Date: Apr 18, 2019
To: "Suzanne Burlone" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-577

RE: Manuscript Number ONG-19-577

Overcoming Barriers to Access Obstetrical Care in Underserved Communities

Dear Dr. Burlone:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by May 09, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Thanks for submitting your commentary titled "Overcoming barriers to access obstetrical care in underserved communities". I have the following comments and queries for this paper:

1. The authors describe the issue clearly and succinctly in the Introduction section.

2. Line 149. Why such a high percentage of uninsured at La Familia medical center? Why don't these patients qualify for Medicaid?

3. Lines 149-151. If the population of Santa Fe proper is about 84,000 and Santa Fe County is about 149,000, and the population that you serve is 17,000, why is it that you provide one-third of the annual births in Santa Fe? Is that because you serve a predominately reproductive-aged population?

4. Line 176. Not having patient outcomes data for your current system is a significant limitation of your paper.

5. Line 179. The authors need to give a numerator and denominator for this survey.

6. I don't think that this model is really all that novel. Many federally funded clinics employee an OB/GYN(s) to do chart reviews in a similar manner and give consultations.

Reviewer #2: Overcoming Barriers to Access Obstetrical Care in Underserved Communities Utilization of the EHR and telehealth is becoming increasingly popular, so proposing its use within this aspect of OB/GYN care is timely. The authors propose a valuable tool to serve patients in low-resource settings. Providing examples of how similar models are already being used in other specialties, further adds support to this model and it is encouraging that it will be accepted for use in other low resource settings. I would consider adding an additional example of telehealth consults being used in other specialties or emphasize that similar models are being safely used in other areas to strengthen this point. From my own experience, this is currently being used by Health and Hospital Corporation in NYC as "eConsults" in EPIC. Here is an example of an article from the Green Journal also using an econsults in obgyn: Shehata, Fady, et al. "Evaluation of an Electronic Consultation Service in Obstetrics and Gynecology in Ontario." Obstetrics & Gynecology, 1 June 2016, insights.ovid.com/pubmed?pmid=27159757.
It is also used by Kaiser Permanente by general ob providers who do electronic consults to MFM provider.

1. Line 99-100 "never meet the patient", Line 102-103 "without the need to physically examine a patient", and Line 111-112 the consultant will use information documented in the EHR. here should alignWhile all of these actions are possible with using EHR for telehealth and are all valuable, try to stay consistent in how you are proposing to its use.

2. Is Are there potential legal ramification to providing recommendations having never interacted with the patient? Obstetrics is a specialty so often associated with medical-legal issues, that this is important to mention, especially if there are corollaries within other specialties using similar models. This week JAMA published Fogel AL, Kvedar JC. Reported Cases of Medical Malpractice in Direct-to-Consumer Telemedicine. JAMA.2019;321(13):1309-1310. doi:10.1001/jama.2019.0395, which may be of use.

3. Line 115-138: You present several other models that link technology and collaboration in a clear and concise way. Your second example of telemedicine models in Canada seems most similar and supports your model, well. Are there other models within large health centers or companies (Kaiser, Epic EMR as mentioned above.) that are being used to send tele-health consults to specialists that you can draw upon rather than using Project Echo, which seems most dissimilar?

Linking Technology with collaboration

4. Line 166 - You do a good job describing our model and how it interacts with the existing clinic. Can the authors further explain whether patients who are in their 3rd trimester are still reviewed every 3-4 weeks or more closely? Are patients followed more closely than every 3-4 weeks near term?

5. Line 178-180- Its very reassuring to see how widely appreciated and helpful this system seems to be.

Reviewer #3: Thank you for your submission of this article. I thoroughly enjoyed the read. I find the information you presented to be relevant and timely. I thought your writing was clear and direct. You used simple language and offered clear solutions to a multi-layered problem. I think it's a good start to tackling this problem of patient's inaccessibility to healthcare in the rural setting. I would encourage you to continue tracking data. As your program appears to be a pilot model, it may be able to provide valuable information for this national problem. Including the survey results of the participating providers is helpful. As you go further you may want to include more specific data regarding patient outcomes. You may also consider including more details of your survey.

