



Article

Virtual Team-Based Care Planning for Older Adults with Dementia: Enablers, Barriers, and Lessons from Hospital-to-Long-Term Care Transitions

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Abstract

Background: Transitions from hospital to long-term care (LTC) facilities are critical periods for older adults living with dementia, often involving complex medical, cognitive, and psychosocial needs. Virtual team-based care has emerged as a promising strategy to improve communication, coordination, and continuity of care during these transitions. However, there is limited evidence on how such approaches are implemented in practice, particularly with respect to inclusion, equity, and engagement of older adults and families. **Objective:** This study aimed to identify the enablers and barriers to delivering virtual team-based care to support older adults with dementia in transitioning from hospital to LTC. **Methods:** We conducted a qualitative study using semi-structured interviews, focus groups, and a policy review. Data were collected from 60 participants, including healthcare providers, older adults, and family care partners across hospital and LTC settings in British Columbia, Canada. Thematic analysis was conducted using a hybrid inductive and deductive approach. Eighteen institutional policies and guidelines on virtual care and dementia transitions were reviewed to contextualize findings. **Results:** Four themes were identified: (1) enhancing communication and collaboration, (2) engaging families in care planning, (3) digital access and literacy, and (4) organizational readiness and infrastructure. While virtual huddles and secure messaging platforms supported timely coordination, implementation was inconsistent due to infrastructure limitations, unclear protocols, and staffing pressures. Institutional policies emphasized privacy and security but lacked guidance for inclusive engagement of older adults and families. Many participants described limited access to reliable technology, a lack of training, and the absence of tools tailored for individuals with cognitive impairment. **Conclusions:** Virtual care has the potential to support more coordinated and inclusive transitions for people with dementia, but its success depends on more than technology. Structured protocols, inclusive policies, and leadership commitment are essential to ensure equitable access



Academic Editor: Deana Davalos

Received: 29 May 2025

Revised: 3 July 2025

Accepted: 19 August 2025

Published: 26 September 2025

Citation: Hung, L.; Santaella, P.; Connelly, D.; Sakamoto, M.; Mann, J.; Chan, I.; Wong, K.L.Y.; Upreti, M.; Hundal, H.; Yous, M.L.; et al. Virtual Team-Based Care Planning for Older Adults with Dementia: Enablers, Barriers, and Lessons from Hospital-to-Long-Term Care Transitions. *J. Dement. Alzheimer's Dis.* **2025**, *2*, 34. <https://doi.org/10.3390/jdad2040034>

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and meaningful engagement. The proposed VIRTUAL framework offers practical tips for strengthening virtual team-based care by embedding ethical, relational, and infrastructural readiness across settings.

Keywords: dementia; transition; virtual technology; team-based planning; long-term care; hospital

1. Introduction

Older adults moving to long-term care (LTC) facilities often present with complex medical conditions, cognitive impairment, and psychosocial vulnerabilities, which place them at heightened risk of functional decline and avoidable hospital readmission [1]. When continuity of care is lacking in transition, healthcare providers report difficulties in delivering person-centred care, leading to breakdowns in communication [2]. Chu et al. [3] reported that older adults experience significant depression, emotional distress, and functional decline within the first two months of entering LTC. Continuity of care is essential not only to manage complex medical needs but also to provide care that is person-centred and responsive to individual needs and preferences [4]. This involves knowing the person, adapting care to align with what matters most to them, and honouring their values, routines, and psychosocial needs. Families, who play a crucial role in caregiving, frequently report being excluded from transitional planning despite providing up to 30% of direct care in LTC [5], including personal care, emotional support, and advocacy [6]. Other studies suggest that family involvement and visits are associated with better health outcomes and improvement of communication with LTC staff [7–12]. However, traditional care models often fail to actively involve older adults and their family members in decision-making processes, leading to frustration and a sense of disempowerment [13]. For healthcare teams, facilitating safe and effective transitions is complex. The complexity of older adults' care needs requires interdisciplinary collaboration among nurses, physicians, care coordinators, rehabilitation practitioners, social workers, pharmacists, dietitians, occupational therapists, physiotherapists, and healthcare leaders. However, existing care coordination mechanisms are often insufficient, leading to gaps in communication, inadequate transfer of medical history and personal history, and limited follow-up support [4,14]. Furthermore, staff shortages, time constraints, and varying institutional discharge policies further complicate efforts to ensure high-quality transitional care [15]. Addressing these challenges underscores the need for integrated, team-based approaches that prioritize person-centred care.

