ORIGINAL RESEARCH

The Experience of Caregivers of Older Adults With Dementia in Using Telemedicine in a Primary Care Setting of Canada During COVID-19

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ABSTRACT

Background

Primary care is essential in dementia management, offering diagnosis, treatment, and support for people living with dementia (PLWD) and their caregivers. Telemedicine became a key advancement during the COVID-19 pandemic, offering crucial access to care. This study explores the pros and cons of telemedicine for dementia care during the pandemic to guide future improvements.

Methods

Data collection involved semi-structured interviews with caregivers recruited from a Montreal memory clinic and secondary analysis of two other studies related to dementia and telemedicine, focusing on the educational needs of patients and the impact of the pandemic on health-care services. Data analysis employed the framework method, combining inductive and deductive approaches to code the data and develop categories aligned with Chang's framework, providing insights into caregivers' experiences and the challenges and benefits of telemedicine.

Results

The study involved interviews with four caregivers of people with dementia, complemented by secondary analysis from two Canadian studies. Through framework analysis, four themes were developed: relationship and communication; the advantages and selective suitability of telemedicine (TM) in dementia care; preferences for in-person consultations; and the need to improve awareness and technical confidence in TM.

Conclusion

This study highlights the potential of telemedicine (TM) as an effective modality for dementia care, particularly during situations like the COVID-19 pandemic, but emphasizes that it cannot fully replace in-person consultations due to the enduring preference for face-to-face interactions.

Key words: COVID-19, telemedicine, primary care, dementia, virtual consultations

INTRODUCTION

The World Health Organization (WHO) recognizes primary health care as a crucial component in reducing the risk of cognitive impairment and dementia.(1) Primary care practitioners (PCPs) are often the first point of contact for people living with dementia (PLWD), enabling early identification and intervention, which are crucial for slowing the progression of the disease and improving quality of life.(2–4) The *Dementia Strategy for Canada* highlights the importance of PCPs as the first point of contact for assessing memory issues and detecting cognitive and behavioral changes.(5) Public policies in Canada have driven best practices, leading to better access to services, continuity of care, and improved quality of life for PLWD and their caregivers.(6) The *Québec Alzheimer Plan* exemplifies this by assigning primary care clinicians to manage PLWD in family medicine groups, with specialized care reserved for more complex cases.(7)

A recent advancement in primary care is the emergence of telemedicine. Telemedicine (TM) has shown to improve access to care in a primary care setting for older adults,(8) and there is consensus that TM could also benefit older adults with dementia.(9) Although the technology has been around for nearly two decades and used as an alternative way to access care, the COVID-19 pandemic sparked a surge in the use of telemedicine, as it was the only way to access care in many instances. In a retrospective analysis by Friedman *et al*., they examined 1,589,777 insurance claims in the United States of America, between January 1, 2018, and March 10, 2020

(pre-pandemic period), and March 11, 2020, and October 31, 2020 (pandemic period). This analysis showed a rapid expansion of telemedicine claims from a mean of 773 pre-pandemic to 45,632 during the pandemic.[10] Similar increases were also noticed in Canada, with virtual visits increasing significantly from 0.07 per 1,000 people per day pre-pandemic to 3.92 during the pandemic.[11]

There are several factors that impede the uptake of TM. Some of the challenges unique to older adults are the user interfaces (e.g., small text and widgets, poor color contrast, or menu bars with hidden interfaces),[12] age-related impairments in vision, and hearing and other complex health conditions in this age group.[13] The age-based digital divide is also significant; a study by Drake *et al*. found that baby boomers (ages 56 to 74) and older generations (75+) were less likely to use TM compared to millennials (ages 25 to 29), and preferred phone consultations over video calls.[14] These challenges are amplified in those with dementia as they face a decline in cognition. People with advanced dementia also often display pathological behaviors and depression, which may complicate clinical management in the advanced phases.[15]

Telemedicine is thus viewed both as a boon and a bane for older adults with dementia. TM, which was used as an adjunct to routine health care in the past, has been pushed into the mainstream primary care due to a crisis of medical necessity. As older adults with dementia adapt to this new normal, the lessons learned from COVID-19 and the experience of people who used the technology can help to shape and reshape the future application of TM for this population. The purpose of this study is to describe the advantages and disadvantages experienced by caregivers of older adults with dementia in using TM during COVID-19 that could improve remodeling of existing and potentially newly developing TM practice to better suit their needs.

