

Palliative HIV Care: Opportunities for Biomedical and Behavioral Change

Eugene W. Farber · Vincent C. Marconi

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Abstract Advances in treatment are contributing to substantial increases in life expectancy for individuals living with HIV, prompting a need to develop care models for the effective management of HIV as a chronic illness. With many individuals continuing to experience symptoms and complications that add to the disease burden across the spectrum of HIV disease, the discussion herein explores the complementary role that early palliative care can play in HIV primary care as a strategy for enhancing long-term quality of life. After first defining the concept of early palliative care, its scope in the context of current clinical realities in HIV treatment and implications for HIV care models is described. After reviewing the emerging extant research literature on HIV palliative care outcomes, a program description is offered as an illustration of how palliative care integration with HIV primary care can be achieved.

Keywords HIV · Primary care · Palliative care · Medical service integration

Introduction

Recent years have witnessed remarkable advances in HIV treatment such that longevity among those receiving antiretroviral therapy (ART) has been substantially extended [1–3]. Among the most striking indicators of just how far HIV treatment has progressed comes from life expectancy studies.

For example, a study examining individuals from the time of HIV diagnosis used Kaplan–Meier life tables with age as the time scale to estimate that, with available 21st century treatments, a 25-year-old living with HIV and no co-morbid hepatitis C infection has a median remaining life expectancy of over 35 years [2]. Life expectancy research also suggests that, when compared to the general population, persons living with HIV who are virologically suppressed on ART and maintain or achieve a CD4 count of at least 500 cells/ μ L may experience no increased mortality risk [3]. Further, emerging findings indicate that early initiation of ART yields such clinical advantages as delaying the time to onset of AIDS-defining events [4].

These treatment successes have led to a reconceptualization of HIV as a chronic illness, prompting the need to develop models and strategies for long-term clinical management of persons living with HIV [5, 6]. Key aims for HIV care in this chronic disease era include early and sustained engagement in treatment, viral suppression, enhanced immune functioning, significantly improved longevity, and heightened quality of life [7]. Also, with research showing that viral suppression resulting from ART has a role in reducing HIV transmission [8], an additional population-based public health objective of HIV treatment is to prevent new infections within a “Treatment-as-Prevention” paradigm [9, 10]. Efforts to achieve these aims are complicated by significant gaps in patterns of HIV health resource utilization across the continuum of care, including testing and diagnosis, linkage to health services, retention in care, and receipt of and adherence to ART [11]. In the USA, only about half of individuals diagnosed with HIV are retained in ongoing medical care. Moreover, only 19–28 % of all persons living with HIV are virologically suppressed [12–14]. The magnitude of this HIV health service utilization crisis has spurred interest in innovating new intervention approaches aimed at maximizing early HIV diagnosis, linkage, and retention [7, 11].

E. W. Farber (✉) · V. C. Marconi
Emory University School of Medicine, Grady Infectious Disease Program, 341 Ponce de Leon Avenue, Atlanta, GA 30308, USA
e-mail: efarber@emory.edu

V. C. Marconi
e-mail: vmarco@emory.edu

To be effective in achieving both the clinical and prevention goals of HIV treatment in the chronic disease era, emerging models of HIV care must take into account the high degree of biopsychosocial complexity of HIV service delivery. Drawing upon principles from general systems theory, the biopsychosocial model highlights the mutual interaction of biological/biomedical, psychological/behavioral, and social/environmental factors to affect experiences of health and illness [15]. Consistent with this framework, research suggests that service utilization patterns across the continuum of HIV health services, including service utilization gaps, are influenced by multiple factors. These include structural (e.g., geographic accessibility of clinical services, availability of transportation resources, flexibility of appointment scheduling, ease of navigability of clinical care systems), biomedical (e.g., physical symptom profile, tolerability of medical treatment regimens, degree of physical well-being or ill health), behavioral (e.g., mental health functioning, substance use patterns, health beliefs and attitudes, knowledge/expectations regarding the risks and benefits of HIV treatment), and psychosocial (e.g., HIV stigma, financial/material resource availability, community/cultural norms, quality of social support, quality of relationships with medical providers and clinical support staff) variables [11, 16, 17]. What these findings suggest is that emerging HIV care models must be context-driven and holistic in approach in order to effectively address the complex biopsychosocial needs and concerns of persons living with HIV.

