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 09, 2021
To: "Ashley E Benson" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-1303

RE: Manuscript Number ONG-21-1303

Transfusion preparedness on labor and delivery: an initiative to improve safety and cost

Dear Dr. Benson:

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 Jul 30, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #2: Benson et al present an implementation study evaluating the use of risk based versus universal type and screen at a single institution. The find that a risk based approach decreases cost without changing outcomes.

- I would recommended a brief description of the CMQCC risk tool for the readers who are not familiar with it.
- Please clarify whether you prospectively applied the CMQCC hemorrhage risk stratification in both epochs, in neither epoch, or only in the post-implementation epoch. If this was only prospectively applied in the post-implementation epoch, do you think that this increased awareness may have impacted your outcomes? Were there other transfusion reduction strategies that were implemented simultaneously to this? I ask because it is interesting that there was a higher PPH rate but a lower transfusion rate post-implementation - I don't think would be related to the actual availability of a type and screen.
- Line 159: What are the percentages of patients receiving transfusion (not just the number of units transfused)?
- Line 178-179: I think figure 2 only describes emergency release units? The legend doesn't specify. Also, are you able to write out the numbers in the text - it might be helpful.
- Do you have any qualitative information about how the blood bank and transfusion medicine physicians felt about your implementation? How easy is a "hold clot" to do? How supportive were they of not having universal type and screen?

Reviewer #3: Single institution academic center with a robust Blood bank capability that studied safety and cost after implementation of a selected Type and Screen approach to all Labor and Delivery admissions vs a universal approach to Type and screen- the traditional approach

1. Can you better describe the patient selection process and the PPH risk based tool you used- this could be included as a Table
2. Can you better describe the implementation. Was this a standardized order set based on their calculated risk? Was this a discussion huddle of all women on admission and then a decision? Was this reevaluated every 12 hours? 8 hours? or 24 hours? A description of implementation process used for education of residents, attendings etc would be helpful. Was this nursing driven or provider driven?
3. Before implementation did you convene a Quality/safety group and complete a process that was multidisciplinary? Please describe
3. Risk can be fluid during an admission to LD. How many women were changed from a Type and Hold to a Type and screen during labor and post partum. It would be good to better understand how this worked and what criteria prompted the change

4. Inclusion criteria "We included all pregnant patients presenting to the labor unit for delivery, whose prenatal testing occurred within our hospital's central lab, with negative antibody screen." Does that mean transfer patients were not included ? How many women were excluded because of this?
5. How did you manage antepartum patients with PPROM and diabetes and preeclampsia? were they part of this at all?

STATISTICAL EDITOR COMMENTS:

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

Table 2 and lines 40-41, 159-161: For comparison of ERT events and transfusion of 4+ RBC units, the counts are small and should use Fisher's test, which changes the p-values, although they remain NS. More importantly, the n(%) are so small that there is insufficient stats power to generalize the NS finding from these data. Also, do you mean outcomes per person in title? It seems these are outcomes per period.

Table 3: Since the costs would be related to the number of patients per month, shouldn't these monthly costs be adjusted per patient? That would not change the inference, but seems fair to adjust for monthly patient volume.

Table 4: The difference in rates of hysterectomies could be calculated using Fisher's test, but (1) will be NS and (2) is underpowered. Also, the counts for ICU admissions lacks stats power to generalize the NS finding.

Figs 1, 3: Again, shouldn't those costs be adjusted for monthly numbers of patients? Maybe simpler, but informative number would be the mean cost per case in the pre vs post protocol periods?

General: Need to include in limitations specific reference to lack of stats power for some adverse outcomes.

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. 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.

The following authors still need to complete the form:
Kelly CAIL (kelly.cail@aruplab.com)
Dane FALKNER (dane.falkner@hsc.utah.edu)

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

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

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: Clinical Practice and Quality articles 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. 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 Clinical Practice and Quality is 300 words. Please provide a word count.

8. 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.

9. 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.

10. 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.

11. 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.

