Clinical Scenario
Mrs. P is an 82-year-old retired farmer’s wife, functionally independent at baseline, who was admitted to post-acute care services at a skilled nursing facility for debility after a seven-day hospital stay for acute exacerbation of her chronic systolic and diastolic heart failure. Her rehabilitation stay was complicated by a weight gain of five pounds in the first week. Her follow-up evaluation at the heart failure clinic (one week after her hospital discharge) recommended intravenous furosemide, for which she was directly transferred to the heart failure clinic’s outpatient infusion center. No additional orders accompanied her return to the SNF, so the primary care provider at the SNF was not notified. A week later, her provider at the SNF was surprised to discover another five-pound weight gain now associated with decreased exercise tolerance secondary to shortness of breath, prompting a differential diagnosis of acute coronary syndrome, pulmonary embolism, or further heart failure exacerbation. Mrs. P was sent back for emergency department (ED) evaluation, resulting in hospital readmission.

Defining Microtransitions
We coin the term microtransitions to emphasize the existence of brief care transitions (usually of a few hours’ and definitely less than 24 hours’ duration) that might include change in location within a care setting or a brief outing from the care setting. More importantly, these transitions are characterized by a transfer in responsibility of care. Transition in responsibility of care is not limited to physicians — it includes all health professionals such as therapists, dentists, activity coordinators, and even family caregivers.

Many post-acute and long-term care providers are very familiar with continuum transitions, but Mrs. P’s case offered among the heart failure clinic, infusion center, and rehabilitation center can be considered “micro” because her care did not involve the hospital or ED. In this scenario, the responsibility for her care transitioned to the provider at the heart failure clinic and subsequently to the staff at the infusion center. A significant intervention was performed when Mrs. P received intravenous furosemide, and this was not communicated to the PALTC facility. As a result, opportunities to adjust the dose of diuretic and to monitor her weight changes more closely were missed. Her care was significantly impacted by the lack of effective communication during these microtransitions.

Microtransitions are not only confined to medical interactions — non-medical interactions also significantly impact PALTC care. For instance, visiting an attorney’s office to sign legal documents may result in a change of the resident’s power of attorney, which is very important for the PALTC team to be aware of. Going to a salon for hair grooming may require communication about supplemental oxygen use. New medications added or medications held, findings of functional status changes, or laboratory findings discovered in one setting may change the calculus for the patient’s decision making and subsequent medical care in another setting. In Mrs. P’s case, knowing about the heart failure clinic’s assessment may have prompted her rehabilitation provider to increase her daily dose for furosemide, preventing her subsequent weight gain and need for readmission to a hospital (a microtransition).

The COVID-19 pandemic has opened a new perspective on these short, routine transitions in PALTC that previously were not given much thought or attention. Microtransitions in PALTC became more evident as they emerged as risk factors for contracting COVID-19 infection. Much like transitions to and from hospitals, the protocols for assessing risk of contracting COVID-19 infection and need for testing and quarantine were drafted based on how long residents were out of PALTC facility or what activities occurred during that period.

Like the risk of exposure to COVID-19 outside the PALTC community, all microtransitions have the potential to impact the clinical health care of PALTC residents.

Impacting Our Health Care Systems
Fragmented or siloed models of health care delivery increase the risk of redundancy, waste, care gaps, and adverse events. Failure to quickly recognize and intervene after microtransitions can potentially result in poor health care outcomes for the patient and the health care system. The risks include increased morbidity, need for hospitalization, readmission after an index hospital stay, ED use, increased health care resource use such as diagnostic testing, and even mortality.

Transitions of care such as the ones described for Mrs. P likely occur every day for many PALTC residents without being recognized, but they care significant impact. Loss of vital health information during microtransitions may impact quality metrics across the health care continuum and lead to high-cost and high-acuity care for PALTC facilities. The events that occur during microtransitions if not attended to diligently can result in macrotransitions: the need for hospitalization or an evaluation in the ED.

Standardizing Workflow for Microtransitions in PALTC
Microtransitions can be operationalized and improved on through quality assurance and performance improvement processes, once they are defined, recognized, and acknowledged. PALTC facilities should start by identifying and standardizing protocols surrounding microtransitions.

