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: Oct 22, 2021
To: "Moeun Son"
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-2021

RE: Manuscript Number ONG-21-2021

Postpartum length of stay and hospital readmission before and during the Coronavirus Disease 2019 pandemic

Dear Dr. Son:

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).

Please be sure to address the Editor comments (see "EDITOR COMMENTS" below) in your point-by-point response.

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 Nov 12, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

General comments: Overall I thought this study was an interesting and appropriate use of EMR data. I do have a few concerns including the following: 1) the data is not presented to allow the reader to understand the change in clinical practice clearly; specifically, what types of patients were more likely to be discharged home early post-pandemic compared to pre-pandemic? These important details of this 'natural experiment' are not provided, 2) there are some unexpected findings that the authors need to review and explain, 3) the discussion spends a lot of time on issues that are not supported by data in the analysis.

Introduction
The introduction is clear and well written.

A question that I do have from the introduction is why use such a long pre-pandemic period? Why not just use 1 year pre-pandemic given the sample size to avoid confounding by other temporal trends?

Methods
One thing that is a little unclear to me is where the different data fields came from in the EMR. Were delivery hospitalizations identified by ICD-10? Or is there uniform EMR delivery documentation? For fields like pre-pregnancy BMI, did that come from fields for the birth certificate data? A question with these studies is always what variables come from billing coding versus uniform preset fields related to clinical care versus other clinical information. I understand that there are appendix tables, but it would be nice to have an overview of where the data comes from in the methods section.

Line 147 'We used Bayesian logistic mixed-effects regression models with a noninformative prior to assess the association between the COVID-19 era and short postpartum hospitalization LOS.' Maybe a couple sentences describing why this regression model was used and what its relative advantages are? One question I am not clear on - was the random effects component related to modeling for clustering at the hospital or hospital system level?

A question I had immediately was: who are the patients who are now being discharged that would not have been pre-pandemic. The study shows that the cohort didn't change significantly pre/post pandemic, but the type of patient who was discharged early and whether they had risk factors may have. When we looked at data on this subject in our institution we found shorter LOS during COVID in the setting of hypertensive disorders was associated with higher readmission risk compared to historical controls. If there is differential risk for readmission with short LOS based on specific complications
that would be helpful to highlight and for clinicians to be aware of.

Results
Line 173 Median number of deliveries is low, presumably because there are a lot of small centers. Mean might be more informative.

I'm surprised that the aOR for short hospitalizations was so high. I understand that ORs overestimate risk compared to RR but I was surprised risk was double given that absolute increase was only about a third higher (48% versus 63%). To address this issue and provide the reader more context, it would be helpful to demonstrate ORs and aORs for the adjusted models for all risk factors for both for short discharge and readmission - these risk factors are probably the most clinically relevant. It would be interesting if to see if early discharge increased mostly among low risk women post pandemic.

Line 203-204 'median readmission LOS was 11 days in the pre pandemic era and 10 days in the COVID-19 era (standardized difference -0.120).'
I thought this was very surprising - that's a very long median stay given that many readmissions are for a few days. Do the authors have any thoughts on this? An 11 day postpartum stay would be an outlier at many hospitals.

Line 211-213 'In addition to readmission, we assessed the frequency of other types of encounters, if any, with the healthcare system, including ambulatory, telemedicine, and urgent or emergency care visits.'
This info should probably be in the methods section.

Might want to mention estimates for ED encounters and telehealth in more detail. This is presented as an afterthought in the results but figures prominently in the discussion.

Figure 1 It's strange that 15% of the cohort was excluded for delivering at centers with <100 births a year. That means that there were >2000 of these centers? That doesn't really line up with national data on where patients deliver. Authors should comment.

Discussion
Line 225-227 'Additionally, while the frequencies of ambulatory and urgent or emergency care visits were unchanged, there was a marked increase in the frequency of telehealth encounters.'
I think if you're going to focus on ED/telehealth data in the discussion you need to have it feature more prominently in the results.

Line 276-289 - I don't think you can speculate on shared decision making based on data from this study.

Line 290-307 - the speculation on telehealth is a little out of place - there was only a small amount of data on this subject presented in the study and not in a form that was helpful in making inferences.

Reviewer #2:
OVERALL: The authors utilize the EPIC Cosmos data platform to understand whether length of stay after delivery (LOS) and postpartum readmission for any indication (secondary) varied in pre vs post COVID time periods. Using a bayesian analytical framework with this national data source, the authors conclude what many clinicians have recognized, which is decreased LOS regardless of mode of delivery and no marked change in readmission rates.

Overall the methods are solid, including statistical analysis, for which I congratulate the authors for their methodological rigor using up to date methods. My main hesitancy with regards to enthusiasm is simply showing lower LOS in an era of COVID is not necessarily a novel finding. Indeed the lower LOS they show here is already standard of care at many centers for some years now based on older data.

The authors conclude that COVID provided a natural experiment to demonstrate that shorter LOS after delivery in safe and reasonable. I would argue there was already considerable regional variation prior to COVID in postpartum length of stay, and their primary dichotomous outcome of short is perhaps short for the Northeast, but was standard of care in many if not most centers in the south and Midwest pre covid. So my concern is the definition of this dichotomous outcome and what the source for short LOS is based on.
I would stratify your data by region and/or hospital networks to see patterns of LOS pre and post pandemic.

SPECIFIC COMMENTS:
1. Page 6-7 include detailed description of covariates which can be summarized in much more succinct fashion. Details about these covariates can then be described in further detail in appendix Tables.

