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: Jul 31, 2019
To: "Rebecca Jeanne Mercier" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1037

RE: Manuscript Number ONG-19-1037

Expedited Interval Tubal Scheduling to Increase Completion of Tubal Ligation: A Randomized Clinical Trial

Dear Dr. Mercier:

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 Aug 21, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This study is a prospective randomized trial with a clearly stated objective of determining whether expedited surgical scheduling of interval tuabl ligation prior to discharge from the hospital after delivery could safely improve and increase the completion rates compared to standard scheduling. Authors do meet the objective, with results showing expedited scheduling increased completion rate and patient satisfaction. Uncertain if same results can be obtained at other institutions, but paper does provide a quality improvement process for others to try.

1. Line 28-30 and 84-86 - please word these the same as the objective is stated differently in each

2. Line 79-82 - reference here please

3. Line 110-116 - please expand and provide details of what this post-partum contraception counseling and provision includes. Did the expedited group also receive this same contraceptive counseling and provisioning?

4. Line 112-114 - how did surgical scheduling procedures in standard group compare to expedited group in terms of if patient maissed pre-op appointment, didn't do labs, etc.? Please provide similar information to compare.
5. Line 125-127 - was this for both groups?

6. Line 237-240 - please explain in more detail if providers wait until these co-morbidities present less risk at some point after delivery?

Reviewer #2: This manuscript reports on an RCT of expedited scheduling for postpartum tubals for women who are not able to obtain them prior to leaving the hospital after a vaginal delivery. This report is well-written, concise, and addresses an important clinical topic: the fulfillment of postpartum tubal requests. It seems to utilize a hybrid effectiveness-implementation design; however this is never clearly stated, and could be more clearly delineated in the text (more below).

1. Intro- the intro is clearly written, establishes the problem, and states the hypothesis and objectives for the study.

2. Methods- Overall, the methods are quite clear, except when describing the sampling. It is not clear to me why an interim analysis was done, and what the decision was based on to stop the study (only if the intervention was favored at that point? would you have kept going if the control was favored?) This is what made me think of the hybrid design mentioned above- was the idea to start implementing the study findings in real life if the results were robust? I think it

would be important to say this, because otherwise it's not fully clear why the study was stopped at the mid-point, and this should be spelled out more clearly.
-also, patient satisfaction with expedited scheduling is a big feature of this study, but it is not clear how that was asked, or measured- a likert scale? There seems to have been only one question about this, so you could consider including the actual question.

3. Results- overall clear, but a few points.
-no need to put p values in Table 1. (fine to state in the text, as you do, that there are no significant differences between groups).
-as above, the patient satisfaction is important but seems a little buried in the text and table 2- ie, since it's an important secondary outcome, you could begin the paragraph that starts on line 199 with that finding, and not that the interval to the surgery was lower.
-would be interesting to look at the 56% of patients who said that they would have liked to have their surgery in the hospital prior to delivery and see their reasons for not getting the surgery-- was it wanting to spend time with family? wanting to eat? not being a good candidate? It would be interesting to be able to note whether the reasons might be modifiable or not, and look into ways that the issues could be addressed to make it better for patients- eg, it might be counseling or managing expectations that could help patients stick with their plan to have the tubal, or scheduling them for postpartum if clearly not mini-lap eligible...(of note, this could be a whole separate sub-analysis, but I think at least a nod to this would be important here in this paper, since it's pretty clear that the main reasons people don't get their expedited tubals is not that there's not staffing)

4. Discussion
-again, I think that placing more emphasis on the "real-world" implementation aspect of this study is important, since it's not explicitly stated but seems to be that this intervention worked so well that you stopped the study and started using it. (it would also be great if you keep a prospective study going and see how the tubal fulfillments change over a year in your department with this new tactic..you could mention that you'll be looking at that if you're planning to)
-along these lines, I think your discussion of how and why different hospital systems could use these findings is important and helpful (though I'm still a little bummed that you only have 67 participants in the whole study; having completed it might have made it even more compelling)
-limited to English-speaking patients is not listed as a limitation

Reviewer #3: Great study, providing insight on an alternative way to expedite the process for patients desiring interval tubal ligation in lieu of an immediate postpartum tubal. I would recommend adding the following clarifications:

1. In the result section, it would be helpful to clarify why only 67 were enrolled. I understand that there was a planned interim analysis at 50% completion, and in the Result paragraph, line 167-168 only explained that 67 participants were enrolled and enrollment stopped due to the pre-planned interim analysis but Figure 1 shows that of the 126 individuals eligible for participation only 67 were enrolled because 37 individuals declined participation, 17 were not contacted by staff (which I assume are the ones who were no longer needed due the interim analysis,) and 5 have a "no staff available" (which also needs to be clarified.)

