Shared care:

Findings from the BHIVA primary care project

Presenting on behalf of the BHIVA shared care team
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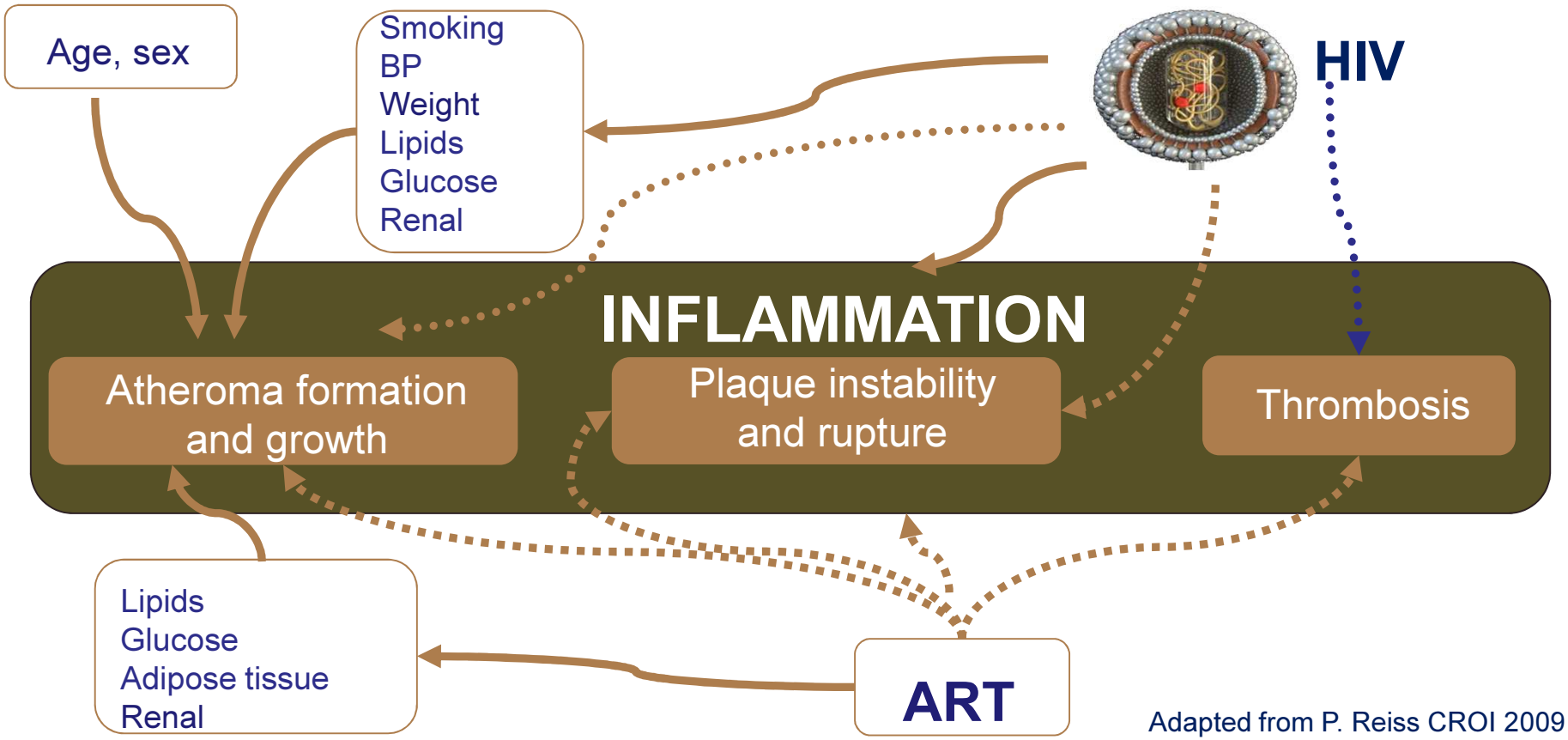
Background (1): HIV as a long-term condition

