# Map to avoid detours on road to HIV treatment success: Focus on transitions in care may improve outcomes

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(Medical Xpress)—Addressing on the challenges that accompany transitions between health care settings could be a key strategy for improving clinical outcomes for people living with HIV, according to researchers from the Perelman School of Medicine at the University of Pennsylvania. The team's plan, which calls for identifying potential challenges before they occur and preparing to address them, is detailed online in the journal *AIDS*.

Despite tremendous advances in antiretroviral therapy, studies have shown that only 28 percent of people living with HIV achieve viral suppression. These patients frequently experience transitions in care – upon discharge from the hospital, between pediatric and adult clinics, from prisons into the community, and when changing medical providers due to moves or changes in economic or insurance status – that can hinder efforts in accessing care, receiving antiretroviral therapy, and remaining adherent to treatment. Often, these transitions occur in conjunction with a change in health status or social state. "Transitions are inherently difficult for patients, but are particularly challenging for patients living with HIV who face high rates of poverty, mental illness, and confront HIV-related stigma and discrimination," the authors write.

These transitions in care may lead to medication errors, difficulty securing housing and employment, insurance hurdles, and problems establishing connections with new providers or related social services.

To tackle the challenges associated with making these transitions, the Penn researchers suggest the adoption of a Dynamic Behavioral Model in which patients, providers, and caregivers work together to anticipate challenges that may occur during care transitions, and develop proactive solutions to address them.

"It's important for medical providers to remember that management of our patients is not confined to a particular health setting," says lead author Baligh Yehia, MD, MPP, MSHP, an instructor in the division of Infectious Diseases. "But rather, we are a part of team that is responsible for the continuous management of our patients between and across different health setting and providers."

Improving case management and providing patient navigation to support and guide patients – particularly following hospitalizations—have proven to be effective strategies for boosting retention in care and improving clinical outcomes, which the authors suggest may be buoyed further by the incorporation of "pre-transfer" visits in which patients meet with both their old and new care teams. For patients transitioning between adolescent clinics to adult care settings, the team recommends that providers work to help young patients develop the skills to manage their health care on their own, and developing an individualized timeframe to ensure patients are prepared to transfer. Effective communication between providers is also essential: Health care organizations and providers should standardize the information necessary for transfer, and leverage health information technology to ensure secure information exchange that maintains proper patient confidentiality.

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