ACT HIV abstract instructions

Formatting Your Abstract

- Abstracts should be no more than 350 words. Use simple fonts.
- *Italics*, underline, **bold**, superscript and subscript formatting, Greek characters (both upper and lowercase), scientific characters, charts, tables, and graphs are accepted.
- Figures are accepted and they do not count towards the word limit.
- The data must be complete at the time of abstract submission for it to be considered.
- Always keep an original copy of your submitted abstract.
- Always proofread your abstract accepted abstracts will be published as submitted.

Implementing a standard operating procedure for PrEP increased provider comfort, knowledge and prescribing in a Georgia residency program

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Southern States are impacted most by Human Immunodeficiency Virus (HIV) morbidity and mortality (1, 2). In July of 2019, Pre-exposure prophylaxis (PrEP) was given a grade A recommendation by the US Preventive Task Force (USPTF) for the prevention of HIV for at-risk populations. Despite having the highest rates of HIV infection in the US, comparatively fewer people are being prescribed PrEP in the South (3). Numerous studies have identified that physician knowledge and comfort with PrEP, including implementing PrEP into their practice, and cost of PrEP have served as barriers to prescribing PrEP.

The project consisted of a baseline survey to assess physician comfort, knowledge, and skill set with HIV and prescribing PrEP followed by a three-month implementation of an SOP and training at the Emory Family Medicine Clinic. The clinical faculty include 10 attendings and 28 residents. Following the three-month implementation, a post survey was used to assess the effectiveness of implementation of the SOP. Additionally, the number of PrEP prescriptions ordered in the 3 months pre-implementation was compared to the number of PrEP prescriptions ordered in the 3 months post-implementation period.

The roll-out of the SOP and training translated to: a) Increased familiarity and knowledge with prescribing PrEP for HIV; b) An increase in the number of PrEP prescription orders from 15 to 35; c) A decrease in the instances of PrEP discontinuation from 18 to 7.

Data developed from this study was used to draft a resolution to increase Georgia physician education on PrEP, as well as encourage lobbying for increased funding to make PrEP more accessible to patients. This resolution was presented to a 100-person Congress of Delegates at the Georgia Academy of Family Physicians (GAFP) meeting on 10/2019, highlighting HIV prevention with PrEP as an educational priority for the GAFP. A similar resolution has been drafted to be presented at the American Academy of Family Physicians (AAFP) meeting in 07/2020.

This pilot study suggests that training residents on HIV prevention with standardized processes early in their resident training could improve patient care with respect to HIV prevention and avoid missed opportunities for HIV prevention.

References

1. Centers for Disease Control and Prevention. HIV in the Southern United States. Issue Brief, September 2019.
2. Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2010–2016. HIV Surveillance Supplemental Report 2019;24(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published February 2019.
3. AIDSVu (aidsvu.org). Emory University, Rollins School of Public Health.