OBSTETRICS & GYNECOLOGY

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- 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.*

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

Date: Dec 11, 2020
To: "Maria Ward Steenland" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-3020

RE: Manuscript Number ONG-20-3020

Health care use by commercially-insured postpartum and non-postpartum women in the United States

Dear Dr. Steenland:

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 Jan 01, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

General Comments:
Using evidence to help reorganize recommended postpartum follow up care is an important and relevant issue, especially in light of the maternal mortality issue facing the US. The authors, additionally, bring up an important issue in the discussion regarding insurance coverage and reimbursement for recommended healthcare utilization. I hope that more articles like this that can support increased need for postpartum health care support can contribute to a different coverage and reimbursement paradigm that will better align with actual healthcare needs.
Introduction:
1- 90-96- Authors lay out a clear argument for why this study is important
2- 104-105- Authors use a comparison group to distinguish from existing studies.
Methods:
3- Overall makes good use of claims data to get numbers for population health, including approximately 8% of all births to commercially insured people.
4- 130-135- Comparison group is simply other women 18-44. Results may have been stronger with age matched controls.
5- 156-158- Authors use practical rationale for grouping of time periods based on ACOG recommendations and HEDIS quality metric.
Results:
6- 216-217- All chronic disease conditions were more prevalent among non-postpartum women. Comparison group was not controlled for age or preexisting conditions. See comment #4.
7- TABLE 1- authors do not assess for statistical differences between the two groups.
8- 273-278- I appreciate the authors' subgroup analysis, further pinpointing where postpartum follow up can make an impactful difference and which group are more at risk.
9- TABLE 3- I thought the presentation was a bit confusing. From the note, it seems like this is the overall percentage of postpartum women but it remains unclear to the reader.
Discussion
10- No comment. Overall an thorough discussion of implications and limitations.

Reviewer #2:

1. In the abstract conclusion, the authors state that commercially-insured postpartum women have "uniquely" high health care use. Their study did not address other populations such as publicly-insured patients who may have even higher health care use. So unique probably not the best descriptor.
2. For the methods, the comparison group of non-postpartum women is completely dissimilar from women who have all had a hospitalization and medical procedure, with over one third having major surgery (cesarean.) Wouldn't a better comparison be women who were not pregnant but had a surgical procedure.
3. The non-postpartum comparison group was assigned to set time periods for early postpartum, postpartum and extended postpartum by means of the calendar year, starting in January. These time periods did not match up with the actual postpartum periods, as all women didn't deliver on January 1st, 2016. How did the authors correct for seasonal variation in healthcare usage that may have affected the groups differently? This is particularly true for commercially insured who may have high deductibles reset every year potentially causing them to avoid healthcare visits in January.
4. For the adjusted probability models, were all the indicators used in the adjustment (all age groups, all chronic conditions, etc) or only those found to be statistically different between the groups? No statistical measures were shown in table 1.
5. Was there any assessment of how accurate the coding was for "problem visits" or preventative visits" versus routine postpartum care?
6. Could the authors speculate on how much preventative care women received during their pregnancy. Things like screening for diabetes or vaccinations are performed as routine pregnancy care but also considered preventative. Similarly, if these were performed during a pregnancy, they would obviate the need for repeating in the postpartum period.
7. In lines 273 to 282, the authors compare women with chronic disease in each postpartum period to postpartum women overall. Was there a comparison of these women to non-postpartum women with chronic diseases? This would reinforce the purpose of the study to identify women who need early postpartum follow-up.
8. As stated above, were there statistics performed on Table 1?
9. For Table 2, would include what was used for the adjusted difference in the legend.
10. For the figures, consider bars graphs by the week with the two groups side-by-side. Might be easier to see the differences than the dots.

Reviewer #3:

The authors use a nationwide database of commercially insured patients to examine health care use in postpartum women, including the early postpartum (<21d), postpartum (21-60d), and extended postpartum (60-1yr) periods. They compared problem visits, ED visits, and preventative visits to non-postpartum women during similar time frames. They found that postpartum women had higher rates of problem and ED visits, but fewer preventative visits, than the non-postpartum women. This was particularly true for women with chronic disease.

The objective of the study is clear and the methods seem appropriate for that objective. They control for confounding in their analysis. It is unfortunately race-ethnicity data were not available in this dataset, as the findings could demonstrate important differences.

The authors use these data to argue that more care should be directed toward postpartum women, beyond the traditional six-week single postpartum visit, or even the new ACOG-recommended additional three-week in-person visit. They suggest use of telehealth and home visits, as well as focus on prevention of escalation of common problems that lead to problem visits, could improve care. They also argue these data call for an extension of what is considered "postpartum" to something beyond the traditional arbitrary 60-day period. They suggest creating reimbursement for individual visits (rather than a global payment) or increasing the global reimbursement with requirements for additional visits would help address the needs of postpartum women.