2. Clearly state when the participants were provided with the paperwork regarding their surgery in lines 116-117.

3. Line 92-93 states that patients admitted to L&D were screened for immediate postpartum tubal during their admission for delivery, the screening procedure is not described: were these patients who had discussed their tubal during their antepartum care and thus the study team only confirmed the patient's intentions at the time of admission or was the screening simply a part of the intake process as these women were being admitted. It would have been interesting to also include in the participants information whether or not they had been counseling about permanent sterilization during their antepartum care.

4. Also please be explicit that the patients screened on admission to labor and delivery were the ones admitted for delivery.line 92-94

5. Line 114, were the participants assigned to the expedited group not counseled on postpartum contraception? Even with an expedited delivery of care model, these patients are still at risk for an unplanned pregnancy, so I assume they were discharged with some form of contraceptive counseling but it is not stated in your method paragraph.

STATISTICAL EDITOR'S COMMENTS:

1. Table 1: Since this is a RCT, there is no need to statistically compare the cohorts. Any difference is thought to be due to random chance. Need units for BMI and Hemoglobin concentration. Parity and Gravidity can only have integer values, so should be formatted as median (range or IQR) or as categories. For age, BMI and hgb, if those are not normally distributed, then should cite as median(IQR or range).

2. Table 2 and lines 157-158: Many of these comparisons should have been tested with Fisher's test, but were not. Many

of the p-values will change (eg, IUD method: 5/22 vs 1/30 has Fisher's p = .07, not .03). Unless the "interval delivery to tubal" had normal distributions, should test with non-parametric stats test, esp given the relatively modest sample sizes. Given the sample sizes (N = 22 and N = 30), there is no basis for citing %s to nearest 0.1%, should round to integer %s.

3. Abstract, Results, lines 150-154 and Table 2: Need to clearly separate the primary outcome from the secondary ones. Since the sample size/power calculation was formatted in terms of difference in proportion to complete tubal ligation within 6 months, the primary outcome should be cited first in that format.

4. lines 158-159, lines 195-196: Given the sample sizes and counts for the primary outcome, it is doubtful that there were sufficient samples to adequately test for interaction terms or confounding (ie, low power, so NS findings are likely not generalizable).

5. lines 196-197: The odds were ~ 10x, but that is not the same as probability, but rather it is literally a ratio of odds. The actually completion rates were 9% vs 50%, which is not 10x.

6. Although unlikely to have changed the analysis, the loss to follow-up of 3 (expedited) and 6 (standard) potentially weakens the argument, which the Authors acknowledge on lines 283-288.

EDITORIAL OFFICE COMMENTS:

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

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

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

3. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the article (after the References section).

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

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

6. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

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).

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 limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

9. Abstracts for all randomized, controlled trials should be structured according to the journal's standard format. The Methods section should include the primary outcome and sample size justification. The Results section should begin with the dates of enrollment to the study, a description of demographics, and the primary outcome analysis. Please review the sample abstract that is located online here: http://edmgr.ovid.com/ong/accounts/sampleabstract_RCT.pdf. Please edit your abstract as needed.

10. 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.

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.

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

15. 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 http://edmgr.ovid.com/acd/accounts/ifauth.htm.

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.