I did notice that your article lacked any tables or graphs. While I find all the material to be clearly stated in the body of the text, you may give some consideration to creating bullets of your main points. This is a matter of author's preference and would not cause any significant change in the value of your piece; in my opinion. I do have one question, in your piece you stated that the physicians that conduct the chart review are physicians who have worked in the clinics and therefore have some personal familiarity with the system. How important is that factor in the success of your model? Since you will no longer have ob/gyn physicians in your clinic, how will you address the issue of attrition and replacement of the physicians providing the chart reviews?

Thank you for your submission.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.

- The Journal style doesn't not use the virgule (/) except in numeric expressions. Please edit here and in all instances.

- is this some sort of interquartile range? Certainly, many women live < 9 and > 65 miles. Please clarify.

- 24/7 is jargon. Could you restate without it?

- This is called a primacy claim: yours is the first, biggest, etc…In order to assert that, you need to provide the search terms used and the data base (s) searched (PubMed ,Google Scholar, etc) to substantiate the claim. Otherwise, it needs to be deleted. It wouldn't belong in the abstract anyway, so make sure you address this in the manuscript body.

- to be clear, its 1 nurse midwife? Perhaps better to say something like "(Family physicians and advance practice nurses)?

- Please consult the Instructions for Authors regarding the use of abbreviations, and what constitutes an acceptable abbreviation. This is not an acceptable abbreviation. Please spell out all abbreviations on first use. It is reasonable to not use abbreviations for words that are seldom used in the paper. We try to limit “unique” abbreviations so that readers don’t have to frequently refer back to the first notation of the abbreviation to remember its meaning. We realize that this may affect word count but believe it makes it easier in most cases for the reader.

- if its one Ob GYN on a regular schedule, what do you mean by "rotating" ?

- Perhaps "the entire world" is a bit of hyperbole: Could you edit?

2. 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, as well as subsequent author queries. 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 response letter and subsequent email correspondence related to author queries.
b. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. 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.

Any author agreement forms previously submitted will be superseded by the eCTA. During the resubmission process, you are welcome to remove these PDFs from EM. However, if you prefer, we can remove them for you after submission.

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: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 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. 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: Current Commentary articles, 250 words. Please provide a word count.

7. 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.

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. 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.

10. 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.

11. If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by May 09, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

_____

April 30, 2019

Dear Editors and reviewers of *Obstetrics & Gynecology*,

Thank you for being willing to give further consideration to a revised version of our manuscript entitled “Overcoming barriers to access obstetrical care in underserved communities” initially submitted on March 26, 2019 for publication as a Current Commentary. We appreciate the opportunity to address both the reviewers’ and editor’s comments as we attempt to improve and clarify our manuscript.

Please see our responses and actions as indicated with each point below; the original reviewer and editor comments are in normal text, and our responses in **bold** text. Our enclosed revised manuscript has all edits as per below in “track changes” within the enclosed revised manuscript document.

Thank you again for this opportunity,

Suzanne Burlone, MD, MSPH, Lisa Moore, MD, and Wendy Johnson, MD, MPH

REVIEWER COMMENTS

Reviewer #1:

Thanks for submitting your commentary titled "Overcoming barriers to access obstetrical care in underserved communities". I have the following comments and queries for this paper:

1. The authors describe the issue clearly and succinctly in the Introduction section. **Thank you. No revision indicated.**

2. Line 149. Why such a high percentage of uninsured at La Familia medical center? Why don't these patients qualify for Medicaid? **The relatively high rate (35%) of uninsured patients at La Familia Medical Center is primarily due to the large population of undocumented immigrant patients at La Familia Medical Center. Undocumented immigrants in New Mexico only qualify for Medicaid for the circumstances of emergency medical services and medical assistance for refugee status (please see** https://www.benefitsapplication.com/apply/NM/Medicaid**). No revision indicated.**

3. Lines 149-151. If the population of Santa Fe proper is about 84,000 and Santa Fe County is about 149,000, and the population that you serve is 17,000, why is it that you provide one-third of the annual births in Santa Fe? Is that because you serve a predominately reproductive-aged population? **Santa Fe County has only ~45,000 women aged 18-65** (https://www.census.gov/quickfacts/santafecountynewmexico)**, as >23% of the Santa Fe County population are over age 65 and >18% are under age 18; 51% of the population are women. As La Familia Medical Center is the only clinic in Santa Fe County which provides both prenatal care to uninsured patients and comprehensive care (including prenatal care) for opiate addiction in pregnancy, a disproportionate percentage of the pregnant population in Santa Fe County is seen at La Familia Medical center. Additionally, reproductive-aged women comprise 31% of the La Familia population. No revision indicated.**