METHODS

Conceptual Framework

To understand the contextual factors influencing the use of telemedicine in primary care, we used the comprehensive evaluation framework for telemedicine implementation proposed by Chang.[16] This framework, with three categories and six dimensions, offers a systematic approach to assessing telemedicine, covering both technical and non-technical aspects essential for successful implementation (see Figure 1).

Research Design

A qualitative descriptive approach, as defined by Sandelowski,[17] was used to provide a holistic portrayal of caregivers' experiences with telemedicine for older adults with dementia, grounded in the data and reflecting their perspectives. The reporting of the data adhered to the COREQ (COnsolidated criteria for REporting Qualitative research) Checklist.[18]

In this study, telemedicine, or teleconsultation refers to the use of synchronous communication methods, including video conferencing and telephone calls that facilitate real-time

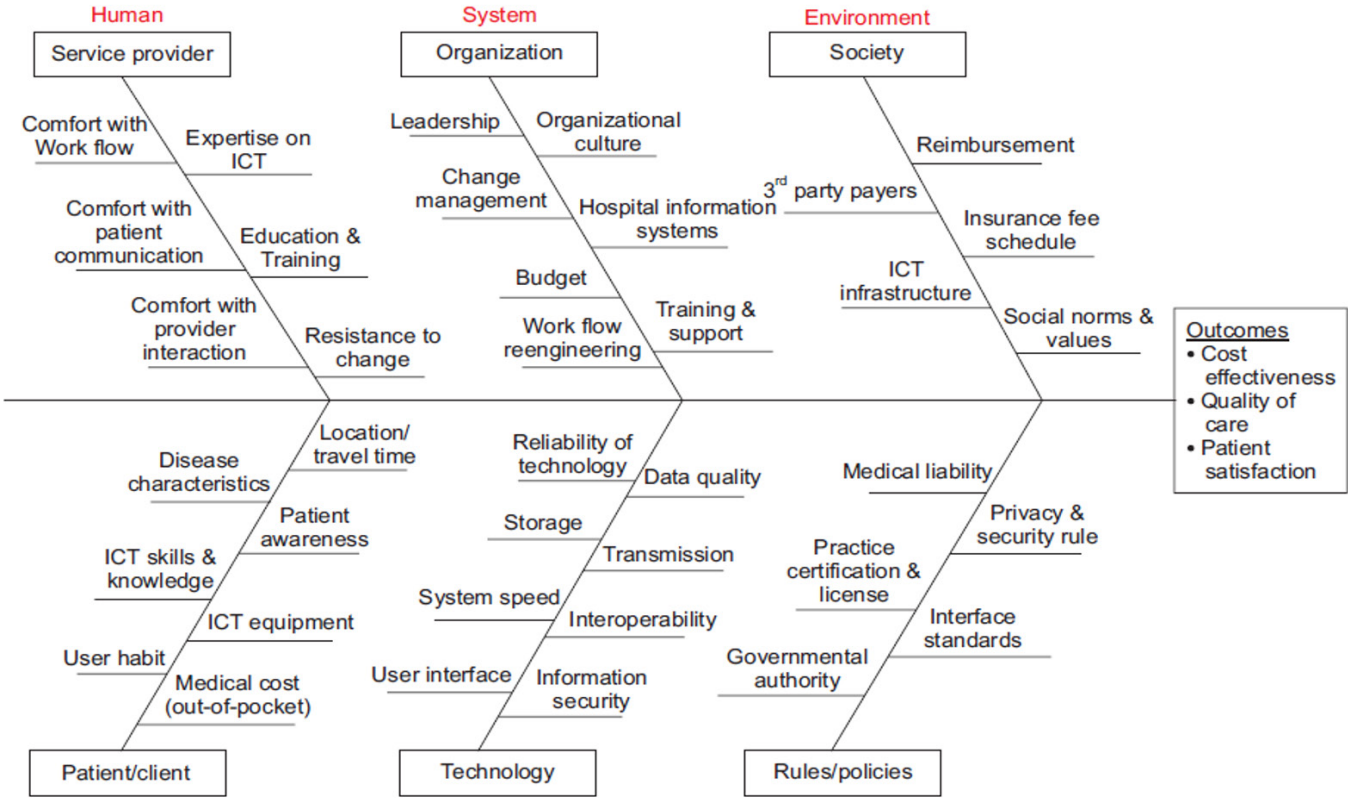

FIGURE 1. Fishbone diagram for a comprehensive evaluation framework for telemedicine implementation, adapted from Chang et al.[15]

