

Peer Review File

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**Reviewer A**

The findings that good internet connection and younger age associated with higher satisfaction with telehealth are not entirely surprising as others have reported this with many other clinical populations and thus am not sure this component of the report adds much value. It would have been more helpful if the survey probed caregivers on the nature of the care that was rendered during the telehealth visit to really assess what types of functions are most suited for telehealth delivery from a caregiver perspective. What I'm baffled with was why the authors didn't work with a large palliative care/hospice provider to conduct such as a survey with family caregivers as part of an ongoing quality improvement effort instead of using an internet panel? I don't think such efforts would be considered to be interfering with the CAHPS administration if the focus was on telehealth use and that could be linked to the CAHPS data after the fact.

>> We considered partnering but felt that might bias the results towards that company's telehealth approach and services.

Please clarify how the caregivers were identified? Is there a denominator from these panel surveys to understand the response rate?

>> The Qualtrics service curated the survey responses by recruiting respondents who specifically stated they were caregivers of seriously ill patients. Thus, a typical response rate is not applicable. We added this to the second paragraph of the Methods.

The survey was deployed in March 2021. I'm very surprised to see so many respondents who reported to be a caregiver pre-pandemic (and using telehealth?) in hospice/palliative care? Telehealth was seldom used in hospice/palliative care pre-pandemic.

>> The authors noticed this as well and verified all respondent answers about hospice and palliative care to ensure accuracy. We also added a limitation about the possibility that patients who received palliative care or hospice care may have received telehealth before they started receiving palliative care or hospice care.

Please clarify whether the subgroup (n=228) caregivers had family members who received telehealth during hospice/palliative care or just hospice/palliative care? Could the authors provide all the survey questions as an appendix so readers can see the questions under each of the 3 domains vs. the just the sample questions in Table 4? Are the 3 outcomes from the regression tables based on all the survey questions or

just those summarized in Table 4? I'm unsure as to how the hospice CAPHS questions were modified to capture care experience w/telehealth

>> The subgroup (n=228) had family members who received palliative care or hospice care. We have added a limitation about the possibility that patients who received palliative care or hospice care may have received telehealth before they started receiving palliative care or hospice care.

Thank you for the suggestion to add the survey questions as a supplementary appendix. We added this supplementary appendix and a reference to this appendix in the 3rd paragraph of the Methods section.

The three outcomes from the regression tables are based on several questions each. In the Methods paragraph 4, we have now added information about the specific questions from the survey that were included for each of the outcomes. Additionally, the survey questions in Table 4 were included to provide the reader with the types of responses we received.

Demographic questions were based on the CAHPS Hospice Survey and telehealth questions were based on the Telehealth Usability Questionnaire. We have added a sentence in the third paragraph of the Methods stating this.

Please provide more details re: what aspects of the survey results informed the construction of the interview questions; how the authors reconciled differences in their coding of the interview data

>> The open-ended questions in our interviews related to the major concerns and benefits reported in the caregiver survey. We added this to the Methods/Hospice Leader Interviews/First paragraph. There were no major differences to reconcile in our coding of the interview data. Rather, the interviews went more in-depth about the concerns and benefits of telehealth and allowed for deeper insights into the issue.

I have concerns regarding the very poor response rate with the hospice leaders but the fact that these leaders took uncompensated time out to be interviewed may illustrate the best-case scenario in terms of their experiences w/telehealth.

>> Thank you for noting this. This has been close to the typical response rate we have received in previous studies that have uncompensated email requests to interview healthcare executives. We agree with you and our third paragraph in the Strengths and Limitations section discusses this. Additionally, given that we were asking hospice leaders to be interviewed during the pandemic, our response rate expectations were not as high as they would be during non-pandemic times.

The paper references Table 3 for the hospice leaders characteristics but that is the regression table for the subset of caregivers who reported receiving hospice/palliative care

>> Thank you for pointing this out. We have changed this to Table 5 and have included Table 5.

### Reviewer B

The authors present findings regarding a survey of caregivers of seriously ill patients and interviews held with hospice leaders to understand the potential benefits and risks of telehealth in providing hospice and palliative care. Their methods utilized 1) multiple linear regression models to assess associations between a variety of dependent and independent variables and caregiver satisfaction with telehealth and 2) apparent thematic analysis of hospice leader interviews. They observed that internet connectivity, access to video, and patient's age were associated with greater satisfaction with telehealth while hospice leaders had concerns about telehealth policies while appreciating the innovation and effect on quality of care due to the rapid adoption of telehealth during the COVID pandemic

The main conclusion reached by the authors is that telehealth may work for specific palliative care services and that addressing possible risks and shortcomings was essential to ensure that telehealth does not detract from care provided.