4. Line 176. Not having patient outcomes data for your current system is a significant limitation of your paper. **We agree that our manuscript would be stronger with patient outcomes data. We favored publishing our model now despite not yet having patient outcome data, however, due to the proven provider satisfaction with our model as well as the ability to share our model as a potential tool for other healthcare systems looking**

immediately to establish a model to confront the obstetric access crisis. We hope in the future to be able to obtain and publish patient outcomes data, and the process of creating this manuscript drove the initial brainstorming of which patient outcomes we would like to evaluate in the future. No revision indicated.

5. Line 179. The authors need to give a numerator and denominator for this survey. **Thank you for this suggestion. Please see the revised manuscript indicating a numerator of 10 and denominator of 14 in new line numbers 194-195.**

6. I don't think that this model is really all that novel. Many federally funded clinics employee an OB/GYN(s) to do chart reviews in a similar manner and give consultations. **We are aware of other federally funded clinics that employ or have formal relationships with obstetrician-gynecologists within a health system, which can include obstetrician-gynecologists doing chart review and general consultation. We are unaware of any clinics that employ an obstetrician-gynecologist ONLY for chart review and maintenance of a high risk pregnancy registry, however. In this regard, we do feel that our model, which utilizes an otherwise unaffiliated obstetrician-gynecologist, is underused at a minimum. A specific word used to describe our model is "alternative" in line 42, as our model is not commonly used elsewhere. No revision indicated.**

Reviewer #2:

Overcoming Barriers to Access Obstetrical Care in Underserved Communities

Utilization of the EHR and telehealth is becoming increasingly popular, so proposing its use within this aspect of OB/GYN care is timely. **Thank you. No revision indicated.**

The authors propose a valuable tool to serve patients in low-resource settings. **Thank you. No revision indicated.**

Providing examples of how similar models are already being used in other specialties, further adds support to this model and it is encouraging that it will be accepted for use in other low resource settings. **Thank you. No revision indicated.**

I would consider adding an additional example of telehealth consults being used in other specialties or emphasize that similar models are being safely used in other areas to strengthen this point. **Our inclusion of information about ProjectECHO was intended to serve as an example of telehealth being used among other specialties. To strengthen the point of telehealth being used more broadly within other specialties, we did reference two additional telehealth programs. Please see additional references as per the revisions within the manuscript in new line numbers 109-113 as well as within the list of references.**

From my own experience, this is currently being used by Health and Hospital Corporation in NYC as "eConsults" in EPIC. **Thank you for this information; we would be interested in knowing if "eConsults" in EPIC are sent to independent obstetrician-gynecologists outside of the Health and Hospital Corporation system. Our claim to be an alternative model is based on our consulting obtetrican-gynecologist for chart review and high risk registry maintenance not having primary clinical relationship to our clinic or "system". No revision indicated.**

Here is an example of an article from the Green Journal also using an econsults in obgyn: Shehata, Fady, et al. "Evaluation of an Electronic Consultation Service in Obstetrics and Gynecology in Ontario." Obstetrics & Gynecology, 1 June 2016, insights.ovid.com/pubmed?pmid=27159757. **Thank you for pointing out this example of an**

efficient use of resources in Ontario, Canada. This model is unique in that a single specialist answered 394 consults over the course of 3.5 years, used a secure web-based tool, and had an opportunity to request additional information if the consult had incomplete patient data. We note that this is different from our model due to our consulting obstetrician-gynecologist providing longevity of care and supervision of pregnancy care throughout a patient's entire pregnancy if the patient has a high risk pregnancy. No revision indicated.