2. Please explain for a clinical audience why a Bayesian analytical approach was taken. I agree this may be appropriate but
further context is necessary.

3. How were variables selected for model inclusion? DAG?

4. First paragraph of the discussion focus on primary analysis and primary outcomes, save the secondaries for later in the discussion.

5. Lines 290-308, too much discussion of telehealth which is not a primary focus of this paper, this should be shortened.

6. Focus your discussion on what is already known about delivery LOS and risk of readmission in the pre covid era, this is not sufficiently discussed, and a discussion focused on this would much better contextualize your findings and conclusions.

Reviewer #3: The authors present a retrospective cohort analysis using Epic systems Cosmos research platform data to analyze the impact of COVID-19 on post-partum length of stay and readmission rates. My main concern is that the study design may not be ideal. The same reasons that created a shorter post-partum length of stay as the primary outcome should also cause a decrease in readmission rates the secondary outcome. Therefore, it is more difficult to draw an association between the primary and secondary outcomes.

Line 24, Abstract and line 224, Discussion: Why the use of "minimal" change in hospital readmissions - there was no statistical difference.

Line 84, Methods: Why was the pre-pandemic group 3 years when the pandemic group is only 1?

Lines 287-289, Discussion: As this study did not assess patient satisfaction with the hospital length of stay, the authors cannot state that their findings "suggest...clinicians were appropriately identifying those ready for an earlier discharge."

Figure 2 is unnecessary and could be removed.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

Since the proportion of short stay has been decreasing vs time (lines 42-43), and the pre-pandemic time epoch in this series is 3 yrs vs 1 yr pandemic, should show the trends vs time in relevant time periods, e.g., 6 month intervals. This would demonstrate the extent to which the increase in short stay was already occurring pre-pandemic. For instance, a time series analysis with graphic display of the short stay proportions over time with analysis of any relevant change in slope or other statistical comparison would be informative for the reader.

lines 149-155 and Table 1: Since the analysis using standardized differences in Table 1 disclosed no significant differences, then why were the covariates listed used to adjust the short hospitalization proportions in the models? How did the aORs differ from unadjusted ORs? Should include both unadjusted and adjusted ORs with their respective CIs in a Table. Should include both the overall and the separate results for vaginal and cesarean births. (The values from Fig 3 are not easily read.)

Is there individual patient level data that would allow for identification of more than one delivery per individual during the time period of study? If so, then need to adjust for repeated measures for an individual, since outcomes could not be assumed to be statistically independent, but rather correlated.

Although the proportion of multiple gestations is similar, (3.7% vs 3.3%), that would seem to be one variable that might skew the length of stay. Should do a sensitivity analysis to include only singleton births.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology have increased 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. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:
* Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
* Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
* Name the IRB or Ethics Committee institution in the Methods section (if applicable).
* Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

3. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you upload your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

4. 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.

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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, 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. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

8. 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. Please provide a word count.

9. 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.

10. 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.

11. ACOG avoids using "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.

12. 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%)

13. 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.

14. 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 references you are citing are still current and available. Check the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document.

If the reference you are citing has been updated and 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.

15. Figure 1-4 may be resubmitted as is with the revision.

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.

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.

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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 as a Microsoft Word document. Your revision's cover letter should include the following:
* A confirmation that you have read the Instructions for Authors (http://edmrg.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 Nov 12, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Jason Wright, MD
Editor-in-Chief, Elect

2020 IMPACT FACTOR: 7.661
2020 IMPACT FACTOR RANKING: 3rd out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
Dear Dr. Wright,

Thank you for the opportunity to revise and resubmit our Original Investigation titled “Postpartum length of stay and hospital readmission before and during the Coronavirus Disease 2019 pandemic.” We have responded to the Editorial and Reviewer comments and incorporated associated suggestions.

We appreciate the thorough review of our manuscript. In our initial submission, Reviewer #1 noted that the readmission LOS was much longer than would be expected (11 days). This comment prompted a re-evaluation of the statistical code and revealed an error in the calculation length of stay. To fully address this issue, we have rerun all components of the study, including identification of the cohort. Because Cosmos is an actively growing research platform, the available data have changed and thus with the same inclusion criteria our analytic cohort has increased in size by 32,823 patients. The study findings are unchanged, though associated numbers reported in the manuscript have changed as they reflect the updated analyses.

As previously stated, this study was deemed non-human subjects research by the institutional review board of the Children’s Hospital of Philadelphia. We affirm that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained. We hereby submit this revised manuscript for consideration in Obstetrics & Gynecology.

There remain no prior publications or submissions with overlapping information. Aspects of this work were presented at Epic’s User Group Meeting on August 24, 2021 in Madison, WI. All authors have seen and approve of the final manuscript.

Thank you for continuing to consider our revised submission for publication in Obstetrics & Gynecology.

Sincerely,

Moeun Son, MD, MSCI
On behalf of all co-authors
COMMENT FROM THE AUTHORS:
We appreciate the thorough review of our manuscript. In our initial submission, Reviewer #1 noted that the readmission LOS was much longer than would be expected (see comment #8). This comment prompted a re-evaluation of the statistical code and revealed an error in the calculation of length of stay. To fully address this issue, we have rerun all components of the study, including identification of the cohort. Because Cosmos is an actively growing research platform, the available data have changed and thus with the same inclusion criteria our analytic cohort has increased in size by 32,823 patients. The study findings are unchanged, though associated numbers reported in the manuscript have changed as they reflect the updated analyses. This is the reason some numbers previously noted in your comments may not appear in the associated response or manuscript text.