Overall, the paper is well written however I have concerns about some of the reporting, more specifically with the Methods section and details about the approach and theoretical framework used by the authors. My points of feedback that should be addressed in major revisions:

- I am concerned by the use of caregiver surveys with hospice leaders completing the interviews. How do the authors reconcile these two perspectives in terms of how telehealth has impacted palliative care delivery? What evidence exists showing that hospice leaders are cognizant of how caregivers approach telehealth? Is there any other existing literature showing hospice leaders to be good surrogates for the caregivers' experience?

>> This is a great question that we discussed during our study approach. The rationale of our chosen approach is that hospice leaders have a broad perspective on how telehealth has impacted care (both on the positive and negative side) because they more consistently have observed both types of care (with and without telehealth). Whereas the caregivers' impressions of telehealth use are critical, very few experience what care would be like with or without it, depending on their specific single experience. To get a holistic view of telehealth use, we felt a combination of caregiver and hospice leaders' points of view was ideal. Thus, we decided to have the in-depth interviews be of hospice leaders given their more permanent expertise within the telehealth/palliative care space instead of individual caregivers whose single individual experiences may be less representative of the overall telehealth movement in this space. We realize this is not typical within the mixed methods sequential explanatory design where usually the same group is used for both the quantitative and

qualitative approach, but felt it was more valuable of an approach in this particular instance.

We appreciate your note and put additional information about this in both our Methods/Hospice Leader Interviews/first paragraph and our Strengths and Limitations/third paragraph.

- The Methods section is vague in terms of the qualitative analysis of interviews. What underlying theoretical framework guided the coding and analysis? How was the codebook developed? How was COVID considered in terms of influencing interviews?

>> Thank you for these suggestions. We used a codebook thematic analysis approach to examine the data. The research team iteratively developed codes after reading, examining, and discussing the data. The researchers also reviewed the interview notes throughout the process to ensure the themes accurately reflected the actual interview content. We have added more details about the qualitative analysis of the interviews to Methods/Hospice Leader Interviews/paragraph two.

We asked about the use of telehealth during the COVID pandemic. In addition to COVID influencing responses directly asking about the pandemic, we realized that the pandemic likely decreased our response rate and interview duration. Hospice leaders have been especially busy during the pandemic, and we were grateful for the time they did provide to us for the interviews. We have added the limitation (Strengths and Limitations paragraph four) of COVID potentially impacting our response rate; that is, some individuals may have been too overwhelmed or stressed to take the time to participate.

- What mixed methods approach was used (e.g. convergent, sequential, etc.)? The paper also refers to the “exploratory focus” (page 10, line 408) which needs to be expanded on as this may refer to the mixed methods approach (e.g., exploratory sequential design).

>> We used the sequential explanatory design. As noted above, we are cognizant that the qualitative respondents were not the same caregiver group surveyed; but we feel reflect stronger and deeper knowledge of telehealth use in this space. These details are now noted in the first sentence of the Methods, in Methods/Hospice Leader Interviews/first paragraph, and the Strengths and Limitations/third paragraph.

- Who are the hospice leaders that were interviewed? It would be useful to know what positions they hold (e.g. healthcare system admin, physicians, etc.) as this greatly influences the conclusions drawn. As it reads, the manuscript refers to a “Table 3” (page 5, lines 196-197) for respondent characteristics but this seems to have been omitted from the manuscript submission.

>> Thank you for pointing this out. We have changed this to Table 5 and have included Table 5.

- Representative quotations in the body of the manuscript need a reference to who said them (e.g. hospice leader's occupation/position). These quotes are also hard to read as they are organized and would benefit from some way of distinction (quotations, italics, etc.)

>> Thank you for pointing this out. They are now in italics.

- More data on the caregiver characteristics is needed in Table 1 given they were the ones completing the survey. This should include sex, race and age if available.

>> We agree with you and have added caregiver sex and race to Table 1. We will also keep caregiver age in that table.

- Citation for JARS Mixed Methods Reporting Standards needed (page 3, line 86)

>> We have added this citation.