It is also used by Kaiser Permanente by general ob providers who do electronic consults to MFM provider. **We appreciate this example as well, and in fact one of our authors works part time within the Kaiser Permanente system and is exposed to this efficient use of resources. We feel that the Kaiser model is different from ours due to having an established network for consultation, rather than an employed consultant specifically to do chart review and high risk pregnancy registry maintenance. No revision indicated.**

1. Line 99-100 "never meet the patient", Line 102-103 "without the need to physically examine a patient", and Line 111-112 the consultant will use information documented in the EHR. here should alignWhile all of these actions are possible with using EHR for telehealth and are all valuable, try to stay consistent in how you are proposing to its use. **We purposefully intended to provide various specific clinical scenarios for which telehealth can be utilized and be valuable; in some models, such as ours, a consultant does not meet or see a patient in person or via video interface (the scenario described in new line numbers 102-104). In other models, a consultant might meet a patient via video interface, but does not physically examine or lay hands on a patient (the scenario described in new line numbers 104-106). Please see the revisions within the manuscript in new line numbers 101-102 to hopefully**

clarify our original intention of highlighting the potential capabilities and various clinical scenarios for the use of telehealth in general, not specific to our model.

2. Is Are there potential legal ramification to providing recommendations having never interacted with the patient? Obstetrics is a specialty so often associated with medical-legal issues, that this is important to mention, especially if there are corollaries within other specialties using similar models. This week JAMA published Fogel AL, Kvedar JC. Reported Cases of Medical Malpractice in Direct-to-Consumer Telemedicine. JAMA.2019;321(13):1309-1310. doi:10.1001/jama.2019.0395, which may be of use. **While our consultant provides a second layer to the primary provision of care directed by the licensed and independent obstetric provider who physically examines, meets, and manages the patient (rather than the consultant providing the direct-to-consumer telemedicine referenced above), one cannot exclude the possibility of legal ramifications for the consultant. Thank you for the suggestion to at least address this issue in our manuscript. Please see the revisions in the manuscript in new line numbers 205-209 to mention this consideration. In our particular model, the consulting obstetrician-gynecologist is covered under the La Familia malpractice insurance policy, which is the Federal Tort Claims Act; this level of malpractice protection at least minimizes the possibility of litigation.**

3. Line 115-138: You present several other models that link technology and collaboration in a clear and concise way. Your second example of telemedicine models in Canada seems most similar and supports your model, well. Are there other models within large health centers or companies (Kaiser, Epic EMR as mentioned above.) that are being used to send tele-health consults to specialists that you can draw upon rather than using Project Echo, which seems most dissimilar? **Please see the response above regarding the additional references added to the**

manuscript to provide another example of the use of telehealth consults. Due to our model specifically not being similar to a large health system such as Kaiser, we hoped to highlight models such as Project ECHO and the additional 2 new references that can apply to any clinic, not necessarily affiliated with a larger health system. Like our model, Project ECHO is designed to give primary care physicians working in smaller practices, especially in rural areas, the tools they need to manager higher complexity patients who would otherwise need to be sent to specialists who are often not available. Also like our model, Project ECHO is based on reviews of specific cases instead of consults with the patient present.

Linking Technology with collaboration

4. Line 166 - You do a good job describing our model and how it interacts with the existing clinic. Can the authors further explain whether patients who are in their 3rd trimester are still reviewed every 3-4 weeks or more closely? Are patients followed more closely than every 3-4 weeks near term? **Patients are standardly reviewed every 3-4 weeks, but when there is an urgent issue, communication exchanges between the consulting obstetrician-gynecologist and primary obstetric provider prompt the chart to be reviewed more frequently. Additionally, occasional high risk issues that need follow-up before the standard 3-4 week window cause the chart to be reviewed sooner. Please see the edits in the manuscript in new line numbers 176-184 to clarify this.**

5. Line 178-180- Its very reassuring to see how widely appreciated and helpful this system seems to be. **Thank you. No revisions indicated.**

Reviewer #3:

Thank you for your submission of this article. I thoroughly enjoyed the read. I find the information you presented to be relevant and timely. I thought your writing was clear and direct. You used simple language and offered clear solutions to a multi-layered problem. I think it's a good start to tackling this problem of patient's inaccessibility to healthcare in the rural setting. **Thank you. No revisions indicated.**

I would encourage you to continue tracking data. As your program appears to be a pilot model, it may be able to provide valuable information for this national problem. **Please see our response above to reviewer #1, point #4. We plan to do this in the future, including patient outcomes.**

Including the survey results of the participating providers is helpful. **Thank you. No revisions indicated.**

As you go further you may want to include more specific data regarding patient outcomes. **Please see the response to point #2 above; we anticipate this in the future.**

