


Program Evaluation of My Life, My Story: Virtual Storytelling in the COVID-19 Age

Megan E. Gately, Sarah Muccini, Brady A. Eggleston & Jaye E. McLaren


To cite this article: Megan E. Gately, Sarah Muccini, Brady A. Eggleston & Jaye E. McLaren (2021): Program Evaluation of My Life, My Story: Virtual Storytelling in the COVID-19 Age, *Clinical Gerontologist*, DOI: [10.1080/07317115.2021.1931610](https://doi.org/10.1080/07317115.2021.1931610)

To link to this article: <https://doi.org/10.1080/07317115.2021.1931610>

 View supplementary material [↗](#)

 Published online: 05 Jul 2021.

 Submit your article to this journal [↗](#)


 Article views: 58

 View related articles [↗](#)

 View Crossmark data [↗](#)



Program Evaluation of My Life, My Story: Virtual Storytelling in the COVID-19 Age

Megan E. Gately PhD, OTD, OTR/L ^a, Sarah Muccini MS, OTR/L^{a,b}, Brady A. Eggleston MS, OTR/L^{a,b}, and Jaye E. McLaren MS, OTR/L^a

^aNew England Geriatric Research Education and Clinical Center, VA Bedford Health Care System, Bedford, Massachusetts, USA; ^bDepartment of Occupational Therapy, Tufts University, Medford, MA

ABSTRACT

Objectives: COVID-19 negatively affected older adults' well-being and quality of life, particularly individuals with dementia. My Life, My Story (MLMS) was developed at Veterans Health Administration as an opportunity for Veterans to interact and share life stories using guided interviews. This paper describes a program evaluation of MLMS delivered to Veterans with cognitive concerns and their caregivers using telehealth technology during COVID-19.

Methods: Fourteen Veteran-caregiver dyads completed MLMS interviews with occupational therapy trainees using telehealth technology. Most (10 of 14) participating Veterans had mild-to-moderate dementia. Trainees ascertained Veteran and caregiver demographics such as age and recent cognitive evaluation scores via chart review. Trainees also gathered Veteran-caregiver technology and interview experience through post-interview program evaluation questionnaires.

Results: Dyads reported generally positive interview and technological experience, despite technological glitches occurring in most (approximately 70%) interviews. Caregivers assisted with videoconferencing setup and participated in ten interviews.

Conclusions: Veterans with cognitive concerns successfully participated in virtual MLMS interviews during COVID-19. Caregivers enhanced Veteran engagement and often provided technological support.

Clinical implications: Telehealth technology enabled participation in My Life, My Story by individuals with cognitive concerns and their caregivers. Post pandemic, clinicians may consider integrating telehealth technology with patients facing access challenges.

KEYWORDS



Telehealth; life narrative; storytelling; videoconferencing; dementia


Introduction

In response to COVID-19, many older adults avoided face-to-face social contact and leaving their homes (Le Couteur, Anderson, & Newman, 2020). While this decreased exposure to the virus, doing so may have increased social isolation, anxiety, anger, stress, and agitation, particularly for individuals with dementia (Canevelli, Bruno, & Cesari, 2020; Cheung & Peri, 2020). Dementia is noted for causing declines in function and cognition related to memory and language, often impairing the ability to connect and communicate (“2020 Alzheimer’s disease facts and figures,” 2020). The forced isolation of COVID-19 resulted in fewer opportunities for engagement, which may have exacerbated dementia symptoms (Numbers & Brodaty, 2021).

Technology offers an alternative to face-to-face dementia care (Astell et al., 2019; Goodman-Casanova, Dura-Perez, Guzman-Parra, Cuesta-

Vargas, & Mayoral-Cleries, 2020; Lorenz, Freddolino, Comas-Herrera, Knapp, & Damant, 2019). Telehealth has been utilized for telepsychology services (Chen et al., 2020; Poletti et al., 2020) and dementia assessment and management. Such remote care has been delivered between two clinic locations (Chang, Homer, & Rossi, 2018; Dang, Gomez-Orozco, Van Zuilen, & Levis, 2018; Lum et al., 2020; Pimentel et al., 2019; Powers, Homer, Morone, Edmonds, & Rossi, 2017) and into patients’ homes (Lindauer et al., 2017; Malmgren Fänge et al., 2017; Moo, Jafri, & Morin, 2014; Shaw, Williams, Lee, & Coleman, 2021). Telehealth has been utilized for dementia-related caregiver support (Astrom et al., 2015; Czaja, Loewenstein, Schulz, Nair, & Perdomo, 2013; Griffiths, Whitney, Kovaleva, & Hepburn, 2016; Lindauer et al., 2018; Williams et al., 2018), rehabilitation (Burton & O’Connell, 2018; Gately,

CONTACT Megan E. Gately  megan.gately@va.gov  Geriatric Research Education and Clinical Center (GRECC), VA Bedford Healthcare System, 200 Springs Road, 17-200, Bedford, MA 01730

 Supplemental data for this article can be accessed on the [publisher’s website](#).

