Shared care:

Findings from the BHIVA primary care project

Presenting on behalf of the BHIVA shared care team
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Outline

- Background
- Aims and objectives
- Methods
- Findings
- Conclusions and recommendations
Think of the last PLHIV you saw in your clinic: What was the main focus of the consultation?

a) Housing, income, immigration or other social issues
b) HIV virological failure (detectable viral load)
c) ARV switching for health or cost reasons
d) Common mental disorders such as anxiety, depression, sleep disorder
e) Common CV risk factors or co-morbidities e.g. hypertension, high cholesterol, diabetes, smoking, weight, or diabetes (primary prevention or management)
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

INFLAMMATION

Atheroma formation and growth

Plaque instability and rupture

Thrombosis

Age, sex

Smoking
BP
Weight
Lipids
Glucose
Renal

HIV

Lipids
Glucose
Adipose tissue
Renal

ART

Adapted from P. Reiss CROI 2009
Prevalence of CV risk factors (Eurosida)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td>Framingham (1504)</td>
<td>17%</td>
</tr>
<tr>
<td>Smoking (4152)</td>
<td>48%</td>
</tr>
<tr>
<td>High cholesterol (39...)</td>
<td>45%</td>
</tr>
<tr>
<td>Hypertension (2811)</td>
<td>32%</td>
</tr>
<tr>
<td>High BMI (2371)</td>
<td>27%</td>
</tr>
<tr>
<td>Diabetes (487)</td>
<td>6%</td>
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<tr>
<td>Total (8762)</td>
<td>100%</td>
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Modifiable risk factors N=8721
Projected comorbidities in the UK based on positive voices

- High Cholesterol
- Hypertension
- Diabetes
- Heart Condition
- Depression/Anxiety

Prevalence of condition among people accessing HIV services

- 2013
- 2018
- 2023
- 2028
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 (health needs and related costs also cluster).
Continuum of HIV care: United Kingdom

- HIV infected (n=103,700) 100%
- HIV diagnosed† (n=85,600) 83%
- On treatment (n=76,900) 90%
- Undetectable VL* (n=72,800) 95%

* Viral load (VL)< 200 copies/ml
† Number diagnosed estimated from MPES
Incidence Rates of Risk Factor Modification (Eurosida)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Indicated for modification n</th>
<th>Modified n (%)</th>
<th>PYFU</th>
<th>Incidence Rate / 100 PYFU</th>
</tr>
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<tbody>
<tr>
<td>Blood Pressure</td>
<td>2077</td>
<td>1205 (58%)</td>
<td>7668</td>
<td>15.7</td>
</tr>
<tr>
<td>Smoking</td>
<td>3919</td>
<td>1283 (33%)</td>
<td>20850</td>
<td>6.2</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>1394</td>
<td>277 (20%)</td>
<td>7907</td>
<td>3.5</td>
</tr>
</tbody>
</table>
What model of care will support improved management of co-morbidity without jeopardising HIV care?
TO INFORM THE COMMISSIONING OF HIGH QUALITY HIV CARE BETWEEN SPECIALIST AND PRIMARY CARE
Objectives

1. Scoping review of the literature on models that support care for PLHIV between primary and specialist services

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

Two models of care from the literature were found:

1. Shared care:
   - formalised shared care agreements between partners in primary and specialist care

2. Collaborative care:
   - more fluid and centred around the patient
   - case based management or structured care plans
   - communicated to everyone involved in health and social care
Shared Care (SE London):

- Networks of care
  - Hub (specialist)
  - Spoke (primary care)
- Financial incentives

- *Use of templates as prompts for GPs*
Collaborative care models of Care co-ordination (Supervised through specialist services):

- HIV Community Nurse Specialist
- Self management
  - Expert patient (default)
  - Hand held EPR systems (PKB)
  - Integrated EPR systems (Scotland)
- **GP or specialist service**
- **Peer navigators**
Effective models of care:

• 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
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
  – Rely on natural or geographical networks between primary and secondary care
• Lack of evidence for effectiveness or efficiency
Primary care model for PLHIV GP rating:

#1 All care to be provided by HIV clinic

60% agreed with the statement: “I am mainly responsible for making sure my GP has to up to date information about my HIV”
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 care-coordination:**
  - 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
Population health systems: going beyond integrated care (King’s Fund 2015)

- organisations working together across systems to improve health outcomes for defined population groups
- population-based budgets to align financial incentives with improving population health
- systems have developed different strategies for different segments of the populations they serve
- community involvement in managing their health and designing local services
- integrated health records
- scaled-up primary care systems
- close working with individuals to understand the outcomes and services that matter to them
- supporting and managing individuals to manage their own health
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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