REVIEWER COMMENTS:

Reviewer #1:

1. Comment: General comments: Overall I thought this study was an interesting and appropriate use of EMR data. I do have a few concerns including the following: 1) the data is not presented to allow the reader to understand the change in clinical practice clearly; specifically, what types of patients were more likely to be discharged home early post-pandemic compared to pre-pandemic? These important details of this 'natural experiment' are not provided, 2) there are some unexpected findings that the authors need to review and explain, 3) the discussion spends a lot of time on issues that are not supported by data in the analysis.

Response: We have addressed the three points made by the Reviewer. For a detailed response to concern #1, see Response to Comment #5 below, for a detailed response to concern #2, see Comment #8, and for detailed response to concern #3, see Comments #12-#14.

Introduction
The introduction is clear and well written.

2. Comment: A question that I do have from the introduction is why use such a long pre-pandemic period? Why not just use 1 year pre-pandemic given the sample size to avoid confounding by other temporal trends?

Response: In response to your comment and similar comments from other Reviewers regarding either the definition of the pre-pandemic era and/or temporal trends, we completed additional analysis examining short postpartum LOS by 6 month intervals. This additional analysis is now referenced in the Methods and Results.

Methods
To assess for other temporal trends, we examined the proportion of short postpartum LOS by six-month intervals and used standardized differences to assess for differences in the trend using late 2019 (July-December) as the reference.

Results: “In the temporal trend analysis, there were small, secular increases in short postpartum LOS prior to the pandemic, but were trivial compared to periods after the pandemic began in early 2020 (Appendix 6).”

Supplemental Digital Content: Addition of Appendix 6

Methods
3. **Comment:** One thing that is a little unclear to me is where the different data fields came from in the EMR. Were delivery hospitalizations identified by ICD-10? Or is there uniform EMR delivery documentation? For fields like pre-pregnancy BMI, did that come from fields for the birth certificate data? A question with these studies is always what variables come from billing coding versus uniform preset fields related to clinical care versus other clinical information. I understand that there are appendix tables, but it would be nice to have an overview of where the data comes from in the methods section.

**Response:** We have edited the Methods to provide this overview.

**Methods:** “Childbirth hospitalizations and associated variables are primarily captured in Cosmos via Epic documentation of birth events, which facilitates uniform documentation of discrete variables including pregnant patient and infant characteristics. Variables pertaining to patient comorbidities and indications for rehospitalization were obtained from International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes and Clinical Classifications Software Refined (CCSR) categories, respectively.”

4. **Comment:** Line 147 'We used Bayesian logistic mixed-effects regression models with a noninformative prior to assess the association between the COVID-19 era and short postpartum hospitalization LOS.’ Maybe a couple sentences describing why this regression model was used and what its relative advantages are? One question I am not clear on - was the random effects component related to modeling for clustering at the hospital or hospital system level?

**Response:** We used Bayesian models for two reasons, which are now detailed in the manuscript, and have clarified that models were clustered on the hospital system level.

**Methods:** “We used Bayesian logistic mixed-effects regression models with a noninformative prior to assess the association between the COVID-19 era and short postpartum hospitalization LOS. Bayesian models were used for two reasons, 1) methodologically, Bayesian models can better fit complex models with a large number of random variance components and 2) technically, Bayesian models were the type of mixed model supported in the Cosmos environment.”

**Methods:** “…high-risk SVI and region with a random intercept for hospital system.”

5. **Comment:** A question I had immediately was: who are the patients who are now being discharged that would not have been pre-pandemic. The study shows that the cohort didn’t change significantly pre/post pandemic, but the type of patient who was discharged early and whether they had risk factors may have. When we looked at data on this subject in our institution, we found shorter LOS during COVID in the setting of hypertensive disorders was associated with higher readmission risk compared to historical controls. If there is differential risk for readmission with short LOS based on specific complications that would be helpful to highlight and for clinicians to be aware of.

**Response:** In response to this comment, completed additional analysis comparing the characteristics of patients who had a short postpartum LOS in the pre-pandemic and COVID-19 eras. This analysis is now referenced in the Methods, Results, and Appendix.

**Methods:** “We also compared characteristics of patients with a short postpartum LOS in the pre-pandemic and COVID-19 eras.”

**Results:** “Characteristics of patients with a short postpartum LOS were similar in the pre-pandemic and COVID-19 eras, apart from an increased proportion of patients from the..."
Northeast region and decreased proportion of the West in the COVID-19 era (Appendix 5)."

**Supplemental Digital Content:** Addition of Appendix 5.

**Results**

6. **Comment:** Line 173 Median number of deliveries is low, presumably because there are a lot of small centers. Mean might be more informative.

**Response:** We appreciate this suggestion, the mean number of births per department in the cohort was 937, however the manuscript continues to report the median and IQR given the skewed distribution of the data.

7. **Comment:** I'm surprised that the aOR for short hospitalizations was so high. I understand that ORs overestimate risk compared to RRs but I was surprised risk was double given that absolute increase was only about a third higher (48% versus 63%). To address these issues and provide the reader more context, it would be helpful to demonstrate ORs and aORs for the adjusted models for all risk factors for both for short discharge and readmission - these risk factors are probably the most clinically relevant. It would be interesting if to see if early discharge increased mostly among low-risk women post pandemic.