© 2021 Taylor & Francis Group, LLC

Trudeau, & Moo, 2019), and home safety (Gately, Trudeau, & Moo, 2020).

My Life, My Story (MLMS), which involves patients' personal narrative interviews, was developed by Veterans Health Administration (VHA) Office of Patient-Centered Care and Cultural Transformation (Nathan et al., 2019; Ringler, Ahearn, Wise, Lee, & Krahn, 2015; Roberts, Ringler, Krahn, & Ahearn, 2020). MLMS aims to increase connectedness between Veterans and patient aligned care teams (PACT) and improve quality of care through patient narratives developed using a guided interview process. MLMS often employs hospital staff, including clinicians and trainees, as interviewers (Nathan et al., 2019). MLMS has been implemented at approximately fifty-five VHA locations across the nation (Ringler et al., 2015), including VA Bedford Healthcare System. This paper describes a program evaluation of My Life, My Story delivered using telehealth to Veterans with cognitive concerns and their caregivers.

Methods

Three occupational therapy Master's-level clinical trainees conducted My Life, My Story interviews with Veterans affiliated with VA Bedford Health Care System between July and August of 2020. Prior to interviews, trainees underwent training in MLMS guidelines and principles, including a Veteran-centric approach to facilitate storytelling (Nathan et al., 2019). Eligible Veterans were previously evaluated for cognitive concerns at the outpatient neurocognitive clinic, referred by the clinic social worker, and had access to at least a telephone. There were no other exclusion criteria. Trainees called Veterans to invite them to participate. To ensure dementia-capable care, which recognizes caregivers' collaboration (Borson & Chodosh, 2014; Jennings et al., 2019), trainees also invited caregivers to participate.

Veteran-caregiver dyads could participate using videoconferencing, phone, or a combination. Veterans used VHA's HIPAA-compliant videoconferencing platform, VA Video Connect (VVC), or a commercial platform. Trainees assisted with technological set-up before the scheduled interview, including sending videoconferencing links.

Interviews were not recorded or transcribed, but clinical trainees took note of interview details to construct the personal narratives, and details such as devices utilized, who set up technology, approximate number and duration of technical issues, and interview length. Trainees and supervisors also participated in regular group discussions about interviews, including perceived challenges, for their clinical training.

Following interviews, trainees wrote Veteran stories in Microsoft Word (using notes), which is how word count was ascertained. Veteran stories were written in first person to reflect Veterans' voice and tone. A story readback was scheduled within a week of the interview in which trainees read completed stories to dyads, who had the opportunity to provide edits. Once approved, finalized stories were entered into Veterans' medical record and hard copies were mailed. In accordance with institutional procedures, this project was reviewed by VA Bedford's Institutional Review Board. The IRB deemed the activity to be not research but an evaluation of an existing hospital program. Though deemed not research, the project was conducted in adherence with VA ethical and privacy protections.

Participants

Forty-one Veteran-caregiver dyads were referred. Twenty Veteran-caregiver dyads declined, for reasons including bad timing or lack of interest. Six could not be reached. Fifteen dyads were interviewed; however, one could not be reached to finalize the story and therefore is not included. Please see Appendix A for a participating Veteran's story, for which permission to publish was obtained.

See Table 1 for participating Veteran and caregiver demographics. Fourteen Veterans participated, all White men between age 70 and 98 ($M = 77.5$). One Veteran was widowed, one divorced, and the rest were married. Caregivers were female family members, mostly spouses, with two adult children, living with Veterans. Based on most recent cognitive evaluation, which was completed with outpatient clinic staff within fifteen months of interviews and gathered via chart review, three Veterans had no cognitive impairment, five had mild, five had moderate, and one had severe

Table 1. Veteran-caregiver Dyad demographics and interview details.