Interdisciplinary collaboration and cross-sectoral coordination are essential to addressing the complexities of hospital-to-LTC transitions. Team-based care models that involve professionals across healthcare settings, along with older adults and their families, have been shown to improve care continuity, enhance communication, and optimize health outcomes [16–18]. One evidence-based approach that has demonstrated success in addressing complex care needs is the PIECES™ Approach [19]. This interdisciplinary approach to shared clinical assessment and supportive care considers the person's Physical, Intellectual, and Emotional health, strategies to support their Capabilities, their social and physical Environment, and Social self (life story, social network, culture, sexuality, gender identity). However, coordinating such team-based approaches across settings remains a persistent challenge. The COVID-19 pandemic accelerated the adoption of virtual care [20], highlighting its potential to bridge communication gaps and enhance care coordination. Virtual team-based care, which involves the use of videoconferencing (Zoom, Teams), telephone, and other digital platforms, such as email and instant messenger, has been

recognized as a viable approach to facilitating timely and efficient transitions from hospital to LTC. Research from Canada, Australia, Norway, and the United States demonstrates that virtual care can increase access to specialists, reduce hospital readmissions, and strengthen interdisciplinary teamwork [17,20–25]. In the literature, the terms virtual care, telehealth, and telemedicine are often used interchangeably to describe digitally enabled healthcare delivery. While these terms vary slightly in scope, they broadly encompass the use of digital platforms to support communication, care coordination, and clinical decision-making across settings. Importantly, virtual care allows geographically distant family members to participate in care planning, enhancing continuity of care and sharing decision-making. Yet, the implementation of virtual care in LTC settings is not without challenges. Barriers include limited access to devices, poor internet connectivity in some facilities, digital illiteracy among staff and families, and concerns about privacy and data security. These factors can undermine the effectiveness of virtual team-based care and limit its potential to foster meaningful engagement.

Given these complexities, further research is needed to understand how virtual care can be effectively integrated into transitional care models in ways that support both healthcare providers and families. While virtual care holds considerable promise, implementation often occurs without sufficient attention to frontline realities—such as the digital readiness of LTC settings, staff capacity, and the unique needs of older adults and their care partners. The success of virtual care hinges not only on technology access but also on meaningful engagement. Understanding the contextual factors that shape adoption, including organizational readiness, training needs, and relational dynamics, is essential for developing sustainable and equitable approaches to virtual team-based care in LTC transitions. This study addresses this gap by examining the implementation of virtual team-based care in hospital-to-LTC transitions. We identify key enablers and barriers for improving person-centred care planning during care transition.

2. Materials and Methods

2.1. Study Design

We adopted a qualitative descriptive design [26,27], grounded in **Interpretive Description (ID)**, a methodological approach developed for applied health disciplines [28]. This design was chosen to capture the perspectives of healthcare providers, older adults, and family members regarding virtual team-based care transitions, with the aim of producing findings that are relevant to clinical practice and system-level planning. ID is a widely used approach in healthcare research to explore the experiences and perspectives of participants, including healthcare providers, patients, and family members. This method is particularly well-suited to applied healthcare settings where the goal is to generate practical, actionable knowledge. This design prioritizes staying close to participants' own words, providing a rich and detailed account of the topic. It is particularly suited to our study, which examines the delivery of virtual team-based care during transitions from hospital to LTC.

2.2. Sampling and Recruitment

We used purposive sampling to recruit participants with direct experience in virtual team-based care during transitions from hospital to LTC. We employed purposive sampling to ensure representation across a range of roles involved in team-based care planning, including nurse clinicians, registered nurses (RNs), licensed practical nurses (LPNs), occupational therapists (OTs), physiotherapists (PTs), rehabilitation workers, social workers, pharmacists, dieticians, physicians, care coordinators, directors, and care management leads. We also sought diversity in gender and lived experience, particularly among family care partners and older adult participants. This inclusive approach was

designed to capture a broad range of perspectives on virtual care during transitions from hospital to LTC. Eligibility criteria for healthcare providers included having supported at least one hospital-to-LTC transition in the past six months. Family care partners were eligible if they had been involved in supporting a relative during such a transition. Older adult participants had to have recently experienced a transition to LTC (within the last six months) and have the cognitive capacity to provide informed consent. All participants were required to have been involved in some form of virtual team-based care during the transition process. Participant demographics are summarized in Table 1 in the Section 3.