The authors list four potentially important limitations of their study: (1) they were only able to examine health care receipt, not need; (2) routine visits may have been missed by being included in global claims; (3) race-ethnicity data were not available, and (4) (for understandable reasons) they only included women with consistent commercially-available insurance, potentially missing differences that would be seen in women with government-sponsored care or shifting commercial insurance. Could the authors elaborate on the extent to which they believe these limitations affect their findings? Clearly they don't believe they are "fatal flaws," but just how important are they in interpreting the data available? What direction would they expect the data to move if these limitations were overcome?

Examining the figures, although they were able to demonstrate differences in health care receipt among all the time periods studied, the differences were most clearly pronounced in the early postpartum and postpartum periods. At least visually, the differences in the extended postpartum period appear negligible, or at least not significantly different from a clinical perspective. This would seem to support the idea that changes in care would be beneficial earlier, but not necessarily throughout the entire year after delivery, as the authors argue in their discussion.

STATISTICS EDITOR COMMENTS:

Lines 162-203: While this section is important, I think that much of it could be summarized in main text and the details elaborated in supplemental material for the interested reader.

Table 1: Need units for age. Should statistically compare the two cohorts. There are nominal and statistical differences in age strata, presence of chronic conditions and others.

Table 2, lines 182-184: Need to include a footnote summarizing the variables used in the adjusted difference calculation. Also, should include in supplemental a table of all the actual counts used to derive the %s and should enumerate all missing values.

Fig 1a and 1b: While I appreciate these figures, the differences are mostly so close to 0 and so close together that it is hard for the reader to appreciate the differences. Unfortunately, since some differences are negative, one cannot change to a log format. Suggest either a separate graph of the differences or perhaps a graph with two separate y-axes to better separate the differences.

Fig 1e: I think this figure is important enough to include in main text.

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. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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. If your study is based on data obtained from the National Center for Health Statistics, please review the Data Use Agreement (DUA) for Vital Statistics Data Files that you or one of your coauthors signed. If your manuscript is accepted for publication and it is subsequently found to have violated any of the terms of the DUA, the journal will retract your article. The National Center for Health Statistics may also terminate your access to any future vital statistics data.

4. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

5. 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), observational studies using ICD-10 data (ie, RECORD), 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, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

6. If your study uses ICD-10 data, please make sure you do the following:
a. State which ICD-10-CM/PCS codes or algorithms were used as Supplemental Digital Content.
b. Use both the diagnosis and procedure codes.
c. Verify the selected codes apply for all years of the study.
d. Conduct sensitivity analyses using definitions based on alternative codes.
e. For studies incorporating both ICD-9 and ICD-10-CM/PCS codes, the Discussion section should acknowledge there may be disruptions in observed rates related to the coding transition and that coding errors could contribute to limitations of the study. The limitations section should include the implications of using data not created or collected to answer a specific research question, including possible unmeasured confounding, misclassification bias, missing data, and changing participant eligibility over time.
f. The journal does not require that the title include the name of the database, geographic region or dates, or use of database linkage, but this data should be included in the abstract.
g. Include RECORD items 6.3 and 7.1, which relate to transparency about which codes, validation method, and linkage were used to identify participants and variables collected.

7. 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 data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

8. 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.

9. 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).

10. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

11. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

12. 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 limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.

13. 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.

14. 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.

15. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

16. 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%").

17. 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.

18. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, 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 at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

19. 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.

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

20. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

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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. Do not omit your responses to the Editorial Office or Editors' comments.

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 Jan 01, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

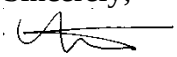
Torri Metz, MD
Associate Editor, Obstetrics

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

Dear Editors,

We appreciate the opportunity to revise our manuscript “Health care use by commercially-insured postpartum and non-postpartum women in the United States” based on the helpful comments from the reviewers and the editor. The suggestions have improved the manuscript, and below we respond to each, including information about the nature of the changes to the revised manuscript. We confirm that we have read the Instructions for Authors. Again, thank you.

Sincerely,



Maria Steenland, SD
Assistant Professor (Research)

Reviewer #1:

1. *90-96- Authors lay out a clear argument for why this study is important*

2. *104-105- Authors use a comparison group to distinguish from existing studies.*

3. *Overall makes good use of claims data to get numbers for population health, including approximately 8% of all births to commercially insured people.*

Thank you for these positive comments.

4. *130-135- Comparison group is simply other women 18-44. Results may have been stronger with age matched controls.*

Thank you for highlighting the differences between the postpartum and non-postpartum groups in our sample. While we did not use matching to obtain more similar samples, we adjusted for age group, chronic disease, zipcode level income, and region in our original submission. The regression models in our resubmitted manuscript also adjust for month when follow-up began to account for seasonality.