You may also consider including more details of your survey. **Thank you for this comment. As per the request of reviewer #1, point#5, we provided the numerator and denominator for our survey's response rate in the revised manuscript new lines 194-195. We also clarified within the manuscript in new line 193 that the survey was performed after 2 years of the model being in place. The remainder of the results of the survey are summarized in the manuscript.**

I did notice that your article lacked any tables or graphs. **We agree that tables and graphs can add to the visual appeal and clarity to some manuscripts, but we did not find that tables or graphs would add to the content and understanding of our model and manuscript in particular. No revisions indicated.**

While I find all the material to be clearly stated in the body of the text, you may give some consideration to creating bullets of your main points. This is a matter of author's preference and would not cause any significant change in the value of your piece; in my opinion. **Thank you for this consideration, but we were unable to find within the body of the manuscript where bullet points would be helpful. No revisions indicated.**

I do have one question, in your piece you stated that the physicians that conduct the chart review are physicians who have worked in the clinics and therefore have some personal familiarity with the system. How important is that factor in the success of your model? **We do recognize that the consultant's prior full-time employment by La Familia contributes to the success of our model, but feel it would not be a requirement for this model to be implemented and successful elsewhere. The familiarity with individual providers at La Familia, the understanding of the Santa Fe immigrant patient population (a large portion of La Familia patients), and other resources in the community were helpful to the consultant's ability to provide pertinent recommendations since the onset of implementing our model, but many of these idiosyncrasies could be learned over time by any consultant. We therefore believe that if this model were to be implemented elsewhere, it would not be necessary that the consulting obstetrician/gynecologist have direct patient care experience at the clinic that is seeking consulting services. Please see the revised text in new lines 209-217 within the manuscript revisions reinforcing this.**

Since you will no longer have ob/gyn physicians in your clinic, how will you address the issue of attrition and replacement of the physicians providing the chart reviews? **La Familia has not had employed obstetricians-gynecologists for the past four years; one of the two obstetrician-gynecologists who was previously employed full-time at La Familia until 4 years ago is the**

obstetrician-gynecologist consultant referenced in this manuscript. Therefore currently these is not a concern for needing to replace the current obstetrician-gynecologist providing chart review. No revisions indicated.

Thank you for your submission.

EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments.

- The Journal style doesn't not use the virgule (/) except in numeric expressions. Please edit here and in all instances. **Please see revised manuscript eliminating (/) except in numeric expressions**

- is this some sort of interquartile range? Certainly, many women live < 9 and > 65 miles. Please clarify. **The particular study referenced examined characteristics of 19 different communities in which the local rural hospital stopped doing deliveries. Among these communities, the distance between the hospital closing its obstetric unit and the closest hospital that continued offering deliveries varied from 9 to 65 miles. Please see revised manuscript new lines 55-56 with clarification.**

- 24/7 is jargon. Could you restate without it? **Please see revised manuscript new line 141 with alternative wording.**

- This is called a primacy claim: yours is the first, biggest, etc…In order to assert that, you need to provide the search terms used and the data base (s) searched (PubMed ,Google Scholar, etc) to substantiate the claim. Otherwise, it needs to be deleted. It wouldn't belong in the abstract

anyway, so make sure you address this in the manuscript body. **Please see the revised manuscript new line 150 deleting the word “unique”.**

- to be clear, its 1 nurse midwife? Perhaps better to say something like "(Family physicians and advance practice nurses)? **One nurse midwife and several nurse practitioners work at La Familia. Thank you for the suggestion of more concise wording; please see the revision in new lines 153-154 within the manuscript.**

- Please consult the Instructions for Authors regarding the use of abbreviations, and what constitutes an acceptable abbreviation. This is not an acceptable abbreviation. Please spell out all abbreviations on first use. It is reasonable to not use abbreviations for words that are seldom used in the paper. We try to limit “unique” abbreviations so that readers don’t have to frequently refer back to the first notation of the abbreviation to remember its meaning. We realize that this may affect word count but believe it makes it easier in most cases for the reader. **We have removed non-standard abbreviations here and elsewhere. Please see revisions within the manuscript.**

- if its one Ob GYN on a regular schedule, what do you mean by "rotating" ? **The one obstetrician-gynecologist reviewer rotates which charts are reviewed each week, based on a regular schedule of reviewing all charts every 3-4 weeks. Please see revisions within the manuscript in new lines 176-178 to hopefully clarify this concept.**

- Perhaps "the entire world" is a bit of hyperbole: Could you edit? **Please see the revised edits within new lines 228-229 in the manuscript.**

2. 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, as well as subsequent author queries. 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 response letter and subsequent email correspondence related to author queries.

b. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

We OPT-IN.

