Comparative Effectiveness Review Disposition of Comments Report

Title: *Effectiveness of Telehealth for Women's Preventive Services*

Draft report available for public comment from February 10, 2022, to March 9, 2022.

Citation: Cantor A, Nelson HD, Pappas M, Atchison C, Hatch B, Huguet N, Flynn B, McDonagh M. Effectiveness of Telehealth for Women's Preventive Services. Comparative Effectiveness Review No. 256. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 75Q80120D00006.) AHRQ Publication No. 22-EHC024. Rockville, MD: Agency for Healthcare Research and Quality; June 2022. DOI: https://doi.org/10.23970/AHRQEPCCER256. Posted final reports are located on the Effective Health Care Program search page.

Comments to Draft Report

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This document includes the responses by the authors of the report to comments that were submitted for this draft report. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Peer Reviewer, Technical Expert, and Public Comments and Author Response

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #1	Introduction	Clearly articulated	Thank you.
Peer Reviewer #2 (TEP)	Introduction	good	Thank you.
Peer Reviewer #4 (TEP)	Introduction	Abstract line 39: Is there a word missing in this part of the sentence? "…evidence was insufficient impact on abortion rates" should it be evidence was insufficient to discern an impact on abortion rates?	Corrected in abstract results section.
Peer Reviewer #4 (TEP)	Introduction	Abstract Line 42 – can you add the results regarding no differences in satisfaction for type of tele services (a differential in how these services are reimbursed exists between phone and video but video can be extremely challenging for certain patient populations) Exec Summary Main points line 10 – can contraceptive care be explained like IPV care (screening, evaluation, treatment)? What is meant by contraceptive care?	In response to AE comments, outcomes for single studies removed from abstract. Clarification added for contraceptive care in ES, main points.
Peer Reviewer #4 (TEP)	Introduction	Exec summary Table A. family planning is listed. As contraception is often used interchangeably within the field, it is important to define this early for clarity as well as for stakeholder buy in that both contraception and pregnancy planning were considered (Can you put a foot note since the definition for family planning comes much later and it might cause confusion for individuals that only read the executive summary?	Family planning definition added as footnote in ES table A. Additional text to define planning services included in ES methods section.
Peer Reviewer #4 (TEP)	Introduction	Exec summary page ES-3 line 42. Also include HPV/cervical cancer screening since self-testing is available now as a future preventative service to look at? Introduction is clearly written	These services were outside the scope of this review.

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Peer Reviewer #5	Introduction	Overall, the introduction is excellent. Per my comments above, if you chose to make a distinction between efficacy and effectiveness, the introduction would benefit from some addition about the mechanisms that telehealth may improve care. This could be by increasing access to services or improving the efficacy of services. That would lead nicely into a brief intro into how telehealth could also make inequity worse by selectively benefitting some with better access or better efficacy, but not others.	Thank you. Effectiveness vs. efficacy issue addressed in discussion based on reviewer comments and suggestions: ”Future studies should move beyond efficacy to more clearly evaluate effectiveness of telehealth interventions and should include studies to assess whether telehealth platforms can increase the reach of services and improve effectiveness for communities.”
Peer Reviewer #6	Introduction	See comment above about key questions. The authors clearly indicate the purpose/scope of the review (e.g., pg. 2, lines 38-42) but do not fully develop a clear rationale for the scope—in other words, why the review focuses on the combination of family planning, contraception, STI counseling, and IPV.	Clarification regarding framing of KQ: “The review is defined by six sub-questions that address two overarching key preventive health services, the first focusing on evidence about women’s **reproductive health** and the second focusing on **interpersonal violence** as they relate to telehealth intervention” was added to the Introduction, Scope and Key Questions section. Purpose and scope clarified in methods to state: “These services are particularly amenable to telehealth interventions and may have been affected by limited in person care early in the pandemic” in the Introduction, purpose of the review section

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Peer Reviewer #6	Introduction	Pg 8, Line 51-55 – The authors indicate that there was "less emphasis on the magnitude of the effect (e.g., large difference in benefits, no difference in harms)." I did not see any mention of the rationale for doing so in this section or potential implications in later sections of the review. For example, are there implications for future research or policy related to the magnitude of effect sizes?	Text edited to limit confusion on rationale: "We created categories of results based primarily on the direction of the effect and whether differences were statistically significant. Results are summarized across studies grouped by preventive service and/or telehealth function/modality." Methods, data analysis and synthesis section
Peer Reviewer #7 (TEP)	Introduction	I would consider addressing the issue that some of the technology in the studies reviewed are dated and the previous internet based interventions are now adapted to apps for smartphones (IRIS to myPlan) and are undergoing additional testing (myPlan with college students, etc) and in different countries/low resource settings (myPlan Kenya) – that this is a rapidly evolving area of research so the interventions being reviewed are not the interventions being used today – iCan has adapted to app for example, etc.	Text added to discussion, applicability section: "Older studies of IPV may have used dated technology. For example, previous internet-based decision aid interventions are now being adapted as applications for smartphones."
Peer Reviewer #1	Methods	Page 22, line 8-9, why were patient knowledge and education excluded- increased patient education helps increase effective use of contraception going forward and awareness and increased access to IPV services Page 22, lines 20-23, why were these other settings excluded. Telehealth is widely used in prisons where women have been victims of IPV, schools, community service settings, and churches have set up private kiosks with equipment to support telehealth for individuals who either do not have access to broadband or an electronic device at home or can not get privacy at home to seek these services. Did the study include pharmacies as Walgreens and Walmart have set up private telehealth rooms.	PICOTs table. Knowledge and education were excluded as outcomes a priori during the scoping phase of the project; measures of effect (engagement, satisfaction) and measures of access were chosen to reflect outcomes that patients experienced. Settings were limited to primary care or primary care referable settings. Schools, pharmacies, and prisons were outside the scope of this review.
Peer Reviewer #1	Methods	Methods should provide a brief summary of the SOE criteria- the appendix can be referenced for more detail but an overview should be included in the body of the methods section	SOE criteria are described in the methods under grading the strength of the body of evidence section.