Dyad ID	Veteran Age	Veteran Cognitive Score	Caregiver Relationship	Interview Platform	Interview Duration (Mins)	Story Length (Words)
1	82	Moderate	Spouse	Video	33	575
2	79	Mild	Spouse	Telephone	90	1383
3	70	Mild	Spouse	Video	42	737
4	75	Mild	Spouse	Telephone and Video	52	592
5	82	Moderate	Adult Child	Video	60	1058
6	76	Severe	Spouse	Video	50	633
7	76	Mild	Spouse	Video	30	495
8	79	Moderate	Spouse	Video	65	1056
9	77	Normal	Spouse	Telephone and Video	90	1398
10	98	Moderate	Adult Child	Video	35	550
11	77	Moderate	Spouse	Telephone and Video	76	1328
12	73	Normal ^a	Spouse	Video	30	1098
13	70	Normal	Spouse	Telephone	50	814
14	71	Mild	Spouse	Video	35	1024

Note. Scores represent most recent evaluation of cognitive ability, either the Montreal Cognitive Assessment (MoCA) or the Mini-Mental State Examination (MMSE), completed with clinic staff within the last fifteen months. Scores on the MoCA and MMSE are categorized into no impairment (MoCA \geq 26; MMSE \geq 25), mild impairment (MoCA 18–25; MMSE 20–24), moderate impairment (MoCA 10–17; MMSE 13–19), or severe impairment (MoCA $<$ 10; MMSE \leq 12). ^aMMSE score; all others MoCA.

cognitive impairment, according to scoring guidelines for the Mini-Mental State Examination, or MMSE (Folstein, Folstein, & McHugh, 1975), and Montreal Cognitive Assessment, or MoCA (<https://www.mocatest.org/faq/> (MoCA: Montreal Cognitive Assessment)).

Post-interview questionnaires

Dyads completed two post-interview questionnaires about technology and interview experience at different time points. Questionnaires included statements with five-point Likert scales of agreement ranging from strongly disagree (1) to strongly agree (5) and a Visual Analog Scale (VAS) (Bushnik, 2011) for Veterans with communication impairments. See Appendices B and C for questionnaires. Clinical trainees completed questionnaires virtually with dyads.

Technology Experience

Immediately following interviews, dyads completed a five-item questionnaire about technological experience. Items included ability to see and hear during interviews. This questionnaire was modified from a dementia telehealth study (Moo et al., 2014).

Interview experience

Following story readback (which was within a week of interviews), dyads completed a four-item questionnaire about interview experience. Because the questionnaire included items about the overall process, including Veterans' intention to share their

story, trainees administered this questionnaire after finalizing Veteran stories. Scores on three items were 5-point Likert scales, with one Yes/No/Not Sure option.

Results

See Table 1 for interview details. According to trainee notes and finalized stories, interview duration ranged from 30 to 90 minutes ($M = 60$) and stories ranged in length from 495 to 1398 words ($M = 910$ words). Interviews with Veterans with no-to-mild cognitive impairment ranged from 30 to 90 minutes ($M = 52$), while interviews with Veterans with moderate-to-severe impairment ranged from 33 to 76 minutes ($M = 53$). Completed stories with Veterans with no-to-mild cognitive impairment ranged from 495 to 1398 words ($M = 943$), while stories with Veterans with moderate-to-severe impairment ranged from 550 to 1328 words ($M = 867$).

Caregivers participated in ten interviews. Caregiver participation varied, but trainees took a Veteran-centric approach by directing questions to Veterans. Veterans responded to clinical trainees most of the time, except for one Veteran with severe cognitive impairment whose caregiver provided most details. Caregiver contribution included prompting to remind Veterans of events, clarifying details, or rephrasing questions into Veterans' more familiar language. Four interviews were conducted with Veterans alone. Of these, one Veteran had no

cognitive impairment, two had mild, and one had moderate cognitive impairment.

Regarding technology, according to trainee notes, five Veterans participated using laptops, one used a desktop computer, four used tablets, two used smartphones, and two used phones without videoconferencing. Most ($n = 11$) interviews were conducted using VHA's videoconferencing software, VVC, one used another videoconferencing platform, and two were phone only. For all interviews involving videoconferencing, caregivers set up technology. For the two interviews by phone only, Veterans initiated and completed interviews without caregiver assistance.

Technical disruptions such as lost audio or video lag occurred in most ($n = 10$) interviews, averaging less than three minutes and ranging from 0–10 minutes, with trainees providing support. Glitches did not prevent interview completion; however, of those using VVC, three converted entirely to phone due to technical disruptions. One dyad used a phone for audio and VVC for video when audio failed. Interview duration and story length were shorter for interviews conducted over video than for phone or combination: video interview duration, $M = 42.2$ and story length, $M = 803$ words, versus phone/combination interview duration, $M = 71.6$ minutes and story length, $M = 1103$ words.

Trainee notes and group discussions also identified overall challenges related to remote MLMS interviews. These included challenges with

technological set up and glitches, communication, interviewing individuals with deficits such as memory loss, and considerations for interviewing dyads. See Appendix D for suggested strategies for adapting interviews.