12. Figures 1-3: Please add tick marks along the x- and y-axes.

13. 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.

If you choose open access, you will receive an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from

publicationservices@copyright.com with the subject line, "Please Submit Your Open Access Article Publication Charge(s)." Please complete payment of the Open Access charges within 48 hours of receipt.

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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://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter. Do not omit your responses to the Editorial Office or Editors' comments.

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Jul 30, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

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

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HEALTH
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Obstetrics & Gynecology
[redacted]

July 10, 2021

Re: Manuscript Number ONG-21-1303

To the Editors of *Obstetrics & Gynecology*,

Thank you for the opportunity to revise our manuscript, entitled “Transfusion preparedness on labor and delivery: an initiative to improve safety and cost”. We appreciate the careful review and constructive suggestions.

With the suggested edits, we believe we are submitting a significantly improved manuscript. We have included reviewer and editor comments and our responses below. All authors have approved this updated version of the manuscript for submission, and authorship has not changed. Additionally, we confirm that we have read the Instructions for Authors.

Again, thank you for the opportunity to submit our paper and please do not hesitate to reach out to us with questions or concerns.

Sincerely,

Ashley Benson, MD MA

Department of Obstetrics and Gynecology
University of Utah School of Medicine
[redacted]

Comments from Reviewer 2

Comment 1: *I would recommended a brief description of the CMQCC risk tool for the readers who are not familiar with it.*

Response: Thank you for this suggestion. We have included a table describing the CMQCC risk tool in greater detail. Please see Table 1.

Comment 2: *Please clarify whether you prospectively applied the CMQCC hemorrhage*

[redacted]

risk stratification in both epochs, in neither epoch, or only in the post-implementation epoch. If this was only prospectively applied in the post-implementation epoch, do you think that this increased awareness may have impacted your outcomes? Were there other transfusion reduction strategies that were implemented simultaneously to this? I ask because it is interesting that there was a higher PPH rate but a lower transfusion rate post-implementation - I don't think would be related to the actual availability of a type and screen.

Response: Thank you for this thoughtful inquiry. The CMQCC risk stratification was applied in both epochs, as our institution began standardly applying this in May 2018 (with our pre-implementation period beginning in October 2018). In the year prior to our study, we also implemented tranexamic acid use on labor and delivery and quantified estimated blood loss. Additionally, our institution implemented electronic clinical decision support for RBC transfusion in April 2019, which substantially reduced RBC transfusion institution-wide by 11% (nearly 2000 units/year). Our institution has published these data (R Metcalf et al. Electronic clinical decision support: Evidence that default settings influence end-user behavior. Transfusion. 2021 Mar;61(3):669-670. doi: 10.1111/trf.16269). We have updated the methods to include these clarifications (lines 160-165).

Comment 3: *Line 159: What are the percentages of patients receiving transfusion (not just the number of units transfused)?*

Response: Thank you for this question, we have updated the manuscript to reflect this information. Lines 216-218.

Comment 4: *Line 178-179: I think figure 2 only describes emergency release units? The legend doesn't specify. Also, are you able to write out the numbers in the text - it might be helpful.*

Response: Thank you for this clarification. Figure 2 does only represent emergency release units, we have updated the legend to specify this. We have also included these numbers in the manuscript in text form (lines 284-285).

Comment 5: *Do you have any qualitative information about how the blood bank and transfusion medicine physicians felt about your implementation? How easy is a "hold*

[redacted]

clot" to do? How supportive were they of not having universal type and screen?