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Published Online: June 16, 2022

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Peer Reviewer #2 (TEP)	Methods	The inclusion and exclusion criteria are justifiable based on AHRQ usual criteria- but as above it is unfortunate that we cant at least move the needle on stating a range of "gold-standard studies".	Agree. This study followed AHRQ methods guidance. “Studies were reviewed and highlighted using a hierarchy-of-evidence approach, where the best evidence is the focus of the synthesis for each key question. RCTs were prioritized and studies with lower risk of bias ratings were given more weight in our synthesis for each clinical indication and outcome.”
Peer Reviewer #2 (TEP)	Methods	In these subject areas of interest within telehealth- definitive studies may never be produced because of the structural issues about what research gets funded - and how large the studies on these topics can actually be given the lack of funding for such topics. so what happens is these types of reviews that basically say we still do not have evidence that demonstrates effectiveness of these approaches. This report does state that the impact of telehealth on patient engagement, access to care, and etc is uncertain... but - What would be helpful is to be able to at least gain some kind of understanding around patient reported outcomes, patient satisfaction in care and patient adherence to visits via telehealth approaches.	We understand that there are limitations to this evidence. This is highlighted in Table 6.
Peer Reviewer #3	Methods	Yes, the approach seems justifiable and logical. I wonder if the date limitation was part of the reason there weren’t as many articles as hoped for. Aug 2021 was a little over a year into the pandemic, maybe not quite long enough for research papers on the telehealth impact to come out. Could this be updated in a year? Perhaps that would allow some metaanalysis as well.	Updated searches were conducted March 2022. No studies met inclusion criteria.
Peer Reviewer #4 (TEP)	Methods	Appears well justified, appropriate and well described	Thank you.
Peer Reviewer #5	Methods	The methods section is clear and understandable. It nicely uses and references AHRQ’s methods for SRs. I commend the authors about clarifying the use of the term “women,” and also saying who the term applies to. I like the approach of being inclusive and saying that the term applies to individuals of all gender identities.	Thank you.
Peer Reviewer #6	Methods	Pg 9, Line 4: How were “key statements” identified? For example, were they related to topics identified a priori? Please clarify.	Revised. “Key statements addressing included outcomes were extracted” from studies, in methods in data analysis and synthesis section.

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Peer Reviewer #6	Methods	Pg 9, Line 10-11: The following sentence should be clarified: "In addition, health equity, access, utilization, and disparities were considered for inclusion but were not reported by studies."	Revised: "In addition, outcomes related to health equity, access, and disparities were considered for inclusion but were not reported by studies" in methods in data analysis and synthesis section.

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Peer Reviewer #7 (TEP)	Methods	I understand that decision aids were not included in this review (rationale is not clear and not logical for me given the review). This is (in my opinion and I am clearly biased as it is my work) an issue specific to IPV studies, as the first two studies that examined the use of technology to facilitated safety decisions and planning with survivors of IPV (Glass and Koziol-McLain) are also the studies that the two trials (iCan and iDecide) are based on are included in the review. It is the same intervention, slightly adapted for context – so not sure rationale for exclusion – is it the use of term safety decision aid rather than safety planning? The iCan (Canada), iSafe (New Zealand) and i-decide (Aus.) are all adaptions/replication of IRIS (Glass et al., 2017 original internet based safety planning intervention, now adapted and call myPlan given change in technology, smartphones and app were developed). Glass NE, Perrin NA, Hanson GC, et al. The longitudinal impact of an internet safety decision aid for abused women. Am J Prev Med. 2017;52(5):606-15. doi: 10.1016/j.amepre.2016.12.014. PMID: 28108189. Koziol-McLain J, Vandal AC, Wilson D, et al. Efficacy of a web based safety decision aid for women experiencing intimate partner violence: randomized controlled trial. J Med Internet Res. 2018;19(12):e426. doi: 10.2196/jmir.8617. PMID: 29321125. I also think the lack of detail related to the inclusion of diverse and marginalized populations, for example in the excluded study Glass et al., approximately 40% of the sample were non-white and 11% self-defined as LGBTQ. Koziol-McLain study included significant number of Maori (indigenous) and found an impact on depression. The lack of detailed discussion about the potential for technology in meeting the needs of stigmatized and vulnerable populations is an important issue when thinking about the discussion and meeting the needs of these populations.	These two studies were added to the report per suggestion. They include additional outcomes of repeat IPV, for which there is now evidence (SOE) – KQ 2a detailed synthesis section, and corresponding evidence tables in text and appendix. One was captured in the original search but was initially excluded for being the wrong intervention. With additional input from this reviewer (who is one of the study authors) clarification on the intervention details was provided to justify inclusion based on further understanding of the intervention. Additional text added to discussion about these populations, per suggestion. (limitations of evidence base): "Statistically significant differences in depression scores were reported in a one study of an IPV intervention that included a subanalysis of intervention effectiveness in an indigenous population, signaling the potential for technology to help meet the needs of stigmatized or vulnerable populations. One study included patients who identified as having non-male partners, but no other studies were specifically conducted in gender diverse populations, further limiting applicability."

