Comparative Effectiveness Review Disposition of Public Comments Report

Project Title: *Postpartum Care up to 1 Year After Pregnancy: A Systematic Review and Meta-analysis*

Draft report was available for public comment from November 16, 2022, to December 31, 2022.

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Comments to Draft Report

Draft reports by the Effective Health Care (EHC) Program undergo peer review and public comment. The Program encourages the public to participate in the development of its research projects. Each draft report funded by the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Outcomes Research Institute (PCORI) is posted to the EHC Program website or the Agency for Healthcare Research and Quality (AHRQ) website for public comment for a 1.5-month period. Comments can be submitted via the website, mail, or email. At the conclusion of the public comment period, authors use the commentators' comments to revise the draft report.

Comments on draft reports and the authors' responses to the comments are posted for public viewing on the website approximately 3 months after the final report is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

This document includes the responses by the authors of the report to comments that were submitted for this draft report. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of AHRQ or PCORI.

Summary of Peer Reviewer Comments and Author Response

An initial draft report for this research review underwent peer review before the draft report was posted for public comment on the EHC website. Peer review comments and responses are summarized here.

- Reviewers found the review "*The authors do an excellent job carrying out a difficult systematic review and meta-analysis. This systematic review and meta-analysis provides a general overview of the current state of the art around postpartum care.*" Another reviewer noted "*Thank you for all of your work! I love all the tables, so easy to navigate and find thigs. There is such useful information synthesized here!"* Reviewers also noted that *"The major findings and their implications were clearly stated."*
- Reviewers asked for various specific clarifications, for example, (1) how "integration of care" was defined; (2) how the process for prioritization of outcomes is characterized; (3) how it was determined that a study addressed "general postpartum care" vs. (for example) "breastfeeding care." The Evidence-based Practice Center (EPC) authors clarified various sections of the report in response to these comments.
- Reviewers also suggested providing details regarding how the study screening (title/abstract and full text) was conducted and why KQ 1 was focused on the United States and Canada and why KQ 2 was focused on the United States only. The EPC authors clarified these aspects.
- Reviewers did not identify any studies that were missed by our search and screening processes. Some were suggested for inclusion, but the EPC authors responded that those studies did not fulfill our *a priori* eligibility criteria.
- Reviewers made some specific suggestions regarding arm names and outcome time-points that were incorrectly extracted for some studies. The EPC authors made these corrections.
- Reviewers also suggested more details regarding study populations to descriptions of various individual outcome sections, as appropriate. The EPC authors incorporated these requested details in the report.
- Reviewers also suggested additions to the *Discussion* section, such as the paucity of studies evaluating differences by racial subgroups. The EPC authors added those details to the *Discussion*.

Public Comments and Author Response

Commenter	Section	Comment	Response
PCORI	Abstract	**Racial Health Equity.** PCORI feels a statement added to the abstract regarding the need for more research aimed at reducing racial health disparities is important. In general, the call for new research should include vulnerable populations and examining whether any strategies can attenuate racial health disparities. This is clearly noted for future studies of Medicaid expansion. PCORI would like to see mention of studies of care strategies that may help reduce racial health inequities. Please know that this is different than the call for studying those "most vulnerable due to socioeconomic factors".	We thank PCORI for reviewing and providing comments. We have added text describing this issue in the Abstract.
PCORI	Introduction	**Two paragraphs Referencing ACOG in the Introduction.** Consider altering the language to reflect that ACOG has worked with the information that was available and the resources available at the time of writing, and that an update of this information will be useful in crafting future statements. As written, the language feels slightly judgmental, which we don't believe is the EPC's intent.	The fact that the existing recommendation is consensus-based (and not evidence-based) is not a judgment of ACOG. With that being said, we've deleted one of the two instances where we had stated that the recommendations were not based on a systematic review.
PCORI	Results	**Term "probably associated."** For findings of KQ2 – why use "probably" associated? Why this uncertain language when noting Moderate SoE finding? [Note: We know EPCs sometimes use "probably" when describing moderate SOE findings but have also noticed that that isn't always the case.	The qualifying language "probably associated" is consistent with AHRQ EPC Program guidance for moderate strength of evidence. This guidance is cited in the last section of the Methods.
PCORI	Discussion	**Accuracy of "sizeable amount of evidence".** At the beginning of the Discussion and again towards the end and at the beginning of the Conclusion, the EPC notes that 70 studies are a sizeable amount of evidence. Given that this review covered broad and potentially large number of interventions, is this accurate? Recall a slide from the P2P that showed how little research attention has been given to postpartum care. Consider a consistent message about how little research exists.	We have removed from the entire report all language suggesting that this body of evidence was "sizeable."
American Psychological Association	General	Thank you for the opportunity to comment on AHRQ's draft systematic review Postpartum Care Up to One Year After Pregnancy.	We thank the American Psychological Association for reviewing and providing comments.

