platform on a hand-held tablet. Using a purposive sampling strategy, we enrolled 20 of the 100 participants in an in-depth interview (IDI). Interview guide development was grounded in the Cognitive Behavioral Model in which thoughts, feelings, and behaviors are inter-related. IDIs were audio recorded, transcribed, de-identified, and formatted for coding. A hierarchical coding system was developed and refined using an inductive-deductive approach.

Results. Among 100 PWH enrolled, median age was 50 years, 89% were Black, 60% were male, and 82% were living below 100% of the Federal Poverty Level. IDI participants felt the tablet was easy to use and the question content was meaningful. Question content related to trauma, sexual and drug use behaviors, mental health, stigma, and discrimination elicited uncomfortable or distressing feelings in some participants. Patients expressed a strong desire to be truthful and most would complete these surveys without compensation at future visits if offered.

Conclusion. The use of an electronic tablet to complete PRO data collection was feasible and well received by this cohort of vulnerable persons in HIV care in the US South. Despite some discomfort, our cohort overwhelmingly believed this was a valuable part of their medical experience. Real-time PRO data collection allows providers to screen for and act on social and behavioral determinants of health. Future research will focus on scaling up the implementation and evaluation of PRO data collection in a contextually appropriate manner.

Disclosures. Peter F. Rebeiro, PhD, MHS, Gilead (Other Financial or Material Support, Single Honorarium for an Expert Panel)

52. PrEP Adherence and Discontinuation at a Pharmacy-Supported PrEP Program in Atlanta, GA
Hiba Yacout, PharmD2; Bradley L. Smith, Pharm.D, AAHVIP1; Shelbie Foster, PharmD2; Meredith Lora, MD1; Lara Niles-Carnes, MPH1; Zizhou Zheng, MD1; Supratik Kandu, PhD2; Judah K. Gruen, MD2; Valeria D. Cantos, MD1; 1Grady Health System, Macon, Georgia; 2Emory University, Atlanta, Georgia

Session: O-11. Disparities in HIV PrEP and Continuum of HIV Care

Background. Pre-exposure prophylaxis (PrEP) is a highly effective biomedical strategy to decrease Human Immunodeficiency Virus (HIV) acquisition. Effectiveness of oral PrEP is linked to medication adherence. In 2018, Grady Health System (GHS) launched a PrEP program to increase PrEP access among un- and underinsured individuals living in metro Atlanta, Georgia. The purpose of this study is to determine PrEP medication adherence, PrEP discontinuation rates, and associated individual factors of patients enrolled during the first 18 months of the program’s implementation.

Methods. A single-center, retrospective chart review was conducted on patients enrolled in the GHS PrEP program between June 1, 2018 and February 29, 2020 who received more than one monthly PrEP prescription. Adherence was estimated using the medication possession ratio (MPR). The primary outcome was mean adherence to PrEP. Secondary outcomes include rate of high percent adherence (MPR > 80%), median time of engagement in care, PrEP discontinuation rates, rates of PrEP re-engagement, and individual factors associated with PrEP discontinuation and low adherence.

Results. This study included 154 patients, 70.8% of them were Black, 62.3% were cisgender men, 59.1% were uninsured, and the mean age was 34. The majority of patients identified as men who have sex with men (51.9%). Mean PrEP adherence was 89.2%; 77.3% of patients demonstrated a high rate of adherence. No individual or social factors were associated with low adherence, but younger age was associated with higher rates of PrEP discontinuation (p< 0.0061). At the end of the follow up period on October 30, 2020, 53.8% of patients were active in the program and 12.7% of those who discontinued had re-engaged with the program. The average length of program engagement was 9.8 months.

