Models of care: is a paradigm shift required to address unmet needs in PLHIV?
Role of GPs and nurses : from the research to clinical practice

Prof Dr Marie-Angélique De Scheerder, UZ Gent
Carolien Wylock, UZ Brussel
Dr Saphia Mokrane, M.D., DMG ULB - Worel

BREACH 2023, 30/11, Dolce La Hulpe

The speakers do not have any declarations of interest regarding the topic discussed

Late ‘80

1st HIV/AIDS infected individuals in CARE----------→ 18083 in care (97% diagnosed, 94% on treatment, 98% undetectable)

2022

MULTIDISCIPLINARY

- AIDS related diseases, end of life, ART toxicity
- Social context: stigma, discrimination, incapacity
- Mental support: sexuality, trauma
- Dietician: waisting, lipoatrophy, hypertrophy

- **chronic HIV CARE:** Comorbidity, aging, frailty, late presenters/aids
- Social context: stigma, aging, frailty, loneliness
- Mental support: sexuality, trauma, usus (chems)
- Dietician: weight gain, obesity pandemic

HIV plan 2020-2026

Prevention

Testing: early diagnosis

Acces to care- Retention to care

Multidisciplinary care

QoL in PLHIV: lifestyle, comorbidity, psycho-sexual health

- Since 1994
- Multidisciplinary care for PLHIV
- Organised in HIV reference centres (HRC) (n=12)

HIV convention

Breach

BREACH

- Scientific organisation (HRC+HRL) to support research
- KAR (1990)-> BREACH (2008)
- Scientific output

Monitoring Comité

- February 2014
- Role: Monitor the implementa HIV plan 2014-2019.
- Constitution:
  - Positive Council
  - representatives of the prevention, testing, care and quality of life pillars of the HIV Plan

HRC College

- Implementation of the HIV convention and HIV plan in the HRCs

HIV PLAN 2020 2026

What are the unmet needs in HIV CARE?

- ‘Journey of HIV’: chronic HIV care
  - Aging cascade
  - Increased comorbidities: multifactorial but partially determined by their HIV history: heterogeneous population of aging PLHIV
  - Different care needs throughout the life: eg psy-soc-med-WLHIV (pregnancy-menopause)
  - STIGMA remains a potentiel barrier for prevention, testing, acces AND retention into care

ntegrated chronic disease clinic in Cambodia

Source: Janssens B et al. Offering integrated care for HIV/AIDS, diabetes and hypertension within chroni disease clinics in Cambodia. *Bulletin of the World Health Organization*, 2007, 85:880–885.

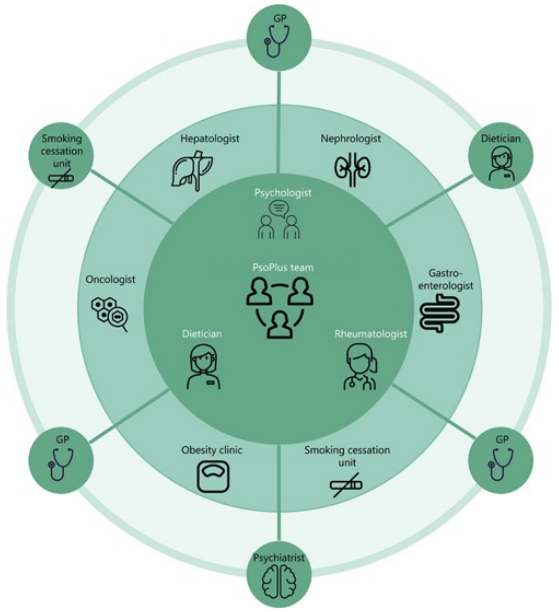
What is needed?:

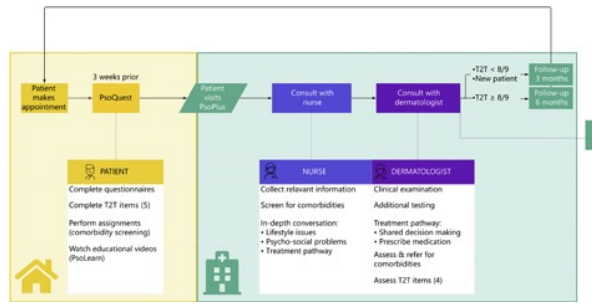
- CARE:
  - National HIV treatment guidelines
  - Definition of a minimal package of care
  - The role of of the different actors in the medical follow-up of PLHIV: nurses, GPs, the PLHIV, the HRC…
  - Screening for risk factors and premature signals of comorbidity and frailty is time and human ressource intensive (‘geriatric approach’)
  - Adjusted ressources to continue to provide this complex and multidisciplinary care in the HRC
  - Include PROMs to evaluate the care we provide
  - Promote self-management
- RESEARCH: HRC offer the ideal setting to promote research on HIV care (menopause, breastfeeding, chemsex, HIV after Prep, long term effects of modern ART) and reservoir/CURE

What is been done in other chronic diseases?

- Value based healthcare
- Example of PsoPlus

(https://psogent.ugent.be/





METHODS ARTICLE | JUNE 13 2023

PsoPlus: An Integrated Practice Unit for Psoriasis

Subject Area: Dermatology , Immunology and Allergy

Niels Hilhorst ; Elfie Deprez; Erin Roman; Joke Borzée; Dirk De Beule; Christel Dullaers; Isabelle Hoorens; Lambert

PsoGent

TO BRING BEST VALUE TO PATIENTS WITH PSORIASIS IS WHAT THE PSOGENT GROUP UNITES

HOME NEWS PROJECTS COLLABORATION WHO'S WHO CAREERS CONTACT

OUR VISION

We choose a **'Value Based Healthcare'** approach, where we organize ourselves into an **Integrated Practice Unit** around the clinical entity of psoriasis, coined PsoPlus®. Inherent to this approach, we keep track of patient-relevant outcome measures (whether or not in official registries). At the same time we investigate and optimize the costs we have to make to achieve these outcomes.

