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: Nov 05, 2020
To: "Christina Pardo" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-2720

RE: Manuscript Number ONG-20-2720

Reducing Perinatal Health Disparities by Placing Equity at the Heart of Performance Improvement

Dear Dr. Pardo:

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 14 days from the date of this letter. If we have not heard from you by Nov 19, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: October 20, 2020

I have the following additional comments about the manuscript:

ABSTRACT:
No additional comments

COMMENTARY:
Page 5, lines 75-77 "we are not suggesting that members of PI committees are the only faculty in a department that have a role to play in assuring equity; everyone must share that commitment." Could you comment on the equity-based education for physicians and other members of the health care teams? When should this ideally happen? How do we assure that all members of the healthcare team have received appropriate education and training in important equity components (e.g. training in implicit and explicit bias) including the members of the PI committees in the hospitals?

Page 5, line 85 "we suggest that PI committees audit equity-related standards" Should members of PI committees be responsible for equity related research? Or should providers with interest and experience in equity-based research become members of those committees?

Page 6, line 95, How do you assure that all members of the healthcare team are aware of the links and resources and how to best utilize them. What is the role of social services referrals? ACOG (Committee Opinion #729) suggested that in order to improve equity referrals to social services in the hospitals should be maximized. Increasing referrals to social services in the hospitals might require hiring more providers experienced and trained in providing those services.

Page 7, line 130 "we focus on the role of PI committees in including SDOH in their audits of patient care", please provide some background info and definitions of SDOH. Could you provide guidance on how to optimize discussions about SDOH in healthcare settings, e.g. the role of motivational interviewing and health coaching? Both patients and providers might feel uncomfortable, at least initially, to openly discuss some aspects of SDOH (e.g. financial stability, home insecurity, immigration status etc.)

Page 11, line 216 "a peer review committee should be equally concerned about a woman whose has an untoward outcome after frequent missed visits", Could telehealth services decrease inequity in some situations (e.g. missed visits, diabetes education and follow up etc.). Are there any recent articles to support the use of telehealth services in improving health equity?

Page12, line 248 When should the screening for SDOH ideally happen? Are there any validated tools available? In depth analysis of all SDOH components might require time. Busy OB/GYNs might not have enough time during regular visits for in depth assessment. Again, referrals to social workers/social services in the hospitals might be imperative. In certain underserved areas these referrals might need to happen on the routine basis. What are the roles of the hospitals and hospital systems in assessing local community healthcare needs?

Page 13, lines 255-271 What is the role of QI projects in addressing equity? Many aspects of SDOH might not be readily available in electronic medical records which might provide barriers for research and quality reviews by PI committees

REFERENCES:
Check if all references comply with journal guidelines (https://edmgr.ovid.com/ong/accounts/ifa_suppl_refstyle.pdf)
The list of references might need to be more comprehensive

SUPPLEMENTARY MATERIAL:
None

Reviewer #2: The authors present a compelling argument that PI committees should take equity into account when trying to improve quality, however, in its current form this commentary does not provide evidence that PI committees largely do not do this already. For instance, the OB quality committee at my institution does attempt to deal with issues related to missed visits, parking costs as they are recognized as affecting quality care but it is sometimes difficult to effect change it requires the cooperation of hospital administrators, a bevvy of businesses (such as owners/operators of parking garages and taxi cab companies) and even local government officials and donors to make an impact; while it is possible (and probably likely) that many PI committees do not operate in this manner, without providing evidence of this, it is difficult to say that the changes proposed in this manuscript are not already taking place. Indeed, some of the specific examples cited in this manuscript do show that equity is being considered when reviewing quality. Specific comments follow below.

line 54: please correct "Performance" to "performance improvement"; also please clarify that PI committees may have different names in institutions, for instance we have a Quality Improvement Committee (QI), this might be a minor point but would serve to clarify the role of PI as it is not necessarily obvious

line 53-59: the paragraph above denotes safety and equity as 2 separate goals, in this paragraph you discuss quality and equity, but not safety. I believe (though I could be mistaken) that what you are trying to say is the neither safety nor equity should be considered in separate silos, and without taking into account how both metrics affect each other, the full mandate of the performance improvement committees cannot be fulfilled.
please correct this discrepancy.