To examine the robustness of our findings to other ways of adjusting for confounding, we used the nearest neighbor matching method to match each postpartum woman to three women in the comparison group. Matching variables were the same as those used as covariates in the multivariate (i.e., adjusted) regression model, except for zipcode level income which was continuous in the adjusted regression analysis but was a categorical variable for income quartile in the matching analysis. We present these findings below in Reviewer Table 1. Overall, the matching results are very similar to results from the adjusted regression model. The only exception is the result for preventive care in the extended period which was statistically significant in results from adjusted regression but not significant in the matching results.

Matching analysis is sensitive to matching methods (propensity score, exact matching), the degree to which data is discarded to create the matched sample, and the caliper selected (the degree to which propensity scores are allowed to differ between matched treatment and control units). Further, propensity score matching, one of the more popular approaches, can actually increase the imbalance of covariates (1). For these reasons, we decided that the adjusted regression analysis was a more transparent approach and have retained the adjusted regression results in the manuscript.

5. *156-158- Authors use practical rationale for grouping of time periods based on ACOG recommendations and HEDIS quality metric.*

Thank you for this comment.

6. *216-217- All chronic disease conditions were more prevalent among non-postpartum women. Comparison group was not controlled for age or preexisting conditions. See comment #4.*

Our adjusted models control for age and chronic conditions (in addition to zipcode level income and region). We apologize that this was unclear in our original submission. For additional clarity, we added a note to Table 2 that includes all of the variables in the adjusted regression models.

"Adjusted regression models included age group (18-24 years, 25-34 years, and 34-44 years), chronic disease (diabetes, asthma, hypertension, mood or anxiety disorder, region (Northwest, West, South, Midwest), income and month when follow-up began."

Our response to comment #4 above provides further explains our choice to use adjusted regression, rather than matching methods.

7. *TABLE 1- authors do not assess for statistical differences between the two groups.*

Thank you for pointing this out. We have added p-values obtained from testing the difference in the mean outcomes between postpartum and non-postpartum women to Table 1.

8. *273-278- I appreciate the authors' subgroup analysis, further pinpointing where postpartum follow up can make an impactful difference and which group are more at risk.*

Thank you for this comment. We agree that the subgroup analysis is important for identifying groups for which postpartum follow-up may make a more significant impact on outcomes.

9. *TABLE 3- I thought the presentation was a bit confusing. From the note, it seems like this is the overall percentage of postpartum women, but it remains unclear to the reader.*

Thank you for pointing out that the information in Table 3 was not presented clearly. We have edited the column heading to provide more detail "Percent of total outpatient visits in the early postpartum period," and added an additional sentence to the note to ensure that the percentages we present are clear to the reader: "Percentages refer to the share of total outpatient visits in the early postpartum period associated with each of the listed conditions."

10. *No comment. Overall a thorough discussion of implications and limitations.*

Thank you again for your thoughtful review of our manuscript.

Reviewer #2:

1. *In the abstract conclusion, the authors state that commercially-insured postpartum women have "uniquely" high health care use. Their study did not address other populations such as publicly-insured patients who may have even higher health care use. So unique probably not the best descriptor.*

Thank you for this comment. We agree that "unique" was too vague a term to accurately express the point that we were trying to make here. We have edited the text in the abstract to make it clear that we are making the comparison between postpartum and non-postpartum women.

"Commercially insured postpartum women use more health care than non-postpartum women, including inpatient care. Differences in problem visits, ED visits and hospitalization are largest in the early postpartum period and persist beyond 60 days postpartum."

2. *For the methods, the comparison group of non-postpartum women is completely dissimilar from women who have all had a hospitalization and medical procedure, with over one third having major surgery (cesarean.) Wouldn't a better comparison be women who were not pregnant but had a surgical procedure.*

We agree that the comparison group of non-postpartum women is different from postpartum women. However, we believe that this comparison group is well-selected to meet our specific study's objectives. While many studies use a comparison group to distinguish the effect of an intervention in one group, using a second similar group without the intervention, the aim of our study was to distinguish the needs of postpartum women compared to those of non-pregnant or postpartum women.

Professional obstetrics groups argue that postpartum women face elevated health needs during a time when the health system is not designed to meet them. Postpartum patients are distinct in the need to navigate the healthcare system to transition from obstetric-focused care to women's healthcare. At the same time, global billing disincentives provision of additional care beyond a single routine visit. While it is acknowledged that these transitions take place when women are most vulnerable, by using a comparison group of non-postpartum women, our aim was to quantify the differences in healthcare use to examine the extent and timing of excess need during the year after birth, as distinguished from those who are not in this time period. We acknowledge that a different comparison group could be possible, and potentially interesting, but would answer a different question than what we were aiming to examine in this analysis.