3. 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.

Any author agreement forms previously submitted will be superseded by the eCTA. During the resubmission process, you are welcome to remove these PDFs from EM. However, if you prefer, we can remove them for you after submission. **All coauthors are anticipating an email regarding the eCTA. We have removed the PDFs from EM.**

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. **We do not have any problems with using the reVITALize definitions.**

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 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. **Thank you for this reminder. We have adhered to the length restriction in word count and page numbers if references are excluded as mentioned at the conclusion of this comment.**

6. 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. **Thank you for this reminder. Our abstract has been reviewed and edited appropriately.**

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Current Commentary articles, 250 words. Please provide a word count. **Word count = 106**

7. 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. **We have removed non-standard abbreviations and acronyms, and have not included any in the title or précis.**

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. **Thank you for this reminder; revisions have been made.**

9. 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. **As of date, all ACOG references are current and available.**

10. 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. **We will anticipate an email with these options.**

11. If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.
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. **Thank you for**

these reminders; each author has given approval to the final form of the revision.

From: [redacted]
To: Randi Zung
Cc: [redacted]
Subject: Re: Your Revised Manuscript 19-577R1
Date: Tuesday, May 14, 2019 3:20:08 PM
Attachments: revisions 19-577R1 ms (5-8-19v2).docx

Hi Randi. Please see the attached revised manuscript with our additional track changes, as well as our responses below in ***bold italics***. Again, I apologize for not having seen your original email on May 8 in my junk mail, and appreciate your understanding for the delay. Please let me know if I should be doing anything else other than replying to this email (should I be addressing anything within Editorial Manager?)
Sincerely,
Suzanne Burlone

1. General: The Manuscript Editor and Dr. Chescheir have made edits to the manuscript using track changes. Please review them to make sure they are correct.
We agree with the edits Dr. Chescheir has made, and have made minor additional changes in new track changes to ensure flow with our additional edits as she suggested.

2. Line 58: The quote from reference 4 is the following: "However, two hospitals reported that women in their communities no longer have local access to prenatal care due to the obstetric unit closure. Rural women in these two communities will need to travel 25.4 miles and 40.8 miles to the nearest hospitals where obstetric services are available. Rural women in the 17 communities where obstetric units were closed but prenatal care is available will need to travel an average of 29 miles with a range from 9 to 65 miles to the next available hospital for obstetric care."

I'm not sure your paraphrasing quite catches the meaning. Perhaps you would consider: "One study of 17 communities in which the local labor and delivery services had closed found that on average women in these communities had to drive 28 miles (range 9-65 miles) to reach the nearest hospital offering obstetrics services". As you have written it, it's unclear what you mean by "additional travel distances."
Thank you for the suggestion for more clarified paraphrasing of the referenced study. Please see our new track changes.

3. Line 107: In the model you are describing, the ob-gyn isn't providing a consultation to the patient, but rather to the doctor. I wonder if the word "consult" in this setting is confusing? Perhaps something like "This feature can enable the clinicians providing direct patient care to obtain advice and management recommendations from a remote provider who may never meet the patient". Consult just has such a loaded connotation, with billing implications, etc., if confused. Change not necessary, but in my opinion, this makes it clearer.
Thank you for the suggestion of how to provide further clarity in describing a general model such as ours. Please see our new track changes.

4. Line 159: Do you mean patient consultation or as I noted above, consultation with the provider on site but not in the classic telemedicine sense?
We attempted to clarify this section as per the suggestions in #3; please see our new track changes.

For more information please visit http://www.symanteccloud.com

---

_---SECURITY DISCLAIMER---

This information including any attachments may contain legally privileged and/or highly confidential information. If you are not the intended recipient(s), or the employee responsible for delivery of this message to the intended recipient(s), you are hereby notified that any dissemination, distribution or copying of this communication and or attachments is strictly prohibited under State and Federal Laws. If you have received this communication in error, please immediately notify the sender and follow appropriate actions for disposal.
