

EACS meeting shifts guideline focus from care to standards of care

EACS members heard in [a meeting on standards of care](#) in Brussels in November that the purpose and structure of the EACS HIV guidelines may have to change radically, now that universal treatment on diagnosis is the clinical consensus.

If a main theme emerged at the meeting, it was what part doctors as a profession can play in broadening guidelines to standards, and what data and alliances are needed in order to do this. It was agreed that a more 'normative' set of guidelines, adapted to the continent, are badly needed in Europe. As Antonella d'Arminio Monforte of the University of Milan said, in recapping [the 2014 EACS meeting on standards of care](#), there has been little positive change in the European HIV epidemic, with continued rises in HIV diagnoses in gay men in the west and HIV threatening to become a generalised heterosexual epidemic in parts of the east, attendant on poor and patchy treatment access.

In general, the meeting concluded that the EACS guidelines should maintain much of their present shape but strengthen their evidence base; however they should also form part of a broader set of standards of care, in collaboration with agencies such as the European Centre for Disease Prevention and Control (ECDC) and the World Health Organisation (WHO), and that interdisciplinary meetings should happen soon to discuss their shape.

Manuel Battegay, outgoing president of EACS, explained that in an era of 'test and treat', 'getting to zero' and the UNAIDS 90-90-90 target, HIV treatment has moved from an individualised patient-care model, like cancer treatment, towards a public health model, like vaccination or tuberculosis (TB) treatment. Battegay said that clinical consensus among globally followed guidelines changes the very nature of what those guidelines are for. The focus shifts from care to the standard of care; public health and quality of life outcomes need to be added to clinical ones.

WHO's Marco Vitoria stressed that quality of care is a multidimensional concept that has to include and synthesise the viewpoints of doctors, patients and healthcare funders. It has to be able to supply measurable benchmarks against which improvements and deteriorations in care can be measured.

Quality-of-care guidelines should be based on, and track, many other variables than clinical outcomes alone, including treatment coverage; laboratory performance; patient retention; nutrition and food insufficiency; transmitted and acquired drug resistance; and psychosocial variables ranging from finances and food sufficiency to mental health and the proportion of people reporting discrimination.

It was emphasised that it is important that if guidelines have more of a public health focus, they continue to outline what is expected to enable optimal patient care, rather than list a minimum set of standards.

There was a general consensus at the meeting that many national surveillance systems would have to improve to provide enough data for even minimal rating against standards of care. Justyna Kowalska of the Warsaw Hospital for Infectious Diseases, presenting the outcomes of [an EACS meeting for physicians working in eastern Europe](#), said that many

eastern European countries could not even provide reliable figures for the number of people with HIV on treatment, let alone the proportion diagnosed

As more generic antiretroviral therapy (ART) regimens become available, guidelines cannot ignore the issues of cost-effectiveness and cost per patient. This means that guidelines have to remain clear about recommended and non-recommended drug regimens but not be blind to issues of cost-effectiveness. This could be a big problem if different European countries pay widely different prices for optimal regimens, or pay significantly cheaper prices for slightly less effective or tolerable ones.

One workshop at the meeting formulated the minimum data needed to establish a set of clinical standards. It concluded that if EACS' aim was to be *the* European HIV guidelines they would have to reform their evidence base, as they do not use [the GRADE system](#) for evaluating the strength of evidence.

One suggestion is that regular CD4 monitoring could be dropped completely as long as there were regular viral load tests. CD4 counts would only be done on diagnosis, in people not on antiretroviral therapy, in cases of virological failure, and when people were on immunosuppressive (e.g. cancer) chemotherapy. However, viral load monitoring is irregular in some countries and in Serbia is not done at all, a situation all delegates agreed needed redressing.

From this discussion arose a suggestion that EACS should start a mapping and monitoring project that would enable members to report on drug and diagnostic shortages, issues of retention, prevalence and eligibility for care of migrants, and usage of generic versus branded drugs.

There was a dedicated workshop on retention in care. It was strongly suggested that the next issue of the EACS guidelines include a short section defining retention and suggesting strategies for tackling loss to follow-up.

One simple definition of retention is based on the proportion of patients failing to appear within a certain number of weeks after a missed appointment. Kevin de Cock, Director of the US CDC mission in Kenya urged that 'test and immediate treat' (i.e. patients walking out of the clinic with their first ART the day they are diagnosed, to avoid loss of retention) should be adopted in Europe as standard. Strategies that can usually restore linkage to care and prevent loss to follow-up in future should be summarised in the guidelines. These might need to be adapted to local expectations of confidentiality, e.g. contacting patients by mobile phone.

A third workshop looked specifically at TB. Currently only 50% of people diagnosed with HIV in Europe are tested for TB (partly because of assumptions that TB prevalence in gay men in high-income countries will be very low) and only 65% of people diagnosed with TB are tested for HIV (in Europe, 5% have HIV). Guidelines should include minimal standards of testing for TB in people accessing HIV care and vice versa.

Justyna Kowalska said that physicians are in an advantageous position to complement and help to modify surveillance data such as that compiled by ECDC – whether this is primary care physicians seeing HIV in their patients, or HIV physicians seeing poor retention, treatment shortages, poor adherence and viral suppression in theirs.

Manuel Bategay said that doctors did have a specific part to play in what should be a much broader and more comprehensive set of standards of care. Points to include in any new document were frequency of CD4 monitoring, viral load monitoring as mandatory and of a given minimum frequency, recommendations for testing in settings likely to yield the highest proportion of diagnoses (including hospital admissions), testing all TB patients, a definition and simple guide to retention in care, and, in the new era of antiretroviral-based prevention, uptake of pre-exposure prophylaxis (PrEP).

He suggested a specific agreement be devised to set out EACS and ECDC's working relationship.

At the same time as a larger set of standards was being formulated, however, it was also emphasised that as a result of the greater consensus between guidelines, there was now an advantage in issuing specific, easy-to-read, perhaps graphically presented factsheets on specific sections, in a broader variety of languages than currently, that could be used by non-HIV doctors, people living with HIV and patient advocates in a variety of settings. These should be clear on best practice but sensitive enough to adapt to local conditions.

Several delegates at the meeting emphasised that moving from clinical to public-health guidelines implied that physicians had to take a somewhat more political role rather than adhering solely to clinical evidence. "To conform to guidelines you *have* to provide access to proper care and diagnostics," commented Andrea Antinori of the National Institute of Infectious Diseases in Italy and Nina Friis-Møller of the Zealand University Hospital, in Denmark. "Where does EACS' responsibility start and end in this? It implies a more political role."

Reference

The programme and all presentations from the 2016 EACS Standard of Care meeting can be downloaded from the EACS website: <http://www.eacsociety.org/conferences/standard-of-care-meeting/standard-of-care-2016.html>