Technology experience

See Figure 1 for mean Technology Experience ratings across dyads. Most dyads indicated positive experience, with highest ratings for ability to hear clearly ($M = 4.9$, $SD = 0.4$, range 4–5) and ease communicating ($M = 4.7$, $SD = 0.6$, range, 3–5), followed by comfort with technology ($M = 4.6$, $SD = 0.9$, range, 2–5), ability to see ($M = 4.6$, $SD = 1.1$, range, 1–5), and enough technical assistance ($M = 4.5$, $SD = 0.6$, range, 3–5). There were two instances of disagreement or strong disagreement. Dyad 8 disagreed with being comfortable using technology (notes indicated this dyad experienced audio loss necessitating a phone) and dyad 14 strongly disagreed with ability to see, with trainee notes indicating that video frequently froze.

Interview experience

See Figure 1 for mean Interview Experience ratings across dyads. Most ratings were positive, with the highest response for the process of sharing the story being worthwhile ($M = 4.4$, $SD = 0.8$, range, 3–5), followed by belief that telling stories allowed Veterans to look back on their lives ($M = 4.3$,

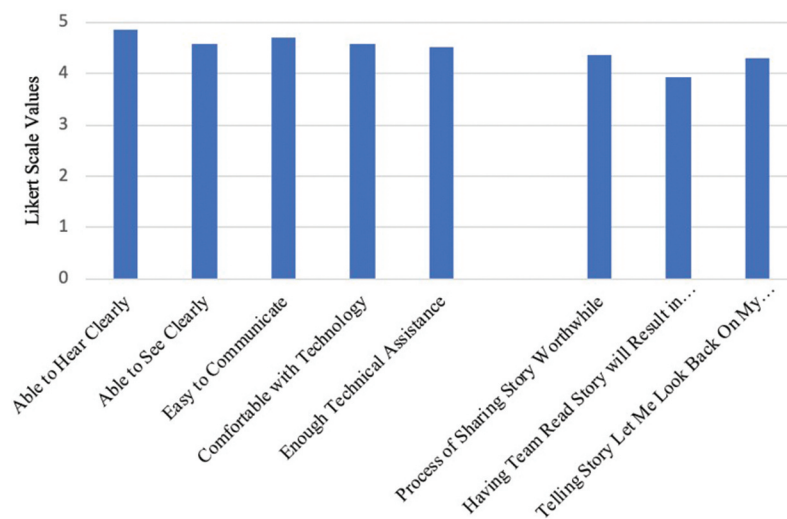


Figure 1. Veteran-caregiver ratings on technology and experience questionnaires.

$SD = 0.9$, range, 2–5). There were two instances of disagreement, with dyad 13 disagreeing that having the medical care team read the story will help them provide better treatment and that telling the story allowed the Veteran to look back on his life. All but one Veteran indicated planning to share stories with family or friends.

Discussion

This paper presents findings from a program evaluation of My Life, My Story (MLMS) conducted using telehealth technology with Veterans with cognitive concerns and caregivers. All Veterans successfully completed remote interviews, with caregivers assisting with more complex aspects of technology and participating in most interviews. Level of cognitive impairment did not appear to affect interview duration or story length, though interviews conducted over video tended to be shorter than those by phone only or combination. Given the small sample, it is difficult to draw conclusions from these findings.

Regarding Interview Experience, there is limited literature about MLMS program outcomes, with no extant study presenting patient outcomes. Of the one study presenting MLMS clinician outcomes, most clinicians strongly agreed that reading Veterans' stories had an impact and was a good use of clinical time (Roberts et al., 2020). This aligns with our finding that Veterans found the process of sharing their story worthwhile. Further evidence for Veteran and clinician perspectives on MLMS would help to validate program aims of enhancing Veteran-care team communication.

Technology Experience was mostly positive, highlighting the acceptance of technology-mediated communication and population-specific considerations. Highest rated items were ability to hear and ease communicating, underscoring the importance of effective communication in videoconferencing (Gately et al., 2020; Serwe, Heindel, Keultjes, Silvers, & Stovich, 2020). Low ratings align with evidence for the negative impact of technological glitches, which may cause patient frustration (Almathami, Win, & Vlahu-Gjorgievska, 2020). Though interviews were completed despite glitches, with strategies such as switching to phone, it is important to note that technical glitches may have

negative consequences on provision of health care (Gogia et al., 2016).

Related to technology, dyads used a range of devices, with most Veterans using videoconferencing. However, videoconferencing required caregiver assistance, underscoring considerations for dementia and potential access gaps. Caregiver participation aligns with their role in technology-based dementia interventions (Astell et al., 2019; Lindeman, Kim, Gladstone, & Apesoa-Varano, 2020; Sriram, Jenkinson, & Peters, 2019). It also reflects the inherent complexity of telehealth (Pereira, 2020), with videoconferencing potentially requiring enabling a camera, clicking on a link, or downloading software. This may necessitate caregiver assistance (Padala, Wilson, Gauss, Stovall, & Padala, 2020), particularly for dementia. In our work using videoconferencing for a dementia home safety evaluation, which required ambulating the home under remote direction, we employed caregivers due to the complexity of the task (Gately et al., 2020).