Table 2. Demographic and Clinical Characteristics of the Study Population

| Characteristic | Median | IQR |
|---------------|--------|-----|
| Age (years) | 34.2 (12.6) | |
| Sex/Gender | | |
| Male | 109 (70.8) | |
| Female | 25 (16.2) | |
| Transwoman | 15 (9.7) | |
| Other/Unknown | 5 (3.2) | |
| Race/Ethnicity | | |
| Black | 109 (70.8) | |
| White | 25 (16.2) | |
| Hispanic | 15 (9.7) | |
| Other | 5 (3.2) | |
| HIV Transmission Risk | | |
| Heterosexual Contact | 59 (39.0) | |
| Male-to-Male Sexual Contact | 59 (39.0) | |
| Injection Drug Use | 22 (14.8) | |
| Other/Unknown | 22 (14.8) | |
| CD4+ cell count (cells/µL) | | |
| Poverty Level | | |
| <100% FPL | 82 (20.0) | |
| 100-139% FPL | 82 (20.0) | |
| 138-199% FPL | 8 (20.0) | |
| >200% FPL | 22 (14.8) | |
| Missing | 4 (20.0) | |
| Housing Status | | |
| Stable/Permanent | 71 (20.0) | |
| Temporary | 71 (20.0) | |
| Unstable | 22 (14.8) | |
| Missing | 1 (20.0) | |
| PrEP indication | | |
| Transgender men | 96 (62.3) | |
| Transgender women | 33 (21.4) | |
| Transgender men | 24 (15.8) | |
| Unmarried | 1 (6.6) | |
| PrEP status | | |
| Uninsured | 91 (59.1) | |
| Commercial | 30 (19.5) | |
| Medicaid | 26 (16.9) | |
| Medicare | 7 (4.5) | |

Table 3. In-depth Interview Summarized Questions and Responses

| In-depth Interview Summarized Questions and Responses | 50% of Participants | 100% of Participants |
|-----------------------------------------------------|--------------------|---------------------|
| How do you feel about the quality of the interview and your responses? | Excellent | Excellent |
| How do you feel about the questions asked? | Relevant | Relevant |
| How do you feel about the way your responses were recorded? | Satisfactory | Satisfactory |
| How do you feel about the overall interview experience? | Satisfactory | Satisfactory |

59. PrEP Adherence and Discontinuation at a Pharmacy-Supported PrEP Program in Atlanta, GA
Hiba Yacout, PharmD2; Bradley L. Smith, Pharm.D, AAHVIP1; Shelbie Foster, PharmD2; Meredith Lora, MD1; Lara Niles-Carnes, MPH1; Zizhou Zheng, MD1; Supratik Kandu, PhD2; Judah K. Gruen, MD2; Valeria D. Cantos, MD1; 1Grady Health System, Macon, Georgia; 2Emory University, Atlanta, Georgia

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| PrEP status | | |
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| Commercial | 30 (19.5) | |
| Medicaid | 26 (16.9) | |
| Medicare | 7 (4.5) | |
Table 2. PreP Adherence and Discontinuation at the GHS PreP Program from 2018 to 2020 (N=154)

| Variable                        | n (%)          |
|---------------------------------|----------------|
| **Adherence on PreP (mean, SD)**|                |
| High adherence                  | 119 (77.3)     |
| Low adherence                   | 35 (22.7)      |
| **Active in program**           |                |
| 83 (53.8)                       |                |
| **Discontinued PreP**           |                |
| Permanently discontinued        | 71 (46.1)      |
| Re-engaged in program           | 62 (37.3)      |
| **Months in program (mean, SD)**|                |
| 9.8 (6.4)                       |                |
| **Positive STI**                | 33 (21.4)      |
| Seroconversion                  | 1 (0.6)        |

Table 4. Multivariate analysis of individual factors associated with PreP discontinuation and low adherence

| Variable                      | P-value  |
|-------------------------------|----------|
| **PreP Discontinuation (n=71)**|          |
| Age at referral               | 0.061    |
| Race                          | 0.1569   |
| Gender                        | 0.3599   |
| Insurance                     | 0.7741   |
| PreP indication               | 0.9314   |
| **Low adherence (n=35)**      |          |
| Age at referral               | 0.5072   |
| Race                          | 0.5801   |
| Gender                        | 0.9988   |
| Insurance                     | 0.0599   |
| PreP indication               | 0.4263   |

**Conclusion.** Mean PreP adherence at a safety net PreP program in Atlanta was high and PreP discontinuation rates were comparable to other PreP clinics nationwide. We found no association with individual factors previously linked to lower adherence, including Black race, younger age, and insurance status. Program-related factors that may have impacted these findings need to be investigated. Other future areas of research include strategies to optimize engagement in care in younger patients.

