

Training and Quality Assurance for a Rapid Test Algorithm: Lessons from Implementation, San Francisco, CA 2007

<i>Abstract Category:</i>	Applications of Point of Care Strategies Using Combinations of Rapid Tests
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PROJECT

As part of a CDC-funded research project to implement a rapid test algorithm with multiple point-of-care tests, the San Francisco Department of Public Health (SFDPH) worked with 5 counseling, testing and referral (CTR) sites in the city sites to: Identify resources and staff necessary for implementation, develop and pilot standard operating procedures, develop and conduct training for all participating staff and develop a quality assurance program for the rapid testing algorithm.

ISSUES

Before implementing a point-of-care rapid testing algorithm (RTA), counselors need to be trained to perform additional rapid tests and to provide modified counseling messages for clients based on the results of the algorithm. Counseling and testing data collection systems and forms also must be modified to collect additional rapid test results. Finally, a quality assurance (QA) program for counseling, testing, referral and data collection must be developed and piloted.

RESULTS

After meeting with CDC, test manufacturers and HIV test counselors, SFDPH developed standard operating procedures, training, and a QA program to ensure that all procedures were consistently implemented at all sites. A site coordinator, counselors and technicians who would run the rapid HIV tests were identified for each site. A plan for data collection was developed, and forms for collection of both CTR and rapid test QA data were designed or modified to ensure that the quality of all aspects of the project (e.g. counseling, rapid testing using 3 different tests, laboratory-based testing, data reporting) could be monitored over time. Thus far, over 100 counselors have been trained to participate in the project, and 25 technicians have been trained to run all three rapid tests. To date, over 1000 tests have been successfully performed at the five intervention sites during the study, with the second and/or third test of the algorithm being run 27 times (19 infected clients, 8 falsely reactive screening tests). Direct observation of counseling sessions to assess quality of pre-test counseling, and role-play counseling of an RTA positive client will be conducted for each of the 100 counselors every three months. During monthly QA testing at the 5 sites the 25 technicians have completed 450 QC tests (HIV-negative, HIV-1, HIV-2 with each test, once a month,) all of which gave the expected results.

CONCLUSIONS

There were three main lessons learned during the development and piloting of this project. First, staff and resources must be adequate in order to successfully run a multi-site, multi-test, point-of-care rapid HIV testing algorithm. Two full-time staff were hired for this study, with one specifically being designated to support intervention sites in the preparation and implementation of new procedures and quality assurance protocols. Each site also needs a designated coordinator to oversee the project, as well as counselors and technicians identified in advance of the roll-out. Second, a plan for data collection must be developed and refined before implementation. Determining up front what data points are needed to ensure quality monitoring is essential in order to support sites and maintain consistency after implementation. Third, a slow roll-out is essential. Initiating this research pilot project required training over 125 staff at 5 sites in new counseling, testing, data collection and quality assurance procedures. Planning for a smaller pilot program and then scaling upward, as well as planning adequate time for development and refinement of protocols and training is essential for success on a large scale.