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Peer Reviewer #1	Results	See my comments in methods- I believe the search criteria was too limited. I also suggest that the terms be expanded to review publications through the end of 2021 as there have been a number of relevant studies published since Aug 2021 on this topic.	We recognize the potential limitations of the searches. However, search criteria was reviewed with the TEP and with AHRQ during the scoping phase of the project. PICOTS criteria were refined and reviewed as well. The searches were updated March 2022, while the report was out for peer review and posted for public comment. No new studies were identified for inclusion.
Peer Reviewer #1	Results	Finally, I'm not clear why family planning was not included in the discussion of contraceptive care	Per HRSA, family planning was defined based on Title X guidelines and included preconception counseling and birth spacing; contraceptive care (screening, counseling, provision, and followup care) was considered separately under reproductive health services. Added to ES table A (footnote) and ES, methods section.
Peer Reviewer #2 (TEP)	Results	the detail is appropriate for what studies you did include. However, i wish you could describe some of the qualitative outcomes- cus at this point as i have said in other parts of this review- it is hard to move the needle or to prompt response for more substantial research- for topics covered in this review. Women's health research is already substantially underfunded and when we publish reviews of the evidence like this that show more of the same (meaning studies that are subpar with respect to AHRQ's bar for evidence) we just perpetuate the inertia of the field. The large scale studies that are needed to meet criteria to be included in your review will be beyond what any funder is willing to do. Thus it would be helpful for those of us on the ground who are trying to clinically care for patients via in person, hybrid and telehealth approaches- to at least see in one section of these types of reviews - what the qualitative results are and patient reported outcomes- even if they were not derived from a rct. - this could be embedded in clinical considerations, or research considerations or an alternate section of the report. or even appendix.	We appreciate the input and perspective. Both qualitative and patient reported outcomes are included. See Results for KQ1b, 1d, 1e; Table 2.

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Peer Reviewer #3	Results	Results are clear. Limited to what was found.	Thank you. Agree that results are limited to what was found.
Peer Reviewer #4 (TEP)	Results	Clear results, appropriate level of detail. Included/excluded studies appear complete	Thank you.
Peer Reviewer #5	Results	The results are generally clear and understandable. Based on my knowledge of the literature and the defined inclusion/exclusion criteria, I am not aware of studies missing. I do have two comments. 1. The risks of bias are reported overall with descriptions saying the types of risks of bias seen across studies. However, the results conclude that the evidence on contraception management has a moderate SOE and the evidence on IPV has a low SOE. Clarifying why one topic has a higher and the other a lower SOE would help understand the evidence better. What is it about IPV that makes it a low SOE? And why is contraception a moderate SOE? This would help future researchers trying to close these gaps know what studies need to be done or don't need to be done.	Thank you. Contraceptive care evidence downgraded to Low SOE given reviewer feedback and reconsideration of available evidence. Added to discussion: "Notably, telehealth interventions to augment or replace in person contraceptive services did not improve outcomes. However, with only two studies included for contraceptive care effectiveness, the evidence was not definitive. Additional studies are needed to determine whether this is a true effect."
Peer Reviewer #5	Results	2. Related to my comments on efficacy vs effectiveness, I had a hard time understanding how study participants were recruited and the sampling frames for evaluations. I generally inferred that the RCTs were more efficacy and not effectiveness designs. Being clear about this would be helpful. Also, from the cohort studies on preferences, acceptance, and use of services, some more detail and clarity to help understand the inferences that can or cannot be made on what the findings mean for increasing the reach of these preventive services would help. For example, the cross-sectional study reported at the end of page 14, how much of the differential access is due to patient preference, acceptability, feasibility versus having the availability of telehealth. Could the differential uptake be an artifact that some family planning clinics had more or less telehealth services? (Note – the description for the study in KQ1e, saying this included those who participated in telehealth is helpful for knowing how the findings apply to and why there may be differences).	Unfortunately, the studies do not provide enough detail to infer causality related to access issues. The cross-sectional design of these studies limits the applicability of the findings and provides limited information more generally. These are intended to supplement RCT evidence, when possible, but do not strengthen the evidence for these research questions.

