OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: Nov 21, 2019
To: "Alex Friedman Peahl" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1905

RE: Manuscript Number ONG-19-1905

Patient preferences for prenatal and postpartum care delivery: a survey of postpartum women

Dear Dr. Peahl:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 12, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: I got that the purpose of this paper was to evaluate patients prenatal/pp care preferences with the overarching aim (line 88) "to inform a larger quality improvement initiative to align care delivery with patient preferences" and to this I think you answered your question. I question though how reproducible these responses would be if given to a more diverse group of mothers. Per Table 2 majority of the patients in the study were white, privately insured and married . This would suggest a more privileged segment of society. I struggle with this single suburban academic practice (line 278) and limited sociodemographic data (line 284) . I think it would be more helpful to the development of a flexible care model tailored to a patients needs to look at the medical and social needs of a diverse population. As well, while the safety of reduced prenatal visits has been established (lines 235-236), there are clear disparities in maternal morbidity and mortality among women of color in the United States so inclusion of these women is imperative to the development of a model that can be applied to various clinical settings across the US. It would be interesting to see if more patients were included in your study if you would see statistically significant difference in the answers of single women or those on public assistance for example.

I was also unclear, based upon the survey results in Table 3 if number of pp visits desired was looked at between those women who had a C/S versus SVD which may impact that answer.

Reviewer #2: General Comments:The authors discovery regarding postpartum care is possibly the highest impact observation to come out of this study. If tailored to patient desires, this may influence postpartum care follow up in the general population. I would be curious to see whether these results hold true for other populations given that the postpartum appointment adherence is very high in this study population compared to the national average. I would also like to see the authors comment on this in the discussion section.

Abstract: To the point and reflects the significant findings of the paper.

Introduction:Lines 75-78: This is extremely important and should be further discussed in discussion section.

Materials and Methods:
Lines 88-89: What are the next steps?Lines 89-93: This appears to be a reasonable approach to the convenience sample.Lines 106-107: This number is high compared to national averages and the authors may consider including this finding in the discussion
Lines 119-125: Although not validated the authors included important steak holders and pilot tested the survey.

Results:169-170: How does this compare with the general population/previous studies?182-184: This is an important finding and should be elucidated in the discussion section with regards to provider feasible and economical suggestions to how to incorporate these patient preferences. At minimum, an area for future study.209-213: As stated in general comments, a truly significant finding whereby changes can impact to our patients.

Discussion:
251-254- I appreciate that this was included in the discussion. A very important point regarding prenatal care and the demands on working mothers and primary care takers.
While generally inclusive of important talking points, additional issues the authors may wish to address:
- Suggestions for abandoning one size fits all model in terms of provider and economic feasibility
- Impact that changing postpartum care can do on a national level
-Area of future study- will changing the postpartum visit(s) timing increase visit adherence and if so, possible implications.

Reviewer #3: Friedman Peahl and colleagues present findings from a cross-sectional survey of postpartum women to assess patient preferences for prenatal and postpartum care to inform more patient-centered models of outpatient maternity care. The authors administered their survey to 332 women and 300 women (90%) completed the survey. The authors note that patient preferences diverge from current prenatal and postpartum care delivery related to number of visits, etc, and women are open to alternative models for prenatal/postnatal care. Overall the paper is well-written and addresses and important aspect of perinatal care related to alternative models for care and patient-centered care. A point-by-point critique of the paper follows:

1) The authors note that a convenience sample of 300 women was identified for their investigation. They administered surveys to 332 women and had 300 complete the survey instrument (90% response rate). How many women were seen in the clinic practice over the time interval that the survey was administered (May 7, 2019 - June 28, 2019)? This information is important to include in the revised paper to provide the reader with a better understanding of the selection process and generalizability of the findings reported.

2) The authors note that 590 births occurred during the study interval and that 252 (43%) of women were excluded from participation as "unavailable". Why were these women unavailable? Were they approached to participate and declined? Were there additional exclusion criteria? Additional specifics should be added to the revised paper.