Table 1. Participant characteristics.

Participant Characteristics	N	%
Occupation/Role		
Older adults	8	13
Family Members	6	10
Nursing Staff (Nurse Clinicians, RN, LPN)	19	32
Rehabilitative Care (PT, OT, Rehab Worker)	4	7
Social Workers	4	7
Pharmacists	2	3
Dietician	1	2
Physicians	5	8
Care Coordinators, Directors, Care Management Leads	11	19
Gender		
Female	42	70
Male	18	30
Racial Background		
White	24	40
East Asian	26	43
South Asian	9	15
Black	1	2

2.3. Data Collection

This study was conducted in Metro Vancouver, Canada, at two care sites: a large urban general hospital and a large publicly funded long-term care (LTC) home. These settings were selected to reflect typical care transition challenges and barriers, as well as the experiences of both care providers and recipients.

Data collection took place between 2023 and 2024. We collected data through semi-structured interviews [29] and focus groups [30], as these methods allow participants to reflect in-depth on their experiences and contribute a range of perspectives. Interview and focus group guides were collaboratively developed by the research team, including patient partner JM, through iterative discussion during regular online meetings (see Supplementary File S1). At each site, a frontline champion (an educator and a care coordinator) supported recruitment by promoting the study among eligible participants.

Interviews and focus groups were conducted via virtual communication that included video conference (Zoom) and telephone, or in person, depending upon participant preference. We conducted 10 semi-structured interviews and four focus groups. Each interview lasted approximately 30 min, while focus group durations were about an hour, varying based on participants’ availability. Focus group sizes ranged from three to thirteen participants. All sessions were audio-recorded with consent, professionally transcribed, and de-identified through the removal of personal identifiers. This multi-method design enabled us to capture diverse individual experiences and team dynamics across care settings. We used semi-structured interviews and focus group guides, which were co-developed by the research team, including a patient partner with lived experience through iterative refine-

ment. The guides were designed to elicit detailed perspectives on virtual care experiences during transitions from hospital to long-term care. The interview and focus group guide are provided in Supplementary File S1. To protect participant confidentiality, pseudonyms were used throughout the transcripts, analysis, and reporting to ensure that individual identities could not be linked to specific responses following research ethical guidelines.

In addition, we reviewed 18 policies and guidelines of the local health authority related to virtual care and dementia care transitions. This combined approach (interviews, focus groups, and policy review) enabled us to examine both lived experiences and institutional frameworks shaping virtual team-based care.

2.4. Data Analysis

We conducted a reflexive thematic analysis following the approach outlined by Braun et al. [31]. This approach emphasizes the active role of researchers in interpreting data and developing meaning through iterative engagement with transcripts. Two team members independently coded the transcripts, met to compare and discuss initial codes, and grouped similar codes into preliminary categories. These were brought to the full research team for discussion and refinement, ensuring consistency with the study's research objectives. Through multiple rounds of review, overlapping categories were consolidated and developed into broader themes. We used an inductive and deductive approach to analysis [32]. Inductive coding allowed themes to emerge from the data itself, while deductive analysis was informed by our research question and the broader literature on care transitions and virtual care. This approach enabled us to capture both anticipated and novel insights from participant narratives.

The final themes were selected through team consensus based on their relevance to the research objectives.

2.5. Rigor

We ensured the rigor of this study through multiple strategies [33]. To enhance credibility, we included direct participant quotes to support our findings. Additionally, our research team comprised members from diverse backgrounds, including interdisciplinary academics, healthcare providers, and individuals with lived experience of dementia. This diversity facilitated critical discussions, allowing us to challenge assumptions and strengthen our interpretations. Notably, the contribution of our team members with lived experience helped ensure the findings' relevance to real-world contexts. To improve transferability, we provided a detailed description of the study context and participants, enabling readers to assess the applicability of our findings to their own settings.

2.6. Ethical Considerations

Ethics approval was granted by the UBC Behavioural Research Ethics Board (H23-00679). All participants provided a written informed consent form prior to participation in the study and agreed to have their excerpts published. Pseudonyms were assigned to participants to maintain anonymity, and participation was voluntary.