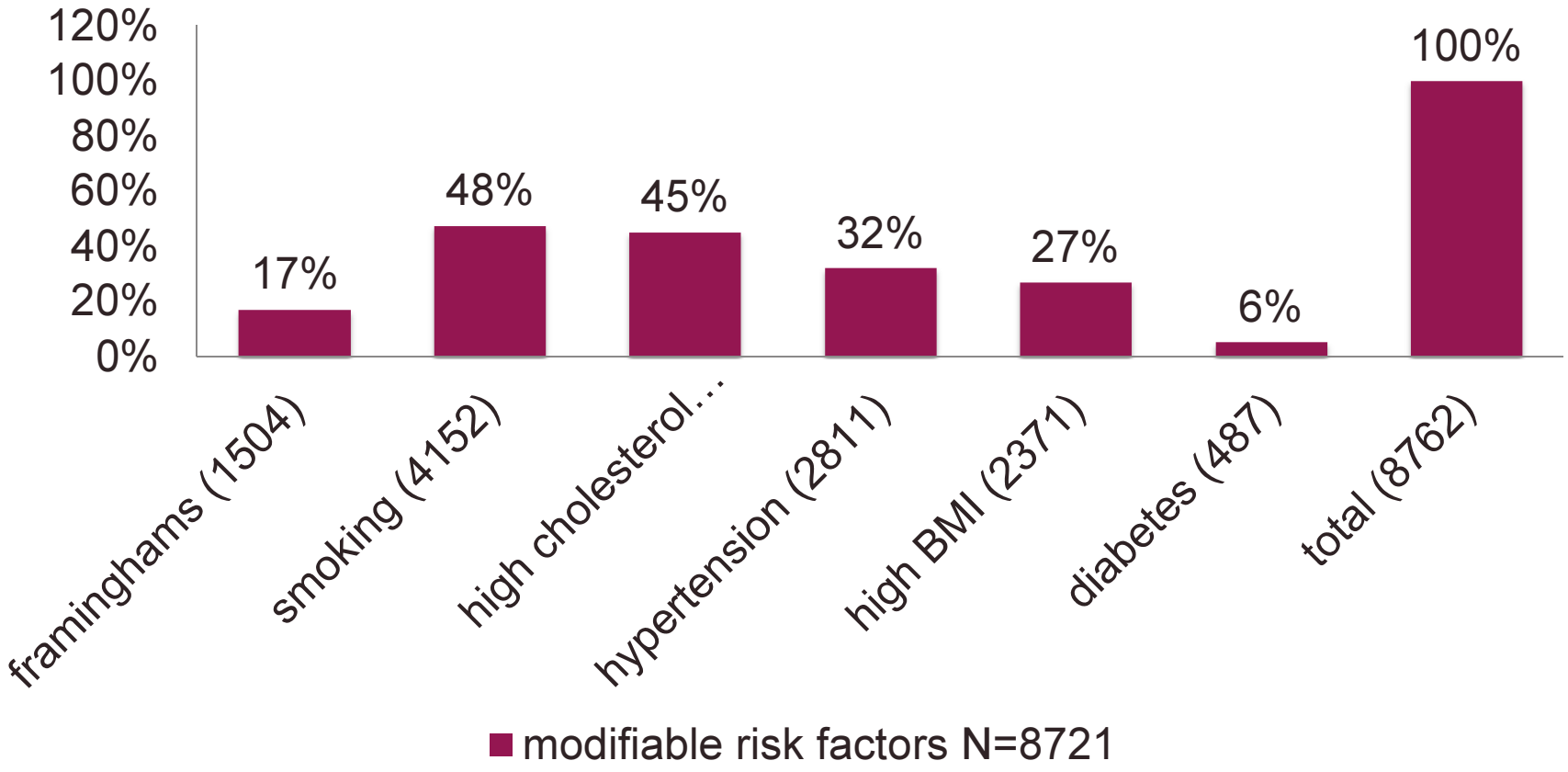
- Over 100,000 people living with HIV in the UK
- Antiretroviral therapy result in aging cohort
- 48% are over the age of 45
- Co-morbidities are common and predicted to rise
  - Depression
  - Cardiovascular risk