**Response:** Indeed, the odds overestimate the risk but are still mathematically correct (OR: (44.5/55.5)/(28.7/71.3)=80.18/40.25=1.99 RR: (44.5/100)/(28.7/100)=1.55. For more transparency, Figure 2 includes the unadjusted OR and adjusted OR for both short postpartum LOS and rehospitalization, stratified by mode of delivery. The inclusion of these data in the Figures is now referenced in the text. A dedicated analysis of low-risk women is beyond the scope of the current paper. Patient characteristics among patients with short postpartum LOS are addressed in Comment #5 and Appendix 5 shows that a higher percentage of healthy patients and those over 18 had a short postpartum LOS. As expected, within the readmission models, pre-existing conditions and birth complications were risk factors for readmission. An example of a Table containing the aORs and credible intervals from the primary readmission model of all births appears at the end of this document. Because readmission risk factors were not the primary focus of the manuscript, we defer to the Editor as to whether such a table should appear in the Supplemental Digital Content.

**Results:** "In unadjusted and multivariable adjusted models, the association between the COVID-19 era and short postpartum LOS was present for all obstetric patients (adjusted odds ratio [aOR] 2.35, 99% credible interval [CI] 2.32, 2.39), patients with vaginal births (aOR 2.14, 99% CI 2.11, 2.18), and patients with cesarean births (aOR 2.90, 99% CI 2.83, 2.98) (Figure 2, panel A)."

**Results:** "This finding was similar in the unadjusted and adjusted models for all patients (aOR 1.02, 99% CI 0.97, 1.08), patients with vaginal births (aOR 1.03, 99% CI 0.96, 1.10), and patients with cesarean births (aOR 1.01, 99% CI 0.94, 1.08) (Figure 2, panel B)."

**Figure 2:** See Figure 2 with addition of ORs and aORs with credible intervals.

8. **Comment:** Line 203-204 'median readmission LOS was 11 days in the pre pandemic era and 10 days in the COVID-19 era (standardized difference -0.120). I thought this was very surprising - that's a very long median stay given that many readmissions are for a few days.
Do the authors have any thoughts on this? An 11 day postpartum stay would be an outlier at many hospitals.

Response: We appreciate this comment, which prompted re-evaluation of the variables used to calculate readmission LOS and revealed an error, addressed at the beginning of the response document. We have updated the text with the updated data, including the recalculated readmission LOS.

Methods: “Among patients who were readmitted, the median number of days between postpartum hospitalization discharge and hospital readmission was 6 in the pre-pandemic era and 5 in the COVID-19 era (standardized difference -0.062) and the median readmission LOS was 2 days in both eras (standardized difference -0.081).”

9. Comment: Line 211-213 ’In addition to readmission, we assessed the frequency of other types of encounters, if any, with the healthcare system, including ambulatory, telemedicine, and urgent or emergency care visits.’ This info should probably be in the methods section.

Response: This information appears in the Methods section.

Methods: “Descriptive analyses regarding indications for readmission and postpartum patient healthcare utilization (the number and type of encounters in the six weeks following postpartum hospital discharge) were compared between eras.”

10. Comment: Might want to mention estimates for ED encounters and telehealth in more detail. This is presented as an afterthought in the results but figures prominently in the discussion.

Response: We have increased the text and associated detail surrounding healthcare encounters in the six weeks following postpartum hospital discharge.

Results: “In addition to readmission, we assessed the frequency of other types of encounters, if any, with the healthcare system, including ambulatory, telemedicine, and urgent or emergency care visits. Among all postpartum patients in the COVID-19 era, there was nearly a 7-fold increase in telemedicine encounters (1.0% to 6.9%, standardized difference 0.308) with no change in ambulatory encounters (standardized difference -0.046) nor urgent care or emergency encounters (standardized difference -0.032) (Figure 3). There was no change in the proportion of patients without encounters with the healthcare system in the six weeks after delivery hospitalization discharge (59.8% to 59.5%, standardized difference -0.006). Appendix 7 and 8 show short postpartum hospitalization LOS, hospital readmission, and healthcare encounters (ambulatory, telemedicine, urgent or emergency care, and no encounters) stratified by mode of delivery.”

11. Comment: Figure 1 It's strange that 15% of the cohort was excluded for delivering at centers with <100 births a year. That means that there were >2000 of these centers? That doesn't really line up with national data on where patients deliver. Authors should comment.

Response: We have clarified the nature of departments in the text.

Methods: “Deliveries in departments with ≤100 births annually in every year of the study period were excluded in order to restrict to departments that intend to routinely provide obstetric care. Department organization and labeling are determined by each contributing hospital system. A department is not synonymous with a hospital; therefore,
hospitals may have more than one department with associated births (e.g., births in the labor and delivery department and births in the emergency department).”

Discussion

12. Comment: Line 225-227 ’Additionally, while the frequencies of ambulatory and urgent or emergency care visits were unchanged, there was a marked increase in the frequency of telehealth encounters.’ I think if you’re going to focus on ED/telehealth data in the discussion you need to have it feature more prominently in the results.

Response: We have increased the data presented in the Results regarding telehealth, ambulatory, and urgent care or emergency encounters and decreased the associated text in the Discussion. Please see responses to Comments #10 and #14, respectively.

13. Comment: Line 276-289 - I don't think you can speculate on shared decision making based on data from this study.

Response: This section of the Discussion has been revised to focus on perceived discharge readiness instead of shared decision making.