3. Results

A total of 60 participants contributed to this study, offering diverse insights into virtual team-based care transitions from hospital to long-term care (LTC). Participants included 8 older adults with dementia, 6 family members, and 46 healthcare professionals from multiple disciplines—such as nursing, rehabilitative care, social work, pharmacy, dietetics, physicians, and leadership roles. Table 1 shows participant characteristics.

This study explored the following research question: What are the enablers and barriers to delivering virtual team-based care to support older adults with dementia in

transitioning from hospital to long-term care (LTC)? Our data analysis identified four interrelated themes: (1) enhancing communication and collaboration, (2) engaging families in care planning, (3) digital access and literacy, and (4) organizational readiness and infrastructure. Each theme integrates perspectives from interviews and focus groups; is grounded in real-world experiences; and is informed by institutional policies that address virtual care, dementia care transitions, and team-based care.

3.1. Enhancing Communication and Collaboration

Participants frequently cited virtual tools—such as Zoom, Teams, and secure messaging platforms—as enabling more frequent and timely communication between hospital and LTC staff. These tools supported interdisciplinary meetings, allowed for case discussions across settings, and provided continuity when face-to-face contact was limited. One caregiver, Mary, described a coordinated virtual care conference: “There were nine of us in the meeting—the head of the LTC home, the psychiatrist, the doctor, the nutritionist... the doctor joined virtually. That was pretty impressive. Everybody just gave a short summary of what they thought was going on.”

Despite this potential, the review of institutional policies revealed a disconnect between formal guidelines and practice. Although local policy documents encouraged interdisciplinary planning and promoted virtual huddles, participants described inconsistent uptake due to workload pressures, lack of formal scheduling protocols, and unclear expectations. David, a physiotherapist, reflected, “We each have 16 to 22 patients. We don’t have time to reach out and give handovers.” The absence of protocols mandating when and how virtual huddles should occur meant that implementation often depended on individual initiative. Furthermore, while some teams created their own structured handover tools to mitigate communication breakdowns, Dr. Chan, a geriatrician, emphasized the need for system-wide consistency: “There should be a format of steps and standards—that would go a long way to facilitate the process.” In this area, policy direction was general and non-prescriptive, offering encouragement without operational guidance. “As a social worker, I find that when we’re included early in virtual huddles, we can flag psychosocial issues and personal history that might otherwise be missed in a medical conversation.”—Lena, social worker.

3.2. Engaging Families in Care Planning

Virtual care facilitated increased family involvement, particularly for those who were working or geographically distant. Participants shared that being able to join care planning meetings by Zoom or receive updates through WhatsApp improved communication and reduced family anxiety. One family caregiver, Jason, noted, “Adult children who work during the day prefer to communicate via Zoom calls or emails,” and Jane, a recreation staff member, described how their team would “send family updates or pictures of the older adults working on something, or videos,” maintaining emotional connection during periods of separation. A family member, Sofia, told us, “My dad doesn’t speak English. Being looped in with the medical team helped me feel less anxious. I knew what was going on.”

However, the institutional policy review revealed a significant omission: while family engagement was valued in practice, there were no formal protocols or expectations for ensuring family involvement in virtual care planning. None of the 18 reviewed policies explicitly identified families or care partners as members of the interdisciplinary team, nor did they include requirements to involve them through virtual means. As a result, family participation was often left to the discretion of individual providers or dependent on local champions.

This gap had tangible consequences. Some families struggled with inconsistent invitations to care meetings or felt unprepared to participate in clinical decision-making. Additionally, there were no tools or adaptations to support participation by older adults with cognitive impairment. Felicia, a nurse practitioner, noted, “Older folks are not familiar or if they are familiar, they don’t want to use it for some reason,” and a family caregiver, Jennifer, described how a virtual translator failed during an important consultation: “We tried using the iPad translator, but it kept getting words wrong... it was exhausting.” The absence of cognitive-friendly communication tools in both policy and practice limited the inclusivity of virtual engagement.

3.3. Digital Access and Literacy

Access to devices, digital platforms, and training emerged as critical factors shaping the success of virtual care. In well-resourced settings, iPads, virtual interpreters, and standardized workflows allow providers to deliver efficient, person-centred care. As one nurse explained, “We use our iPads to help with translation. . . I used the interpreter on the iPad, and that’s very helpful.” Similarly, structured virtual support during leave-pass trials helped prevent readmissions; “90 to 95% of the time, it’s successful, and they don’t come back here,” said one nurse clinician.

