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: Apr 22, 2021
To: "Alex Friedman Peahl" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-627

RE: Manuscript Number ONG-21-627

The Michigan Plan for Appropriate Tailored Healthcare in Pregnancy (MiPATH) Prenatal Care Recommendations

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 May 13, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

This is an interesting study to try to reorganize prenatal care in "low risk patients" to make it more efficient without compromising outcomes. They point out that current prenatal care guidelines regarding frequency of prenatal visits were developed in the 1930's . Historically they were based on the early identification of preeclampsia and other hypertensives diseases of pregnancy with reliance on regular visits and monitoring BP, Fundal ht, maternal weight and proteinuria. The authors, motivated by the COVID crisis's effect on prenatal care used this opportunity to develop new guidelines employing hybrid in person and video/telehealth visits.
The authors use an unusual definition of low risk pregnancies - pregnancies cared for by Ob-Gyn's without maternal fetal medicine consultation or input. It is difficult for this reviewer to understand how hypertensive and diabetic mothers as well as those socioeconomically challenged can be considered low risk when in fact these are some of the highest risk patients. We are also not told how many patient are afected by these various risk factors. Certainly a better definition of low risk pregnancy would be one without any medical , surgical , fetal , or obstetrical complications. This would truly separate low risk from high risk pregnancies. Another difficulty in separating high and low risk patients is that risk factors develop and evolve during pregnancies. What may start off as low risk pregnancy can evolve into serious complications whether from gest DM, Gestational HTN, IUGR, Preeclampsia/eclampsia, so it would be more appropriate to have ongoing assessment of risk at each visit with an exit strategy for patients who develop these issues
It was also unclear to this reviewer what the 1,230 "clinical scenarios" were that were judged appropriate or inappropriate. Were these different patients, were they measurements and if so what type, were they clinical decisions?

This was a lot of work to achieve a conclusion that fundal ht measurements in the first trimester was inappropriate.
I am also troubled when consultants become involved in prenatal care , especially for socio-economically challenged patients and try to take away services, space out visits and have less intervention, when in reality these patients need more services with assistance in food insecurity, housing insecurity, and protection from domestic violence as well as support for treatment of drug, alcohol or smoking dependence.
Whereas I do agree that in truly low risk patients they can have fewer visits, fewer services and involve telehealth, but not in the population of low risk patients as defined in this paper

Reviewer #2:

The authors report their process and results of using the RAND Corporation/UCLA Appropriateness Method to assess timing and components of prenatal care delivery. The COVID pandemic, which changed frequency of care and use of telemedicine, made pressing an already-recognized need for updating current guidelines. This effort was at the invitation of ACOG, in collaboration with the University of Michigan. They used evidence from existing literature and panel consensus to assess guidelines for "low-risk" pregnancy (pregnancies not requiring MFM care) and those with medical conditions (HTN, diabetes, depression/anxiety) and pregnancy disorders (gestational HTN, gestational diabetes, h/o early miscarriage). They also considered how social and structural determinants of health could influence prenatal care recommendations. Prenatal care included frequency of in-person visits/telemedicine visits, fetal heart tones, fundal height, weight, and blood pressure monitoring. Ratings were classified as acceptable (high score benefits outweigh risks, agreement among panelists), unacceptable (low score, agreement), and uncertain (middle score or disagreement).

Line 99 - Most readers will not be familiar with the RAND Appropriateness Method. Could the authors briefly list examples of where this has been used elsewhere in medicine?

Line 102 - Why was this done specifically in conjunction with the University of Michigan? Previous experience with RAM or with recommendation development?

As with many issues across medicine and society in general, COVID demonstrated necessity being the "mother of invention," and recommendations for prenatal care proved no different. Using a wide variety of stakeholders and an established method of assessment, ACOG built support for changing recommendations forced to be re-examined by the needs of the pandemic. Perhaps most importantly, the RAM established the minimum number of in-person visits (four) for routine pregnancy care and which components can be monitored remotely (all of them, BP, FHT, weight, and fundal height, when beyond the first trimester).