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Peer Reviewer #6	Results	The “Detailed Synthesis” section provides brief summary paragraphs for some KQs, for example, KQ 1a (pg 14, line 34-37) and KQ 2a (pg 20, lines 16-18), which are useful. It would be useful to have such summaries for each KQ.	Detailed synthesis was reported for each KQ based on available data.
Peer Reviewer #7 (TEP)	Discussion	“Studies evaluating the effectiveness of telehealth methods for IPV screening demonstrated differences in scores for depression favoring the intervention in one trial but not 2 others;increase in self-efficacy favoring the control group in one trial; more safety behaviors for intervention group in one trial. Trials indicated no differences for other outcomes. Measures were predominantly based on clinical scales that may have limited relevance or unclear diagnostic implications. Surveys reflect how strategies to ensure safety when using virtual platforms for IPV interventions are critical.” I found this paragraph challenging – specifically, the interventions (iCan and i-Decide) are not screening interventions (identification/disclosure of IPV to providers as potentially perceived by readers) Both of these interventions are adaptions of the myPlan (previously IRIS) safety decision and planning intervention that focuses on increasing safety behaviors for women in unsafe, abusive relationships. The outcomes is increased use of helpful safety behaviors, not simply increase use of safety behaviors.	IPV section revised, per suggestions: “Studies evaluating the effectiveness of telehealth methods for IPV interventions demonstrated differences in scores for depression favoring the intervention in one trial but not in four others; increase in self-efficacy favoring the control group in one trial; and more helpful safety behaviors for the intervention group in one trial. Trials indicated no differences for other outcomes. Measures were predominantly based on clinical scales that may have limited relevance or unclear diagnostic implications.”
Peer Reviewer #7 (TEP)	Results	See above, with exclusion of the two first technology facilitated safety planning interventions, in my opinion the studies and thus findings on outcomes reviewed are incomplete.	IPV section revised. Two related studies were added to the report per suggestion. They include additional outcomes of repeat IPV, for which there is now evidence (SOE) – KQ 2a detailed synthesis section and corresponding evidence tables in text and appendix. One was captured in the original search but was initially excluded for being the wrong intervention. With additional input from this reviewer (who is one of the study authors) clarification on the intervention details was provided to justify inclusion based on further understanding of the intervention.

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Peer Reviewer #7 (TEP)	Results	I would add a table related to challenges/benefits in use of telehealth (safety, privacy, access) and potential solutions for challenges – see manuscripts.	Details of limitations provided in table in Discussion section.
Public Reviewer #2 **Anonymous**	Results	In the patient preferences and choices section, it completely ignores the fact that this was only conducted on willing volunteers. I would be more interested to know how many patients said hell no to participating in the trial. Because for me personally, there is no way in living hell I would have ANY telehealth consultation, let alone one for something as sensitive as reproductive health or STIs. There is just no way in hell. The privacy issues listed should be seen in that context too - it is only the opinions of a small subset of patients who were willing to engage in a telehealth consult in the first place. They are not a representative sample of the broader patient base.	Unfortunately, the study does not report this information. We recognize the limited applicability of these data. Point added to discussion: "Patients included in these surveys may also represent those who self-selected into a group willing to receive services via telehealth."

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Public Reviewer #3 **Nina Zeldes** **National Center for Health Research**	Results	We are writing to express our views on the Agency for Healthcare Research and Quality's (AHRQ) draft competitive effectiveness review on the Effectiveness of Telehealth for Women's Preventive Services. The National Center for Health Research (NCHR) is a nonprofit think tank that conducts, analyzes, and scrutinizes research on a range of health issues, with particular focus on which prevention strategies and treatments are most effective for which patients and consumers. We do not accept funding from companies that make products that are the subject of our work, so we have no conflicts of interest. We support the objective of this report and agree that there is a need to evaluate the effectiveness, use, and patient preferences regarding telehealth for women's reproductive healthcare services and intimate partner violence (IPV) services. However, we agree with the report's assessment that the "systematic review demonstrates a paucity of data to inform the effectiveness," and there are several limitations in the data that are particularly problematic: The data on the use of telehealth for reproductive health services has numerous shortcomings because the studies have different interventions that are not comparable. For example, in one survey cited in the report, 93% of telehealth visits took place over the phone, whereas only 7% of them took place on a video call. If both video and phone telehealth meetings are combined, the data can't really be considered an evaluation of either. The largest RCT cited by the report examined those who received in-clinic services plus "phone-enhanced interventions" of weekly phone calls from a counselor until they started taking oral contraceptives, which was followed by 6 months of monthly counseling by phone. This study compared phone-enhanced interventions on top of in-clinic care to those receiving in-clinic care; it did not directly compare telehealth-only visits to in-clinic visits. Therefore, the largest study cited in support of the claim that those receiving telehealth did not differ in contraceptive use at 12 months from those receiving in-clinic care did not actually compare the two. A direct comparison would be needed to determine the comparative benefits of telehealth care to those receiving in-clinic care.	We recognize the limitations of the included studies and agree that a direct comparison would be ideal. Discussion revised: "Notably, telehealth interventions to augment or replace in person contraceptive services resulted in similar outcomes as in person care. However, with only two studies included for contraceptive care effectiveness, the evidence was not definitive. Additional studies are needed to determine whether this is a true effect, including direct comparisons to determine the comparative benefits of telehealth care alone to those receiving in-clinic care."