Despite their involvement, caregiver needs in video visits are unknown (Bertoncello, Colucci, Baldovin, Buja, & Baldo, 2018). Caregivers may face similar challenges as older patients, including decreased digital skills (Casillas et al., 2020). Individuals with dementia may face barriers if caregivers are not available. Further, while some Veterans participated using phone only, videoconferencing has additive value to quality of life and caregiver burden when compared to phone alone (Lai et al., 2020). Videoconferencing also affords a view of patients in their natural context, providing opportunities for clinical observation (Moo, 2020). Therefore, while phone may be better than nothing, video may enhance the experience for patients and clinicians.

Our findings also suggest considerations for balancing caregiver involvement with MLMS's patient-centric approach. Regarding triadic communication, that is, communication involving patients, family members, and care teams (Laisaar-Powell et al., 2013), evidence suggests that caregiver presence often leads to increased provider understanding of health status and increased advocacy for individuals with dementia (Gitlin & Hodgson, 2016; Schmidt, Lingler, & Schulz, 2009; Vick et al., 2018). While gathering the most accurate information is crucial, it is important for clinicians to not rely solely on

caregivers but prioritize patient perspectives (Mitnick, Leffler, & Hood, 2010).

Limitations and future directions

This study's small, homogenous sample limits generalizability. We did not systematically capture caregiver's contribution to stories. While recognizing caregivers' vital role in dementia care, Veterans' responses may have differed if caregivers were not present. Future studies may formally assess caregiver contributions to My Life, My Story interviews. Similarly, comparing remote and traditional face-to-face interview experience is another avenue for future studies. Gathering baseline prior use of technology, and more granular details on technical glitches, may help to contextualize Technology Experience ratings and inform the potential need for technical support.

Conclusion

Technology allowed Veterans with cognitive concerns and their caregivers to participate in My Life, My Story during COVID-19. All Veterans participated and contributed stories despite cognitive concerns ranging from mild to severe, often aided by caregivers. Participation in MLMS enabled inclusion of Veteran stories in the medical record at a time when communication between families and care teams was limited. Many older adults rely on caregivers to advocate and provide information to care teams about what they value most (Schwartz et al., 2020). At times when caregivers are unable to be present with care teams (such as during COVID-19), remote MLMS may increase understanding of patients by care teams.

Clinical Implications

- When conducting narrative life story interviews with individuals with cognitive impairments, simplify language, consider broader questions that do not rely on memory, and encourage sharing of feelings over facts.
- During virtual interviews, caregivers are critical to setting up and trouble-shooting video-conferencing technology.
- Caregiver collaboration during interviews, including prompting, clarifying and providing details, may facilitate patient engagement.

Acknowledgments

The authors wish to acknowledge all the Veterans and caregivers who generously contributed their life stories to this project and Andrew Delao, OT/s, for his contribution as interviewer. We would also like to thank Sarah A. Poole, LICSW at the Neurocognitive Clinic for assistance with recruitment of Veterans and Nadene E. Stillings, LMHC, ATR-BC, Creative Arts Therapist at the VA Bedford HCS for providing education regarding the MLMS process and additional resources.


Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This study was not funded.

ORCID

Megan E. Gately PhD, OTD, OTR/L  <http://orcid.org/0000-0002-0319-8046>

Disclaimer

This material is the result of work supported with resources and the use of facilities at the Department of Veterans Affairs. The contents do not represent the views of the U.S. Department of Veterans Affairs or the United States Government.

References

- 2020 Alzheimer's disease facts and figures. (2020). *Alzheimers Dement.* doi:10.1002/alz.12068
- Almathami, H. K. Y., Win, K. T., & Vlahu-Gjorgievska, E. (2020). Barriers and facilitators that influence telemedicine-based, real-time, online consultation at patients' homes: Systematic literature review. *Journal of Medical Internet Research, 22*(2), e16407. doi:10.2196/16407
- Astell, A. J., Bouranis, N., Hoey, J., Lindauer, A., Mihailidis, A., Nugent, C., & Robillard, J. M.; Technology, & Dementia Professional Interest, A. (2019). Technology and dementia: The future is now. *Dementia and Geriatric Cognitive Disorders, 47*(3), 131–139.
- Austrom, M. G., Geros, K. N., Hemmerlein, K., McGuire, S. M., Gao, S., Brown, S. A., ... Clark, D. O. (2015). Use of