Line 398 and 426 - The authors correctly point out that while they used existing published literature to support their conclusions, the existing recommendations are based on literature from controlled environments and will need updating as more evidence becomes available.

Line 442 - The potential for inequities influencing access to telemedicine is substantial. Imagining its role in prenatal care emphasizes the need to expand access to at-home tools and broadband services.

Reviewer #3:

This is very valuable and timely work. Some comments:
1. Through the document, you refer to "Psychosocial conditions", although on lines 153-156 you take the time to state that you changed your terminology away from that term. The definition of "psychosocial" refers to the interrelation between social factors and behavior, but throughout the document it's used with the word "condition" in a way that doesn't make sense to me. For instance, on lines 233-235, you list three such conditions: mood or anxiety disorders, pregnancy-related anxiety and increased pregnancy education needs. The first two are medical (psychiatric) conditions, not social. Increased education need isn't a condition per se, nor is it social. " I might be nitpicking but it threw me off while reading and I think it needs to be addressed throughout the document as to when you are referring to living conditions (food, water, shelter), low-literacy, etc. vs medical conditions such as opioid use disorder, poor dentition, etc.

2. Line 280 - this was already stated on line 265, so is redundant.

3. Lines 287-288 - I was surprised to see the term "viability ultrasound" because it's not something we routinely do outside of assisted reproduction services. Many insurers won't cover this as an indication, and we wait for the nuchal translucency scan as part of the first trimester screening to confirm gestation age for most patients. I don't believe this is routinely performed across the country.

4. Lines 293-299 - It's not clear in this paragraph whether or not the panel felt that the blood pressure needed to be taken in the provider's office or could be a reading at home. AHA recommendations are that the ambulatory readings are often more reflective of the status quo, so it would be helpful to clarify the intent of the panel if that was discussed.

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). Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have no yet done so.

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), 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.

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 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.

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).
* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

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 limit for Original Research articles is 300 words.

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. 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.

11. 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%").

12. 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.

13. 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).

14. Figures 1-2: Please upload as high-res figure files on Editorial Manager

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.

15. 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.

16. 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.

You will be receiving an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line 'Please Submit Your Open Access Article Publication Charge(s)'. Please complete payment of the Open Access charges within 48 hours of receipt.

***

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 May 13, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

John O. Schorge, MD
Associate Editor, Gynecology

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

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

[redacted]

Dwight J. Rouse, MD MSPH
Editor-in-Chief, *Obstetrics & Gynecology*

May 17, 2021

Dear Dr. Rouse,

We are pleased to submit our revised manuscript "Prenatal Care Recommendations from the Michigan Plan for Appropriate Tailored Healthcare in Pregnancy Panel: MiPATH" as an original manuscript to *Obstetrics & Gynecology* for further review. We appreciate the comments from the reviewers and editorial staff, and have made revisions as requested. Our responses to each are detailed below. Line numbers refer to the clean version of the revised manuscript.

This paper has not been published elsewhere and is not currently submitted elsewhere. All authors made contributions to the preparation of this manuscript. None of the authors report any conflicts of interest.

Thank you for your continued consideration.

Sincerely,

Alex Friedman Peahl, MD MSc
Clinical Lecturer, Department of Obstetrics and Gynecology
University of Michigan

REVIEWER 1:

Reviewer 1, Comment 1:

The authors use an unusual definition of low risk pregnancies - pregnancies cared for by Ob-Gyn's without maternal fetal medicine consultation or input. It is difficult for this reviewer to understand how hypertensive and diabetic mothers as well as those socioeconomically challenged can be considered low risk when in fact these are some of the highest risk patients…Certainly a better definition of low risk pregnancy would be one without any medical , surgical , fetal , or obstetrical complications. This would truly separate low risk from high risk pregnancies. Another difficulty in separating high and low risk patients is that risk factors develop and evolve during pregnancies. What may start off as low risk pregnancy can evolve into serious complications whether from gest DM, Gestational HTN, IUGR, Preeclampsia/eclampsia, so it would be more appropriate to have ongoing assessment of risk at each visit with an exit strategy for patients who develop these issues… Whereas I do agree that in truly low risk patients they can have fewer visits, fewer services and involve telehealth, but not in the population of low risk patients as defined in this paper.

