"It's better than nothing, but I do not find it to be ideal": Older adults' experience of TeleRehab during the first COVID-19 lockdown

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Abstract

This qualitative study used descriptive thematic analysis to explore the experiences of 16 older adults (age: 71 ± 6.4) who transitioned from an in-person to telerehabilitation (TeleRehab) group intervention in March 2020. We found the following themes: (1A) Technology Use, describing challenges and need for support; and (1B) Technology Self-Efficacy, describing how technological ability was attributed to past-experience and/or age. Four themes described the intervention experience. First, "Not The Same, But Better Than Nothing" (2A), reflected a preference for in-person intervention. Specifically, in-person training provided a better social experience (theme 2B), and stronger accountability, although the content was well delivered in both modalities (theme 2C). Contextual factors (theme 2D) that played a role were ease of commute, especially important during the winter, and the context of the lockdown, that positioned the TeleRehab intervention as a meaningful social activity. However, sensory impairments, and/or distractions in the home diminished the TeleRehab experience.

Keywords

COVID-19, health services, information technology, qualitative methods

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What this paper adds

- Community-dwelling older adults with subjective cognitive decline or mild cognitive impairment participating in group intervention preferred in-person sessions to TeleRehab, but acknowledged benefits of TeleRehab.
- A hybrid intervention model, combining in-person and TeleRehab sessions, may be optimal.
- Group intervention via TeleRehab provided meaningful social interactions and a distraction from the stress and uncertainty related to the pandemic lockdown.

Applications of study findings

- Technological support is crucial for older adults to engage in TeleRehab.
- Digital self-efficacy should be addressed.
- Emotional connection among group members can be achieved by establishing virtual group norms, providing opportunities for informal interactions, and complementing TeleRehab with in-person sessions.

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Introduction

The use of telerehabilitation (TeleRehab) with older adults has increased substantially over the past two decades as a result of advancements in health science and technology, a global increase in the aging population; and recently due to the coronavirus disease 2019 (COVID-19) physical distancing policies (Oh-Park et al., 2021). TeleRehab refers to the delivery of clinical rehabilitation services through a real-time interaction between clinicians and clients, using tele-communication devices (Richmond et al., 2017). TeleRehab offers improved access to healthcare services by reducing efforts and costs associated with travel for both clinicians and clients, and increasing the availability of care-providers and duration of sessions (Grigorovich et al., 2021), often with equivalent outcomes to in-person rehabilitation (Shigekawa et al., 2018).

The clinical vulnerability of older adults to COVID-19 accelerated the development of TeleRehab services for their needs and likely enhanced its acceptance by older clients (Hoffman et al., 2020). The use of telehealth serviced by older adults has significantly increased during the pandemic, with 21.1% of older adults using telehealth services currently, compared to 4.6% pre-pandemic (Choi et al., 2022). Nonetheless, this rate is still lower than that of younger people (Reed et al., 2020). This is to be expected, given the age-based digital divide, whereby older adults own and use internet-based technology significantly less than younger age groups (Davidson & Schimmele, 2019). A major challenge to older adults' adoption of TeleRehab is limited digital access and digital literacy (Foster & Sethares, 2014; Oh-Park et al., 2021), and low digital self-efficacy (van Houwelingen et al., 2018). Self-efficacy refers to a person's beliefs in their abilities to organize and carry out a course of action to achieve a specific objective, based on one's judgment of their own skills and resources in relation to a specific domain (Bandura et al., 1999). Although family assistance can be instrumental in supporting use of technology by older adults (Chu, 2010), for TeleRehab, it may be perceived by older adults as undermining their health privacy and autonomy (Cimperman et al., 2013).

This study examined the experience of TeleRehab in community-dwelling older adults with subjective cognitive decline (SCD) or mild cognitive impairment (MCI), who transferred from in-person to virtual training. SCD is the subjective experience of cognitive decline without objective evidence of cognitive impairment (Jessen et al., 2020), while MCI is characterized by an objective, modest, cognitive decline (American Psychiatric Association, 2013). Older adults with SCD and MCI reported less use of everyday technologies, and perceived their technological abilities as worse, compared to older adults with no subjective (or objective) cognitive decline (Malinowsky et al., 2017). Although TeleRehab was shown to improve cognitive functioning, emotional status, subjective memory problems, and quality of life in older adults with SCD and MCI (Alaimo et al., 2021; Fadzil et al., 2022), more research is needed on facilitators and barriers to its acceptance and adoption from older users' perspective (Foster & Sethares, 2014).