3) The authors report that 88% of women returned for scheduled postpartum visits. This is a very high rate compared to national rates. How do the authors explain this high rate of postpartum followup? Are there processes in place in your clinic that encourage postpartum followup?

4) The demographic characteristics of the surveyed population are predominantly Caucasian (70%), insured (71%), and married (72%). This demographic mix diverges significantly from many urban academic centers. Can the authors provide insights into how this divergent population may have impacted results noted and ultimate generalizability of findings beyond their institution?

5) The authors note that their survey tool was not a previously validated survey tool. They did a test on 3 postpartum women. Was there any other attempt to internally or externally validate the survey instrument?

6) Table 2- is this the number of prenatal visits or all prenatal and postpartum visits. Additional specificity would be helpful to the reader. The significant differences among racial/ethnic groups is very interesting and should be explored further. Why do the authors believe these differences exist?

STATISTICAL EDITOR'S COMMENTS:

1. lines 89-91, 109-117, 161-163, Fig 1: Did the final cohort of 300 differ from the initial group of 590 in any characteristics (eg, age, race, insurance, marital status etc) which may have limited the generalizability of the conclusions that were based on the respondents?

2. line 152-158: Should include the level used for inference testing.

3. lines 182-190: Should include CIs for the proportions cited (for the "all patients" group and for other relevant groups).

Associate Editor's Comments:

Please report as integers things such a visits which can only be integers.

If you haven't stressed it, please make it clear as a limitation that the demographics of the women you studied are not representative of the broader population of women giving birth in the United States

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

2. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

4. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

6. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

7. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows:

Original Research articles, 300 words. Please provide a word count.

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

10. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

11. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

12. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

13. The Journal's Production Editor had the following to say about the figures in this manuscript:

"Figures 1–2: Please upload as separate figure files on Editorial Manager. Figure 2 should be high-res (eps, tiff, jpeg, PDF). "

When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

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If you choose to revise your manuscript, please submit your revision through Editorial Manager at

http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 12, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

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MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

[redacted]

Nancy C. Chescheir, MD
Editor-in-Chief
Obstetrics & Gynecology

November 22, 2019

Dear Dr. Chescheir,

We are pleased to submit our revised manuscript "Patient preferences for prenatal and postpartum care delivery: a survey of postpartum women" to *Obstetrics & Gynecology* for review. We appreciate the thoughtful comments from the review, and have responded individually to each of the recommendations below.

We confirm that this study has not been published elsewhere and is not currently submitted elsewhere. All authors made contributions to the preparation of this manuscript. The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

Thank you for your consideration.

Sincerely,

*Alex Friedman Peahl, MD
National Clinician Scholar, Institute for Health Policy and Innovation
Clinical Lecturer, Department of Obstetrics and Gynecology
University of Michigan

Reviewer 1:

Comment 1: I got that the purpose of this paper was to evaluate patients prenatal/pp care preferences with the overarching aim (line 88) "to inform a larger quality improvement initiative to align care delivery with patient preferences" and to this I think you answered your question. I question though how reproducible these responses would be if given to a more diverse group of mothers. Per Table 2 majority of the patients in the study were white, privately insured and married . This would suggest a more privileged segment of society. I struggle with this single suburban academic practice (line 278) and limited sociodemographic data (line 284). I think it would be more helpful to the development of a flexible care model tailored to a patients needs to look at the medical and social needs of a diverse population. As well, while the safety of reduced prenatal visits has been established (lines 235-236), there are clear disparities in maternal morbidity and mortality among women of color in the United States so inclusion of these women is imperative to the development of a model that can be applied to various clinical settings across the US. It would be interesting to see if more patients were included in your study if you would see statistically significant difference in the answers of single women or those on public assistance for example.

Response: We appreciate the reviewers' comment about the generalizability of our findings and the importance of including women of color and women from less affluent backgrounds in future work. We believe that our work demonstrates that prenatal care does not meet *some* women's preferences, and that it is possible that preferences have even greater variation in more diverse. groups. We believe future work will need to define preferences in a variety of populations, including rural/urban, and populations with a higher percentage of patients with public insurance, greater racial diversity, and a broader range of socioeconomic statuses. All of these preferences should be included in the process of redesigning prenatal care, with a focus on improving care disparities. Still, we believe the importance of this work lies in demonstrating a process for eliciting these preferences, which can be applied more broadly.