***

If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

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

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

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

Sincerely,

The Editors of Obstetrics & Gynecology

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

_____

Nancy C. Chescheir, MD
Editor in Chief
Obstetrics and Gynecology

Dear Dr Chescheir,

Thank you for the opportunity to provide revisions to our manuscript "Expedited Interval Tubal Scheduling to Increase Completion of Tubal Ligation: A Randomized Clinical Trial", under consideration for publication in Obstetrics & Gynecology. We have considered all of the reviewer comments, and have provided responses and appropriate changes in the manuscript, as outlined below. We have formatted our response to have the answer to the comment immediately below each comment, and for clarity, placed our responses in italics while the reviewers' words remain in plain text. For any text that has been added or modified, we have provided revision line numbers where these can be found. We have used 'track changes' to make revisions as suggested; therefore these revision numbers do reflect the line numbers with track changes visible, and may not reflect where changes will appear when track changes are accepted.
Thank you in advance for your consideration.
Sincerely,

Rebecca J. Mercier MD, MPH

REVIEWER COMMENTS AND RESPONSES

Reviewer #1: This study is a prospective randomized trial with a clearly stated objective of determining whether expedited surgical scheduling of interval tubal ligation prior to discharge from the hospital after delivery could safely improve and increase the completion rates compared to standard scheduling. Authors do meet the objective, with results showing expedited scheduling increased completion rate and patient satisfaction. Uncertain if same results can be obtained at other institutions, but paper does provide a quality improvement process for others to try.

1. Line 28-30 and 84-86 - please word these the same as the objective is stated differently in each
The objective statement has been changed at the second location to match the wording of the abstract at revision lines 85-87.

2. Line 79-82 - reference here please
This sentence has been re-worded to clarify that we describe barriers to attending the postpartum visit, and a reference supporting this statement has been added at revision lines 80-83.

3. Line 110-116 - please expand and provide details of what this post-partum contraception counseling and provision includes. Did the expedited group also receive this same contraceptive counseling and provisioning?
Thank you for this comment, all patients in both groups received counseling on contraceptive options, and were provided a bridge method such as progesterone-only pills or depo if desired. As originally written, out text implied this was only done with one group, which was not true. This passage has been revised, and a more detailed explanation counseling and provision has been provided, this is at revision lines 114-119.

4. Line 112-114 - how did surgical scheduling procedures in standard group compare to expedited group in terms of if patient maissed pre-op appointment, didn't do labs, etc.? Please provide similar information to compare.
More detail has been provided to clarify what were the 'typical workflows' for the standard group at revision lines 122-126.

5. Line 125-127 - was this for both groups?
This section is specifically describing the process for expedited scheduling. This has been clarified, hopefully, by the addition of the above section describing scheduling process for standard patients, and the addition of the term 'expedited' as a modifier throughout these lines on revision lines 129-140.

6. Line 237-240 - please explain in more detail if providers wait until these co-morbidities present less risk at some point after delivery?
This segment has been modified to clarify that we are suggesting that these co-morbidities, combined with the immediate post-partum state may be more concerning to providers; providers may be more reluctant to perform surgery on postpartum day 1 or 2, but generally feel more comfortable approaching the case as an outpatient surgery more remote from delivery, on revision lines 267-270 a.

Reviewer #2: This manuscript reports on an RCT of expedited scheduling for postpartum tubals for women who are not able to obtain them prior to leaving the hospital after a vaginal delivery. This report is well-written, concise, and addresses an important clinical topic: the fulfillment of postpartum tubal requests. It seems to utilize a hybrid effectiveness-implementation design; however this is never clearly stated, and could be more clearly delineated in the text (more below).

1. Intro- the intro is clearly written, establishes the problem, and states the hypothesis and objectives for the study.
Thank you!

2. Methods- Overall, the methods are quite clear, except when describing the sampling. It is not clear to me why an interim analysis was done, and what the decision was based on to stop the study (only if the intervention was favored at that point? would you have kept going if the control was favored?) This is what made me think of the hybrid design mentioned above- was the idea to start implementing the study findings in real life if the results were robust? I think it would be important to say this, because otherwise it's not fully clear why the study was stopped at the mid-point, and this should be spelled out more clearly.
The reviewer exactly states the reason for the interim analysis in this comment. A statement clarifying this has been added to the text at revision lines 172-173.

-also, patient satisfaction with expedited scheduling is a big feature of this study, but it is not clear how that was asked, or measured- a likert scale? There seems to have been only one question about this, so you could consider including the actual question.
This was measured on a Likert scale – statements clarifying this have been added to the text at revision lines 151-153..

3. Results- overall clear, but a few points.
-no need to put p values in Table 1. (fine to state in the text, as you do, that there are no significant differences between groups).
Thank you for this comment! The authors fully understand the reasons why p-values are not needed for an RCT, and only provided because we have had them requested in the past in other studies. They have been removed!