Response: Thank you for this, it is a great question. Unfortunately, we do not have any qualitative data regarding response to our implementation, but in hindsight this would have been valuable to collect. We did however design and implement this policy in conjunction with our transfusion medicine physicians, anesthesiologists, and nursing administrators. It was our experience that there was some hesitancy from key stakeholders, including nursing staff, physicians, and the blood bank due to safety concerns that this could pose to transfusion preparedness (lines 78-81). As a part of our implementation is was necessary for us to have endorsement from all pertinent parties, which we arrived at prior to implementation. It was also important at our center to plan for a short time period of follow-up to evaluate safety signals and the potential for overuse of emergency blood products (we have added additional implementation details to our methods to acknowledge these questions: lines 134-146). Hold clot at our institution is easy to perform and is selectable as an automated order; standard order sets were updated to allow for this selection. Education of house staff, nursing, and attending physicians was required to ensure that hold clot was transitioned to crossmatch in the event of clinically meaningful bleeding. We have updated the manuscript to reflect this component of the implementation process in more detail (lines 153-159).

Comments from Reviewer 3

Comment 1: *Can you better describe the patient selection process and the PPH risk based tool you used- this could be included as a Table*

Response: Thank you for this suggestion. We have included a table describing the CMQCC risk tool in greater detail. Please see Table 1.

Comment 2: *Can you better describe the implementation. Was this a standardized order set based on their calculated risk? Was this a discussion huddle of all women on admission and then a decision? Was this reevaluated every 12 hours? 8 hours? or 24 hours? A description of implementation process used for education of residents, attendings etc would be helpful. Was this nursing driven or provider driven?*

Response: We thank reviewer 3 for their interest in these implementation details and

[redacted]

agree that this will be helpful to the reader. We have included more detail regarding implementation in lines 153-159.

Comment 3: *Before implementation did you convene a Quality/safety group and complete a process that was multidisciplinary? Please describe.*

Response: Thank you for this question and agree with the importance of discussing this in our manuscript. We did convene a multidisciplinary group and have added additional detail to the manuscript in lines 134-146. Several of our authors have formal quality and safety expertise and training.

Comment 4: *Risk can be fluid during an admission to LD. How many women were changed from a Type and Hold to a Type and screen during labor and postpartum. It would be good to better understand how this worked and what criteria prompted the change.*

Response: We thank Reviewer 3 for addressing risk fluidity throughout admission. This is a limitation of our study and we agree that capturing this data would have been informative. Per our protocol, any patient risk-stratified as high risk underwent conversion of hold clot to type and cross. Therefore, we can use risk stratification at time of admission and at time of delivery as a proxy for this, although imperfect. We could provide this proxy data if the Editors think it would add value to our manuscript. Meanwhile, we have described this limitation in our discussion (lines 293-295).

Comment 5: *Inclusion criteria "We included all pregnant patients presenting to the labor unit for delivery, whose prenatal testing occurred within our hospital's central lab, with negative antibody screen." Does that mean transfer patients were not included? How many women were excluded because of this?*

Response: We thank Reviewer 3 for bringing this to our attention. The sentence as we have written it above does not adequately describe our policy. There is a need to distinguish the policy (how patients were assessed and tested) from the study (how the system fared under a new policy. We included all patients who delivered in our study, but the policy did not allow some patients to be eligible for “selective type and screen.” For clarification, the only exclusion criteria for a risk-based selective type and screen was suspected placenta accreta. Patients whose prenatal testing occurred within our

hospital's central lab and had a negative antibody screen were eligible for risk-based selective type and screen. Patients whose testing occurred outside of the system (including transfer patients) underwent our pre-implementation protocol of universal type and screen and were ineligible for hold clot; however all patients are captured in the data with regards to resource utilization, cost, and safety outcomes. We have added additional detail to clarify this in the methods (lines 102-108).

Comment 6: *How did you manage antepartum patients with PPROM and diabetes and preeclampsia? were they part of this at all?*

Response: Thank you for the detailed questions regarding our implementation. We have added additional details regarding antepartum patients in lines 147-152.

Statistical Editor Comments

Comment 1: *Table 2 and lines 40-41, 159-161: For comparison of ERT events and transfusion of 4+ RBC units, the counts are small and should use Fisher's test, which changes the p-values, although they remain NS. More importantly, the n(%) are so small that there is insufficient stats power to generalize the NS finding from these data. Also, do you mean outcomes per person in title? It seems these are outcomes per period.*

Response: Thank you for the critique of these data. We have implemented Fisher's and reported the non-significant p-values accordingly (Table 3, lines 41, 44, 209 and 220). Additionally, we agree and have acknowledged these limitations regarding insufficient statistical power for rare outcomes in the discussion (lines 286-289). Thank you, too, for the clarification of our table 2 title—these are outcomes per period and the title has been updated accordingly.