Given the low numbers of patients in our study who are from racial/ethnic minorities, have public insurance, or are unmarried, we are not able to draw specific conclusions about these populations. We agree that there is great value in repeating this work in a more diverse cohort, and we plan to explore these findings in a variety of populations in the future. We have highlighted these limitations throughout the manuscript, particularly in the discussion section:

> "Current prenatal/postpartum care delivery does not match patients' preferences for visit number or between-visit contact and patients are open to alternative models of prenatal care, including remote monitoring. Future prenatal care redesign will need to consider diverse patients' preferences and flexible models of care that are tailored to work with patients in the context of their lives and communities." (**Line 59-63)**

> "Our study population was from a single, suburban academic center and included predominantly white, privately insured patients. Given the homogenous demographics of our sample, it is possible that even greater variation in patient preferences exists across the country. Future work is needed to define the preferences of various populations, all of which should be incorporated into prenatal care redesign." (**Line 247-250)**

"Our study has several limitations. First, the survey was conducted at a single suburban, academic center, where a majority of the patients are white, have public insurance, and are married. Understanding how urban/rural location, insurance, marital status, and racial/ethnic identities, will be an important part of tailoring care across a variety of settings beyond our institution. Including underserved women and women of racial/ethnic minority groups will be particularly important given the disparities in care access and outcomes seen in our current system." (**line 308-314)**

"Future work will explore how to best capture the preferences and medical/social needs of diverse patients to design tailored prenatal and postpartum care plans. **(line 324-325)**

Comment 2: I was also unclear, based upon the survey results in Table 3 if number of pp visits desired was looked at between those women who had a C/S versus SVD which may impact that answer.

Response: We appreciate the insight about the connection between delivery type and desire for postpartum follow-up. We analyzed the desired number of postpartum visits by delivery type, and found there was no significant difference by delivery type (vaginal delivery 3, cesarean delivery 3; p=0.57). We have included this addition in our results section:

"There were no other significant differences by age, insurance status, or delivery type ($p>0.05$)." (**line 235-236).**

Reviewer 2:
Comment 1: General Comments: The authors discovery regarding postpartum care is possibly the highest impact observation to come out of this study. If tailored to patient desires, this may influence postpartum care follow up in the general population. I would be curious to see whether these results hold true for other populations given that the postpartum appointment adherence is very high in this study population compared to the national average. I would also like to see the authors comment on this in the discussion section. 209-213: As stated in general comments, a truly significant finding whereby changes can impact to our patients.

Response: We have emphasized the uniquely high postpartum follow-up rate in our population in the discussion. We have also emphasized the importance of exploring postpartum preferences in patients with lower follow-up rates:

"Our findings should be interpreted in light of the high postpartum follow-up rate in our hospital system: 88% compared to the national average of 60%.[36,37] Postpartum preferences in our population may differ if higher attendance is because women in our population desire more care, have fewer barriers to postpartum care, or perceive the care delivered to be particularly valuable. Understanding how these preferences extrapolate to populations with poorer attendance can guide efforts to support the most vulnerable patients." **(line 300-306)**

Comment 2: Abstract: To the point and reflects the significant findings of the paper. Introduction: Lines 75-78: This is extremely important and should be further discussed in

discussion section.

Response: We agree that including patients' voices is a crucial part of designing guidelines in areas of low evidence. We have further emphasized the importance of incorporating patients in our discussion:

> **"**Many elements of prenatal care delivery lack sufficient evidence to support one single approach. Rather than suggesting a one-size-fits-all prenatal care plan for women, we believe tailored approaches that incorporate women's preferences with medical and social needs through shared-decision making can optimize costs, outcomes, and patient experience.**" (line 263-267)**

Comment 3: Materials and Methods: Lines 88-89: What are the next steps? ("In this manuscript, we present our findings on care delivery preferences, including visit frequency, visit type, and between-visit contact, and patient characteristics associated with those preferences, to inform future efforts to redesign prenatal care.")

