OBSTETRICS & GYNECOLOGY

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Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: Oct 25, 2019
To: "Elizabeth A. Howell" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1856

RE: Manuscript Number ONG-19-1856

Within-Hospital Disparities in Severe Maternal Morbidity Exist, But Not Because of Medicaid

Dear Dr. Howell:

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 Nov 15, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present a manuscript on the relationship between maternal morbidity and race in NYC hospitals. Overall I found this to be a well written paper which examines a critically important factor same hospital admissions/outcomes as seen by race.

1) Please rework the title as it is awkward

2) Fundamentally however, is the disparity with regards to race in the same hospital confounded by where the patients got their prenatal care? This is far more important to the outcome than simply where the patient delivered. Did all of these patients receive their prenatal care in the same clinic?

3) Lines 87-88 This is substantial weakness of your work- ICD9 discharge diagnosis codes are notoriously unreliable for the true diagnosis. How do you account for this? This should be further discussed in the discussion section.

4) The statistical analysis seems reasonably sound; however it is a bit verbose and not many of the readers will understand it.

5) The results section is written well in a clear and cogent manner.

6) Overall- why do the authors think the disparity in outcome exists even accounting for insurance type and other socioeconomic factors? I don;t think that you have addressed this in the detail that you should. Since that is main question that a reader would take from this I think you should do a better job of this.

7) Lines 200-201; I think this line should be removed. I don't think there is broad evidence to support this and the citation is from a fairly weak journal.

Reviewer #2: This is an excellent study of an important and under-represented topic of health care disparities in maternal morbidity. I recommend it for publication after a few changes/additions are considered.

1. The finding that severe maternal morbidity was higher in black and Latina women, yet not increased in poor women, is compelling. Poor women are represented as a group by being insured by Medicaid. The finding that Black women delivering in the same hospital, regardless of their socioeconomic status, had a higher risk for severe maternal morbidity is

compelling and an important point to emphasize, postulate why, and suggest next steps to evaluate or change and improve their outcomes. An expansion of the authors' thoughts and ideas around next steps for further evaluation or potential interventions to change this would add to the value of this manuscript. The lack of association of poor outcome and poverty, and especially the presence of the association of race and poor obstetric outcome, is compelling and new information. It would be nice to have the authors note this and emphasize the importance of this genetics over environment issue.

2.At the end of the piece the authors state, "Differences in quality of care, whether within the same hospital or between hospitals, are potentially modifiable and targets that we can address now." This is an important statement and would be improved if the authors could give their thoughts on examples/ideas about what actions might be done. The lack of the authors' suggestions makes it harder for the reader to visualize what the potential solutions or actions here could have been or might be next time to improve things. I suspect the authors have ideas that they would like to test themselves, or wish they could consider, and these ideas might inspire our readers to action on their own local complex cases.

Reviewer #3: This a cross-sectional cohort study using a birth registry dataset from a 4-year time period (2010-2014) in New York City examining severe maternal morbidity by insurance type and ethnicity. The authors stratified and analyzed the cohort group by insurance type (Medicaid versus commercial), and into three ethnicities: non-Latina Black, non-Latina White, and Latina. The study found that the type of insurance a woman had did not increased their risk of severe morbidity. However, being Black or Latina did increase the risk of severe morbidity.

Methods:

1. Line 91: The Latina population is a very heterogenous community including women of mixed ancestry/lineage (e.g. African, European and/or Indigenous). This leads to a limitation of "self-identified race" as a Latina could possibly be more of a "Black" ancestry than "White", or vice versa. Something to consider and comment in the Discussion section.

2. Line 107: Adjusting for body mass index was essential given that the Black women in this cohort were more likely to be overweight, obese or morbidly obese. Similarly, more black women had hypertension, thus, adjusting for all these variables of interest is a significant strength.

Results:

3. Line 163: Having the data come from similar settings (urban, teaching, and with Level 3/4 nurseries) adds validity when comparing morbidity as opposites (urban vs rural, teaching vs private, with lower vs higher level nurseries) diminishes the confounding in the data.

Discussion:

4. The increased awareness of the racial and ethnic associations with severe maternal morbidity have many medical and public health implications as described by the authors. Moreover, it is important to discuss the biologic plausibility of these findings, especially when a socioeconomic element (such insurance type) is found to be less influential. Also, from a social behavioral standpoint the differences of how Black and Latina advocate for themselves when receiving medical care compared to their White counterparts might be a corollary worthwhile investigating

STATISTICAL EDITOR'S COMMENTS:

1. lines 98-100: Should provide a summary (could be on-line material) of the component parts of SMM and the proportion of each for the population evaluated in this study. Often transfusion is one of the largest proportions, should do sensitivity analysis to show whether the conclusions materially changed if transfusion were omitted from SMM.

2. lines 235-237: Should include a random sample of sufficient size to validate the ascertainment of SMM from the database.

3. Tables: Should include a summary table of medicaid vs non-medicaid with subsets by race, showing the n/N for SMM for each group and should also show the same Table for SMM without inclusion of transfusion. This will help the reader to put in context the various aORs cited in the text.

EDITORIAL OFFICE 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:
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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. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

4. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

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 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.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports 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).

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If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

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* 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 21 days from the date of this letter. If we have not heard from you by Nov 15, 2019, 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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