As part of the evolving discussion of treatment models and strategies to extend the reach of state-of-the-art HIV care in the context of an emerging chronic illness framework, some have begun to advocate for integrating holistic, palliative care strategies with primary care intervention across the spectrum of disease course [18, 19, 20••]. Although palliative care has traditionally been thought of as an end-of-life medical intervention, it is increasingly regarded as a valuable clinical resource that can be brought to bear across the course of chronic disease in combination with traditional medical care. Reflecting this view, the World Health Organization (WHO) endorses the inclusion of palliative care in the management of chronic illness as early as is feasible to help reduce symptoms and enhance quality of life [21]. Similarly, UNAIDS envisions a key role for palliative care as part of the ongoing management of HIV across the disease spectrum [22]. Advocating for access to palliative care as a human right, several international palliative care associations along with Human Rights Watch drafted the Prague Charter, which takes the position that governments and health authorities worldwide have an obligation to offer palliative care services [23]. Among its provisions, the Prague

Charter highlights the value added of palliative care in addressing the complex needs of persons living with HIV as a chronic illness.

Palliative care figured prominently in the early years of the HIV epidemic when treatments for long-term management of the disease had not yet been developed. However, with the exception of end-of-life care, palliative care has tended to be de-emphasized in the chronic disease era of HIV primary care, with some suggesting that an erroneous divide has been drawn between curative and palliative treatments despite the potential for palliative care to enhance quality of care at all stages of disease [20••, 24]. In light of evolving views of the relevance of palliative care across the spectrum of chronic illness, the notion of including early palliative care intervention as part of ongoing HIV treatment is now beginning to gain traction, though the literature in this area remains sparse [20••]. As such, the purpose of this article is to explore opportunities to integrate palliative care with primary care across the spectrum of HIV disease.

Palliative Care in the Chronic Disease Era of HIV Primary Care

Palliative Care Defined

According to the WHO definition [21], palliative care is "...a holistic approach to improve the quality of life of patients with incurable disease and their families through the prevention and relief of suffering by means of early identification and careful assessment and treatment of pain and other problems, physical, psychological, and spiritual" (p. 7). Consistent with a biopsychosocial perspective, this conceptualization of palliative care reflects a whole person treatment approach designed to address concerns at the interface of biomedical, behavioral/psychological, social, and spiritual dimensions in the lives of patients living with chronic disease. Accordingly, whereas HIV primary care is concerned first and foremost with clinical intervention aimed at achieving virologic suppression, palliative care focuses on reducing symptoms and facilitating the amelioration of psychosocial concerns with the objective of enhancing quality of life [18, 20••].

Clinical Challenges in the HIV Chronic Disease Era

Although current ART regimens have enjoyed overwhelming success, mortality rates for persons living with HIV remain significantly higher than those for the general population [1, 6]. Additionally, clinically significant symptoms are common across the spectrum of the disease [20••, 25, 26]. Consequently, many individuals experience challenges that contribute to the overall disease burden of HIV. Early palliative care can be especially useful for helping to manage these challenges, key

examples of which include biopsychosocial complications occurring across the spectrum of disease, medical problems associated with late entry into HIV care, and emerging clinical concerns related to HIV and aging. For example, palliative care can support a comprehensive primary care strategy for an individual with advanced HIV disease who is newly presenting for care that includes holistic multidisciplinary assessment and intervention to address the combined impact of biomedical, behavioral, psychosocial, and spiritual concerns on overall quality of life.

Biopsychosocial Complications Across the Disease Spectrum

Individuals newly diagnosed with asymptomatic HIV experience a range of concerns such as pain, depression/worry, spiritual unease, social apprehensions, and need for information [27]. At the opposite end of the disease spectrum, individuals found to have advanced HIV disease often present with multiple medical co-morbidities, one or more co-occurring psychiatric or neuropsychiatric conditions, and psychosocial instability that add to the complexity of care [28].

Even when viral replication is reliably and durably controlled by ART, persons with HIV are at elevated risk for serious non-AIDS-related medical conditions, examples of which include cardiovascular disease, cancer, liver disease, kidney disease, and neurocognitive disorders [5•]. Several factors may contribute to this increased risk for serious non-AIDS events [1, 5•]. Among these are lifestyle and behavioral factors such as smoking, excessive alcohol use, recreational drug use, and co-occurring viral hepatitis and/or sexually transmitted diseases. Toxicities associated with antiretroviral agents used to treat HIV infection as well as metabolic changes that occur with long-term ART may also contribute to serious non-AIDS events, though these complications tend to be less common with newer antiretroviral medication formulations. Additionally, immunological and inflammatory processes associated with HIV also are implicated in the risk for serious medical co-morbidities and mortality as well as the potential for accelerating the biological aging process [5•, 29, 30].