Response: We appreciate the reviewer's comment about the next steps of our quality improvement process. Discussions are ongoing how to improve prenatal care at our institution. We are currently modeling the impact of reduced visit schedules and implementation of telemedicine on our health system. We are also piloting surveys to capture providers' perspectives of prenatal care delivery, and understand barriers to implementation of flexible care models. We look forward to sharing these findings in the future. We have included additional information in our discussion section about our next steps in the prenatal care redesign process:

> "Future work will explore how to best capture the preferences and medical/social needs of diverse patients to design tailored prenatal and postpartum care plans.[2] Right-sizing prenatal care—matching patients' needs with services delivered—will be an important next step in preventing both overutilization of unnecessary services and underutilization of valuable care. Next steps will also need to incorporate providers' perspectives, including barriers and facilitators to adopting more flexible care models." **(line 324-329)**

Comment 4: Lines 89-93: This appears to be a reasonable approach to the convenience sample. Lines 106-107: This number is high compared to national averages and the authors may consider including this finding in the discussion

Response: We have highlighted our high rate of postpartum follow-up in the discussion (see Reviewer 2, Comment 1 above).

Comment 5: Lines 119-125: Although not validated the authors included important steak holders and pilot tested the survey. Results:169-170: How does this compare with the general population/previous studies?

Response: Previous work assessing satisfaction with prenatal care demonstrates high levels of satisfaction, as demonstrated by Littlefield et al and Heaman et al. In this preliminary work, we

used a single question, “how satisfied were you with your prenatal care?” We have added this description into the methods section when introducing rates of satisfaction with prenatal care:

> **“**We assessed overall satisfaction by asking: “how satisfied were you with your prenatal care?” Prior work has demonstrated that the majority of patients report satisfaction with their prenatal care.[25-27]” **(line 159-161)**

Comment 6: 182-184: This is an important finding and should be elucidated in the discussion section with regards to provider feasible and economical suggestions to how to incorporate these patient preferences. At minimum, an area for future study. (“The majority of patients preferred to have contact with their care team between prenatal visits [n=253 (84%), 95% CI(79-88%)]. Most women desired either scheduled contact between visits [n=95 (40%), 95% CI(26-37%)] or a combination of scheduled and unscheduled contact [n=120 (39%), 95% CI(34-45%)].”)

Response: We have provided a clearer connection between the findings on patient preferences for between visit contact, and the alternative care models outlined in the discussion, including connected care models, telemedicine, and community health worker models. We have additionally emphasized the need for further research in this area for more diverse populations:

> “These findings are consistent with the OB Nest connected care model,[32] which includes a reduced visit schedule, remote monitoring, and nurse care coordination. A randomized controlled trial of OB Nest versus usual care demonstrated equal pregnancy outcomes with higher patient satisfaction.[26] Still, this trial was conducted in a homogenous patient population, emphasizing the need for future studies in diverse groups. Other modalities such as telemedicine, community health workers, and group prenatal care may offer similar flexibility for patients with different needs and preferences.[12,33-35] Early data suggests these models are both preferred by patients and reduce costs, providing a rare “double win” for health care finances and patient-centered outcomes.” **(line 282-289)**

Comment 7: Discussion: 251-254- I appreciate that this was included in the discussion. A very important point regarding prenatal care and the demands on working mothers and primary care takers. While generally inclusive of important talking points, additional issues the authors may wish to address:

- Suggestions for abandoning one size fits all model in terms of provider and economic feasibility
- Impact that changing postpartum care can do on a national level
- Area of future study- will changing the postpartum visit(s) timing increase visit adherence and if so, possible implications.