Response: The panel leadership agrees that the lack of current definitions for low-risk pregnancies is problematic. We thus sought to create a definition that would include patients cared for by the majority of maternity care health professionals in the United States. The panel recognized that increasingly more patients experience comorbidities, adverse social and structural determinants of health, or develop pregnancy complications (e.g. gestational diabetes and hypertension). In order to develop guidelines that would apply to the majority of patients, we included the lowest risk patients (i.e. those with no additional comorbidities, pregnancy complications, or adverse social and structural determinants of health) *and* sample conditions that might influence prenatal care delivery (i.e. common specific comorbidities, pregnancy complications, or adverse social and structural determinants of health). This broader definition allows for a greater degree of care tailoring, and provides more specific guidance for a broader range of patients routinely cared for by maternity care health professionals. Of note, the panel did include recommendations for more frequent visits and monitoring for patients with comorbidities and psychosocial risk factors, as well as guidance on intensifying care for patients who develop complications over the course of pregnancy. In order to clarify how our definition of risk differs from former definitions, we have modified the text to read “average risk” rather than “low risk.” Additionally, we have referred to the specific population considered (e.g. patients with no medical or pregnancy conditions; patients with chronic hypertension) where possible to avoid confusion. Finally, we have further emphasized the need for care tailoring, and called out the need to adjust schedules to meet patients’ evolving risk.
Changes made throughout the manuscript.

Reviewer 1, Comment 2:

We are also not told how many patient are afected by these various risk factors.

Response: The purpose of this manuscript was to describe the MiPATH panel process and results. Panelists were provided resources on individual conditions through the resources provided in Appendix 2, which include epidemiologic information.

Reviewer 1, Comment 3:

It was also unclear to this reviewer what the 1,230 "clinical scenarios" were that were judged appropriate or inappropriate. Were these different patients, were they measurements and if so what type, were they clinical decisions?

Response: Thank you for highlighting this opportunity to provide greater clarity. Panelist rating materials were divided into “chapters,” with one chapter for each of the medical and pregnancy conditions considered (e.g. hypertension, gestational diabetes). Within each of the 8 chapters, panelists were asked to rate the appropriateness of individual prenatal care delivery recommendations, including timing of first

prenatal appointment and ultrasound, use of home devices, frequency of prenatal visits, and telemedicine for prenatal appointments. Each delivery recommendation was posed at a variety of time points. For example, for the chapter on chronic hypertension, panelists were asked to rate the appropriateness of the timing of the first prenatal appointment from 4 to 14 weeks. This resulted in 10 "scenarios." We have added clarifying text to better outline this process.
Lines 198-207: "As risk of pregnancy-induced complications increases over time, all components of prenatal care were considered at four key time points: presentation to care through the end of the first trimester (13 6/7 weeks); second trimester (14 0/7 to 27 6/7 weeks); early third trimester (28 0/7 to 35 6/7 weeks); and late third trimester (36 0/7 weeks to delivery). This resulted in multiple scenarios: for example, for the prenatal care component appropriate frequency of monitoring blood pressure, panelists were asked to rate the appropriate frequency of monitoring for each condition (e.g. no medical or social conditions, chronic hypertension) over relevant trimesters. For conditions that affected all trimesters, panelists completed four ratings, whereas for conditions that affected specific trimesters (e.g. gestational diabetes), panelists only completed ratings for the appropriate trimester (e.g. early and late third trimester)."

Reviewer 1, Comment 4:
This was a lot of work to achieve a conclusion that fundal ht measurements in the first trimester was inappropriate.