Discussion: “Drivers and decisions surrounding discharge timing for obstetric patients in this study were unknown, however, the increase in short postpartum hospitalization LOS and no change in rehospitalization suggest patients medically appropriate for an earlier discharge were identified. Efforts have been made to assess discharge readiness after childbirth; mothers who identify as less ready are more likely to report physical and psychosocial issues and utilize postpartum services (telephone, urgent, and emergent visits) in the six weeks following discharge.33 One study received survey responses from 1,276 of 1,555 postpartum patients, an 82% response rate, and the majority (62%) reported that their postpartum hospital LOS was “just right”, while the remainder thought their stay was “too short”.34 In the time of the COVID-19 pandemic, it is plausible that patient perception of the ideal LOS changed, whether related to a desire to minimize potential exposure to SARS-CoV-2 in the hospital or reunite sooner with family and friends given limited hospital visitation policies.”

14. Comment: Line 290-307 - the speculation on telehealth is a little out of place - there was only a small amount of data on this subject presented in the study and not in a form that was helpful in making inferences.

Response: We have edited and reduced the text regarding studies of telehealth.

Discussion: “This study also highlights the rapid adoption of telehealth, as we found a nearly 7-fold increase in telehealth encounters during the COVID-19 era. Notably, the increase in telehealth encounters did not change the proportion of obstetric patients who utilized ambulatory, urgent care, or emergency services or had any encounter with the healthcare system (59.8% in the pre-pandemic era to 59.5% in the COVID-19 era [standardized difference -0.006]) in the six weeks following postpartum hospitalization discharge. The increase in telehealth usage is consistent with the transition many institutions made to provide telehealth-based care in the prenatal and postpartum periods.35,36 Telehealth co-interventions utilized in our study cohort are unknown and likely varied across departments and health systems, however it is plausible that the increase in telehealth encounters helped to mitigate potential hospital readmissions, especially if healthcare professionals were targeting specific, high-risk populations.”
Reviewer #2:

OVERALL: The authors utilize the EPIC Cosmos data platform to understand whether length of stay after delivery (LOS) and postpartum readmission for any indication (secondary) varied in pre vs post COVID time periods. Using a Bayesian analytical framework with this national data source, the authors conclude what many clinicians have recognized, which is decreased LOS regardless of mode of delivery and no marked change in readmission rates.

Overall the methods are solid, including statistical analysis, for which I congratulate the authors for their methodological rigor using up to date methods. My main hesitancy with regards to enthusiasm is simply showing lower LOS in an era of COVID is not necessarily a novel finding. Indeed, the lower LOS they show here is already standard of care at many centers for some years now based on older data.

The authors conclude that COVID provided a natural experiment to demonstrate that shorter LOS after delivery is safe and reasonable. I would argue there was already considerable regional variation prior to COVID in postpartum length of stay, and their primary dichotomous outcome of short is perhaps short for the Northeast, but was standard of care in many if not most centers in the South and Midwest pre-COVID. So, my concern is the definition of this dichotomous outcome and what the source for short LOS is based on.

1. **Comment:** I would stratify your data by region and/or hospital networks to see patterns of LOS pre and post pandemic.

   **Response:** We acknowledge the variation in postpartum discharge practices across regions and health systems and constructed our mixed effect models to specifically account for regional and health system variation. The Discussion now acknowledges how generalizability of these findings may differ in hospitals with different definitions of a short postpartum LOS. We anticipate future studies dedicated to regional practice variation. We acknowledge that the duration in hours of short postpartum LOS varies based on the time of birth, which is now included in the limitations section.

   **Discussion:** “Although generalizability of these findings may differ for hospitals with different definitions of short postpartum LOS, this cohort captures and models account for health system and regional differences in postpartum management during the delivery hospitalization and thresholds for hospital readmission.”

   **Discussion:** “First, using the data available, short postpartum hospitalization LOS was defined in midnights, not hours. Thus, the actual duration of a short postpartum hospitalization varies based on the time of birth (e.g., a one midnight length of stay after an 11pm vs 1am vaginal birth). While hospital or regional definitions of short postpartum LOS may vary, the study definition using midnights likely captures most short or shorter postpartum hospitalization LOS definitions.”

SPECIFIC COMMENTS:

2. **Comment:** Page 6-7 include detailed description of covariates which can be summarized in much more succinct fashion. Details about these covariates can then be described in further detail in appendix Tables.

   **Response:** We have shortened the description of variables and covariates.

   **Methods:** “Patient characteristics assessed were age, race, ethnicity, insurance type, smoking status, multiple gestation, mode of delivery, SARS-CoV-2 status during pregnancy, and among patients with a diagnosis of hypertension the receipt of an
antihypertensive medication or magnesium sulfate infusion during the birth hospitalization. ICD-10-CM codes were used to identify patients with pre-existing comorbidities and pregnancy-associated conditions (Appendix 1). Obesity (body mass index [BMI] >30 kg/m²) was determined using the pre-pregnancy BMI and if unavailable was calculated by subtracting the recommended weight gain during pregnancy¹⁷ from the earliest weight obtained during the pregnancy. Infant gestational age at birth was categorized and birth weight with small- or large-for-gestational age (defined as <10th percentile [SGA] and >90th percentile for gestational age [LGA], respectively¹⁸) assessed using the Fenton growth curves. Common obstetric indications for hospital readmission including hypertension, hemorrhage, sepsis or infection, thrombosis, psychiatric disease, other (not one of the five preceding categories), or not otherwise defined were identified using CCSR v2020.3 categories (Appendix 2).¹⁹

Area-level variables were ZIP code, region, urbanicity and the social vulnerability index (SVI).²⁰ The SVI is a composite of indicators reflecting socioeconomic status, household composition and disability, minority status, and language. For each ZIP code, the census ZIP Code Tabulation Areas (ZCTAs) were employed to create a weighted average of the composite SVI scores across all census tracts overlapping the ZIP code based on relative population. Mapping of ZIP codes to Rural-Urban Commuting Area (RUCA) codes (1-3 were considered urban) was obtained from the US Department of Agriculture.²¹ Based on the patient’s residential ZIP code the SVI was used as a proxy for the social context and high SVI was defined as a value in the top quartile.”

