Primary Care for Patients with HIV Infection: It's Not Who Should Provide It, It's How to Provide It

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In this issue of *American Family Physician*, we present an article on initial management of patients with human immunodeficiency virus (HIV) infection.[1] Among the issues we did not address are studies showing that clinicians with more experience in the management of HIV infection have better results in some key performance measures. This raises the logical question of whether clinicians without substantial experience in the management of HIV infection should provide care for these patients. Not surprisingly, the answer is not so simple.

Most of these studies compared various HIV-specific performance measures, such as achieving CD4 lymphocyte count and viral load targets, prescribing antiretroviral therapy (ART), and providing prophylaxis against opportunistic infection.[2-4] Study methodologies varied considerably, including the criteria for "HIV-experienced" clinicians and which performance measures were assessed. Nevertheless, these studies consistently showed that more experience is associated with better performance on HIV-specific measures. A separate study from the Veterans Administration showed not only improved performance measures, but also improved survival among patients who received at least 80% of specified measures, including achieving CD4 count targets, receiving ART, attending a requisite number of clinic visits, and meeting other HIV-related measures (e.g., influenza and pneumococcal vaccinations, hepatitis C screening), although it did not compare HIV experience levels among clinicians.[5] Additional support for the importance of HIV experience comes from clinics predominantly staffed by HIV-experienced clinicians (e.g., Ryan White programs,[6,7] Veterans Administration and Kaiser clinics); these clinics report high rates of ART prescription and virologic suppression.

However, HIV-specific performance measures are not the stand-alone barometer of care. Non-HIV care is becoming increasingly important as persons with HIV infection live longer. Recognizing this, some federal performance measures, including those for Ryan White programs, now include broader quality indicators, such as cancer screening, immunizations, tobacco screening, linkage to care, and gaps between medical visits.[8] One would expect primary care clinicians to better manage the multimorbidities of aging (which is an essential role—and strength—of primary care), but this has not been studied extensively. Canadian studies of HIV subspecialists or family physicians who care for patients with HIV infection examined non–HIV-specific performance measures, such as general cancer screening, and found that subspecialist-dominant care models had lower screening rates, although the difference was not statistically significant.[9,10]

The prognosis of HIV has changed dramatically since nearly all of these studies were performed. Now, with long-term effective ART, near-normal life expectancies are forecast. Few patients die from immunodeficiency-related illnesses, and most live long enough to develop the multimorbidities of aging, including the ones more common in patients with HIV infection, such as diabetes mellitus, hyperlipidemia, hypertension, atherosclerotic disease, chronic kidney and liver disease, and cancer. Broader performance measures will become increasingly relevant over time, especially quality of life, patient satisfaction, continuity of care, and management of multimorbidities. Additionally, health care system changes, including a diminishing HIV expert workforce and insurance coverage and patient panel reassignments, will also push primary care clinicians to assume a larger share of HIV care.

The major challenge, therefore, is not to address whether primary care clinicians without substantial HIV experience should provide HIV care, but to create a framework that allows all primary care clinicians to provide the best possible care for their patients living with HIV infection. The framework contains at least four components. First, the scope of clinical responsibility needs to be clarified: primary care clinicians need to know that they can provide the broad range of primary care necessary for their patients, and that they are not expected to manage ART or complex HIV-related complications without consultation. Although selecting and following an initial HIV treatment regimen can be part of the scope of their primary care management,[1] it need not be. Currently recommended initial ART options are better tolerated and more straightforward than in years past, but one regimen does not fit all patients. Primary care clinicians without expert HIV knowledge will almost always benefit from consultation or comanagement of antiretroviral resistance or toxicity. Second, consultation or comanagement can have many forms.

Consultation can be local or distance-based (such as with our Clinician Consultation Center).[1] Comanagement typically assigns specific functions (usually prescribing and monitoring ART) to HIV-experienced clinicians. Telemedicine is another model of comanagement. The extent of consultation and/or comanagement will change over time as experience is accrued. Third, primary care–oriented articles and resources that are current and clearly lay out the essentials of care need to be available as go-to tools. Other comprehensive guides, including the frequently updated federal HIV treatment guidelines, can augment those basic resources.[1] Fourth, selected HIV performance measures can be embedded in practice via electronic medical records and expanded team responsibilities within medical homes (e.g., one study noted maximal increase in medication adherence using a primary care clinician plus pharmacist plus health care coordinator team[11]); these measures can also be part of general quality-improvement programs. With these and other tools, primary care clinicians will increasingly provide longitudinal, high-quality comprehensive primary care for persons living with HIV infection.

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