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: May 29, 2020
To: "Denisse Holcomb" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-1441

RE: Manuscript Number ONG-20-1441

Patient Perspectives on Audio-Only Virtual Prenatal Visits Amidst COVID-19

Dear Dr. Holcomb:

Your manuscript has been rapidly reviewed by the Editors. We would like to pursue fast-track publication. If you can address the comments below and submit your revision quickly, the Editorial Office will start working on it as soon as possible. I am setting the due date to June 2nd, but we will start working on it whenever you can submit.

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).

REVIEWER COMMENTS:

Reviewer #2: The authors describe their experience with audio-only telehealth visits during the COVID-19, and make recommendations for continuing this option after the pandemic ends. This is a Current Commentary, and not Original Research, so their survey is not described in the detail that one would prefer for that type of study, but I think it is still appropriate.

1. it would be helpful to start with two sentences describing the types of "telehealth": audio-only telephone vs. video "virtual" visits.

2. it would be useful to spend a little more time on reimbursement. Currently, at least in my region, even when audio-only telehealth visits are "covered" they reimburse at a much lower rate than the "virtual" visit that includes video. For example, a one-hour consultation by video reimburses at the same rates as in person (about $200-500, based on payer), whereas a 1-hour audio-only consultation reimburses at $75. the ratios are about the same for shorter visits. this drives providers to push video over audio-only, with minimal incremental benefit, yet significant more resources required for the clinic and the patient. this would seem like an easy fix to reduce overall burden on the healthcare system.

Reviewer #3: The authors report their experience with the implementation of audio based prenatal visits as an adaptation to the COVID pandemic. This is a well written description of their experience.

1. Line 90: you refer to the first date of COVID in Dallas; please add the time frames for these changes and assessments. You do discuss implementation as of March 24th, but the the timeframe from recognition to implementation would be important to understand.

2. On your list of visits, you write that GC/chlamydia testing was performed in person at 36 weeks: when was GBS screening performed? This should be added.

3. You should make clear earlier in your text that these audio- only visits are interspersed with some prenatal care, and comprise less than 25% of prenatal care (as you state, about 4 visits); this is first stated on Line 118 .

4. It should be clear that about 65% of those called agreed to discuss and take the survey and how you believe that might skew your results. You state that your institution performed about 900 virtual visits: it is not clear how many patients that reached, since it is not a long enough timeframe for each patient to undergo 4 visits during an entire pregnancy. If you tried to survey 431 patients, how many is that of your total that initiated audio visits?

5. How did you decide, given your huge obstetric population, which patients could initiate telehealth and was there something different or specific about this population? Were patients given a choice or an opt out option for this process?

ASSOCIATE EDITOR

1. Please reformat as a “Clinical Practice and Quality” paper and formally present the survey result. Be sure to change the article type when you upload your revised manuscript. Review the requirements for this article type in our Instructions for Authors at http://ong.editorialmanager.com before sending your revision and make sure you have the correct headings throughout.

2. Please shorten by a third.

3. Please address reimbursement a bit more.

4. What did you do about non-English speakers, especially non-Spanish speakers (as I make the assumption, perhaps incorrectly, that many of the docs and other staff at Parkland speak Spanish and can carry out a visit without the aid of a translator).

5. Line 181: what is a 1115 waiver?

EDITOR COMMENTS:

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

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

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

3. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Methods section of the body text, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

4. Your study uses ICD-10 data. Please make sure you do the following:
a. State which ICD-10-CM/PCS codes or algorithms were used as Supplemental Digital Content.
b. Use both the diagnosis and procedure codes.
c. Verify the selected codes apply for all years of the study.
d. Conduct sensitivity analyses using definitions based on alternative codes.
e. For studies incorporating both ICD-9 and ICD-10-CM/PCS codes, the Discussion section should acknowledge there may be disruptions in observed rates related to the coding transition and that coding errors could contribute to limitations of the study. The limitations section should include the implications of using data not created or collected to answer a specific research question, including possible unmeasured confounding, misclassification bias, missing data, and changing participant eligibility over time.
f. The journal does not require that the title include the name of the database, geographic region or dates, or use of database linkage, but this data should be included in the abstract.
g. Include RECORD items 6.3 and 7.1, which relate to transparency about which codes, validation method, and linkage were used to identify participants and variables collected.

5. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric data

definitions at https://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.

6. 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 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

7. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

8. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

9. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

10. 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.

11. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

12. 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.

13. When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

Figures 1-2: Please upload as a figure file on Editorial Manager (Word doc is okay).

Figure 3: Please update squares to solid colors as we find that gradient don't look great in print. Please upload as a figure

file on Editorial Manager.

14. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

15. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

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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 in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

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

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

Again, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by Jun 02, 2020, we will assume you wish to withdraw the manuscript from further consideration..

Sincerely,

The Editors of Obstetrics & Gynecology

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

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Response to Reviewers:

Reviewer #2: The authors describe their experience with audio-only telehealth visits during the COVID-19, and make recommendations for continuing this option after the pandemic ends. This is a Current Commentary, and not Original Research, so their survey is not described in the detail that one would prefer for that type of study, but I think it is still appropriate.

1. it would be helpful to start with two sentences describing the types of "telehealth": audio-only telephone vs. video "virtual" visits.

We have added language related to the different telehealth modalities in lines 81-83.

2. it would be useful to spend a little more time on reimbursement. Currently, at least in my region, even when audio-only telehealth visits are "covered" they reimburse at a much lower rate than the "virtual" visit that includes video. For example, a one-hour consultation by video reimburses at the same rates as in person (about $200-500, based on payer), whereas a 1-hour audio-only consultation reimburses at $75. the ratios are about the same for shorter visits. this drives providers to push video over audio-only, with minimal incremental benefit, yet significant more resources required for the clinic and the patient. this would seem like an easy fix to reduce overall burden on the healthcare system.

We have elaborated on billing and coding for audio-only virtual visits in the introduction. In the discussion section, we added language consistent with the reviewer's sentiment that video-enabled virtual visits provide only minimal incremental benefit compared to audio-only with significantly more cost and patient burden. Thank you.

Reviewer #3: The authors report their experience with the implementation of audio based prenatal visits as an adaptation to the COVID pandemic. This is a well written description of their experience.

1. Line 90: you refer to the first date of COVID in Dallas; please add the time frames for these changes and assessments. You do discuss implementation as of March 24th, but the timeframe from recognition to implementation would be important to understand.

We have included information regarding first Dallas County COVID-19 case as well as timeframe for community changes in lines 126-128.

2. On your list of visits, you write that GC/chlamydia testing was performed in person at 36 weeks: when was GBS screening performed? This should be added.

At Parkland Hospital, we perform a risk-based approach to GBS intrapartum prophylaxis in lieu

of universal GBS screening. We politely decline to incorporate this into the text in the name of brevity and focusing on the message.

3. You should make clear earlier in your text that these audio- only visits are interspersed with some prenatal care, and comprise less than 25% of prenatal care (as you state, about 4 visits); this is first stated on Line 118 .

As this paper has been converted to a "Clinical Practice and Quality" paper, per the Associate Editor's request, we have incorporated language related to this within both the abstract in lines 32-34 and in the methods in lines 142-145.

4. It should be clear that about 65% of those called agreed to discuss and take the survey and how you believe that might skew your results. You state that your institution performed about 900 virtual visits: it is not clear how many patients that reached, since it is not a long enough timeframe for each patient to undergo 4 visits during an entire pregnancy. If you tried to survey 431 patients, how many is that of your total that initiated audio visits?

We have incorporated our survey response rate of 65% more clearly into the text. We unfortunately do not have data available on the number of unduplicated patients that were represented in those virtual visits. During the period of manuscript revision, we were able to update visit volumes for May, which is shown in figure 1. We were also able to obtain visit-level dwell times (instead of monthly averages), and have included this as an additional figure, given the demonstrable improvement. We feel this is an important addition to the story, as we have proven patient satisfaction and an operational benefit as well.

5. How did you decide, given your huge obstetric population, which patients could initiate telehealth and was there something different or specific about this population?
Were patients given a choice or an opt out option for this process?

