Pharmacy-Based Rapid Diagnostic Testing: Improving Patient Care and Outcomes

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Target Audience
This knowledge-based activity was developed specifically for pharmacists.

Disclosure Statement
The author has indicated that she does not have any conflicts of interest, nor does she have financial relationships with a commercial interest, related to this activity.

Learning Objectives
At the end of this activity, participants should be able to:

- describe the value of rapid diagnostic testing (RDT) to patient care.
- identify some of the current tests available by pharmacy-based RDT.
- explain how to overcome obstacles associated with RDT.
- recognize proper procedures for implementation of RDT.

Introduction
Rapid diagnostic testing (RDT) is the process of conducting convenient diagnostics in a way that will provide the patient with timely results. These can also be classified as point-of-care testing (POCT) because the tests are obtained and processed at the patient’s current location, as opposed to offsite. POCT, which provides a more patient-centered approach to the delivery of health care, was originally used in hospitals for simple tests that could be performed in the patient’s room, such as blood tests and urinalyses. With an expansion to RDT, patients are provided with their specific diagnosis in the convenience of their desired location, such as their home, primary care clinic or the emergency room, with minimal laboratory equipment needed. Also, RDT can utilize simple chemistry with no electronics required, thereby allowing the tests to be completed in areas without many resources and at a minimal cost.

In order to collect a specimen from a patient outside of a normal laboratory, the pharmacy has to meet certain requirements. Any facility that performs tests on a human specimen to provide a diagnosis, prevention or treatment of disease is defined as a laboratory by the Clinical Laboratory Improvement Amendments (CLIA), which place standards for all sites performing these types of tests. CLIA requires a development of comprehensive, quality standards that ensure accuracy, reliability and timeliness for the patient tested. CLIA also specifies the quality standards for patient test management, quality control, proficiency testing (PT), personnel and quality assurance. There are three categories that can be obtained by CLIA: high complexity, moderate complexity and waived complexity. Most tests performed through RDT are considered to be of waived complexity, due to the minimal amount of laboratory equipment required to perform them. More information on how to obtain CLIA certification for a pharmacy will be discussed later in this article.

Community pharmacy-based RDT is being performed in select pharmacies throughout the country. Because pharmacists have frequent interaction with their patients, it is ideal to be able to perform these tests in the pharmacy. As RDT allows the patient to receive his/her diagnosis at the point of care, it increases the chances that the patient will receive the desired treatment sooner, feel better faster and save money. By developing a collaborative practice agreement with a physician, pharmacists are able to perform the test and, based on test results, provide the patient with an appropriate medication. A pharmacist has an important role in this process, not only in the dispensing of the medication, but in specimen collection, performing the test, interpreting results and counseling the patient.
The Value of Pharmacy-based RDT to Patient Care

Integration of RDT programs into community pharmacy practice provides a variety of benefits, not just to the pharmacy, but to the patients as well. One such benefit is the reduction of the overall cost incurred by a patient or third-party payer for a health care encounter. In 2011, the average charge in America for an office visit was $68-$234, with the price varying based upon the complexity and severity of the patient’s condition. The charge does not include other services performed at the office visit. Specific average charges of services performed are highlighted in Table 1. Receiving RDT in a pharmacy introduces a possibility to provide the patient with the most cost-effective service. Patients will essentially save money by having the test performed at the pharmacy.

Table 1. Average Cost of Services Performed

<table>
<thead>
<tr>
<th>Service Performed</th>
<th>Average Charge</th>
<th>Pharmacy A</th>
<th>Pharmacy B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Shot</td>
<td>$25</td>
<td>$31.99</td>
<td>$24.99</td>
</tr>
<tr>
<td>Cholesterol Test</td>
<td>$72</td>
<td>$30</td>
<td>$10</td>
</tr>
<tr>
<td>Glucose Tolerant Test</td>
<td>$60</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Fasting Blood Glucose</td>
<td>--</td>
<td>$3</td>
<td>$4</td>
</tr>
<tr>
<td>Hemoglobin Alc</td>
<td>--</td>
<td>$35</td>
<td>$30</td>
</tr>
<tr>
<td>Tetanus Shot</td>
<td>$28</td>
<td>$63.99*</td>
<td>$49.55*</td>
</tr>
</tbody>
</table>

*These immunizations included tetanus, diphtheria and pertussis.