3. **Comment**: Please explain for a clinical audience why a Bayesian analytical approach was taken. I agree this may be appropriate but further context is necessary.

**Response**: We used Bayesian models for two reasons, which are now detailed in the manuscript.

**Methods**: “We used Bayesian logistic mixed-effects regression models with a noninformative prior to assess the association between the COVID-19 era and short postpartum hospitalization LOS. Bayesian models were used for two reasons, 1) methodologically, Bayesian models can better fit complex models with a large number of random variance components²⁵ and 2) technically, Bayesian models were the type of mixed model supported in the Cosmos environment.”

4. **Comment**: How were variables selected for model inclusion? DAG?

**Response**: All variables compared in the pre-pandemic and COVID-19 era, which were chosen based on prior literature and potential risks for obstetric complication, were included in the models.

**Methods**: “Based on prior literature and risks of obstetric complications, models were adjusted for the following covariates: age, race, ethnicity…”

5. **Comment**: First paragraph of the discussion focuses on primary analysis and primary outcomes, save the secondaries for later in the discussion.

**Response**: We have removed mention of secondary outcomes from the section of the text.

**Discussion**: “In this large, diverse, observational study of US obstetric patients, we found that the frequency of short postpartum birth hospitalizations increased significantly
during the COVID-19 pandemic with no change in hospital readmission within six weeks of delivery hospitalization discharge. Our study suggests that shorter postpartum hospitalization, following either a vaginal or cesarean birth, may be appropriate with respect to rehospitalization when discharge decision making occurs between obstetric patients and their care teams.”

6. **Comment:** Lines 290-308, too much discussion of telehealth which is not a primary focus of this paper, this should be shortened

**Response:** We have edited and reduced the text regarding studies of telehealth.

**Discussion:** “This study also highlights the rapid adoption of telehealth, as we found a nearly 7-fold increase in telehealth encounters during the COVID-19 era. Notably, the increase in telehealth encounters did not change the proportion of obstetric patients who utilized ambulatory, urgent care, or emergency services or had any encounter with the healthcare system (59.8% in the pre-pandemic era to 59.5% in the COVID-19 era [standardized difference -0.006]) in the six weeks following postpartum hospitalization discharge. The increase in telehealth usage is consistent with the transition many institutions made to provide telehealth-based care in the prenatal and postpartum periods.35,36 Telehealth co-interventions utilized in our study cohort are unknown and likely varied across departments and health systems, however it is plausible that the increase in telehealth encounters helped to mitigate potential hospital readmissions, especially if healthcare professionals were targeting specific, high-risk populations.”

7. **Comment:** Focus your discussion on what is already known about delivery LOS and risk of readmission in the pre covid era, this is not sufficiently discussed, and a discussion focused on this would much better contextualize your findings and conclusions.

**Response:** The discussion has been modified to emphasize what is already known about delivery LOS and risk of hospital readmission pre-pandemic.

**Discussion:** “Most published studies on early postpartum discharge and hospital readmission have been performed in non-pandemic settings. Consistent with our findings, these studies, recently summarized in a Cochrane systematic review and meta-analysis, report no difference in hospital readmission rates after early postpartum hospital discharge.12 However, these studies and have limitations. Even the most recent meta-analysis was hindered by sample size (<9,500 obstetric patients) and significant heterogeneity in study definitions of short postpartum LOS.12 Given the society-wide desire to minimize exposure to hospital settings, the COVID-19 pandemic created an opportunity to address these limitations and conduct a large scale, observational study of early postpartum hospital discharge.”

**Reviewer #3:**

1. **Comment:** The authors present a retrospective cohort analysis using Epic systems Cosmos research platform data to analyze the impact of COVID-19 on post-partum length of stay and readmission rates. My main concern is that the study design may not be ideal. The same reasons that created a shorter post-partum length of stay as the primary outcome should also cause a decrease in readmission rates the secondary outcome. Therefore, it is more difficult to draw an association between the primary and secondary outcomes.
Response: The concern for systematic differences in both discharge and readmission criteria are stated in the limitations.

Discussion: “Fourth, beyond data limitations, there are likely systematic differences between the pre-pandemic and COVID-19 eras with respect to changes in postpartum care delivery protocols as well as patient and health care professional thresholds for hospital readmission given concerns surrounding potential exposure to SARS-CoV-2.”

2. Comment: Line 24, Abstract and line 224, Discussion: Why the use of "minimal" change in hospital readmissions - there was no statistical difference.

Response: We have edited the text in the Abstract, Results, and Discussion to state there was “no change”.

3. Comment: Line 84, Methods: Why was the pre-pandemic group 3 years when the pandemic group is only 1?

Response: In response to your comment and similar comments from other Reviewers regarding either the definition of the pre-pandemic era and/or temporal trends, we completed additional analysis examining short postpartum LOS by 6 month intervals. This additional analysis is now referenced in the Methods and Results.

