**Supplementary Materials**

Supplementary Table 1. Demographic information of patient cohort.

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| Patient # | Sex | Age | Marital Status | Living Situation | Employment Status | Income | HighestEducation | Regular HCP/Family physician | Symptom Onset Location | Time since diagnosis | Co-Morbidities |
| 1 | M | 78 | Married | PurchasedHouse | Retired | $30,000-$60,000 | High School | Yes | Upper Limb | >2 years | CAD, CHF, OSA |
| 2 | F | 77 | Married | PurchasedHouse | Retired | Unknown | High School | Yes | Upper Limb | Unknown | Migraine, Atrial Fibrillation |
| 3 | M | 61 | Married | PurchasedHouse | Employed | $90,000-$120,000 | University | Yes | Bulbar | 1-2 years | Chronic Pain, Depression, OSA |
| 4 | M | 76 | Married | PurchasedHouse | Retired | >$150,000 | High School | Yes | Upper Limb | 1-2 years |  |
| 5 | M | 64 | Married | PurchasedHouse | Retired | $30,000-$60,000 | High School | Yes | Lower Limb | 1-2 years | Depression, Anxiety,  |
| 6 | M | 67 | Married | PurchasedHouse | Retired | $60,000-$90,000 | High School | Yes | Bulbar | >2 years |  |
| 7\* | M | 74 | Married | PurchasedHouse | Retired | >$150,000 | High School | Yes | Bulbar | 1-2 years | Skin Cancer, Gout |
| 8 | M | 52 | Married | PurchasedHouse | Retired | $60,000-$90,000 | High School | Yes | Lower Limb | 6mo-1 year | Chronic Pain, Depression, Anxiety, OSA |
| 9 | M | 37 | Married | RentalHouse | Disabled | $30,000-$60,000 | CommunityCollege | Yes | Lower Limb | >2 years | Chronic Pain, Depression, Diabetes |
| 10 | M | 63 | Married | PurchasedHouse | Disabled | $60,000-$90,000 | Community College | Yes | Upper Limb | >2 years | Chronic Pain, Depression |
| 11 | F | 76 | Married | PurchasedHouse | Retired | $60,000-$90,000 | High School | Yes | Lower Limb | < 6mo |  |

HCP: healthcare provider, CAD: coronary artery disease, CHF: congestive heart failure, OSA: obstructive sleep apnea, \* Patient 7 passed away prior to completion of the 6-month follow-up visit

Supplementary Table 2. Visit and travel information summary.

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| Patient #  | # of Total Visits | Virtual % of Total Visits | One-way travel distance (home to clinic) | Estimated one-way travel time (home to clinic)\* | Estimated travel time per in-person clinic visit | Estimated travel time saved by virtual visits† |
| 1 | 2 | 50% | 44.1KM | 35 m | 1h10m | 1h10m |
| 2 | 2 | 100% | 90.9KM | 58 m | 1h54m | 3h52m |
| 3 | 3 | 33.3% | 15.3KM | 18 m | 36m | 36m |
| 4 | 2 | 100% | 115KM | 1h15m | 2h30m | 5h |
| 5 | 2 | 100% | 36.9KM | 33m | 1h6m | 2h12m |
| 6 | 1 | 100% | 186KM | 1h51m | 3h42m | 3h42m |
| 7 | 3 | 100% | 83.1KM | 1h1m | 2h2m | 6h6m |
| 8 | 4 | 50% | 13.1KM | 18m | 36m | 1h12m |
| 9 | 2 | 50% | 99.8KM | 1h4m | 2h8m | 2h8m |
| 10 | 2 | 100% | 150KM | 1h29m | 2h58 m | 5h56m |
| 11 | 2 | 100% | 88.3KM | 1h5m | 2h10 m | 4h20m |
| **Mean (SD)** | **2.27 (0.79)** | **80.3% (28.4%)** | **83.8KM (54.4KM)** | **57m (29.1m)** | **1h54m (58.3m)** | **3h18m (1h57m)** |
| **Total** | **25** | **-** | **922.5KM** | **10h27m** | **20h54m** | **36h14m** |

H: hour, M: minute, \*Calculated using fastest route, usually 401; †, Calculated using round trip travel times multiplied by virtual visits

Supplementary Table 3. Advantages of incorporating virtual care in ALS multidisciplinary care.

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| 1. Multidisciplinary ALS Clinic care can be provided using VC modalities as demonstrated by us and others.2–5
2. Physical characteristics of patients with ALS (progressive physical disability, fatigue, equipment needs respiratory and mobility-related, associated challenges with accessible transportation) has the potential to make VC more applicable and impactful for this population.3–5
3. VC can address geographic barriers to accessing multidisciplinary ALS Clinic care for patients and families/caregivers living in rural, remote, and non-major urban communities.3,4
4. Patients and families/caregivers with ALS face financial challenges (e.g., loss of employment/income, out of pocket expenses for equipment, travel, renovations) and providing VC has the potential to offset some of these challenges.3,4,T1
5. Patients are often significantly affected by fatigue,3,5 and by limiting in-person visits to only, when necessary, VC can potentially improve the value and efficiency of in-person assessments, relieving unnecessary stress on patients.
6. VC could provide an option for timely check-ins with patients and families to support them during periods of specific issues or concerns (e.g., psychological distress/crises, assistance with transferring or personal care techniques, or feeding tube troubleshooting). T2
7. VC can potentially improve the efficiency of the multidisciplinary ALS Clinic staff and operations. T2,T3
8. Emerging data suggests that VC can reduce patient and healthcare costs associated with multidisciplinary ALS Clinic care. Using cost-sensitivity analysis, each tele-visit saved patients $997 USD (45% of estimated costs) when accounting for mode of travel, lodging, travel time, and missed work days, while also saving $325 USD to the institution (20% of estimated costs).T1
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VC: virtual care; 3-8,10: 1 The ALS care team includes a nurse, physiotherapist, occupational therapist, respiratory therapy (hospital and community-based providers), speech language pathologist, as well as physicians in neurology, palliative care, physiatry, and respirology. See References section list; T1 Paganoni S, van de Rijn M, Drake K, et al. Adjusted cost analysis of video televisits for the care of people with amyotrophic lateral sclerosis. Muscle Nerve. 2019;60(2):147-154.; T2: Capozzo R, Zoccolella S, Musio M, Barone R, Accogli M, Logroscino G. Telemedicine is a useful tool to deliver care to patients with Amyotrophic Lateral Sclerosis during COVID-19 pandemic: results from Southern Italy. Amyotroph Lateral Scler Front Degener. 2020;21(7-8):542-548; T3: Howard IM, Burgess K. Telehealth for Amyotrophic Lateral Sclerosis and Multiple Sclerosis. Phys Med Rehabil Clin N Am. 2021;32(2):239-251.