In March 2020, participants in this study were receiving intervention as part of an ongoing randomized controlled trial (RCT; NCT03495037), examining the efficacy of a strategy-based group intervention in improving the daily functioning of older adults with SCD and MCI, delivered in community and senior centers across the Greater Toronto Area. Participants were randomly allocated to one of two intervention approaches: (1) Adult Strategies Put Into Real-world Environments (ASPIRE) experimental arm, that included meta-cognitive strategy training; or (2) Brain-Education control arm, that received knowledge about brain structure and function. When physical distancing policies were implemented in Ontario, all intervention groups were transferred to online delivery. These circumstances provided an opportunity to examine the perspectives of older adults with SCD and MCI on participation in a TeleRehab intervention, from a unique position, allowing them to compare their TeleRehab experience to their experience of the same intervention program previously provided in-person, by the same facilitator and with the same group of participants. We aimed to understand the overall experience of older adults with SCD and MCI who transferred from in-person to virtual intervention during the first pandemic wave. Specifically, we explored how they: (1) experienced the use of a virtual platform for TeleRehab; and (2) experienced the changes in content delivery and group dynamics after the transfer to TeleRehab.

Methods

Design and Procedure

This is a qualitative study, using thematic analysis with a descriptive, semantic, participant directed analysis approach (Braun & Clarke, 2021). This design provides a rich, unfiltered, first-hand description of participants' experiences, and is suitable in health services research that aims to gain the perspectives of vulnerable populations, to develop or refine health interventions for their needs (Neergaard et al., 2009). Participants from both the experimental and control arms of the RCT, who transferred from in-person to virtual training in March 2020, were invited to participate in virtual in-depth interviews at the end of their 10-week training period. In addition to participants' TeleRehab experience, the interviews explored their life experiences during the first lockdown, published elsewhere (Rotenberg et al., 2021). This study was approved by the Research Ethics Board at Baycrest Health Sciences. The intervention was delivered using the Ontario Telemedicine Network (OTN) virtual platform, funded by the Ontario Ministry of Health and Long-Term Care (Brown, 2013).

Table 1. Demographic Characteristics.

Participant	Age	Self-identified race	Self-identified gender	Education (years)	Cognitive status	Arm allocation
Pt-1	63	Caucasian	Woman	17	SCD	ASPIRE
Pt-2	63	Caucasian	Woman	22	MCI	ASPIRE
Pt-3	77	Caucasian	Woman	18	SCD	ASPIRE
Pt-4	73	Caucasian	Woman	15	SCD	B-Ed
Pt-5	72	Caucasian	Man	12	SCD	B-Ed
Pt-6	70	Caucasian	Man	19	SCD	B-Ed
Pt-7	83	Caucasian	Woman	17	SCD	B-Ed
Pt-8	64	Caucasian	Woman	17	SCD	ASPIRE
Pt-9	63	Asian	Woman	16	SCD	ASPIRE
Pt-10	75	Caucasian	Woman	12	SCD	ASPIRE
Pt-11	75	Asian	Man	17	SCD	ASPIRE
Pt-12	76	Caucasian	Woman	25	SCD	B-Ed
Pt-13	60	Caucasian	Woman	13	SCD	B-Ed
Pt-14	69	Caucasian	Woman	17	SCD	B-Ed
Pt-15	71	Caucasian	Man	18	MCI	B-Ed
Pt-16	74	Caucasian	Woman	15	SCD	B-Ed
Sample mean / Percentage	71 ± 6.4	Caucasian: 87.5% Asian: 12.5%	Women: 75% Men: 25%	16.9 ± 3.4	SCD: 87.5% MCI: 12.5%	ASPIRE: 43.8% B-Ed: 56.2%

Note. Pt-X = Participant-X; SCD = Subjective cognitive decline; MCI = mild cognitive impairment; ASPIRE = Adult Strategies In Real-world Environments; B-Ed = Brain-Education control group.