line 58-59: "As a corollary, if all groups are recipients of equally substandard care there is no quality" this a superfluous statement

line 61-77: I would rephrase this as that "That is not to say that contemporary PI efforts do not, at times, consider equity and safety together when conducting quality improvement initiatives". As this paragraph is currently written, it is a counterargument to your central thesis. I also recommend providing examples of how QI initiatives that don't consider safety and equity as branches of the same quality tree tend either to have marginal improvements in quality or none at all, without demonstrating that many (or even some) QI initiatives don't consider equity when trying to improve safety, the argument presented in this manuscript is not supported.

line 79-80: the examples provided in the preceding paragraph might demonstrate that it might not be as a big of a paradigm shift as imagined, (which would make the transition to broadly applying equity to QI that much more feasible and appealing)

line 86: recommend changing "portfolio" to "mandate"

line 86: "...we are not asking committees..." recommend to changing to "it would be unreasonable to expect..."

line 93: "...we would not ask..." change to "one would not expect..."

line 97-99: what evidence do you have of this ? again, the examples you cite in paragraph lines 61-77 suggest that PI committees at least have some grasp of equity's impact on quality. I am in agreement with the sentiment of this piece, but supporting evidence would strengthen this review. Is there any research on the objectives/mission of PI committees at different institutions? or even just a review of their mission statements on hospital websites ?

line 114-116: "Faulty systems may increase the likelihood of accidents; to use Reason's Swiss cheese model of accident causation, they may create more porous barrier to errors" this sentence is difficult to read in current structure, please rephrase

line 119-121: on what basis are you stating how committees typically define environmental factors? a survey of committee members? peer reviewed literature? anecdotal experience? if the latter, this is limited and should not be applied as a broad statement regarding all PI committees

line 125-126: an argument that "personally mediated racism" and "structural racism" are forms and/or the result of cognitive bias, which is very much under the jurisdiction of PI committees; this would reinforce your argument that PI committees are one of the better places to institute equity based initiatives

line 104-130: this paragraph should be split into 2, it is difficult to read as is

line 140: "There are a burgeoning number of tools for doing so", recommend either elaborating on these tools somewhat as many people may not be familiar or eliminating this part

line 192: eliminate "due", will make sentence flow easier

line 205-206: recommend rephrasing as "As important as these expanded definitions of processes and outcomes have been shown to be, they may not always find their ways onto the agendas of PI committees"

line 207-208 change "This failure reflects..." to "This reflects..."

line 215: "peer review committee", assume you mean "PI committee"?

line 219: "To incorporate equity into PI, members of committees". change to "...members of committees must understand how inequity can impact care quality...."

line 226-231: this is a very difficult ask of a PI committee, particularly for things like food deserts, financial ability to pay for things, childcare issues. even if you identify these as reason for bad outcomes, a PI committee has almost no power to facilitate change; even if something like paying for parking or transportation issues are identified as possible causes for adverse outcomes, a PI committee can do nothing more than suggest that parking is free or develop a transportation system, this is incumbent on the hospital/donors to facilitate and requires a much bigger restructuring and refocusing than the agenda of a PI committee. As such, this paragraph is out of the scope of your manuscript. and I recommend re-framing the paragraphs 233-275

Reviewer #3: I appreciate the focus of the article and the authors drawing attention to the role that equity plays and that without equity there is no quality and without quality there is no equity (lines 54-59).

They are correct in the assertion that the Performance Improvement Committees are the watch dogs in OB/GYN departments (line 54).

The authors recognize that tasking these committees to integrate equity standards into this process and audit these standards will require increased efforts and resources (line 78-81).

They do say that it would be the role of the PI committee to recognize the needs but not necessarily make the referral however if community resources links are available they need to make sure they are being utilized (91-95).

This all sounds wonderful in theory, however after reading the manuscript I was left with more questions than answers. For example, How does one go about disaggregating their hospital population in a fair and meaningful way (157-160).

I understand the importance of this and the role it could make in identifying areas of need, but I would suspect that most physicians have little expertise in doing this. The authors state that training committee members will need to occur and this might be undertaken by experts (line 221) but who this would be is unclear.

I think this paper would be helped by focusing and giving the reader examples of how they are navigating this in their own institution. Not necessarily an instruction manual, but an overview of how this looks at their institution, otherwise it appears daunting. I think most PI and QI committees as they stand would be unable to accomplish these goals.

EDITOR COMMENTS:

1. Thank you for this excellent manuscript. Please in your revision 1) Shorten it somewhat, and 2) Consider creating a

table for information that would lend itself to tabular presentation.

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. 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.

3. 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.

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

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

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: 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.

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

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

8. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limit for Current Commentary articles is 250 words. Please provide a word count.

9. 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.

10. 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.

