RE-FRAMING HOW FRAILTY IS IDENTIFIED, DIAGNOSED AND MANAGED AMONG PEOPLE LIVING WITH HIV: EXPLORATORY PERSPECTIVES FROM CLINICAL PRACTICE

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Introduction of the ‘F.R.A.I.L. in H.I.V.’ framework

The F.R.A.I.L. in H.I.V. framework has been created to provide a more holistic and memorable way of identifying those who may be at risk of frailty across HIV services. It is adapted from the EACS 2021 algorithm for frailty screening.

It encourages clinicians to look beyond physical signs of frailty such as those outlined by the F.R.A.I.L. scale.

It also considers other risk factors in the context of HIV.

Background

Definitions and guidance traditionally position frailty as an ‘age-related’ or ‘general’ construct associated with functional and mobility impairment. People living with HIV can present with frailty at an earlier age and via less typical routes than the general public.1 Prevalence of disability in this population is also high.2

Despite more than 50% of people living with HIV in the UK estimated to be aged 50 or above by 2028,3 there is still no consensus on how UK healthcare practitioners should identify, diagnose and manage frailty in this population. Frailty tools exist but are either not sufficiently validated or labelled as inappropriate in the context of HIV.4 5

We explored the perspectives and experiences of senior practitioners to understand what works in practice and what else needs to happen to improve models of care across the field.

Materials and methods

Semi-structured interviews were conducted virtually with six healthcare professionals with expertise across different disciplines of HIV care. Interviews were audio-recorded, transcribed and thematically analysed to:

1. explore current practice
2. identify key barriers
3. curate suggestions to make identification, assessment and management of frailty easier in practice.

Results

The interviews highlighted three core barriers to identifying, diagnosing and managing frailty in HIV:

1. lack of awareness and understanding within the field
2. lack of optimised tools and processes for frailty in HIV
3. lack of care coordination, integration and resource

Approaches varied across centres but increasing and improving identification of those living with HIV and at risk of frailty was seen as the greatest priority by all. Suggested actions were compiled and a new ‘F.R.A.I.L. in H.I.V’ acronym co-developed to support staff in looking beyond a FRAIL scale to consider implications in the wider context of HIV.

Not frail but still at risk?

Regardless of the outcome of the frailty screen, any issues or vulnerabilities identified by the ‘H.I.V.’ acronym or equivalent questioning should be noted and explored further, as soon as possible, by a relevant service. Providing additional care to limit or manage ongoing vulnerabilities will help optimise an individual’s ability to age well and minimise the risk of frailty developing over time.

Summary and conclusions

Addressing frailty in people living with HIV requires a more holistic approach than traditional models of care, and taking small actions now was seen as better than waiting for a unified approach. Our collated guidance hopes to reframe frailty in the context of HIV and address existing barriers to screening, diagnosis and management in clinical practice.

References