Participants

As per the RCT inclusion criteria, participants were aged 60–85, community-dwelling, able to converse in English and had confirmed subjective cognitive problems (defined by confirming at least one of the following questions: "Do you feel that you have problems with your memory or cognition?" and "Do you feel that your memory has become worse?"). Participants had no current depression (Patient Health Questionnaire score ≤ 9 (Kroenke et al., 2001)), and no self-reported neurological or psychiatric history. Participants underwent neuropsychological assessment, and were classified as having either SCD or MCI through consensus diagnosis by two licensed clinical neuropsychologists. Participants with more severe impairments (e.g., meeting criteria for early dementia) were excluded from the RCT. Of the 27 participants who transitioned from in-person to virtual intervention in one of three community centers in March 2020, 16 were interested in being interviewed, and provided informed consent. Their demographic characteristics are presented in Table 1.

Data Collection

Demographic data were collected using a self-report questionnaire. Qualitative data were collected using individual semi-structured interviews, lasting 60–75 min. An interview guide (Table 2) provided a general outline, and allowed for additional questions and/or prompts to enhance clarity and thoroughness and allow for unanticipated topics and ideas to emerge. The interviews were conducted by trained healthcare professionals experienced in working with older adults, virtually or by phone, depending on participants' preference. The interviews were recorded, transcribed verbatim, and coded using NVivo 12 (QSR International, 2018)

Data Coding and Analysis

Data were coded and analyzed using qualitative thematic analysis (Braun & Clarke, 2021), with a descriptive semantic approach, whereby themes were developed from the explicit meanings of the words used by participants (Braun & Clarke, 2021). We followed the 6-phase process outlined by Braun and Clark (2021). First, the coders (SR, YB, and JO) familiarized themselves with the data by reading through the 16 interviews several times and noting analytic ideas and insights. Second, the coders applied code labels, which are words or sentences that describe an idea expressed in the data. We used a semantic approach, using codes that describe the explicit meaning of the data. We developed a provisional codebook of codes and sub-codes, in an iterative process, using three interview transcripts, then coded the entire dataset. Each interview was coded by two team members, independently. Additional codes were added as they were identified and discussed in routine team meetings. See supplementary material for the final iteration of the codebook. Third, the coders generated candidate themes that capture a broader shared meaning among codes. In phase four, the themes were re-examined and revised several times through discussion between all team members, renaming, removing, or merging themes and sub-themes. In phase five, we summarized each theme in writing, and further discussed the themes and the

Table 2. Interview Guide.

Experience of using the virtual platform for TeleRehab:
- How did you find the process of learning how to access and use the virtual platform?
- How was your overall experience with the technological aspects? Where there specific aspects that were more challenging?
- Did you experience any technical difficulties during the training? What were they?
- What helped you address them? What could have been helpful in addressing this type of problems?

Overall experience of the intervention:
- Did you find the training to be different when performed online compared to the sessions performed in-person? What were the main differences? What were the similarities?
- What were the advantages of each method of delivery? What were the disadvantages?
- What was the main contribution of this training for you during times of social distancing? Was the contribution different than while the intervention took place in-person?

relationship among them until a consensus was reached. The regular team discussions and meticulous documentation of decisions enhanced the reliability of the findings. The sixth stages, the integrative write-up, are presented below.

Results

We generated six themes, depicted in Figure 1. Two themes were related to the experience of the use of a virtual platform for TeleRehab (study aim 1): (1A) Technology Use, describing the learning process, technological challenges, and factors that supported technology use; and (1B) Technology Self-Efficacy. For the second study aim, we developed four themes. Theme 2A, "Not The Same, But Better Than Nothing," is an overarching theme describing a general preference for in-person intervention while acknowledging the value of TeleRehab. This preference is explained through positive and negative qualities of TeleRehab, represented by three additional themes: (2B) Group Dynamics and Interactions; (2C) Intervention Content and Process; and (2D) Contextual Factors. The six themes are explained and demonstrated below. Participant quotes are presented verbatim to support the description of the themes. Some quotes were edited to enhance clarity. Deleted words were replaced by an ellipsis (…) and contextual information added by the authors appears in square brackets.

Technology

Theme 1A. Technology Use. The experience of learning to use the virtual platform varied. Some described it as smooth and easy, such as Pt-2 who stated: "you just click on the link, bang bang… It was easy as anything. OTN… is fabulous. Fantastic. So easy." Others found it harder. Pt-14 described her initial experience as "terrible," explaining that "I couldn't figure out… I couldn't get the sound to work." Some described a learning curve, whereby the use of technology became easier with time: "once you get over the hurdle of the connection challenges it would be okay." (Pt-9).

