

British HIV Association (BHIVA) guidance for virtual consultations for people with HIV 2021: May 2021

Writing group

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Due to the unprecedented circumstances of the coronavirus disease 2019 (COVID-19) pandemic, to produce pragmatic advice in a timely manner, our usual rigorous guideline development process has not been followed.

A goal of the NHS Long Term Plan, published in January 2019, is to enable digital technology to become 'mainstream' in primary care and outpatient services, to afford greater patient choice and reduce the need for up to one-third of face-to-face outpatient visits [1]. This process has been accelerated by the COVID-19 pandemic, which has significantly affected how health services are delivered for people living with HIV in the UK. There has been a sudden and substantial fall in the number of face-to-face consultations and a rise in virtual consultations [2,3], and this may continue for the longer term. For the purposes of this guidance, virtual refers to any non-face-to-face consultation, namely by telephone, email or video. The General Medical Council (GMC) [4] and Royal College of Physicians (RCP) [5] have developed good practice guidance for remote consultations. In addition, evidence and guidance for email consultations predating the COVID-19 pandemic are available [6-8].

Remote consultation and management will remain important modalities to deliver care as the pandemic–recovery phases evolve. Much of the transition to virtual consultation was rapid and lacked stakeholder consultation, especially with the patient community [9]. HIV disproportionately affects already marginalised and underserved communities. Access to hardware and data may be limited. HIV-associated stigma and discrimination continue to be considerable challenges and it may be difficult for people with HIV to find adequate privacy for remote consultation. Poor mental health, language barriers, comorbidities and polypharmacy may also add complexity to the consultation. Therefore while data on the outcomes for people living with HIV in the era of virtual consultations are collected, in addition to the GMC and RCP guidance, we suggest the following issues are considered.

1. Patient choice

Patient choice should be at the centre of HIV clinical care. The BHIVA Primary Care Project [10] highlighted the importance of patient choice in the type of consultation. People living with HIV who are symptomatic may prefer face-to-face consultation with an HIV specialist whereas those experiencing fewer symptoms may prefer virtual models of care [11].

We recommend:

- The consultation type should be guided by informed patient preference, except where specific public health restrictions necessitate virtual care, or clinical need necessitates in-person assessment.
- For people choosing virtual consultations, a face-to-face appointment should be offered at least annually and when clinically indicated. The opportunities that face-to-face consultation offer in terms of vaccination, sexual health screening and physical examination should be considered. While there is no published evidence at present to support specific recommendations with regard to visit frequency, our advice is consistent with a recent international consensus viewpoint which suggests a follow-up schedule that includes two to three patient–clinician encounters each year, alternating one face-to-face meeting and one or two virtual consultations 4–6 months apart [12].

2. Equity of access

Digital inequality is an important barrier to virtual care; access to the internet or a telephone network, appropriate hardware, digital literacy and a confidential space are prerequisites for virtual care and should be considered when developing virtual pathways. Language barriers may also be a challenge and a longer appointment duration is advised for consultations requiring an interpreter, whether face to face or virtual.

3. Clinic resources and infrastructure

Services will need to consider their facilities, technology, governance arrangements and environment and whether changes are required to optimise virtual services. The fact that some clinicians may be working remotely will also need to be considered. The majority of virtual appointments in 2020 were by telephone [13]. Video consultations may require additional technological and governance considerations and national/local policies should be followed as pathways are designed and adapted.

4. Privacy, confidentiality and safeguarding

Virtual consultations present additional challenges for confidentiality and safeguarding and concerns over privacy and confidentiality may hinder virtual consultations [14]. There may be barriers for some patients [15] and healthcare professionals [16] to find a private space for a confidential consultation where they will not be disturbed.

The following should be addressed at the start of a virtual consultation:

- Right person – confirm the identity of the patient (name, date of birth).
- Right time – is it convenient to talk? Is the patient alone and safe? The latter may be particularly difficult to assess for telephone consultations in the absence of non-verbal cues.

- Right place – check the person’s location and contact details. This is important for subsequent safety concerns or if you are disconnected during the call; clarify that if you are disconnected you will contact them.