consultations between caregivers of older adults with dementia and health-care providers.

Data Collection

The data collection process consisted of primary data collection through interviews with caregivers, and secondary analysis of two other data sources related to dementia and telemedicine.

Combining Different Data Sources

Combining primary data with secondary analysis of two additional sources offers several benefits. Though secondary analysis in qualitative research has been practiced since the 1990s, it lacks a unified approach. In 1994, Sally Thorne introduced five categories, two of which are relevant to our study.[19] First, "analytic expansion" explored unanticipated questions in additional data, deepening our understanding of telemedicine. Second, "cross-validation" compared themes across the three datasets to refine interpretations. Perry and O'Connor used a similar method in 2002, analyzing independent studies on women caregiving for husbands with Alzheimer's.[20]

Primary Data Collection: Interviews with Caregivers

Participants: Caregivers of adults with mild to moderate dementia (65+), who used teleconsultation with their family physician between March 2020 and March 2021, were purposively sampled and referred by a Montreal memory clinic.

Recruitment: The memory clinic identified eligible participants, and the research team contacted them to explain the study and obtain informed consent.

Data Collection Process: JK and MR conducted remote semi-structured interviews via phone or video to explore caregivers' telemedicine experiences. Interviews were audio-recorded, transcribed verbatim, and guided by an interview guide (see Appendix A). JK was a graduate student in family medicine at McGill University and MR was a research assistant at McGill University.

The study was approved by the Research Ethics Board of CIUSSS du Centre-Ouest-de-l'Île-de-Montréal.

Secondary Analysis of Other Data Sources

The primary data from interviews were enhanced by secondary analysis of two studies, focusing on qualitative data. The first analysis was from the study "Understanding the Educational and Resource Needs of Patients Living with Dementia, Their Caregivers, and Their Family Physicians," conducted in partnership with the Alzheimer Society of Canada (ASC), College of Family Physicians of Canada (CFPC), McGill University, and Baycrest Health Sciences (Note: a project title; findings available at https://link.springer.com/article/10.1186/s12875-025-02710-7). This study used data from the ASC-CFPC Survey, conducted from October 2020 to April 2021, which provided insights into caregiving during the COVID-19 pandemic.

The second analysis examined data from the study "Improving the Care of Older Adults Living with Dementia Across Canada During the COVID Pandemic: A Mixed Methods Study to Inform Policy and Practice" (an ongoing study; info available at: https://www.mcgill.ca/familymed/research/projects/research-organization-healthcare-services-alzheimers-rosa/activities-and-projects), which explored the pandemic's impact on health and social services from the perspectives of individuals with dementia and their caregivers. Interviews for this study were conducted between April 29 and October 31, 2022, in both English and French, with French interviews translated to English before analysis.

Data Analyses

Data were analyzed iteratively using the framework method developed by Richie and Spencer[21] and proposed by Gale *et al*. for applied health research.[22] Gale *et al*.'s method comprises seven distinct stages: transcription, data familiarization, coding, developing a collaborative analytical framework, applying the framework to all transcripts, charting data into a framework matrix, and interpreting the data to move from description to explanations of observed phenomena.

The framework method was enhanced by an inductive-deductive approach. JK and RZ initially coded the primary data inductively, refining the codebook through reviews and meetings. JK then applied this codebook deductively to the secondary data, with no new codes. The coded data were organized into categories based on Chang's framework,[16] such as classifying difficulties in provider connections as workflow reengineering. JK and RZ iteratively discussed categories and subthemes before finalizing themes.