HIV and CVD co-epidemics

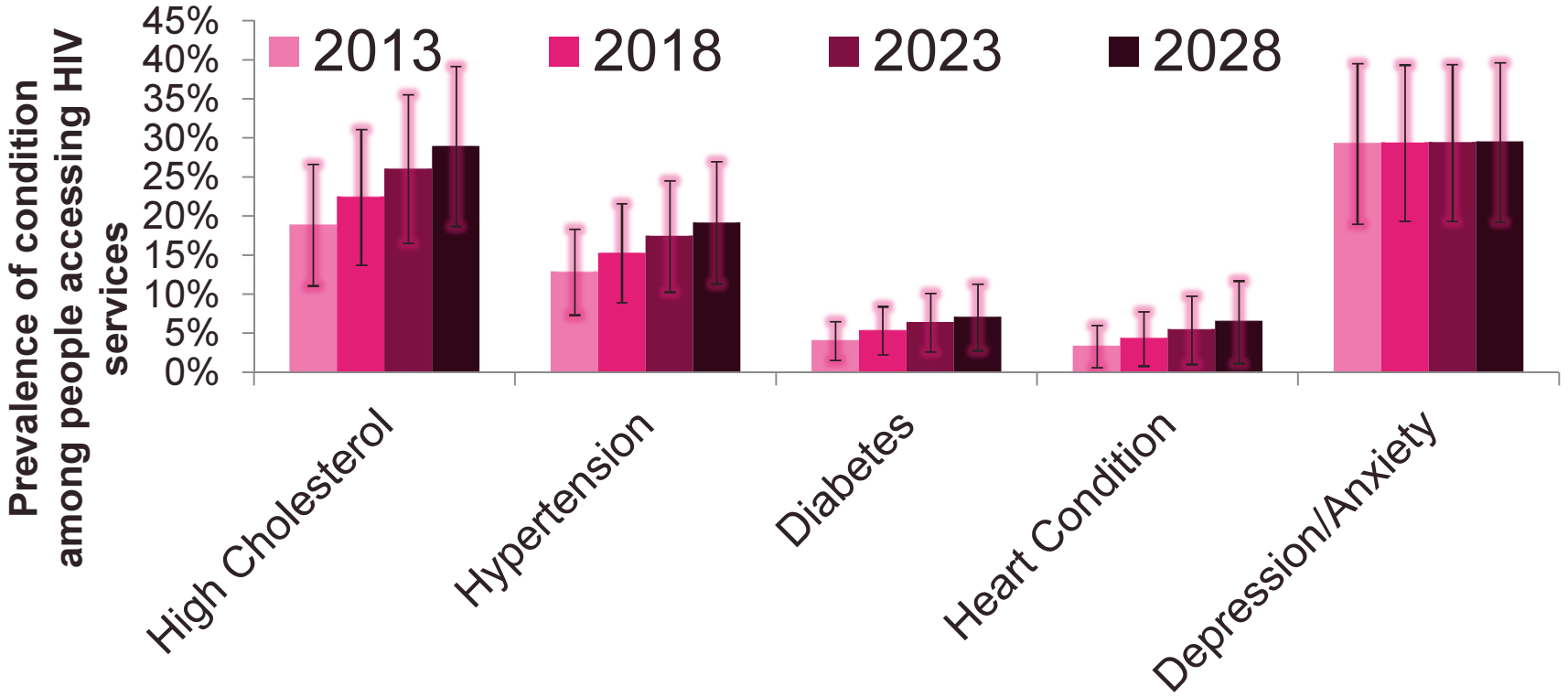


Adapted from P. Reiss CROI 2009

Prevalence of CV risk factors (Eurosida)