3. *The non-postpartum comparison group was assigned to set time periods for early postpartum, postpartum and extended postpartum by means of the calendar year, starting in January. These time periods did not match up with the actual postpartum periods, as all women didn't deliver on January 1st, 2016. How did the authors correct for seasonal variation in healthcare usage that may have affected the groups differently? This is particularly true for commercially insured who may have high deductibles reset every year potentially causing them to avoid healthcare visits in January.*

Thank you for raising this important issue. This was indeed an important limitation in our original manuscript. In our revision we implemented a solution meant to eliminate any bias from seasonal variation. Instead of starting follow-up for all non-postpartum women on January 1, 2016, we created randomly assigned start dates for follow-up in 2016 for the non-postpartum group. In addition, we create dummy variables for month of follow-up start for both postpartum and non-postpartum women (e.g., births between January 1 – January 30, 2016 are assigned a 1

for the January dummy variable, and a zero for all other months) to further control for the effect of seasonal variation in healthcare use.

4. *For the adjusted probability models, were all the indicators used in the adjustment (all age groups, all chronic conditions, etc.) or only those found to be statistically different between the groups? No statistical measures were shown in table 1.*

We have added p-values obtained from testing the difference in the mean outcomes between postpartum and non-postpartum women to Table 1. Adjusted regression analysis included all of the variables in Table 1, in addition to control variables for the month when follow-up started. We have added the full list of control variables to the table notes for Table 2: "Adjusted regression models included age group (18-24 years, 25-34 years, and 34-44 years), chronic disease (diabetes, asthma, hypertension, mood or anxiety disorder, region (Northwest, West, South, Midwest), income and month when follow-up began."

5. *Was there any assessment of how accurate the coding was for "problem visits" or preventative visits" versus routine postpartum care?*

We agree that it would be useful to determine the share of preventive visits that were routine postpartum visits. However, coding limitations make it difficult to identify routine postpartum care in insurance claims data. Specifically, this is because postpartum care can be billed as part of a global maternity bundle shortly after the birth rather than separately at the time of the visit. For these reasons, we chose to examine preventive care visits overall (using a method employed in prior literature) rather than postpartum care visits specifically.

6. *Could the authors speculate on how much preventative care women received during their pregnancy. Things like screening for diabetes or vaccinations are performed as routine pregnancy care but also considered preventative. Similarly, if these were performed during a pregnancy, they would obviate the need for repeating in the postpartum period.*

Pregnant women receive a lot of preventive care during pregnancy including, as the reviewer pointed out, vaccinations and screening for diabetes, depression screening, STI screening, etc. We agree that postpartum women may be more likely than non-pregnant or postpartum women to be up to date on preventive screenings that are part of routine prenatal care such as screening for sexually transmitted infection, diabetes, depression and the Pap test. However, current recommendations state that all women should have a well woman visit annually, regardless of whether they were recently pregnant. Furthermore, pregnancy is a unique state and health issues that are present during pregnancy may be different from postpartum health. For example, blood pressure can be normal in the 1st and 2nd trimester even in women with underlying hypertension. The testing intervals for the screenings tests that are part of well women care vary based on age and other factors. Some types of screenings – including screening for anxiety and depression, obesity screening and counseling, substance use screening and counseling (2) – identify issues that may have worsened or improved since pregnancy.

7. *In lines 273 to 282, the authors compare women with chronic disease in each postpartum period to postpartum women overall. Was there a comparison of these women to non-*

postpartum women with chronic diseases? This would reinforce the purpose of the study to identify women who need early postpartum follow-up.

Thank you for this suggestion. We have added Appendix Table 3 to the study Appendix which includes a table comparing the study outcomes between postpartum women with chronic disease and non-postpartum women with chronic disease.

8. *As stated above, were there statistics performed on Table 1?*

We have added p-values obtained from testing the difference in the mean outcomes between postpartum and non-postpartum women to Table 1.

9. *For Table 2, would include what was used for the adjusted difference in the legend.*

We have added the full list of control variables to the table notes for Table 2: "Adjusted regression models included age group (18-24 years, 25-34 years, and 35-44 years), chronic disease (diabetes, asthma, hypertension, mood or anxiety disorder, region (Northwest, West, South, Midwest), income and month when follow-up began."

10. *For the figures, consider bars graphs by the week with the two groups side-by-side. Might be easier to see the differences than the dots.*

We include alternative versions of the Figures below based on this suggestion. We agree that the bars side-by-side show the differences between groups clearly. However, as the reviewing statistical Editor included a different suggested edit to the Figures, we will leave the decision of which version to include to the Editors.