All low-risk patients were offered interspersed telehealth visits throughout their prenatal schedule, as shown in Table 2. Patients that were followed in the Maternal Fetal Medicine clinic for a variety of different comorbidities were also offered interspersed telehealth visits, though their frequency was more individualized, based on comorbidity, and each decision reviewed by faculty physicians. This is better described in lines 146-147 of the methods. Patients were given the option to opt out of this process. They all verbally consented to participating in virtual visits, and this was documented in the virtual visit clinic note.

ASSOCIATE EDITOR

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the correct headings throughout.

As per your recommendation, we have reformatted this manuscript as a "Clinical Practice and Quality" paper.

2. Please shorten by a third.

We have shortened the manuscript to 1839 words. Given the request to reformat this manuscript to a "Clinical Practice and Quality" paper in addition to the requests for additional information, we were challenged by both reducing the word count and adding sections to fulfill the formatting requirements of this new manuscript type.

3. Please address reimbursement a bit more.

We have further addressed reimbursement within the introduction.

4. What did you do about non-English speakers, especially non-Spanish speakers (as I make the assumption, perhaps incorrectly, that many of the docs and other staff at Parkland speak Spanish and can carry out a visit without the aid of a translator).

Any patient that required translation services would receive a certified translator during the virtual visit. The advanced practice nurse or physician performing the virtual visit would perform a conference call with both the patient and translator. This was documented in the virtual visit encounter note if utilized. We have incorporated this into the Methods section, in lines 139-141.

5. Line 181: what is a 1115 waiver?

Through the 1115 waiver, under the Social Security Act, the Secretary of Health and Human Services is given the authority to approve certain projects and may waive provisions of Medicaid law to help improve state programs as needed.

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All co-authors confirm that any disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Methods section of the body text, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

We have added language to the methods section regarding IRB exemption from approval.

4. Your study uses ICD-10 data. Please make sure you do the following:

a. State which ICD-10-CM/PCS codes or algorithms were used as Supplemental Digital Content.

b. Use both the diagnosis and procedure codes.

c. Verify the selected codes apply for all years of the study.

d. Conduct sensitivity analyses using definitions based on alternative codes.

e. For studies incorporating both ICD-9 and ICD-10-CM/PCS codes, the Discussion section should acknowledge there may be disruptions in observed rates related to the coding transition and that coding errors could contribute to limitations of the study. The limitations section should include the implications of using data not created or collected to answer a specific research question, including possible unmeasured confounding, misclassification bias, missing data, and changing participant eligibility over time.

f. The journal does not require that the title include the name of the database, geographic region or dates, or use of database linkage, but this data should be included in the abstract.

g. Include RECORD items 6.3 and 7.1, which relate to transparency about which codes, validation method, and linkage were used to identify participants and variables collected.

No ICD-10 codes were used to identify patients for the patient survey or data on appointment types or dwell times. Instead, operational reports were run within the electronic medical record were utilized for clinic dwell times and appointment information; this was validated in the electronic medical record (Epic) through review of clinic schedules appointment information.

5. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric data definitions at https://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.

Thank you. We have reviewed the reVITALize initiative definitions.

6. 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 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

Thank you. We have complied with all length restrictions.

7. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:
*** All financial support of the study must be acknowledged.**
*** Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.**
*** All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.**
*** If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).**

We have complied with all rules governing acknowledgements.

8. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

Our short title is provided.

9. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

Precis is provided on the second page.

10. 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.

Abstract has been reviewed and under the word limit.

11. ACOG is moving toward discontinuing the use of "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.

We have replaced the term “provider” with more specific terms.

12. 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.

The checklist has been reviewed and all tables conform to the checklist requirements.

13. When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.
When you submit your revision, art saved in a digital format should accompany it. Please

upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).
If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.
Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.
Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

Figures 1-2: Please upload as a figure file on Editorial Manager (Word doc is okay).

Figure 3: Please update squares to solid colors as we find that gradient don't look great in print. Please upload as a figure file on Editorial Manager.

Thank you. All figures have been revised and uploaded as specified. We have also added an extra figure given our ability to obtain more specific dwell time data (figure 2).

14. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

Thank you. We have no supplemental digital content to include.

15. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.
Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

Thank you. We will look out for this future email.