Projected comorbidities in the UK based on positive voices



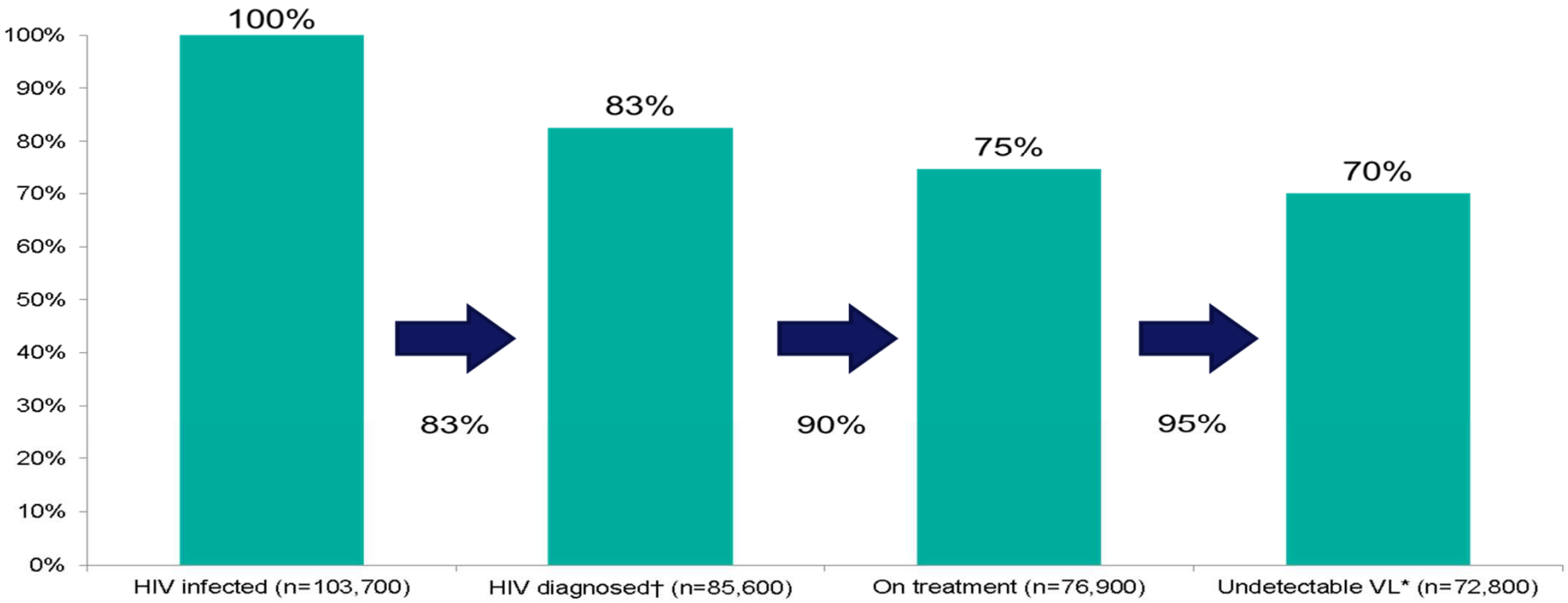
Background 2: HIV and co-morbidities

- Stepped approach to long term disease management
  - Primary prevention
  - Screening for risk factors
  - Non-pharm management of modifiable risk
  - Pharmacological management of modifiable risk
  - Specialist care

