INSIDE STORY

AGING AND HEALTH

A Mother's Goodbye
Barriers to Microtransitions in Care

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A.S.G.: She made it to the parking lot of her physician's clinic, only to collapse while exiting her vehicle. After a long, debilitating battle with lupus, my cousin died at the doorsteps of our health system.

My first thought was for my cousin's mother—my aunt. At 78 years old, she has now outlived both her children. She lives in a skilled nursing facility and requires a bariatric wheelchair for mobility. While my aunt maintains general awareness, she has an expressive aphasia that makes conversations difficult. Who would tell her that her daughter had died? Who would work with her care team to ensure she could travel the 40 miles to the funeral? As a geriatrician and certified medical director of a skilled nursing facility, I was the logical choice to coordinate my aunt's travel from her nursing home to the funeral.

I started by calling the social work department. A game of telephone tag resulted in a stalemate after 2 days. I resorted to email, requesting their assistance with scheduling nonemergent wheelchair van transportation to and from the funeral.

While waiting for a reply, I contacted nursing to ensure they had all the required information to get my aunt ready to attend the funeral. When I explained why I was calling, the nurse responded, telling me the funeral was mentioned in the morning meeting and that such coordination was not nursing's responsibility. They suggested I reach out to social work instead. I clarified that I wanted to address medical questions.

"My aunt is Hoyer transfer–dependent and incontinent, correct?"

They affirmed this.

"Can you place a Foley catheter before the trip to help manage her incontinence and preserve her dignity, since she will be gone for several hours?"

They affirmed that could be done.

Thinking that she would be hugging family and friends at church, I requested that staff coordinate her bath and catheter placement the evening prior. I knew that she would want to smell good and not worry about incontinence, and I thought it might be too fatiguing for her the morning of the funeral.

They agreed.

Three days before the funeral, I heard back from the social work department. They explained that while the facility had a bariatric-accessible van and a driver, they did not have a driver working on the day of the funeral to transport my aunt. I would have to arrange and assume financial responsibility for her transportation. I was provided with a list of transportation services. I called every company on it. The first only provided medical transportation. The second could not accommodate bariatric wheelchairs. I called the next 2 companies—no answer. I left messages and waited.

Eventually a company called back; they could not provide drivers but offered to provide a bariatric-accessible rental van. When the van was delivered to the facility the day prior to the funeral, we learned that the wheelchair was too wide to fit inside. Staff sawed off the wheelchair's hand rims. It barely fit. The facility confirmed that orders for the Foley catheter and bath were in place, and my aunt would be ready at 9:00 AM as planned.

The funeral was at 11:00 AM. I arrived at the facility at 8:45 AM. Although the catheter was in place, my aunt was undressed, with remnants of breakfast on her gown. She had not been bathed. A staff person and I broke a sweat as we worked to clean her, change her briefs, and dress her. When we finally transferred her to the wheelchair, it was 10:30 AM. I noticed an oxygen concentrator at bedside and asked the staff if we needed oxygen for the trip. They acknowledged that was a good idea. I was shown the half-filled canister across the room.

The staff and I wheeled my aunt outside and attempted to load her into the van. The wheelchair must have been only partially expanded when tested the day before. Once my aunt was in the chair, it could not fit through the van door.

My aunt was devastated. I was exhausted. The staff were disappointed. We went back inside, and I thanked the staff for their assistance. Remaining solutions oriented, I contacted the church and requested they livestream the ceremony. My aunt and I watched virtually. We cried together in the facility's activity room. It was not what I hoped or planned for, but it was the best I could do. Despite my experience as a long-term care physician and medical director, I could not successfully navigate this transition for my own aunt.

Later that day, I told my colleague (B.E.C.), a geriatric occupational therapist, how humbling this situation felt. Together, we reflected on how many people with lower levels of health literacy may have struggled to advocate for the care coordination needed in this situation. He is a coauthor of this piece; his comments follow.

B.E.C.: As a colleague and friend, I reached out to Aval-Na'Ree again after the funeral. It was clear to us that as a family member, there was little that Aval-Na'Ree could have done differently.

Aval-Na'Ree and I are members of the Post-Acute and Long-Term Care Medical Association Transitions of Care Subcommittee, which coined the term *microtransition*. A microtransition is a temporary transfer in custodial care that is nonurgent yet carries risks similar to

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major transitions in care.[1,2] These trips are often overlooked due to their brevity,[1,2] but Aval-Na'Ree's experience demonstrates how seemingly minor transitions can go awry without proper processes in place. This failed microtransition meant that a mother missed her chance to say goodbye to her daughter.

Nursing homes are limited in resources—staffing, wheelchairs, vans—yet ultimately what failed this transition was not resources but rather a lack of care coordination. Because this transition was not a medical health care appointment, the facility did not coordinate the resources, including use of the van, that were necessary for it to occur successfully. In contrast, had this been a medical outing, such as a weekend dialysis appointment, the facility would have been required to provide transportation. If this microtransition had been treated like a major health care transition, perhaps it would have had a better chance of success. Nursing teams use checklists during major care transitions; similar procedures should apply to microtransitions.

While some may argue that the term *microtransition* unnecessarily medicalizes ordinary outings, this perspective neglects that for individuals with complex care needs, even these transitions have medical implications. These nonmedical outings still require clinical care coordination to be executed safely. Ensuring that individuals are able to participate in such activities thus requires a paradigm shift in how these activities are framed —from nonmedical trips to events that warrant clinical attention. Clinicians and health care administrators should develop facility-specific policies to optimize outcomes during microtransitions. The use of standardized care coordination processes could ensure that other families like Aval-Na'Ree's can focus on spending time with loved ones rather than trying to manage medical issues.

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