However, the digital literacy of staff, patients, and families varied significantly, and these differences were not accounted for in institutional guidelines. While several policies broadly encouraged virtual care adoption, none included targeted guidance for training non-clinical users, nor did they address the digital capacity needed meaningfully to include older caregivers of people living with dementia.

Elaine, a family member, gave an example, “I was asked to download Zoom I’d never use. I just gave up.” One geriatrician highlighted the inefficiencies this created: “Without a structured approach, providers must navigate different platforms and protocols, which can lead to inefficiencies and potential errors.” Older adults, particularly those with cognitive or sensory impairments, were often excluded by default due to a lack of appropriate tools or staff support to assist them.

3.4. Organizational Readiness and Infrastructure

The degree of organizational readiness reflected in infrastructure, leadership support, and access to secure communication tools varied widely across care settings. In some cases, stable Wi-Fi and secure messaging facilitated smooth interdisciplinary collaboration. One provider shared, “We’re starting to use secure conversation, we text it, and we get orders back. A text is often quicker than trying to coordinate a call.”

In contrast, many participants described outdated infrastructure and lack of employer-provided devices as major obstacles. “The internet connection is really poor here, disrupting communication with family and staff over Zoom,” one LTC staff member noted. Others described needing personal phones for virtual care due to the absence of institutional resources, a practice that raised privacy concerns. For instance, Tom, an LTC nurse, said, “We don’t have enough tablets or tech support like the hospitals. It’s not a level playing field.”

Institutional policies consistently emphasize the protection of privacy and confidentiality in digital communication. However, these same policies did not include accompanying implementation strategies to ensure access to institutional devices or provide risk mitigation plans for common issues like poor connectivity. Participants reported reliance on fax machines and non-integrated systems despite policy-level commitments to modernization. “We had a case where two facilities needed to share patient records,” said a hospital admin-

istrator, “but because of different systems and privacy regulations, we had to rely on faxing documents. It slowed everything down.”

In addition, staff were often unsure how to document virtual interactions or navigate consent protocols—further evidence of the gap between policy ideals and practice realities. Privacy rules were emphasized in every document reviewed, but there was limited support for navigating them in real-world, fast-paced care transitions.

4. Discussion

This study examined the enablers and barriers to delivering virtual team-based care during hospital-to-LTC transitions for older adults living with dementia. Our findings demonstrate that virtual care can strengthen interdisciplinary collaboration and increase opportunities for family involvement in care transitions. Participants described how virtual huddles allowed teams to communicate flexibly across sectors (hospital and LTC) and how families, especially those with work or geographic constraints, were able to participate in care planning. Virtual messaging and video platforms also enable the timely sharing of information, reducing some of the communication breakdowns that often occur during transitions. However, these benefits were inconsistently realized across sites. Competing clinical demands, limited digital infrastructure, and the absence of standardized workflows frequently undermined the effectiveness of virtual approaches.

While institutional guidelines promoted virtual communication, they focused primarily on privacy, documentation, and consent protocols. Critically, the policies reviewed did not identify older adults and family caregivers as core care team members. There was no guidance on how to include people living with dementia in virtual care processes or how to support meaningful engagement from families. In practice, this policy gap translated into variable involvement. Some providers went to great lengths to include families, while others lacked the tools, time, or organizational support.

Our findings align with and extend the existing literature. For example, Chew et al. [34] described how long-term care staff in rural and northern areas of Western Canada faced similar barriers, including limited internet access, insufficient scheduling support, and staff shortages. They noted that older adults often required substantial staff assistance to engage in virtual activities and that registered care aides lacked necessary support from health authorities, echoing our participants' experiences with under-resourced facilities. Similarly, a literature review by Gao et al. [20] identified a striking gap in including older adults and families in virtual care planning, with only four studies reporting such engagement, largely due to lack of training and technological support, a concern echoed throughout our research.