Along with decreased costs, pharmacy-based RDT also has increased access, which can decrease the patient’s overall time spent. In many pharmacies, RDT is offered as a walk-up service that does not require an appointment; therefore, it can be done on the patient’s schedule. When the appropriate collaborative practice agreements are in place, RDT can also be completed in one stop for the diagnosis and treatment. Also, most pharmacies have increased access with longer hours than primary care physicians, including 24-hour pharmacies. With increased access, the patient does not have to wait until the doctor’s office is open and available for an appointment to get treated.

Decreased time and cost are two valuable benefits for the patient, but the most important value that pharmacy-based RDT can provide is improved health outcomes. The benefit to a faster diagnosis, aside from saving time for the patient, is the allowance for earlier treatment. When the patient starts treatment sooner, they will feel better faster. This is especially important for influenza, as it needs to be diagnosed within 48 hours of onset in order for the medication to provide maximum benefit. In this situation, a pharmacist could conduct RDT to confirm the influenza diagnosis and, if the appropriate collaborative practice agreements are in place, the pharmacist can initiate treatment. Early treatment can also decrease the rate of transmission of the illness as well as prevent secondary conditions. Specifically, group A streptococcus secondary complications that are reduced by earlier treatment include acute rheumatic fever, peritonsillar abscess, otitis media, sinusitis, glomerulonephritis and mastoiditis. Because there is minimal wait time for the results from RDT (generally 15 minutes or less), it has also been suggested that RDT can decrease empiric treatment for the patient by decreasing the use of broad spectrum antibiotics and increasing the ability to treat for a specific diagnosis. With the proper results of the patient’s condition, the treatment the patient receives will be optimized. Specific treatment, instead of broad spectrum, also has the potential to decrease antibiotic resistance because the drug dispensed for the patient will directly target the pathogen.

Tests Available

Pharmacies have the ability to provide many different rapid diagnostic tests. The tests that have been available in pharmacies and are utilized most currently in pharmacies are chronic disease
assessment tests. The types of tests that pharmacists can provide have extended further into tests for infectious diseases. Since the infectious disease tests are newer and less commonly used, pharmacists may require more information and training before they are comfortable administering these tests.

**Infectious Disease Tests**

Some of the community pharmacy-based RDT CLIA-waived tests currently being offered are influenza, group A streptococcus, HIV and hepatitis C (HCV). Influenza and group A streptococcus can present at any time, with late fall being the most common for influenza and early spring the most common for strep. Both HCV and HIV require blood exposure to develop the disease state, so normally the patient would need to have had an event that triggered them to seek care or be considered at risk for an event by a health care provider. Table 2 shows the common clinical presentation for each disease state.\(^{10}\)

**Table 2. Common Clinical Presentation of Each Disease State**\(^{10}\)

<table>
<thead>
<tr>
<th>Influenza</th>
<th>Group A Strep</th>
<th>HIV</th>
<th>HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>High fever</td>
<td>Sore throat (sudden)</td>
<td>Primary Infection:</td>
<td>Acute Viral Phase:</td>
</tr>
<tr>
<td>Headache</td>
<td>Fever</td>
<td>Flu-like, rash,</td>
<td>Malaise</td>
</tr>
<tr>
<td>Myalgia</td>
<td>Headache</td>
<td>diarrhea, night</td>
<td>Lethargy</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Nausea</td>
<td>sweats and aseptic</td>
<td>Yellow eyes/skin</td>
</tr>
<tr>
<td>Rhinitis</td>
<td>Vomiting</td>
<td>meningitis</td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td>Abdominal pain</td>
<td>Chronically:</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>Inflamed and patchy</td>
<td>Absence of symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tonsils</td>
<td>and very low viral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tender nodes</td>
<td>load</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palatal petechiae</td>
<td>Symptomatic (AIDS):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue, weight loss,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>night sweats, fever</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>and opportunistic</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>infections</td>
<td></td>
</tr>
</tbody>
</table>