Two processes allowed a smooth transition and ongoing participation in the virtual training. First, having an individual session with a research assistant before the first online group session, to guide participants through virtual program features, was viewed as helpful in learning to connect to virtual platform and alleviating stress related to technology use. Second, ongoing ad hoc technical support was viewed as helpful, and was essential for some:

> I was having technical problems… and they… called me and hooked me up again. As soon as I ran into a problem I was contacted. I didn't even have to let them know that I was having the sound problem, they contacted me. (Pt-14)

Overall, participants were able to log on to the virtual platform and successfully participate in the group sessions, though many mentioned technical problems. Common issues were related to audio and sound (e.g., multiple participants speaking at the same time; a participant's microphone or speakers not working; unable to mute or unmute; background noises from other participants); video (e.g., participant unable to turn video on; video freezing); visual (e.g., delay in slide transition) limited options due to participants' outdated equipment; and poor or unstable internet connection. For the most part, technical problems were viewed as minor: "It's all manageable… inconveniences… I can deal with trivial things." (Pt-15)

Theme 1B. Technology Self-Efficacy. The ability to use the virtual platform was explained by the level of pre-existing personal digital proficiency. Pt-6 explained that he had no issues because "I don't have a problem with technology." Many participants had a different experience: "The problem is of course… that I'm not technologically proficient, we'll put it that way… If things go wrong, I can't do anything about it. I muddle my way through." (Pt-7). In some cases, participants attributed the technological challenges to their age or life stage: "I'm not from the new generation that they do all their work like that [using technology]… when I was working I did have computers and knowledge of computers, but computers change… I'm not interested in learning the new things. I had enough of that" (Pt-11)

A few participants described initial apprehension of using technology, which was alleviated though a positive experience of using the virtual platform, resulting in an empowering experience:
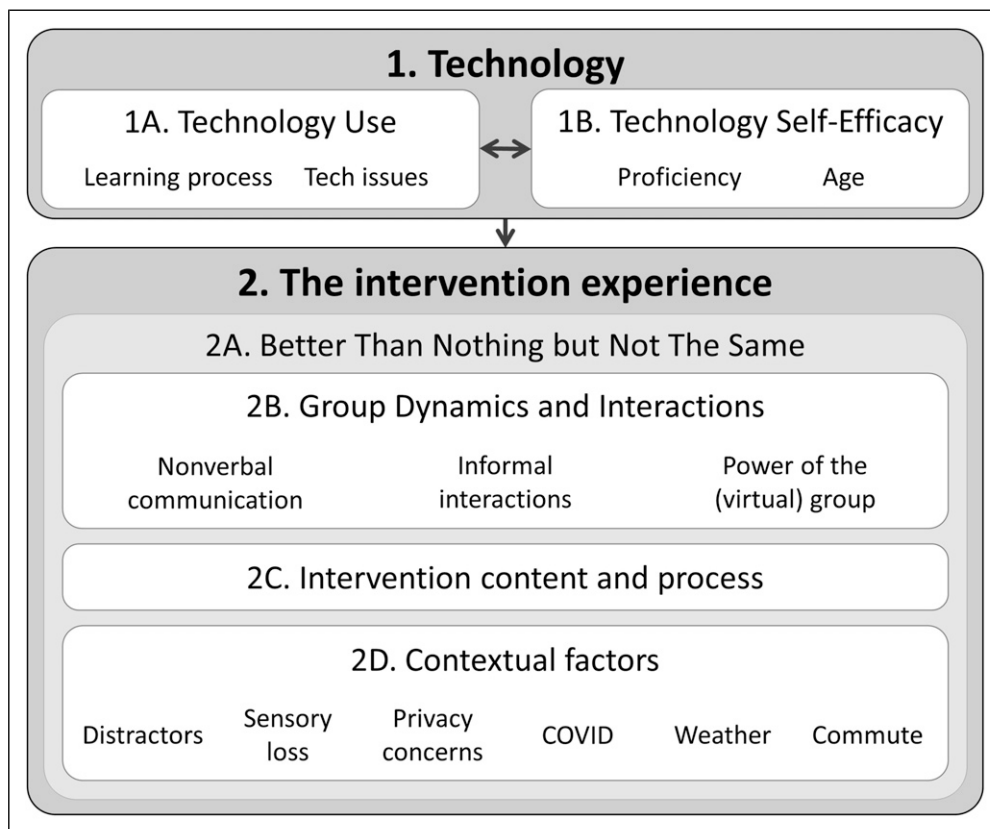
Figure 1. Thematic analysis.