- a multiparty web based videoconference support group for family caregivers: Innovative practice. *Dementia (London)*, 14 (5), 682–690. doi:10.1177/1471301214544338
- Bertoncello, C., Colucci, M., Baldovin, T., Buja, A., & Baldo, V. (2018). How does it work? Factors involved in telemedicine home-interventions effectiveness: A review of reviews. *PLoS One*, 13(11), e0207332. doi:10.1371/journal.pone.0207332
- Borson, S., & Chodosh, J. (2014). Developing dementia-capable health care systems: A 12-step program. *Clinics in Geriatric Medicine*, 30(3), 395–420. doi:10.1016/j.cger.2014.05.001
- Burton, R. L., & O'Connell, M. E. (2018). Telehealth rehabilitation for cognitive impairment: Randomized controlled feasibility trial. *JMIR Research Protocols*, 7(2), e43. doi:10.2196/resprot.9420
- Bushnik, T. (2011). Visual analog scale. In J. S. Kreutzer, J. DeLuca, & B. Caplan (Eds.), *Encyclopedia of clinical neuropsychology* (pp. 2626). New York: Springer. doi:10.1007/978-0-387-79948-3_1788
- Canevelli, M., Bruno, G., & Cesari, M. (2020). Providing simultaneous COVID-19-sensitive and dementia-sensitive care as we transition from crisis care to ongoing care. *Journal of the American Medical Directors Association*, 21 (7), 968–969. doi:10.1016/j.jamda.2020.05.025
- Casillas, A., Cembali, A. G., Abhat, A., Lemberg, M., Portz, J. D., Sadasivaiah, S., ... Lyles, C. R. (2020). An untapped potential in primary care: Semi-structured interviews with clinicians on how patient portals will work for caregivers in the safety net. *Journal of Medical Internet Research*, 22(7), e18466. doi:10.2196/18466
- Chang, W., Homer, M., & Rossi, M. (2018). Use of clinical video telehealth as a tool for optimizing medications for rural older veterans with dementia. *Geriatrics*, 3(3), 44. doi:10.3390/geriatrics3030044
- Chen, C. K., Nehrig, N., Wash, L., Schneider, J. A., Ashkenazi, S., Cairo, E., ... Palfrey, A. (2020). When distance brings us closer: Leveraging tele-psychotherapy to build deeper connection. *Counselling Psychology Quarterly*, 1–14. doi:10.1080/09515070.2020.1779031
- Cheung, G., & Peri, K. (2020). Challenges to dementia care during COVID-19: Innovations in remote delivery of group cognitive stimulation therapy. *Aging & Mental Health*, 1–3. doi:10.1080/13607863.2020.1789945
- Czaja, S. J., Loewenstein, D., Schulz, R., Nair, S. N., & Perdomo, D. (2013). A videophone psychosocial intervention for dementia caregivers. *The American Journal of Geriatric Psychiatry*, 21(11), 1071–1081. doi:10.1016/j.jagp.2013.02.019
- Dang, S., Gomez-Orozco, C. A., Van Zuilen, M. H., & Levis, S. (2018). Providing dementia consultations to veterans using clinical video telehealth: Results from a clinical demonstration project. *Telemedicine and e-Health*, 24(3), 203–209. doi:10.1089/tmj.2017.0089
- Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mental state". A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12(3), 189–198. doi:10.1016/0022-3956(75)90026-6
- Gately, M., Trudeau, S. A., & Moo, L. R. (2019). In-home video telehealth for dementia management: Implications for rehabilitation. *Current Geriatrics Reports*, 8(3), 239–249. doi:10.1007/s13670-019-00297-3
- Gately, M. E., Trudeau, S. A., & Moo, L. R. (2020). Feasibility of telehealth-delivered home safety evaluations for caregivers of clients with dementia. *OTJR : Occupation, Participation and Health*, 40(1), 42–49. doi:10.1177/1539449219859935
- Gitlin, L. N., & Hodgson, N. A. (2016). Who should assess the needs of and care for a dementia patient's caregiver? *AMA J Ethics*, 18(12), 1171–1181. doi:10.1001/journalo-fethics.2016.18.12.ecas1-1612
- Gogia, S. B., Maeder, A., Mars, M., Hartvigsen, G., Basu, A., & Abbott, P. (2016). Unintended consequences of tele health and their possible solutions. Contribution of the IMIA working group on telehealth. *Yearbook of Medical Informatics*, 1, 41–46. doi:10.15265/IY-2016-012
- Goodman-Casanova, J. M., Dura-Perez, E., Guzman-Parra, J., Cuesta-Vargas, A., & Mayoral-Cleries, F. (2020). Telehealth home support during COVID-19 confinement for community-dwelling older adults with mild cognitive impairment or mild dementia: Survey study. *Journal of Medical Internet Research*, 22(5), e19434. doi:10.2196/19434
- Griffiths, P. C., Whitney, M. K., Kovaleva, M., & Hepburn, K. (2016). Development and implementation of tele-savvy for dementia caregivers: A department of veterans affairs clinical demonstration project. *The Gerontologist*, 56(1), 145–154. doi:10.1093/geront/gnv123
- Jennings, L. A., Turner, M., Keebler, C., Burton, C. H., Romero, T., Wenger, N. S., & Reuben, D. B. (2019). The effect of a comprehensive dementia care management program on end-of-life care. *Journal of the American Geriatrics Society*, 67(3), 443–448. doi:10.1111/jgs.15769
- Lai, F. H., Yan, E. W., Yu, K. K., Tsui, W. S., Chan, D. T., & Yee, B. K. (2020). The protective impact of telemedicine on persons with dementia and their caregivers during the COVID-19 pandemic. *The American Journal of Geriatric Psychiatry*, 28(11), 1175–1184. doi:10.1016/j.jagp.2020.07.019
- Laidsaar-Powell, R. C., Butow, P. N., Bu, S., Charles, C., Gafni, A., Lam, W. W., ... Juraskova, I. (2013). Physician-patient-companion communication and decision-making: A systematic review of triadic medical consultations. *Patient Education and Counseling*, 91(1), 3–13. doi:10.1016/j.pec.2012.11.007
- Le Couteur, D. G., Anderson, R. M., & Newman, A. B. (2020). COVID-19 through the lens of gerontology. *J Gerontol A Biol Sci Med Sci*, 75(9), e119–e120. doi:10.1093/gerona/glaa077
- Lindauer, A., Croff, R., Mincks, K., Mattek, N., Shofner, S. J., Bouranis, N., & Teri, L. (2018). "It took the stress out of getting help": The STAR-C-telemedicine mixed methods pilot. *Care weekly*, 2, 7–14. doi:10.14283/cw.2018.4

