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Current models of care for the management of HIV patients with comorbidities in England: a survey

Background: The number of people aged ≥50 living with HIV in the UK is rapidly increasing. Effective treatment means HIV is usually well controlled, however there has been an increase in individuals experiencing comorbid conditions associated with ‘normal’ ageing. This aim of this study was to find out what models of care are currently in place for the management of patients with comorbidities.

Materials and methods: A link to an online questionnaire was sent via the British HIV Association (BHIVA) Audit Committee to one HIV clinician in each HIV unit in England.

Results: Forty four units responded. Only 11 units (25%) provided specialised clinics for the management of comorbidities. These included: 1) Specialist clinics for the management of a non-infectious comorbidity (any age) e.g. a liver or renal clinic (n=10). These clinics utilised in-person appointments (n=3), or a combination of virtual and in-person appointments (n=7). They were managed by an HIV clinician and non-HIV clinician together (n=8), HIV clinician with an interest in the specialist area (n=4), or specialist with an interest in HIV (n=4). 2) Services for HIV patients with multiple comorbidities (any age) (n=2) 3) Dedicated clinics for older people (n=5) with eligibility determined by age (≥50 years) or the presence of a comorbidity.

Additionally, 2 HIV units employed a GP on site and 2 had set up a locally enhanced service providing enhanced primary care for HIV-positive patients. Six HIV units ran nurse-led clinics for patients with comorbid conditions. Coordination of care for patients with comorbid conditions was conducted by an HIV specialist doctor (n=27), the patient’s GP (n=18), HIV specialist nurse (n=11) or the patient themselves (n=9). Eleven clinics reported using case management for patients with multiple comorbid conditions. Self-management support (e.g. nurse-led or as part of an expert patient programme) for patients with comorbid conditions was provided at 18 HIV units.

Conclusions: Only a quarter of the clinics surveyed had set up clinics for the management of comorbidities in people living with HIV. While a variety of different approaches were used, services were usually focused on the management of one comorbidity, and few provided services for multiple comorbidities. This is an increasing priority in the context of an ageing population.