

## PEER REVIEW COMMENTS

### Article ID: 2022-0083

**Article title:** Telemedicine perceptions and experiences of socially vulnerable households during the early stages of the COVID-19 pandemic: a qualitative study

**Article authors:** Alayne M. Adams PhD, Khandideh K. A. Williams PhD, Jennifer C. Langill PhD, Mylene Arsenault MD, Isabelle Leblanc MD, Kimberly Munro MD, Jeannie Haggerty PhD

### Reviewer 1: Dr. Erica Barbazza / University of Amsterdam

Thanks to the authors for this very interesting and well-conducted study. I really enjoyed the read and found the piece very well-written. My comments touch on a few points where the text could be further clarified or elaborated on. I hope you find the feedback helpful.

Title: The phrasing of the title currently adopts the perspective of the provider (why am I not seeing my high-needs patients?) which seems a bit like a missed opportunity, in a piece that attempts to rebalance the perspectives and capture the patients experience. I can appreciate that the question was the premise behind the study though I would invite the authors to reconsider and find a title that stays truer to the perspective and voice that the paper is trying to capture. Also, to the second half of the title, it could be noted 'in the early stages' of the pandemic as the title currently misses a temporal element. [Editor's note: Please see suggested title in Editor Comments]

### This has been clarified.

Abstract: the abstract notes: "In this context, a Quebec family physician observed that many of her high-needs patients were not accessing tele-medicine" This point reads a bit differently in the main text, where it appeared as a group of physicians? "In Quebec, several family doctors....." This appears to need correcting and revising; in the abstract the current formulation reads as very specific and suggests the sample drew solely from that practice. I would suggest to phrase the problem statement more as a general trend that was observed by local physicians. [Editor's note: this should be removed from the Abstract.]

### This has been corrected.

Introduction: similar to the above, the introduction of the trend observed may need revising so this is consistent (one or across practices?). Perhaps clearer to refer to 'members of the study team' rather than name abbreviations? [Editor's note: it is fine to include author initials, but we agree that it is important to be specific about whether this was a general trend or 1 physician.]

### Initials have been removed and references to "members of the study team" are included instead.

Methods: study setting and sample – the methods overall are clear and detailed. I found I only missed a clearer description of the participant inclusion criteria. I would invite the authors to better list what were the criteria for participation. That participants were: (1) registered with the Quebec Health Insurance Plan; (2) living in households in which healthcare had been experienced since the onset of the COVID-19 crisis (meaning they had a proven attempt to access services?).... But they also had chronic care needs (was this an inclusion criteria?), (#) were of lower SES (determined based on their use of a community food bank?). By virtue of "living in a household" re point 2, it means that people experiencing homelessness were excluded? If so, were there others that meet the criteria of 'socially vulnerable' but were also excluded (perhaps also people that are also of lower socioeconomic status but living in long- term care/assisted living?). If any of these factors

have influence on possible limitations those should also be added

**Thank you for pointing out this out. Clarifications have been made in the participant, data source limitations sections.**

Data collection: following the sentence “Guidelines were loosely structured around concepts from the Patient-Centred Accessibility Framework” it would be helpful to describe in a sentence briefly the topics/nature of the interview guide. E.g. it was organized in x number of parts and included questions around x, y, z.

**Thank you for the suggestion. This has been included.**

Analysis: “Emerging findings were shared with clinician collaborators for their insights” – these are study team members? And also the clinicians that originally observed this trend? Perhaps the study team could be introduced more clearly in the study design section, noting the composition included both the clinicians observing this trend at the outset and qualitative researchers (as described in the data collection section).

**This has been clarified in the study design and setting section.**

Results: minor points:

page 7 – “vulnerable households in our sample:” should be a period

**Done.**

page 7: “their health problems in face” --- needs revising (in the face of?, or when faced with?).

**A correction has been made.**

In quoting participants, there is a bit of inconsistency in the labelling, it seems: immigration status, gender, health status. Does it mean e.g. ‘female, chronic health issue’ is not a new immigrant? And ‘recent male immigrant’ is healthy? I suggest to develop a more consistent labelling system, also so the order of the descriptors is the same.