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American Psychological Association	General	We also appreciate the inclusive language when referring to "pregnant and postpartum individuals." We encourage the continued use of inclusive language throughout the framework and document, and we invite you to refer to APA's (2021) Inclusive Language Guidelines for further guidance.	Thank you.
American Psychological Association	Appendix	In Key Question 1 of the detailed PICOTSD section, we appreciate the inclusion of "clinical psychologist or other mental health professional" as it is important to integrate mental health care with other health services (Thomas et al., 2017).	Thank you.
American Psychological Association	Discussion	We particularly appreciate that you highlight racial/ethnic disparities in health outcomes such as the maternal mortality ratio, that you call attention to many potential effect modifiers, and that you call for more information by subgroup.	Thank you.
American Psychological Association	Discussion	We appreciate your call for more patient centered outcomes reporting.	Thank you.
American Psychological Association	Methods	Please consider further differentiating the general postpartum care category to indicate whether it is mental or physical health care. This may be particularly relevant when it comes to mental health outcomes. Related, it is helpful to see the breakdown of who provides care (e.g., for breastfeeding)	We have clarified in the Methods section that general postpartum care could include studies in which multiple aspects of postpartum care (e.g., physical health care, breastfeeding care, mental health care) were evaluated (see section *2.4 Study Selection*). Most studies, however, did not describe these aspects in detail.
American Psychological Association	Discussion	We recommend highlighting within the discussion section that there is no "one size fits all" approach to integrating mental health care with physical health care (please see appended information on the evidence-based model "Primary Care Behavioral Health Model Services").	We have added the following text to the Discussion (see section *4.5 Implications for Research*): "It should be recognized that a one-size-fits-all approach to provision of postpartum care may not address the needs of all postpartum individuals."

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American Psychological Association	Discussion	There is also a need for more research in providing quality postpartum care for individuals who are Deaf/Hard-of-Hearing, as a recent study reported that Deaf/Hard-of-Hearing pregnant individuals had higher hospital readmission rates than their hearing counterparts (McKee et al., 2022)	We have added the following phrase to the text that describes the types of individuals who should be included in future studies (see section *4.5 Implications for Research*): "…, or due to disabilities, such as movement disorders, vision loss, and hearing loss."
20/20 Mom	Discussion	While noted in the systematic review, 2020 Mom feels it is important to highlight and echo the fact that there is a scarcity of evidence and research with high strength of evidence on maternal mental health outcomes across various aspects of postpartum care. As such, 2020 Mom continues to champion the need to prioritize funding and policies that encourage and enable more research in maternal mental health.	We thank 20/20 Mom for reviewing and providing comments. We have added mental health outcomes to the list of outcomes that should be more consistently evaluated and reported in future studies (see section *4.5 Implications for Research*).

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20/20 Mom	Discussion	In regards to where postpartum care is given, the systematic review states: *Regarding where breastfeeding care is provided, whether the initial visit is conducted at home or at the pediatric clinic may not impact mental health (depression symptoms up to 6 months postpartum or anxiety symptoms up to 2 months) or unplanned care utilization (hospital readmission by 3 months or other unplanned care utilization up to 2 months).* Our recommendation regarding future reviews examining maternal mental health outcomes is to examine studies not tied to breastfeeding care. While breastfeeding care is an important touchpoint for maternal care and mental health screening, utilizing breastfeeding care as an assessment of maternal mental healthcare outcomes may be misleading as the focal point may not specifically be on improving mental healthcare outcomes. Furthermore, there has been substantial recognition that obstetric providers, as the primary medical home during the perinatal period, should be the primary source of maternal mental health screening and initial assessment and treatment plan development both during pregnancy and in the postpartum period. With national recognition of the importance of adequate "4th trimester"	Based on conversations with the Key Informants and the TEP, mental health outcomes were considered important for all targets of intervention, including breastfeeding care. We were interested in mental health outcomes up to 1 year after delivery, but these were rarely reported.