RESULTS

A total of 13 caregivers of people with dementia were contacted for the primary data collection, out of which four consented to participate in the study. The rest of the potential participants either had an elder who progressed to advanced dementia or were not available for the interview. The interviews lasted between 25 minutes and 65 minutes.

Demographic Details of Participants in Primary Data Collection

The demographic details of the participants in the primary data are outlined in Table 1. The average age of the caregivers was 76. All the caregivers who participated in the study were female and had university-level degrees.

Demographic Details of Participants from Other Data Sources

The CFPC-ASC data source included two surveys: one capturing the perspectives of people living with dementia (PLWD) and another reflecting caregiver experiences. The CFPC-ASC Survey gathered 489 responses from caregivers about their experiences, 228 responses from caregivers on behalf of PLWD, and 78 responses directly from PLWD. Participants were from various provinces and territories, including Alberta, British Columbia, Nova Scotia, Ontario,

Manitoba, Newfoundland, Quebec, Saskatchewan, Nunavut, and Yukon. They answered 33 questions, with three specifically addressing virtual consultations. For the secondary analysis, only qualitative responses from caregivers related to their knowledge and experience with virtual consultations were included. This analysis encompassed 717 responses from caregivers, with the demographic breakdown provided in Table 2.

In the 'Improving Care Study', out of all the interviews, 16 participants from Quebec mentioned virtual consultations and the qualitative part of their responses were included in the secondary analysis. Table 3 outlines their age and gender.

Themes, Subthemes, & Chang's Categories

Through the framework analysis, a total of four themes and 10 sub-themes were developed. These were documented in a data framework matrix, which is presented in Table 4 along with illustrative interview excerpts. Additionally, Table 4 demonstrates how each theme corresponds to Chang's categories, determinants, and dimensions. These themes are described below.

1. Relationship and Communication: Communication is a vital component of telemedicine experience. Caregivers who had a good rapport with the providers had a better experience and felt more comfortable with telemedicine.

> "Family doctor has taken the time to speak via phone directly with me and address my concerns regarding my loved one's health." (50-59F, caregiver, CFPC ASC Survey)

Telemedicine meant new way of doing things and new processes. Gaps in processes were perceived as poor communication.

> "I called to see what the results were, and they said they will call back, but they didn't. So I didn't get any results back." (76F, caregiver, primary study)

While many providers offered telephone calls, video calls were preferred for continuity of care as they were more personal. Caregivers shared how certain examinations for people with dementia depended on the video interface and could not be achieved through a phone call.

> "I prefer video because.. doctor...could see him then..The other doctor was just a phone call... So I think I think the video was more helpful." (76F, caregiver, primary study)

2. Selective Suitability and Advantages of TM in Dementia Care: Telemedicine proved to be advantageous during the

TABLE 1.
Demographic details of caregivers in primary data collection

Participant No.	*Age*	*Sex*	*Education*
1	73	Female	Masters
2	78	Female	Bachelors
3	76	Female	Masters
4	77	Female	Bachelors

TABLE 2.
Demographic details of caregivers from CFPC-ASC Survey

Age				*Gender*			
Caregiver Survey		*Caregiver Completing Survey on Behalf of PLWD*		*Caregiver Survey*		*Caregivers Completing Survey on Behalf of PLWD*	
30 - 39	19			Female	296	Female	49
40 - 49	40			Male	72	Male	41
50 - 59	96	45 - 59	5	Other	1		
60 - 69	105	60 - 69	7	Prefer not to say	2		
70 - 79	72	70 - 79	32				
80 - 84	16	80 - 84	17				
85 or older	19	85 or older	28				
Under 30	4	Under 45	1				
No data	118	No data	138	No data	118	No data	138
Totals	489		228		489		228

TABLE 3.
Demographic details of caregivers from Improving Care Study

Participant #	*Age*	*Gender*
1	62	Woman
2	59	Woman
3	58	Woman
4	49	Woman
5	66	Woman
6	66	Woman
7	59	Woman
8	54	Woman
9	56	Man
10	63	Man
11	76	Woman
12	76	Woman
13	73	Man
14	66	Woman
15	73	Woman
16	49	Woman

COVID-19 pandemic in improving the access to care. Amidst travel restrictions and lockdowns, telemedicine helped people with dementia to continue care.