**Disclosures.** Bradley L. Smith, Pharm.D., AAHIVP; Gilead Sciences, Inc (Advisor or Review Panel member)

3. Sex and Race Disparities in Premature Mortality among People with HIV: A 21-Year Observational Cohort Study

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**Session:** O-11. Disparities in HIV PreP and Continuum of HIV Care

**Background.** Since the availability of antiretroviral therapy, mortality rates among people with HIV (PWH) have decreased, however, this trend may fail to quantify premature deaths among PWH. We assessed trends and disparities in all-cause and premature mortality by sex, HIV risk factor, and race, among PWH receiving care at the Vanderbilt Comprehensive Care Clinic from January 1998 – December 2018.

**Methods.** We examined mortality trends across calendar eras using persons-time from clinic entry to date of death or December 31, 2018. We compared mortality rates by demographic and clinical factors and calculated adjusted incidence rate ratios (AIRR) and 95% confidence intervals (CI) using multivariable Poisson regression. For individuals who died, years of potential life lost (YPLL) were obtained from the expected years of life remaining by referencing US sex-specific period life tables at age and year of death; age-adjusted YPLL (aYPLL) rates were calculated risk (CR) of HIV infection in active duty US Air Force (USAF) members with available case report forms included (n=142). Chart reviews were performed and demographic, social, and clinical characteristics were collected from initial Infectious Disease specialty encounters and case report forms. Adjusted incidence ratio for HIV infection was calculated as Low or High and compared to CR derived by the Denver HIV Risk Score (DHRS) by points based on patient demographic and risk exposure characteristics.

**Results.** Among the 6,531 individuals (51% non-Hispanic [NH] White race, 40% NH Black race, 21% female) included, 956 (14.6%) died. Mortality rates dramatically decreased during the study period. After adjusting for calendar era, age, injection drug use, hepatitis C virus (HCV), year of HIV diagnosis, history of AIDS-defining illness, CD4 cell count, and HIV RNA at clinic entry, only female sex (AIRR=1.32, 95% CI: 1.13–1.55 vs. males) and not NH Black race (AIRR=1.02, 95% CI: 0.88–1.17 vs. NH White race) was associated with increased mortality. In contrast, aYPLL per 1,000-person years was significantly higher for both female and NH Black PWH (Table 1). In adjusted models including CD4 cell count, HIV RNA, HCV, and year of clinic entry, higher YPLL remained associated with NH Black race, female sex regardless of HIV risk factor, and younger age at HIV diagnosis (Table 2).

**Conclusion.** Despite marked improvement over time, sex disparities in mortality as well as sex and race disparities in YPLL remained among PWH in care in this cohort. YPLL is a useful measure for examining persistent gaps in longevity and premature mortality among PWH.

**Disclosures.** Peter F. Rebeiro, PhD, MHS, Gilead (Other Financial or Material Support, Single Honorary for an Expert Panel)

54. Self-Perception of Risk for HIV Acquisition and Calculated Risk for HIV Acquisition Among Active Duty Air Force Members with Newly Diagnosed HIV Infection

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**Session:** O-11. Disparities in HIV PreP and Continuum of HIV Care

**Background.** Persons may underestimate their risk of HIV infection despite presence of risk factors. Accurate appraisal of HIV risk may assist both patients and providers in preventing HIV acquisition. We evaluated self-perceived risk (SPR) versus calculated risk (CR) of HIV infection in active duty US Air Force (USAF) members with incident HIV infection.

**Methods.** USAF members with new HIV diagnosis evaluated at a specialty care medical center between January 2015–March 2020 with available case report forms were included (n=142). Chart reviews were performed and demographic, social, and clinical characteristics were collected from initial Infectious Disease specialty encounters and case report forms. SPR was characterized as Low or High and compared to CR derived by the Denver HIV Risk Score (DHRS) by points based on patient demographic and risk exposure characteristics.

**Results.** Overall, patients were predominantly male (98%), with a median age of 26 years (IQR 22–30), and the majority (85%) reported same-sex partners (Table 1). Patients more commonly characterized themselves as Low SPR (n=78; 55%) than High SPR (n=64; 45%). Demographic characteristics were similar except a higher proportion of Low SPR...