

PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (<http://bmjopen.bmj.com/site/about/resources/checklist.pdf>) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Telemedicine Guided Education on Secondary Stroke and Fall Prevention Following Inpatient Rehabilitation for Texas Stroke Patients and their Caregivers: A Feasibility Pilot Study
AUTHORS	Jhaveri, Mansi; Benjamin-Garner, Ruby; Rianon, Nahid; Sherer, Mark; Francisco, Gerard; Vahidy, Farhaan; Kobayashi, Kayta; Gaber, Mary; Shoemake, Paige; Vu, Kim; Trevino, Alyssa; Grotta, James; Savitz, Sean

VERSION 1 - REVIEW

REVIEWER	Anand B. Joshi Duke Health, USA
REVIEW RETURNED	26-Apr-2017

GENERAL COMMENTS	Well planned and presented study. There are minor typographical and grammatical errors that should be addressed before publication.
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REVIEWER	Nicola Saywell Auckland University of Technology, New Zealand
REVIEW RETURNED	15-May-2017

GENERAL COMMENTS	<p>I think this study is really important and could inform an effective TR programme to an under-served population. However I am concerned about the absence of acknowledgement of the population from which participants are recruited (see below). Once that is addressed I think establishing the feasibility of the programme as a population intervention will be possible from your results.</p> <p>TM-SAFER feedback to authors</p> <p>Abstract</p> <p>Introduction</p> <p>Page 2</p> <p>Line 46 - 'cognitive deficits and falls'</p> <p>Line 47 – I suggest something less emotive than 'fight', perhaps struggle?</p> <p>Line 48- 'readmission and worse stroke outcomes'</p>
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Methods and Analysis

Line 57 - 'People with stroke' or 'patients with stroke', not 'ischaemic stroke patients'

Page 3

Line 10- 'primary outcomes **are...**'

Strengths and limitations

It would be good for the authors to separate strengths and limitations, mainly because there are some significant strengths. The access for underserved populations is potentially very important.

I think the claim that the study personnel can intervene quickly in the case of medical problems is somewhat overstated. If the participant is experiencing aspiration or swallowing difficulties, week 3 post-discharge is very late to pick up a potentially life-threatening problem. However, I am sure that problems of a less acute nature would be picked up, which would be beneficial.

Primary objectives and statistical analysis

The biggest problem I see with this protocol is the complete absence of any mention of the people who refuse the intervention. The feasibility study firstly needs to look at the number of people who consent to being part of this study out of the total number of people who are eligible. It is only that percentage, which gives you any idea of the feasibility of this as an intervention for the population in question. I could see no mention of the percentage of eligible participants who consented being important in the final statistics. This is a serious omission but probably ameliorable as your ethics application will have required consent and informed consent is mentioned, you will therefore have the numbers of those who were eligible, approached but did not consent. If you have any information about their reason for refusal, that would also be extremely helpful when planning a further study. If a large percentage of people do not want to use the technology, do not think it is useful, or have no internet connection for example, that would be an important finding.

'Participants' not 'subjects' when referring to people who willingly consent to participate in research.

Page 6**Intervention**

Have you factored in any way of a particular professional re-visiting a participant who was having difficulty? For example if a participant on week 1 was showing some evidence of not complying with prescribed medication, what facility is there to give any ongoing guidance or support after that first week?

Figures

	<p>Nowhere on figure 1 does it mention informed consent and the exclusion of those who do not give it.</p> <p>Ensure you have defined acronyms after each figure to allow easy reading of the information.</p>
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VERSION 1 – AUTHOR RESPONSE

TM-SAFER feedback to authors Abstract

Introduction

Page 2

Line 46 - 'cognitive deficits and falls'

Line 47 – I suggest something less emotive than 'fight', perhaps struggle?

Line 48- 'readmission and worse stroke outcomes'

Methods and Analysis

Line 57 - 'People with stroke' or 'patients with stroke', not 'ischaemic stroke patients'

Page 3

Line 10- 'primary outcomes are...'

We would like to thank the reviewers for their time and thoughtful feedback, and helping us to make the manuscript better. The grammatical errors above have been modified and corrected in the revised manuscript.

Strengths and limitations

It would be good for the authors to separate strengths and limitations, mainly because there are some significant strengths. The access for underserved populations is potentially very important.

We would like to thank the reviewer for the kind feedback. The strengths and limitations have been separated as below:

Strengths and Limitations of this Study

Strengths

- Study incorporates a multidisciplinary team of specialists who have the opportunity to intervene on medical problems for stroke rehabilitation patients discharged to the community.
- The study population includes underserved stroke rehabilitation patients who may be uninsured, living in rural locations, and Spanish speaking with limited access to healthcare resources.
- The study uses an IT security approved videoconferencing application and conducts all TR home visits in a private setting to protect patient confidentiality.

