step. Policymakers, clinicians and payers must ensure that what pregnancy reveals about future health informs care not only in the postpartum year, but across the life course.

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About the California Quality Collaborative (CQC)

For nearly two decades, health plans, providers and purchasers have entrusted the California Quality Collaborative to bring stakeholders together to align and co-design common solutions to shared challenges. This drives scalable, sustainable improvement across the health care delivery system.

CQC brings together health plans and delivery system partners serving more than 20 million Californians, representing over half the state, translating collective action into measurable improvements in quality, equity and outcomes across the state.

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