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Feature Article

A growing need – HIV education in long-term care

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ABSTRACT

As people living with HIV (PLHIV) age, knowledge of HIV and the associated care of those aging with HIV will become an increasingly important component of education for long-term care (LTC) providers. This descriptive study piloted two different approaches to distribute narrative-based HIV educational videos. Four LTC facilities were assigned to receive the videos to implement 'as usual' or to receive the videos in addition to blended learning sessions where the videos were shown with facilitated discussion with a nurse educator and a PLHIV. In LTC facilities where external educators were provided, a larger proportion of staff watched the videos. However, increases in staff comfort level providing care to PLHIV were comparable between both groups. Narratives of PLHIV, administrator engagement and coordination of online education were identified as facilitators to improving HIV knowledge and compassion in LTC, while fear of HIV transmission and limited time for education, especially when not mandated or identified as immediately applicable, were identified as barriers. From our findings, HIV-related stigma still exists in LTC and these videos may be a strategy for disseminating basic knowledge about HIV transmission and sensitizing staff to the experience of living with HIV.

Introduction

The proportion of older adults living with HIV has increased in all regions of the world since 2007.[1] Based on data from the national Dutch ATHENA cohort study, it is predicted that 73% of individuals who are living with HIV will be age 50 or older by 2030.[2] Similar age profiles are expected in North America and other high-income countries as people living with HIV (PLHIV) achieve life expectancies comparable to the general population.[2–6]

Despite these advances, aging PLHIV continue to face specific clinical and social challenges. Higher rates of HIV-associated comorbidities, chronic conditions and neurocognitive disorders are well-documented among this population.[2,6–13] Furthermore, many older PLHIV experience or anticipate stigma associated with ageism and living with HIV, as well as any additional stigma from identifying with marginalized sexual, social and/or racial groups.[10–21] Stigma is one of the reasons why aging PLHIV tend to have limited traditional, informal support networks and rely more heavily on formal care providers.[9–13,17,19–24] Thus, there is a need for long-term care (LTC) services for this growing geriatric population.

Knowledge and awareness of HIV, as well as the associated care and experiences of those aging with HIV, will become increasingly important in order to provide inclusive and appropriate care in an LTC environment. Aging PLHIV commonly cite their anxiety or concerns about acceptance in LTC facilities.[13,21,25,26] A large body of literature also highlights the lack of training and the need to provide more HIV education for care providers.[6,12,13,22–24,27] While HIV-related stigma may still exist in healthcare settings, studies demonstrate that HIV knowledge and training may influence and reduce prejudicial attitudes.[14,28–32] Furthermore, an empathy-based approach showcasing the personal perspectives of PLHIV may improve understanding and care for this population.[14,28–31]

The goals of this descriptive study were to pilot two methods of distributing a narrative-based, freely available video education program to deliver HIV/AIDS information to LTC providers and to identify barriers and facilitators to dissemination and uptake of HIV education in an LTC setting.

Abbreviations: AIDS, acquired immune deficiency syndrome; HIV, human immunodeficiency virus; LTC, long-term care; PLHIV, person/people living with HIV.

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Methods

Design

This descriptive pilot study trialled two different educational approaches for disseminating HIV training materials. Four LTC facilities in the Greater Toronto Area, Canada were randomly assigned either as a control group to implement HIV educational videos 'as usual', or assigned to receive facilitated training sessions where the educational videos were introduced, viewed, and discussed with a registered nurse educator and a PLHIV educator. Data were collected from front-line staff and administrators to understand the impact of the materials and educational approach, as well as the barriers and facilitators to HIV education in each setting.

Sample

LTC facilities in a for-profit management group in Greater Toronto Area were approached by an LTC facility administrator who was part of the study team. Seven homes were invited to participate. Two homes declined due to upcoming or recent management or staff changes. A third home declined after agreeing to participate but being unable to complete any project activities. Staff turnover was cited as a barrier to participation in this study.