Guidance for safe enquiry about domestic abuse in virtual consultations has been produced [17].

5. HIV-specific considerations

Within HIV virtual pathways every opportunity should be taken to ‘make every contact count’ and to maximise the value of face-to-face contact when it occurs [18]. For example, where it is feasible to do so, blood monitoring appointments could be expanded to include basic health promotion, domestic abuse screening, vaccination and provision of pre-appointment questionnaires where appropriate. In addition, all clinics should provide written or online information about clinic pathways, the type of consultation to expect and what the consultation will entail. Clinics must also provide clear information for patients about where to seek emergency advice and support.

There is currently a limited evidence base to guide provision of virtual HIV care and it is important that HIV service models are adapted as further evidence becomes available [19].

Patient safety

Ensuring patient safety should be the overriding principle when considering a virtual versus a face-to-face consultation. For example, is monitoring, imaging or examination needed that requires a face-to-face consultation? Based on the health domains included in the European AIDS Clinical Society guidelines [20], a follow-up framework was recently proposed, in which 13 procedures (such as blood collection) require a face-to-face consultation and 13 assessments (such as medication reconciliation and patient-reported outcomes) can be carried out by virtual consultation [12].

A face-to-face appointment may be preferable for the following groups and situations, taking into account individual COVID-19 risk:

- People who have a new diagnosis of HIV or are transferring their care. Evidence from non-HIV services demonstrated better virtual consultations when the clinician and the patient knew and trusted each other [21].
- People who are immunosuppressed, requiring a focused physical examination.
- Patients switching antiretroviral therapy; the consultation can be undertaken virtually if the patient and clinician feel it is appropriate. If post-switch blood monitoring is required (which may not be the case for all patients), this could also provide the opportunity for a contemporaneous face-to-face consultation.
- During pregnancy, in order to undertake recommended HIV viral load monitoring and sexually transmitted infection (STI) screening and to be able to assess effectively any complex social factors.
- For consultations in which an interpreter is required.

HIV viral load

In some settings, the frequency of HIV viral load testing has decreased substantially during the COVID-19 pandemic [22]. HIV viral load should be monitored according to the BHIVA monitoring guidelines [23]. Interim COVID-19 guidance [24] recommends that a longer interval of monitoring may be appropriate in the setting of a national lockdown or specific public health restrictions on

a case-by-case basis, while considering adherence, need for treatment as prevention and the individual's antiretroviral regimen. The balance of risk will depend on the local incidence of COVID-19 at that time and whether the individual is fully vaccinated. Evidence from centres where less frequent monitoring has been conducted will be reviewed for the next update of the BHIVA monitoring guidelines and recommendations made at that time.

Health promotion, vaccination and testing

Services should consider how to maximise opportunities for health promotion, STI screening and vaccination within virtual pathways. Opportunities for monitoring weight, blood pressure and urine dipstick testing are also missed with virtual consultation and may be more important for selected patients.

Women's health and contraception

Incorporation of strategies to ensure uninterrupted contraception and cervical cytology may be needed, perhaps in collaboration with general practice or other services [25,26].

6. The healthcare relationship

Demonstrating empathy virtually when non-verbal cues are limited or absent is challenging. Studies have demonstrated that patients disclose more when clinicians are empathetic and are more likely to adhere to medication regimens [27]. Thus empathy is a critical component of effective clinician–patient communication associated with various benefits for patient satisfaction and outcomes.

7. Consideration for clinical staff in training

Exposure to both virtual and face-to-face consultations should be considered for trainees and for undergraduate students. This will need to be accounted for as pathways develop, including mechanisms for trainees and students to join virtual consultations where there is consent to do so.

Summary

Existing plans to increase the proportion of consultations carried out remotely have been accelerated by the COVID-19 pandemic. To support clinicians, and optimise patient experience, this guidance highlights issues important for safe and effective consultation, including awareness of the limitations of remote consultation. Confidentiality, patient safety and information governance are key as always.

This rapid guidance was last reviewed in May 2023 and will be reviewed again by May 2024.

Comments and feedback are welcomed through BHIVA: <https://www.bhiva.org/rapid-guidance>.

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