- Lindauer, A., Seelye, A., Lyons, B., Dodge, H. H., Mattek, N., Mincks, K., ... Erten-Lyons, D. (2017). Dementia care comes home: Patient and caregiver assessment via telemedicine. *The Gerontologist*, 57(5), e85–e93. doi:10.1093/geront/gnw206
- Lindeman, D. A., Kim, K. K., Gladstone, C., & Apesoa-Varano, E. C. (2020). Technology and caregiving: Emerging interventions and directions for research. *The Gerontologist*, 60(Supplement_1), S41–S49. doi:10.1093/geront/gnz178
- Lorenz, K., Freddolino, P. P., Comas-Herrera, A., Knapp, M., & Damant, J. (2019). Technology-based tools and services for people with dementia and carers: Mapping technology onto the dementia care pathway. *Dementia (London)*, 18(2), 725–741. doi:10.1177/1471301217691617
- Lum, H. D., Nearing, K., Pimentel, C. B., Levy, C. R., Hung, W. W., & Kaskie, B. (2020). Anywhere to anywhere: Use of telehealth to increase health care access for older, rural veterans. *Public Policy & Aging Report*, 30(1), 12–18. doi:10.1093/ppar/prz030
- Malmgren Fänge, A., Schmidt, S. M., Nilsson, M. H., Carlsson, G., Liwander, A., Dahlgren Bergström, C., ... Chiatti, C. (2017). The TECH@HOME study, a technological intervention to reduce caregiver burden for informal caregivers of people with dementia: Study protocol for a randomized controlled trial [journal article]. *Trials*, 18(1), 63. doi:10.1186/s13063-017-1796-8
- Mitnick, S., Leffler, C., & Hood, V. L.; American College of Physicians Ethics, P., & Human Rights, C. (2010). Family caregivers, patients and physicians: Ethical guidance to optimize relationships. *Journal of General Internal Medicine*, 25(3), 255–260.
- MoCA: Montreal Cognitive Assessment. Retrieved from <https://www.mocatest.org/faq/>
- Moo, L. R. (2020). Home video visits: Two-dimensional view of the geriatric 5 M's. *Journal of the American Geriatrics Society*, 68(11), 2425–2427. doi:10.1111/jgs.16843
- Moo, L. R., Jafri, Z., & Morin, P. J. (2014). Home-based video telehealth for veterans with dementia. *Federal Practitioner : For the Health Care Professionals of the VA, DoD, and PHS*, 31(12), 36–38. <https://www.ncbi.nlm.nih.gov/pubmed/29398887>
- Nathan, S., Fiore, L. L., Saunders, S., Vilbrun-Bruno Pa, S. O., Hinrichs, K. L., Ruopp, M. D., ... Moye, J. (2019). My life, my story: Teaching patient centered care competencies for older adults through life story work. *Gerontology & Geriatrics Education*, 1–14. doi:10.1080/02701960.2019.1665038
- Numbers, K., & Brodaty, H. (2021). The effects of the COVID-19 pandemic on people with dementia. *Nature Reviews Neurology*, 17(2), 69–70. doi:10.1038/s41582-020-00450-z
- Padala, K. P., Wilson, K. B., Gauss, C. H., Stovall, J. D., & Padala, P. R. (2020). VA video connect for clinical care in older adults in a rural state during the COVID-19 pandemic: Cross-sectional study. *Journal of Medical Internet Research*, 22(9), e21561. doi:10.2196/21561
- Pereira, R. B. (2020). Participating in telehealth is a complex occupation [Letter to the Editor]. *Australian Occupational Therapy Journal*, 67(3), 284. doi:10.1111/1440-1630.12671
