

Implementing Rapid HIV Testing on Labor and Delivery Units: Limiting mother to child transmission and providing access to care for HIV-infected women

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Issues

HIV testing of pregnant women is key to the prevention of mother-to-child transmission (PMTCT) of HIV and helping HIV-infected women access services. Women who know their HIV infection status in pregnancy and receive appropriate care and treatment have <2% chance of delivering HIV-infected infants. Without such intervention, the risk of infant infection is approximately 25% in the United States.

In California, a 2003 law specifies that the most rapid HIV test available be offered to a pregnant woman at labor and delivery (L&D) if no previous test result is accessible. However, a previous assessment of California birthing hospitals found that most did not routinely offer rapid HIV testing to women without a documented HIV test result, resulting in missed prevention opportunities. In order to improve hospital's capacity to offer rapid testing, the Rapid Testing at Labor and Delivery project (RTLD) began in 2006.

Description

RTLD provides training and technical assistance to help L&D staff access HIV test kits, implement testing, discuss results with patients, initiate PMTCT, and connect infected women to services.

The Pacific AIDS Education and Training Center (PAETC) provides the training and technical assistance, and Stanford University evaluates the project. The 232 birthing hospitals in California are divided by region into Northern and Southern CA, with training provided by regional PAETC offices.

Training and technical assistance began in 2007. Hospitals began with telephone and e-mail contact initiated by PAETC. Among those hospitals requesting training, most began with an interactive training, often at a routine meeting. Generally this initial training included reviewing basic information about perinatal prevention and rapid HIV testing, as well as time for facility-specific questions. This initial meeting also provided trainers with the opportunity to identify: (1) key allies, (2) anticipated barriers to the implementation process, and (3) possible areas for technical assistance.

This training was followed with ongoing technical assistance toward implementation, such as creating standardized policies and procedures, provision of care referrals, and additional trainings as requested. Data was collected from all participating hospitals on outcome measures such as changes in rapid testing offer status as well as process measures such as time spent on training and technical assistance.

Lessons Learned

PROCESS

From January 2007 to May 2010, all 232 facilities providing L&D services in California were contacted. 184/232 (79.3%) of the hospitals responded to contacts. Of those, 45 (24.46%) already had appropriate testing in place, leaving 139 which needed intervention.

There was no one-size-fits-all approach to implementing rapid testing. Rather, each facility needed to first gather stakeholders to discuss the barriers to implementing testing in that specific organizational environment. A median of 4 contacts, often over several months, were needed at each hospital to gather preliminary information and begin the intervention.

Lessons Learned (con't)

Table 1. Number of facilities contacts prior to first meeting or training

Range	1 – 40 Contacts
Mean	5 Contacts
Median	4 Contacts

The median time allotted for trainings was about 1.5 hours. Several trainings were generally required at each facility. Attendance was best when trainings were held at regular, mandatory staff meetings.

Table 2. Duration of training sessions

Range	18 Min. – 6 Hours
Mean	2 Hours
Median	1 Hour 37 Minutes

Most hospitals required a significant amount of technical assistance over a long period of time (often >1 year). Examples of the most commonly-provided technical assistance were reviewing rapid HIV testing policies and procedures and talking with laboratory directors in order to gain their cooperation. The median amount of time required for technical assistance was 2 hours (Table 3).

Table 3. Time spend on technical assistance

Technical Assistance	
Range	9 Min – 14 Hours
Mean	2 Hours 16 Minutes
Median	2 Hours

OUTCOMES

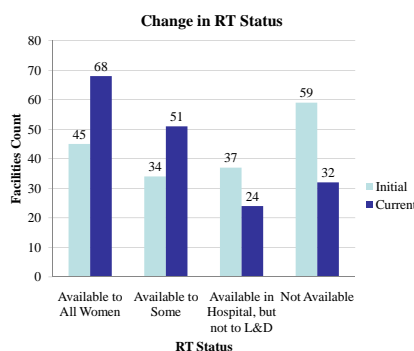
The major outcome of RTLD is moving all facilities towards offering rapid HIV testing to all laboring women who lack a prenatal test result.

Of the 139 facilities who received training and technical assistance from PAETC, 113 (81.3%) now offer testing to at least all women who present to L&D with no record of a test in prenatal care.

A major lesson from this project is that not all progress has been forward. Some facilities initially report offering tests, but in actuality were not testing, or facility changes such as staff turn-over resulted in less commitment to test offer.

RTLD staff continues to work with facilities to implement testing where it is lacking, to meet training needs, and to ensure that testing is still in place.

Figure 1. Cumulative change in rapid testing status, January 2007 through May 2010.



Barriers to implementing RTLD, as reported by L&D staff, were also collected. These barriers were reported cumulatively over the life of the project.

Lessons Learned (con't)

Table 4. Most commonly reported barriers to rapid HIV testing in L&D

Barriers
(1) L&D staff beliefs, perceptions, (such as only doctor can do informed consent) and commitment
(2) Insufficient training on how to offer and explain HIV testing
(3) Perceived lack of HIV risk in patient population
(4) Need hospital policy
(5) Senior Leadership / Managerial attitude
(6) Cost concerns

Key Findings

• Anecdotes can be more effective than data: An important tool was telling hospital staff about perinatal HIV transmissions or “close-calls” in perceived low-risk hospitals.

• Use a personalized, local approach: Some hospitals responded to a lunch meeting or grand rounds training, others needed a letter from the California Department of Public Health outlining their legal responsibilities in order to initiate participation.

• Identify champions: Identifying and working through internal advocates was essential in most hospitals.

• Cover all the angles: Multiple contacts with different types of staff (nurses, doctors, laboratory) were often needed to create relevant training and technical assistance sessions.

• Change takes time: As large, complex organizations, hospital procedures and norms do not change quickly.

Limitations

The major limitation of this project analysis is under-reporting of training and technical assistance activities. This is a public health intervention, not a research project. The project staff is primarily professional trainers and clinicians, and their approach was clinical, not research-oriented. Therefore, there is under-reporting in numbers of contacts with facilities as well as time on training and technical assistance.

Next Steps

• The project serves as a model for facilities looking to improve prenatal HIV testing rates, as well as for hospitals implementing rapid testing in Emergency Departments.

• The RTLD project currently has funding through 2011, and it is expected that all 232 California birthing hospitals will have participated by that date.

• It is hoped that the long-term impact on improving rapid HIV test offer rates will be achieved through both having policies and procedures in place and rapid test offer becoming a routine part of the labor intake among the targeted population.

• This project should have a public health impact by linking labor and delivery staff to other, ongoing HIV-specific resources such as local perinatal HIV centers and the National Perinatal HIV Hotline. It is hoped that these linkages will persist in the future and provide long-term access to appropriate information even after this more-intensive intervention ends.