What is being done elsewhere?

- Modena HIV Metabolic Clinic (MHMC), 2000, Guaraldi et al.

This referral centre offers a multidisciplinary team approach to HIV patients with metabolic abnormalities and offers a multidimensional evaluation of ageing HIV infected patients. More than 4500 patients are followed at this Centre.

- The Sage Clinic, T. Barber,

A dedicated frailty service for ageing patients with HIV infection

Reviews in Antiviral Therapy & Infectious Diseases 11, 2019
Presented at 10th International Workshop on HIV & Aging
Abstract 48

The SAGE Clinic: The introduction of a new HIV frailty service at our London centre

Stafford A[1], *McClintock-Tiongco A*[1], *Burns F*[1], *Cope N*[1], *Katiyar A*[1], *Procter A*[1], *Swaden L*[1], *Williams J*[1], *Barber T*[1]

[1]*Royal Free London NHS Trust, London, United Kingdom*

Background: Recent work has identified 101 HIV positive patients over 70 years old who are known to our service. Of these, 50% were classified as "frail" on the Electronic Frailty Index, with 4% of patients having a "severe" frailty status. In response to this ageing HIV population, our centre has introduced a dedicated HIV frailty service: The SAGE Clinic. This clinic provides joint clinical reviews with an HIV specialist and Elderly Care physician as well as input from occupational therapy, physiotherapy and HIV specialist pharmacists. With this multi-disciplinary team approach, we aim to provide a service which effectively tackles the biggest challenges seen amongst our ageing HIV population, namely multi-morbidity, polypharmacy and functional decline. Patients can gain access to the clinic through onward referral from other clinicians based upon individual assessment of need. Our referral guidelines are: HIV positive, >50 years old and >1 co-morbidity or polypharmacy.

Methods: We are measuring baseline and 6-monthly outcomes in four main areas:

1. Improvement in the disability status and quality of life patients - this will be assessed using World Health Organization Quality of Life in HIV-infected Persons instrument (WHOQOL-HIV-BREF) and WHO Disability Assessment Schedule (WHODAS).

2. Improvement in patients' mood (depression and/or anxiety) – this will be assessed using Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder 7 (GAD-7).

3. Patient and staff satisfaction - this will be assessed using patient and staff retention, as well as satisfaction/acceptability questionnaires.

4. Cost-effectiveness - this will be assessed by onward referrals and analysis of resource cost.

Results: Since the establishment of the SAGE Clinic in March 2019, we have seen a total of 15 patients – 12 male and 3 female, with a mean age 65 years (range 55-81). The mean number of co-morbidities per patient was 4 (range 1-8) and the mean number of medications the patient was receiving was 10 (range 3-19).

Baseline results:

WHODAS: No disability n=1, mild n=0, moderate n=2, severe n=3, extreme n=6. Mean 33.9 (n=12, range 0.375-87.5)

WHOQOL: Domain I "Physical" mean 11.6 (range 6-20); Domain II "Psychological" mean 11.8 (range 6.4-17.6); Domain III "Level of Independence" mean 10.9 (range 5-20); Domain IV "Social Relationships" 13.4 (range 6-17), Domain V "Environment" mean 13.4 (range 7.5-17.5); Domain VI "Spirituality/Religion/Personal Beliefs" mean 14.6 (range 9-19).

PHQ-9: Minimal symptoms n=4, mild depression n=0, moderate n=4, moderately severe n=3, severe n=2. Mean 11.5 (n=13, range 3-23).

GAD-7: No anxiety n=5, mild anxiety n=5, moderate n=1, severe n=2. Mean 6.4 (n=13, range 0-16)

Conclusion: The vast majority (92%) of patients had at least moderate disability at presentation to the clinic, with 50% scoring as "severe". In addition, the majority of the patients have a baseline mood disorder, with 15% of patients exhibiting severe depression and 15% severe anxiety. Preliminary results have shown that therapies have had the biggest impact on patients. Data collection is still ongoing, but we hope this clinic will help improve the care of ageing HIV patients within our centre, and may provide data that helps support introduction of similar services at other centres.

- Chelsea and Westminster hospital, M. Boffito

Evaluation of a Clinic Dedicated to People Aging with HIV at Chelsea and Westminster Hospital: Results of a 10-Year Experience

Branca Pereira [1 2], Maria Mazzitelli [1 3], Ana Milinkovic [1], Christina Casley [1], Javier Rubio [1], Rachel Channa [1], Nicolo Girometti [1], David Asboe [1], Anton Pozniak [1], Marta Boffito [1 2]

Affiliations + expand

PMID: 34269603 DOI: 10.1089/AID.2021.0083

BIEN VIEILLIR
AVEC LE VIH

GARANTIR LE BIEN-ÊTRE ET UNE PRISE EN CHARGE DE QUALITÉ DES PERSONNES VIVANT AVEC LE VIH DE PLUS DE 50 ANS

Self-care skills represent decisions that the patient makes with the intention of modifying the effect of the illness on their health, and which consist of:
- Relieve symptoms, take into account the results of self-monitoring, self-measurement;
- Adapt medication doses, initiate self-treatment;
- Carry out technical procedures and treatments;
- Implement lifestyle changes (dietary balance, physical activity program, etc.);
- Prevent avoidable complications;
- Deal with the problems caused by illness;
- And involve those around you in the management of the disease, the treatments and the repercussions that result from it.

Who are the potential actors involved?

- ID/HIV specialists
- **Nurses**
- **GPs**
- Community based workers
- PLHIV
- …


I AM IN SAFE SPACE

What do we do?