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 examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, the American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the 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 at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

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

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. Do not omit your responses to the Editorial Office or Editors' comments.

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

Again, your paper will be maintained in active status for 14 days from the date of this letter. If we have not heard from you by Nov 19, 2020, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Dwight J. Rouse, MD, MSPH

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

Dear Editor,

We appreciate the editor's and reviewers' comments and willingness to consider a revised version of our manuscript entitled, "Reducing Perinatal Health Disparities by Placing Equity at the Heart of Performance Improvement."

The reviewers' and editor's concerns and suggestions, which the authors found quite helpful, are addressed below. All changes to the original manuscript have been highlighted with the track changes feature in the attached Word document. Because of our edits, the line numbers in the edited manuscript are inconsistent with the line numbers in the original manuscript. In our responses to the comments below, we use the updated line numbers.

We were very mindful of the editor's reasonable request to shorten the manuscript, and we did trim quite a bit (the manuscript is now less than the allotted 3,000 words). However, our efforts were undermined to some extent by the reviewers' not infrequent requests to add additional language. We hope that complying with their requests did not prevent us from achieving the editor's goal. If there is a need for further shortening, however, we would be happy to do so.

Thank you again for reviewing this manuscript.

Sincerely,

Christina Pardo, MD MPH
Fouad Atallah, MD
Shifra Mincer, MD
Howard Minkoff, MD

REVIEWER COMMENTS:

Reviewer #1: October 20, 2020

I have the following additional comments about the manuscript:

ABSTRACT:
No additional comments

COMMENTARY:
Page 4, lines 83-85 "we are not suggesting that members of PI committees are the only faculty in a department that have a role to play in assuring equity; everyone must share that commitment." Could you comment on the equity-based education for physicians and other members of the health care teams? When should this ideally happen? How do we assure that all members of the healthcare team have received appropriate education and training in important equity components (e.g. training in implicit and explicit bias) including the members of the PI committees in the hospitals?

Authors' response: Thank you for your comment. We added on page 4, line 83 to 85 the following: "We therefore also suggest that equity be integrated into departmental continuing education, such as mandatory trainings and grand rounds."

Page 5, line 85 "we suggest that PI committees audit equity-related standards" Should members of PI committees be responsible for equity related research? Or should providers with interest and experience in equity-based research become members of those committees?

Authors' response: Thank you for your comment. We clarified this point by stating on Page 4 lines 78 to 80: "While members of PI committees may not be experts in the field, we recommend they work in consultation with those who have expertise in equity-based research.

Page 6, line 95, How do you assure that all members of the healthcare team are aware of the links and resources and how to best utilize them. What is the role of social services referrals? ACOG (Committee Opinion #729) suggested that in order to improve equity referrals to social services in the hospitals should be maximized. Increasing referrals to social services in the hospitals might require hiring more providers experienced and trained in providing those services.

Authors' response: In most underreserourced institutions social workers are in fact overburdened and understaffed. In this article we focus on efficient linkage to community-based resources that can achieve a dual effect of supporting a patient's needs while also reducing burden on hospital social services. In addition, there are several guides that exist, like the AAFP The EveryONE Project, which provide detailed instructions for social needs screening. We have now included a table that details some of these SDOH screening tools. We refer readers to this table on line 160, where we also provide several examples of new software platforms that are focusing on referrals to community-based organizations.

We have also edited the sentence on page 8 lines 158-160 for clarification and added several references: "There are a burgeoning number of social needs screening tools that can be implemented by anyone in the healthcare team (see Table 1) and software platforms that can facilitate efficient referrals."

Page 7, line 130 "we focus on the role of PI committees in including SDOH in their audits of patient care", please provide some background info and definitions of SDOH. Could you provide guidance on how to optimize discussions about SDOH in healthcare settings, e.g. the role of motivational interviewing and health coaching? Both patients and providers might feel uncomfortable, at least initially, to openly discuss some aspects of SDOH (e.g. financial stability, home insecurity, immigration status etc.)

Authors' response: Thank you for this suggestion. While a longer discussion of the various SDOH - and how a provider can best address them - is beyond the scope of this article, we have added on page 6-7 lines 134-137 a definition of SDOH with additional background references.

In response to the second part of your comment, we have added a table with information about social needs screenings. This is detailed in response to the previous

comment.

Page 11, line 216 "a peer review committee should be equally concerned about a woman whose has an untoward outcome after frequent missed visits", Could telehealth services decrease inequity in some situations (e.g. missed visits, diabetes education and follow up etc.). Are there any recent articles to support the use of telehealth services in improving health equity?