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Public Reviewer #3 **Nina Zeldes** **National Center for Health Research**	Results	The report also aimed to assess patient preferences regarding telehealth services for reproductive health services, and it noted that half of patients surveyed said that they preferred telehealth services over in-person services. However, the data used to support that claim were collected from April to June 2020. This was during the height of the COVID-19 pandemic shut-downs, before vaccines were available. It is not surprising that many patients preferred telehealth services when many likely deemed in-person services unsafe to attend. The data can't be considered generalizable to other time periods because the nature of the pandemic and people's attitudes have changed over time. In order to have a more accurate assessment of overall patient preferences, additional data are needed now that vaccines are available, the numbers of hospitalizations and deaths are decreased, and masks are not required for all in-person visits. In addition, longer-term data are needed regarding patient preferences in order to collect data that are more generalizable to a future where COVID is considered endemic rather than a pandemic.	Noted. Agree that there are limitations to the evidence and the timing of when the data was collected. Point added to discussion:" Most studies were conducted when in person care was considered unsafe, and need to be further evaluated in non-pandemic conditions."
Public Reviewer #3 **Nina Zeldes** **National Center for Health Research**	Results	There are also limitations to the data on telehealth for IPV services. For example, many of the studies cited on IPV services were specifically studying women receiving treatment for substance use disorder. In one study, all participants were pregnant women who were patients at an academic health center. Results from these non-representative study samples cannot be generalized to all women. Other study limitations include the inconsistencies in study design and outcome measures, and the modest evidence that telehealth interventions for IPV are as effective as in-person interventions. Given these limitations and the fact that there is insufficient evidence comparing the benefits of telehealth interventions to in-person screening for IPV, we agree with the recommendations of a number of organizations (such as the World Health Organization) that telehealth interventions should not replace traditional screening for IPV, but rather should be used to augment traditional screening services.	Noted. Text added to discussion: ". Many of the IPV studies were conducted in specific study populations such as women receiving treatment for substance abuse, or women attending an academic health center." …"Results from these select study samples cannot be generalized to all women. More research is needed to identify the disadvantages telehealth may pose in effectively delivering preventive services to specific underserved populations and whether telehealth interventions should augment or replace traditional screening services."

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Public Reviewer #3 **Nina Zeldes** **National Center for Health Research**	Results	Some differences have been observed regarding demographic differences in the utilization of telehealth services, while some remain to be explored. There are a variety of demographics that need to be assessed, such as geographic locations, ethnicity, age, and socioeconomic status. Understanding the reasons for any observed differences is necessary to assess how different groups benefit from or are disadvantaged by telehealth services. Until that is determined, it will be difficult to reduce disparities in usage and possibly in benefits.	Agree. Added to limitations table under outcomes: "Demographic differences in utilization of telehealth services; how different groups may benefit from or are disadvantaged by telehealth services."
Public Reviewer #3 **Nina Zeldes** **National Center for Health Research**	Results	Overall, the limitations of the data cited undermine the credibility of the report's claims about effectiveness, use, and patient preferences. A major shortcoming is the low number of RCTs that compare telehealth to in-person services. While the report notes the gaps in the evidence and that more research is needed, it is not explicit enough about the shortcomings of the data available. The report needs to discuss the data limitations more explicitly in all sections.	Details added to discussion.
Peer Reviewer #1	Discussion and Conclusions	Conclusion should be stated more affirmatively. The wording indicates that there is not sufficient evidence to make a determination. It should be restated to explain that all studies showed that telehealth is equivalent to in person care but the studies themselves had low SOE.	Revised: "Limited evidence suggests that telehealth interventions for contraceptive care and IPV services result in equivalent clinical and patient-reported outcomes as in-person care. Uncertainty remains regarding the most effective approaches for delivering these services and how to best mobilize telehealth, particularly for women facing barriers to health care."
Peer Reviewer #1	Discussion and Conclusions	There should also be information about the discussion- for example the issue of privacy in an individual's home and mention of alternatives (like services in a private room within a clinic)	Noted. Added to discussion: "Surveys reflect how strategies to ensure safety and privacy when using virtual platforms for IPV interventions are critical."

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #2 (TEP)	Discussion and Conclusions	i worry that reports like this will prompt policy makers and leaders of healthcare systems and teams to discourage telehealth especially for women's health care delivery- but indeed they should not come to this conclusion with this report. Patient reported outcomes and provider burnout and relative satisfaction with the option of providing telehealth should be included or mentioned. Adherence to telehealth visits was indeed increased over in person visits with decreased no show rates. providers appreciated being able to conduct visits via telehealth for decreased experience of burnout. patients appreciate faster access times to a provider via telehealth.	We appreciate this perspective and have aimed to highlight the gaps in the evidence and emphasize the non-inferiority aspect of most studies in the review.
Peer Reviewer #2 (TEP)	Discussion and Conclusions	Instances like this when we do not have robust RCTs or robust studies that meet the high bar of an AHRQ review, we must consider perhaps some of the qualitative studies or results that were in studies that did not reach statistical significance to at least comment on - for future research, policy and clinical considerations- can you add more to the report regarding these things- i think that section is underdeveloped.	Point added to discussion: "However, observational studies also demonstrated that telehealth interventions generally resulted in similar outcomes as in person care. Importantly, for many studies that did not reach statistical significance, there was a signal that there were similar outcomes for both telehealth and in person groups." **Discussion section, limitations of the evidence base.**
Peer Reviewer #3	Discussion and Conclusions	Yes, next steps are clear, as summarized well in this sentence: "future research should include rigorous studies measuring the impact of telehealth on health equity, access to care, and evaluating the effectiveness and harms of telehealth for women's preventive services, including studies in diverse populations and rural settings"	Thank you.
Peer Reviewer #4 (TEP)	Discussion and Conclusions	Appreciate the discussion regarding the fact that a 'benefit' of telehealth may be that it is similar to standard inperson care and not necessarily 'better' as opposed to comparing it to no care (although future outcomes may be able to determine that the accessibility for individuals that would otherwise not seek care or could not access care)	Thank you.

