A review of referrals and interventions within a specialist HIV outpatient Physiotherapy service

RHIVA
REHABILITATION IN HIV ASSOCIATION

D. Brown (MSc) & Dr M. Nelson
Chelsea and Westminster NHS Foundation Trust

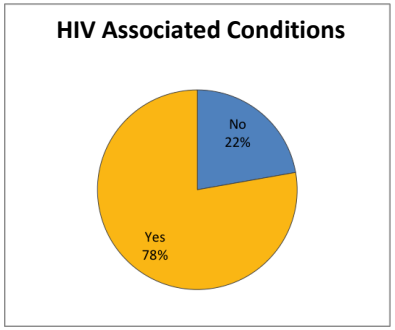
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Background:

As people live longer with HIV with increasing comorbidities and above average risk for cardiovascular, metabolic, bone and neurological problems, chronic long-term condition management is increasingly relevant[(1)]. Attention to physical dimensions of patient care is suggested to optimise well-being[(2)]. Poor physical function in HIV outpatients, including mobility problems, pain and reduced self-care are associated with worse self-reported health status[(2)]. Physiotherapy aims to optimise function, well-being and promote self-management. This review aims to identify sources of referral into a specialist HIV outpatient Physiotherapy service, the reason for referral and interventions received. The aim is optimise service delivery to address patient requirements.

Methods:

Data was collected for all HIV patients referred to HIV outpatient Physiotherapy between February and December 2012.



Contact: Darren.Brown@chelwest.nhs.uk

Results:

72 patients were referred to HIV outpatient Physiotherapy. 90% were male, median age 52yrs (range 32-79yrs), 50% aged 50 and over. 26% had a dual HIV and Haemato-Oncological diagnosis. HIV clinicians referred 40% of patients and other referrals were via Physiotherapists and Occupational Therapists (18%), Dieticians (12.5%), Nurse specialists (12.5%), Oncology/Palliative care Clinicians (11.1%) and Psychologists (2.7%).

The most frequent reasons for referral were musculoskeletal (36.1%), neurological (15.3%), reduced exercise tolerance (11.1%) and pain management (9.7%). 22% were not HIV related conditions.

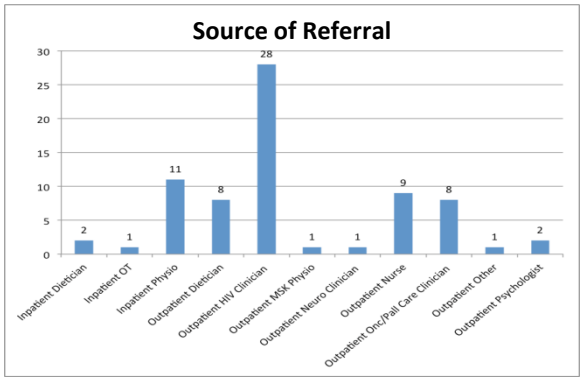
The most frequent Physiotherapy interventions consisted of 1:1 treatment (46%) or 1:1 followed by a twice weekly, 10-week group HIV rehabilitation programme (27%). 30% of patients were referred to the group rehabilitation programme. 6.3% did not attend 1:1 and were discharged. 7.9% received an onward referral to external services. Hydrotherapy and 1:1 were provided to 1.6% of patients.

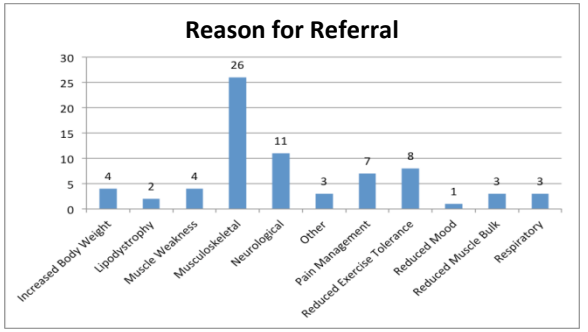
Conclusion:

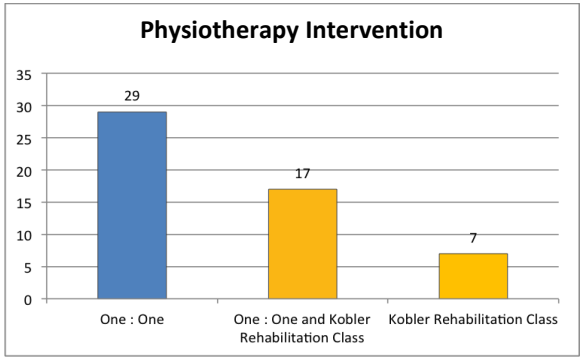
Referrals to a specialist HIV outpatient Physiotherapy service come from a range of multidisciplinary professionals. Less than a quarter were non-HIV related conditions within an ageing population, referred for diverse reasons. The majority of patients require 1:1 Physiotherapy or a twice weekly, 10-week group HIV rehabilitation programme. This reflects 2 key service provision requirements for this patient cohort.

Implications:

Delivery of an HIV outpatient Physiotherapy service requires both 1:1 clinics and group HIV rehabilitation programmes to address diverse patient needs.







1) BHIVA standards of care for people living with HIV; 2013
2) Harding et al. What factors are associated with patient self-reported health status among HIV outpatients? A multi-centre UK study of biomedical and psychosocial factor. AIDS Care, 2012;24(8):963-971