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CONFERENCE ABSTRACT

Shared Care Unit: a new model of coordinating HIV care between Primary Settings and Hospital

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Olga Barba[1], Thais Clusa[2], Ignacio Menacho[3], Ethel Sequeira[4], Laura Moreno[5], Eva Gonzalez[5], Xavier Freixa[4], Laia Cayuelas[4], Susana Muñoz[2], Emma Fernández[5], Lorna Leal[5], Felipe García[5], Agathe Leon[5]

1: CAP Borrell, Barcelona, Spain;
2: CAP Raval Sur, Barcelona, Spain;
3: CAP Les Corts, Barcelona, Spain;
4: CAP Casanova, Barcelona, Spain;
5: Hospital Clinic Barcelona, Spain.

Introduction: Antiretroviral therapy (cART) has changed the natural history of human immunodeficiency virus (HIV) infection in developed countries, where it has become a chronic disease. In addition, the profile of HIV infected patients is changing to an elderly population with increasing morbidities. This clinical scenario requires a new approach to coordinate the care between health teams responsible for the care of patients. To promote communication, cooperation and optimize the control of HIV infected patients, a multidisciplinary unit called Shared Care Unit (UCC) was created in 2008 among the Hospital Clinic of Barcelona and four primary care centers (CAP). In this unit, doctors and nurses from Primary Care settings and The Infectious Diseases Department from the Hospital, meet each two months to coordinate activities involving teaching, research and assistance in the field of HIV infection. We present now the results of a pilot study undertaken in 2013 for evaluating the shared care unit for HIV stable patients.

Objectives: To compare the HIV standard of care (controls) with the care in UCC (cases).

Methods: A pilot prospective case-control study with duration of 1.5 years was performed in the Hospital Clinic and three CAPs of the same health district.

Inclusion criteria for cases were stable patients (Chronic HIV infection with CD4 above 350 cells/mm3 during the last 6 months and if on ART with an undetectable viral load). Exclusion criteria were HIV-infected adults with current therapeutic failure (defined by detectable viral load on cART or CD4 cell count below 250 cells/mm3), tumours, opportunistic infections, or pregnant women.

Control patients were HIV infected patients matched for age, sex, primary care center, use of cART and undetectable viral load at the date of inclusion in the study.

HIV care during the 18 months of follow-up was performed in control patients as usual in hospital (3 visits), whilst cases made two visits in CAP and the last one in the Hospital.

Variables regarding clinical performance [HIV clinical parameters (CD4 cell count, viral load, opportunistic infections, death] and cART-compliance were evaluated throughout the study follow-up. Adherence was estimated at each clinical consultation by monitoring pharmacy refills and through self-reports and was considered high if the patients take more than 90% of the scheduled medication. Quality of life was evaluated through a questionnaire that has been validated in HIV patients (Mini International Neuropsychiatric Interview (MINI). Psychological and emotional Impact was evaluated using several validated screening questionnaires: the Hospital Anxiety and Depression (HAD) Scale to measure anxiety and depression. A qualitative statement about health services utilization in the study population was registered as well as acceptability and satisfaction with the type or care.

Results: 93 patients (31 cases and 62 control patients) were included. The mean age of patients was 42 years, 86% were men, 81% men who have sex with men (MSM) and 29% were foreigners. The CD4 count, viral load and adherence to ART showed no significant differences in both groups. Quality of life, psychosocial assessment, the number of emergency room visits and other specialists was similar in cases and controls. 85% liked UCC and 93% considered in the future continue to use the UCC.

Conclusions: A Shared Care Unit of HIV infection between Hospital and Primary Care Centers is possible and in this pilot study has been a safe tool for the clinical management of stable HIV infected patients. Sharing clinical management of stable HIV infection between Hospitals and Primary care centers might be an additional model of care.

Keywords: hiv care; primary settings; hospital