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Peer Reviewer #5	Discussion and Conclusions	The discussion is generally excellent. Continuing with my theme of differentiating efficacy vs effectiveness, this is a good place to discuss in greater depth what can or cannot be inferred from the evidence on the impact of telehealth on reach/delivery of the preventive services. The discussion about access only addresses the provision of services to communities that don't have those in person services. It should be expanded to include the other ways telehealth increases access that I mentioned in the general comments. And the evidence gaps should highlight the need for studies that move beyond efficacy to understand effectiveness.	Noted. Point about access added to discussion: "Furthermore, telehealth may facilitate access to and utilization of essential preventive services for populations who forgo preventive care due to challenges with access, transportation, or distance to care." Discussion, implications for clinical and policy decisions section. For efficacy vs effectiveness, text added; "Future studies should move beyond efficacy to more clearly evaluate effectiveness of telehealth interventions and should include studies to assess whether telehealth platforms can increase the reach of services and improve effectiveness for communities." Discussion, limitations of evidence base section.
Peer Reviewer #5	Discussion and Conclusions	However, in the results, there is no mention as to whether the study samples were inclusive or if any conclusions could be drawn across various gender identities. I suspect that no studies reported on transgender, gender non-binary, or other gender identities. Maybe mentioning this in the results and in the evidence gaps would help.	Point added to discussion, limitations of evidence base section: "no other studies were specifically conducted in gender diverse populations, further limiting applicability.".
Peer Reviewer #6	Discussion and Conclusions	Pg 30, Line 6-55: This section could be more specific about the new results emerging from the review, highlighting findings that were not included in prior reviews. For example, the paragraph on decision aids could be better positioned within the results of the review. How do decision aids relate to, or potentially complement, interventions that were included in this review?	Noted. Discussion of telehealth application of decision aids expanded in this section.

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Peer Reviewer #6	Discussion and Conclusions	Pg 31, line 3-32: The discussion about implications of the comparison to usual care vs. no care at all stops short on specifying the implications, which is a missed opportunity. More could be said about potential impact of telehealth on access to and utilization of needed services.	Point added to discussion, implications for clinical and policy decisions section: “Furthermore, telehealth may facilitate access to and utilization of essential preventive services for populations who forgo preventive care due to challenges with access, transportation, or distance to care.”
Peer Reviewer #6	Discussion and Conclusions	Pg 33, line 11-15: Providing an example or two to illustrate the following limitation would help clarify its importance: “Evaluating the impact of interventions is less clear when patient outcomes are found to be similar with and without telehealth. However, some of the available trials demonstrated benefit in both groups, which is particularly challenging when outcomes are measured on scales with unclear clinical application.”	Additional text added for clarification to discussion, limitations of evidence base section: “However, some of the available trials demonstrated benefit in both groups, which is particularly challenging when outcomes are measured on scales with unclear clinical application, such as self-efficacy scores or safety behaviors, rather than as health outcomes.”
Peer Reviewer #7 (TEP)	Discussion and Conclusions	P. 26 Screening for IPV during the COVID-19 pandemic has presented many challenges. I think it is important to elaborate on this statement, what challenges and what potential benefits for survivors and providers – need to reference evidence for the statement related to challenges – see a couple of useful references attached. I also think including some specific recommendations as in the Jama article in the discussion would be useful for those reading to think about clinical practice but also implementation science and further testing of technology facilitated screening and response interventions. I think focusing on prevention, primary, secondary and tertiary prevention is important for these interventions, as noted above the iCAn and iDecide studies would be tertiary prevention, safety planning for women who have disclosed IPV to providers.	Noted. Text added to discussion, key findings and strength of evidence section: “strategies to ensure safety and privacy when using virtual platforms for IPV interventions are critical.” We are careful not to over interpret the limited evidence available, especially in light of the limited applicability of some of the IPV studies conducted in specific populations.
Peer Reviewer #7 (TEP)	Discussion and Conclusions	Significantly more attention is needed on the challenges of maintaining technology facilitated interventions for reproductive health and IPV, ever developing technology, evolving operating systems, resources for referrals to local and national services, and costs of maintain and updating software and hardware as technology changes.	Noted. Future research needs described in discussion.

Source: https://effectivehealthcare.ahrq.gov/products/telehealth-women/research
Published Online: June 16, 2022