Commenter	Section	Comment	Response
20/20 Mom (cont'd)	Discussion (cont'd)	care by the American College of Obstetrics and Gynecology (ACOG) and others, to prevent maternal mortality and morbidity the expansion of obstetric visits during the postpartum period to more than one is also an important acknowledgment and consideration for future research. Finally, utilizing data from an initial postpartum visit is not the same as data measuring maternal mental health outcomes, which should be tracked in combination with appropriate and adequate maternal mental health interventions over the first year postpartum. As maternal mental health disorders can develop up to 1 year postpartum (or beyond this timeframe if triggered by weaning breastfeeding), it is therefore our recommendation to look at studies that examine mental health outcomes up to 1 year postpartum, rather than depression symptoms up to 6 months postpartum or anxiety symptoms up to 2 months postpartum.	(response above)

Commenter	Section	Comment	Response
AC	Results	When looking at the studies that examined how postpartum care is given, the systematic review states: *General Postpartum Care – Clinical Outcomes 3.3.4.2.1 Mental Health Outcomes Three RCTs (Koniak-Griffin 2003, Hans 2018, and Laliberte 2016) reported data. Each RCT compared integrated and nonintegrated care and reported comparable rates of depression symptoms. Hans 2018 reported comparable rates of significant depression symptoms (defined as Center for Epidemiologic Studies Depression [CES-D] score ≥15) comparing those who did not receive case management by community case managers or social services providers versus those who did at 3 weeks (adjOR 0.96, 95% CI 0.53 to 1.71) and at 3 months (adjOR 0.95, 95% CI 0.47 to 1.91). Koniak-Griffin 2003 reported depression symptom absolute scores using the CES-D. Participants in the Early Intervention Program (EIP; 17 home visits and 4 prenatal classes provided by public health nurses) and participants who received Traditional Public Health Nursing Care (TPHNC) had comparable scores at 1 year (net mean difference [NMD] 1.30, 95% CI −2.51to 5.11). Laliberte 2016 reported that integrated postpartum clinic attendees and standard postpartum care recipients had comparable depression symptom absolute scores using on the EPDS at 3 weeks postpartum (MD −0.2, 95% CI −0.9 to 0.5). Among these three RCTs, only Hans 2018 reported on baseline depression symptoms, which were similar among the treatment groups.* The analysis of the impact of integrative care on mental health outcomes based on the comparative factors of case management/social services provided may not currently be the best comparators for examining the actual impact of integrative care on maternal mental health outcomes. Since many case managers and social workers may not have appropriate maternal mental health training or access to appropriate maternal mental health resources, the impact of current case management and social services on maternal mental health is unclear. When comparing the effectiveness of Early Intervention Programs (EIP) to Traditional Public Health Nursing Care, it is unclear to what extent the EIP educates patients on maternal mental healthcare risks and resources. It is our recommendation that future studies examine the effectiveness of early intervention programs specific to maternal mental health when attempting to examine maternal mental health outcomes in the postpartum period.	Based on conversations with the Key Informants and the Technical Expert Panel, mental health outcomes were considered important for all targets of intervention, including coordination or management of care.

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AccessMatters	General	Understanding that the Department will receive considerable clinical guidance on the review, we are focusing our comment on language, as we believe it also has significant impact on inclusivity, equity, and true access.	We thank AccessMatters for reviewing and providing comments.
AccessMatters	General	• While we recognize the needs assessment generally strives to use inclusive language, it still utilized the term "maternal health." Generally, we strongly recommend the use of gender-inclusive language throughout the documents, particularly as it relates to the terms "mom(s)," "woman/women," "breastfeeding," and "maternal health." To raise the visibility of transgender men and non-binary people who are pregnant or parenting, we suggest that gendered and binary terms are replaced with more gender-inclusive terms which could include, as appropriate: ○ "people who are pregnant or parenting" ○ "pregnant, birthing, and parenting people" ○ "person/people" ○ "women and other pregnant people" ○ "chest/breastfeeding" ○ "perinatal and postpartum health" ○ "health and social services during the perinatal and postpartum periods" ○ "pregnancy-related deaths" ○ "pregnancy-related health outcomes" ○ "birth outcomes" ○ "people who face gender oppression" – instead of women.	We have retained "breastfeeding". In our view, breastfeeding is anatomically accurate, and the term "chestfeeding" would not be clearly understood. We have also retained "maternal" because we have not found an appropriate substitute term ("parental" is not sufficiently accurate). We have, though, replaced all references to "women" with "postpartum individuals" as appropriate.
Neil Jackson	Evidence Summary	Main points should provide considerable attention to the effects to postpartum care that addiction, specifically to opiates have on both the mother and infant. Neonatal abstinence syndrome is an incredible and evil attack on the child during development and post delivery.	The Main Points (and Key Points) summarize the salient findings from the evidence. The evidence did not provide sufficient evidence to comment about the subpopulation of postpartum individuals with substance use disorders such as opioid use disorder.
Susan Thomas	General	As a labor and delivery/postpartum RN for over 25 years, I see the necessity for this type of coverage. Especially for women who get pregnancy-related Medicaid and are left without coverage after their 6 week postpartum checkup. Thank you for doing this valuable review.	We thank Susan Thomas for reviewing and providing comments.