More generally, with the HIV epidemic concentrated disproportionately among those living at the low end of the socioeconomic status continuum and in historically socially disenfranchised communities, individuals living with HIV frequently encounter financial, material, and social resource concerns along with stigma that can add to the illness-associated stress burden and adversely influence health behavior practices [31]. Additionally, mental health conditions are highly prevalent among the general population of persons living with HIV, approximating 50 % in both nationally representative and primary care samples [32, 33]. Left untreated, these disorders can compromise HIV adherence and retention in care [34–36].

Late Entry into Care

Roughly one-third of individuals living with HIV in the USA are diagnosed late in the disease course [37]. Consequently, many individuals are late in entering HIV care (defined as presenting with a CD4 count below 350 cells/ μ L or an AIDS-defining illness regardless of CD4 count) [38] or have progressed to advanced HIV disease (defined as presenting with a CD4 count below 200 cells/ μ L or an AIDS-defining illness irrespective of CD4 cell count) [38] when HIV treatment is initiated. Late presentation for care significantly complicates clinical management, as it is associated with heightened difficulty in achieving viral suppression, along with increased risk for drug toxicities, likelihood of clinical events or need for hospitalization, and short- and long-term mortality [39].

Older Adult Populations

An emerging clinical challenge in HIV care, related in part to the successes of ART in increasing longevity, is that as people live longer with the illness, age-related medical co-morbidities and polypharmacy concerns become increasingly common and add to the complexity of clinical management [40, 41]. Immuno-inflammatory processes may be involved in the development of the observed increase in medical co-morbidities among older adults living with HIV [30, 40]. Older adults living with HIV also may experience mental health complications, HIV-associated neurocognitive deficits, and psychosocial concerns that add to the overall disease burden, posing challenges to medical intervention [42].

The Role of Early Palliative Care

Collectively, the range of concerns and potential complications across the disease spectrum that often are a part of the clinical picture in the chronic disease era of HIV medicine contribute to the potential for a high degree of care complexity. The evidence base demonstrates that attending to these multiple clinical, behavioral, and psychosocial concerns in patients presenting for HIV care, particularly ongoing symptom assessment and management, is critical to promoting HIV treatment adherence and retention and enhancing quality of life [25, 36]. Yet, efforts to manage the complex array of concerns with which many patients present during routine appointments can be challenging for primary care providers given high patient caseload volumes, increasing documentation requirements, and relatively brief time frames within which to conduct routine medical visits.

Early palliative care, with its holistic, collaborative, and interdisciplinary team approach, can complement primary care efforts by focusing directly on systematic assessment and intervention to ameliorate troubling symptoms, address

behavioral complications, manage psychosocial instability, and attend to health-related spiritual matters. The palliative care framework is explicitly patient-centered and collaborative, emphasizing dialogue and communication in making health-related decisions [43]. Specifically, palliative care aims to help individuals articulate their goals relative to the illness, increase the experience of control, enhance understanding of illness, provide strategies for managing pain and symptoms of illness, offer support to individuals and family members, and enhance social support networks [19, 20••]. Because clinical needs change across the continuum of illness, the emphasis of palliative care interventions may vary depending on whether an individual is newly diagnosed, in ongoing care, or in the later phases of HIV disease [44].

Overall, palliative care is well positioned to complement primary care across the spectrum of HIV disease course as a clinical resource for enhancing quality of life. Early palliative care may even contribute to improved retention in care and health outcomes because of its whole person focus on a spectrum of biopsychosocial concerns that, left unaddressed, could pose obstacles to individuals remaining in care and adherent to ART [20••, 27].