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #7 (TEP)	Discussion and Conclusions	I think in the discussion it is critically important to state/re-state that at least in the context of iCan and iDecide and the previous studies by Glass and Koziol-McLain – the technology facilitated interventions are not to replace advocacy/clinical services and skilled providers but to provide an evidence-based tool to support survivors and clinicians in delivery of trauma informed care to IPV survivors.	Text added to discussion, findings in relation to what is already known section: “Importantly, these decision aids provided an evidence-based tool to support survivors and clinicians to deliver trauma informed care to IPV survivors.”
Peer Reviewer #7 (TEP)	Discussion and Conclusions	I would review the iCan study, there was a focus on rural areas, although challenging to recruit. Important that technology-facilitated interventions in the case of iCan, (Glass and Koziol-McLain) had national research areas with multiple states that recruited from non-traditional sources, like Craigslist (this was 2015)– so these are not women survivors that are necessarily already accessing IPV services, important distinction from the typical clinical research with survivors.	Noted. Text added to discussion, key findings and strength of evidence section: ”In addition, most studies of IPV interventions were conducted outside clinical settings or practices, but are feasible for implementation within clinical practice.” Two related studies were added to the report per suggestion. They include additional outcomes of repeat IPV, for which there is now evidence (SOE) – KQ 2a detailed synthesis and corresponding evidence tables in text and appendix. One was captured in the original search but was initially excluded for being the wrong intervention. With additional input from this reviewer (who is one of the study authors) clarification on the intervention details was provided to justify inclusion based on further understanding of the intervention.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #7 (TEP)	Discussion and Conclusions	More emphasis on future research related to implementation science, use of social media for dissemination of resources, engaging diverse and underserved populations in intervention design and implementation (human centered design), challenges in restricting access to technology to specific clinics/settings – so expanding to community based samples, etc.	Noted. Social media engagement is outside the scope of this review. Comment added to discussion: "Future research related to implementation of telehealth should engage diverse and underserved populations to better understand challenges with access to technology in specific settings."
Peer Reviewer #7 (TEP)	Discussion and Conclusions	Importance of outcomes – one use of a intervention (safety planning) will likely not reduce IPV but could increase awareness of risk for severe violence, available resources and importance of tailored safety plan to prepare for danger for self and children. Outcomes focused on use and helpfulness of safety behaviors, decreased risk of future violence, etc. I think we (myself in the field of IPV) have made a mistake with outcomes of depression and PTSD related to use of technology-facilitated intervention, the intervention is part of the pathway (increased safety) to reduced IPV, improved mental health, etc. but so many other intersectional challenges, housing, poverty, transportation, access to care, stigma, racism, etc. We need to be realistic about what a technology facilitated intervention can achieve and thus advocate for this area of research to be imbedded in the larger structure and comprehensive approach to increasing safety and prevention of violence. (I am stepping down from my soap box now).	We appreciate the perspective and have added to the discussion: "…strategies to ensure safety and privacy when using virtual platforms for IPV interventions are critical."
Public Reviewer #2 **Anonymous**	Discussion	Again, insufficient understanding that research into telehealth and ehealth has mostly only been conducted on willing participants. Whereas research that asks a broad cross-section of patients how they feel about ehealth tends to produce negative results. This is reflected in public anger in Britain, Australia and other countries when patients found out ehealth was being forced on them without their consent. It is also possibly reflected in the dramatic decline in patients seeking healthcare at the start of the pandemic when doctors moved wholesale to telehealth consults. Patients boycotted.	Limitations noted in discussion: "Patients included in these surveys may also represent those who self-selected into a group willing to receive services via telehealth".
Public Reviewer #2 **Anonymous**	Conclusion	Bit short? And ignores unrepresentativeness of sample who participate in telehealth studies. Patients who recoil in horror at the thought are not included in those studies, so harms would be dramatically under-reported. Can I suggest more research which simply asks patients how they feel about telehealth, if it would affect their trust etc, rather than limiting questions to patients who are prepared to engage in it? Ask the rest of us too.	Noted. Addressed in discussion: "Patients included in these surveys may also represent those who self-selected into a group willing to receive services via telehealth"

Commentator & Affiliation	Section	Comment	Response
Public Reviewer #2 **Anonymous**	References	Consider looking at the research from when Australia was introducing the PCEHR/MHR system, on how people felt about it, if they were prepared to have a record or were going to opt out etc. It was somewhere in the mid-30s that were saying hell no in those studies, and the system crashed on the first day of the opt-out period. That's ehealth, but telehealth and ehealth are the same thing in many patients' minds.	Noted.
Peer Reviewer #2 (TEP)	General	In general this is an good report, even though it does not bring to light any new evidence - The challenge to practicing clinicians right now is that we are struggling with how best to move beyond the pandemic with telehealth care continuing - as a supported method of care delivery for more than just what has been studied in the past- contraceptive continuation. Many clinicians and patients want telehealth access for a wide range of clinical and preventive services- including women's health services beyond just family planning. It is unfortuate that AHRQ must continue with RCT as gold standards for reporting the "highest level of evidence".	Noted. See methods in PICOTS table; we included NRCTs when evidence from RCTs was unavailable. Per methods: “Studies were reviewed and highlighted using a hierarchy-of-evidence approach, where the best evidence is the focus of the synthesis for each key question. RCTs were prioritized and studies with lower risk of bias ratings were given more weight in our synthesis for each clinical indication and outcome.”
Peer Reviewer #3	General	Thank you for the opportunity to review this rigorous review of telehealth in the context of women’s health. The report is organized well. The key questions are clear and the report is clinically meaningful.	Thank you.