Methods: “To assess for other temporal trends, we examined the proportion of short postpartum LOS by six-month intervals and used standardized differences to assess for differences in the trend using late 2019 (July-December) as the reference.”

Results: “In the temporal trend analysis, there were small, nonsignificant increases in short postpartum LOS prior to the pandemic, which became significant only once the pandemic began in early 2020 (Appendix 6).”

Supplemental Digital Content: Addition of Appendix 6

4. Comment: Lines 287-289, Discussion: As this study did not assess patient satisfaction with the hospital length of stay, the authors cannot state that their findings "suggest...clinicians were appropriately identifying those ready for an earlier discharge.”

Response: We have revised this sentence.

Discussion: “Drivers and decisions surrounding discharge timing for obstetric patients in this study were unknown, however, the increase in short postpartum hospitalization LOS and no change in rehospitalization suggest patients medically appropriate for an earlier discharge were identified.”

5. Comment: Figure 2 is unnecessary and could be removed.

Response: Figure 2 has been removed.

STATISTICAL EDITOR COMMENTS:
The Statistical Editor makes the following points that need to be addressed:

1. Comment: Since the proportion of short stay has been decreasing vs time (lines 42-43), and the pre-pandemic time epoch in this series is 3 yrs vs 1 yr pandemic, should show the
Response: In response to your comment and similar comments from other Reviewers regarding either the definition of the pre-pandemic era and/or temporal trends, we completed additional analysis examining short postpartum LOS by 6 month intervals. This additional analysis is now referenced in the Methods and Results.

Methods: “To assess for other temporal trends, we examined the proportion of short postpartum LOS by six-month intervals and used standardized differences to assess for differences in the trend using late 2019 (July-December) as the reference.”

Results: “In the temporal trend analysis, there were small, nonsignificant increases in short postpartum LOS prior to the pandemic, which became significant only once the pandemic began in early 2020 (Appendix 6).”

Supplemental Digital Content: Addition of Appendix 6

2. Comment: Lines 149-155 and Table 1: Since the analysis using standardized differences in Table 1 disclosed no significant differences, then why were the covariates listed used to adjust the short hospitalization proportions in the models? How did the aORs differ from unadjusted ORs? Should include both unadjusted and adjusted ORs with their respective CIs in a Table. Should include both the overall and the separate results for vaginal and cesarean births. (The values from Fig 3 are not easily read.)

Response: Although the covariates did not differ between eras, they have been associated with obstetric complications in prior literature, thus, we ran the models with and without covariates. This has been added to the text. As suggested, the values associated with the unadjusted and adjusted ORs, stratified by mode of delivery have been added to Figure 2 (previously Figure 3).

Methods: “Although there was not a detectable imbalance in covariates between eras (all standardized differences <0.1) models were run with and without multivariate adjustment.

Figure 2: Includes unadjusted and adjusted ORs and credible intervals.

3. Comment: Is there individual patient level data that would allow for identification of more than one delivery per individual during the time period of study? If so, then need to adjust for repeated measures for an individual, since outcomes could not be assumed to be statistically independent, but rather correlated.

Response: There were 116,492 individuals (11.7% of the analytic cohort) who gave birth more than once during the study period. Our initial analysis treated each birth as independent observations. As a sensitivity analysis, we randomly excluded 1 birth for those who had 2, 2 for those who had 3, etc., and repeated the analysis. This sensitivity analysis and associated results are now included in the text.

Methods: “Third, to account for the potential correlation of repeated measures from the same individual, analyses were performed including one birth hospitalization encounter for each distinct obstetric patient. For patients who gave birth more than once during the study period, the included birth hospitalization encounter was selected at random.”
Results: “We found that 116,492 patients (11.7% of the study cohort) had more than one birth during the study period. In the sensitivity analysis in which only one birth hospitalization encounter was included for each obstetric patient (n=877,776), the findings remained unchanged for both outcomes (short postpartum hospitalization LOS aOR 2.26, 99% CI 2.23, 2.29; hospital readmission within six weeks of discharge aOR 1.01, 99% CI 0.95, 1.06).”

4. Comment: Although the proportion of multiple gestations is similar, (3.7% vs 3.3%), that would seem to be one variable that might skew the length of stay. Should do a sensitivity analysis to include only singleton births.

Response: While proportion of multiples is quite small and their inclusion is most likely to bias results away from the null (patients who had multiples likely stayed in the hospital longer), we completed the suggested sensitivity analysis and the findings were unchanged, which is noted in the text.

Methods: “Second, patients who delivered multi-fetal gestations (i.e., twins, triplets, higher-order gestations) were excluded given the possibility that this characteristic may affect their postpartum hospitalization LOS.”

Results: “Model results from the sensitivity analysis including only singleton gestations were also similar for both outcomes (short postpartum hospitalization LOS aOR 2.35, 99% CI 2.32, 2.38; hospital readmission within six weeks of discharge aOR 1.00, 99% CI 0.95, 1.06).”

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology have increased 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. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:
   * Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (i.e., meeting presentations, preprint DOIs, assistance from non-byline authors).
   * Funding information (i.e., grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
   * Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
   * Name the IRB or Ethics Committee institution in the Methods section (if applicable).
   * Add any information about the specific location of the study (i.e., city, state, or country), if necessary for context.
3. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you uploaded your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

Response: It has been confirmed that my coauthors and I have or will complete this form, and disclosures have been reported.