HIV Palliative Care Outcomes

Worldwide, the need for HIV palliative care services is substantial. Illustrative of this point is a study reporting that, of 731 patients who presented for HIV care in Tanzania during a 1-month period, nearly 52 % were candidates for palliative care based on experiences of physical symptoms, pain, psychosocial concerns, or spiritual needs [45]. As early palliative care approaches are developed to address this need, outcomes research is required to evaluate these programs. However, while there is a compelling evidence base documenting the biopsychosocial complexity of HIV and the importance of addressing this clinical complexity in a systematic and coordinated way [25–28, 36], research examining the outcomes of HIV palliative care approaches is limited [44]. Empirical support for early palliative care interventions in the management of several different chronic illnesses comes from randomized controlled trials showing that palliative care not only can contribute to enhanced quality of life but also may lower costs of care and increase survival [46]. For example, in a randomized controlled trial investigating the role of early palliative care in the clinical management of individuals with metastatic non-small-cell lung cancer, participants who received early palliative care evidenced greater quality of life and fewer depressive symptoms than participants who received the standard of care [47]. Additionally, study participants who received early palliative care also demonstrated longer median survival even though they received less

aggressive care at the end of life than did their counterparts in the standard care condition.

Even with the relative paucity of research on HIV palliative care outcomes, a small body of literature in this area is emerging, including reports on randomized controlled trials that are now underway and for which results are likely to be available in the near future [48]. In a systematic review, investigators reported on findings from 17 studies that evaluated patient outcomes or satisfaction with care in persons living with HIV who received services that included at least some aspects of palliative care such as symptom control, pain management, psychosocial support, and/or end-of-life care [49]. Studies meeting these criteria were included even if they did not specifically use the term palliative care to characterize the services being evaluated. Several different service models (e.g., home-based care, inpatient care) and varying combinations of services (e.g., palliative medicine consultation, palliative nursing, psychosocial support, spiritual care, family support) were represented across the studies included in the review. Findings were presented based on a grading of the methodological rigor of the quantitative studies that were reviewed, including a single randomized controlled trial, two observational studies with comparison groups, seven single-group longitudinal studies, and one cross-sectional study. Results from six qualitative studies also were reported. While acknowledging significant methodological challenges associated with the evidence base that comprised their systematic review, the authors concluded that there was support for improved outcomes for patients receiving HIV palliative care, particularly for home palliative care and inpatient hospice care programs where participants evidenced improved pain and symptom control, reduced anxiety, heightened insight, and enhanced spiritual well-being. The sole randomized controlled trial reported in the review, which compared an integrated interdisciplinary case-managed home care approach to standard home care, showed possible benefits of case-managed home care over standard care, though this finding was not statistically significant.

In Vietnam, where the Ministry of Health has developed and implemented a national palliative care strategy [50], investigators have reported on research examining the accessibility, acceptability, and feasibility of HIV palliative care services integration in outpatient settings. Among the study findings was that the palliative care intervention resulted in high levels of symptom assessment and care along with an increase in screening, availability, and utilization of mental health services [51]. Additionally, interviews and focus groups conducted with palliative care service recipients suggested improvements in physical and psychosocial well-being and high acceptability of these services.

Similar findings were reported from a largely qualitative outcome evaluation of palliative care services implemented through home- and community-based care programs in Ethiopia [52]. This investigation utilized participatory rapid appraisal methods involving interviews, focus groups, and case studies to evaluate the program impact. Among the key outcomes highlighted was a reduction in HIV-associated stigma and discrimination along with increasingly open communication between persons living with HIV and their families and community peers. Health and well-being also were enhanced, with improvements in access to care and support for ART adherence reflected in a decline in opportunistic infections and reduced mortality.

In a study in South Africa, the feasibility of early ART initiation was examined in ART-naïve patients with HIV, tuberculosis, or acute HIV-associated opportunistic infection receiving inpatient care [53]. Early ART was administered in an inpatient step-down center where an interdisciplinary palliative care team provided clinical services. The results established the feasibility of this intervention, with 93 % of those who completed 24 weeks of follow-up experiencing virologic suppression.

A prospective, longitudinal controlled investigation conducted in Tanzania compared outcomes from an HIV outpatient program that incorporated palliative care to those observed in a standard care HIV clinic [54••]. The results showed that reports of pain were reduced significantly more in the program where staff received training in palliative care than in the standard care program. Similar outcomes were found on a self-report measure of physical and mental health quality of life as well as an index of 3-day prevalence of physical, psychological, emotional, and spiritual problems in patients and their families.

