Providing integrated HIV treatment and care for stable patients in General Practice

Alexander H[1], Munro -Wild H[2], Richards P[1], Ortiz A[2], Adams E[2], Brady M[1]
1. King's College Hospital, London 2. Aquarius Population Health Ltd.

Background

As a result of successful antiretroviral therapy (ARV) people living with HIV (PLWHIV) are increasingly stable and well. 90% of those with HIV in the UK in 2013 were on ARVs and of those 90% had a viral load of less than 200 copies/ml at their last attendance[1]. These advances in HIV therapy provide the opportunity for novel models of service delivery including nurse delivered services and an increased involvement of primary care in the monitoring and management of people living with HIV. Community delivered services may be more acceptable and accessible to patients and allow for better integration with primary care, however there is no consensus or evaluated models to indicate how best to deliver this.

Methods

In 2012 we developed a nurse-delivered integrated HIV and primary care service for stable patients in two local inner city General Practices; the One Clinic. Patients are eligible if they are on therapy with an undetectable viral load (VL) or are ARV naive with a CD4 count > 500 cells/µL. A specialist HIV nurse runs the service and was trained to deliver services provided by a primary care practice nurse as well as routine HIV monitoring and care. Clinics run outside working hours and patients are encouraged to register with a secure on-line electronic patient record (EPR) to enable communication and support clinical supervision; Patient Knows Best (PKB). An HIV consultant oversees the clinic and provides governance support, clinical supervision and sees patients as and when required. We present the data describing the patients, their treatment outcomes and the results of a satisfaction survey.

Results

To date a total of 103 patients have been recruited to the clinic (4% of our patient cohort). Mean time in the clinic is 17 months (range 4 – 29 months). The majority of patients were male (82%) and men who have sex with men (64%).

Treatment outcomes

We are presenting data on the first 96 patients recruited to the clinic. Of the 86 patients on ARVs at entry to the One Clinic, 78 had a VL <40 copies/ml, 7 had a VL between 40 - 100 copies/ml and one patient had a VL of over 100 copies/ml. At the point of data analysis 3 of the naïve patients had started treatment and are now undetectable; the rest do not require treatment according to BHIVA guidelines. Of those patients on treatment at entry and with a VL <100 only one had a viral load of over 100 at most recent bloods. In total only 2 patients have disengaged or transferred care which compares favourably to national rates and our local experience.

Figure 1: Demographics

Gender	82% male
Age	Mean 42 (26-68)
Ethnicity	White British (33%) Black African (23%) White European (13%) Black British (6%) Black Caribbean (4%)
HIV risk factor	64% MSM 31% heterosexual transmission
ARV status	90% on ARVs 10% ARV naive

Figure 2: Patient Satisfaction

The 64 patients registered with PKB were sent a link to a survey monkey questionnaire assessing their experience of the service; 38 responded (40% of the cohort).

Are the One Clinic opening times convenient?	Yes 97%
Overall which environment do you prefer?	One Clinic 94%
Do you find it easy to talk to your nurse?	Yes 97%
Would you recommend One Clinic to a friend?	Yes 97%
Overall which opening times are more convenient?	One Clinic 94%
Is the location of the One Clinic convenient for you?	Yes 100%

Conclusions

Our service represents a novel model of nurse-delivered HIV care with a greater emphasis on patient convenience and the delivery of a more integrated service model that provides both HIV monitoring and care and simple primary care services. We are seeing high levels of patient satisfaction and comparable treatment outcomes to our 'traditional' service model.

As HIV is now a manageable long term condition it is essential we develop service models that better reflect the lives of PLWHIV. We should increase the involvement and integration of primary care into management of HIV, continue to develop the nursing workforce to effectively manage case loads and, by doing so, increase capacity in specialist services to focus on those with greatest and most complex needs. We continue to develop our nurse-delivered and community based services and further work is on-going to determine the health economic impact of this service and the implications for further roll-out.

References
1. HIV in the United Kingdom: 2014 Report . Public Health England

Contact: hannahalexander@nhs.net

Supported by a grant from the Burdett Trust for Nursing