- Long term conditions cluster

Public Health England

Continuum of HIV care: United Kingdom, 2014



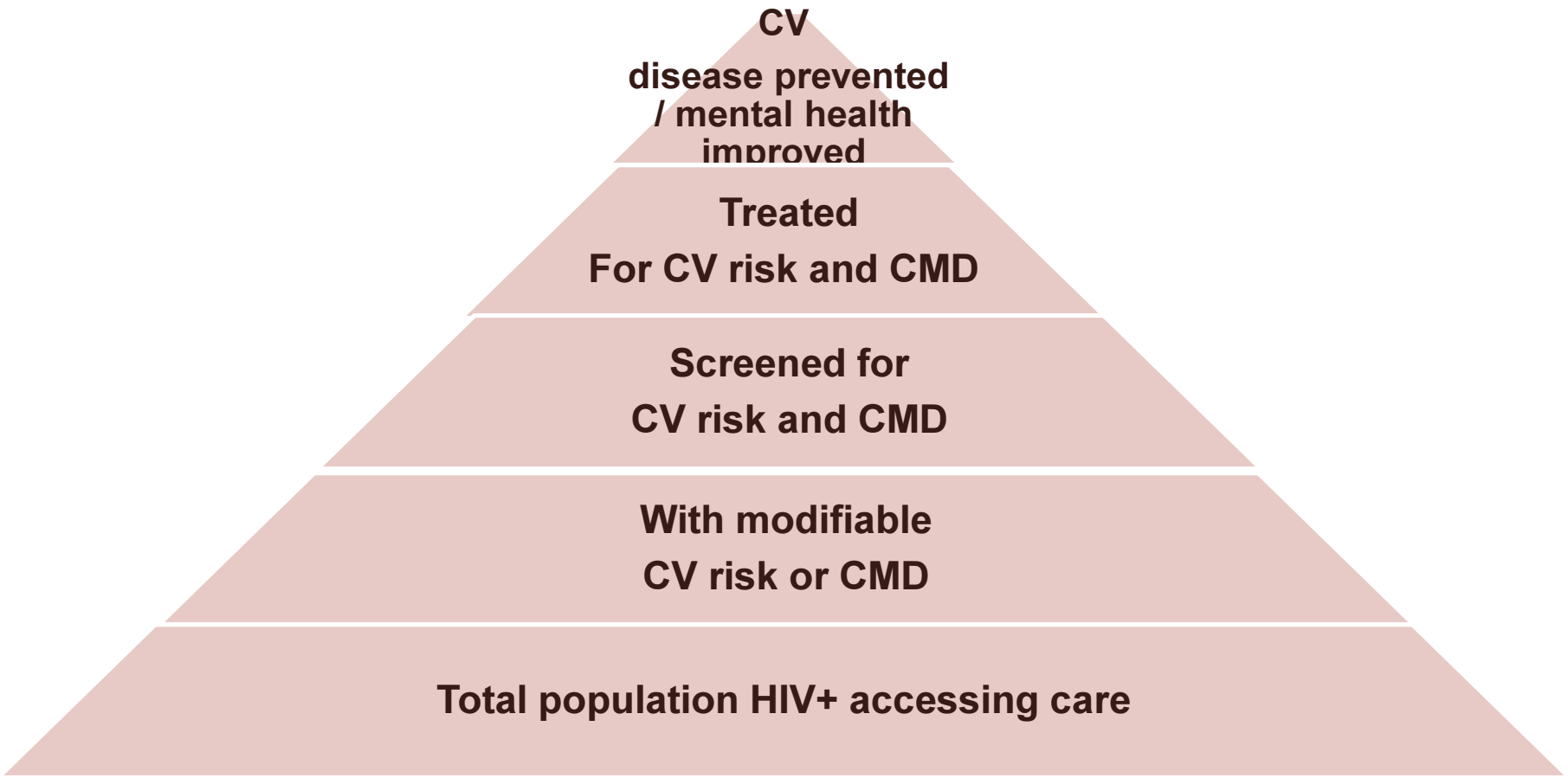