Authors' response: Thank you for this comment. We agree that telehealth might be a solution to the example we gave, but in this case we are using the example of missed visits to illustrate the need to trigger review of cases through a health equity lens. While telehealth services may at times be a solution, there are contexts in which there exist significant barriers to telehealth services. Therefore, an understanding of local context is imperative.

Page12, line 248 When should the screening for SDOH ideally happen? Are there any validated tools available? In depth analysis of all SDOH components might require time. Busy OB/GYNs might not have enough time during regular visits for in depth assessment. Again, referrals to social workers/social services in the hospitals might be imperative. In certain underserved areas these referrals might need to happen on the routine basis. What are the roles of the hospitals and hospital systems in assessing local community healthcare needs?

Authors' response: Thank you for your comment. We added the following sentences on Page 7-8, lines 154 to 158: "Screening with validated tools should be used at standardized intervals throughout pregnancy, postpartum and interconceptional care. We recognize that physicians are overburdened, and, as such, institutions should consider innovative models to incorporate the SDOH."

Page 13, lines 255-271 What is the role of QI projects in addressing equity? Many aspects of SDOH might not be readily available in electronic medical records which might provide barriers for research and quality reviews by PI committees

Authors' response: Thank you for your comment. We agree and that is part of our purpose in submitting this opinion. We hope that institutions begin to screen for SDOH and subsequently incorporate these and other elements of health equity into the medical record, such that they are readily available for practitioners. On page 8 line 164, we incorporated mention of the electronic medical record and added a reference.

REFERENCES:

Check if all references comply with journal guidelines (https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Fifa_suppl_refstyle.pdf&data=04%7C01%7Cchristina.pardo%40downstate.edu%7C83e5571d86e346a7d07308d881cad216%7C22670793760f482993153e427c362e69%7C0%7C1%7C637402055401479376%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=6BtXiUNvBg4qDOohznJNTYZhZwwPFgwm443yjjzY1Bo%3D&reserved=0)

The list of references might need to be more comprehensive

Authors' response: Thank you for this comment. We added additional references to support our commentary.

SUPPLEMENTARY MATERIAL:
None

Reviewer #2: The authors present a compelling argument that PI committees should take equity into account when trying to improve quality, however, in its current form this commentary does not provide evidence that PI committees largely do not do this already. For instance, the OB quality committee at my institution does attempt to deal with issues related to missed visits, parking costs as they are recognized as affecting quality care but it is sometimes difficult to effect change it requires the cooperation of hospital administrators, a bevvy of businesses (such as owners/operators of parking garages and taxi cab companies) and even local government officials and donors to make an impact; while it is possible (and probably likely) that many PI committees do not operate in this manner, without providing evidence of this, it is difficult to say that the changes proposed in this manuscript are not already taking place. Indeed, some of the specific examples cited in this manuscript do show that equity is being considered when reviewing quality. Specific comments follow below.

> *Authors' response: Thank you for your comment. We appreciate your perspective. The work of your OB quality committee is notable, but we believe many PI committees are not adequately addressing issues of health inequity. In addition, we are familiar with the work of PI committees within our area and network, and we believe this aspect of PI committees is often either nonexistent, underutilized, or misapplied. Hence, this commentary.*

line 54: please correct "Performance" to "performance improvement"; also please clarify that PI committees may have different names in institutions, for instance we have a Quality Improvement Committee (QI), this might be a minor point but would serve to clarify the role of PI as it is not necessarily obvious

> *Authors' response: Thank you for this comment. "improvement" was added to this sentence, on page 3 line 53. We also added the following sentence on lines 59-61: "We recognize that these committees have different names in different institutions, e.g., peer review, Quality Assurance, and Quality Improvement, but we use PI committee."*

line 53-59: the paragraph above denotes safety and equity as 2 separate goals, in this paragraph you discuss quality and equity, but not safety. I believe (though I could be mistaken) that what you are trying to say is the neither safety nor equity should be considered in separate silos, and without taking into account how both metrics affect each other, the full mandate of the performance improvement committees cannot be fulfilled.
please correct this discrepancy.