Paramedical support

- Provide basic information
- Guidance before and during start-up phase of therapy
- Optimizing HIV therapy when experiencing difficulties
- Provide emotional and psychosocial care and support
- Administrative help (insurance, financial difficulties, other concerns)

Medical support

- Optimization vaccinations
- Prevention and treatment STI’s
- Prevention of cardiovascular disorders
- Administration LAM

BUT

→ Medical support falls outside the convention

→ No legal framework

→ We all do what we can – our own way: no uniformity between centres

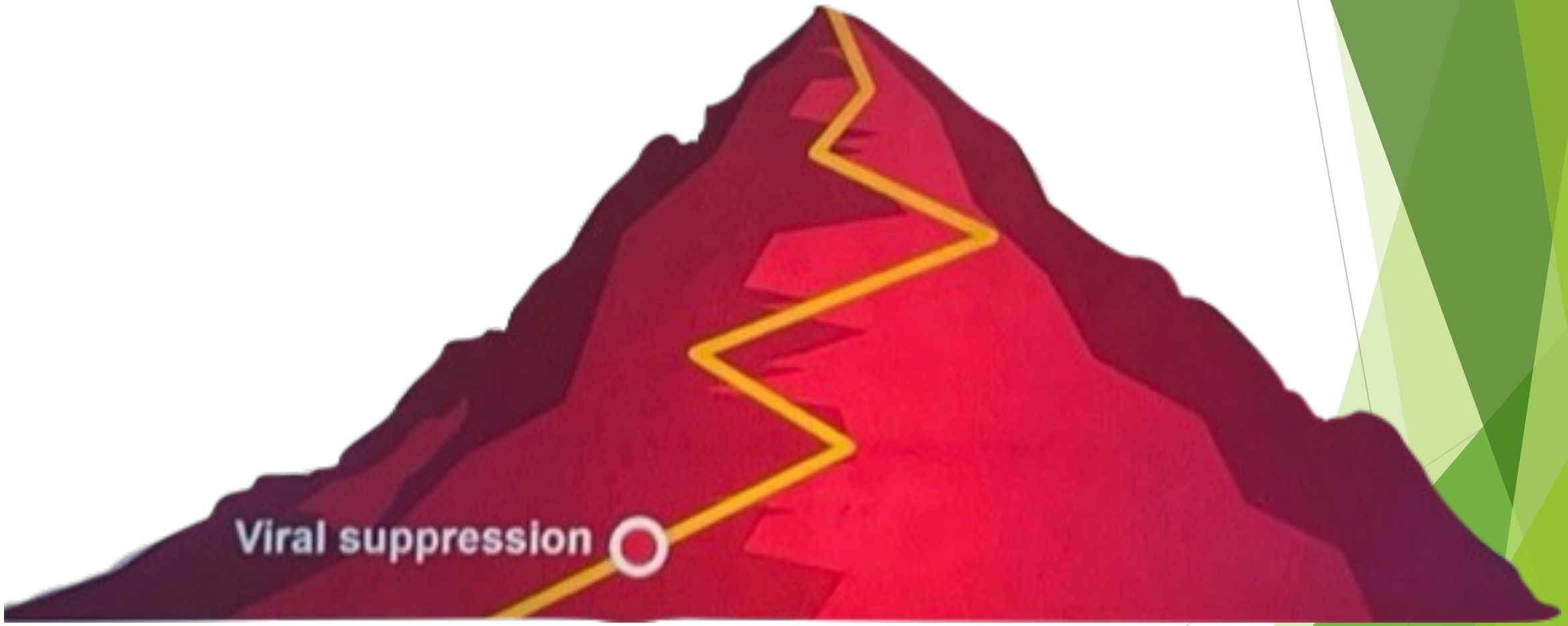
→ No recognition, no financial framework (IFIC)

The added value of HIV nurses?