Taken as a whole, the findings from this relatively small evidence base demonstrates the clinical benefits of offering palliative care as part of HIV treatment regardless of disease phase [49–53, 54••]. It also yields empirical support for the WHO and UNAIDS recommendations specifying the importance of offering palliative care across the spectrum of illness [21, 22]. Yet even with the continuing high physical, psychological, social, and spiritual/existential burden associated with HIV disease, implementation of early palliative care in the chronic disease era of HIV primary care has been slow to develop. In the USA, only a few such programs have been characterized in the clinical literature [55, 56]. Given this state of affairs, and with the aim of contributing to the dialogue in this area, a programmatic illustration is offered presently as one example of how palliative care integration with HIV primary care can be achieved.

Integrating HIV Palliative Care with Primary Care: A Programmatic Example

Setting and Overview of Palliative Care Services

Located within a large academically affiliated outpatient HIV primary care program in a major southeastern city in the USA, the palliative care clinic serves as a complementary service to primary care intervention. The primary care program within which the palliative care clinic is set is organized in accordance with a comprehensive, integrated biopsychosocial “medical home” model of HIV primary care [7]. Specifically, in addition to primary care, the program houses a large spectrum of services, key examples of which include medical subspecialty care, oral health care, mental health/substance abuse care, medical case management, pharmacy, and clinical research trials. In coordination with their primary care providers, patients receiving palliative care can also be referred to one or more of these on-site specialty services. Almost all of the patients served have incomes below 300 % of the US federal poverty level, and clinic enrollment requires adult patients to have advanced disease based on a history of a CD4 count below 200 cells/ μ L and/or an AIDS-defining illness.

Palliative care is offered to patients upon referral by their primary care providers and delivered by a multidisciplinary team comprised of a palliative care physician, registered nurse, psychologist, registered dietician, physical therapist, social worker, and chaplain. Patients are seen by all members of the palliative care team at the point of service during palliative care clinic visits. This approach permits comprehensive evaluation and intervention as well as real-time dialogue and care coordination among the multidisciplinary team members. Ongoing communication and coordination with primary care providers is also an essential component of care. This overall structure is depicted in Fig. 1.

Framework of Care

Palliative care services are offered within a holistic care framework anchored by the biopsychosocial model [15]. Accordingly, clinical problems are conceptualized in the context of the mutually interacting physical/biomedical, psychological, social, and spiritual functional domains in the life of the patient.

Service delivery is also patient-centered [43, 57]. Service provision is individualized, flexible, and collaborative, taking into consideration the world view, beliefs, and values of patients [57]. Active patient participation in health-related decision-making is emphasized, open communication is cultivated, and a shared approach to treatment planning by the patient and palliative care team is