Comment 2: *Table 3: Since the costs would be related to the number of patients per month, shouldn't these monthly costs be adjusted per patient? That would not change the inference, but seems fair to adjust for monthly patient volume.*

Response: This is a fair critique and we agree that reporting the data as described above would not change the inference. By reporting per patient, the results would appear even more impressive. However, there are strict rules for how data from the Value-Driven Outcomes tool may be reported, so as not to compromise price negotiations between the institution and the many different payers and vendors with which it does business. Unfortunately, because per-patient summary statistics would violate these rules, we are not allowed to report results in this way.

[redacted]

Comment 3: *Table 4: The difference in rates of hysterectomies could be calculated using Fisher's test, but (1) will be NS and (2) is underpowered. Also, the counts for ICU admissions lacks stats power to generalize the NS finding.*

Response: Thank you for this critique, we agree with these comments. We have calculated differences in hysterectomies using Fisher's test. We have reiterated in the discussion that we are underpowered to generalize these findings (lines 286-289).

Comment 4: *Figs 1, 3: Again, shouldn't those costs be adjusted for monthly numbers of patients? Maybe simpler, but informative number would be the mean cost per case in the pre vs post protocol periods?*

Response: Thank you for this question and we agree that reporting these costs per patient is a logical way to present these data; however, as stated above, we are not able to report per-patient summary statistics because this would violate our data use agreement for the Value-Driven Outcomes tool.

Comment 5: "General: Need to include in limitations specific reference to lack of stats power for some adverse outcomes."

Response: Thank you, we agree with this critique. In our discussion, we have included a reference to the limitations of these data, particularly the lack of statistical power for rare adverse outcomes (lines 286-295). However, in this implementation study we were looking for obvious safety signals and find it reassuring that none were found.

Editor Comments

Comment 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.

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

Comment 2: *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.*

[redacted]

The following authors still need to complete the form:
[redacted]

Response: Thank you for this information. We have confirmed with the editorial office staff that the authors above have completed their eCTA and there are no disclosures to include on the title page.

Comment 3: *For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.*

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

Response: Thank you for this important suggestion. Race in our database is self-reported and includes “other” box for individuals to select if they choose. Unfortunately, this results in suboptimal data capture for race and ethnicity and admittedly should be changed, but cannot be for the current study. We have described this in the Table 2 footnotes.

Comment 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.*

Response: Thank you for this information, we have updated the manuscript to be consistent with the obstetric data definitions.

Comment 5: *Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Clinical Practice and*

[redacted]

Quality articles 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: Thank you for this reminder, the manuscript adheres to length restrictions at

Comment 6: ** 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: Thank you for this, the manuscript has been updated accordingly.

Comment 7: *The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.*
In addition, the abstract length should follow journal guidelines. The word limit for Clinical Practice and Quality is 300 words. Please provide a word count.

Response: Thank you for this reminder. The abstract included in our revised manuscript is consistent with the body of the manuscript. It is 300 words and therefore adherent to the abstract length limit.

Comment 8: *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: Thank you for this information. We have updated the manuscript to remove and virgule symbols in sentences with words.

Comment 9: *ACOG avoids using "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for*

[redacted]

example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

Response: Thank you for this critique. We have updated the manuscript accordingly to eliminate the term “provider”.

Comment 10: *Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.*

Response: Thank you. All tables have been updated to ensure they conform to the journal style.

Comment 11: *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.

Response: Thank you, all references have been updated accordingly.

Comment 12: *Figures 1-3: Please add tick marks along the x- and y-axes.*

Response: Thank you, these figures have been updated to include tick marks along the axes.

Comment 13: *Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice,*

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