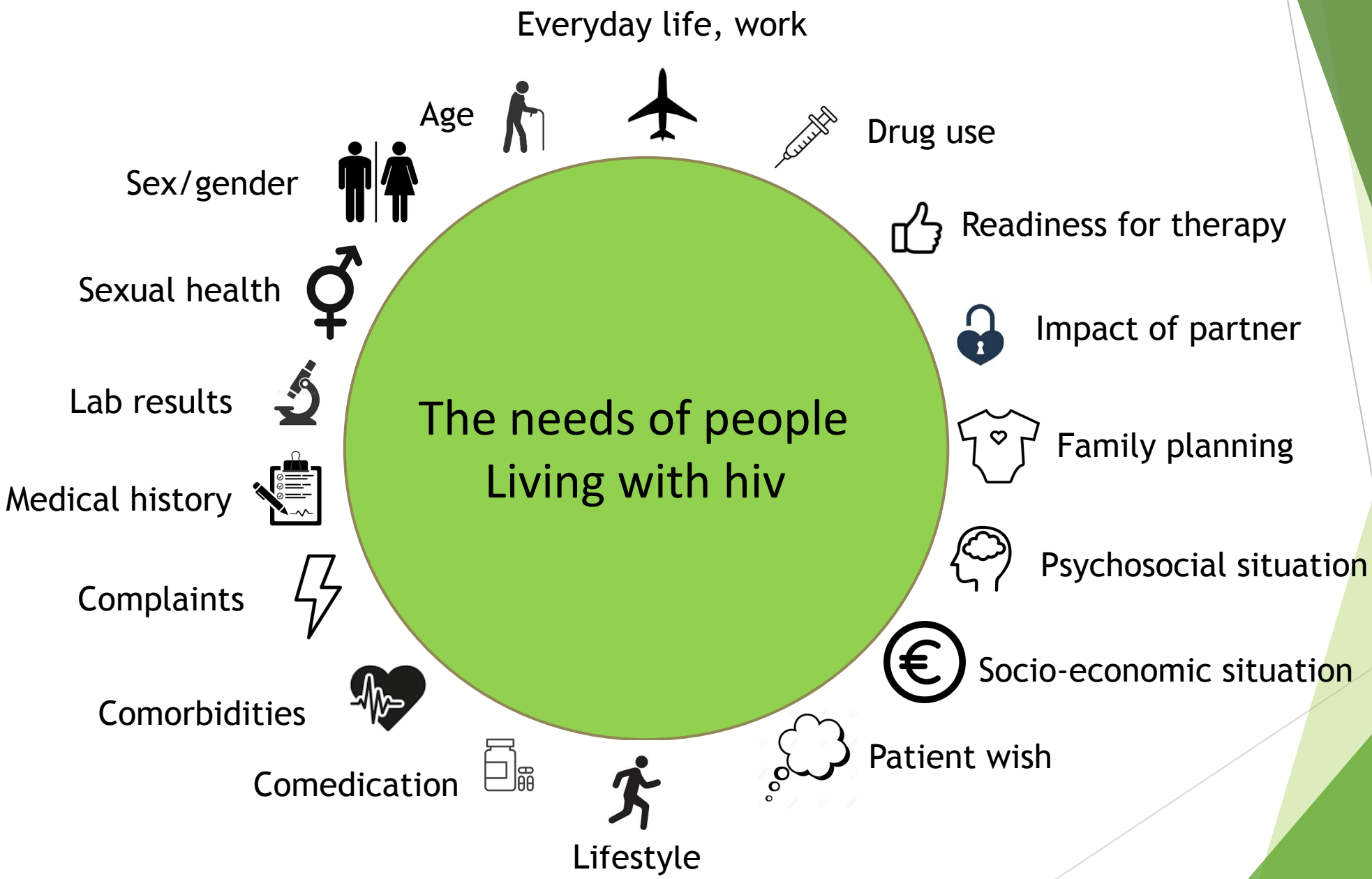
- significant change in HIV care over the last 20 years
- shift from acute care to chronic care
- increased number of HIV-patients requiring medical follow-up
- the population of HIV patients is aging (47% >50y in 2021)
- people living with HIV not only a complex biological machine
- HIV infection generates a multiplicity of complex needs
- extend beyond daily pharmacotherapy alone

→Need to define advanced practice in the HIV setting

Summit
long term health and well-being



Base camp


Everyday life, work
Age
Drug use
Sex/gender
Readiness for therapy
Sexual health
Impact of partner
Lab results
Family planning
Medical history
Psychosocial situation
Complaints
Socio-economic situation
Comorbidities
Patient wish
Comedication
Lifestyle
The needs of people
Living with hiv

What are the benefits of task shifting between different professionals?

- relieving doctors
- better accessibility for patients
- fewer waiting times
- increase psychosocial well-being for patients
- trust relationship
- increased job satisfaction of nurses

How can this be implemented in clinical practice?

- Follow-up stable patients with hiv on successful therapy, without complex comorbidities and complications

- Seeing all patients together with the doctor with a focus on psychosocial aspects for the nurse and medical aspects for the doctor

- Collaboration with doctor for complex patients in a supporting role by checking off a number of items, more standardized.

→What type of care should be provided

→Always under the supervision of a doctor

Can we learn from what is already there? Advanced practise nurse or nurse specialist

1. Clinical expert and practitioner: the nurse specialist as an autonomous nursing expert and clinical practitioner
2. Communicator: the nurse specialist as a communicator with patients, their environment and other professionals
3. Health promoter: the nurse specialist as a coach and counselor and as a participant/leader in the social debate
4. Collaborator: the nurse specialist as a promoter of interprofessional collaboration
5. Researcher: the nurse specialist as a researcher and implementer of evidence-informed practice and as a trainer and supervisor of other professionals
6. Organizer of quality care: the nurse specialist as an initiator, innovator, coordinator and organizer of quality care

- works in various domains such as acute and chronic care, primary care and mental health care.
- or are active within pathology-specific domains such as oncology, diabetes, heart failure and within certain healthcare domains such as pain, wound care and palliative care.
- patient-centered and quality care is the challenge
- works closely with doctors, other nurses, paramedics and management.
- autonomous and flexible to meet the changing needs of patients and the increasing complexity in healthcare.

My question to cabinet of Minister of Health Vandenbroucke

"As the Federal Nursing Council describes our profession, we 'HIV nurses' could also be seen as specialized nurses.
Can you let us know how we could have this officially recognized?
What steps, if any, should we take for this?"

"The title of nurse specialist was included in the legislation in 2019, but no implementation decree has yet been issued. The Federal Nursing Council has issued an opinion, but nothing has yet been converted into legislation.
So I cannot answer your question at the moment, we will have to wait and see how all this is translated into law."

Legal framework Belgium

12 november 2018, communiceert minister Maggie De Block het nieuws dat verpleegkundig specialisten hun langverwacht wettelijk kader krijgen binnen de WUG (Wet op de uitoefening van de gezondheidszorgberoepen), het oude 'KB 78'.

M. De Block: "De verpleegkundig specialist krijgt een plaats binnen de wet op de uitoefening van de gezondheidszorgberoepen. Het wetsontwerp daarover is eind vorige maand in eerste lezing goedgekeurd door de ministerraad en daarna voor advies naar de Raad van State vertrokken."

Dit eerste wettelijk kader is noodzakelijk om deze functie in al zijn facetten (opleiding, competenties, taken/rollen, bevoegdheden) verder uit te werken. De concrete functie omschrijving zal worden uitgewerkt in de volgende legislatuur.