**This has been clarified in the data table.**

Discussion: the authors provide a range of different strategies that could be taken forward to concretely address the inequities of telemedicine. I would challenge a further reflection on what is needed at practice level versus beyond the practice and in collaboration with other actors either in the community, city or provincially. Some strategies can be tackled at the practice-level but what needs to be done at a policy level? How can practices be best supported to monitor their telemedicine services and receive feedback? I think it would be really relevant and useful for the sake of the necessary window of opportunity there is at present around telemedicine in Canada to try to be more specific in how the agenda is taken further both from a practice and research perspective but also for policy. [Editor’s note: This should be in a paragraph or 2 before the Limitations in the Interpretation.]

**Some additional remarks are offered on policy and systems issues on page.**

**Reviewer 2: Dr. Martina Kelly / University of Calgary**

Thank you for sharing this paper. I read it with great interest as a family physician caring for patients with experiences of structural vulnerability. While telemedicine has brought advantages, it has created barriers and its essential we think about these as we integrate telemedicine going forward.

General feedback: topical, of interest to wide readership (as messages apply to other disciplines working with these populations), I liked the mix of the team and how the team approached the project. My main suggestion is to provide some more detail, which may be

more for the committed reader but should help with credibility of your work.

Introduction: easy to read, succinct.

Methods: Perhaps, because I am so curious, I have a few suggestions which authors may be able to provide, maybe as additional tables or supplementary material.

Can you clarify eligibility criteria and how sampling was achieved – I was unclear who screened (member of the team?) and how consent was obtained (in context of different language mentioned, were people given info or did they consent at that time, verbal or written consent). I wasn't clear what a 'knowledgeable adult member' meant – was that different to the person giving consent or did it differ? Were the same eligibility criteria used for the hospital? I'm asking these as might be useful to other researchers interested in your approach.

**Thank you for these suggestions. The process of screening into the study and the application of eligibility criteria have been clarified.**

I think the word 'guidelines' refers to the interview schedule – might it be possible to see what questions were asked as this will inform data collected and interpretation.

**These are provided in the text and in Appendix 2.**

How many of the interviews were recorded (or not).

**All interviews were recorded following participant consent.**

I'm not familiar with narrative summary approach – can a reference be provided?

**We have provided a reference.**

How /who deemed if a quote 'was deemed memorable and worth preserving' – was that based on a single member of the team or was that decided as a team?

**A memorable quotes file was kept in a teams file for everyone to add to.**

I think the approach to using audio for analysis is sensible but may be less familiar to readers and so appreciated the reference.

**A reference is provided.**

Were results shared with any participants?

**This was one of the highlights of this research! Results were shared with family doctors, nurses and administrators from participating clinics, as well as community organizations working with vulnerable populations. The results of these dialogues are included in Appendix 3.**

Results: Recognising space issues, I might have liked to see a little more of the data - perhaps as a table or an appendix to illustrate the data. Also, I'm unclear if the quotes in the text are from the same or different participants?

**A table of quotes has been appended with ID references.**

I very much appreciated attention to relational continuity, the value of physical exam, and non- verbal communication which resonate with my experience as a family doctor.

**So important!**

I think there were many 'take-home' points for readers that could make a useful table (or even clinic leaflets in different languages) for patients and for clinics. e.g. advising patients about booking, what to expect, what to do if a call was late, attending to privacy, trying to book for relational continuity. But appreciate that may be beyond the scope of your report. [Editor's note: As the reviewer has indicated, this is a nice-to-have appendix, but not needed for this paper.]

**In Appendix 3 we include a report that describes a series of deliberative dialogues undertaken to disseminate findings to participating clinics for their consideration and action. Two clinics have subsequently put measures in place based on our findings, and a third used our results to justify continued investment in existing measures such as interpretation and navigation for diverse multicultural and socially vulnerable patients.**