Reviewer #3:

1. *The authors list four potentially important limitations of their study: (1) they were only able to examine health care receipt, not need; (2) routine visits may have been missed by being included in global claims; (3) race-ethnicity data were not available, and (4) (for understandable reasons) they only included women with consistent commercially-available insurance, potentially missing differences that would be seen in women with government-sponsored care or shifting commercial insurance. Could the authors elaborate on the extent to which they believe these limitations affect their findings? Clearly, they don't believe they are "fatal flaws," but just how important are they in interpreting the data available? What direction would they expect the data to move if these limitations were overcome?*

Thank you for this thoughtful question. We will address each limitation below.

1) While underuse and overuse of care are both theoretically possible, we believe that using claims data in this population likely underestimates need. However, this issue probably affected both postpartum and non-postpartum groups and we do not expect it to cause

bias in our estimates of differences between groups. We added further elaboration on this to the discussion: “First, claims data documents health care receipt not health care need, which would better inform clinical guidelines and reimbursement strategies for postpartum women. However, this issue would affect both postpartum and non-postpartum groups and we do not expect it to bias our estimates of differences between groups.”

2) Global claims billing during the postpartum period most likely resulted in an underestimate of the share of postpartum women experiencing health issues in the early and postpartum period. When care use was greater among postpartum women, as was nearly always the case in our results, underestimating care among postpartum women would cause a bias toward the null. We added further elaboration on this to the discussion: “Second, the timing and occurrence of the routine postpartum visit may not be fully observable in claims data since the routine visit can be billed inside the global maternity payment. This could result in an underestimate of the share of postpartum women experiencing health issues in the early and postpartum period, which would bias differences between the postpartum and non-postpartum groups towards the null.”

3) Lack of data on race ethnicity is an important limitation because understanding whether care use pattern differ between non-Hispanic Black women and non-Hispanic white women would be an important contribution to the literature. However, we do not think that this issue caused any bias in our findings. Given the paucity of research examining care use patterns among postpartum women, we believe that our study adds important evidence despite this limitation. In addition to acknowledging this limitation, we added a note for the need for further work on racial disparities in postpartum care in the discussion: “Further research on racial-ethnic and insurance-related disparities in postpartum care use would be an important contribution that could inform policy debates and health care reforms to improve access to postpartum care.”

4) Similar to issue 3, the inclusion criteria used in our study does not bias our results. However, lack of data from women covered by public insurance is an important limitation in our work. Pregnancy Medicaid coverage ends after 60 days postpartum and documenting the duration of excess healthcare needs associated with pregnancy in this population would be an important contribution that could inform policy debates. We added a note about the need for further work on racial disparities in postpartum care in the discussion: “Further research on racial-ethnic and insurance-related disparities in postpartum care use would be an important contribution that could inform policy debates and health care reforms to improve access to postpartum care.”

2. *Examining the figures, although they were able to demonstrate differences in health care receipt among all the time periods studied, the differences were most clearly pronounced in the early postpartum and postpartum periods. At least visually, the differences in the extended postpartum period appear negligible, or at least not significantly different from a clinical perspective. This would seem to support the idea that changes in care would be beneficial earlier, but not necessarily throughout the entire year after delivery, as the authors argue in their discussion.*

We agree that the differences are largest in the early and postpartum periods and that earlier intervention might reduce the severity of common postpartum health issues. Thus, we focused the majority of the discussion on the differences in these periods, especially the early postpartum period. We also chose to mention that differences remain beyond 60 days to point out that postpartum health needs decline continuously and do not abruptly stop at the 12 weeks currently suggested in ACOG guidelines. We also find that the return to "normal" non-postpartum levels appears to happen later around 16 weeks postpartum. To ensure that we do not overemphasize differences between groups after 60 days postpartum we have revised the study's conclusion to remove the first sentence which referred to the full year after birth, and to edit the last sentence so that it refers to ongoing health issues past 60 days postpartum rather than preventive care after 60 days postpartum. The revised text is below.

"Current patterns of health care use among this large sample of commercially-insured postpartum women suggest that existing models of postpartum care may not be responsive to the timing, frequency, and type of health care needed by women after birth. Health care payment and delivery reforms should focus on ensuring that postpartum women can access timely care for early postpartum problems and maintain access beyond 60 days postpartum to address ongoing health issues."

Statistics Editor comments:

3. *Lines 162-203: While this section is important, I think that much of it could be summarized in main text and the details elaborated in supplemental material for the interested reader.*

We have moved the study methods for identifying preventive and problem visits, including the procedure and diagnosis codes, to the study's Supplement.

4. *Table 1: Need units for age. Should statistically compare the two cohorts. There are nominal and statistical differences in age strata, presence of chronic conditions and others.*

We have added the units for age and p-values comparing differences between groups to Table 1.