- Specialized nurse
- Advanced Nurse Practitioner
- Nurse consultant

→position of nursing specialist approved on 26/2/19

→but no clarity about tasks and content

Ministerial decisions regarding the criteria for recognition of a special professional title or special professional competence

- April 19, 2007 - nurse specialized in intensive care and emergency care
  - nurse specialized in geriatrics
- January 28, 2009 - nurse specialized in oncology
- February 12, 2012 - nurse specialized in pediatrics and neonatology
- February 20, 2012 - nurse with special expertise in diabetology
- April 24,2013 - nurse specialized in mental health care and psychiatry
- July 8, 2013 - nurse with special expertise in palliative care
- March 26, 2014 - nurse specialized in perioperative care

→ So there are already nurses specialized
→ May 12, 2016 establishment of Belgian association of nurse specialists
→ Question is whether nurses working in HRC can be authorized to bear the special professional title of nurse specialized in HIV

"You are confusing specialized nurses with nurse specialist (advanced practice nurse). There are indeed specialized nursing titles, but there is no HIV specialization"
Cf Royal Decree of 27 September 2006 containing the list of special professional titles and special professional qualifications for nursing practitioners in the appendix.

Duh
I know
That is my question

"There is a major reform of specializations underway and you should know that not all specializations from 2006 have been recognized by ministerial decisions, so we are moving towards more transdisciplinarity and less hyper-specialization"

Discussions are about to begin and should be completed by late 2023 or early 2024.


16:51

Donderdag, 9 november

Vooraan Binnenland Buitenland Econo

© AZ Monica

GEZONDHEIDSZORG

Verpleegkundige kan straks zelf bepaalde medicatie voorschrijven

Wie voert in de toekomst een uitstrijkje uit of schrijft een hiv-test voor? Minister Frank Vandenbroucke wil de rol van verpleegkundigen versterken en opwaarderen. Een nieuwe studie van het Kenniscentrum toont ook aan dat ze meer aankunnen.

What is already done in other countries?

The Netherlands

- The position of HIV nurse consultant was created in 1985
- In 2020, approximately 80 HIV nurse consultants work in the 24 certified HIV treatment centers in the Netherlands.
- Approximately 50% of consultants are nurse specialists or advanced nurse practitioner

UK

- The National HIV Nurses Association (NHIVNA) is the leading UK professional association representing nurses in HIV care
- Founded in 1998, in response to the need for an organization to bring together nurses caring for people living with and affected by HIV
- Around 350 members, including nurses from various disciplines (clinical research, mental health, sexual health, paediatrics, acute care and community) and colleagues from overseas.

Belgium is lagging behind

Implementation?

- What do we want: revision of the specialised nurse title with a transparant financial and legal framework
- Only for HIV? Most centres have OPAT, travel, PrEP, pandemic care… ID specialist nurse?
- Requirements: master? Transitional measure based on expertise, training?
- Constant evaluation: ‘blijven leren’

Management of patients living with HIV: the Belgian recommandations for the first line

S. Mokrane, N. Dekker, P. Van Royen, C. Martin, D. Van Beckhoven, S. Swannet, E. Florence, R. Koeck, T. Cornelissen, L. De Coninck, M. Goossens, S. Cordyn, J. Laermans, V. Borra

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Saphia Mokrane, M.D., DMG ULB - Worel

Worel
Werkgroep Ontwikkeling Richtlijnen Eerste Lijn
Groupe de travail Développement de Guides de pratique de Première ligne
Working group Development of Primary Care Guidelines

Development of a guideline on VIH : **Motivation**

- HIV Infection has become a chronic disease
- Improving the implication of the first line in the management and follow-up of PLHIV

Comorbidities	Linkage to care
Risk factors of complications	Adherence to ART
Sexual & reproductive health	Retention in care

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Development of the guideline : Participants

- General practitionners Médecins généralistes
- Nurses
- Infectiologists - HIV reference center (HRC)
- Methodologists
- Patients
- Laboratoiories
- Sciensano
- Gynecologist
- KCE

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Niveau de recommandation et GRADE

Forte recommandation (GRADE 1) en faveur	« Il est recommandé de » ; « Prescrivez ….»
Forte recommandation (GRADE 1) en défaveur	« Il n'est pas recommandé de » ; « Ne prescrivez pas … »
Faible recommandation (GRADE 2)	« Envisagez de / ne pas … »

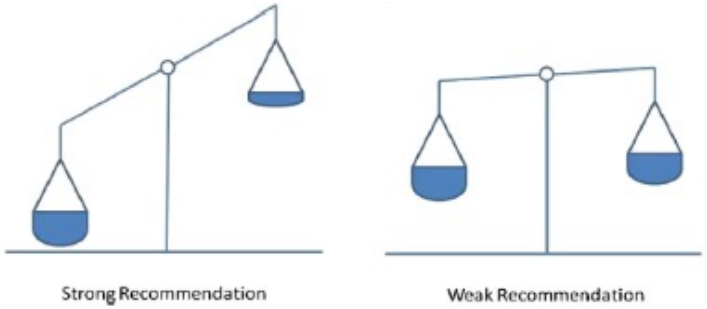


Fig. 2. Balance scales to depict strong vs. weak recommendations.

Good Practice Point - consensus

GPP	Recommandation forte sans données probantes directes à l'appui (sans mention d'un GRADE).

Clinical questions

Clinical question 1: **What should be done after a positive test? (primary care)**
1.A. Post-test consultation
1.B. Following consultations

Clinical question 2: **Which medical follow-up of a person living with HIV in primary care?**
2.1. ART observance and retention in care
2.2. General follow-up of the global health
2.3. Specific follow-up

What should be done after a positive test? (primary care)

1.A. During the first consultation post test

1.A.1. Counseling post-test

1.A.1.1. Post test conselling should be (**GPP**) :

- based on an empathic, non-judgmental relationship where building trust is a priority
- given face to face, only to the patient, and confidentially.