> *Authors' response: Thank you for this comment. Current understanding from patient safety experts includes safety under the quality umbrella and not as a separate concept. Hence, we used 'quality' because it is a broader term and is consistent with current use in the safety literature.*

line 58-59: "As a corollary, if all groups are recipients of equally substandard care there is no quality" this a superfluous statement

Authors' response: Thank you for this comment. Although we understand that this sentence can be viewed as superfluous, but we think it highlights our central thesis. Furthermore, another reviewer specifically appreciated this phrase. We have however edited page 3 lines 56-59 as follows: "No organization or department can be credited with attaining high quality if any particular group is left behind, and if all groups are recipients of equally substandard care there is no quality."

line 61-77: I would rephrase this as that "That is not to say that contemporary PI efforts do not, at times, consider equity and safety together when conducting quality improvement initiatives". As this paragraph is currently written, it is a counterargument to your central thesis. I also recommend providing examples of how QI initiatives that don't consider safety and equity as branches of the same quality tree tend either to have marginal improvements in quality or none at all, without demonstrating that many (or even some) QI initiatives don't consider equity when trying to improve safety, the argument presented in this manuscript is not supported.

Authors' response: Thank you for your comment. On page 3 lines 63 to 64 we have edited the sentence to incorporate some of your suggestions. To answer your second point, the second half of this paragraph explains our reasoning. While contemporary PI efforts can reduce disparities, we argue that these initiatives are not sufficient at addressing the SDOH. We believe that without a formalized approach that systematically disaggregates outcomes, it is easy to overlook health disparities.

line 79-80: the examples provided in the preceding paragraph might demonstrate that it might not be as a big of a paradigm shift as imagined, (which would make the transition to broadly applying equity to QI that much more feasible and appealing)

Authors' response: Thank you for this comment. On lines 87, we changed the words "paradigm shift" to "significant change."

line 86: recommend changing "portfolio" to "mandate"

Authors' response: Thank you for this comment. Lines 93-95 has been re-phrased.

line 86: "...we are not asking committees..." recommend to changing to "it would be unreasonable to expect..."

Authors' response: Thank you for this comment. We changed the wording as suggested on line 85.

line 93: "...we would not ask..." change to "one would not expect..."

Authors' response: Thank you for this comment. On line 94 we changed the wording as suggested.

line 97-99: what evidence do you have of this ? again, the examples you cite in paragraph lines 61-77 suggest that PI committees at least have some grasp of equity's impact on quality. I am in agreement with the sentiment of this piece, but supporting evidence would strengthen this review. Is there any research on the objectives/mission of PI committees at different institutions? or even just a review of their mission statements on hospital websites ?

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line 119-121: on what basis are you stating how committees typically define environmental factors? a survey of committee members? peer reviewed literature? anecdotal experience? if the latter, this is limited and should not be applied as a broad statement regarding all PI committees

Authors' response: Thank you for this comment. In deference to the editor's request to shorten the manuscript, this line has been eliminated.

line 125-126: an argument that "personally mediated racism" and "structural racism" are forms and/or the result of cognitive bias, which is very much under the jurisdiction of PI committees; this would reinforce your argument that PI committees are one of the better places to institute equity based initiatives

Authors' response: Thank you, we agree. In our conclusion, on page 15, lines 336-338, we write: "Although not the focus of this article, the inclusion of patient reported experience within PI is an important step toward mitigating personally mediated racism within hospitals." We have added two references supporting this claim.

line 104-130: this paragraph should be split into 2, it is difficult to read as is

Authors' response: Thank you for this comment. We have split the paragraph and cut some of the words to make the writing clearer and more concise.

line 140: "There are a burgeoning number of tools for doing so", recommend either elaborating on these tools somewhat as many people may not be familiar or eliminating this part

Authors' response: Thank you for this comment. We have elaborated on this point by changing the sentence. On lines 158-160, the text now reads: "There are a burgeoning number of social needs screening tools that can be implemented by anyone in the health care team and software platforms that can facilitate efficient referrals." We have also added a table with additional information (see Table 1).

line 192: eliminate "due", will make sentence flow easier

Authors' response: Thank you for this comment. In deference to the editor's request to shorten the manuscript, this line has been eliminated.

line 205-206: recommend rephrasing as "As important as these expanded definitions of processes and outcomes have been shown to be, they may not always find their ways onto the agendas of PI committees"

Authors' response: Thank you for this comment. In deference to the editor's request to shorten the manuscript, this line has been eliminated.

line 207-208 change "This failure reflects..." to "This reflects..."

Authors' response: Thank you for this comment. In deference to the editor's request to

shorten the manuscript, this line has been eliminated.

line 215: "peer review committee", assume you mean "PI committee"?

Authors' response: Yes, thank you for noticing this. We have substituted the language.

line 219: "To incorporate equity into PI, members of committees". change to "...members of committees must understand how inequity can impact care quality...."