When a patient has presented with a suspect clinical presentation, or requests to have a test done, the pharmacist can start the RDT process. A physical assessment should be done first before the specimen collection, which includes vital signs, vital statistics and topic-specific physical examinations to ensure the patient is clinically stable. All patients should have their vital signs and statistics taken at every visit. The vital signs include pulse, respiratory rate, blood pressure, oxygen saturation and temperature. Vital statistics include age, height, weight, medication allergies and smoking status. It is important to take both the signs and statistics at each visit to evaluate the patient’s current state and see what may have changed from previous visits. For suspected influenza patients, a pulmonary examination should also be done, including an inspection, auscultation and pulse oximetry after vitals. In addition, oral, otoscope and lymph node exams should be conducted, specifically for suspected group A streptococcus patients after vitals. A physical assessment should also be completed, not only to ensure that the patient is clinically stable and a candidate for pharmacist-managed RDT, but to help guide diagnosis.\(^{10}\)

After the patient has undergone a thorough physical assessment, they’re ready for a specimen collection. Depending on the suspected illness, the specimen collection can vary. For influenza tests, a nasal swab would be performed. A throat swab would be used for group A streptococcus tests. For HIV and hepatitis C, a whole blood or oral fluid test can be performed, although a whole blood test is preferred for hepatitis C diagnosis. Table 3 below shows the specimen collection options for each test performed.\(^{10}\)
Table 3. Rapid Diagnostic Tests and FDA-Approved Specimen Collection

<table>
<thead>
<tr>
<th>Test</th>
<th>Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nasal Swab</td>
</tr>
<tr>
<td>Influenza</td>
<td>X</td>
</tr>
<tr>
<td>Group A Strep</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>X</td>
</tr>
</tbody>
</table>

*This test is approved (CE-marked) in the European Union (EU), but has not been FDA approved.

**Chronic Disease Assessment Tests**

Some of the chronic disease assessment tests that pharmacies perform include cholesterol, hemoglobin A1c, liver function tests and blood glucose. These tests are generally offered at health clinics provided by the pharmacist, but they can also be another walk-up service from the pharmacy. Typically patients with the correlating disease state will receive these tests, but any patient can request to have a test done. In certain circumstances, a patient may utilize the pharmacy for the desired annual test from his/her doctor. Almost all of these tests require a blood sample to analyze, and generate a lab value rather than a positive or negative result. The specifics of these tests will not be discussed in detail in this article.

**Implementing RDT into the Pharmacy**

As stated earlier, in order to provide RDT in a pharmacy, the pharmacy needs to obtain a CLIA Certificate of Waiver. Considering that rapid diagnostic tests are considered CLIA-waived, a pharmacy needs to fill out the CLIA Application for Certification and select “Certificate of Waiver.” An application is available through the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS), who collaboratively produced the final CLIA Quality Systems laboratory regulations that are utilized today. All sites where tests will be performed should apply for a waiver, and only tests that are CLIA-waived should be performed. For a list of all tests that are CLIA-waived, pharmacists can refer to the Food and Drug Administration’s (FDA’s) CLIA Currently Waived Analytes.

When preparing to incorporate RDT into the pharmacy, there are certain plans that should be worked out to ensure success. Plans for the promotion, physical assessment, check out and ordering of the tests are some examples of the areas of focus. The test may take up to 15 minutes to complete, but once the specimen is collected, the pharmacist can complete other tasks while waiting for the results. The actual RDT will only take up minimal time that the pharmacist cannot fulfill other pharmacy duties. The pharmacy could have one pharmacist trained that performs all the tests or train every pharmacist so that RDT duties can alternate between pharmacists. Also, the work load of the entire process can be lightened by utilizing other pharmacy staff such as pharmacy technicians. Technicians play an important role in processing and billing the RDT order in the computer and getting it ready for the pharmacist. They can also be utilized to promote the testing options at the cash register. Finally, someone in the pharmacy should be in charge of ordering the supplies needed for RDT and having the necessary forms copied. Figure 1 below illustrates a potential workflow option for pharmacies.
In order to make RDT successful in a pharmacy, patients need to know that the service is available. The marketing of RDT is suggested to be done in many ways in order to appeal to a wide variety of patients. Posters or large signs declaring the services that will be provided should be placed throughout the pharmacy. Along with the posters, handouts should go out with every prescription so that the patients can take advantage of the service in the future. A pharmacy could also mail letters to the patient population to ensure that everyone receives the announcement. Some patients may be more receptive to announcements made audibly instead of visually. All workers in the pharmacy should let patients know that the tests are available and overhead announcements should be made. Instead of just providing a broad advertisement to everyone, another option would be to target the patient populations that would benefit from specific RDT. For example, putting signs or floor mats out in the aisles where OTC medications would be located to treat influenza or telling a patient that is receiving a medication for strep throat that he could have had the test performed in the pharmacy. Whatever the marketing scheme may be for the pharmacy, RDT should be highly emphasized.