-as above, the patient satisfaction is important but seems a little buried in the text and table 2- ie, since it's an important secondary outcome, you could begin the paragraph that starts on line 199 with that finding, and not that the interval to the surgery was lower.
The suggested change to better highlight the satisfaction result has been made in the text, this is seen in revision lines 219-222.

-would be interesting to look at the 56% of patients who said that they would have liked to have their surgery in the hospital prior to delivery and see their reasons for not getting the surgery-- was it wanting to spend time with family? wanting to eat? not being a good candidate? It would be interesting to be able to note whether the reasons might be modifiable or not, and look into ways that the issues could be addressed to make it better for patients- eg, it might be counseling or managing expectations that could help patients stick with their plan to have the tubal, or scheduling them for postpartum if clearly not mini-lap eligible...(of note, this could be a whole separate sub-analysis, but I think at least a nod to this would be important here in this paper, since it's pretty clear that the main reasons people don't get their expedited tubals is not that there's not staffing)
Agree with the reviewer that this would be interesting to look at; unfortunately our data does not allow this to be examined with any great precision on a statistical level. A line has been added to the results section commenting on the number who would have preferred earlier surgery (lines 221-223), and a line in the discussion reflecting that better patient teaching may help patients have realistic understanding of timing and expectations has been added at revision lines 275-277.

4. Discussion
-again, I think that placing more emphasis on the "real-world" implementation aspect of this study is important, since it's not explicitly stated but seems to be that this intervention worked so well that you stopped the study and started using it. (it would also be great if you keep a prospective study going and see how the tubal fulfillments change over a year in your department with this new tactic..you could mention that you'll be looking at that if you're planning to)
-along these lines, I think your discussion of how and why different hospital systems could use these findings is important and helpful (though I'm still a little bummed that you only have 67 participants in the whole study; having completed it might have made it even more compelling)
-limited to English-speaking patients is not listed as a limitation
A line acknowledging this limitation has been added to the discussion section at revision line 312-313.

Reviewer #3: Great study, providing insight on an alternative way to expedite the process for patients desiring interval tubal ligation in lieu of an immediate postpartum tubal. I would recommend adding the following clarifications:

1. In the result section, it would be helpful to clarify why only 67 were enrolled. I understand that there was a planned interim analysis at 50% completion, and in the Result paragraph, line 167-168 only explained that 67 participants were enrolled and enrollment stopped due to the pre-planned interim analysis but Figure 1 shows that of the 126 individuals eligible for participation only 67 were enrolled because 37 individuals declined participation, 17 were not contacted by staff (which I assume are the ones who were no longer needed due the interim analysis,) and 5 have a "no staff available" (which also needs to be clarified.)
Please see above comment from Reviewer 1 regarding reason for interim analysis – a line has been added to results section stating that the reason for interim analysis was to facilitate clinical implementation if results appeared robust.

Figure 1 has been updated to clarify this, in addition to the text change to explain interim analysis. Of the 126 patients who were eligible to enroll, a total of 59 were not. 37 declined to participate. A total of 22 should have been offered enrollment but were not, due to logistic problems – study staff was not contacted regarding eligible patients for 17, and for 5 potential participants, study staff was contacted, but due to staff limitations, were not able to see the patient prior to discharge.
We provided this level of detail regarding the reasons for the non-enrollments in an attempt to be transparent, but if the reviewers do feel it would be better to simplify these classifications, we would be happy to do so.

2. Clearly state when the participants were provided with the paperwork regarding their surgery in lines 116-117.
Lines have been added clarifying that date assignment occurred immediately following randomization, and that paperwork was also given at that time, at revision lines 127-130.

3. Line 92-93 states that patients admitted to L&D were screened for immediate postpartum tubal during their admission for delivery, the screening procedure is not described: were these patients who had discussed their tubal during their antepartum care and thus the study team only confirmed the patient's intentions at the time of admission or was the screening simply a part of the intake process as these women were being admitted. It would have been interesting to also include in the participants information whether or not they had been counseling about permanent sterilization during their antepartum care.
Text has been added to clarify the process for screening admitted patients at revision lines 97-99.
Regarding the timing of counseling regarding sterilization; we did collect this data by asking the participants when they had requested a tubal at the time of enrollment; of the 65, 56 had requested prior to admission and 9 had not. Due to the number of patients who we deliver who receive either limited prenatal care, or care at another institution where we are unable to verify records directly, our ability to objectively confirm this is limited, and therefore this was not included in the paper as a major finding.