Commenter	Section	Comment	Response
Wangnan Cao	General	This is a super nice report and very interesting to read. Glad to see it coming out! I have a few minor comments:	We thank Wangnan Cao for reviewing and providing comments.
Wangnan Cao	Methods	For the texts below: "Because KQ 1 compares strategies to deliver interventions, we modified the traditional structure for defining KQ eligibility criteria (PICOTDS). Specifically, we restructured the Interventions and Comparators elements to be Target of Interventions Provided, Delivery Strategies, and Comparator Delivery Strategies. " I am still unsure about what modifications did the study make particularly? What does traditional mean here?	Traditional means that PICODTS is the conventional structure that has been used for systematic reviews. For clarity, we have added to that sentence the full form of the PICODTS acronym (i.e., Population, Interventions, Comparators, Outcomes, Timing, Design, and Settings). The next sentence states the modification that was made for this systematic review: "Specifically, we restructured the Interventions and Comparators elements to be Target of Interventions Provided, Delivery Strategies, and Comparator Delivery Strategies."
Wangnan Cao	Methods	1. It is good to see mental health as a prioritized outcome; however, mental health-focused care was not analyzed separately as one target of the intention (but included as part of the screening and preventive care).	None of the studies evaluated the provision of mental health care as a specific intervention target. This is likely related to our having excluded studies that were exclusively of patients with mood disorders (e.g., major depression, anxiety).
Wangnan Cao	Methods	2. The report mentioned that "Outcomes reflecting offspring health were outside the scope of this review. ", which was a bit disappointing to me.	Based on conversations with the Key Informants and the Technical Expert Panel, offspring health outcomes were considered beyond the scope of this systematic review.

Commenter	Section	Comment	Response
Wangnan Cao	Title	3. It might be better to add "US and Canada" in the SR title.	In the interest of conciseness, we would prefer to keep the title as is because Canadian studies were eligible only for KQ 1.
Wangnan Cao	Methods	4. For adjusted NRCSs, the review did not provide sufficient details on "adjusted". Did you have a variable list that had to be adjusted to be included as one eligible NRCS?	Because of the complex and disparate nature of the interventions evaluated in this systematic review, we did not develop an a priori list of variables that would need to have been adjusted for a study to be eligible. We have clarified in the Methods section that we used maximally adjusted analyses (see section *2.7 Data Synthesis*).

Commenter	Section	Comment	Response
Anonymous	Results	There are several studies that have examined the content and quality of care provided during postpartum visits and/or the postpartum period by insurance type / insurance status that were not included in the review. These studies examine services such as contraceptive care, referrals to other providers (e.g., PCP), depression screening and other services recommended by ACOG and other professional guidelines. These studies would likely be included in Section 3 of the report (e.g., sections 3.4.3.1.2 and 3.4.3.2.4), examining healthcare utilization outcomes and clinical outcomes for those with Medicaid compared to uninsured and those with private insurance. Some of these studies were published outside of the original timeframe of the systematic review, while others were within. • Interrante JD, Admon LK, Carroll C, Henning-Smith C, Chastain P, Kozhimannil KB. Association of Health Insurance, Geography, and Race and Ethnicity With Disparities in Receipt of Recommended Postpartum Care in the US. JAMA Health Forum. 2022;3(10):e223292. doi:10.1001/jamahealthforum.2022.3292 • Kathryn Wouk, Alan C. Kinlaw, Narges Farahi, Henry Pfeifer, Brandon Yeatts, Moo Kho Paw, and Whitney R. Robinson. Correlates of Receiving Guideline-Concordant Postpartum Health Services in the Community Health Center Setting. Women's Health Reports.Dec 2022.180-193. • Geissler K, Ranchoff BL, Cooper MI, Attanasio LB. Association of Insurance Status With Provision of Recommended Services During Comprehensive Postpartum Visits. JAMA Netw Open. 2020;3(11):e2025095. doi:10.1001/jamanetworkopen.2020.25095	We thank this anonymous reviewer for reviewing and providing comments. We have provided below a disposition of why these three studies were not included in the systematic review: • Interrante 2022 – This article was published after the date of last search at the time of the draft report. We found it in the update search but excluded it because it addressed KQ 1 but was a cross-sectional study. • Wouk 2022 – This article was published after the date of last search at the time of the draft report. We found it in the update search but excluded it because there was no intervention of interest. • Geissler 2020 – We had found this article in our original search but excluded it because it addressed KQ 1 but was a cross-sectional study.