Specific steps for gathering and sharing information, depending on the type of microtransition, and for notifying facility providers of any new findings and recommendations promptly must be incorporated into the routine workflow. PALTC medical record documentation must designate sections promoting microtransition documentation rather than focusing only on hospital or ED events.

Recognizing that the patient is the central focus of every transition and that care must be patient-centered, the system may designate providers, nurses, caregivers, schedulers, and transport staff to fulfill well-defined roles during these transitions, including microtransitions. Discussion with Mrs. P and her caregiver by a PALTC staff member would promote Mrs. P’s awareness that the findings from the heart failure clinic are important to her rehabilitation providers to facilitate the best medical care for her.

Providers must conduct medication reconciliation, handoffs with other

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Transitions of Care
By Sandeep R. Pagali, MD, MPH, Sing Palat, MD, CMD, and Aval Na-Ree S. Green, MD, MHA, CMD

Microtransitions: A Crevise in the Bridge Before It Cracks

Continued to next page
In Pakistan, where I grew up, caring for aging parents or grandparents was seldom an issue. Family members either lived close by or had a big family house that accommodated at least two or three generations while allowing privacy. Interdependency and codependency were one of the norms for many families. Nowadays, this concept is fading away in Pakistan and other eastern societies, particularly as the nuclear family system becomes more common than a joint family system. This trend is being seen all over the world, diminishing on many levels the value of the interdependent extended family. How does this affect older adults who once maintained their independence and now require assistance and support inside and outside their homes?

These shifts in family dynamics as well as changes in health status among older adults are often the driving reason behind the search for an appropriate assisted living community. I now work in Maryland in the United States, where older adults or their children often feel compelled to look for alternative living solutions as the risk of living independently outweighs the benefits. The daughter of one of my patients shared her concern: “I don’t want my mom to leave her house and lose her independence. But now she is forgetting to turn on the stove, she cannot drive due to her recent car accident [driving on the wrong side of the road], and she’s not able to cook or clean for herself.” The daughter paused and stated, “I don’t feel she is safe at home, and in the event of a fall or accident, she won’t be able to ask for help due to her restricted mobility and advancing dementia.”

In the United States and in other parts of the world, assisted living facilities (ALFs) offer families another option besides home care. Often, adults can maintain some of their autonomy in assisted living while they receive medical and/or assistance with daily care activities that was not available to them in their independent homes. This autonomy is often lost in nursing homes due to multiple factors including complex state and federal regulations, inadequate staff-to-patient ratio, and lack of resources or time required to provide specific person-centered care.

Of course, there are challenges of caring for older adults in assisted living communities as opposed to them being at home or in nursing homes, including the financial burden on families due to the high monthly cost of living. Only those families who can afford the cost of an ALF may choose it. The unavailability of routine medical care is another issue. Unlike nursing homes, ALFs rarely require an in-house medical director. Instead, they require that the residents have a designated primary care physician, and many facilities allow providers to come into their buildings for medical and psychiatric evaluations and treatments.

Oftentimes larger ALFs hire or contract an advanced practitioner to treat their residents’ acute and chronic health conditions, particularly as there is a wide range of variability in the medical status of the residents. However, issues like medication management for older adults with complex comorbidities in such a fractured setting can be an issue. To ensure that the needs of older adults are met appropriately, person-centered medical and psychosocial care are required, particularly to locate gaps in routine medical care and attend to family needs.

It is crucial to be mindful of cultural differences, particularly for communities where intergenerational family care is still common.

Returning to where I started, it is also crucial to be mindful of cultural differences, particularly for communities where intergenerational family care is still common. Residents and their families who are, for example, Korean, Indian, Muslim, Chinese, African, and Black Americans may want to carry their own traditional values and belief systems into the facility. Maryland has a few ALFs that focus on providing care to a particular religious or ethnic group, such as Korean, Jewish, and Catholic communities. Such facilities allow the aging population to practice their culture and faith openly and without restrictions. However, it’s important that staff in all ALFs are trained in cultural competencies, especially because the staff themselves likely come from diverse backgrounds.

Overall, the key to a successful care delivery model is establishing an effective nonverbal and verbal communication process while maintaining empathy and humility. After all, every patient has a life story, and each story is unique. Individuals go through multiple trials and triumphs in life until they reach a point of needing greater support and assistance. ALFs support them while they are going through this physical and/or mental transition from an independent state to requiring assistance and support.

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