- Pimentel, C. B., Gately, M., Barczi, S. R., Boockvar, K. S., Bowman, E. H., Caprio, T. V., ... Hung, W. W. (2019). GRECC connect: Geriatrics telehealth to empower health care providers and improve management of older veterans in rural communities. *Federal Practitioner : For the Health Care Professionals of the VA, DoD, and PHS*, 36(10), 464–470.
- Poletti, B., Tagini, S., Brugnera, A., Parolin, L., Pievani, L., Ferrucci, R., ... Silani, V. (2020). Telepsychotherapy: A leaflet for psychotherapists in the age of COVID-19. A review of the evidence. *Counselling Psychology Quarterly*, 1–16. doi:10.1080/09515070.2020.1769557
- Powers, B., Homer, M. C., Morone, N., Edmonds, E., & Rossi, M. I. (2017). Creation of an interprofessional tele-dementia clinic for rural veterans: Preliminary data. *Models of Geriatric Care, Quality Improvement, and Program Dissemination*, 65(5), 1092–1099. doi:10.1111/jgs.14839
- Ringler, T., Ahearn, E. P., Wise, M., Lee, E. R., & Krahn, D. (2015). Using life stories to connect veterans and providers. *Federal Practitioner : For the Health Care Professionals of the VA, DoD, and PHS*, 32(6), 8–14.
- Roberts, T. J., Ringler, T., Krahn, D., & Ahearn, E. (2020). The my life, my story program: Sustained impact of veterans' personal narratives on healthcare providers 5 years after implementation. *Health Commun*, 1–8. doi:10.1080/10410236.2020.1719316
- Schmidt, K. L., Lingler, J. H., & Schulz, R. (2009). Verbal communication among Alzheimer's disease patients, their caregivers, and primary care physicians during primary care office visits. *Patient Education and Counseling*, 77(2), 197–201. doi:10.1016/j.pec.2009.03.023
- Schwartz, A. W., Hawley, C. E., Strong, J. V., Phillips, S. C., Amir, O., Ludwin, B. M., ... Moye, J. (2020). A workshop for interprofessional trainees using the geriatrics 5Ms framework. *Journal of the American Geriatrics Society*, 68(8), 1857–1863. doi:10.1111/jgs.16574
- Serwe, K. M., Heindel, M., Keultjes, I., Silvers, H., & Stovich, S. (2020). Telehealth student experiences and learning: A scoping review. *Journal of Occupational Therapy Education*, 4(2). doi:10.26681/jote.2020.040206
- Shaw, C. A., Williams, K. N., Lee, R. H., & Coleman, C. K. (2021). Cost-effectiveness of a telehealth intervention for in-home dementia care support: Findings from the FamTechCare clinical trial. *Research in Nursing & Health*, 44(1), 60–70. doi:10.1002/nur.22076
- Sriram, V., Jenkinson, C., & Peters, M. (2019). Informal carers' experience of assistive technology use in dementia care at home: A systematic review. *BMC Geriatrics*, 19(1), 160. doi:10.1186/s12877-019-1169-0
- Vick, J. B., Amjad, H., Smith, K. C., Boyd, C. M., Gitlin, L. N., Roth, D. L., ... Wolff, J. L. (2018). "Let him speak:" a descriptive qualitative study of the roles and behaviors of family companions in primary care visits among older adults

with cognitive impairment. *International Journal of Geriatric Psychiatry*, 33(1), e103–e112. doi:[10.1002/gps.4732](https://doi.org/10.1002/gps.4732)

Williams, K., Blyler, D., Vidoni, E. D., Shaw, C., Wurth, J., Seabold, D., . . . Van Sciver, A. (2018). A randomized trial

using telehealth technology to link caregivers with dementia care experts for in-home caregiving support: FamTechCare protocol. *Research in Nursing & Health*, 41(3), 219–227. doi:[10.1002/nur.21869](https://doi.org/10.1002/nur.21869)