> "It's (Telemedicine) been extremely helpful, and...save time, and allowed me to discuss my issues without having to wait weeks for an appointment in person." (78F, caregiver, primary study)

Similarly simple screening procedures and prescription refills were able to be completed through telemedicine. However, TM was not sufficient or suitable to meet the complex care which people with dementia needed occasionally.

> "..the questionnaire that they do for dementia.. you only can do half of it on the phone.. The (other) half of it is sort of writing, drawing figures and writing a sentence... and so that doesn't get done on the phone... and of course he doesn't take his blood pressure, doesn't see how he how we looks.." (77F, caregiver, primary study)

Additionally, people with dementia have cognitive challenges which limit their ability to use technology. This often results in relying on caregivers to operate TM and obtain care.

> "I'm quite technical, I mean. I I think I can figure things out now (but) my husband would not be able to do that... if I wasn't with him...". (76F, caregiver, primary study)

3. Telemedicine Limitation and In-Person Consultation Preferences: People generally prefer direct communication with providers and in person consultations. Caregivers especially appreciate being able to connect with providers, and find it challenging when that connection is not established.

> "We didn't have access to the doctor... the professional was difficult to reach...". (73F, caregiver, improving care study)

Despite the advantages with remote consultations that people experienced during the pandemic, they continue to embrace in-person consultation and would prefer it as the mainstream.

> "It's the missing part that happens when you go to a doctor like if I.. have a doctor's appointment, I go in. She takes my blood pressure...They all listen to my chest because I usually have something wrong with my chest.... and then you have the conversation. and with my husband (patient) there was again like blood pressure, Stand up, walk.. it's all kinds of stuff... When you go (in person) there's a physical part of it." (77F, caregiver, primary study)

4. Bridging the Awareness and Technical Confidence in TM: Telemedicine was not a new concept to the caregivers. They were acquainted with the topic and often imagined it as an option for care only in remote settings. However, the COVID-19 pandemic allowed them to use telemedicine.

> "I was aware of them (Telemedicine). But I wasn't really.. used as much, certainly before the pandemic." (78F, caregiver, primary study)

With regard to the technology itself, the caregivers did not experience any difficulty in using the technology. There were no concerns of information security. Bridging this awareness and technical confidence in TM with the above-stated adaptations could help benefit the implementation of TM.

> "I really don't worry about the confidentiality bit at all." (77F, caregiver, primary study)

DISCUSSION

This study explores the experiences of caregivers of older adults with dementia using telemedicine in Canadian primary care during the COVID-19 pandemic. A key factor influencing caregivers' experiences was a prior established relationship with the health care provider and their communication skills. Clear and effective communication helped caregivers feel more confident and supported, while gaps during the adaptation phase led to frustration. Scholars emphasize the importance of "webside manners" in telemedicine, as they can reduce anxiety and enhance rapport through empathic communication.[23-27] Reducing anxiety is essential for patient satisfaction and perceived medical care value, requiring empathetic communication to alleviate patients' and families' concerns.[23]

An essential aspect of "webside manner" is video conferencing, which caregivers valued for allowing them to express concerns clearly and receive thorough assessments. For the caregivers, being able to see the health care provider