* Viral load (VL)< 200 copies/ml

† Number diagnosed estimated from MPES

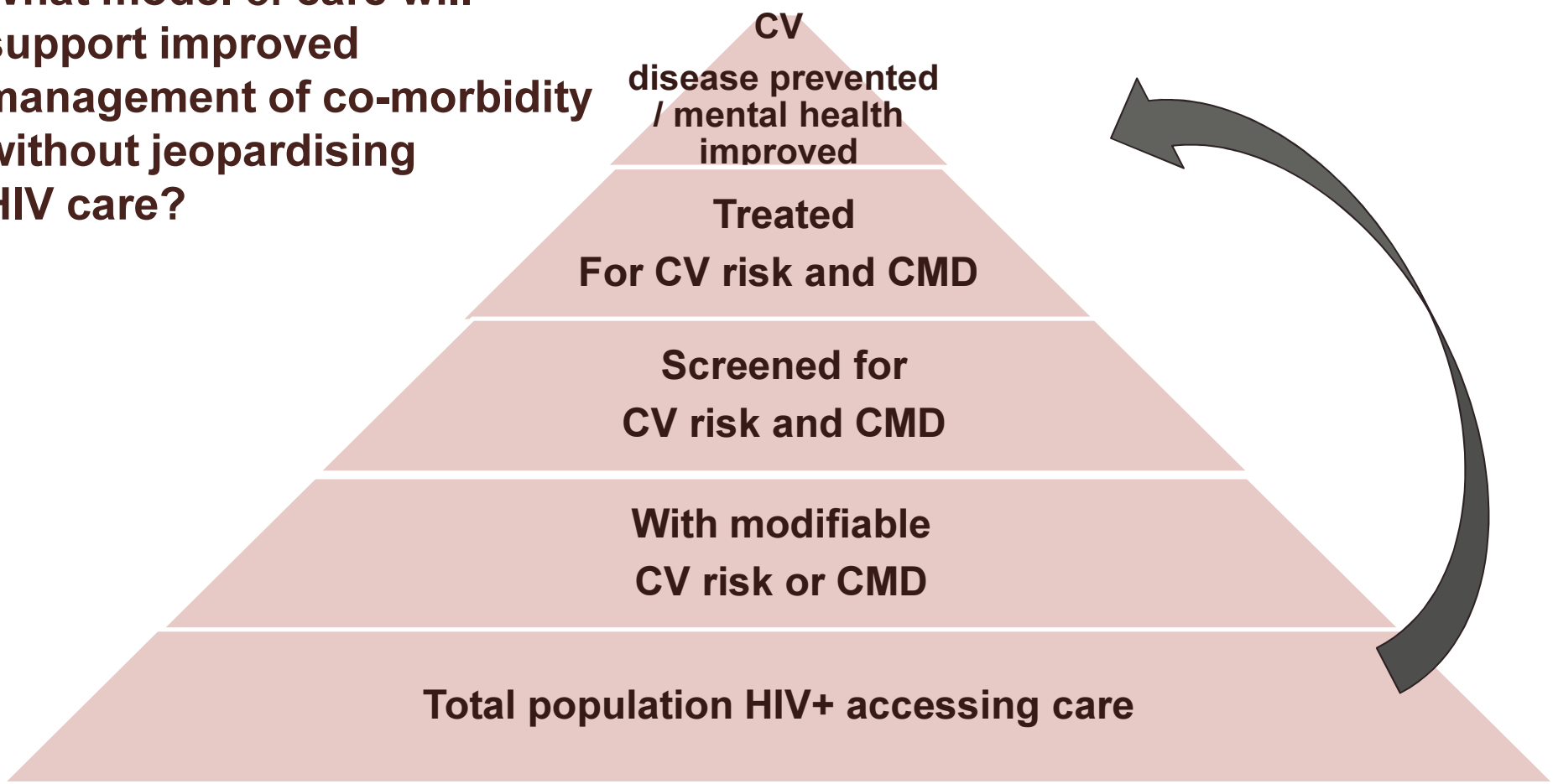
Incidence Rates of Risk Factor Modification (Eurosida)