Additionally, Connelly et al. [35], in their evaluation of the PIECES™ Approach integrated with virtual care conferences, emphasized that leadership support, alignment with organizational culture, and staff capacity were critical to successful implementation. Our findings reinforce this by highlighting how strong leadership and staff engagement influenced whether virtual care was prioritized or treated as optional and burdensome. Finally, Cole et al. [36] identified four key telehealth challenges in Canadian LTC homes—connectivity, device, privacy, and information access barriers—which closely mirror those reported by our participants, who frequently cited unreliable Wi-Fi, limited access to shared devices, lack of private meeting spaces, and restricted electronic health record access as constraints on their ability to deliver or participate in virtual team-based care.

Participants described digital inequities, including poor Wi-Fi, limited device access, and the use of personal phones by staff in under-resourced LTC facilities. These infrastructure gaps disproportionately affected the ability of older adults and family caregivers to participate, particularly those with cognitive or language barriers. Staff also reported feeling unprepared to troubleshoot technical issues or facilitate virtual meetings, underscoring the need for targeted

training and dedicated IT support. The reliance on fax machines and incompatible electronic records systems further complicated efforts to ensure continuity of care. Despite the promise of virtual care, its implementation was often shaped more by institutional constraints than by policy intentions or person-centred values. This highlights concerns about equitable access to digital resources, which are increasingly essential for both older adults and the families and healthcare providers who support them. Insufficient or poor-quality access to these resources can compromise the quality of care. Previous studies by Fang et al. [37,38] and Wong et al. [39] have also emphasized equity issues related to digital access in elder care, arguing that although digital equity is a concern across various populations, older adults often remain overlooked compared to other age groups, such as youth. It is important to note that older adults are not a homogeneous group; the population examined in this study—older adults living with dementia transitioning from hospital to long-term care—may face heightened vulnerabilities due to their specific contexts.

Overall, the findings point to a misalignment between what virtual care could achieve and how it is currently practiced. The lack of structured protocols, inclusive engagement strategies, and adequate infrastructure limits the full potential of virtual team-based care during dementia-related transitions.

Future research should focus on evaluating the long-term impacts of virtual team-based care on health outcomes, care transitions, and system efficiency. Specifically, research is needed to examine how co-designed tools and inclusive practices affect the quality of care, older adult and caregiver satisfaction, and staff burden. Comparative studies could identify how different organizational models—public, private, urban, or rural—navigate the challenges and opportunities of virtual care implementation. Additionally, research should explore strategies to involve people with dementia and their families in designing, delivering, and evaluating virtual care systems. Participatory approaches can help develop tools and protocols that are accessible, culturally relevant, and tailored to real-world needs. Finally, implementation science frameworks should be used to understand how virtual care innovations scale and sustain across settings and what policy levers can support their uptake equitably and ethically.

To address these challenges, we propose the VIRTUAL framework as a practical and mnemonic guide to improving virtual team-based care for older adults transitioning to LTC. This acronym synthesizes key recommendations grounded in our findings and offers useful tips for organizations seeking to implement virtual team-based care practices to improve the transition to dementia care.

4.1. VIRTUAL: Practical Tips/Actionable Strategies for Implementing Virtual Team-Based Care

V—Virtual Huddles and Team Communication: Encourage structured, routine virtual meetings to promote real-time interdisciplinary collaboration across care sectors. For example, use the PIECES Approach (Physical, Intellectual, Emotional; Capabilities; Environment; Social) to guide team conversations about older adults with complex needs. Employ standardized templates (e.g., PIECES huddle documentation forms) to ensure consistent and comprehensive information-sharing.

I—Involvement of Families, Caregivers, and Older Adults: Proactively include caregivers and older adults in care planning to ensure that decisions reflect lived experience, values, and preferences. For example, provide clear instructions and an onboarding brochure for families unfamiliar with virtual platforms. Use conversations and cognitive-friendly materials (e.g., visual aids, simplified summaries) to support older adults.

R—Reliable Technology and Digital Access: Provide equitable access to devices, secure Wi-Fi, and user-friendly platforms for all team members, including LTC staff and families. For example, supply shared tablets/laptops in LTC homes designated for virtual care use.

Conduct regular Wi-Fi audits and install boosters where needed. Select platforms with accessibility features (e.g., large text, captioning) and low-bandwidth options.

T—Timely Support: Ensure immediate access to technical assistance and troubleshooting to reduce disruptions and maintain continuity in virtual care planning. For example, invest in IT support within each care team. Create a step-by-step troubleshooting guide and post it in hospital and LTC settings.