TABLE 4 (part 1 of 2).
Data framework matrix along with illustrative excerpt

Themes	*Subthemes*	*Chang's Dimensions*	*Chang's Determinants*	*Chang's Categories*	*Illustrative Excerpt*
Relationship and communication	Strong communication skills and relationship with health care provider improves TM experience	Human Dimensions	Health Care Providers	Comfort with provider interaction	"Family doctor has taken the time to speak via phone directly with me and address my concerns regarding my loved one's health -- not only with my loved one." (50-59F, caregiver, CFPC ASC Survey)
					"He (Doctor) has a very thick Persian accent. So yes, we we have to ask, "I am Sorry? Sorry?" But he's very sweet." (77F, caregiver, primary study)
	Gaps in processes were perceived as poor communication.	System Dimension	Organization	Change management	"I called to to see what the results were, and they said they will call back, but they didn't. So I didn't get any any results back. Nobody called back to say there was no problem with with it." (76F, caregiver, primary study)
	Video based TM is preferred over phone call for continuity, examination and personal connect	Human Dimensions	Patients & Caregivers	Disease characteristics	"I prefer video because.. doctor..could see him then. And sometimes she also asked him to walk so she could look at how he was walking...The other doctor was just a phone call... So I think I think the video was more helpful" (76F, caregiver, primary study)
		System Dimension	Technology	User interface	"I found for my husband in particular to be able to see the physician who he actually never remembers... it gives much more continuity and is more personal.. instead of just hearing a voice.." (78F, caregiver, primary study)
Selective Suitability and Advantages of TM in Dementia Care	TM is not sufficient for certain aspects of dementia care like physical examination or cognitive screening tests. But TM is sufficient for prescription refills and simple screening procedures.	Human Dimensions	Patients & Caregivers	Disease characteristics	"Well, you know the.. questionnaire that they do for dementia.. you only can do half of it on the phone.. The (other) half of it is sort of writing, drawing figures and writing a sentence... and so that doesn't get done on the phone... and of course he doesn't take his blood pressure, doesn't see how he how we looks.." (77F, caregiver, primary study)
					"I remember, with the dermatologist...I was concerned about some sort of mark in my husband's face because he had melanoma in the past, and .. he was able to put face up very close to the .. video camera, and she was able to look. And she said... there's no problem there, and ..was able to evaluate it over video, which really was great, very helpful" (78F, caregiver, primary study)
					"It (TM) was okay. But I would far rather they had him up on a table and took his blood pressure once in a while and listen to his heart" (76F, caregiver, improving care study)
	People with dementia would require the support of caregivers or care providers to operate TM	Human Dimensions	Patients & Caregivers	Technology skills and knowledge	"I'm quite technical.. (but) my husband would not be able to do that..if I wasn't with him... so it would have to be a phone call, and even that he might have difficulty picking it up on his phone. " (76F, caregiver, primary study)

TABLE 4 (part 2 of 2).
Data framework matrix along with illustrative excerpt

Themes	*Subthemes*	*Chang's Dimensions*	*Chang's Determinants*	*Chang's Categories*	*Illustrative Excerpt*
Selective Suitability and Advantages of TM in Dementia Care	TM saves times, mobility and exposure to infections	Human Dimensions	Patients & Caregivers	Location/travel time	"It (teleconsultation) was certainly easier than trying to organize,... getting him there.. He has mobility issues and so getting him even from the car to the office involved stairs. So, yeah, the phone call was certainly helpful." (73F, caregiver, primary study) "It's (Telemedicine) been extremely helpful, and...save time, and allowed me to discuss my issues without having to wait weeks for an appointment in person" – (78F, caregiver, primary study)
Telemedicine limitation and in-person consultation preferences	In person consultation is still preferred as mainstream	Human Dimensions	Patients & Caregivers	User Habit	"It's the missing part that happens when you go to a doctor like if I.. have a doctor's appointment, I go in. She takes my blood pressure...They all listen to my chest because I usually have something wrong with my chest.... and then you have the conversation. and with my husband (patient) there was again like blood pressure, Stand up, walk.. it's all kinds of stuff... When you go (in person) there's a physical part of it" (77F, caregiver, primary study)
	Physician assistants were easier to reach than physicians. Would prefer to reach physicians directly.	System Dimension	Organization	Workflow reengineering	"The fact that I can text his assistant and feel heard is wonderful. That's the connection that is really absolutely important and wonderful for me, because I really do feel that I get to tell him." (77F, caregiver, primary study) "We didn't have access to the doctor, we didn't have it. You really had to put your foot down and then say no no no, that was difficult. But she had the care. But the professional was difficult to reach, the doctor, especially the doctor, was difficult to reach." (73F, caregiver, improving care study)
Bridging the awareness and technical confidence in TM	Caregivers of PLWD were aware of TM before the pandemic but never really used it	Human Dimensions	Patients & Caregivers	Patient Awareness	"I was aware of them (Telemedicine). But I wasn't really, you know, used as much, certainly before the pandemic" (78F, caregiver, primary study)
	People had technical confidence in TM	System Dimension	Technology	Reliability of technology	"I'm quite technical, I mean. I I think I can figure things out now" (76F, caregiver, primary study)
		System Dimension	Technology	Information security	"I really don't worry about the confidentiality bit at all." (77F, caregiver, primary study)

during consultations made interactions feel more personal and reassuring. Video-based interactions enhance interpersonal communication by incorporating more than just words; they also involve tone of voice, facial expressions, body language, and the ability to accurately read and respond to others' emotions.[23,27-28] Notably, caregivers in our study expressed comfort with the technology, indicating that familiarity with video-based tools was not a limiting factor for effective consultations.