5. *Table 2, lines 182-184: Need to include a footnote summarizing the variables used in the adjusted difference calculation. Also, should include in supplemental a table of all the actual counts used to derive the %s and should enumerate all missing values.*

We have added the full list of control variables to the table notes for Table 2 and a Table in the Supplement (Appendix Table 4) with the counts used to derive the percentages. This table does not include missing values because there was no missingness in the study outcomes due to the construction of the analytic dataset. We included only women who maintained continuous

coverage during the entire follow-up period; therefore, women with a claim were considered to have received care and women without a claim were considered to have no received care.

6. *Fig 1a and 1b: While I appreciate these figures, the differences are mostly so close to 0 and so close together that it is hard for the reader to appreciate the differences. Unfortunately, since some differences are negative, one cannot change to a log format. Suggest either a separate graph of the differences or perhaps a graph with two separate y-axes to better separate the differences.*

We present alternative versions of the main study figure below. The first alternative using bar graphs was suggested by Reviewer 2. The second alternative included a second y axis for the differences between groups. We defer to the Editors about which version is preferred.

7. *Fig 1e: I think this figure is important enough to include in main text.*

We have included this figure in the main text in the manuscript revision.

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:*

OPT-IN: Yes, please publish my point-by-point response letter.

2. *Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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.

We have noted this request.

3. *If your study is based on data obtained from the National Center for Health Statistics, please review the Data Use Agreement (DUA) for Vital Statistics Data Files that you or one of your coauthors signed. If your manuscript is accepted for publication and it is subsequently found to have violated any of the terms of the DUA, the journal will retract*

your article. The National Center for Health Statistics may also terminate your access to any future vital statistics data.

We do not use data from the National Center for Health Statistics in this manuscript.

4. *For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.*

   Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

We do not report the race of study participants in this study.

5. *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), observational studies using ICD-10 data (ie, RECORD), 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, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.*

We have included the STROBE checklist with this submission.

6. *If your study uses ICD-10 data, please make sure you do the following:*
   a. State which ICD-10-CM/PCS codes or algorithms were used as Supplemental

Digital Content.

b. Use both the diagnosis and procedure codes.

c. Verify the selected codes apply for all years of the study.

d. Conduct sensitivity analyses using definitions based on alternative codes.

e. For studies incorporating both ICD-9 and ICD-10-CM/PCS codes, the Discussion section should acknowledge there may be disruptions in observed rates related to the coding transition and that coding errors could contribute to limitations of the study. The limitations section should include the implications of using data not created or collected to answer a specific research question, including possible unmeasured confounding, misclassification bias, missing data, and changing participant eligibility over time.

f. The journal does not require that the title include the name of the database, geographic region or dates, or use of database linkage, but this data should be included in the abstract.

g. Include RECORD items 6.3 and 7.1, which relate to transparency about which codes, validation method, and linkage were used to identify participants and variables collected.

We have noted these requests. Our study primarily relies on ICD10 codes (diagnosis and procedure). All of the codes are listed in the Supplemental Digital Content.

7. *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 data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.*

We have reviewed these definition which are consistent with the language in our manuscript.

8. *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.*

Our manuscript meets this requirement.

9. *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).*

We have acknowledged that all financial support and previous conference presentations of this work.

10. *Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.*

We have added a short title to the title page.

11. *Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."*

We have added a precis to the second page.

12. *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.*

We have checked the abstract to ensure that it conforms to these requirements.

13. *In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.*

The abstract is 285 words.

14. *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.

We have noted these requirements.

15. *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.*

We have removed the virgule symbol from the manuscript.

16. *ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.*

We have removed the term ‘provider’ from the manuscript.

17. *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%").*

We use relative risk expressed with confidence intervals, percentages with a single decimal place.

18. *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.*

We have noted these requirements.

19. *Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications,*

*letters to the editor, theses, package inserts, submissions, meeting pre*sentations, and abstracts may be included in the text but not in the reference list.

In addition, 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 at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

We have formatted our references to be consistent with the current style.

20. *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.

    Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

We have noted these requirements.

21. *Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.*

We have noted these requirements.

22. *Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at https://wkauthorservices.editage.com/open-access/hybrid.html.*

    Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

Noted.