Commenter	Section	Comment	Response
Ellen Mason	General	I 'attended' the three day meeting on postpartum care prior to the release of this review. As an attendee, I felt there was limited opportunity for people who were not part of the expert panels, to comment or ask questions, I think its critical that I make this comment now. My major problem with all ot the issues raised and the expert questions during the meeting and in this document was that nowhere, is the importance of continuity of care mentioned. I am a faculty member at the University of Illinois School of Public Health, in the Center of Excellence in Maternal Child Health. But I have also been a provider of clinical care- both ambulatory maternal fetal medicine care, and subsequent to the end of pregnancy, primary care, for over thirty yeats in Chicago's Cook County Hospital. I experienced first hand the dramatic difference it makes both to patient satisfaction and patient outcomes, short term and long term, to have a committed provider who knows patients both antepartum and postpartum. My broader view of this issue of continuity, is that wealthier and more highly resourced individuals are far more likely to experience changes in providers over times, have much more access to qualified health care providers who know them and their past obstetric and medical histories well. The literature on 'hand offs" in the in patient setting clearly establishes the lhuge likelihood of omissions in care, errors in care and lack of patient adherence when continuity is not valued and prioritized. We will continue to have glaring health disparities in the outcomes of higher SES folks compared to low SES folks and worse outcomes for people of color if a strong mandate for continuity, and choice of provider is not hard wired into effective postpartum care delivery. Thank you for the opportunity to comment on this critical work.	We thank Ellen Mason for reviewing and providing comments. Based on conversations with the Key Informants and the Technical Expert Panel, we did not consider continuity of care as a delivery strategy (for KQ 1). However, we considered transition to primary care providers as a prioritized outcome (for both KQs). Unfortunately, this was a rarely reported outcome in the included studies, which we comment in the Discussion (see section *4.2.1 Strengths and Limitations of the Evidence Base).*
Margaret Miller	Background	The Background and Objectives section included a succinct but relevant summary of the data on maternal morbidity and mortality and provided an excellent argument for the need to improve postpartum care	We thank Margaret Miller for reviewing and providing comments.
Margaret Miller	Methods (Appendix)	For both KQ1 andf KQ2, the eligibility criteria specifically exclude women with chronic medical conditions. Women with chronic medical conditions represent a disproportionate # of maternal deaths and account for a high percentage of severe maternal morbidity. If maternal morbidity and mortality is a primary outcome, it seems this population should be included or you risk ending up with a guideline that may improve outcomes for only the lowest risk women.	Based on conversations with the Key Informants and the Technical Expert Panel, this population of individuals was beyond the scope of this systematic review.
Margaret Miller	Methods (Appendix)	Under the heading "Outcomes" a number of potential effect modifiers are included. This list is quite thorough but wouls also consider inlcuding: a measure of caretaker responsibilities (# of children	Based on conversations with the Key Informants and the Technical Expert Panel, we did not consider number of children as a potential effect modifier.

Commenter	Section	Comment	Response
Margaret Miller	Background, Discussion	Our team of 5 obstetric medicine physicians at Brown Univ/Lifespan Health System reviewed the draft protocol. We are a group of internists specializing in medical problems in pregnancy. We welcome this project as an opportunity to improve postpartum care and agree with the authors that the 2018 ACOG committee opinion, while an important step forward, did not go far enough in defining appropriate timing of care. Chronic medical issues affect so many women in pregnancy (especially if you include obesity in that category) and we feel strongly that care of women before, during and after pregnancy should be coordinated and collaborative in order to achieve the best outcomes.	Thank you.