Caregivers also acknowledged the convenience and time-saving benefits of telemedicine, as remote consultations reduced the stress associated with in-person visits, which can be particularly challenging for PLWD. This convenience aligns with other research showing that telemedicine can alleviate logistical challenges and improve access to care.[29]

While caregivers acknowledged the benefits of telemedicine, they also observed its limitations, especially where physical examinations are required. Telemedicine excels in providing convenience and facilitating communication for routine consultations, but it falls short when it comes to the need for hands-on evaluations that are often crucial in dementia care. Certain symptoms or changes may require direct observation by health-care professionals, and comprehensive assessments of physical and cognitive health can be challenging remotely. This limitation of telemedicine is well-documented.[28,30-31] There remains a strong preference for in-person consultations, underscoring the importance of personal connection in dementia care, which can be difficult to replicate virtually. This suggests a need for a hybrid care model integrating telemedicine and in-person visits based on patient-specific needs, aligning with the recognition of hybrid service delivery in primary care.[30-31]

People are increasingly familiar with using technology, extending to telemedicine, where caregivers expressed minimal concern about privacy breaches. This finding aligns with observations from researchers in Los Angeles, who noted similar comfort levels among telemedicine users.[32] The pandemic has heightened awareness and acceptance of telemedicine, presenting opportunities for its broader application in primary care. Additionally, as future generations of elderly patients are likely to be more comfortable with technology, this trend may further facilitate telemedicine's acceptance in health care.

The study's strengths include its holistic approach, combining primary data collection through interviews with secondary data analysis, allowing for a thorough exploration of caregivers' experiences. Established frameworks, such as Sandelowski's qualitative description, Gale's framework method, and Chang's evaluation framework for telemedicine implementation, further enriched the analysis, providing a solid foundation for data analysis.

However, the study faced limitations. Despite multiple attempts, only a small number of individuals consented to participate, all of who were female and university graduates, limiting diversity. Additionally, many caregivers were managing loved ones whose dementia had progressed to an advanced stage, leading to their exclusion based on the study's focus on patients with mild-to-moderate dementia. Recall bias may also have affected the accuracy of recollections, as interviews were conducted in 2022/23, reflecting on experiences from 2020/21. Finally, participants were recruited from a tertiary care memory clinic, which may have made it difficult to distinguish between their telemedicine experiences in primary care and specialized settings. To address these limitations, secondary data analysis was conducted, drawing insights from a more diverse geographic range across Quebec and Ontario. Notably, no new codes were identified in the secondary data, indicating the credibility of the insights from the primary data.

CONCLUSION

This study highlights the benefits and challenges of telemedicine (TM) in dementia care, showing it as a promising option for older adults, especially during crises like COVID-19. While TM improves care continuity, enhancing communication between patients and providers is key. However, TM alone proves insufficient in circumstances requiring physical or cognitive exams, underscoring the value of a hybrid model that allows patients and caregivers to select the appropriate care modality based on specific needs, providing a more balanced solution. Ongoing evaluation is crucial to keeping TM patient-centered, and insights from this study can help develop tailored interventions for dementia caregivers.

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CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal*'s policy on conflicts of interest disclosure and declare we have none.

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APPENDIX A. Sample interview guide for semi-structured interviews (a) and facilitator guide for focus groups (b).

First question to ask:

1. For remote consultations, did you use a phone or video? Were you provided a choice?
2. How many times did you speak to your doctor by phone/video since the beginning of the pandemic?
3. Was a family member/caregiver present during your consultation? Was your husband present during his consultation. Or you were the one who received the call ?
4. Were you aware of remote consultations before the pandemic?