Tables and Figures in response to review and Editor comments

Figure 1 Alternative 1: Weekly percent of recently pregnant women (n=149,563) and non-pregnant or postpartum women (n=2,048,831) with a preventive visit

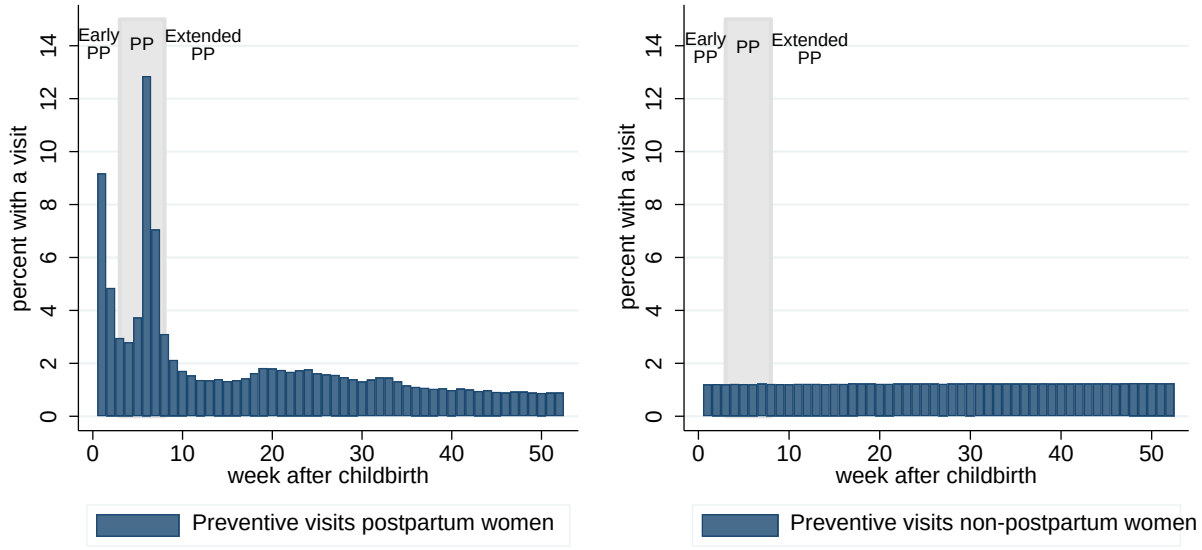


Figure 2 Alternative 1: Weekly percent of recently pregnant women (n=149,563) and non-pregnant or postpartum women (n=2,048,831) with a problem visit

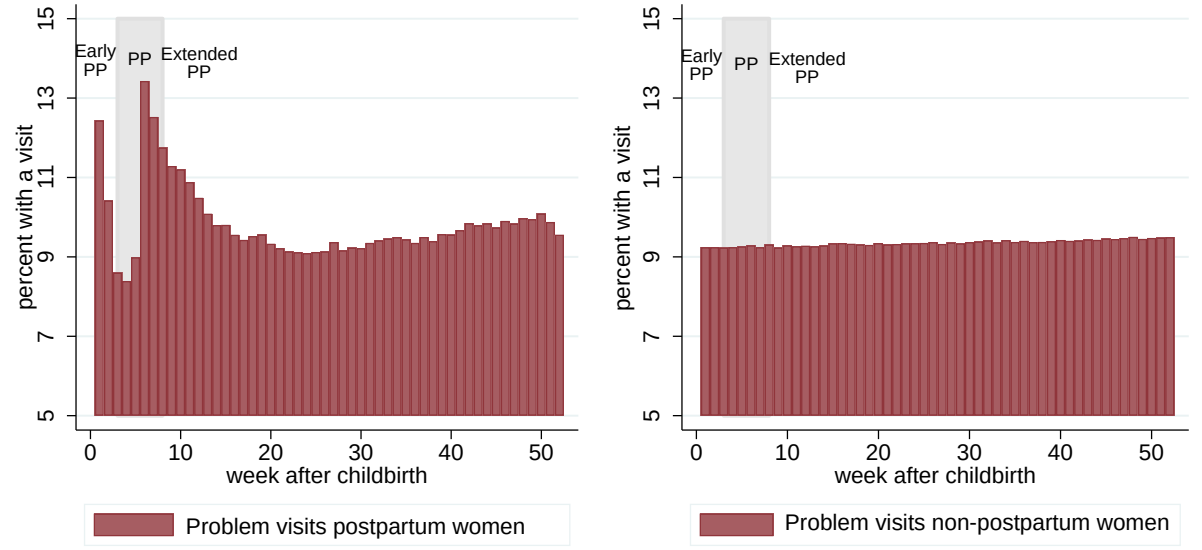


Figure 1 Alternative 2: Weekly percent of recently pregnant women (n=149,563) and non-pregnant or postpartum women (n=2,048,831) with a preventive visit (Alternative version with separate y-axis)