Authors' response: Thank you for this revision. We have made this change.

line 226-231: this is a very difficult ask of a PI committee, particularly for things like food deserts, financial ability to pay for things, childcare issues. even if you identify these as reason for bad outcomes, a PI committee has almost no power to facilitate change; even if something like paying for parking or transportation issues are identified as possible causes for adverse outcomes, a PI committee can do nothing more than suggest that parking is free or develop a transportation system, this is incumbent on the hospital/donors to facilitate and requires a much bigger restructuring and refocusing than the agenda of a PI committee. As such, this paragraph is out of the scope of your manuscript. and I recommend re-framing the paragraphs 233-275

Authors' response: Thank you for your comment. We agree that there are many aspects that are out of the control of PI committees and even institutions. However, we believe and there has been evidence of actions and innovative models that can address components of the social determinants of health. Further, we also realize that different locales have different components of the healthcare ecosystem. There has to be a component of outreach and "thinking outside of the box." We have edited and re-framed lines 226-275. We have also added some references to support our argument that institutions can and should address the SDOH.

Reviewer #3: I appreciate the focus of the article and the authors drawing attention to the role that equity plays and that without equity there is no quality and without quality there is no equity (lines 54-59).

Authors' response: Thank you for this comment.

They are correct in the assertion that the Performance Improvement Committees are the watch dogs in OB/GYN departments (line 54).

Authors' response: Thank you for this comment.

The authors recognize that tasking these committees to integrate equity standards into this process and audit these standards will require increased efforts and resources (line 78-81).

Authors' response: Thank you for this comment.

They do say that it would be the role of the PI committee to recognize the needs but not necessarily make the referral however if community resources links are available they need to make sure they are being utilized (91-95).

Authors' response: Thank you for this comment.

This all sounds wonderful in theory, however after reading the manuscript I was left with more questions than answers. For example, How does one go about disaggregating their hospital population in a fair and meaningful way (157-160).

Authors' response: Thank you for your comment. On lines 182-184, we added the following sentence: "There exist multiple tools and guides detailing how departments and institutions can meaningfully collect and analyze disaggregated data." We have also added multiple references at this point.

I understand the importance of this and the role it could make in identifying areas of need, but I would suspect that most physicians have little expertise in doing this. The authors state that training committee members will need to occur and this might be undertaken by experts (line 221) but who this would be is unclear.

Authors' response: Thank you for this comment. We believe we have addressed this in our response to the previous comment.

I think this paper would be helped by focusing and giving the reader examples of how they are navigating this in their own institution. Not necessarily an instruction manual, but an overview of how this looks at their institution, otherwise it appears daunting. I think most PI and QI committees as they stand would be unable to accomplish these goals.

Authors' response: Thank you for this suggestion. We have included additional references and tools to provide more concrete steps for readers. In terms of our own work, we recognize that we are at the same starting point as other institutions. We see a need and are instituting some of the initial steps we outlined in our text. We have done our best to provide a road map as we embark on our own journey to health equity at our institutions. We hope that by adding in some more concrete tools and references, we have made this process less daunting.

EDITOR COMMENTS:

1. Thank you for this excellent manuscript.
Please in your revision:
1) Shorten it somewhat, and
2) Consider creating a table for information that would lend itself to tabular presentation.

Authors' response: Thank you for these suggestions. We have shortened the manuscript and included two tables, one on SDOH screening tools and the second outlining our recommendations. They are included in the revised manuscript after the references.

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. 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:

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Author response: We choose option A. Please publish my point-by-point response letter.

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

Author response: Thank you. We have capitalized "Black" and "White" throughout the manuscript when referring to race.

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://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-obstetrics-data-definitions&data=04%7C01%7Cchristina.pardo%40downstate.edu%7C83e5571d86e346a7d07308d881cad216%7C22670793760f482993153e427c362e69%7C0%7C1%7C637402055401479376%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=%2F2uN5zG7j21BjrFgaRJsYWrPsrnr8XvXTyIJuzVzqYM%3D&reserved=0 and the gynecology data definitions at https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-gynecology-data-definitions&data=04%7C01%7Cchristina.pardo%40downstate.edu%7C83e5571d86e346a7d07308d881cad216%7C22670793760f482993153e427c362e69%7C0%7C1%7C637402055401479376%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJ

BTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=SbJ5OEnsgoa4%2FFeCNgTaagwdipXXrh8YAWBHZO9VZkU%3D&reserved=0. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

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