HIV education materials

HIV/AIDS and LTC: Compassionate Care in a Changing Landscape is an educational video series developed through a unique partnership between Casey House, a sub-acute care HIV/AIDS hospital, and The Rekai Centres, two Toronto LTC facilities. The videos are readily accessible and available free of charge in DVD format and online at www.hivlongtermcare.com.

Two videos from the series, *Bedside Care* and *Families & Networks of Support* were piloted in this study. *Bedside Care* highlights essential information for frontline care providers about HIV transmission. *Families & Networks of Support* focuses on the perspectives of PLHIV and those affected by HIV, and the vital role friends and family play in support of the care of PLHIV.

Procedures

After LTC facilities agreed to participate, an administrator or education lead participated in a consultation with a member of the team to discuss the HIV and LTC training materials, including relevant evaluation forms, and determine the best ways for the training to be delivered, taking into account the existing structures and resources for education within the facility. For the homes that were to receive facilitated training sessions, dates for the sessions were planned. It was explained that the session facilitators would describe the need for HIV education and answer any questions staff had after watching the videos. All video education sessions were implemented as the LTC facilities would implement any of their facilitated or non-facilitated training. LTC administrators organized the invitation to the training and training sessions were made available to all staff.

Data collection

Data were collected from all LTC facilities in the form of questionnaires, for all staff that attended a training session or viewed a video, and through semi-structured interviews with an LTC centre administrator at each facility. LTC facilities were asked to distribute and collect questionnaires from all staff who viewed the videos for four months. After four months, the LTC facilities were contacted to schedule an interview and collect completed questionnaires.

There were a total of 14 items in the questionnaire, including staff profession and experience providing care for PLHIV. Impact and impression of the video was captured by indicating level of agreement on a five-point Likert scale. Open-ended questions were also posed in the questionnaire to capture staff members' key takeaway messages and the perceived value of having someone living with HIV present to facilitate the education session.

Semi-structured interviews were conducted with LTC centre administrators at each facility at the completion of the project. Interview questions included questions about the characteristics of the LTC facility, previous HIV training, how they would implement the HIV video series in the future, and their opinions on how to improve accessibility to HIV education. Interviews with LTC administrators were not audio-recorded but extensive notes were taken during and immediately following the interview.

Analysis

All quantitative questionnaire data were entered into Excel for descriptive analysis. Open ended responses from questionnaires and interview notes were read and reviewed by two authors and analyzed inductively, identifying and organizing data into themes in an iterative process.

Ethical considerations

The primary purpose of this pilot study was for quality improvement of Casey House's education program and to inform knowledge translation strategies; as such Research Ethics Board approval was not sought. Participating LTC facilities', and during all project activities, staff were informed of the purpose of the pilot and that evaluation forms and interviews would be reported anonymously in reports at the completion of the study. Administrators gave verbal consent for the interviewer to make written notes and utilize anonymous quotes in reports.

Results

Education implementation in long-term care facilities

To increase feasibility in the facilitated discussion model, educators accommodated the LTC facilities schedules, repeating education sessions with each video twice on the same day during their shift break, once for the day shift and again for the night shift staff. To increase accessibility in both the facilitated and non-facilitated model the videos were provided in multiple formats (DVD, USB) to best accommodate the facilities audio visual resources. None of the facilities chose to make the training mandatory for staff.

Demographic data of the four LTC facilities and the staff that completed the evaluation survey are summarized in Table 1. The majority of staff who watched the education sessions were personal support workers. Three of the four LTC centres had at least one PLHIV residing there in the last three years. Across all four LTC centres, a total of 96 staff questionnaires were completed evaluating the *Bedside Care* video/education sessions and a total of 53 staff questionnaires were completed evaluating the *Families and Networks of Support* video/education sessions. The number of completed questionnaires is representative of the total number of LTC staff who viewed the educational videos.