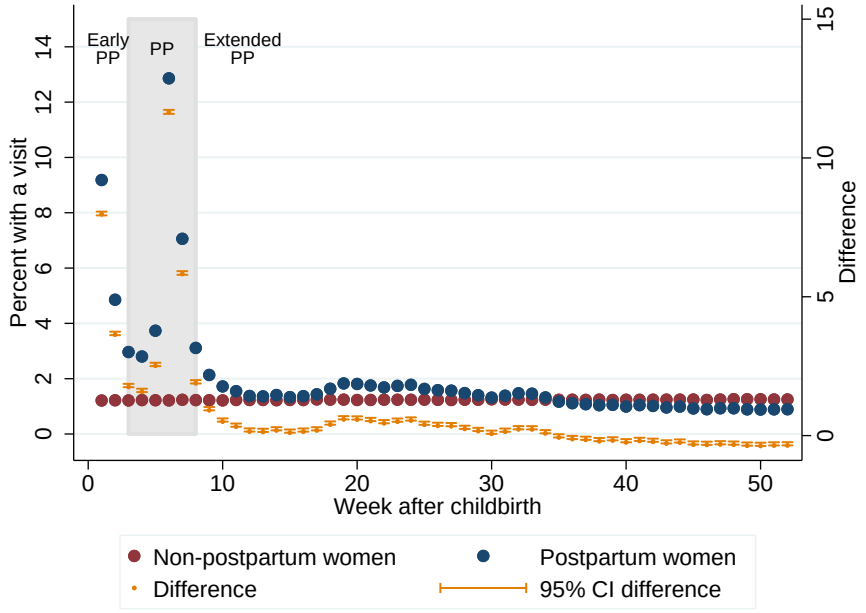
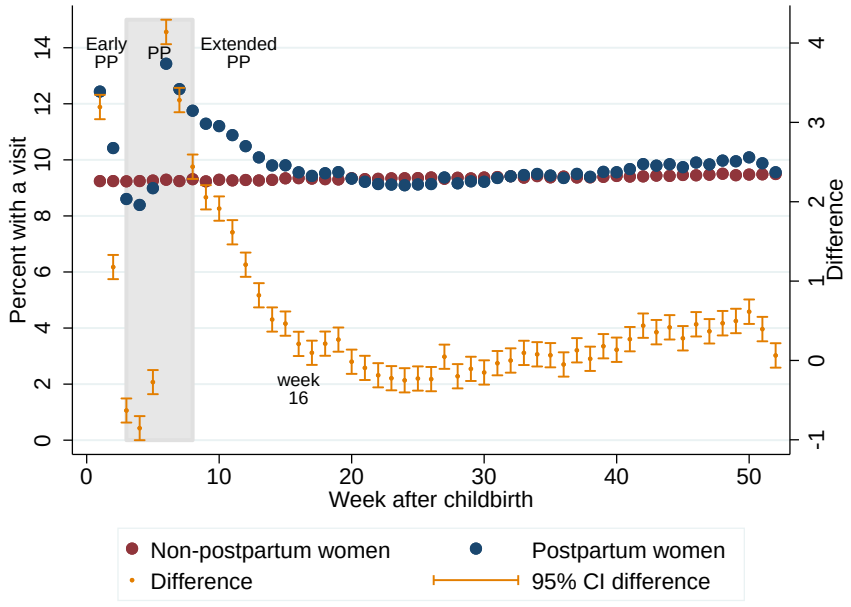


Figure 2 Alternative 2: Weekly percent of recently pregnant women (n=149,563) and non-pregnant or postpartum women (n=2,048,831) with a problem visit (Alternative version with separate y-axis)



References

1. King G, Nielsen R. Why Propensity Scores Should Not Be Used for Matching. Political Analysis. 2019;27(4):435-54.
2. Batur P, Phipps M, Qaseem A. The Women's Preventive Services Initiative Well-Woman Chart: A Helpful Tool for the Practice of Internal Medicine. The American journal of medicine. 2020.

Reviewer Table 1: Health care use among recently pregnant women and non-pregnant or postpartum women with commercial health insurance in the United States, analysis using matched sample

	All postpartum women	Comparison women	Difference (unadjusted)
Early postpartum	Percent	Percent	Percentage point
Preventive visits	15.0	3.3	11.7*** (11.6,11.9)
Problem visits	23.7	18.0	5.6*** (5.4,5.9)
ED visit	3.2	0.9	2.3*** (2.2,2.4)
Inpatient stay	0.8	0.1	0.7*** (0.7,0.7)
Postpartum			
Preventive visits	28.2	6.5	21.7*** (21.5,21.9)
Problem visits	39.4	28.0	11.4*** (11.1,11.6)
ED visit	2.0	1.7	0.3*** (0.2,0.4)
Inpatient stay	0.3	0.2	0.1*** (0.0,0.1)
Extended			
Preventive visits	42.5	43.0	-0.3 (-0.6,0.0)
Problem visits	79.5	71.3	8.3*** (8.0,8.5)
ED visit	11.2	10.3	0.9*** (0.7,1.1)
Inpatient stay	1.4	1.4	0.1* (0.0,0.1)
N	149,563	439,770	586,360