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Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #3	General	I don't think contraceptive care and IPV represent the full range "women's preventive services." I guess if you looked for more studies and didn't identify any that met criteria, then you can say that's all that exists in this realm, but on the flip side, contraception and IPV do not represent the broad kind of care women's preventive services could include (such as cancer screening, HIV screening, mental health screening, bone density scans, obesity prevention, breastfeeding services, and more). As you note in future needs, more is needed on family planning and STI counseling, too. The list on the WPSI website referred to (https://urldefense.com/v3/__https://www.womenspreventivehealth.org/about/__;!!Mi0JBg!bQUyDoDmKRiOUN-jcwfeoUjwpRDUmz7LbUyPFvGz7wzOStUhODwDu9hHIoKW_gY$) is much more inclusive than what ends up in this review. Somehow the title needs to be squared with the findings – right now it reflects what was looked for, but not what was ultimately reviewed and evaluated.	Additional context added to methods section: "These services are particularly amenable to telehealth interventions and may have been affected by limited in-person care early in the pandemic." The WPSI already covers a broad range of services. These services were considered because they may have been delivered via TH previously or may have fallen off as a result of the pandemic. Others (cancer screening, HIV screening) are not currently feasible for TH delivery.
Peer Reviewer #4 (TEP)	General	The report is clinically meaningful and the target population and audience well defined. Contraceptive care and what it consists of is not well defined early in the report while IPV is (like in the executive summary).	Thank you. Details added to ES to clearly define contraceptive care.
Peer Reviewer #5	General	Overall, I think this is an excellent report that will help to inform and guide care as well as research for reproductive health and IPV. The target population, audience, and interventions are well described. For the most part the results and the evidence gaps are clear and understandable. I think the key questions are appropriate and explicitly stated.	Thank you.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #7 (TEP)	General	I think the exclusion of the two first studies to examine technology facilitated safety decisions and planning with survivors (national US sample and national NZ sample) is problematic as the review includes two later studies that are examining the same intervention, slightly adapted to context. The lack of discussion of the diversity (race, ethnic, orientation, identity) of the populations in included studies is problematic.	The report has been revised to include the 2 suggested studies. Additional recognition of diversity issue also added to discussion: "Statistically significant differences in depression scores were reported in one study of an IPV intervention that included a subanalysis of intervention effectiveness in an indigenous population, signaling the potential for technology to help meet the needs of stigmatized or vulnerable populations. One study included patients who identified as having non-male partners, but no other studies were specifically conducted in gender diverse populations, further limiting applicability. More research is needed to identify the disadvantages telehealth may pose in effectively delivering preventive services to specific underserved populations."

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #5	General	I have one over-arching concern/comment that I will explain further in the below sections. My concern is whether SR is more reporting on efficacy vs effectiveness findings. It is labelled throughout as being about effectiveness, which I think is ultimately what we want to know about when thinking about care delivery. However, I would argue that the findings are more about efficacy. One potential major benefit of telehealth is the ability to reach people with a preventive service that they would not otherwise receive. This is particularly important and unique for reproductive health and IPV, both under-utilized and under-delivered preventive services. Telehealth could increase delivery of these services through several mechanisms: (1) allow people to access care in places it is not available, (2) let people know that these are services available and that they should get (many women may not know their clinician can help with these services and may not expect them with routine in person care), and (3) provide a potentially more comfortable or easier delivery mechanism (some women may not be comfortable or able to talk about these in person, but could through synchronous or asynchronous telehealth OR some women may not be able to take time to do this in person, but could through telehealth). To me, effectiveness is a product of the efficacy (outcomes of in person vs telehealth interventions) and the reach (proportion of eligible participants receiving the intervention if in person vs telehealth). The ideal study designs for effectiveness would be practice of system level interventions. It seems the studies presented in the SR are largely efficacy studies with some cohort studies on preference, acceptance, and use of services. Two approaches to address the issue of efficacy vs effectiveness would be to change the term effectiveness to efficacy throughout. The other option (which I assume you prefer) is to be more explicit throughout about efficacy and effectiveness, call out what data we have and don't have, and be clearer in the discussion about the limitations we have on understanding effectiveness and what would be needed to make stronger effectiveness conclusions. (I will share that I read this as a positive that telehealth seems to have a similar efficacy, with the SOE limitations appropriately raised, but we need more studies and data to know whether telehealth platform can increase the reach of services and improve effectiveness for communities.)	We appreciate the perspective on efficacy versus effectiveness. However we cannot change terminology throughout the report. Many of the observational and cross-sectional studies do evaluate the performance of interventions in real world conditions (effectiveness) rather than under ideal and controlled circumstances (efficacy). However, we understand the tension between these two issues and view them on a continuum, especially in the context of the relatively newer adoption of telehealth interventions during a pandemic. Point added to discussion: "Future studies should move beyond efficacy to more clearly evaluate effectiveness of telehealth interventions and should include studies to assess whether telehealth platforms can increase the reach of services and improve effectiveness for communities."

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #6	General	The key questions could be clearer if the "two overarching questions" (pg 3, line 13) were actually stated as questions—that is, one about reproductive health and one about IPV. Currently, there are no overarching questions indicated. Instead, the authors list the two topics (reproductive health and IPV) and then list the same six sub-questions beneath each. Stating two over-arching questions followed by the sub-questions to be explored for each overarching question could be more reader-friendly.	Language changed for clarity: "The review is defined by six sub-questions that address two overarching preventive health services," methods, scope and key questions section.
Public Reviewer #1 **Sherrie Truitt**	General	Talking about preventative services as in domestic violence screening, counseling for STIs and contraceptives might work via telehealth, but as an ADDITION to in-person care, not as a default replacement for in-person care. This will do nothing to serve women who need in-person care like testing, and exams. This is offering table scraps instead of a meal at the table. Many undeserved do not seek care due to finances or accessibility issues like environmental illnesses that preclude us from getting access into the building in the first place. Fix the barriers you have first then move on to supplemental through Telehealth.	We recognize these limitations. Agree that future research should consider different comparisons.
Public Reviewer #2 **Anonymous**	General	Inadequate discussion of the fact that this only relates to the benefits and harms of willing participants. When there is a very real risk of doctors and politicians forcing telehealth on patients (at least here in Australia), there needs to be more research into how the broader population base feel about telehealth, not just research into people who willingly sign up to a telehealth study. They are not a representative sample.	Issue now addressed. Text added: "Patients included in these surveys may also represent those who self-selected into a group willing to receive services via telehealth," to the discussion, applicability section.