1.A.1.2. Inform the PLHIV as soon as possible of the HIV positive diagnosis as soon as the diagnosis is confirmed (**GRADE 1C**).

1.A.1.3. Ask questions about PLHIV's ideas, concerns and expectations (ICE) and where they get support (**GPP**).

1.A.1.4. Ask if the PLHIV informed someone she/he has been tested (**GPP**).

What should be done after a positive test? (primary care)

1.A. During the first consultation post test

1.A.2. **Linkage to care, retention in care, ART adherence**

1.A.2.1. Refer as soon as possible to HRC after HIV diagnosis to quickly start the antiretroviral therapy (ART), irrespective of CD4 count or clinical stage (**GRADE 1B**).

1.A.2.2. Refer as soon as possible to HRC after HIV diagnosis for multidisciplinary care, irrespective of CD4 count or clinical stage (**GRADE 1B**).

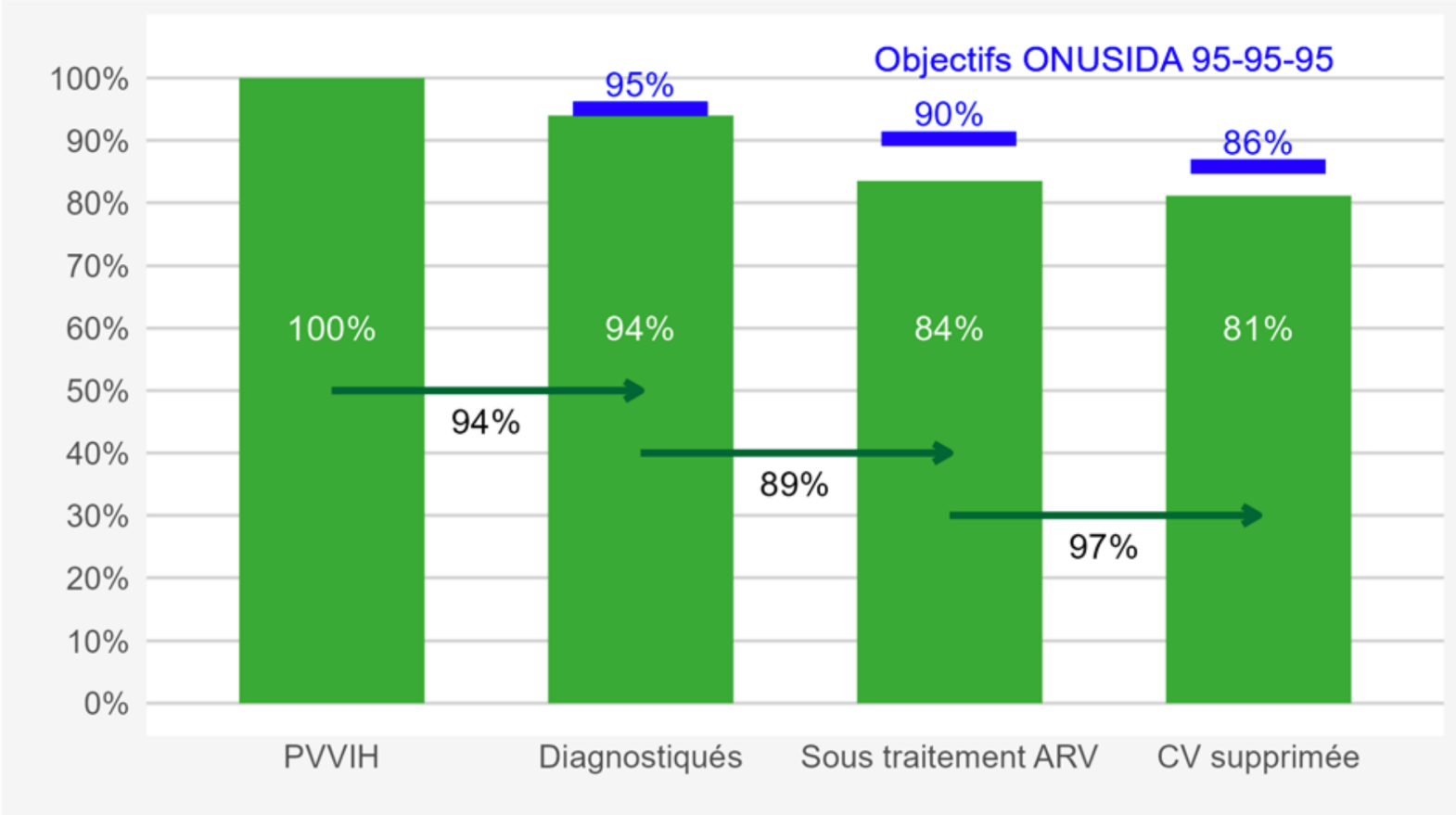
1.A.2.3. Inform the patient about the importance of linkage to care and retention in care (primary and secondary care) and taking ART as soon as possible (**GPP**).

1.A.3. Information and notification of sexual partners

1.A.3.1. Inform about notification methods to propose to the newly diagnosed individuals to have their partners tested for HIV

linkage to care, retention in care, ART adherence: Continuum care

Figure 41 : Continuum de soins des personnes vivant avec le VIH en Belgique en 2021 par rapport aux objectifs de l'ONUSIDA 2025



Épidémiologie du sida et de l'infection à VIH en Belgique. Rapport 2022

What should be done after a positive test? (primary care)

1.B. At the following consultations

1.B.1. Counselling post test
1.B.1.1. Ask questions about PLHIV's ideas, concerns and expectations (ICE) and where they get support (**GPP**).
1.B.1.2. Ask if the PLHIV informed someone she/he has been tested (**GPP**).

