

“I’m 51 but living in the body of a 65-year old”: Exploring the experiences and needs of those living with HIV and multiple comorbidities

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Background

- The UK cohort of people living with HIV is ageing
- Age-related comorbidities such as diabetes, osteoporosis and CVD are more prevalent and more challenging to control compared to the general population¹

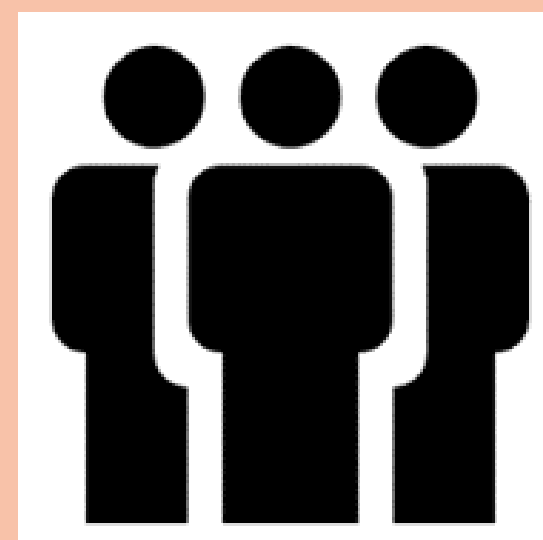
Aim: This study, designed to explore the health needs and experiences of those with HIV and diabetes, facilitated insights into those living with multiple comorbidities.

Methods

- Research interviews were conducted with adults living with both HIV and either type 1 or type 2 diabetes
- Purposive sampling ensured a diversity of the UK’s HIV positive population was represented
- A topic guide informed the interview
- Thematic analysis was conducted using the Framework
- We used the NICE guidelines for management of multiple health conditions to model recommendations

The Interviewees

n=22



- ← From Scotland, Wales and England
- ← Mean age 53.0 ±7.7 years
- ← Living with HIV for a mean 18.1 ±6.9 years
- ← Living with 3-10 (median 5) comorbidities

Results

TASK	RATIONALE	EXAMPLE
Identify patients with multiple comorbidities	Patients may not be immediately apparent	Patients may be relatively young and working in full time employment
List the primary provider for each comorbidity	HIV patients may have multiple primary providers	A participant living with 9 comorbidities had 6 specialist providers
Establish disease and treatment burden	Specialists may be unaware of total and HIV-related burden across the comorbidities	Participants reported chronic fatigue and poor mental health issues from comorbidities
Maximising benefit from existing treatments	Drug interactions and synergistic treatments should be considered	Participants report periods of months / years before drug errors rectified
Can any treatments be stopped?	Polypharmacy is a significant burden. Consider potential for non-drug therapies	Regular review of medications led to rationalisation
Establish patient goals values and priorities	May range from remaining in employment to coping with pain	Participants report priorities not being addressed, and being unsure who to question
Agree an individualised management plan	Care plans can be complex. Consider HIV factors	Some participants feel ignored
Plans for future care	Discuss future care with patients approaching milestones	Participants reported fears for their longevity secondary to comorbidities
Establish who coordinates care	Whoever adopts the role of coordinator must be fluent regarding the impact of HIV	Few patients reported effective coordination
Establish how the plan is communicated to all professionals	Communication plan should be individualised. Include assessment of HIV stigma	Participants reported ineffective letter writing, and specialists changing each other’s plans
Agree communication plan with patient	Patients may experience communication failures	Participants report having to communicate plans themselves
Rationalise follow up appointments	Coordination of follow ups across specialties reduces investigation burden	Some patients with many comorbidities are trying to remain in work.
Coordinate phlebotomy	Multiple phlebotomy across services is a burden	Patients report blood work repeated x3 within one month, and results not shared
Follow up any agreed actions	Follow up should be time specific	Participants report plans not actioned

Conclusions

- Patients living with multiple comorbidities should be identified, and a stepwise care approach used
- Collaborative care should be fostered, where a care coordinator communicates plans to everyone involved
- Enablement of self-care should be encouraged
- Improved HCP knowledge and improved treatment pathways are key to improving quality of care

Reference

1. Duncan AD, Goff LM and Peters BS (2018). Type 2 diabetes prevalence and its risk factors in HIV: a cross-sectional study, PLOS One 13(3) e0194199