**Figure 1. Sample RDT Workflow**

A. **Promotion**: It is suggested that this be completed by all workers in the pharmacy.
B. **Physical Assessment**: This should be done by the pharmacist. If there are two pharmacists working, the duties can be evenly distributed.
C. **Process**: A technician can be responsible for having the patient fill out appropriate forms and completing appropriate billing.
D. **Check Out**: Another technician can check out the patient at the cash register.
E. **Test Performed**: The pharmacist should do this.
F. **Ordering**: A technician or pharmacist can be responsible for all the ordering.

**STOP AND REFLECT**
As the owner of an independent pharmacy, you decide that you will start offering RDT at your pharmacy. What are some of the ways you will incorporate testing into the workflow and how will you market it to your patient population?

**Overcoming Obstacles**
Every new opportunity welcomes new challenges. Although RDT will provide value for the patient population, the challenges for a pharmacy should be assessed. The cost for the pharmacy to provide these services may be a challenge. Also, some people may question the efficacy of RDT.
There may be a struggle to establish the role in pharmacy-based RDT as well. Finally, there is some training that is recommended in order to conduct the tests. While there are multiple obstacles, there are simple ways to overcome them.

The cost of establishing RDT may deter some from implementing a program into their pharmacy. When assessing the cost of RDT, both economic and personal costs should be analyzed. The tests cost money to obtain and reimbursement may be limited at this time. Also, it takes time for the pharmacist to perform these tests, which will take him or her out of the pharmacy. Although these are valid arguments, they should not create a roadblock for providing RDT. Compensation for the tests provided can come in multiple ways, not just from the actual test, but from the prescription filled because of the test and the relationship built with the potential patient for the future. Also, as discussed previously, the time that it takes to perform the tests is minimal so this should not prevent a pharmacy from offering them. It will take time management by the entire staff to allow RDT into the workflow, but all pharmacies are capable of this. With the value of patient care in mind, the initial costs to the pharmacy are minimal and as the services expand, RDT will pay for itself. Table 4 below illustrates a potential cost and profit margin of two tests done by RDT in the pharmacy.

### Table 4. Potential Cost and Profit Margin for Strep and Influenza Tests

<table>
<thead>
<tr>
<th>Test Performed</th>
<th>Price per Box (25 tests)</th>
<th>Cost of a Single Test</th>
<th>Price Charged</th>
<th>Profit Margin</th>
<th>Mark Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strep</td>
<td>$34.50</td>
<td>$1.38</td>
<td>$17</td>
<td>$15.62</td>
<td>92 percent</td>
</tr>
<tr>
<td>Influenza</td>
<td>$249.50</td>
<td>$9.98</td>
<td>$60</td>
<td>$50.02</td>
<td>83 percent</td>
</tr>
</tbody>
</table>

Some people are skeptical of the efficacy of RDT in comparison to regular lab tests, but there are statistics and practices to reduce the possibility of poor results. RDT can lack sensitivity and typically produce only “yes/no” answers. The sensitivity of the test is defined as the proportion of patients who do have the disease that test positive, and the specificity is the proportion of patients that do not have the disease that test negative. For influenza specifically, sensitivities are generally 40-70 percent (range of 10-80 percent) but specificities are usually 90-95 percent (range of 85-100 percent). In order to increase the likelihood of correct results, there are a few steps that should be taken. Specimens should be collected as soon as possible following all the manufacturer’s instructions. Also, a follow-up of negative results with a confirmatory test can be obtained to be certain. After training of RDT, a pharmacist should be prepared to make proper decisions on what the results mean for the patient.