At first when we went online… I thought I can't possibly do it, I'm low on technology… and next thing [I know] I'm doing this brain project and I'm also doing a whole bunch of other things. ...and I was amazed that I actually could do it.... it scared me at first but the things is, as soon as I tried it, I thought 'oh, this is okay'." (Pt-16)

For some, the ability to use technology was viewed as haphazard: "I don't know what I was struggling with the first time. I couldn't log in. I think somebody fixed something. This time I had no trouble, so I don't quite know." (Pt-9). Pt-8 noted that although she appreciated the technological support, the way it was delivered made her feel frustrated: "So it was helpful having somebody walk me through it, but I also find sometimes people talk to me as if I don't know anything. Which I find frustrating… I'm not as stupid as I look, which I tell people."

The Intervention Experience

Theme 2A. Better than Nothing but Not the Same. There was a broad agreement that although the virtual training had value, the in-person experience was better: "It just felt a little bit more removed than if I'd been sitting across a table from them… but not to any extent where I felt it didn't work. It

worked fine for what we had." (Pt-3). In-person training provided a more holistic experience:

I enjoyed it [in-person training] more because it would've been a complete experience, an opportunity to dress up, go outside of the house, stop for a coffee, maybe have coffee there … all of these things are missing during the virtual part of it. Not to diminish it in any way, but the human element is not there." (Pt-14).

Specific positive and negative qualities of the two intervention modes are described below.

Theme 2B: Group Dynamics and Interaction. Although the participants were mostly happy at the opportunity to meet virtually, there was a consent that group dynamics were not as good through TeleRehab. In-person training was described as more intimate and warm, allowing for better rapport, openness and honesty, and providing better conditions for personal connection.

When I'm in a group online I basically feel like I'm watching it on TV, and I don't participate very much… I find it harder to participate because you have to unmute and then you're talking over somebody and it cancels out and it's not really the same. It

definitely loses that personal feeling of communicating with people… I listen to what everybody else says, but… I participate less than I normally would (Pt-8).

Technological issues sometimes limited engagement with others: "I struggled [to connect], so I was late joining. So I didn't listen to everybody's discussion… so we're missing that togetherness because we were learning the technology" (Pt-9). Some participants felt that people having their cameras off, by choice or because of technological issues, was not good for interpersonal relationships. Even with cameras on, participants felt that nonverbal communication was often missed:

> In a group in-person you can instantly spot who's speaking and there's more of that personal connection and there's the eye contact and all of that and the body languages I find is lacking. So… you know, it's better than nothing, but I do not find it to be ideal. (Pt-8)

> When you're in a contact with a person live, you're reading body language… [Virtually] you're only seeing a person's face you can read expressions but you can't read body language so you're really getting half the message. (Pt-14)

Participants missed the informal interactions that took place before, during, and after the in-person sessions, and could not happen virtually: "[in-person] you get the chance afterwards to talk to some of the people in the group… like chatting with somebody afterwards or walking with them a bit." (Pt-2). The in-person intervention allowed informal interactions that had an added value:

> The goal, I felt, was reached in discussing what we needed to discuss. It was just that… interpersonal comments back and forth… Sometimes those comments, I find, are helpful as we get into little side discussions and obviously there was very little of that online. (Pt-8)

Despite the limited nonverbal communication and informal interactions, participants described positive group interactions occurring through the virtual platform. A few participants said that having previous in-person interactions was helpful in creating a positive group dynamic virtually:

> "I guess it would be very different if we'd never met those people before in person… if we had not had those early sessions in person, it probably would have been very awkward to meet those people online… having history of meeting in-person made it easier." (Pt-12)

Theme 2C. Content and Process. Participants in both groups felt that the training content was well delivered through TeleRehab. Pt-2 from the ASPIRE group said: "You still used… the chart [table for tracking strategy **use**]… I'm not sure that it was substantially different. I still took notes. We still covered the bases. People got a chance to talk." Similarly, Pt-6 from the Brain-Education group described the delivery of content: "I enjoyed it… We understood what was being taught to us."