PHONE CONSULTATION

1. Tell me about your experience of use of phone for medical consultations during the pandemic
   a. (PROMPT) How did you feel/how comfortable are you about using phone services for your medical consultations?
   b. (PROMPT) Did you need help from a family member/friend?
   c. (PROMPT) Do you have easy access to phone at home? If they answer no, please explain.
   d. (PROMPT) Did the nurse/physician office offer any technical support to help you set up?
2. Did you experience any challenges hearing/remembering information giving by your family physician or nurse?
   a. If they answer yes, please explain.
3. I would like to go back and talk about the things that you liked or did not like about phone medical consultations.
   a. Do you think that phone medical consultations help to follow-up your health better? Why?
   b. Do you think that phone medical consultations can improve your quality of life? How?
   c. Do you think that phone medical consultations had an impact in the number of times you go to the emergency room? Why?
   d. Do you trust technology to be reliable for your medical consultations? Why?
   e. Did you face any specific technical challenges during the consultation? (network interruption, audio not working, etc,)
   f. Are you concerned about confidentiality by using teleconsultation? Why?
4. Would you recommend phone/video medical consultations to your family member or friend? Why?
5. What would you change in phone or video consultations?
   a. What could be done differently by your family medicine practice to provide a better service?
6. If you had the choice, would you have preferred a phone, video or in person consultation? Why?
7. Would you have preferred a combination (video, phone, and in person consultation)? Why?
8. During the COVID-19 pandemic and with teleconsultation, would you feel comfortable in speaking with a nurse first before your doctor?
9. When you have sudden medical needs, how important is it for you to have easy access to consult your family physician or nurse by phone?
   a. If it is not possible to consult with your usual family physician or nurse, would you accept having rapid access by phone to any other family physician or nurse?
10. Do you use phone medical consultations outside of your family medicine clinic?
    a. If yes, for what other medical services (e.g., social worker, dietician, therapist)?
    b. How was your experience?
11. Do you think the current healthcare system was prepared for phone medical consultations? Why?
12. Would you prefer to continue with phone consultations after the pandemic?
13. Do you have any other comments on video/phone medical consultations?

VIDEO CONSULTATION:

User habits:

1. Tell me about your experience of use of video for medical consultations during the pandemic
   a. (PROMPT) How did you feel/how comfortable are you about using video services for your medical consultations?
   b. (PROMPT) Did you need help from a family member/friend?
   c. (PROMPT) Do you have easy access to video device at home? If they answer no, please explain.
   d. (PROMPT) Did you have to purchase any device for your medical consultations during the pandemic (e.g., computer, tablets, headphones, hearing aids, etc.)
2. Did you experience any challenges hearing/remembering information giving by your family physician or nurse?
   a. If they answer yes, please explain.
3. I would like to go back and talk about the things that you liked or did not like about video medical consultations.
   a. Do you think that video medical consultations help to follow-up your health better? Why?
   b. Do you think that video medical consultations can improve your quality of life? How?
   c. Do you think that video medical consultations had an impact in the number of times you go to the emergency room? Why?
   d. Do you trust technology to be reliable for your medical consultations? Why?
   e. Are you concerned about confidentiality by using teleconsultation? Why?
4. Would you recommend video medical consultations to your family member or friend? Why?
5. What would you change in video consultations?
   a. What could be done differently by your family medicine practice to provide a better service?
6. If you had the choice, would you have preferred a phone, video or in person consultation? Why?
7. Would you have preferred a combination (video, phone, and in person consultation)? Why?
8. During the COVID-19 pandemic and with teleconsultation, would you feel comfortable in speaking with a nurse first before your doctor?
9. When you have sudden medical needs, how important is it for you to have easy access to consult your family physician or nurse by phone?
   a. If it is not possible to consult with your usual family physician or nurse, would you accept having rapid access by video to any other family physician or nurse?
10. Do you use video medical consultations outside of your family medicine clinic?
    b. If yes, for what other medical services (e.g., social worker, dietician, therapist)?
    c. How was your experience?
11. Do you think the current healthcare system was prepared for video medical consultations? Why?
12. Do you have any other comments on video/phone medical consultations?