Response: We agree that the rating process is time-consuming and meticulous. We believe this is part of the rigor of the RAND-UCLA process, and ensures the conclusions of the experts are carefully considered.
No textual changes.

Reviewer 1, Comment 5:
I am also troubled when consultants become involved in prenatal care , especially for socio-economically challenged patients and try to take away services, space out visits and have less intervention, when in reality these patients need more services with assistance in food insecurity, housing insecurity, and protection from domestic violence as well as support for treatment of drug, alcohol or smoking dependence.

Response: We agree with the assessment that patients facing adverse social and structural determinants require assistance with addressing their needs. These patients often need ancillary services (e.g. social work, referral to local community resources), not more obstetric care. The panel, which included representatives from pediatrics and public health, recognized the importance of a team-based approach to care that ensures patients have excellent coordination of medical and non-medical services. The goal is not to have less overall services, but to ensure patients are provided the right kind of service. We have added text highlighting this nuance.
Lines 348-352: "Panelists uniformly agreed that when individuals' identified needs could be met through additional services, the patient should be connected to these services, and that there was rarely a need to increase visit frequency beyond the average-risk visit schedule. Panelists discussed that in this scenario, additional prenatal visits were unlikely to address non-medical needs and could potentially create more burden for patients."
Lines 364-367: "Panelists acknowledged that for many of these conditions, additional practitioner visits may not address the underlying condition, but that the inability to meet the patient's need through additional services or patient preference might be an indication for increased frequency of contact."

REVIEWER 2:

Reviewer 2, Comment 1:

Line 99 - Most readers will not be familiar with the RAND Appropriateness Method. Could the authors briefly list examples of where this has been used elsewhere in medicine?

Response: We have included a reference to other groups that have utilized the RAM method for guideline development.

Lines 99-103: "The RAM has been used to develop guidelines for diverse topics, including cesarean delivery criteria,[16] indications for adult and pediatric intravenous catheters,[17,18] and appropriate medication prescribing.[19,20] This method was particularly advantageous, as panel leaders recognized many topics (e.g. telemedicine, frequency of monitoring blood pressure) lacked a robust evidence base in the established literature."

Reviewer 2, Comment 2:

Line 102 - Why was this done specifically in conjunction with the University of Michigan? Previous experience with RAM or with recommendation development?

Response: ACOG and the University of Michigan had previously discussed the need for a consensus conference on prenatal care delivery, and had planned to pursue this effort in 2022 prior to the urgent need created by the public health crisis. The University of Michigan has a unique combination of expertise in prenatal care delivery (AFP), as well as experts in the RAM (VC, SJB), including one member who participated in the initial development of the RAM (SJB).

Reviewer 2, Comment 3:

Line 398 and 426 - The authors correctly point out that while they used existing published literature to support their conclusions, the existing recommendations are based on literature from controlled environments and will need updating as more evidence becomes available.

Line 442 - The potential for inequities influencing access to telemedicine is substantial. Imagining its role in prenatal care emphasizes the need to expand access to at-home tools and broadband services.

*Response**:*** We completely agree with this reviewer's assessment of the need for both improved evidence on real-world use of new prenatal care models, as well as the importance of ensuring equity in telemedicine.

REVIEWER 3:

Reviewer 3, Comment 1:

This is very valuable and timely work. Some comments:

1. Through the document, you refer to "Psychosocial conditions", although on lines 153-156 you take the time to state that you changed your terminology away from that term. The definition of "psychosocial" refers to the interrelation between social factors and behavior, but throughout the document it's used with the word "condition" in a way that doesn't make sense to me. For instance, on lines 233-235, you list three such conditions: mood or anxiety disorders, pregnancy-related anxiety and increased pregnancy education needs. The first two are medical (psychiatric) conditions, not social. Increased education need isn't a condition per se, nor is it social. " I might be nitpicking but it threw me off while reading and I think it needs to be addressed throughout the document as to when you are referring to living conditions (food, water, shelter), low-literacy, etc. vs medical conditions such as opioid use disorder, poor dentition, etc.