In terms of process, however, participants in the experimental arm felt less accountable to the group and therefore less motivated to work on their everyday life goals: "In person, you're more accountable. And part of the program was coming to the sessions and not pretending, and being honest about what you actually did. So… you were accountable. And you're more accountable when you're in person, and you're looking at them." (Pt-10). The facilitator was described as having an important role in keeping the group focused, which participants thought was harder to do through TeleRehab compared to in-person training: "She's [facilitator] very animated and lively. It's more difficult when all you have is the flat screen, right? But she did a great job. I don't think people were any less interested…" (Pt-12).

Theme 2D. Contextual Factors. Several contextual factors played a role in participants' experiences of TeleRehab training compared to in-person training. The home environment was described as more distracting and requiring more effort to stay attentive to the virtual conversation. Personal factors such as impaired hearing and vision interfered with the virtual experience more than they did with the in-person experience. Pt-9 expressed concern about privacy issues that may occur during the virtual intervention because other people in participants' homes may be overhearing the conversations.

In contrast, some contextual factors made the virtual intervention advantageous over the in-person intervention. First, TeleRehab eliminated the need to commute, which was convenient:

> It was nice not to have to go anywhere. It's close to the subway, but it is… you know there's a bit of a walk involved. And timing was difficult to get it right, so sometimes I'd be late… So, you know to be able to do away with the transportation aspect all together was fine. (Pt-13)

This was especially important in the winter months in Toronto: "the weather was really cold, and we were all slogging through the snow to get to the meetings. [In virtual sessions] you didn't have to do that." (Pt-3). The ease of participating virtually led one participant in the ASPIRE group to suggest that the group continue to meet virtually to provide ongoing support to maintain the behavioral changes over time:

> I think it will be helpful to check in with people to see how they're doing. Have they made a difference to how they're living their life?.. Even longer term, our group talked about how do we

keep up with doing the way we were doing it? The benefit of having to face your group next week, and doing your action and plan, is always that kind of pressure, but you end up doing more. But once you relax it, would you actually still do it?.. So even that would be a lot easier to meet online, if you just have half an hour kind of checking in with someone, with the group, would be easier to do [virtually] than having to meet in person. (Pt-9)

Despite the advantages of TeleRehab, there was a strong preference to in-person training: "I would hate to see… your project only online… they're good if that's the only way to do it… hey, we went for it, it's great! But I think in person really has a benefit…. there's just an advantage to be with other people, in person." (Pt-16)

Another contextual factor that impacted the intervention experience was the COVID-19 pandemic and the related public health guidelines. First, participants valued the virtual social interactions at a time when social interactions were limited by physical distancing policies: "Because when you're practicing social distancing, you're already lack connection with people. So, any connection would be beneficial I think." (Pt-9). Second, participating in the training helped fill up time when many routine activities were not available: "I found myself looking forward to it more when it was online than when it was competing with a bunch of other stuff." (Pt-13). Third, it provided a much-needed distraction from the stress and uncertainty that characterized the first pandemic wave: "I think it was very helpful during the time of COVID, to have it, because really that two hours Wednesdays I was really just… absorbed in the project and really wasn't worrying about anything else. Just like a vacation" (Pt-16). Continuing the intervention virtually provided closure and prevented participants from feeling that the time spent in the in-person sessions had gone to waste.

Discussion

The closure of all community non-essential services and in-person research activities in Toronto in March of 2020 provided an opportunity to gain insight into the experience of older adults with SCD and MCI with TeleRehab. This study explored how a TeleRehab intervention compared to an in-person experience, when the intervention approach, facilitator and peer personas were identical. Our participants were able to use the virtual platform, with some support, and described benefits from TeleRehab. There was a strong preference for in-person intervention, that provided a more holistic experience and resulted in better interpersonal interactions. Nonetheless, the participants identified advantages to TeleRehab in reducing commute efforts and exposure to extreme weather. They appreciated the opportunity to interact with others during the lockdown.