4. 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.

Response: ICD-10-CM codes were used for this data and specific codes used are included in the Supplemental Digital Content. The selected codes apply for all years of the study.

5. 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://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-obstetrics-data-definitions&amp;data=04%7C01%7CHANDLEYS%40chop.edu%7C6C5234d9828c404b31139e08d995671a80%7C611241607b041a59bb1d146b575c975%7C0%7C637705094014796396%7CUunknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJTNCI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&amp;sdata=usvm3m2AXk8YRJpVK7C6boYb3ehBtao7HilM6gkFw2EA%3D&amp;reserved=0 and the gynecology data definitions at https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-gynecology-data-definitions&amp;data=04%7C01%7CHANDLEYS%40chop.edu%7C6C5234d9828c404b31139e08d995671a80%7C611241607b041a59bb1d146b575c975%7C0%7C637705094014806353%7CUunknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJTNCI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&amp;sdata=J3oqCD2QVym4RlCqV%2F2Fm8e7X16xT83YXeC2jmx4VLm%3D&amp;reserved=0. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.
Response: Only standard abbreviations have been used in the manuscript.

6. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

Response: This original research manuscript does not exceed the word limit.

7. 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: The following guidelines have been reviewed and are not applicable to this manuscript. There was no financial support, no manuscript preparation assistance, and no acknowledgements. Aspects of this study were presented at Epic’s User Group Meeting in Verona, WI on August 24th, 2021.

8. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

Response: Postpartum length of stay and readmission

9. 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. Please provide a word count.

Response: We have reviewed the abstract and believe it is consistent with the manuscript. The abstract length is within the recommendation, and a word count has been provided.

10. Only standard abbreviations and acronyms are allowed. A selected list is available online at https://nam10.safelinks.protection.outlook.com/?url=http%3A%2F%2Fedmgr.ovid.com%2FFong%2Faccounts%2Fabbrweptations.pdf&amp;data=04%7C01%7CHANDLEYS%40chop.e du%7C5234d9828c404b31139e08d995671a80%7Ca611241607b041a59bb1d146b575c97 5%7C1%7C0%7C637705094014806353%7CUunknown%7CTWFpbGZsb3d8eyJWljoIMC4w LjAwMDAiLCJQIjoV2luMzliLCJBTii6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&amp;:sdata=Q xVahzEBImGlq%2Fdp9sQp%2BC64SGH07pslvD%2BEPWnThaU%3D&amp;:reserved=0. 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: Standard abbreviations and acronyms have been used. There are no abbreviations or acronyms used in the title or précis.

11. 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: The virgule symbol is only used to express measurements in the manuscript.

12. ACOG avoids using "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: The word “provider” has been replaced with “healthcare professional” throughout the manuscript.

13. 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: In general, effect size is presented using odds ratios with appropriate credible intervals. Standardized differences are used for other comparisons. The presentation of data is standardized throughout the manuscript.

14. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: https://nam10.safelinks.protection.outlook.com/?url=http%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Ftable_checklist.pdf&amp;data=04%7C01%7CHANDLEYS%40chop.edu%7C5234d9828c404b31139e08d995671a80%7Ca611241607b041a59bb1d146b575c975%7C0%7C637705094014806353%7CUunknown%7CTWFpbGZsb3d8eyJWIjoIMC4wLjAwMDA1LCJQIjojV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&amp;amp;sa=Y1vkYvBcXDUn2UoKLJLF2GB5iEJS8hIoe7dbMUwvFs%3D&amp;amp;reserved=0.

Response: The tables have been edited to adhere to the journal’s Table Checklist.

15. Please review examples of our current reference style at https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fclinical&amp;amp;data=04%7C01%7CHANDLEYS%40chop.edu%7C5234d9828c404b31139e08d995671a80%7Ca611241607b041a59bb1d146b575c975%7C0%7C637705094014806353%7CUunknown%7CTWFpbGZsb3d8eyJWIjoMC4wLjAwMDA1LCJQIjojV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&amp;amp;sa=TajSBvHyysk7aEDCNhK%2FZguFWtBVYeSpokYf7aD40%3D&amp;amp;reserved=0 (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-progress 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 references you are citing are still current and available. Check the Clinical Guidance page at https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fclinical&amp;amp;data=04%7C01%7CHANDLEYS%40chop.edu%7C5234d9828c404b31139e08d995671a80%7Ca611241607b041a59bb1d146b575c975%7C0%7C637705094014806353%7CUunknown%7CTWFpbGZsb3d8eyJWIjoMC4wLjAwMDA1LCJQIjojV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&amp;amp;sa=5Dp%2B9OQCyuDD4R9rABFq69Lh66tLqK5%2BuhPmc5TU4IU%3D&amp;amp;reserved=0 (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn’t listed as "Withdrawn," it’s still a current document.

If the reference you are citing has been updated and 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.
Response: The references have been formatted to the Obstetrics and Gynecology style. ACOG documents are not cited in this manuscript.

16. Figure 1-4 may be resubmitted as is with the revision.

Response: We have removed Figure 2, based on a comment from Reviewer #3. The unadjusted and adjusted odds ratios and associated credible intervals have been added to Figure 2 (previously Figure 3) based on a comment from the Statistical Editor. Figure 1 was revised based on the slightly modified cohort as explained in comments above. Figure 3 was renamed as it was previously Figure 4.