1.B.2. **Linkage to care, retention in care, ART adherence**
1.B.2.1. Re-inform the patient about the importance of linkage to care and retention in care (primary and secondary care) and taking ART as soon as possible (**GPP**)**.**
1.B.2.2. Support PLHIV in linkage to care, especially those in vulnerable situations and/or with mental health issues (**GPP**).
1.B.2.3. Support PLHIV in retention in care, especially those in vulnerable situations and/or with mental health issues (**GPP**).
1.B.2.4. Support PLHIV in ART adherence, especially those in vulnerable situations and/or with mental health issues (**GPP**).

What should be done after a positive test? (primary care)

1.B. At the following consultations

1.B.3. Information and notification of sexual partners

1.B.3.1. Inform about notification methods to propose to the newly diagnosed individuals to have their partners tested for HIV (**GPP**).

1.B.4. Prevention of HIV transmission

1.B.4.1. Give information about prevention of transmission (sexual, blood and mother-to-child) (**GPP**).

1.B.4.2. Inform PLHIV about **"Undetectable=Untransmittable" (U = U)** (**GPP**).

1.B.4.3. Assess the risk of HIV (sexual, blood and mother-to-child) transmission (**GPP**).

What should be done after a positive test? (primary care)

1.B. At the following consultations

1.B.5. Disclosure
1.B.5.1. Search to identify barriers to disclosure to closed people (**GPP**).
1.B.5.2. Discuss disclosure of the diagnosis to healthcare professionals (**GPP**).

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2. Which medical follow-up of a person living with HIV in primary care?

2.1. **ART adherence and retention in care**
2.1.1. Monitor/assess (**GRADE 1C**) and support regularly (**GPP**) all PLHIV with regard to **ART adherence**.
2.1.2 Monitor/assess (**GRADE 1C**) and support regularly (**GPP**) all PLHIV with regard to **retention in care**.

2. Which medical follow-up of a person living with HIV in primary care?

2.2. Follow-up and management of global health

2.2.1. Take in charge the **global health** of PLHIV (including basic vaccinations, screening for non-hiv co-morbidities and cancer screening according to the screening programmes) (**GPP**).
2.2.2. Inform as soon as possible the HRC when detecting a new health issue of concern for PLHIV (**CVD, diabetes, chronic kidney disease, liver disorders, respiratory disorders, psychiatric disorders, vertebral fractures, frailty and osteoporosis**) (**GPP**).
2.2.3. Search for **medication interactions** when prescribing any new medication and inform PLHIV for interactions (medications over the counter) (**GPP**).

GP
Global management

HIV
- Chronic disease
- ART and drugs interactions,
- Comorbidities: screening & management,
- Individual risk factors,
- High risk of metabolic disorders

PLVIH
- un patient parmi d'autres
- Social & sexual context
- Screening : metabolic disorders and usual programs

www.bcfi.be; www.cbip.be
www.hiv-druginteractions.org

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2. Which medical follow-up of a person living with HIV in primary care?

2.3. Specific follow-up of PLHIV

2.3.1. Make sure PLVIH is vaccinated against (**GPP**) :

- le pneumococcus (full vaccination); COVID19*; influenza.
- HBV/HAV;
- HPV;

2.3.2. Make sure, in collaboration with the HRC, that the PLHIV has a follow-up for sexual and reproductive health (**GPP**).

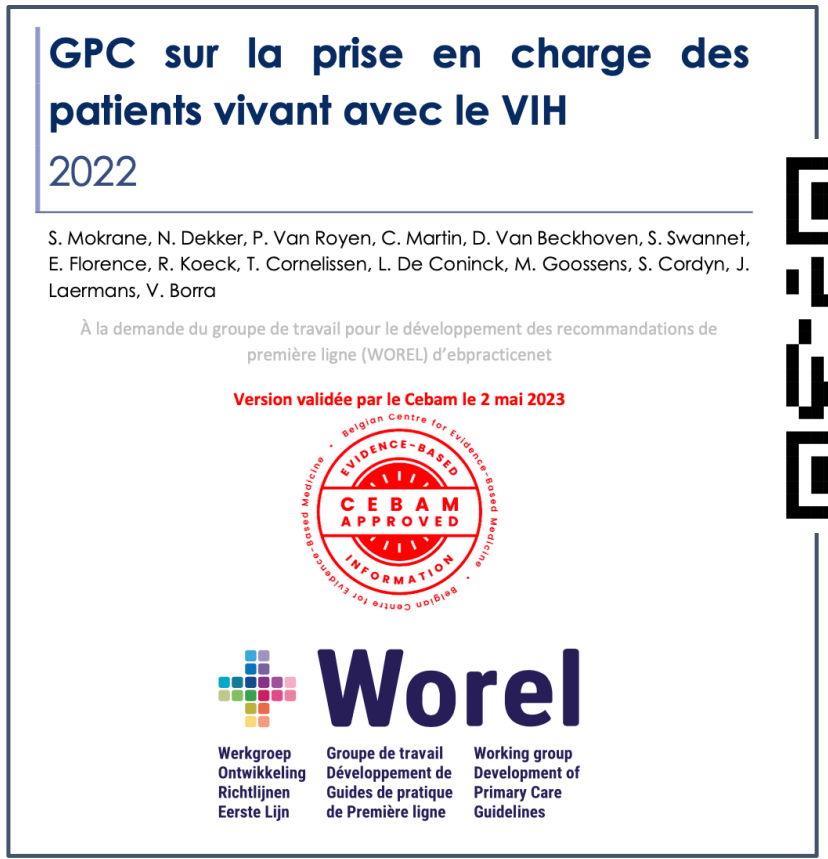
2.3.3. Refer PLHIV to the HRC and/or other specialists regarding (**GPP**) :

- Art side effects,
- Art-related complications,
- Opportunistic infections when CD4 count is below 200/mm3
- Co-infections,
- Stis (syphilis, chlamydia, gonorrhea, monkeypox)
- Cancers,
- Compliance problems,
- Sexual health problems,
- Addiction problems and recreational drug use (« chemsex »).