4. Also please be explicit that the patients screened on admission to labor and delivery were the ones admitted for delivery.line 92-94
Text has been added to clarify this at revision lines 97-99.

5. Line 114, were the participants assigned to the expedited group not counseled on postpartum contraception? Even with an expedited delivery of care model, these patients are still at risk for an unplanned pregnancy, so I assume they were discharged with some form of contraceptive counseling but it is not stated in your method paragraph.
Please see above response to similar comment by reviewer 1 – text has been added to answer this comment at revision lines 114-119..

STATISTICAL EDITOR'S COMMENTS:

1. Table 1: Since this is a RCT, there is no need to statistically compare the cohorts. Any difference is thought to be due to random chance. Need units for BMI and Hemoglobin concentration. Parity and Gravidity can only have integer values, so should be formatted as median (range or IQR) or as categories. For age, BMI and hgb, if those are not normally distributed, then should cite as median(IQR or range).

- *The p-values in table 1 have been removed.*
- *Units have been added for BMI and hemoglobin values*
- *Hemoglobin was normally distributed, as verified with sktest in STATA.*
- *BMI was NOT normally distributed; table 1 has been changed to show median and range*

2. Table 2 and lines 157-158: Many of these comparisons should have been tested with Fisher's test, but were not. Many of the p-values will change (eg, IUD method: 5/22 vs 1/30 has Fisher's p = .07, not .03). Unless the "interval delivery to tubal" had normal distributions, should test with non-parametric stats test, esp given the relatively modest sample sizes. Given the sample sizes (N = 22 and N = 30), there is no basis for citing %s to nearest 0.1%, should round to integer %s.

- *Regarding use of fishers test: the reviewer is correct regarding the stats for the IUD use; this was the author's mistake. The table has been updated, and the text corrected to note that this was not a statistically significant difference at revision lines 234-235*.
- *Fishers test was used (and re-verified for this review) for the outcomes of completed tubal and scheduling satisfaction.*
- *Regarding data for interval to tubal – the reviewer is correct, this data was not normally distributed, and when tested with a kruskal wallis test, the difference lost statistical significance (likely related to the small number of tubal completed in the standard group). This has been updated in the table and the text (revision lines 225-227)/abstract amended to note the large numerical difference, but that is did not reach statistical significance.*
- *Overall, text has been updated to reflect the use of Fishers exact test and nonparametric tests as appropriate.*
- *The percentages have been changed in the table to be whole integers*

3. Abstract, Results, lines 150-154 and Table 2: Need to clearly separate the primary outcome from the secondary ones. Since the sample size/power calculation was formatted in terms of difference in proportion to complete tubal ligation within 6 months, the primary outcome should be cited first in that format.
The primary outcome of number of tubals completed is cited first in both the abstract and the results section prior to any secondary outcomes. The primary and secondary outcomes are presented within the same table (table 2) in an attempt to save space. Formatting has been added to table 2 to more

clearly call attention to the primary outcome. If the editors/reviewers would like these to be separated into 2 different tables for further clarity, we would be happy to do so

4. lines 158-159, lines 195-196: Given the sample sizes and counts for the primary outcome, it is doubtful that there were sufficient samples to adequately test for interaction terms or confounding (ie, low power, so NS findings are likely not generalizable).
This testing was done just to ensure completeness as the authors were taught to do so with any data set. If the reviewer/editor would prefer that reference to this testing should be removed, we will be happy to do so – but we have left in at this time, as we were unsure if the reviewer was stating that it would be best to remove this, or just pointing out that the testing was likely not necessary.

5. lines 196-197: The odds were ~ 10x, but that is not the same as probability, but rather it is literally a ratio of odds. The actually completion rates were 9% vs 50%, which is not 10x.
Thanks for this comment, the reviewer points out our wording is ambiguous; the text has been changed to more clearly note that this is an OR, not a probability.

6. Although unlikely to have changed the analysis, the loss to follow-up of 3 (expedited) and 6 (standard) potentially weakens the argument, which the Authors acknowledge on lines 283-288.