To further assess the likelihood that a pharmacist should consider the prevalence of a given disease in the community, as this prevalence can impact the results of the RDT, the positive predictive value (PPV) and negative predictive value (NPV) are available for each test. The PPV is a probability that a patient who had a positive result actually has the disease. As the prevalence of the disease increases, so does the PPV. For example, during the winter season when influenza is more common, the PPV will increase. In contrast, the NPV is the likelihood that a patient without the disease produces a negative result. The NPV also changes with disease prevalence. Higher PPV or NPV percentages should demonstrate more confidence in the proper results, although typically only one predictive value will be high at a time due to their inverse relationship. Figure 2 illustrates how to calculate the desired predictive value.
Since RDT will be a new service provided by the pharmacy profession, there are two other important parties that may need to be convinced of the pharmacist’s role in RDT: providers and patients. Some providers may feel that the testing and diagnosing is their responsibility and they do not want pharmacists moving into their scope of practice. Instead of looking at this as an intrusion, primary care providers are encouraged to believe that performing these relatively simple tests in a pharmacy will allow providers to have additional time to focus on more complex patient problems. As the need for primary care providers increases, the role of RDT in a pharmacy will become a great benefit for providers to make their workload more manageable.\textsuperscript{16} Also, when a cost analysis was performed for the diagnosis and treatment of strep throat, it was found that it is cheapest for the pharmacy to do in comparison with a walk-in clinic and physician’s office.\textsuperscript{17} Although a disagreement with providers is not ideal, the more important party to persuade into getting tests done are patients. Patients may feel that they have to go see a doctor to be diagnosed and receive a prescription to be treated, but pharmacists should be prepared to convince their patients otherwise. By discussing some of the patients’ issues with pharmacy-based RDT and instilling confidence in the services provided, patients should be easily persuaded to use the pharmacy for this service.\textsuperscript{16,17}

Finally, training via a pharmacy-based RDT certificate course is encouraged for all pharmacists wishing to perform these tests. The training requires time outside of working and requires development of both skill and knowledge in RDT. The training can be done at the convenience of the pharmacist. It requires reading before the live training, which can be done in several days on the pharmacist’s schedule, and one day of live training, which can be completed on the weekend if needed. Although the certification may seem intimidating at first, all pharmacists

\begin{align*}
\text{Positive Predictive Value (PPV)} &= \frac{\text{True Positives}}{(\text{True Positives} + \text{False Positives})} \times 100\ \text{percent} \\
\text{Negative Predictive Value (NPV)} &= \frac{\text{True Negatives}}{(\text{True Negatives} + \text{False Negatives})} \times 100\ \text{percent}
\end{align*}

\textbf{STOP AND REFLECT}

Patient AB comes in with a sore throat, headache, nausea and feels like she has a fever. She asks if there is something she can take over-the-counter because she cannot get in to see her doctor until tomorrow afternoon. You tell her the symptoms seem like she could have strep throat but she refuses to do an RDT because she feels that this is something her physician should do. What are some reasons it would be beneficial for her to get an RDT in your pharmacy?
have the experience to be an excellent candidate to become certified and there are many opportunities to seek help from others before, during and after certification.\textsuperscript{10}

**Certification**

Pharmacy-based RDT provides value to patient care and increases the value of a pharmacy in the community. Becoming certified starts the process of expanding the pharmacy’s role in current and potential patient’s lives. All pharmacists should become certified to provide a standard of care for patients. The course provides a knowledge base to ensure all patients are receiving similar care, and it also includes information on other aspects of RDT. In addition, as some of the results can be patient sensitive, training helps to ensure that proper procedures are followed and correct results are given. With the certification of pharmacy-based RDT, pharmacists establish their role of performing RDT to patients and other providers.\textsuperscript{10}

The only certification program for community pharmacy-based RDT in Michigan is available through Michigan Pharmacists Association (MPA). The price of the certificate program available from MPA varies depending on the type of registration, but currently it is $500 for the certificate only, $1,300 for the train-the-trainer program only, and $1,500 for both the certificate and train-the-trainer program. The course is usually an eight-hour day with approximately eight hours of reading to complete prior to the training. Participants also have the option to become a trainer (train-the-trainer mentioned above) so that they can train their current or future employees.\textsuperscript{10}