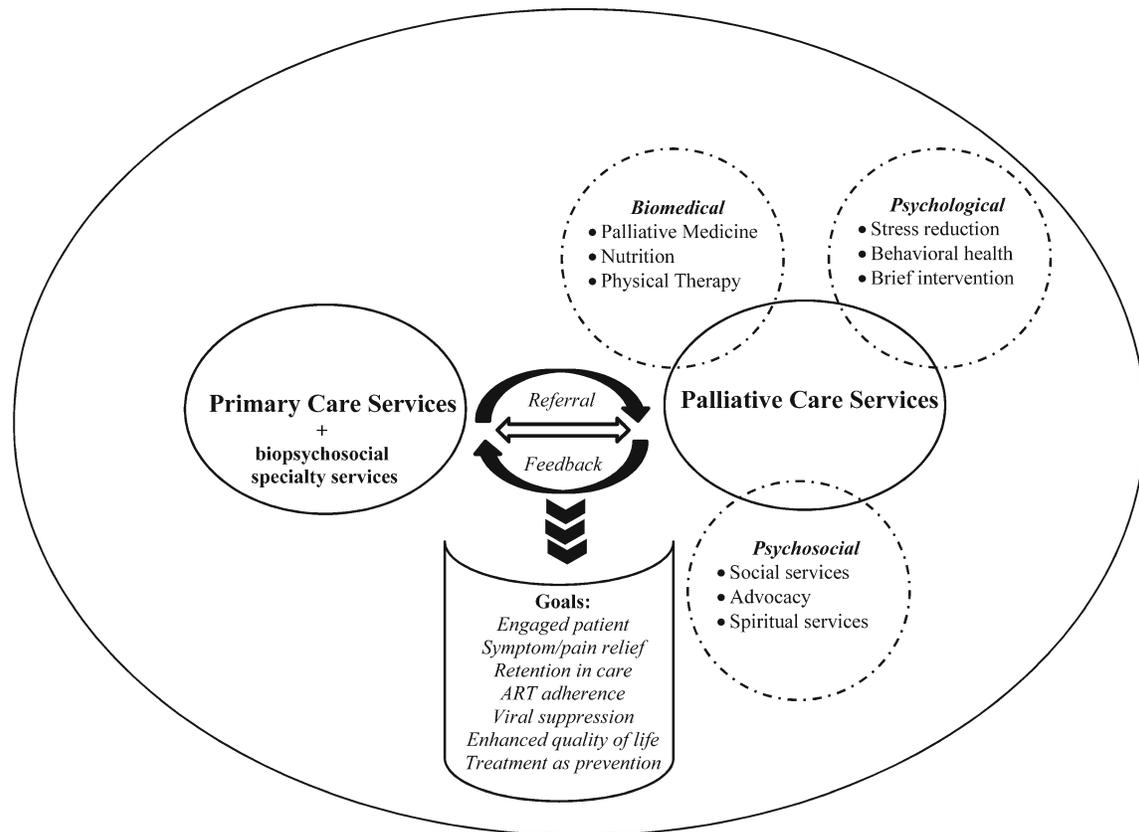


Fig. 1 Model of HIV palliative care integrated with primary care

facilitated where medically feasible. For example, the provider team may actively solicit input from patients regarding their perceptions of HIV and its significance and impact in their lives. Patients may also be asked about what is important to them relative to their HIV-related health and well-being along with factors that they believe contribute to good working relationships with their health care providers.

This patient-centered approach is supported by an evidence base demonstrating positive associations between engagement in care and perceptions by patients that medical providers are respectful, willing to listen, able to explain matters clearly, and interested in knowing them as persons [58]. Qualitative investigations have similarly found that social connectedness with providers is important to successful entry into HIV care and that support by providers of autonomous functioning in their patients contributes to retention in care [59]. Apropos of this latter point, recent behavioral science research has shown that autonomy of choice, sense of competence, and self-efficacy all are positively associated with ART adherence [60, 61]. Taken together, these findings suggest that aspects of the patient-centered approach that involve cultivating the patient-provider relationships and supporting

patient agency and autonomy are key ingredients for successful treatment adherence and retention in care.

Service Delivery Strategy

The multidisciplinary palliative care team provides care in a coordinated and synergistic fashion, as depicted in Fig. 1. Prior to each clinic, the team meets to review the needs of patients scheduled to be seen that day, maintain ongoing dialogue during clinic visits, and convenes a post-clinic meeting to confer retrospectively on patient encounters and establish follow-up plans. Assessment and intervention to address symptoms or problems involve consideration of a combination of medical indications, psychological/behavioral patterns, social circumstances, personal and cultural-based values and beliefs, and spiritual views. For example, consistent with a biopsychosocial framework for conceptualizing pain syndromes [62•], pain intervention may follow a carefully coordinated protocol comprised of pharmacological strategies managed by the palliative care physician, behavioral pain management interventions implemented by the psychologist, and exercise strategies for pain control provided by the physical therapist. Where indicated, the social worker can assist the patient in ameliorating social circumstances that might

exacerbate the pain-related stress burden and the chaplain can work with spiritual aspects of the pain experience as needed. In addition to coordination with the primary care provider, the palliative care team also coordinates with one or more of the subspecialty services housed in the larger primary care program as needed to optimize care.

Programmatic Considerations and Lessons Learned

Implementation of an HIV palliative care program requires considerable forethought and planning. This begins with an assessment of resources in order to evaluate the scale of palliative care services that may be feasible in a given clinical setting, including funding considerations, physical clinical space, and staffing availability for palliative care programming. In the case of the program described herein, palliative care is delivered in a twice-monthly clinic, with the palliative care role of each interdisciplinary team member comprising only a small part of their overall clinical activities in the HIV primary care program within which the palliative care service is located. Accordingly, palliative care services are provided using existing staff resources and are carried out within the established funding structure for the program. However, it is important to underscore that a palliative care framework can be adapted to a continuum of clinical service resource parameters. For example, primary care practitioners can directly incorporate palliative care strategies into their practices, including holistic clinical evaluation (e.g., assessing functional impact of pain and symptoms, behavioral patterns, psychosocial needs, and spiritual concerns), patient-centered formulation of treatment goals, and consultation with interdisciplinary clinical specialists where indicated to address specific biopsychosocial concerns affecting a given patient's quality of life [46]. As such, implementation of HIV palliative care does not necessarily presuppose the availability of an interdisciplinary clinical specialty team.