Thank you for your attention!

@ saphia.mokrane@ulb.be

https://www.worel.be/home



Panel discussion

- Nurse: Carolien Wylock, UZ Brussel
- MD/GP: Saphia Mokrane
- PLHIV: Axel Vandeperre en Grace Ntunzwenimana
- Moderator: M-A De Scheerder

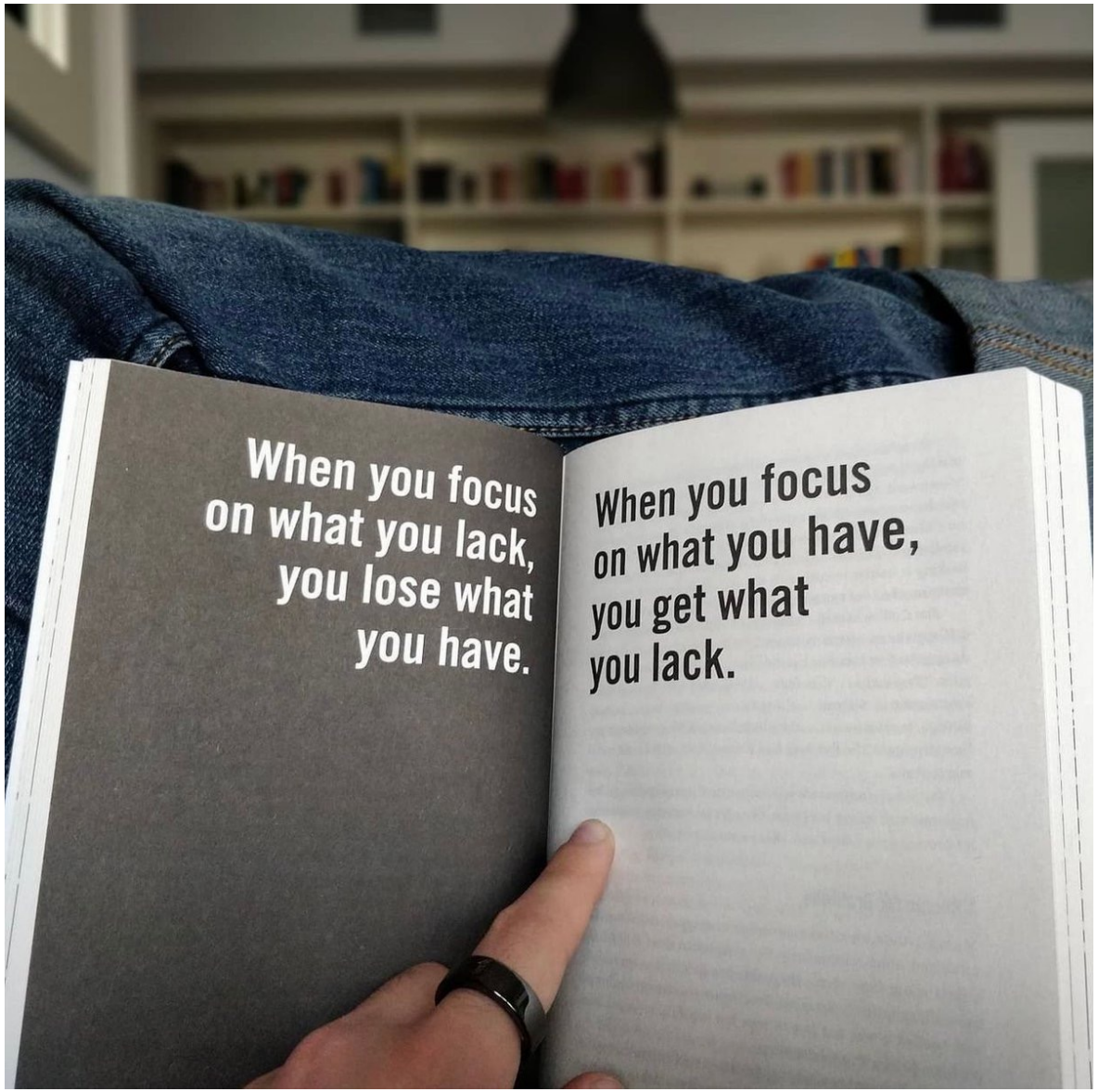
1) In your opinion, which actor could do which task?

TASK	PLHIV	GP	nurse HRC	MD HRC
Intake New HIV diagnosis				
Care for aids patient				
Start ART				
Switch ART				
Start and F-U LAM				
Prescription of ART				
Screening programs				
Management of C-V comorbidities				
Frailty assessment, functional screening				
Administration of vaccines				
PROM/PREM				

2) In your opinion, which PLHIV require more intensive follow-up?

	Frequency/y	HRC/GP?	MD	Nurse	Psychologist
WLHIV: pregnancy/breastfeeding/ menopause? Migrant?					
Refugee/sans papier					
Vertical transmission					
Early diagnosis					
Chronic stable HIV no comorb					
Chronic stable HIV with comorbidities					
Aids stadium					
Aging >50?>65?					
Psychological/Chemsex issues					

3) What are you currently lacking to contribute
As a PLHIV, as a GP, as a nurse?



To conclude

- Lifelong ART and aging with HIV demands a **multidisciplinary care system** where patients are seen by different actors with the main goal to **maintain viral suppression** for a lifetime and to act in **a preventive and therapeutic way on medical en psychosocial comorbidities** that are particular in this population compared to other populations

- The intensity of care for HIV patients is depending on several factors of which HIV is one but intensity of F-U should be guided by other factors and can shift during the journey of living with HIV

- **HIV CARE is teamwork and each teammember should get the recognition they deserve!**