As suggested in Figure 3 below, a pharmacy should apply and obtain a CLIA waiver first to make sure that the pharmacy is authorized to conduct the tests. It is then suggested to complete the RDT certification. Once a pharmacy has a certified pharmacist, the pharmacy can pick their implementation date. Between the certification and the implementation dates, the pharmacy should be marketing the services to be provided and preparing for the increased workload. Once training is complete with the course evaluation completed, the certification is complete. If the pharmacy has already received the CLIA waiver and Application for Certification, RDT could start immediately following certification. Depending on how proactive the pharmacist is will dictate how soon RDT will begin in the pharmacy. If the pharmacy and pharmacist plan ahead, there are no time constraints to how soon RDT could be initiated in a pharmacy.\textsuperscript{10}

**Figure 3. Suggested Timeline for Implementation of RDT**

![](image)

**Conclusion**

Rapid diagnostic testing has the potential to be a new, sustainable service that pharmacists provide, along with immunizations, medication therapy management and other daily duties. Pharmacy-based RDT improves patient outcomes while saving time in getting proper treatment for the specified diagnosis to the patient. With the knowledge of how RDT can benefit the patient and how it can be successful in the pharmacy, the implementation of the testing should be viewed as an opportunity to advance the pharmacy profession that all pharmacists should embrace in order to improve patient care.
Continuing Education Self-Assessment Questions

1. Which of the following best defines rapid diagnostic testing?
   a. Typical lab tests that require less time than normal
   b. Convenient diagnostic tests that provide the patient with results at the point of care
   c. Simple blood tests that only diagnose certain blood conditions
   d. None of the above

2. Which of the following diagnoses are not matched correctly with their clinical presentation?
   a. HIV = Malaise, lethargy, yellow eyes/skin
   b. Influenza = High fever, headache, myalgia, fatigue, rhinitis, sore throat, cough
   c. Group A Streptococcus = Sore throat, fever, headache, nausea, vomiting
   d. Hepatitis C = Malaise, lethargy, yellow eyes/skin

3. What diagnosis is matched correctly with the proper specimen collection?
   a. HIV – Nose swab
   b. Hepatitis C – Throat swab
   c. Influenza – Whole bentod test
   d. Group A Step – Throat swab

4. Which of the following is false about pharmacy-based RDT?
   a. It may decrease overall cost compared to a similar service provided by a physician’s office.
   b. Because other clinical services provided at a pharmacy cost more than the price physician’s charge, it can be assumed that RDT will cost more when provided by the pharmacy.
   c. It decreases overall time spent by increasing accessibility.
   d. An appointment may not be necessary, as it is often provided as a walk-up service.

5. How does pharmacy-based RDT improve patient outcomes?
   a. Patients receive their medication sooner
   b. Patients feel better faster
   c. Patients receive specific treatment for disease state
   d. All of the above

6. To better integrate RDT into the workflow, pharmacists are encouraged to:
   a. allow their technicians to take care of some of the processing duties.
   b. limit the number of RDT performed each day.
   c. only do certain types of RDT.
   d. not advertise the service.

7. What documents does a pharmacy need to obtain before implementing RDT?
   a. CLIA Certificate of Waiver
   b. CLIA Application of Certification
   c. A and B
   d. None of the above

8. How can a pharmacist increase the likelihood of obtaining a correct result from RDT on an influenza test?
   a. There is documented activity in the community
   b. Follow the manufacturer’s directions
   c. Follow up negative results with a confirmatory test
   d. All of the above
9. Pharmacists may have to persuade which of the following stakeholder groups of the appropriateness of pharmacy’s role in conducting RDT?
   a. Patients and providers
   b. Patients and other pharmacists
   c. Providers and other pharmacists
   d. Pharmacy staff and family members

10. How much total time (pre-reading and live training) does the certification process take?
    a. Eight hours
    b. Sixteen hours
    c. Twenty-four hours
    d. Thirty-two hours
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3. New Mexico Department of Health [Internet]. Santa Fe (NM): New Mexico Division of Health Improvement; [date unknown] - . Clinical Laboratory Improvement Act (CLIA); [date unknown; cited 2013 Nov 18]; [about 2 screens]. Available from: http://dhi.health.state.nm.us/CLIA/clia88.php


