**Reviewer's report**

**Title:** Implementation of a Multidisciplinary Discharge Videoconference for Children with Medical Complexity: A Pilot Study

**Version:** 0  **Date:** 19 Nov 2019

**Reviewer:** Jody Lin

**Reviewer's report:**

The focus of this study is on the important topic of transitions from hospital to home for a vulnerable population, but the results are limited based on the low participation rate and limited description of the intervention itself. The study is a good starting point for future work, but I worry about the generalizability of the findings given the small sample size. I also wonder why different recruitment methods were not attempted throughout the pilot since the study seems to be taking an implementation science approach. Further discussion about why the recruitment approach was selected and whether there were resource constraints may help justify the study design. I think the main finding from this pilot is that the initial screening and enrollment process can be a big barrier to implementing a videoconference study, and the article could spend more time discussing the pitfalls they faced with regards to this and the lessons they would take away from this project for their future directions.

**Introduction:**

Linking high quality discharge communication to potentially moveable health outcomes could strengthen the motivation behind this project.

p.4 line 68: include some problems that occur that you think videoconferencing could help address

**Methods:**

p.5 line 98-100: Further description of the framework would be helpful in understanding the intervention. Another important topic to address is how the structure of the videoconference differs from usual care discharge planning. Since you are including the mention of a framework here, it made me wonder whether this was truly an implementation only study or a hybrid implementation/effectiveness study. If the discharge framework is different from usual care, I would recommend further discussion on why this framework was chosen.
p.5 line 108: change "efficacy" to "face validity"

p.6 line 112-116: Please clarify if the quantitative assessments. Was a Likert scale used? Were they binary options? etc.

p. 6 line 117: Consider a different word than "framework," which typically evokes for me traditional implementation science frameworks like RE-AIM, CFIR whereas the reference identifies/defines implementation outcomes.

Results:

p.6. line 130: I would move this sentence to the methods section and provide an explanation of why this recruitment strategy was chosen.

p.6 line 131: Consider including counts of those who were ineligible due to discharge date and those for whom the hospitalist did not respond. The latter might be suggestive of low acceptability and low adoption.

p.7 line 138: delete "CMC"

p.7 line 142: How many of the 4 hospitalists surveyed actually had a patient undergo videoconferencing? Did each of these providers have just one patient who completed the intervention? Were the providers the ones who referred the participant into the study? Were these providers the same ones who were the attending on the day of discharge?

p.7 line 147: I would make clear throughout the manuscript that the "cost" was quantified using MD hospitalist provider time. Please also clarify if the 1.75 contact attempts were for scheduling the conference or for actually conducting the videoconference. I think both would be important data to report.
p.7 line 152: why were the hospitalists not interviewed? It seems that both outpatient and inpatient provider perspectives would be important to captured both for the quantitative and qualitative portions.

p.9 line 191: Consider removing "intangible humanistic element" as it seems that "comfort" captures both quoted experiences or "connection."

line 227-232: This paragraph is a bit of an overstatement given the low numbers of true participants. Even for the 11 who were eligible, less than half enrolled. I would make clear that for those who used the intervention, it was deemed acceptable. The addition of the word "appropriate" seems to be a new concept and I would recommend removing.

line 234-237: I would spend more time discussing future directions given these barriers. I would also recommend including here or earlier in the paper more information about how the intervention was implemented. How was it publicized? What communication approaches were used with the health care providers? Why were these chosen? How did this change over time? For example, one of the PCPs was reached out to via email. Was this always a potential approach? Or did you use email outreach when you had low response from PCPs?

line 274: add "to" in front of "meet"

Table 2: consider changing the age of child and age of caregiver sections to median (range) rather than proportions

Table 3: consider making separate columns of quotes providers and caregivers

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