Given the diversity of individuals receiving HIV care, a cultural framework for the delivery of palliative care services has been critically important to the implementation of the program described here. This perspective requires consideration of the intersection of a range of culturally relevant factors in the lives of individual patients, including such factors as age, gender, race, ethnicity, nationality, sexual orientation, socioeconomic status, language, literacy, and disability. Within this cultural intersectionality model [63], clinicians aim to grasp the patient's experiences in living with HIV in the context of the interconnecting socio-demographic dimensions that influence health-related beliefs, attitudes, and concerns. Such an approach is essential to the collaborative patient-centered stance that is among the hallmarks of palliative care intervention.

Even with the efforts by international health organizations to provide education on the importance of early palliative care

in the treatment of chronic illness [21, 22], an important lesson learned at the outset of the palliative care program implementation depicted herein involved the education of medical providers regarding early palliative care models. Since the vast majority of primary care providers regarded palliative care as an end-of-life intervention and were unaware of evolving models of early palliative care in the treatment of chronic illness, a series of education modules were provided that covered concepts, guidelines, and evidence-based literature on the role of palliative care as a value-added complement to HIV primary care. These modules also provided a forum within which to develop strategies for ongoing communication between primary care providers and the palliative care team in order to support continuity of clinical service delivery on behalf of patients.

In light of the limited research literature on outcomes for HIV palliative care models, incorporating mechanisms for evaluating palliative care intervention outcomes is an essential programmatic task. This can be accomplished by utilizing symptom measures and quality of life tools incorporated as part of the palliative care assessment. Medical record review also can be used to examine outcomes involving key clinical variables that reflect the focus of palliative care intervention (e.g., symptom and pain control, reduced frequency of comorbid conditions, decreases in mental health symptoms). Tracking improvements in viral load outcomes among those not virologically suppressed at the time of initiating palliative care due to inconsistent treatment adherence and retention in care has implications not only for clinical outcomes but also for palliative care as a "Treatment-as-Prevention" strategy. Further, documenting reduced medical co-morbidities and fewer hospitalizations over time provides a basis for demonstrating the cost-effectiveness of early palliative care. Overall, these program evaluation efforts can assist in justifying ongoing funding of palliative care, thereby contributing to the sustainability of these services.

Conclusions

Underscoring the need for accessible early palliative care for individuals living with chronic disease across the spectrum of illness, WHO has developed a public health strategy for integrating palliative care into national health care systems across the globe [64]. Yet, in the chronic illness era of HIV disease management, implementation of early palliative care has been slow despite the evidence documenting its effectiveness. By addressing symptoms and syndromes that adversely affect overall functioning, early palliative care also can play a role in supporting ART adherence along with engagement and retention in HIV care. Accordingly, adoption of early palliative care as a complement to primary care may not only help to

facilitate favorable clinical outcomes but may also contribute to a comprehensive HIV treatment as prevention strategy.

As the landscape of care for individuals living with HIV continues to evolve in the chronic disease era, efforts are needed to bridge the unfortunate distinction that has been drawn between disease-specific ART care aimed at achieving viral suppression and palliative intervention. This can begin with education regarding the scope and reach of palliative care, emphasizing its value added as a complement to HIV primary care across the disease spectrum and not exclusively for end-of-life care. Additionally, more topical focus on early palliative care in the HIV clinical literature is needed to raise awareness of its role in the context of comprehensive HIV care, disseminate information about HIV palliative care models and their modes of implementation, and explore avenues for creating cost-effective HIV palliative care approaches. Finally, additional research is needed to expand the evidence base on clinical outcomes resulting from palliative care integration with HIV primary care.

Despite remarkable advances in treatment, HIV care remains a complex endeavor and patients across the disease spectrum experience a myriad of symptoms and complications that add to the disease burden. Routine implementation of early palliative care can contribute substantively to address these complications and, thereby, enhance overall HIV care.

Compliance with Ethics Guidelines

Conflict of Interest Eugene W. Farber and Vincent C. Marconi declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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