Risk Factor	Indicated for modification n	Modified n (%)	PYFU	Incidence Rate / 100 PYFU
Blood Pressure	2077	1205 (58%)	7668	15.7
Smoking	3919	1283 (33%)	20850	6.2
Cholesterol	1394	277 (20%)	7907	3.5

Chronic disease paradigm for cv disease and CMD



What model of care will support improved management of co-morbidity without jeopardising HIV care?



BHIVA commissioned one year program

TO INFORM THE COMMISSIONING OF HIGH QUALITY HIV CARE BETWEEN SPECIALIST AND PRIMARY CARE

Objectives

1. Scoping review of the literature on collaborative/ shared models of care

2. Explore emergent models of HIV care within primary care

3. Describe the strengths and weaknesses of models of care

4. Describe the relevance across the life-course

Methods

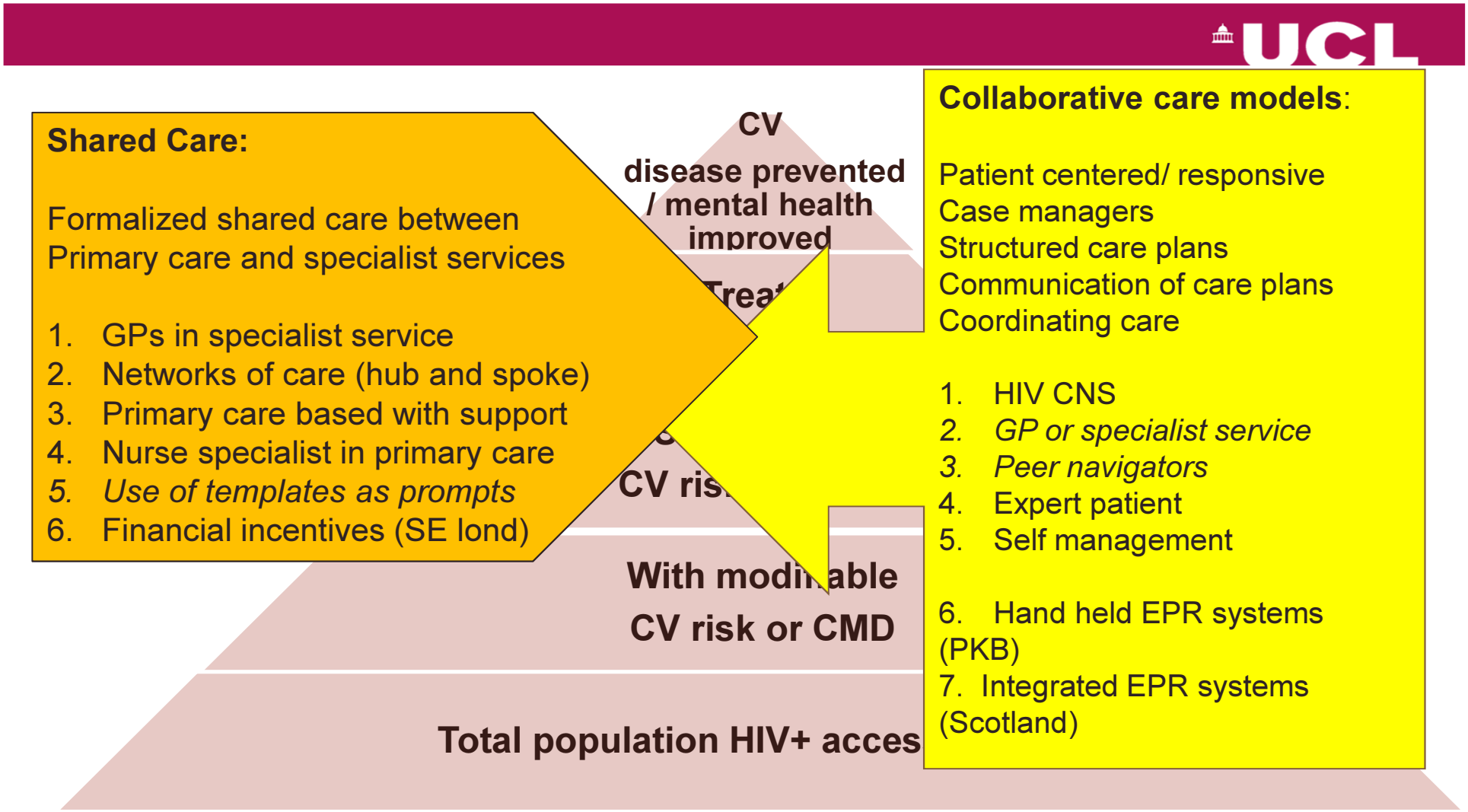
- Multi-perspective scoping project

- August 2015- June 2016
  - Scoping review of the literature
  - Key informant interviews n=65
  - Focus group discussion with service users n=13
  - GP web based survey n=152
  - Service users web based survey n=187

- Limited by time

Findings

- Effective models of care were responsive to change
  - Changes in management of HIV across time
  - Evolving care needs along the life course
- Effective models of shared care were:
  - Patient and not facility centered
  - Case based management
  - Good communication of care plans
- Sporadic and evolved locally
  - Acceptable and feasible
  - Small networks of professionals
  - Leadership of practitioners and commissioners
  - Cost unclear


UCL
Shared Care:
Formalized shared care between Primary care and specialist services
1. GPs in specialist service
2. Networks of care (hub and spoke)
3. Primary care based with support
4. Nurse specialist in primary care
5. Use of templates as prompts
6. Financial incentives (SE lond)
CV
disease prevented / mental health improved
With modifiable CV risk or CMD
Total population HIV+ acces
Collaborative care models:
Patient centered/ responsive
Case managers
Structured care plans
Communication of care plans
Coordinating care
1. HIV CNS
2. GP or specialist service
3. Peer navigators
4. Expert patient
5. Self management
6. Hand held EPR systems (PKB)
7. Integrated EPR systems (Scotland)

Challenges

- Legacy of HIV services
- Stigma and fear
- Evolution of HIV management
  - unknowns e.g. aging
- Structural barriers
  - Poor integration of EPR systems
  - Less than half of GPs had HIV training
  - Poor communication
  - Time constraints in general practice
  - Separate commissioning HIV testing, treatment and co-morbidity care
- Lack of evidence for effectiveness or efficiency

Recommendation for Clinical Care

- Improve communication:
  - Produce best practice guidance for communication
  - Advocate for shared EPR
- Develop GP templates embedded in EPR
  - prompts HIV specific primary care,
  - D-D interaction alerts
  - HIV testing prompts
- Support case based management:
  - By CNS or other cadre across social care, primary care and specialist services
  - Self management (online or through peers)
- Embedded training
  - SHIP or STIF
  - Stigma through third sector

Recommendation for Commissioning

- Person-centered and not facility based or disease specific commissioning
- Commission care coordinators
- Support development of shared EPR
- Financial incentives and support for HIV testing
- Resources and financial support for the primary care of PLHIV

Urgent need for future research

- Experimental evaluation of collaborative versus shared models of care
  - HIV and non HIV outcome
- Evaluate models of person centered commissioning of care for HIV prevention and treatment
- Cost effectiveness analysis

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