U—Upskill Teams and Partnerships Across Sectors: Invest in training that enhances both digital proficiency and relational competence across hospital, community, and LTC settings. For example, provide onboarding sessions for new staff, family members, and older adults on virtual care tools. Offer refresher workshops quarterly to keep up with technology updates.

A—Address Privacy, Ethics, and Equity: Strengthen protocols that protect data while also promoting ethical engagement and equitable access to virtual tools for diverse populations. For example, monitor participation data by demographics to assess and improve digital equity. Ensure translation and interpretation services are always available for virtual care meetings.

L—Leadership and Staff Engagement: Promote strong leadership support and staff engagement to embed virtual care within organizational culture and everyday clinical practice. For example, recognize staff champions publicly (e.g., newsletters, meetings) to foster buy-in. Allocate protected time for staff to participate in virtual meetings and related documentation.

These VIRTUAL principles provide actionable guidance for organizations and health authorities to build virtual care programs that are not only technologically functional but also inclusive, person-centred, and sustainable. Importantly, they also reflect what current institutional policies often fail to address—namely, the need for structured inclusion of families, frontline support for staff, and digital tools that meet the needs of people living with dementia. Health authorities should update policies and guidelines to reflect these principles. Comprehensive protocols must clearly define expectations for virtual interactions, embed family and patient engagement, and standardize documentation and follow-up. Training programs should go beyond the technical use of platforms to include communication strategies, cultural safety, and trauma-informed approaches to engaging older adults and their families. Investments in digital infrastructure, interoperability, and secure platforms must be matched with workflow integration and scheduling supports that recognize frontline staff's pressures.

4.2. Limitations

There are a few limitations to this research. Most of our data were gathered from hospital-based healthcare providers due to infection outbreaks in LTC and access restrictions, limiting our ability to capture a full perspective from LTC older adults and staff. As a result, our findings primarily reflect the experiences and challenges encountered in hospital settings, with less insight into how transitions are managed within LTC homes. To better understand the tensions across sectors in a more comprehensive way, future research should further explore the perspectives of LTC staff, older adults, and family members to identify key facilitators and barriers to seamless transitions. Additionally, staff interviews focused less on team conflicts and dynamics, making it difficult to fully capture the complexities of interdisciplinary collaboration across hospital and LTC settings. Future research should explore what enables effective collaboration between sectors, examining factors such as shared communication strategies, role clarity, and structural supports that enhance coordination. Furthermore, the role of family members in ensuring continuity of care remains an important area for further investigation, particularly in understanding how

they can be better integrated into virtual team-based care planning. Expanding research in these areas will provide deeper insights into optimizing person-centred approaches for hospital-to-LTC transitions.

5. Conclusions

Virtual team-based care has the potential to improve communication, support continuity, and enhance person-centred planning during transitions from hospital to LTC for older adults living with dementia. This study identified critical enablers: structured virtual huddles, family involvement, reliable technology, organizational support, and systemic barriers. Current policies often overlook the relational and practical elements needed to implement virtual care equitably and effectively. Meaningful inclusion of older adults and families, tailored support for accessibility, and investment in workforce capacity are essential to closing the gap between policy intent and practice reality. The proposed VIRTUAL framework offers helpful tips for embedding inclusive, ethical, and coordinated virtual care into transitional planning. As health systems continue to integrate digital tools, the challenge ahead is not simply technological but relational, ethical, and organizational. Ensuring that virtual care models are grounded in the lived realities of those they aim to support will be critical to advancing equitable, person-centred dementia care across settings.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/jdad2040034/s1>. File S1: Interview guides.

Author Contributions: Conceptualization, L.H.; methodology, L.H.; data collection and analysis, L.H., I.C., M.U., D.C., M.S., J.M., P.S., K.L.Y.W., H.H., M.L.Y. and J.C.; writing—original draft preparation, L.H., I.C., M.U. and P.S.; writing—review and editing, L.H., I.C., M.U., D.C., M.S., J.M., P.S., K.L.Y.W., H.H., M.L.Y. and J.C.; supervision, L.H.; project administration, I.C.; funding acquisition, L.H. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the Canadian Institutes of Health Research, grant number CIHR AWD-024816.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of The University of British Columbia (REB H23-00679, 12 March 2023).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The datasets generated and/or analysed during the current study are not publicly available to protect participants' privacy, but are available from the corresponding author upon reasonable request.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

LTC Long-term care

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