Limitations

- The videoconferencing application may be difficult for older or cognitively impaired stroke patients to use, and may require caregiver assistance.
- The videoconferencing technology may not work in rural locations with poor reception.

I think the claim that the study personnel can intervene quickly in the case of medical problems is somewhat overstated. If the participant is experiencing aspiration or swallowing difficulties, week 3 post-discharge is very late to pick up a potentially life-threatening problem. However, I am sure that problems of a less acute nature would be picked up, which would be beneficial.

We would like to thank the reviewer for this comment because it is an important point. It is understandable that the claim that study personnel can intervene quickly in the case of medical problems sounds overstated, and we have modified the language. Under strengths and limitations, we

have modified as below:

Strengths

- Study incorporates a multidisciplinary team of specialists who have the opportunity to intervene on medical problems for stroke rehabilitation patients discharged to the community. (word "quickly" was deleted)

I do think the flexibility of changing specialist calls depending on participant need, mentioned in the intervention section, helps to facilitate timely evaluation of medical problems (for example, if participant is complaining of difficulty swallowing, speech therapist may do TR Home visit on week 2 instead of week 3). However, we agree this should not come off as overstated to the readers.

Primary objectives and statistical analysis

The biggest problem I see with this protocol is the complete absence of any mention of the people who refuse the intervention. The feasibility study firstly needs to look at the number of people who consent to being part of this study out of the total number of people who are eligible. It is only that percentage, which gives you any idea of the feasibility of this as an intervention for the population in question. I could see no mention of the percentage of eligible participants who consented being important in the final statistics. This is a serious omission but probably ameliorable as your ethics application will have required consent and informed consent is mentioned, you will therefore have the numbers of those who were eligible, approached but did not consent. If you have any information about their reason for refusal, that would also be extremely helpful when planning a further study. If a large percentage of people do not want to use the technology, do not think it is useful, or have no internet connection for example, that would be an important finding.

The reviewer makes an excellent point with respect to reporting number of patients approached but who refused to consent to the study out of the total number of eligible patients as an important feasibility measure, and we have included this in our manuscript revision.

Specifically, in the abstract, we added statement: Primary outcomes are proportion of eligible patients consenting to the study, participation rate in all 6 TR home visits, and satisfaction score.

Under background section, we added statement: We are seeking to determine what proportion of persons with stroke would consent to this type of study.

Under primary objectives, we added statement: This prospective pilot study is evaluating several feasibility objectives, including the proportion of eligible patients who consent to the study,

Under Methods section, we added statement: Total number of patients eligible for study who refuse to consent, and reasons for refusal, will be recorded.

Under Primary Outcomes section, we added statement: The primary feasibility outcomes include response rate, define as the proportion of eligible patients who consent;

Under statistical analysis section, we added statement: Assessment of primary feasibility aims include: 1) Calculating the response rate as number of eligible patients divided by number who consented

Finally, we have updated Figure 1 to include patients who consented to the study and exclude those who do not. We also updated Figure 3 to include eligibility and consent in pre-intervention, and primary outcomes to include response rate as number of eligible patients divided by number who consented.

'Participants' not 'subjects' when referring to people who willingly consent to participate in research.

We agree with the reviewer's comment, and have searched the manuscript for the word "subjects" and replaced with the word "Participants".

Page 6

Intervention

Have you factored in any way of a particular professional re-visiting a participant who was having difficulty? For example if a participant on week 1 was showing some evidence of not complying with prescribed medication, what facility is there to give any ongoing guidance or support after that first week?

We agree this is an important point that we should have mentioned, and have added a statement at the end of intervention section: Research coordinator will be in contact with study participants for the duration of the study, and will relay any important issues to the rehabilitation physician who will then communicate with the rest of the team for follow up as needed.

Figures

Nowhere on figure 1 does it mention informed consent and the exclusion of those who do not give it. Ensure you have defined acronyms after each figure to allow easy reading of the information.

We agree this is an important point, and we have modified the Figure 1 and defined acronyms after each figure.

VERSION 2 – REVIEW

REVIEWER	Nicola Saywell Auckland University of Technology, New Zealand
REVIEW RETURNED	29-Jun-2017

GENERAL COMMENTS	I feel very satisfied that you have addressed all my concerns. My only minor comment is that you have used the description 'portion' on a few occasions when what you meant was 'proportion'. Other than that I think this is a really interesting study and very timely. I am really impressed with your inclusion of such a broad interprofessional team. I also applaud your targeting of a population that is frequently overlooked. Thank you for the opportunity to review this manuscript.
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