Response: Thank you so much for this important point. The panel extensively discussed the importance of terminology for these crucial non-medical factors that affect patients. In our discussions, we discovered multiple terms, including psychosocial conditions, social determinants, structural determinants, and social and structural determinants. Ultimately, the panel believed social and structural determinants best captured the diverse risk factors and conditions included in this section. We have modified the language throughout the manuscript to avoid confusion.
Changes made throughout the manuscript.

Reviewer 3, Comment 2:
Line 280 - this was already stated on line 265, so is redundant.

Response: Thank you for this point. We have removed the text.

Reviewer 3, Comment 3:
Lines 287-288 - I was surprised to see the term "viability ultrasound" because it's not something we routinely do outside of assisted reproduction services. Many insurers won't cover this as an indication, and we wait for the nuchal translucency scan as part of the first trimester screening to confirm gestation age for most patients. I don't believe this is routinely performed across the country.

Response: The panel referred to the ACOG guidance on ultrasound, which states that "the best gestational age for obstetric ultrasonography will depend on the clinical indication for the examination. For patients with uncertain or unreliable menstrual dating or with an indication to confirm viability, first-trimester ultrasonography is most accurate." The practice bulletin continues, "ultrasound measurement of the embryo or fetus in the first trimester is the most precise method to confirm or establish gestational age."[1] In order to better align the panel recommendations with ACOG guidance, we have replaced the term "viability ultrasound" with "dating ultrasound" throughout the manuscript.
Changes made throughout the manuscript.

Reviewer 3, Comment 4:
Lines 293-299 - It's not clear in this paragraph whether or not the panel felt that the blood pressure needed to be taken in the provider's office or could be a reading at home. AHA recommendations are that the ambulatory readings are often more reflective of the status quo, so it would be helpful to clarify the intent of the panel if that was discussed.

Response: The panelists rated the appropriateness of home measurement of routine pregnancy parameters for *all* conditions. After discussions, panelists agreed that the appropriateness of home monitoring should not differ between conditions, though the appropriate frequency might change. Thus, home monitoring of blood pressure was seen as appropriate for all conditions. We have added text to emphasize this point.
Lines 267-271: "Panelists agreed that monitoring all identified assessments (blood pressure, fetal heart tones, weight, and fundal height) was appropriate in-person *and* remotely in the second and third trimester. Monitoring of blood pressure and weight was also considered appropriate in-person and at home in the first trimester.

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

[1] Committee on Practice Bulletins-Obstetrics, American Institute of Ultrasound in Medicine. Practice Bulletin No. 175: Ultrasound in Pregnancy. Obstet Gynecol 2016;128:e241-e56.

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:

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

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (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. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have no yet done so.

Response: We will ensure all authors complete the agreement.

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), 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.

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 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.

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.

Response: Our revised manuscript text meets the word count restrictions.

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).
* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

Response: We have included all relevant acknowledgments.

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 limit for Original Research articles is 300 words.

Response: Our abstract is 300 words.

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.

Response: We have spelled out abbreviations at first usage and have used only the non-standard “RAM” and “MiPATH,” as they are central components of our 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.

Response: We have replaced instances of “/” with “or” where appropriate.

10. 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.

Response: We have used “clinician” throughout.

11. 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%").

Response: Not applicable

12. 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.

Response: We have consulted the table checklist for adherence to style.

13. 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).

Response: We have consulted the formatting instructions for adherence to reference style.

14. Figures 1-2: Please upload as high-res figure files on Editorial Manager

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.

Response: We have uploaded Figures 1 and 2 and removed them from the manuscript.

15. 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.

Response: We have labeled our appendices as noted.

16. 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.

You will be receiving an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line 'Please Submit Your Open Access Article Publication Charge(s)'. Please complete payment of the Open Access charges within 48 hours of receipt.