

Bridging the Gap: Culturally Responsive mHealth Interventions to Unite Diverse Paid and Family Caregivers

Featured Research Session — as the dementia care ecosystem grows more diverse, cultural and linguistic discordance between unpaid family caregivers and the paid direct care workforce intensifies miscommunication, mistrust, and fragmented care. This session evaluates culturally adapted mobile interventions across workforce readiness, cross-cultural trust, clinical safety, and equitable implementation.

Presented by Arshia Khan (presenting-author assumption — please confirm) — featuring research from Shana Sites, Theresa McCarthy, and Catherine McCarty

Guided Poster Session • Single Presenter

AAIC 2026 • Poster aaic2026.0cc016d





Arshia Khan

Technology & Workforce

Mission vs. Mechanism: Workforce Readiness for Technological Augmentation

Background

The dementia care workforce shortage is often attributed to “compassion fatigue.” Emerging evidence instead points to regulatory and administrative burden as a major driver of burnout, detracting from direct patient engagement.

Methods

Semi-structured interviews with memory care staff (n = 3) spanning Executive Leadership, Administration, and Operational Support. Inductive thematic analysis mapped stressors against technology “wishlists,” distinguishing “care” tasks from “compliance” tasks.

Findings

A “Mission vs. Mechanism” conflict emerged: administrative tasks (reporting, funding logistics), not the emotional demands of caregiving, were the primary stressor. Staff showed high “technological optimism” and asked for tools that automate compliance work rather than replace human interaction.

“Mission vs. Mechanism”

Key Takeaway

Technology should prioritize administrative offloading, freeing staff to focus on the empathetic interpretation at the heart of dementia care.



Shana Sites

Cultural Mediator — Session Moderator

The Cultural Mediator: Reducing Role Ambiguity and Stigma in Cross-Cultural Care Dyads

Background

Cultural and linguistic discordance between paid home health aides and family caregivers fuels a “trust gap” — role ambiguity and “territorial” friction that raise psychosocial burden, compounded by stigma around dementia symptoms.

Methods

A sociotechnical framework examines how objective data logging (shared calendars, activity tracking) functions as a third-party validator in the care relationship, reducing “he said / she said” subjective friction.

Findings

Digital tools act as a “truth-teller”: an objective record of care events depersonalizes conflict and lowers the emotional labor of navigating cultural misunderstanding. App-facilitated “role clarity” buffers against burnout for both paid and unpaid caregivers.

“Neutral Mediator”

Key Takeaway

Shared, transparent digital records can turn disjointed care dyads into collaborative partnerships.



Theresa McCarthy

Clinical & Safety

Tech as a Translator: Icon-Based Interfaces for Reducing Medication Errors

Background

Language barriers between agency staff and families create real safety risks in medication management and care transitions; text-based instructions often fail when literacy or English proficiency is low.

Methods

Clinical workflow review of home-based medication management identifying “failure points” where linguistic discordance leads to errors, with a strategy for real-time translation to synchronize care plans.

Findings

Linguistic discordance is framed as a modifiable risk factor for adverse drug events. Icon-based visual tools and real-time symptom synchronization enable earlier clinical intervention and are linked to fewer preventable ED visits.

“Icon-First Design”

Key Takeaway

Visual, translation-first design is a patient-safety intervention, not just a convenience feature.



Catherine McCarty

Epidemiology, Ethics & Implementation

Equitable Implementation: The Digital Divide and Ethics of Surveillance

Background

mHealth scales care coordination but risks “intervention-generated inequalities”: rural broadband instability, and low-income paid caregivers’ ethical concerns about workplace surveillance.

Methods

An implementation-science critique of deployment models compares rural vs. urban barriers and the ethical friction points around data privacy in paid-care relationships, applying “Tech-Readiness” and “Digital Inclusion” principles.

Findings

Trust is as critical a determinant of adoption as physical infrastructure. Offline-first architecture and transparent privacy protocols are needed to counter digital-divide and surveillance-fear barriers among low-wage workers.

“Co-Design for Equity”

Key Takeaway

Equitable mHealth requires “low-resource robustness” and ethical transparency, not one-size-fits-all deployment.



Take-Home Message

Across four lenses — workforce readiness, cultural mediation, clinical safety, and equitable implementation — this session argues that culturally responsive mHealth succeeds when it offloads administrative burden, serves as a trusted neutral record-keeper, communicates visually across language barriers, and is deployed with deliberate attention to equity and privacy for both paid and family caregivers.