This study provides insight on ways to support TeleRehab engagement in older adults with SCD and MCI, who are less likely to use TeleRehab (Reed et al., 2020). Our participants thought that training on the use of technology prior to the start of the intervention, and ongoing technical support were useful, and sometimes critical, as previously suggested by primary care physicians providing telehealth services to older adults (Chen et al., 2022). In a group context, the group facilitator cannot attend to individual technological issues, and this required additional person-power. Although funding technical support will reduce the cost-effectiveness of TeleRehab (Barnett et al., 2018), we argue that investing financial resources is critical for ensuring health equity (Nouri et al., 2020; Oh-Park et al., 2021). TeleRehab is likely to complement in-person rehabilitation interventions post pandemic (Nuara et al., 2022; Oh-Park et al., 2021), and we must ensure that the age-related digital divide does not limit older adults from accessing healthcare. Previous studies have shown that the healthcare system cannot rely on family support for TeleRehab use by older adults, even when such support is available, because it is perceived as a threat to health privacy and confidentiality (Oh-Park et al., 2021). This underscores the importance of incorporating technical support as an integral part of a TeleRehab service plan for older adults.

Some of the participants who described themselves as having low digital self-efficacy experienced initial doubt regarding their ability to engage in TeleRehab. However, some described feeling more competent and confident over time, seeing that they were able to take part in the TeleRehab intervention, with technological support. This strengthens the contention that digital self-efficacy can be developed and enhanced through supported technology use (Jin et al., 2019). Digital self-efficacy does not necessarily develop simply through ongoing use of technology (Wild et al., 2012), and health providers aiming to improve digital self-efficacy can consider incorporating methods shown to improve digital self-efficacy among older adults, such as slow-pace repeated practice with technology, use of written instructions; collaborative problem-solving of vision and hearing related technology-use issues; and psychoeducational discussions of the potential benefits of technology-use (Gatti et al., 2017).

Our participants experienced the in-person phase of the intervention as providing more optimal group dynamics and enhanced accountability compared to TeleRehab delivery. We identified several ways through which better group dynamics can be established in TeleRehab group interventions. First, our findings highlighted the importance of establishing virtual group norms of active cameras during the sessions. Education research suggests that social presence is critical for effective learning because it helps learners feel connected with the instructor and peers and encourages active participation. In online learning, activated cameras support the experience of social presence (Al-Dheleai & Tasir, 2019). Second, to address participants' wish for informal interactions, we suggest providing time and opportunities for informal interactions using the virtual

platform that may be beneficial for social connection. This can be achieved by providing additional online time before and/or after each session for participants to interact; establishing break-time norms that encourage participants to stay on screen during the break; and, with permission, sharing participants' contact information to provide an opportunity to connect between sessions. Finally, the participants thought that their previous in-person acquaintance supported emotional connection when the intervention went online. This is in line with other TeleRehab studies that showed that people were more inclined to participate in a TeleRehab sessions with a health provider with whom they had established a relationship through in-person visits (Welch et al., 2017), and suggest that a hybrid model might be beneficial. Primary Care physicians working with older adults reported that using a mix of in-person and telehealth modalities helped in meeting older patients' needs (Chen et al., 2022).

Limitations

The study sample was homogenous, comprised mainly of Caucasian, highly educated older adults. Also, although the age range of the study sample was wide (60–83 years), the mean age of the sample was relatively young. Because sociodemographic factors such as low education level, older age, and being part of a racial minority are related to decreased digital literacy and use (Davidson & Schimmele, 2019), the experience of our sample may not be representative. Also, the sample was comprised mostly of older adults with SCD, and the experience of those with MCI may not have been fully captured. Due to the nature of the study, we were unable to use purposeful sampling methods to recruit a diverse sample in terms of age, socioeconomic status, race, level of digital-literacy and self-efficacy, cognitive status and other factors that may play a role in TeleRehab experience. Further research is needed to explore how TeleRehab experience varies across demographic and other personal characteristics, using a mixed methods approach. Finally, the intervention and study interviews were performed during the first months of the first pandemic lockdown in Toronto, associated with a great deal of anxiety and uncertainty that may also have influenced the results.

Conclusion

TeleRehab holds advantages that extend beyond overcoming the limitation of physical distancing (Nuara et al., 2022). By providing ongoing technical assistance, defining virtual group norms, and providing opportunities for informal social interaction online, healthcare providers can improve the experience of older adults with SCD and MCI in TeleRehab interventions. For group interventions, seeing the strong preference for in-person training and the stronger interpersonal connection it provided, our study supports a hybrid model of care, whereby TeleRehab is used to complement, not replace, in-person health services (Nuara et al., 2022). As postpandemic healthcare is likely to be considerably more virtual than it was pre-pandemic, a hybrid model may be optimal for older adults, to achieve the social connections established during the in-person sessions, while benefitting from ease of commute and access.

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Supplemental Material

Supplemental material for this article is available online.

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