Response: We appreciate the suggestions from the reviewer to broaden the discussion points to address more concretely how to improve outpatient perinatal care. We believe “right-sizing”—better matching patient needs with services delivered—will be important for providing more economic and patient-centered care that reduces provider burden. We have added a few suggestions of the potential effects of modifying prenatal care, but have been careful to only emphasize the components that come directly from the data in our study:

"Right-sizing prenatal care—matching patients' needs with services delivered—will be an important next step in preventing both overutilization of unnecessary services and underutilization of valuable care. Next steps will also need to incorporate providers' perspectives, including barriers and facilitators to adopting more flexible care models. Considering over 98% of the 4 million women who give birth each year receive prenatal care, improving prenatal care delivery has huge implications for women's health, patient-centered outcomes, and health expenditures across the country.[1] By abandoning a "one-size-fits-all" approach to maternity care, we can ensure every patient has access to high-value, patient-centered care that works in the context of their lives and communities." **(line 325-333)**

Reviewer 3:

General Statement: Friedman Peahl and colleagues present findings from a cross-sectional survey of postpartum women to assess patient preferences for prenatal and postpartum care to inform more patient-centered models of outpatient maternity care. The authors administered their survey to 332 women and 300 women (90%) completed the survey. The authors note that patient preferences diverge from current prenatal and postpartum care delivery related to number of visits, etc, and women are open to alternative models for prenatal/postnatal care. Overall the paper is well-written and addresses and important aspect of perinatal care related to alternative models for care and patient-centered care. A point-by-point critique of the paper follows:

Comment 1: The authors note that a convenience sample of 300 women was identified for their investigation. They administered surveys to 332 women and had 300 complete the survey instrument (90% response rate). How many women were seen in the clinic practice over the time interval that the survey was administered (May 7, 2019 - June 28, 2019)? This information is important to include in the revised paper to provide the reader with a better understanding of the selection process and generalizability of the findings reported.

Response: We appreciate the reviewer's comments about defining our study population. For recruitment, patients were contacted during their postpartum hospitalization following delivery, not in the outpatient setting. During that time, 590 births occurred. Of those births, 253 women were not available when our RA attempted to contact them, which we defined as 1) being with a health care provider, 2) sleeping, or 3) being in the bathroom/not in the room. We were unable to collect additional information on the women who were not approached. As the demographic and delivery characteristics match our general population characteristics at our institution we believe the sample is representative of our general obstetric population. Additionally, of the 332 patients approached, only 32 declined participation, resulting in an overall response rate of 90%. We have provided additional clarity in our methods section to better convey our process:

"Women were approached in their postpartum room by a research assistant and invited to participate in the study. Patients were considered unavailable and not invited to participate if they were 1) with a member of their care team (provider, nurse, lactation consultant, etc.); 2) sleeping; or 3) were not in the room (e.g., visiting their infant in the

NICU). Two attempts were made to reach patients who were initially not available**" (line 120-125)**

Comment 2: The authors note that 590 births occurred during the study interval and that 252 (43%) of women were excluded from participation as "unavailable". Why were these women unavailable? Were they approached to participate and declined? Were there additional exclusion criteria? Additional specifics should be added to the revised paper.

Response: Please see above for a full discussion. We have also further specified the inclusion criteria for the study: women were required to be age ≥18, English-speaking, and have had a live-born infant.

> "We included all women ≥18 years old, including high-risk patients and those who experienced complications during delivery, who were able to read and write in English.**" (line 118-120)**

Comment 3: The authors report that 88% of women returned for scheduled postpartum visits. This is a very high rate compared to national rates. How do the authors explain this high rate of postpartum followup? Are there processes in place in your clinic that encourage postpartum followup?

Response: We agree that the postpartum follow-up rate at our institution is higher than the national average of 60%. We believe this is in part due to our patient population, and also due to reminder protocols in place at our institution to help women present for their postpartum visits. We have added this to the methods section to more clearly describe our hospital's practices:

> **"**To ensure high postpartum follow-up rates, several institutional workflows facilitate appointment scheduling. An appointment for postpartum care is created during the third trimester. When its timing needs to be adjusted for actual delivery, hospital staff help facilitate scheduling an appointment prior to discharge. All women receive automated reminders and a phone call from a clinic staff member the day before their appointment, and all "no-shows" are contacted to reschedule. Most women (88%) present for a postpartum appointment in the office 4-6 weeks after delivery.**" (line 109-115)**

Comment 4: The demographic characteristics of the surveyed population are predominantly Caucasian (70%), insured (71%), and married (72%). This demographic mix diverges significantly from many urban academic centers. Can the authors provide insights into how this divergent population may have impacted results noted and ultimate generalizability of findings beyond their institution?

Response: We appreciate the reviewer's comment about the generalizability of our findings given the homogeneity of the population included. We believe our work highlights that many women's preferences are not being met through current prenatal care delivery, and future work will need to explore patient preferences in settings with more diverse patient demographics. The preferences of this population *and* others should be considered in future plans for prenatal care redesign. Please see Reviewer 1, Comment 1 for a full discussion of the modifications in this manuscript to address this comment.

Comment 5: The authors note that their survey tool was not a previously validated survey tool. They did a test on 3 postpartum women. Was there any other attempt to internally or externally validate the survey instrument?

Response: In addition to trialing the survey with three postpartum women and soliciting their specific feedback, the survey was also developed with three survey experts (VD, JB, and MH) and a multidisciplinary patient education team. To highlight our efforts at pilot testing and refinement, we have revised the methods text:

> **"**We included three experts in survey methodology (VD, JB, MH) in our survey design. The survey was then reviewed by a multidisciplinary group of women's health professionals who currently serve on the patient education committee (including obstetrician/gynecologists, midwives, nurses, prenatal education specialists, and administrators). The committee's feedback was incorporated into the survey and reviewed a final time. The survey was pilot tested with three postpartum patients to confirm readability, comprehension, and length, and was iteratively revised.**" (line 130-136)**

Comment 6: Table 2- is this the number of prenatal visits or all prenatal and postpartum visits. Additional specificity would be helpful to the reader. The significant differences among racial/ethnic groups is very interesting and should be explored further. Why do the authors believe these differences exist?

Response: Thank you for highlighting this ambiguity. We have revised the title of Table 2 to be: "**Table 2. Patient characteristics by preferred number of prenatal care visits."** We conducted post-hoc pairwise comparisons across racial/ethnic groups as well as insurance status, and were unable to detect specific differences amongst groups. We have emphasized the need for further exploration of our findings in diverse populations in our discussion, but unfortunately cannot draw specific conclusions at this time (please see Reviewer 1, Comment 1 for greater detail).

<u>Statistical Editor</u>:

Comment 1: lines 89-91, 109-117, 161-163, Fig 1: Did the final cohort of 300 differ from the initial group of 590 in any characteristics (eg, age, race, insurance, marital status etc) which may have limited the generalizability of the conclusions that were based on the respondents?

Response: We unfortunately were unable to collect information on the patients who were not included in the study; however, the characteristics of the cohort in this survey match the characteristics of the general population delivering in our hospital annually. We therefore believe we have achieved a representative patient sample. We have added this to the limitation section of our paper:

> "We were unable to collect demographic information on the women who were unavailable for our survey; however, as our sampled group matches the general

characteristics of our hospital's patient population, we believe we have a representative group." **(line 317-320)**

Comment 2: line 152-158: Should include the level used for inference testing.

Response: We have added a description of the level used for inference testing in our study:

"Analyses were performed using STATA-IC, version 15. Statistical significance was set at $p<0.05$ with two-sided tests." **(line 172-173)**

Comment 3: lines 182-190: Should include CIs for the proportions cited (for the "all patients" group and for other relevant groups).

Response: We have added confidence intervals for all groups included in this section.

Associate Editor's Comments:

Comment 1: Please report as integers things such a visits which can only be integers.

Response: We have revised all descriptions of visits to be reported as integers.

Comment 2: If you haven't stressed it, please make it clear as a limitation that the demographics of the women you studied are not representative of the broader population of women giving birth in the United States

Response: We appreciate the editor's comment about the limitations of our study population. We have emphasized throughout the manuscript that patient preferences for prenatal care delivery differed from current practice within our homogenous patient population, and that surveying more diverse groups may result in an even wider range of preferences. We have highlighted the need for understanding preferences in populations with a variety of demographic characteristics, and that future prenatal care redesign should incorporate the perspectives of all patient groups. Please see Reviewer 1, Comment 1 for a full response to this point.